Perceptions of Nurse Managers on Patient Safety Culture and Safety Culture Maturity Level of Selected Internationally Accredited Hospitals in Metro Manila, Philippines

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Abstract - *Patient safety is a global issue which lead to patient harm and can be attributed to the culture of the organization. Thus, as a researcher and clinical staff I would like to determine the perception of nurse managers onthe culture of patient safety in selected internationally-accreditedhospitals in Metro Manila, Philippines. In addition, also explored the safety culture maturity levels of study participants. The goal is to propose a framework forr sustainable safety practices in organization. Mixed method research design was utilized to 261 respondents that were conveniently selected. An open-access, validated standardized questionnaire for Patient Safety Culture was adopted from the Hospital Survey for Culture of Safety of Agency of Health Research and Quality (AHRQ) and from the Safety Culture Maturity Model of Fleming.*

Improvements in specific areas of patient safety practices are needed, particularly instaffing, communication openness and hand -off and transition which had an impact to the clinical outcome. Furthermore, the selectedinternationally-accredited hospitalorganizations vary in terms of their safety maturity level which they are in the managing level which characterized by reactive in dealing with an incident or event I the organization.

The Morales' Model for Sustained Safety Practices for Reliable Care had been the outcome of this research. This could be a guide for progressive hospital organizationthat is essential in enhancing patient safety and sustaining quality service. Hospitaladministrators are essential in building aculture of safety and resilience into workflows and patient care processes enablinghealthcare organizations to progress toward high reliability. Communication across the organization is vital in sustaining a safe and quality environment a long side with proper human resource management which entails proper staffing ratio and trained staff. One of the vital foundations of matured organization is the established processes which based on evidence and gearing towards risk based approach. Aligning patient safetyand safety culture maturity, when coupled with effective leadership, can provide along-term approach for quality care.

Keywords: *patient safety culture; safety culture maturity; patient safety*

INTRODUCTION

Patient safety is a serious global public health concern. Similar to one in a million chances of a person being harmed while travelling by plane. In health care, there is a 1 in 300 chance of a patient being harmed during confinement. Industries with a perceived higher risk such as in aviation and nuclear industries have a much better safety record than health care. It is essential for every health care institution to develop and institutionalize a culture of patient safety among all staff involved in health care delivery because of its impact on patient care outcomes [1].

A well-grounded culture on patient safety affects clinical outcomes, the safety of healthcare providers, the financial capacity of the organization and the satisfaction of patients and the employees. Based on clinical outcomes the contributing factor related to patient safety in developing countries; there is a huge gap in knowledge, because the metrics used to evaluate these clinical outcomes are focused on the risk of patient infection in healthcare delivery, medications errors/use, the quality and provision of maternal and perinatal care, and the quality of healthcare provision overall[2]. Patient safety affects clinical outcomes alongside with the financial aspect of the healthcare deliver enterprise. This reality puts heavy burden on out-of-pocket patients as much as the health care institutions they serve. Based on the research

observation, one adverse event (fall with injury) could cause financial burden for the organization, increasing length of stay due to another clinical problem which might lead to another possible nosocomial infection.

Promoting a culture of safety in clinical practice includes a broad range of interventions rooted in principles of promoting leadership, creating effective teamwork, and behavior change rather than a single specific process, team, or technology. Developing a culture of safety is a core element of many efforts to improve patient safety and the quality of care.Accreditation identifies leadership standards for safety culture measurement and improvement, and promoting a culture of safety as designated by the National Patient Safety Foundation Safe Practice and the Agency for Healthcare Research and Quality (AHRQ) Patient Safety Net [3]

The safetyculture has its factors including transparent report culture, teamwork culture, commitment to organizational learning, effective communication and management support which sustain and strengthen the safety culture of the organization. This will be affected by human factors, managerial systems and strategies and communication system and strategies. In the organizational level the safety culture could be affected by the organizational and environmental factors. In a national and global level these factors should also be considered political, social and economic factors which lead to a different safety culture outcome [4]. The model of safety culture maturity model was also used by the researcher .This model depicts the organizational maturity level from emerging which focuses of developing management and commitment, managing level which realize the importance of frontline staff and develop personal responsibility, involving level which show an well engaged staff to develop cooperation and commitment to improving safety, cooperating level which develop consistency and fight complacency and last is continually improving which there had been proactiveness and risk based approach of leading. Through the different level of maturity level there is a directly affecting the safety culture of the organization.

