

تأثير الثقافة التنظيمية على فعالية إدارة المخاطر بين العاملين في مجال الرعاية الصحية في مستشفى
الملك فيصل التخصصي ومركز الأبحاث

إعداد الطالب/

عصام مطران حربي

إشراف/

د. الفيصل عبد الحميد

د. فايز جراد

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ABSTRACT

Background: Patient safety culture is a critical component of healthcare quality and risk management. It shapes staff attitudes, influences clinical behavior, and impacts the frequency and transparency of error reporting. Despite increasing global efforts to improve safety culture, there remains a gap in multi-professional, institution-wide assessments that integrate both perception-based and behavioral indicators.

Objective: This study aimed to evaluate the perceptions and practices related to patient safety culture among healthcare professionals at King Faisal Specialist Hospital & Research Centre (KFSHRC), with particular focus on teamwork, communication openness, leadership response, and the frequency and severity of reported medical mistakes.

Methods: A cross-sectional survey was conducted among 423 healthcare workers across various departments using a validated safety culture assessment tool. Descriptive statistics were used to analyze demographic variables, perception scores, and error-reporting frequencies across mild, moderate, and fatal incidents.

Results: Participants had a mean age of 38.15 ± 8.35 years and average work experience of 15.15 ± 8.16 years. Nurses (47.3%) and physicians (29.1%) formed the majority. Most participants reported high levels of teamwork (77.8%) and communication openness (87.7%). However, only 34.3% believed the organization responded effectively to mistakes. Mean reported incidents were 6.89 mild, 3.20 moderate, and 1.09 fatal mistakes. Only 47.3% believed learning occurred from errors, and just 33.6% acknowledged cross-unit information sharing.

Conclusions: While the study revealed strengths in communication and collaboration, it also highlighted key areas for improvement—particularly in leadership response, feedback systems, and learning culture. These findings can guide policy enhancements and training programs aimed at fostering a more proactive and transparent safety culture.

Keywords: Patient safety culture; incident reporting; healthcare professionals; teamwork; communication; tertiary hospital; Saudi Arabia.

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CHAPTER I: Introduction, Background and rationale and Research Context

This chapter describes the identified research problem and statement of the problem and justifies the significance of the delineated problem.

Introduction

In today's rapidly evolving healthcare environment, risk management has become a central pillar of patient safety and operational quality **(Kim & Jung, 2022)**. While many healthcare institutions adopt official policies and systems for managing clinical and organizational risks, their true effectiveness often depends not solely on protocols but on the prevailing organizational culture and the behaviors of healthcare professionals **(Mendes & França, 2024)**. A culture that does not support open communication, learning from mistakes, and consistent adherence to safety guidelines may undermine even the most technically robust risk management systems. As hospitals continue to embrace advanced technologies and expand their scope of services, the human factors embedded in cultural attitudes become increasingly critical to sustaining safety outcomes. In particular, healthcare professionals' awareness and engagement with risk practices directly affect the institution's ability to mitigate harm and ensure continuous improvement **(Lee, 2024)**.

Research Problem

Despite the increasing emphasis on patient safety and clinical risk management in modern healthcare systems, many institutions continue to face significant challenges in effectively implementing these strategies. While standardized policies and technologies are essential components, their successful execution depends heavily on the organizational culture—

specifically how healthcare workers perceive, interpret, and act upon safety protocols (**Tang, 2017**).

In Saudi Arabia, numerous studies have explored patient safety culture across various hospitals; however, there is a notable lack of research focused on King Faisal Specialist Hospital & Research Centre (KFSHRC). This institution holds a unique position as the highest-ranked healthcare provider in the Middle East, globally recognized for its innovation in telemedicine, artificial intelligence, and robotic surgery. Yet, the extent to which KFSHRC's organizational culture supports or hinders effective risk management remains empirically unexamined (**Mendes & França, 2024**).

