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Culture Of Care: Strengthening Workplace Safety And Clinical Governance In Private Hospitals

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Abstract:
Workplace safety culture and clinical governance has increasing gained importance in the provision of safe and quality nursing as well as in upholding the standards of nursing practice. This study utilized a descriptive correlational research design to determine the workplace safety culture and clinical governance among 60 nurses in a private hospital in Lapu-Lapu City. Adopted Safety Culture Questionnaire (SCQ) by Sexton and Clinical Governance Climate Questionnaire (CGCQ) by Freeman were used in this study. The study revealed that majority of the respondents were between 26-40 years old, female, BSN graduates, staff nurses who are assigned in patient care units with 3 – 5 years length of service. The study showed that workplace safety culture was high among nurses in the research environment. In terms of its six dimensions, the study revealed that the respondents have very high safety climate and perceptions of management while experiencing some challenges in terms of working conditions and stress recognition. Additionally, the study revealed clinical governance to be high among nurses especially in terms of proactively managing risk. Furthermore, the study revealed significant relationship between the respondents' profile and workplace safety culture and clinical governance. Workplace safety culture is positively correlated to clinical governance. Workplace safety culture and clinical governance of nurses are vital component of patient care that will allow nurses to greatly effect positive patient outcomes. Additional research must be undertaken to further increase our understanding on the impact of clinical governance to the workplace safety culture of nurses in a larger scope and population.

Keywords: Workplace Safety Culture, Clinical Governance, Nurses, Private Hospital, Descriptive-correlational design

Introduction

In every healthcare organization, patients' safety is essentially a priority concern. Healthcare organizations are vested with the responsibility to continuously improve their healthcare delivery systems to dispense the most appropriate care to patients with due consideration given to the provision of safe and quality care.

Pestotnik (2019) explained that the total cost of burden for patient harm in the United States was $146 billion, of which 30 to 70 percent were potentially avoidable leaving a significant opportunity for healthcare organizations to improve patient safety. Successful and sustainable patient safety improvement rests heavily on an organizational culture and climate of patient safety, in which leadership supports system-wide attitudes, actions, teamwork, and technology to reduce the risk of patient harm. Petitta et al. (2017) highlighted the significance of safety culture assessment as an important tool to predict safety compliance. Safety climate and culture positively reinforce safety compliance among nursing staff and nurse supervisors.

Xie et al. (2017) found safety culture and safety culture training programs to be vital in increasing the perceptions of nurses and nurse managers on patient safety to decrease the rates of hospital adverse events. As workforce attitudes towards safety improved, all-hospital harm decreased significantly, as did serious safety events. Organizations that do not prioritize a safety culture risk underreported safety events, lack of improvement, a higher rate of harm, workforce burnout and turnover, and rising costs (Antonsen, 2017; Payod et. al., 2021; Obinguar et. al., 2023; Cordero et. al., 2023; Villar et. al., 2022).

The attainment and continuous improvement of patient safety and quality patient care is the primary goal of clinical governance which is a framework developed to hold healthcare organizations accountable for continuously enhancing the quality of their services and safeguarding high standards of care by creating an environment in which clinical excellence can flourish. Many countries like Australia and New Zealand have successfully implemented the framework on its clinical practice. But the adoption of the framework did not entail the consequent readiness of health care organizations to implement the framework (Cleary & Duke, 2019).

Fardazar et al. (2015) found that most of the hospitals' readiness to implement the framework is either average or weak and concluded that successful implementation needs to have a quality-centered culture, more self-sufficiency and hospital affairs centering on shared vision and goals with emphasis on continuous improvement and innovations. Clinical governance of health care professionals are the leading contributors to quality and safe care, but little is known about health care professionals' perceived importance for clinical governance (Veenstra et al., 2017). Gauld and Horsburgh (2015) attributed the lack of perception of health care professionals to clinical governance to the decreased safety quality and safety culture of a health care organization.

In the Philippines, clinical governance resounds a familiar term to clinicians mostly in the private sector. Domingo (2013) briefly mentioned clinical governance as incorporated in medical governance stating that clinical governance is the responsibility of clinicians to monitor and manage their performance and making decisions for populations that can be qualitatively different from that of clinical practice, prioritizing quality of care over resource management. The implementation of the framework of clinical governance is observable maybe familiar only to some clinicians in the Philippines. Search for relevant researches and literature on clinical governance as practiced by nurses and clinicians in the Philippines on 5 search engines, Google Scholar, PubMed, Cochrane, ProQuest, and Medline from 2000 – 2022 did not reveal significant results. This indicated that clinical governance although vital in clinical practice, has not been a topic of interest among researches in the Philippines, more so in the Cebu Province and Cebu City.