This research paradigm shows the interaction of the variables with the demographic variables includes the age, sex, educational attainment, and length of service of the nurse managers. These variables will be correlated to their safety practices and safety culture maturity level respectively towards a sustained reliable care. The researcher wants to prove the relationship of the demographic profile against their safety practices and demographic profile on their safety culture maturity level which could be beneficial in the creation of a sustained reliable care in an internationally accredited healthcare organization.

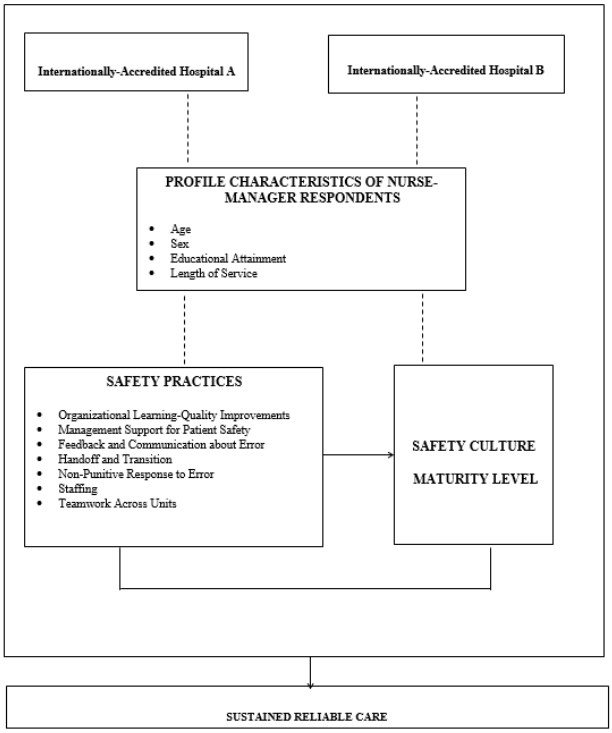

Figure 1. Research Paradigm

This research examines the safety practices and culture maturity in internationally accredited hospitals in Metro Manila, Philippines, through analysis of hospitals‘ strength and areas for patient safety culture improvement, as well as areas that further require enhancement for safe reliable care.This figure 3 compared the 2 healthcare institution based on their demographic profile (age, sex, educational attainment and length of service), correlate in in each safety practices and compared it to their safety culture maturity level towards sustained reliable care. This study is significant in the healthcare leadership to create a program that is focus on their organizational weakness which could improve their safety culture maturity level. Moreover, it is beneficial to the academic institution which could improve curricula on healthcare delivery systems, based on identified gaps from safety practices.

METHODS

Research Design. Triangulation Design, a mixed method technique, was used in this study. The purpose

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of this design is to obtain complimentary results from quantitative findings to better understand the research problem [6].

Participants. Study participants were nurse managers regardless of their position and area of deployment. The quantitative part of this research had been 261participants who participated in the survey questions. With 130 in hospital A and 131 in hospital B respectively. For the qualitative portion of the research there had been 55 respondents, (30 in hospital A and 25 in hospital B).

Instrument. The research instrument is comprised of four parts. First part included the profile characteristics of the respondents (age, sex, educational attainment and length of service). Second part referred to an open access, validated standardized questionnaire for patient safety culture designed for hospitals by the AHRQ. The questionnaire used 5-point Likert scale and written in an interrogative manner with domains in: organizational learning - quality improvements; management support for patient safety; feedback and communication about error; communication openness; handoff and transition; non-punitive response to error; staffing; and teamwork across units.

Third part of this research instrument included the Safety Culture Maturity Level tool which was a researcher-made questionnaire based on the Safety Culture Model of Fleming. The tool was validated by three experts on the field of quality management (manager for patient safety, manager for risk management, university professor). The safety culture maturity level, also on 5-point Likert scale, was categorized as: level 1 emerging, level 2, managing, level 3 involving, level 4 cooperating and level 5 continually improving. To test the validity, it was pilot-tested for 30 nurses which were excluded in the actual data gathering. After pilot testing, test validity has yielded 0.81 Cronbach alpha.

