DEVELOPING A FUNCTIONAL PATIENT SAFETY FRAMEWORK FOR TRANSITIONING HEALTH SERVICES:

A VISION FOR QUALITY MANAGEMENT IN A JORDANIAN ACUTE CARE HOSPITAL

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This thesis is submitted in accordance with the requirements for admission to the degree of

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CERTIFICATE OF AUTHORSHIP / ORIGINALITY

I certify that the work in this thesis has not been previously submitted for a degree nor has it been submitted as part of requirements for a degree except as fully acknowledged within the text. I also certify that the thesis has been written by me. Any help that I have received in my research work and the preparation of the thesis itself has been acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

Signature of Candidate

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Mahmoud Alja'afreh

DEDICATION

I dedicate this thesis to my family. My wife Sana gave me extensive and continuous support in this endeavour provided me the space to think and write and took on the weight of domestic responsibilities for the family in a new country. I am also grateful to my children Tamer, Tala and Mohammad who have missed spending time with a father who has been busy with his doctoral thesis. I hope that one day they can understand and forgive me for this absence.

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ABBREVIATIONS (KEYS)

A&E	Accident and Emergency
AHCPR	Agency for Health Care Policy Research
AIN	Assistant in Nursing
AN	Associated Nurse
BP	Blood Pressure
C	Clinical
CCU	Coronary Care Unit
CGU	Clinical Governance Unit
CI	Clinical Instructor
CM	Meeting at Clinical Level
CPR	Cardio Pulmonary Resuscitation
CSB	Civil Service Bureau
CVA	Cerebro Vascular Accident
DON	Director of Nursing
Dr	Doctor
DVT	Deep Vein Thrombosis
EBP	Evidence-based practice
ECG	Electrocardiogram
EPUAP	European Pressure Ulcer Advisory Panel
FMW	Female Medical Ward
GDP	Gross Domestic Product
GI	Gastro Intestinal
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
I	Interview
ICPS	International Classification for Patient Safety
ICU	Intensive Care Unit
IDC	Indwelling Catheter
IOM	Institute of Medicine
JD	Jordanian Dinar JD = US$ 1.41, AU$ 2.32
JNC	Jordanian Nursing Council
JUST	Jordan University of Science and Technology
KPI	Key Performance Indicator

LOA	Liaison Accreditation Officer
MD	Medical Department
MMW	Male Medical Ward
MOH	Ministry of Health
N	Nurse
NDU	Nursing Development Unit
NICE	National Institute for Clinical Excellence
NPUAP	National Pressure Ulcer Advisory Panel
NSW	New South Wales
O	Observation
OPD	Out Patient Department
Org	Organisation
Org M	Meeting at Organisational Level
P	Policy
p	Page
PHCs	Primary Healthcare Centres
PHR *Plus*	Partners for Health Reform*plus* Project (USAID)
Pt	Patient
PU	Pressure Ulcer
QC	Quality Committee
QD	Quality Department
QU	Quality Unit
RAS	Risk Assessment Scale
RCT	Randomised Controlled Trial
RMS	Royal Medical Services
RN	Registered Nurse
SOP	Standard Operating Procedure
TOR	Term of Reference
UNRWA	United Nations Relief Works Agency
UK	United kingdom
USA	United States of America
USAID	United States Agency for International Development
WHO	World Health Organisation

