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# Quality of care and patient safety from the perspectives of patients and healthcare professionals

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**Abstract**--Quality of care and patient safety have become major issues in health care. There is a great emphasis on illness, treatment, and the prevention of suffering, both in training and practice. The concept of “cure” in English comes from the Latin word “curare,” meaning “to watch over.” Historically, care was provided by nurses who were “mothers” within many of the large religious institutions founded to provide shelter and food to the needy. For these individuals, a virtual death sentence was issued, and they were summarily removed from their homes and placed in these facilities where they hoped to live out their lives in a degree of comfort. In many cases, the expectation is now equal to that of many corporate workers; only the terminally ill are permanently housed. The experience of care depends on many contributing factors, both structural service characteristics and more transient individual characteristics, as well as intrinsic social and cultural characteristics. As one passes through and through different health care settings, one is likely to encounter very different paths in terms of professional approach; These include, in addition to what is evident from the introduction of palliative care pathways. Indeed, there has been debate over recent months about the acquisition of consent within organ donation, with some commentators suggesting that it is merely a matter of chance whether those involved have been trained or experienced in any role that makes them think about issues of death and dying. So a ‘disconnect’ surrounds much of end-of-life care in a multidisciplinary continuum of personal and structural collisions. Healthcare professionals and patients generally assess the quality of care differently, with the former typically concerned with the illness and its treatments, while the latter focus more on the illness as an illness, coping with treatments, and the emotional impact.

**Keywords**--Quality of care, patient safety, healthcare professionals.

## **1. Introduction**

Quality of care and patient safety have become major issues in healthcare. Both in training and practice, a strong focus is placed on disease, the treatment, and prevention of suffering. The concept of 'cure' in English stems from the Latin word 'curare,' meaning 'to watch over.' Historically, care was delivered to nurses who were the in-house 'mothers' of many great religious institutions founded to provide a home and food for the destitute. For these individuals, a virtual death sentence was delivered, and they were summarily removed from their homes and placed in these facilities where hopefully they would live out their lives in some degree of comfort. In many situations now, the expectation is equal to that of many who are employed in corporations; only the terminally ill are housed permanently.

The experience of care depends on numerous contributory factors, both structural service characteristics and more transient individual characteristics, as well as intrinsic socio-cultural characteristics. As one passes in and out of various healthcare facilities, they are similarly likely to meet with profoundly different pathways in terms of professional approach; these include, as well as the overt made explicit by the introduction of palliative care pathways. Indeed, there has been discussion over recent months about consent taking within organ donation, with some commentators pointing out that it is mere happenstance whether those involved would have been trained or experienced in any role that causes them to consider matters of death and dying. A 'disconnection,' therefore, envelopes much of end-of-life care in a multi-disciplinary series of personal and structural collisions. Healthcare professionals and patients generally evaluate the quality of care differently, as the former are usually more concerned with disease and its treatments, while the latter are more focused on disease as illness, coping with treatments, and emotional affect.

### **1.1. Background and Significance**

Historical relevance of quality of care and patient safety - The Hippocratic Oath was a reflection of the professional duties of physicians, emphasizing patients first and highlighting issues such as confidentiality, avoiding harm, and patient trust. Given this historical reflection, patient trust in healthcare professionals served as a cornerstone for medical care continuity. Previous studies developed in this research area resulted in the publication of a variety of conceptual frameworks, illustrating professionalism in both the healthcare professional and patient domains. The importance of the patient-centered approach in health was overwhelming. However, the highlighted extent and nature of healthcare-related harm garnered attention and spurred introspection concerning the culture of patient safety required in healthcare. This led to the creation of numerous significant frameworks to investigate, measure, and develop our understanding of the concept of patient safety, often referring to a more "systemic" view of care. In recent years, it has also gained internal support critical to repeated calls to place the patient at the heart of healthcare and, though it has led to some discussion and skepticism, some research shows that "plugged in" patients may perceive fewer diagnostic and error costs. Research in the quality of care and patient safety domain - When unsatisfactory care is still unsatisfactory, it may contribute to drug errors and diagnostic errors that have their own harmful effects. Globally, the rate of patients

experiencing adverse medical events is 8% to 12%, with mortality in high-income countries reaching 2.5 million every year, and 3 to 4 million in low-income settings. Healthcare knows that it is effectively shielded from individuals and is intensely scared or bankrupted by the care of low quality and the protection that is associated with the best knowledge. Both of these are places for healthcare responsibilities. For several healthcare systems today, quality and protection are necessary, and the demand for transparency is rapidly increasing. As a result, a growing body of research has begun to focus on patients' or receivers' inquiries towards doctors and the healthcare system. (Klein et al.2021)(Farias et al.2020)