Study Procedures. Upon approval of the research outline from the Ethics Board of the Trinity University of Asia, permission was secured from the target research locales. Informed consent was initially obtained from the qualified respondents prior to the distribution of the questionnaires. Voluntary participation was ensured among the respondents. The researcher personally administered floating of questioners to answer any clarification regarding the study. The respondents took approximately 15 minutes to accomplish the questionnaires. After the respondents had accomplished the survey, the researcher double checked the completeness of the survey questionnaires for them to be viable for statistical analysis.

Quantitative procedures. The researcher collated the data manually and check for incompleteness of the questionnaire. Then the researcher tallied the responses and validated the answers of the participants. Then submitted to the statistician for computation and initial analysis of data with the references. Then it had been validated based on the hypothesis identified.

Statistical Analyses. Measures of central tendencies had been used for the demographic profile. For the quantitative data, correlations and comparisons between Safety Practices and Safety Culture Maturity level were conducted using ANOVA. Parametric method of statistical analysis with the p value of .05.

Qualitative Procedures. The researcher collated the response from the open-ended question from the survey. It was arranged based on the commonalities. It has been reviewed for emerging of themes and associated meaning. The researcher also removed the unnecessary response that is not in line with the research objectives.

The qualitative data identified themes from the open-ended questions. The use of Collaizi's method of identifying themes had been used, wherein, the statements had been placed in common themes and associated meaning had been identified. This had been validated to some of the participants.

Ethical considerations. This study was approved by the Trinity University of Asia Ethics board following the Data Privacy Law. The study had been conducted to two internationally accredited hospitals in Metro Manila, Philippines. Informed consent was obtained prior to implementing the study procedures.

RESULTS

Majority (>50%) of study participants were middle aged, females, with Bachelor's degree in Nursing, and with under 10 years in service (Table1). Demographic profile affects safety culture and practices. In terms of age of the nurse managers participants they are in the middle age which comprise majority is the millennial group which have the characteristics of autonomy and they are goal-driven and impulsive in nature which tends to have superficial decision making skills. In terms of sex distribution, which nurses had been associated with female roles which had been observed based on this research (> 70 %) had the position of managerial in theory institution. Females have an innate characteristic of a caring attitude.

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Table 1. Summary of the Demographic Profile of the respondents

		Hospital A		Hospital B	
		Frequency	**Percentage**	**Frequency**	**Percentage**
Age	under 30 years old	55	42.3	80	**61.1**
	31-40 years old	68	**52.3**	46	35.1
	41-50 years old	5	3.8	5	3.8
	51-60 years old	2	1.5	0	0
Sex	Male	38	29.2	40	30.5
	Female	92	**70.8**	91	**69.5**
Educational Attainment	Bachelor of Science in Nursing	117	**90.0**	103	**78.6**
	Master's degree	12	9.2	25	19.1
	Doctorate degree	1	.8	3	2.3
Length of Service	under 1 year	22	16.9	5	3.8
	1- 5 years	34	26.2	56	**42.7**
	6 - 10years	67	**51.5**	53	40.5
	11-15 years	6	4.6	17	13.0
	16-20 years	1	.8	0	0

In terms of the educational attainment majority is a graduate of bachelor's degree (> 79 %) which not in accordance with the RA 9173 which stipulated that nurse's manager position should at least have units of master's degree. This could be contributing factor which affects the culture of safety of the organization. In terms of length of service majority of the respondents were with under 10 years of experience (>40 %). this could pose a positive or negative effect to the culture of safety. Based on research the tenureship could create a lax culture and they tend to be comfortable which lead to reactive reaction rather than proactive and risk-based approach.

Based on Table 2, this is the interpretation, in terms of Sstaffing**,** Hospital A had an overall mean score of 1.82 verbally interpreted as fair; and Hospital B had an overall mean score of 1.79 verbally interpreted as poor. This had been supported by the identified theme of depleting quality care with associated meaning of unsafe patient ratio as verbalized by the respondents ―*the safety of the patient is compromised in POS because of understaff*‖. it clearly depicts that in the perception of the staff there is a direct effect of the declining of manpower in any unit of the hospital to the safety and quality of service. This solidify the claim that proper staffing ratio delivers appropriate and acceptable care to the patients. The healthcare organizations variances and errors can be attributed based on the study of De Castro, AB et Al. (2009) the issues of the healthcare workers in the Philippines were the following : greater than one third worked 1 to 2 episodes of mandatory or unplanned overtime monthly and reported 1to 16 hours overtime per month, 30 % had other jobs in addition to their main nursing job, more than half worked 41 to 60 hours per week , 30 % of Filipino nurses reported that they felt either somewhat safe or not safe at all where they work as a nurse.