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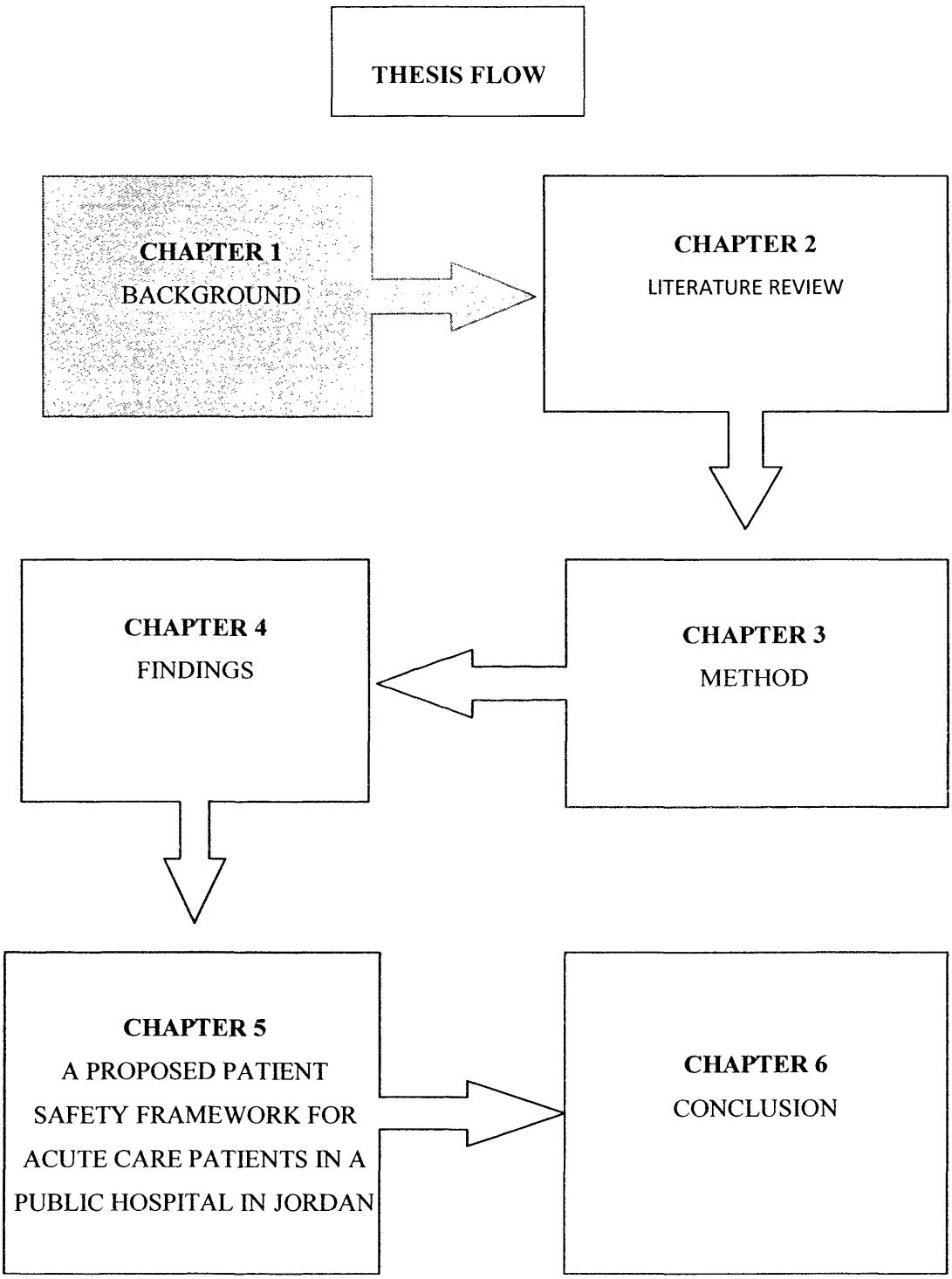
ABSTRACT

The purpose of this study, conducted in a tertiary public hospital in Jordan, was to identify and critically examine existing attributes that were seen to be problematic in managing patient risk. The management of pressure ulcers (PUs) was chosen as a representative exemplar to focus the research. A case study design using both qualitative and quantitative methods was used to generate an in-depth account of safety and quality issues. Data were analysed interpretatively and the findings used to develop a proposed patient safety framework for patients in the acute care sector.

The main findings include an urgent need to begin the modification of the traditional hierarchical bureaucracy within the organisation and the disciplines, towards structures and processes that promote a multidisciplinary approach to patient care. Processes such as the provision of multidisciplinary evidence-based practice guidelines to reduce variation in practice standards, the implementation of multidisciplinary progress notes in patients' medical records to prevent duplication inaccuracies and a team model of nursing care are required and included in the proposed model. Improvements in the organisational culture are likely to be achieved by engaging clinicians in organisational decision-making structures and processes and providing them with performance feedback by developing an incident monitoring system. The instability of the hospital workforce makes the achievement of cultural change extremely difficult. Changes in the employment of staff from one centralised government agency to a system that enables managers to have more control of workforce employment in their organisations, with staff themselves able to nominate where they work, are recommended. Organisational managers also require more control in how funds are allocated to their organisations to allow them to formulate budgets and identify funding priorities within their organisations. The greatest impact on improvement will be achieved if reforms are concurrently implemented.

A proposed framework incorporating these recommendations as a way to improve patient safety in acute care has been developed for countries attempting health care

transition. The framework positions the patient as central to clinical care decisions and clinical process management, and links the three key levels of the hospital together, i.e. the clinical, organisational and ministry levels, as one interconnected activity. Such an integrated framework will facilitate the concurrent implementation of the proposed new structures and processes that research findings show are at the heart of patient safety.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