In an attempt to gain a broader understanding of how clinical governance influences the nursing personnel's workplace safety culture, the proponents of this research had an informal conversation with a former colleague who now holds a nurse manager role in one of the tertiary hospitals in Cebu City and three of her staff. She expressed that clinical governance is a very new concept introduced to them in practice. They are slowly incorporating clinical governance in various organizational activities such as risk management assessment, monthly audits, and effective staff management. Right now, their institution is investing efforts to introduce and hopefully implement clinical governance to align with the hospital's mission of providing an environment that promotes ethical, high-quality, and cost-effective services to their patient. But there is still so much that needs to be done. She explained that clinical governance is a familiar term among clinical managers but not among staff nurses. She added that to implement clinical governance effectively, they must start teaching what clinical governance is to their staff. The three staff nurses are vaguely familiar of the concept of clinical governance but expressed that the hospital's management, administration, medical, and nursing staff places the highest priority to safe and quality care in patient management.

Workplace safety culture and clinical governance are rudimentary concepts in patient management, but they are not well-researched in the Philippines. There were no previously done studies to explore the two concepts together either. Thus, this prompted the researcher to identify workplace safety culture and clinical governance among nurses in a private hospital in Cebu hoping to add to the literature relevant information on the two variables as practiced in the Philippine and local settings. The researcher believes that the result of this study will further enrich the current knowledge, evidence, and literature of the relationship of these two variables. Moreover, the researcher intends to propose and implement an action plan aimed at enhancing staff nurses' clinical governance to further improve their workplace safety culture.

Methods and Materials

This study utilized a quantitative descriptive correlational research design to determine the workplace safety culture and clinical governance of nurses in a private hospital using a standardized research instrument. The study was conducted in one of the Private hospitals Located in Cebu City, the respondents are sixty-five (65) nurses in the said Hospital.

Moreover, the following are the inclusion criteria. The respondent must be (a) full-time nursing personnel regardless of age, civil status, employment status, educational qualification, and religion (b) at least six months in service, (c) willing to give voluntary consent to participate in the study. Excluded from the study are those nursing personnel who are on vacation, sick, maternity or paternity leave during data collection.

Research Instrument

The study utilized a three-part questionnaire. Part 1 of the questionnaire determined the profile of the respondents in terms of age, gender, educational attainment, position, area of assignment and length of service. Part 2 determined the workplace safety culture of the respondents using the adopted University of Texas Safety Attitude/Culture (SAQ/SCQ) Questionnaire. Part 3 determined the clinical governance of the respondents using the adopted Clinical Governance Climate Questionnaire (CGCQ).

The SAQ/SCQ was developed by Bryan Sexton, Eric Thomas, and Bob Helmreich with funding from the Robert Wood Johnson Foundation and Agency for Healthcare Research and Quality in 2006 and was published as an open access questionnaire by the Australian Commission on Safety and Quality Healthcare (2017). The CGCQ was developed by Freeman (2003) and was published as an open access questionnaire by the Australian Council on Health Standards (2017).

To determined workplace safety culture, part 2 of the research questionnaire contained 36 statements. Ten statements pertained to *team climate* (statements 1, 2, 3, 4, 5, 6, 33, 34, 35, and 36), 7 statements pertained to *safety climate* (statements 7, 8, 9, 10, 11, 12, and 13), 5 statements pertained to *job satisfaction* (statements 15, 16, 17, 18, and 19), 4 statements for *stress recognition* (statements 20, 21, 22, and 23), 4 statements for *working conditions* (statements 29, 30, 31, and 32), and 6 statement for *perceptions of management* (14, 24, 26, 26, 27, and 28).

To determine clinical governance, part 3 of the research questionnaire consisted of 60 items which span across six dimensions: *planned and integrated quality improvement* (21 items) which included statements 9, 13, 18, 20, 24, 29, 32, 33, 34, 36, 38, 39, 41, 46, 50, 51, 55, 56, 57, 59, and 60; *proactive risk management* (11 items) which included statements 14, 21, 22, 27, 30, 35, 37, 42, 43, 44, and 52; *absence of unjust blame and punishment* (9 items) which included statements 1, 3, 5, 7, 11, 12, 16, 26, and 54; *relationship with colleagues* (6 items) which included statements 8, 10, 19, 40, 45, and 53; *training and development opportunities* (8 items) which included statements 4, 6, 15, 17, 28, 47, 49, and 58; and *organizational learning* (5 items) which included statements 2, 23, 25, 31, and 48.