In terms of the patient safety practices all of the components were in a good to very good both Hospital A and B however In terms ofcommunication openness, Hospital A had an overall mean score of 2.53 verbally interpreted as fair while Hospital B had an overall mean score of 2.67 verbally interpreted as good. Open communication practice is not common in Filipino culture due to the hierarchy of professionals from physicians, nurses , nursing attendants there had been a gap of practices which contribute to following orders without question however as a globally competitive healthcare practitioner , we should be the advocate of the patient through inquiry of orders, clarifications and others. This can be supported with the narration of the respondents ―*Every patient involved in accidents or any harm should be reported to the heads and should submit a letter for the awareness of all.* On the contrary, one of the identified theme was effective communication with associated meaning of clear communication as verbalized by the respondents *"surgical patients are clearly informed of the risks and adverse of the procedures*‖ The gap of this results from the numerical interpretation was based on the context and content of the communication and information delivered. There can be a clear communication if it is informing the patient, discussion of the illness and health education but if it is clarification there was a difference such as the identified lowest score item.

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Table 2. Summary of Mean and Verbal Interpretation of the Assessment of Nurse-Respondents on Their Safety Culture Components

Safety Practices	Hospital A		Hospital B	
	Mean	**Verbal Interpretation**	**Mean**	**Verbal Interpretation**
1. Organizational Learning- quality improvements	3.42	Agree	3.42	Agree
2. Management support for patient safety	4.58	Strongly Agree	4.40	Strongly Agree
3. Feedback and Communication about errors	3.73	Agree	3.71	Agree
4. Communication openness	2.53	Disagree	2.67	Agree
5. Teamwork across the units	3.49	Agree	3.50	Agree
6. Staffing	1.82	Disagree	1.79	Disagree
7. Handoff and Transitions	2.79	Neither	2.94	Neither
8. Non- punitive response to error	4.29	Strongly Agree	4.26	Strongly Agree
Overall Mean	**3.41**	**Agree**	**3.34**	**Agree**

In terms of **non- punitive response to error,** Hospital A had an overall mean score of 4.29 verbally interpreted as excellent; and Hospital B had an overall mean score of 4.26 verbally interpreted as excellent as well. However based on the emerged theme of holistic and motivating culture with associated meanings of the following : culture building ―*building and maintaining safety culture starts from staff to managers*‖, enhancing staff motivation ―*stronger motivations and constant monitoring are essential for safety practices* and supportive management ― *employee are supportive as well as management*‖. These meanings were contradicting with the quantitative results but this can be enhanced through the involvement of the leadership , the staff 90 should be oriented to the monitoring process for improving the safety practices and culture building of non-punitive approach should start from management to the staff.

Ssummary of assessment of nurse respondents on their safety practices in internationally-accredited hospitals in terms of management support for patient safety, Hospital A had an overall mean score of 4.58 verbally interpreted as excellent; and 4.40 for Hospital B verbally interpreted as very good. Management support in patient safety should be practiced by all internationally accredited institutions. This was supported with the identified theme of supportive management with its associated meaning of leadership involvement ―*safety practices in the hospital is best support by the management level and the rank and file* and collaborative efforts ― *we have patient safety committee program that is properly monitored our practices in the institution*‖. This greatly depicted that there had been a strong leadership support in terms of the patient safety initiatives of the organization. This also include the support of other healthcare staff in the fulfillment of a reliable quality care.

Based on Table 3, this can be interpreted that even though the respondents came from an international accredited organization they have not reach the continually improving level which is more proactive, and data driven organization. The organization's involved is at the level which had a policy in placed, properly implemented, and executed and monitored but there is no risk assessment and likelihood to happen again. In a mature organization, their data is the blood line of the system which continuously collected, interpreted and analyzed and reported to respective partners of the units.