This gap is particularly critical given the hospital's role as a benchmark for clinical excellence and its strategic alignment with **Saudi Vision 2030**, which seeks to transform the national healthcare sector. The failure to understand and address cultural barriers—such as underreporting of errors, resistance to change, or inconsistent adherence to safety standards—could limit the effectiveness of risk initiatives, even in technologically advanced settings.

Thus, the central research problem is:

How does the organizational culture at KFSHRC influence the effectiveness of risk management among healthcare workers, and what factors within this culture support or impede the hospital's safety performance?

This study seeks to investigate this problem systematically by examining the perceptions and behaviors of healthcare workers regarding risk management, identifying cultural enablers and obstacles, and providing evidence-based recommendations for improvement.

Background and Rationale

Organizational culture—defined as the shared values, norms, and behaviors that shape how people interact and make decisions—has been consistently linked to performance across sectors, particularly in healthcare settings where safety and risk tolerance must be carefully managed (**Akpa et al., 2021**). The literature demonstrates that a positive safety culture fosters higher compliance with risk protocols, promotes timely reporting of errors, and encourages collaborative problem-solving, all of which lead to improved patient outcomes and fewer adverse events. According to **Denison's (2004) and Schein's (1992)** models, effective cultures are those with high levels of consistency, adaptability, mission alignment, and involvement. In risk-sensitive domains like hospitals, these attributes influence how employees respond to uncertainty and system vulnerabilities (**Mendes & França, 2024**).

Despite widespread acknowledgment of the importance of culture in healthcare risk management, there is a significant gap in empirical research examining this relationship in leading institutions within the Middle East (**Yazid et al., 2012**). Specifically, King Faisal Specialist Hospital & Research Centre (KFSHRC)—a technologically advanced hospital ranked among the world's top 20 academic medical centers—has not been extensively studied in terms of how its organizational culture shapes its risk practices. Given its status as a model of excellence within Saudi Arabia's Vision 2030 transformation plan, understanding how internal cultural dynamics influence safety outcomes is crucial. This research is driven by the need to explore how a globally recognized hospital integrates risk management into its organizational DNA and what lessons can be drawn for other institutions aspiring to similar standards (**Riaz et al., 2023**).

Research Context

King Faisal Specialist Hospital & Research Centre (KFSHRC) represents a unique research context for studying the relationship between organizational culture and risk management. As the leading tertiary care and research institution in Saudi Arabia, KFSHRC has achieved global recognition for its deployment of artificial intelligence, robotics, and telemedicine. It has also been listed among

the “World’s Best Smart Hospitals 2025,” a designation that underscores its technical and infrastructural sophistication. However, despite these advancements, organizational effectiveness in healthcare still largely depends on cultural factors—how staff perceive risk, how willing they are to report incidents, and how committed leadership is to fostering transparency and learning **(Kim & Jung, 2022)**.

The hospital’s scale, complexity, and global standing make it a representative case for studying the dynamics of organizational culture in a high-stakes, highly regulated healthcare setting. The hospital employs thousands of healthcare professionals across a wide range of disciplines, offering a rich sample for measuring perceptions of risk and culture **(Yanka Perkasa & Fardinal, 2021)**. Moreover, KFSHRC plays a leading role in setting benchmarks for quality and patient safety within the region, making the findings of this study not only institutionally relevant but nationally significant. The study’s results are expected to inform hospital leaders and policymakers on how to better align safety initiatives with cultural realities, close gaps between policy and practice, and foster a culture of accountability and continuous learning **(Kim & Jung, 2022)**.

While foundational theories **(Schein, 1992; Denison, 2004)** affirm the role of organizational culture in shaping workplace behavior, very few empirical studies have systematically examined how this culture influences the implementation of clinical risk protocols in high-acuity healthcare settings.