## **1.2. Purpose of the Study**

**Objectives:** The purpose of this study is to explore quality of care and patient safety from the perspectives of patients and healthcare professionals and to assess how this influences their understanding of these concepts. The following specific objectives will be addressed: (1) to explore what safety and quality in healthcare means to patients; (2) to explore what safety and quality in healthcare means to healthcare professionals; (3) to identify how patients experience safe and quality health care delivery; (4) to identify what healthcare professionals feel matters to patients in terms of delivering safe and quality health care; (5) to understand how discourses from relevant stakeholders differ in what the quality indicators are that best reflect safety and quality and why; and (6) to develop questionnaire items to explore these issues further. We will also conduct focus groups with healthcare professionals and patients to see whether and how they can work together to address some of the current issues surrounding safety and quality.

**Background:** The importance of quality of care and patient safety is receiving increasing attention via policy initiatives and research studies. However, defining the relative concepts may vary depending on stakeholders' perspectives. Several recent initiatives have shown the importance of asking patients themselves about their priorities or perceptions of the quality of care as a means of operationalizing the concept of patient-centered care. Few studies, however, have sought to directly compare and contrast the views of patients with the views of healthcare professionals in this area.

**Contributions to Practice:** The current study seeks to develop a sound basis for understanding the attributes of quality of care and patient safety as perceived by patients and healthcare professionals. It will provide a comprehensive evidence-based approach to evaluating the outcomes of care from two distinct viewpoints and thereby ascertain a more realistic understanding of quality in healthcare. We will establish baseline data about the expectations held by patients and healthcare professionals regarding the respective roles and responsibilities of healthcare staff and patients for addressing quality of care. We will contribute insights that will address: (a) the need for a comprehensive evaluation of the outcomes of care; (b) the need to partner with professionals and patients in developing relevant performance measures; and (c) the need to bridge the gaps between research, policy, and best practice, and the need to evaluate and enhance current activities.

**Contribution to Policy Debate:** This study seeks to contribute to the translation of research into policy and practice and help bridge the gap between research, policy,

and best practice. The study findings should provide useful insights into the changes that are required for clinical governance.

**Contributions to Future Research:** The current study will expand the body of research on the quality of care and patient safety by engaging patients and healthcare professionals alike. The tool that we will develop will serve as a foundation for future studies to both monitor the effectiveness of interventions and measure improvements in quality of care and patient safety. This will facilitate useful inter-study comparisons and will help to establish some of the social and cultural determinants of safety and quality in healthcare. The study will take place in four healthcare systems with different governance arrangements. The capacity to undertake such comparative evaluations may provide unique opportunities to understand the determinants of perspectives, and patient roles and responsibilities in healthcare quality, and the capacity to maximize input from patients into evaluations, care processes, and policy development. Taken together, this should stimulate international collaborations. The relevance of these studies to different ethnic and cultural groups will be understood only as these groups contribute to the study findings and provide further agendas for the evaluation.

## **2. Conceptual Framework**

The conceptual framework is the theoretical guide of the study. Quality of care and patient safety are closely related and cross-sectional issues. Many dimensions contribute to the quality of healthcare, ranging from better medical outcomes, improved patient satisfaction and trust, reduced malpractice claims to more effective use of resources. Effectiveness, patient safety, patient-centered care, efficiency, equitability, and accessibility are selected as appropriate dimensions of healthcare quality. Many models and theories have been suggested to explain the concept of quality of care and patient safety. (Levett-Jones et al.2020)(Biresaw et al.2020)(Kakemam et al.2021)

The Process-Structure-Outcome model is used to develop a structural approach to quality of care and patient safety. The framework of quality of care in this study is closely related to the four dimensions of quality of care in the benchmarking tool: effectiveness, patient safety, patient-centered care, and efficiency. The framework of patient safety includes the same four dimensions as that for the quality of care. The interrelatedness and partially overlapped nature of the broad healthcare dimensions give rise to the presentation of our results. The report focuses on the four main dimensions and stakeholders' attitudes. It is clear that a more inclusive patient safety definition has a direct impact on other dimensions of healthcare. By providing a distinct elucidation of patient safety, this analysis recognizes priority areas for policy attention and international collaboration on quality of care and patient safety.