Based on the results of this study, the safety culture maturity of the organization was in the managing level which focused on the organization's accident rate is average for its industrial sector but they tend to have more serious accidents than average. Safety is seen as a key business risk and management time and effort is put into accident prevention. Safety is based on the policies and engineering innovative practices. Safety events are preventable. The errors are due to the unsafe behavior of the frontline staff as seen by their managers. Safety performance is measured in terms of the clinical outcomes. Senior managers are reactive in their involvement in health and safety (i.e. they use punishment when accident rates increase). The organization develops personal responsibility to their staff. Encourage cooperation and commitment to improving safety. The organization is committed to develop consistency and fight complacency.

Based on the researcher observation the organization is thriving to achieve a higher level of maturity however the barriers had been with the building of culture as evidenced by the themes development opportunities with associated meaning of imperfect organization and declining processes.

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Table 3. Summary of Mean and Verbal Interpretation of the Assessment of Nurse-Respondents on Their Safety Culture Maturity Level

Areas	Hospital A		Hospital B	
	Mean	**Verbal Interpretation**	**Mean**	**Verbal Interpretation**
1. Emerging	3.12	Manifested	3.04	Manifested
2. Managing	**3.24**	Manifested	**3.35**	Manifested
3. Involving	3.07	Manifested	3.11	Manifested
4. Cooperating	2.83	Manifested	2.88	Manifested
5. Continually improving	2.60	Least Likely Manifested	2.71	Manifested
Overall Mean	**2.97**	Manifested	**3.02**	Manifested

These supports the level of maturity of the organization that has a process that should be improve such as hand - off and transition, communication openness, non-punitive response to error and staffing issues. These safety practices were vital in sustaining and achieving a higher level of maturity because it entails effective communication, holistic motivating culture with collaboration to other units.

In terms of safety culture maturity level of the internationally accredited hospitals had an overall mean score of 2.97 for Hospital A verbally interpreted as manifested; and 3.02 for Hospital B verbally interpreted as manifested as well. Both had been in the level of least likely manifested in the level of involving.

However, there was a contradiction with the identified theme of collaborative endeavor with associated meaning of shared responsibility (*"organizational safety is the collaboration of the different department in the agency"*). This showed that in the views of the middle manager they should have cooperation and teamwork through staff involvement and enhancing accountability and responsibility among the staff. It should be collaborative approach in whatever dilemmas and issues in the organization this creates a more solid foundation for safety practices. As the researcher observed in the organization, the middle manager exerted efforts to increase the involvement of their staff through interactive discussion, reward system and recognition on their units. It is evidenced by the respondents' narration ―*Patient safety in place; any event was investigated. RCA was done and action plans are implemented and monitored.*

DISCUSSION

This study is the first to show that safety practices and safety culture maturity level of the organization will be based on the quality of the staff, leadership support and robust communication and processes in place. There should be in the right age, with proper education, and with ample experience this makes a organization a futile ground to grow a reliable and sustained culture. …. The study has clinical implications which include _safety practices should always be on top of the objectives of the management based on this study , there had been identified that management support, open communication, proper staffing and non-punitive culture enhanced safety and prevents harm to the patient. As other claims that they achieved a level of continually improving level because they had the international accrediting, they could review the results that accredited organization and been in the involving level which had identified as reactive. Thus, the healthcare organization should thrive to achieve the level 4 and level 5 which is more on risk based and proactive approach in situation. That could also be attributed with the proper staff qualification, education, and experience.

An organization with a robust safety culture is characterized by: communication founded on mutual trust, by shared perceptions of importance of safety and by confidence in the efficacy of preventive measures. Trust takes hold when an organization eliminates intimidating behaviors that undermines cohesion and suppress reporting in the workplace. Accountability, when an organization has achieved high levels of accountability, all staff takes responsibility for their own roles in a culture of safety. Based on this research safety culture is based on leadership initiatives and dealing with the reports in non-punitive way. Enhancing manpower to achieve a safer environment for the patient [7].

Benefits of improved safety culture are the following: company's management and the realities at the sharp end, a more balanced positioning of middle management between what feeds downward from upper management and what feeds upward from the sharp end, an improvement in material and psychosocial working conditions, continuous improvement and innovation, through increased participation, improved reflection on vocational training programs and onboarding. These outcomes can be achieved based on the results of the study if the management would focus in proper human resource

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management, changing communication styles and harnessing teamwork among the healthcare staff. Which in turn related to the level of maturity among the healthcare organization which is only in the managing level, that the staff will intervene if there will be an incident rather than do a proactive measure because there had been a barrier, the communication , the lack of staffing that adds burden in implementation of innovative solution [8].