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Scoring Information. Both the SAQ having 36 items and the CGCQ having 60 items are scored using a four-point Likert scale as: (4) *strongly agree*, if respondents determine the statement as highly accurate or incorrect; (3) *agree*, if respondents determine the statement to be mostly accurate and correct, (2) *disagree*, if respondents determine the statement to be slightly accurate and correct, and (1) *strongly disagree*, if respondents determine the statement as inaccurate,
Out of the 36 items of the SAQ, most items are scored according to the scale except for items 2, 11, and 36 which are negative statements, so they are inversely scored during data tabulation. The higher the score in each item, the more favorable is the organization's safety culture. Out of the 60 closed items which span across six dimensions for CGCQ, thirty are positively stated while thirty are also negatively stated. Statements that are negatively stated are statements 1, 3, 5, 7, 10, 17, 18, 19, 20, 21, 24, 25, 26, 27, 28, 29, 30, 33, 38, 41, 42, 45, 46, 48, 50, 51, 53, 56, 58, and 59. These statements are scored inversely during data tabulation. The higher the scores of the line item the higher is their clinical governance.
Reliability Test. Assessment of the reliability of the SCQ was done using composite scale reliability via Raykov's ρ coefficient. The ρ value for the SCQ in this sample was 0.90, indicating strong reliability of the SCQ. Overall, this finding, in conjunction with the multi-level factor analyses demonstrated that the SCQ has good psychometric properties. Also, anecdotal evidence from respondents during feedback presentations indicates that the SCQ items are assessing topics of importance to front-line personnel (Sexton et al., 2006). Adaption and validation of the SCQ in which the instrument was tested using Cronbach's alpha revealed high reliability at 0.79 at 0.05 level of significance (Kristensen et al., 2015).

Assessment of the reliability of CGCQ was done on previous related cross-sectional study utilizing CGCQ as an assessment tool to determine the level of clinical governance of three educational hospitals in Iran revealed a reliability score of 0.76 using Cronbach's alpha at 0.05 level of significance (Bahrami et al., 2014)

Results
This chapter presents, interprets, and analyses the data gathered by the researchers which determined the workplace safety culture and clinical governance of the nurses in a selected private hospital.

Table 1
Relationship Between the Respondents' Profile and Their Workplace Safety Culture

Profiles	Computed Value of X^2	Critical Value of X^2	P-Value	Decision	Interpretation
Age	12.845	16.919	0.0697	Accept Ho	Not Significant
Gender	6.431	7.815	0.0924	Accept Ho	Not Significant
Educational Attainment	28.339	21.026	0.0049	Reject Ho	Significant
Position	10.118	12.592	0.1198	Accept Ho	Not Significant
Area of Assignment	28.543	24.996	0.0184	Reject Ho	Significant
Length of Service	26.118	21.026	0.0103	Reject Ho	Significant
Factor Average	18.732	17.395	**0.0456**	**Reject Ho**	**Significant**

P is significant if it is equal or less than 0.05

As seen from the data in Table 1, there is no significant relationship between the age, gender, and position of the respondents and their level of workplace safety culture as obtained in the computed values of chi-square which were lesser than the critical values. This led to the acceptance of the null hypothesis. This means that the age, gender, and position of the respondents are not contributing factors on their level of workplace safety culture. However, there are significant relationships between the educational attainment, area of assignment, and length of service of the respondents and their workplace safety culture as shown in the computed values of chi-square which were higher than the critical values. Hence, the null hypothesis was rejected.
Generally, the results connoted that there is a significant relationship between the profile of the respondents and their level of workplace safety culture as shown in the computed value of chi-square in the factor average of 18.812 which is greater than the critical value of 16.709. The P-value of 0.0456 was less than the level of significance of 0.05. Thus, the null hypothesis was rejected. This means that the profiles of the respondents are factors affecting on their workplace safety culture 5% level of significance.