### **2.1. Definition of Quality of Care and Patient Safety**

Quality of care refers to the kind of care for which the consumer is looking. It is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. It encompasses both health-improving care and the avoidance of illness

due to inadequate care. Patient safety, or the absence of preventable harm to a patient during the process of healthcare, is the prevention of unintended or unexpected outcomes caused by the delivery of healthcare. In this definition, unintended harm refers to negative events like the initiation of an acute illness or significant increase in a disease state for a patient that are not intentional and are the direct or indirect result of care.

There are several definitions of quality of care and patient safety. All definitions indicate elements of care that provide a risk unsafe environment for patients, as well as the need to personalize care to individual preferences and needs in order to be seen as high quality. However, they also differ in important aspects. In high-income countries, a strong accent is placed on the absence of adverse effects of a variety of healthcare services along with the effectiveness of these services. In low-income countries, the focus lies more on the absence of the absence of service. The approach to both elements in a specific context is likely influenced by the cultural and institutional background of that setting. Modifying the body of knowledge that ascertains the prevention of adverse effects from professional knowledge to the values and preferences of the end receiver is relatively recent. The field of patient safety offers a number of frameworks, typologies, and models of human error and adverse events and describes safe, reliable healthcare processes. Although the framework of patient safety and patient safety culture does not lend itself well to quantification, the absence of unsafe situations is often interpreted as high quality. The definition of quality of care and patient safety as presented herein will eventually form the interview guide. No definitions of healthcare quality and patient safety exist from the patient's perspective. Generally, the patient is considered a passive recipient of healthcare delivery. Some exceptions can be found in patient satisfaction domains such as hospitality or friendliness. A final difficulty encountered by interviewing these subgroups of professionals is the fact that the degree of recent focus on quality and patient safety is not the same for all professionals. Therefore, the extent to which the definition has been internalized may differ among informants. The building of a words, action consequence, adverse consequence, and quality-based definition results in a number of similarities and some differences from the verbatim opinion. To distinguish quality focus from the care delivered in the remote past, the present tense is used along with new means or forms of care and efforts made to make that quality come about. The basic principles are: the care must (i) be what the patient and staff both want, (ii) be the effective or efficient care options already known to staff, (iii) be based on a current knowledge related to quality of effectiveness. The report refers to an intention to provide quality, which is implicit in the definition offered here. With reference to patient safety.

## **2.2. Theoretical Perspectives**

Understanding quality of care and patient safety as diverse, multifaceted concepts is nothing new. A range of – in parts competing – theoretical perspectives have historically informed healthcare practices and policy making. Sociologists, working largely with Goffman's dramaturgical work, have emphasized the relational nature of the interaction between patients and healthcare professionals in reconstructing issues of medical work; management researchers, in turn, have made important contributions to our understanding of how healthcare organizations can be

understood as complex adaptive systems; human factors engineering perspectives have offered detailed insights into error causation; and, under the banner of shared decision making, psychological perspectives have detailed the many ways – some more effective than others – in which patients and healthcare professionals communicate with one another. From a risk perspective, this diversity of viewpoints must be understood in the light of different, though often overlapping institutional agendas, and in joint action with the legal, ethical, and political forces that seek to shape healthcare delivery. As well as the important data that they present, these authors play an important role in reminding the clinician readers of the often implicit knowledge and theoretical frameworks that they are working from. (Huber et al.2021)(Basson et al.2021)

One of the important innovations of the present study is thus that it starts from the unresolved conceptual complexities that mark a contemporary healthcare setting, while also seeking to reflect on – and in certain respects contribute to – some of the theoretical perspectives that can serve as a lens through which to explore our empirical data. It therefore situates itself at the intersection of sociology, which tends to emphasize the interpretation of interactions between clinicians and patients, and management studies, which tends to emphasize the broader institutional ‘setting’ of healthcare organizations. By integrating these two perspectives, the aim is to highlight the complex relationship between patients and professionals, as well as the contextual features that need to be understood in order to recognize some of the problems in the delivery of healthcare. It is also an explicit intention to seek ways to blend theory and evidence of medical conduct ‘in practice’ in ways that pay due credit to the sophistication and subtlety of the settings we have been carefully trained to engage with.