Moreover, the communication in turn strengthens the trust that led to the reports and fosters further identification and reporting of problems even further upstream from harm. Maintaining trust certainly requires the organization to hold employees accountable for adhering to safety protocols and procedures [9].

In the study of Goncalves and colleagues (2012) study, findings revealed that higher levels of safety management maturity tend to display the features associated with higher levels of safety culture maturity. This study asserted that an established safety culture is crucial for the risk management system to prosper. Positive safety culture in an organization certainly manifests in the attitude and behavior of the staff. The safety culture of the organization will depend on the structure which includes staff, processes, and training. This is the foundation of culture and which can affect the maturity of the organization [10].

In the Patient Safety Culture Framework of AHRQ (2015), they mentioned that safety culture comprises effective communication, commitment to organizational learning, transparent report culture, teamwork culture and management support. Based on the findings of this study the lowest patient safety practices scores were from staffing and communication openness which could be correlated to the factors affecting safety culture which includes human factors, managerial and strategies and communication and system strategies. This means that staffing concerns and communication openness could be addressed through proper management strategies and robust systems in place. For the staffing this includes (recruitment, hiring, deployment, retention, and even succession planning). For communication openness (creation of policy regarding collaborative approach in care planning for all the healthcare should be have an equal opportunity to give their expert opinion to the patient).

In the Safety Culture Maturity Model of Fleming (2010), with 5 levels of the organization. From emerging to continually improving organization. Per level have its goals which should be achieved by the organization. Based on the findings of the study, the organization had reached only the managing level which characterized by reactive approach in dealing with an adverse event. The staff might be afraid in questioning his/her superior because based on the respondents age they are in the millennial age and they have the tendency to follow only what had been prescribed to them. And based on their educational back ground they have finished BS Nursing degree but holding a managerial position which could be a factor in not voicing their concerns because in the Philippine , the healthcare is more on hierarchical in nature that the doctor is superior than nurses. Which could be contributing factor of level of maturity.

Based on the study, the management should focus on their human resource management which includes the healthcare staff ratio, their capacities / credentials as a middle manager position, considering their multi generational gaps and their different learning styles. Through proper allocation and training among staff would be a good start in creating a better culture in the organization. In terms of the communication openness, the management should create a collaborative approach in caring for the patient. This should be participated by different specialties and they must communicate and all of them should be heard. In this manner, all the team members will have opportunity to give his/her observations. In this study also highlighted that the management supports the initiative of culture building which is a good manifestation that the organization has the culture of safety however this should be translated and properly communicated among the healthcare staff and through modelling and doing leadership walk rounds it enables the leaders to listen and for the staff to observe what the culture really is. In the maturity level of the organization, both internationally accredited organization has only reached managing level which can be correlated to the culture of the organization. That they have not fully embraced the culture of reporting, risk based planning and proactive approach in the situation.

Based on the study findings, a model for sustained safety practices has been proposed (Figure 2). The goal of this model is to maintain the level of maturity of the organization through utilization/ observation of patient safety practices in coordination with the human resource, communication. leadership and processes. Prior models of safety practice do not discuss the relationship of patient safety and maturity level of the organization.

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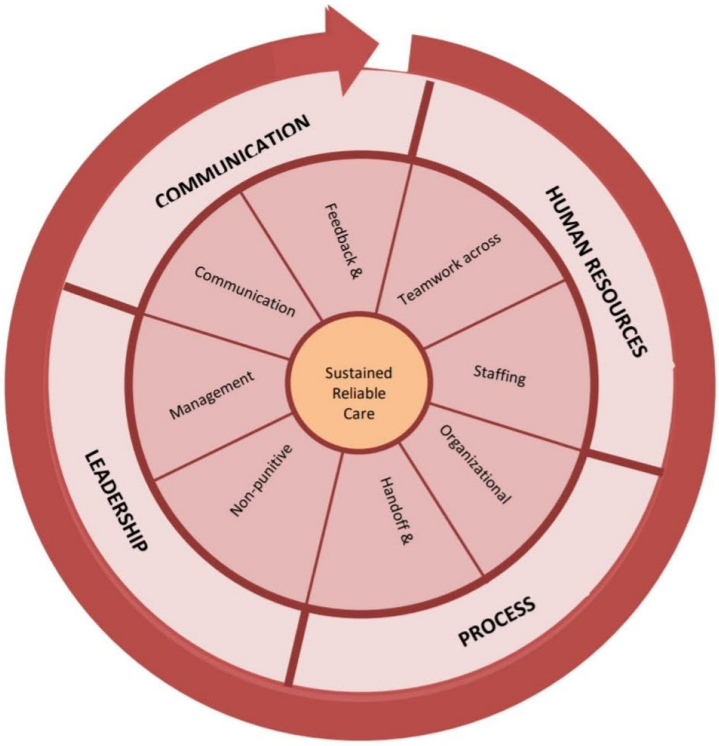