Contrary to the investigator’s claim of “widespread acknowledgement,” the available literature—particularly in the Gulf region—is fragmented. A 2022 systematic review by Kim and Jung included only three studies from Saudi Arabia, none of which focused on risk culture at tertiary hospitals. Mendes & França (2024) found that while Lean thinking improves safety processes, cultural variables remain underexplored.

The strongest evidence comes from Western contexts, such as **Cooper (1998; 2000)** and **Fraser & Henry (2007)**, which highlight how culture enhances safety, but their transferability to the Saudi context is unclear. Studies like **Hassan et al. (2022)** stress the need for contextualized frameworks when examining risk governance in Arab healthcare settings.

Therefore, this study not only fills a geographic and institutional gap by focusing on **King Faisal Specialist Hospital**, but also addresses the **lack of localized, culture-specific research** exploring the intersection of staff perceptions, leadership norms, and risk adherence in a region undergoing rapid healthcare reform under Vision 2030.

CHAPTER II: Literature Review

Introduction

This chapter introduces the related literature and studies following a comprehensive and in-depth review conducted by the researcher on the impact of organizational culture on the effectiveness of risk management among healthcare workers at King Faisal Specialist Hospital & Research Centre. It also presents the synthesis of the theoretical and conceptual frameworks essential to fully understand the scope, direction, and foundation of the study.

Literature Review Process

Although rarely applied in cultural-risk management studies within tertiary healthcare settings, I adopted a systematic approach to identify and synthesize relevant literature related to organizational culture and risk management effectiveness in hospitals. I used a combination of targeted keywords such as *organizational culture*, *risk management*, *patient safety*, *safety reporting*, *hospital culture*, *healthcare workers*, and *King Faisal Hospital* across major academic databases, including **PubMed**, **ScienceDirect**, **CINAHL**, and **DOAJ (Directory of Open Access Journals)**. This search yielded a total of **1,498 research articles** related to the subject matter.

From these, **58 articles** were shortlisted for detailed review after applying preliminary screening criteria. This deeper evaluation considered factors such as research design, setting, study population (especially hospital staff), focus on safety or risk culture, and the relevance of findings to the Saudi healthcare system. After excluding outdated, regionally irrelevant, or non-healthcare-focused studies, a final selection of **10 high-quality peer-reviewed articles** were retained and incorporated into this research. These sources form the theoretical and empirical foundation of the study and support the development of its conceptual framework.

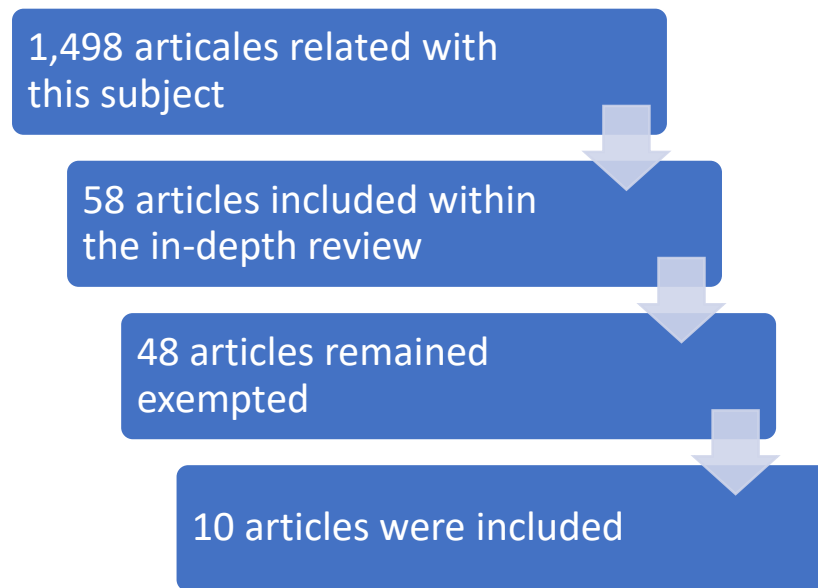


Figure 2.1 Literature review process

Organizational Culture

Organizational culture is commonly defined as the collective system of values, beliefs, norms, and interpretations shared by members within an institution **(Susanto, 2017)**. It provides the foundational philosophy that shapes how an organization functions, establishes criteria for decision-making, and sets behavioral expectations among its workforce **(Borges, 2013; Hsu et al., 2011)**. More than a background element, culture plays a dynamic role in determining the "rules of the game," influencing perceptions, shaping internal atmospheres, and guiding employee conduct on both formal and informal levels **(Riaz et al., 2023)**.