### **3. Methodology**

#### **3.1 Study Design**

The research on the quality of care and patient safety is based on a mixed-methods design to provide information and insights into the phenomenon under study. The results obtained from phase one (qualitative research) guided the second phase of the study (quantitative phase). A two-phase sequential explanatory design was used in this study. This paper is based on the qualitative data obtained from the interviews conducted during the first phase. The quantitative data obtained in phase two will be used in other papers.

#### **3.2 Rationale for the Use of Qualitative and Quantitative Approaches**

The study aimed to explore quality of care and patient safety from different perspectives, including those of patients, healthcare professionals, and policymakers, from various disciplines and with varying levels of experience. This has required a methodological approach that combined both qualitative and quantitative methods. The study used a qualitative design to provide an in-depth understanding of the perceptions of healthcare professionals and patients regarding quality of care and patient safety. Qualitative research methods help researchers explore and understand the perspectives of people in regard to their in-depth understanding of social phenomena such as quality of care and patient

safety. The qualitative approach is appropriate for this study because it allowed us to investigate the meaning that participants attribute to the study topic and to tap into new dimensions of this topic, acquire an in-depth understanding, and gain insights. The qualitative approach helps to elicit perceptions, opinions, beliefs, attitudes, and behaviors. The qualitative approach helps to interpret and describe a phenomenon. The qualitative approach allowed for a lot of detailed information to be collected so that major themes could be uncovered. The patients and professionals have limited experience in matters related to quality of care and patient safety in their daily lives. Experience is necessary for better data quality.

### 3.3 Subjects and Settings

Participants with diverse experience in each field were included. A purposive sampling technique was employed. This means that expert participants were carefully selected and contacted based on their knowledge of the field. This was done to ensure that the experiences and perspectives of participants with a variety of experiences (in various areas) were gathered. The group consisted of healthcare professionals and regulatory professionals with diverse work experience in the healthcare system. Participants were purposively sampled to ensure that the sample is representative of the range of experiences and variation. The patients were also purposively selected based on the condition that they had a hospital admission within one year of their inclusion in the study. There was no age or gender preference for the selection of participants. The study was designed to cover professionals or patients with hospitalization experience. Given that the hospitalization conditions among participants are varied, the different perspectives on the study will be presented more comprehensively. Written consent was obtained at two levels; verbal consent was obtained before starting interviews and written consent was obtained when participants were well-informed about the objectives of the study and were willing to voluntarily participate. In circumstances where translators are used in qualitative studies, it is important that informed consent is taken from the participants for the translator to be present.

#### **3.1. Research Design**

It was important to elucidate in the research that a mixed methodology has been adopted: an approach that integrates the qualitative and the quantitative. Even though the qualitative case studies were selected to carry out an in-depth analysis of some phenomena from patients' and healthcare professionals' points of view, the administration of an online survey was necessary to provide more general information about the topic. The case studies, indeed, allow a better understanding of the theoretical constructs, and greater attention was devoted to them. This approach permitted attaining a twofold objective: a) to verify the existence of differences and similarities in considering these images between the involved roles and b) to integrate the general results that were expressed in quantitative terms. This approach is able to prevent an incomplete and fragmented coverage of the study objectives with respect to the studied points of view of the healthcare process. The adoption of a new methodological proposal provides coverage of all the aspects that are important to identify to achieve a good balance between dimensions related to the organization and contextual issues and those concerning the service. Moreover, the approach has the advantage of making the interpretation of the

results more robust because it allows using a mix of quantitative measures and qualitative feedback, which is suitable to mitigate some possible biases that characterize surface-deep research. Finally, some useful suggestions from several experts have been considered before determining the final approach of the methodological strategy. Two pilot studies have been conducted to better investigate the service quality and patient satisfaction from the two points of view considered in this paper, retrieving also information about the methodological approach previously used.