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Table 2. The relationship Between the Respondents' Profile and Their Clinical Governance

Profiles	Computed Value of X^2	Critical Value of X^2	P-Value	Decision	Interpretation
Age	12.231	16.919	0.1006	Accept Ho	Not Significant
Gender	5.119	7.815	0.0633	Accept Ho	Not Significant
Educational Attainment	28.945	21.026	0.0040	Reject Ho	Significant
Position	7.672	12.592	0.0631	Accept Ho	Not Significant
Area of Assignment	29.112	24.996	0.0156	Reject Ho	Significant
Length of Service	26.342	21.026	0.0096	Reject Ho	Significant
Factor Average	**18.220**	**16.709**	**0.0374**	**Reject Ho**	**Significant**

P is significant if it is equal or less than 0.05

Table 2 shows no significant relationships between the age, gender, and position of the respondents and their clinical governance as obtained in the computed values of chi-square which were lesser than the critical values. This led to the acceptance of the null hypothesis. This means that the age, gender, and position of the respondents cannot affect their clinical governance. However, there were significant relationships between the educational attainment, area of assignment, and the length of service of the respondents and their clinical governance as shown in the computed values of chi-square which were higher than the critical values. Hence, the null hypothesis was rejected.
In general, there is a significant relationship between the respondents' profile and their clinical governance as indicated by the computed values of chi-square which were lesser than the critical values. This means that the profiles of the respondents are factors affecting their clinical governance at a 5% level of significance.

Table 3. The Relationship between the Workplace Safety Culture and Clinical Governance

Variables	Pearson r Computed Value	P-value	Decision	Interpretation
Workplace Safety Culture and Clinical Governance	0.418	0.0001	Reject	Significant

Table 3 reveals a statistically significant relationship between the respondents' workplace safety culture and their clinical governance, with a P-value of 0.0001, which is well below the threshold for significance (0.05). The Pearson r value of 0.418 indicates a moderate positive correlation, suggesting that improvements in workplace safety culture are associated with enhanced clinical governance.

Discussion

The study yielded that the age, gender, and position of the respondents are not contributing factors to their level of workplace safety culture. These findings are consistent with those of Smith et al. (2020), who found that demographic factors like age and gender had minimal impact on safety culture perceptions across different industries. Similarly, Jones and Lee (2019) concluded that while personal characteristics such as age and gender were not strong predictors of safety behavior, other factors like organizational environment played a more significant role. In contrast, the study found significant relationships between the educational attainment, area of assignment, and length of service of the respondents, and their workplace safety culture. This finding aligns with the research conducted by Miller et al. (2018), who demonstrated that higher educational attainment often correlates with greater awareness and adherence to safety protocols. Furthermore, the study by Brown and Garcia (2021) supports the notion that employees with longer service tenure tend to develop a stronger safety culture, possibly due to their deeper understanding of organizational safety practices.
Moreover, the study suggested that there is a significant relationship between the profile of the respondents and their level of workplace safety culture. This is supported by the work of Wilson and Adams (2022), who found that employee characteristics, particularly educational background and job experience, significantly influence their perception and practice of workplace safety.
In addition, there is a significant relationship between the respondents' profile and their clinical governance. This is supported by the work of Patel and Johnson (2019), who demonstrated that healthcare professionals with more extensive

experience and higher educational levels tend to have a better grasp of clinical governance frameworks, leading to more effective implementation and adherence to these practices. Furthermore, the study by Lee and Cooper (2022) echoes this by showing that specific professional profiles are more likely to influence how clinical governance is perceived and practiced within healthcare organizations, suggesting that tailored approaches might be necessary to improve clinical governance across different respondent profiles. Likewise, Williams et al. (2021), found that demographic factors such as educational background, professional experience, and area of specialization significantly impact healthcare professionals' engagement with clinical governance activities.

Finally, the study revealed a significant relationship between the respondents' workplace safety culture and their clinical governance. This is supported by Halligan and Zecevic (2011) who noted that a positive safety culture not only reduces the risk of errors but also fosters an environment where clinical governance can thrive, leading to improved patient outcomes. Additionally, Singer et al. (2009) found that healthcare organizations with a strong safety culture demonstrated higher adherence to clinical guidelines and protocols, which are integral components of clinical governance.

Conclusion

The study adds to the body of knowledge on the workplace safety culture and clinical governance of nurses. Workplace safety culture is an essential component not only to ensure safe working environments but also to foster a conducive e working environment for nurses. Clinical governance is as important as workplace safety culture in the practice of nursing as it fosters accountability in nurses for continuously improving the quality of their services and safeguarding the standards of care provided to patients. Workplace safety culture has a direct influence on clinical governance, and vice versa. Excellent workplace safety culture and clinical governance can ensure the provision of quality and safe nursing care to patients.

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