Figure 2. Morales' Model for Sustained Safety Practices for Reliable Care

They only focus on the characteristics of every level of maturity for Fleming model. And for AHRQ model they only had a goal of safety culture that might vary in an organization but in the proposed model its goal is not only high culture of safety but it should be sustainable and reliable in context.

Figure 2 shows that the interaction of the variables from the safety practices and factors affecting it towards continuous improvement towards sustain reliable care. This fosters a reliable care embarks on safety practices and culture of maturity. The model for sustained safety practices for reliable care is outlined in three dimensions including sustained reliable care (core); safety practices (mantle); culture maturity (crust); and the continual improvement (cyclical arrow). The model emphasizes a safety culture that demonstrates alignment to international quality criteria while serving as a steppingstone to higher level safety culture maturity.

The core of the model depicts the sustained safety practices for reliable care in which is the outcome of safety practices and culture maturity as outlined on the middle and outermost sphere in the illustration. In achieving a truly positive safety culture, it would mean that all personnel, regardless of position, job description, or time spent at the work site share equal responsibility in upholding safety standards and procedures to keep the entire job site safe.

The middle sphere of the model reflects the integral components of safety practices that define culture maturity. Safety practices are integral part of a sustained reliable care. These include management support; non-punitive response to error; communication openness; feedback and communication; teamwork across units; staffing; organizational learning; and handoff and transition.

The crust or the outermost circle pertains to culture maturity that represents the product of safety practices as determined by commitment to, the style and proficiency of an organization to safety culture. The general dimensions of a matured safety culture entail leadership, communication, process, and human resources.

Leadership is derived through strong management support and adoption of non-punitive response to error. Leadership plays a significant role in safety performance and has the power to enforce safety, standards and values among staff in an organization. An effective communication strategy also identifies culture maturity. The overall effectiveness of

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communication in the workplace safety and security measures is defined by communication openness as well as feedback and communication. Maturity is created by transparency that generates trust and engagement. Finally, a well-established and efficient process is achieved through organizational learning and handoff and transition. The concept of high reliability equates with standardized healthcare process. High reliability organization is cultivated by resilience that relentlessly prioritize safety over other performance measures. Meanwhile, human resources are essential in enhancing safety culture practices. Embracing a culture of great teamwork and investing in staff develops a pool of talent who can respond to the organization's ever-changing needs.

The cyclical arrow that circles the components of culture maturity connotes a continual improvement in the important dimensions of a matured safety culture. Since healthcare is constantly pushed by changing regulations, an aging workforce, the rise of consumerism, the population health movement, and several other factors affecting the industry, establishing a culture of continuous improvement remains a high priority initiative. Building a culture of continuous improvement largely depend on sustained strategies that involve measuring work, improving work, and changing work.

CONCLUSION AND RECOMMENDATION

Safety Culture of the organization greatly affects the safety maturity level. The healthcare organization should focus on their strengths by staring with their hospital leadership. Leaders should take the initiative in creating a culture of safety program in the organizationwhich should be formalized as hospital wide program and with corresponding action plans and timelines. Through this intervention the culture will be sustained. The healthcare organization should also invest in continuous learning through innovation and research which enables the staff to be more competent and confident in dealing with their patients.

Human resource management and communication had been always the identified factors for improvement. The healthcare organization should create a comprehensive plan from recruitment until succession planning. This should be attended by different stakeholders of the organization for the management to see the different perspective of the situation. Communication in the healthcare organization could be build through collaboration among staff. Create a multidisciplinary approach in care planning of the patient. Initiate a hospital wide policy of teamwork and collaboration across the organization (eg. changing of forms, relaying of results)

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