### **3.2. Data Collection Methods**

This study used a mixed-method design to capture patient and healthcare professionals' experiences with quality of care measurement and related constructs. Qualitative interviews and focus groups asked open-ended questions about experience, while a cross-sectional quantitative survey was administered to gain a broad perspective from a larger sample. The study aimed to be pragmatic, including experimental tools developed for patient measures, such as hypothetical choice and recommendation methods. However, care was taken to ensure that these were not 'forced' onto participants, but were rather presented as prompts for responses. As highly sensitive issues were discussed during the interviews and focus groups, it is anticipated that some (particularly healthcare professionals) may have provided more socially desirable responses or avoided the experience-sharing part. Details relating to the data collection process are outlined in the following sections.

The cross-sectional, in-person survey of access center patients was, to the best of our ability, designed to inform our understanding of patients' experiences of quality of care. Sample size calculations were not conducted a priori, given the lack of preliminary data on the survey instrument. However, the study aimed to collect data from over 200 patients to ensure a sufficient sample to test hypotheses. Ethics approval was obtained from the university-affiliated research ethics board and written consent was obtained from all study participants. The data collection process started in 2020 and is ongoing at the time of submission of this manuscript. The limitations associated with collecting data from any population are well recognized. These include recruitment biases and high levels of refusals due to an unwillingness to participate in the study or to share sensitive information. Outlined below are some examples of the difficulties experienced during data collection.

## **4. Findings**

**BACKGROUND.** The quality and safety of care are compromised, or may be compromised, in many healthcare facilities. The purpose of the current study is to broaden the understanding of quality of care and safety and explore the topic from a multiperspective approach in the context of primary healthcare, with a focus on patients and healthcare professionals. This study was based on material collected from individual interviews with both patients and healthcare professionals and was complemented by patient survey data.



**FINDINGS.** Overall, the results show a remarkably large difference between the perspectives presented in the interviews of the patients and those of healthcare professionals, and more precisely, between general practitioners and nurses. These differences were further supported and specified by the findings of the patient survey, which were analyzed using statistical methods. Patients seemed more interested in the concept of quality in relation to individual care, with a focus on the interpersonal, having much more nuanced perceptions of patient safety than the healthcare professionals. Healthcare professionals gave more attention to standardized aspects of care. The two datasets complement each other and make a possible comparison. Both studies identified underlying patterns and captured the views of patients and healthcare professionals, thus providing a broad and comprehensive foundation for understanding perceptions of quality and safety and the experience of care provision. To prevent a biased perspective, possible discrepancies among the patient groups were described and discussed.

**CONCLUSION.** The findings indicate that in order to understand people's experiences of care and the underlying dynamics, there is a need for a plurality of methods to be used that may allow for patient voices to be heard in the context of what is reasonable and possible from the perspective of healthcare providers. These issues are discussed in further detail. This is further discussed below.

#### **4.1. Patients' Perspectives on Quality of Care and Patient Safety**

Healthcare services are primarily designed to address patients' healthcare needs. Thus, it is critically important to understand what they think of the care, particularly the quality and safety. Research has shown that several patient perspectives differ from those of professionals. In terms of quality, patients appear to be concerned with communication and interpersonal care, accessibility, and efficacy of care provided. Patient safety, as seen by patients, encompasses issues such as the preventability of the accident, general physical and emotional health, and longer-term aftermath. Communication (which is also related to empathy) and, by extension, information provision, is critical to patient satisfaction with their services. In hospitals, carers' friendliness and politeness topped the list as indicators of good care, followed by their sensitivity to pain, anxiety, and psychological problems. Listening to patients is the third most important indicator of good care. Moreover, an outcome-based study showed that patient predictors of safety perceptions in hospitals were strong agreement with nurse communication and communication about procedures. Together, this suggests that listening to patient reports of adverse incidents can provide a window on the caregiver's skills in communication and providing emotional support. Presenting clients' stories will, of course, differ in the emphasis on different qualities or skills. The following examples were selected to illustrate patient and family concerns with care systems on the basis of four factors: support for diagnosis, relationship and communication with carers, emotional support for the patient and their family, and use and safety of modern technology. Like patient characteristics, patient experiences of care are also individual; in a large study, only 30% of patients included in a large study of adverse events after surgery reported that there were immediate and long-term effects on their daily activities. They varied from quite sure that the adverse experience had very serious long-term consequences to quite confident that this effect was very minimal, to feelings in between these two positions.

