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Awareness among cardiac catheterization health care team members regarding occupational health hazards and safety practices in Cairo university hospitals

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The aim of the study was to assess cardiac catheterization health care team member's awareness regarding occupational health hazards and safety practices in Cairo University Hospitals. A descriptive, comparative design was utilized. The study was conducted at all cardiac catheterization units in Cairo University Hospitals. Convenient sample of all health care team members (80) who divided into physicians (12), bachelor nurses (11), technical nurses (27), radiologists (16) and nurses aid (14). Two tools were developed by the investigator utilized for data collection. Finding of this study indicated the physicians had the highest total mean awareness score towards occupational hazards while the lowest total mean score of awareness for nurses aids. The New Kaser Elaine catheterization unit had got the highest mean score of safety measures while Emmanuel University catheterization unit had gotten the lowest total mean score. All health care team members had got a moderate level of awareness toward occupational health hazards. The physicians were the most aware group of health team members with occupation health hazards while the nurses' group was the lowest aware group with occupational health hazards and all cardiac catheterization units had a low level of safety practices. The study recommended that a training program can be conducted to improve knowledge on occupational health hazards and periodic medical checkup and checkup for radiation level.

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Assessment of patient safety culture in primary healthcare services in Alexandria

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Background: Patient safety is critical component of health care quality. This study aimed at assessing the perceptions of primary healthcare staff members about patient safety culture and explores the areas of deficiency and opportunities for improvement concerning this issue.

Methods: This descriptive cross sectional study surveyed 328 staff members in 28 primary health care facilities in Alexandria using face to face interview format of a modified "Hospital Survey on Patient Safety Culture" adapted questionnaire. The total number of respondents was 250 participants (response rate=76.2%).

Main Outcome Measures: The patient safety culture score, including subscores on 12 dimensions and 42 items; patient safety grade, number of events reported and factors contributing to the adverse events.

Results: The overall median% score for positive perception of patient safety culture at the facility level was 68.6 (IQR=8.2). No differences were found by staff members' profession.The domains with the highest positive score and are thus considered areas of strength were teamwork within units (80.0%), management support for patient safety (80.0%), supervisor expectations & actions promoting patient safety (75.0%) and handoffs & transitions (75.0%). Dimensions scoring the lowest and as such can be considered areas requiring improvement were overall perceptions of patient safety, and frequency of events reported and staffing (60% give positive response for each). More than two fifths (43.6%) did not report any events in the 12 months preceding the survey. The difference between professions regarding the most common procedure that causes adverse event is statistically significant. Patients' related factors such as ignorance and socio cultural acceptance seemed to be the most common factors that contributed to the adverse events (92.4% of the studied participants reported that).

Conclusions: Improving patient safety culture should be a priority among health center administrators. Healthcare staff should be encouraged to report errors

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