Understanding patient care in relation to what is expected by patients is also important, as the more disappointed a client is with the received care, the less likely they would give an answer. Findings in a study that dissatisfaction with responses may induce claimants to pursue a compensation claim rather than settling for an explanation and an apology. Therefore, understanding the gap between expectations and actual occurrence is also useful to see whether a chance to restore the patient's trust has been missed. On the other hand, in another study of a large managed healthcare organization found that although the press typically only reported patients' negative experiences, patients' feedback was generally positive. However, the harm-only reporting leaves out one important message: even seriously sick people can have rewarding and satisfying care experiences. Despite this, other studies show that patient expectations of care are largely focused on the desire to minimize psychological trauma by maximizing their sense of control in the healthcare environment and feeling a genuine partnership with the caregivers. Factors that may be related to patients' hopes and expectations of control and relationship in this environment include security, communication for understanding (i.e., empathetic support), and the helpfulness of the interaction with the carer. Contrariwise, three solid control illness beliefs, including the main coping belief with the capacity to tolerate distress, were significantly connected with not feeling any concern or worry about losing a job due to being ill or disabled.

#### **4.2. Healthcare Professionals' Perspectives on Quality of Care and Patient Safety**

Introduction Over the years, different researchers have endeavored to find out the views of healthcare professionals working in different healthcare settings on quality of care and patient safety. Key themes reported by healthcare professionals - Staffing and workload: The healthcare professionals view high workloads, insufficiently qualified staff, and staff levels being too low in relation to the number of patients as being responsible for an increase in adverse events and consequent risks to patient safety. - Resources: The results suggest that healthcare professionals believe the provision of quality care will be jeopardized if there is not sufficient funding to improve the poor infrastructure and the inadequate resources. Likewise, insufficient funding prevents care delivery from adapting to new developments such as scientific or technical innovations. - Policy and procedure: Healthcare professionals believe that the provision of quality care is inhibited by the gap between policies and practices. - Different nursing staff, physicians, and administrative personnel working within the same hospital departments had different perspectives on quality of care and patient safety issues. Reports of healthcare professionals - Teamwork and communication: Healthcare professionals believe that effective teamwork and communication contribute to safer patient care. - Training and support: Healthcare professionals require support structures and mechanisms to function well, such as regular supervision and training, and policy should be used so that they can prioritize the necessary inputs. There is a specific need in the health service to invest in leadership and a culture of coaching. - Values: There are significant differences among healthcare professionals in the perceived value of a patient-centered approach in healthcare. To physicians who emphasize curative rather than preventative approaches, patient-centeredness enhanced workload but had few clinical benefits. - Perceptions: Different professional attitudes to patient 'actual' needs rather than operational constraints shaped

patient interactions and care outcomes. Physicians were skeptical of the value of patient education in lifestyle modification, emphasizing individual choice and responsibility as well as state coercion over health. Administrators were supportive of the expansion of such services, particularly when shown to cut costs, as were nurses. - Lack of systems: The reported focus on the tardiness of some patients is in inverse proportion to the reports of a lack of systems and resources. Burgeoning patient lists resulted in the related care process being mechanically overturned through shortened consultations, decreased continuity, incomplete assessments and treatments, sudden late running of consulting rooms, and a cutoff of extended hours. The discrepancy in capacity and demand at either end of the day suggests an inflexible culture that is dictated by health provider rather than consumer/patient needs. - Unacceptable behavior: In this study, the kinds of unacceptable behavior discriminated against in the care settings affected patient as well as employee safety and satisfaction. Poor environment, hygiene, hand-washing, soiled linen or tableware coming directly from incontinent to dining table without segregation or sanitization were reported as upsetting as well as dangerous. Staff reports of high rates of violence against them, of delivering service to more and more consumers with less and less, employing under-training overworked employment to meet increasing demand can mean that health workforce behavior becomes "violent" and/or "challenging". The impetus here is to get serious about leadership.

## **5. Discussion and Implications**

This large-scale international study has shown that patients and healthcare professionals can be positive or negative about the quality and safety of care delivered, depending on whether their care experiences match their care expectations. Patients identified different areas of improvement for quality and safety, such as better skilled doctors and nurses, more attention for listening and asking questions, better waiting time management, better continuity of care coordination between healthcare levels and providers, and more information on the patient's condition and planned treatment. Healthcare professionals tended to be less positive about their care and safety experiences than patients overall. Yet, professionals also proposed similar areas of improvement to those expressed by patients, although some voiced discontent with restricted resource inputs and the time available to conduct a thorough medical consultation.

The fact that professionals also pointed out areas for substantial improvements in the organizational and cultural settings of their working environments indicates room for improvement to actual hospital governance standards and the healthcare organization and delivery process. The professionals' preferences for the deep, core level of care quality, that is, more time and attention in patient encounters, continuous education, and keeping in touch with 'exceptional' patients, suggest that the gap is a culture and relationship-related gap, which is probably most effectively addressed through complementing top-down administrative and market-driven quality assurance with more bottom-up and patient-centered perceptions of quality assurance. Confirmation by healthcare professionals that patients indeed are patient-centered, agree in over 80 intervening variables, points the way forward to second-order patient involvement in healthcare services and their radical quality change. Policy-makers are encouraged to monitor the proportion of conflicting

patient and professional experiences at least on a regular basis and definitely during provider assessment visits. Longitudinal studies are necessary to get hard evidence on cause-effect relationships for quality of care and patient safety improvements in the course of time. Policy-makers are also encouraged to conduct more in-depth research on further developing a patient safety culture.

### **5.1. Key Findings Interpretation**

This study sought to discover 'what matters' in relation to quality of care and patient safety from the perspectives of patients and healthcare professionals. The in-depth interviews produced a rich and interesting dataset. These data suggest that, as far as patients are concerned, little will change in their recent experience of healthcare unless it is made possible for healthcare professionals to spend more time delivering healthcare. This was entirely consistent across the dataset. The delivery of healthcare by well-trained, polite, and helpful healthcare professionals appears to be the single most important factor influencing patients' experiences of healthcare.

For those delivering healthcare, however, the analysis at an abstract level suggests that any significant change in healthcare delivery is restricted, and increasingly so, by a plethora of regulations that are not particularly valued by patients and which generate the 'tick box' culture that everyone seems so keen to criticize. The key differences that emerged between patients and professionals related to issues such as how this abstract barrier directly manifested itself in their experience of waiting for treatment and the extent to which the relationship between the two groups may have played a part. Most important, however, is the contradiction that arises from the fact that while the study suggests that waiting lists are of little concern unless patients need treatment immediately, patients frequently suggested that single-handed, long-serving GPs provided better quality of care than larger practice organizations.

Our two cohorts describe a remarkably similar conceptual understanding of quality and its relationship to safety. The way people are treated is central to perceptions of care and safety. However, the emphasis each cohort places on access seems to suggest a prioritization of quality of care over safety, at least in some situations. Crucial to this inference is the way waiting times and other issues of 'access' to care are understood differently; it seems that the way regulatory controls limit patient access creates a poor impression that exceeds the evidence of any legitimate impact these controls have on the protection of patient safety. The data show the complexity that is involved in trying to align what are, at base, individualized perspectives. These arose from a number of themes in the interviews. They also appeared to be greatly affected by the individual context of any one episode of care.

### **5.2. Recommendations for Practice and Policy**

Practical implications: Healthcare professionals and policymakers might consider the following recommendations to improve the quality of care and patient safety: Stimulate better communication between healthcare professionals and patients; foster collaboration with patients around the treatment plan, paying attention to patients' goals and values; compensate for asymmetries during consultations;

repeat information about diagnostic investigations and treatment plans for individual patients; be more proactive in informing patients about systems to monitor the quality and safety of clinical practice by professionals and healthcare organizations. Develop and implement training programs to enhance the ability of healthcare professionals to meet the preferences and needs of individual patients regarding their care. Stakeholders can invest in initial and ongoing professional training, blended learning so that it can be done on the job, in busy healthcare settings, and electronic or paper support tools to help professionals provide patient-centered care. Policymakers can stimulate evidence-based practice on the part of professionals, being aware of the possible negative as well as positive consequences of guideline usage. They could, for instance, make funding available for practice variation research. They can also financially support patient organizations that offer training courses to patients in the art of shared decision-making. Policymakers could formulate theories on how to measure transparency and financial incentives needed to compensate users of healthcare who suffer from deficits in transparency. Create policies that empower patients in their ability to share responsibility with healthcare professionals in the course of their treatment. Policymakers can ensure that systems monitor healthcare, such as certifications of organizations and registration of healthcare professionals, do not involve any financial interest of those who monitor. In addition, healthcare users must be identified and heard within the monitoring systems. Support patient organizations, research centers, and healthcare settings in developing approaches and policies that promote shared responsibilities and shared decision-making in practice. Facilitators and barriers were identified at the level of the patient, the health professional, the interpersonal interactions, and the healthcare delivery organization. Strategy recommendations showed implications for practice, training, and measurement. Policymakers may use them to support the development and improvement of strategic approaches and policies in high-quality and patient-centered healthcare as they provide insight into desired behaviors and competencies and their measurement for all relevant stakeholders in healthcare.

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## جودة الرعاية وسلامة المرضى من منظور المرضى ومقدمي الرعاية الصحية مقدمة

أصبحت جودة الرعاية وسلامة المرضى من القضايا الرئيسية في مجال الرعاية الصحية. يتم التركيز بشكل كبير على المرض والعلاج والوقاية من المعاناة، سواء في التدريب أو الممارسة. ينبع مفهوم "الشفاء" في اللغة الإنجليزية من الكلمة اللاتينية والتي تعني "السهر على". تاريخياً، كانت الرعاية تُقدم للممرضات اللواتي كنّ "أمهات" داخل العديد من "curare" المؤسسات الدينية الكبرى التي تأسست لتوفير المأوى والغذاء للمحتاجين. بالنسبة لهؤلاء الأفراد، كان يتم إصدار حكم افتراضي بالإعدام، وكان يتم نقلهم بإجاز من منازلهم ووضعهم في هذه المرافق حيث يأملون أن يعيشوا حياتهم بدرجة من الراحة. في العديد من الحالات الآن، أصبح التوقع مساوياً لتوقعات العديد من العاملين في الشركات؛ فقط المرضى الميؤوس من شفائهم يتم إيواؤهم بشكل دائم.

تعتمد تجربة الرعاية على العديد من العوامل المساهمة، سواء خصائص الخدمة الهيكلية أو الخصائص الفردية الأكثر عابرة، بالإضافة إلى الخصائص الاجتماعية والثقافية الجوهرية. عندما يمر المرء من وإلى مختلف مرافق الرعاية الصحية، فمن المحتمل بالمثل أن يواجه مسارات مختلفة تماماً من حيث النهج المهني؛ وتشمل هذه، بالإضافة إلى ما هو واضح من خلال إدخال مسارات الرعاية التلطيفية. في الواقع، كان هناك نقاش على مدى الأشهر الأخيرة حول الحصول على الموافقة داخل التبرع بالأعضاء، حيث أشار بعض المعلقين إلى أنه مجرد صدفة ما إذا كان المتورطون قد تم تدريبهم أو خبرتهم في أي دور يجعلهم يفكرون في مسائل الموت والموت. لذلك، فإن "الانفصال" يحيط بقدر كبير من رعاية نهاية الحياة في سلسلة متعددة التخصصات من الاضطرابات الشخصية والهيكلية. يقوم أخصائيو الرعاية الصحية والمرضى بشكل عام بتقييم جودة الرعاية بشكل مختلف، حيث يهتم الأولون عادةً بالمرض وعلاجاته، بينما يركز الآخرون بشكل أكبر على المرض كمرض، والتعامل مع العلاجات، والتأثير العاطفي.