Scholars have long recognized the anthropological roots of organizational culture, with foundational contributions from Schein, Smircich, and others linking it to how organizations adapt to internal pressures and external challenges **(Taylor, 2017)**. **Schein (1992)** conceptualized culture as a pattern of basic assumptions developed through organizational learning and problem-solving. These assumptions influence how members perceive risk, collaborate, and respond to strategic shifts. Wallach's classification and Denison's cultural model further identified critical dimensions—such as

adaptability, mission, and involvement—that connect culture to performance and resilience **(Hassan et al., 2022)**.

A well-developed organizational culture not only enhances alignment and cohesion but also reduces undesirable outcomes like employee turnover **(Schandl & Foster, 2019)**. Robins suggests that strong cultural values anchor employees, while **Achillas et al. (2014)** argue that culture increasingly acts as a guiding force in modern workplaces. Leaders play a vital role in this process, though shaping culture requires more than routine management **(Achillas et al. 2014)**. Unlike functional departments, culture cannot be controlled or measured in the short term. Its development depends on continuous, strategic, and system-wide interventions **(Akpa et al., 2021)**.

Schein’s three-tier model offers a practical lens for managing culture across different layers: observable artifacts, underlying values, and deep-seated assumptions **(Yanka Perkasa & Fardinal, 2021)**. Efforts at the artifact level—such as redesigning office layouts, establishing a corporate identity system (CIS), celebrating institutional rituals, or embedding feedback mechanisms—can serve as entry points for broader cultural change **(Filippini et al., 2012)**. These tangible initiatives help operationalize cultural values and support consistent behaviors aligned with the organization’s mission **(Yanka Perkasa & Fardinal, 2021)**.

In healthcare and other high-reliability sectors, organizational culture is particularly relevant for driving performance and risk awareness **(Jacobsen et al., 2014)**. Studies have shown that institutions with strong learning cultures are better equipped to manage uncertainty, promote safety, and encourage innovation **(Hult et al., 2003; Frances & Morriss, 2020)**. Moreover, integrating cultural change with knowledge-sharing systems and leadership engagement can amplify outcomes across departments. Therefore, cultivating an adaptive and value-driven culture is not only a matter of internal alignment but a strategic imperative for long-term organizational effectiveness **(Soomro & Shah, 2019)**.

Organizational Effectiveness

Organizational effectiveness is a broad and intricate concept that has been interpreted differently by various scholars. At its core, it refers to how well an organization achieves its intended goals (**Gebauer et al., 2012**). This includes evaluating how effectively resources are utilized in meeting objectives and measuring the gap between expected outcomes and actual performance (**Qu, 2012**). **Agrawal (2012)** also stresses that the primary measure of effectiveness is whether the organization attains its predetermined targets (**Agrawal 2012**).

Effectiveness encompasses more than just achieving results—it involves doing so with optimal use of time, effort, and resources, indicating a high input-output efficiency (**Koutoupis & Pappa, 2018**). **Jacobsen et al. (2014)** explain that organizational performance relates to how closely the actual achievements align with the organization's strategic aims. Enhancing performance is a major goal behind most business strategies, making the link between strategy and results a key focus in management research (**Saeidi et al., 2021**).

Srivastava and Singh (2013) argue that effective organizations require leaders who not only manage resources efficiently and respond to environmental challenges but also apply balanced leadership approaches. For instance, the competing values framework helps leaders guide various aspects of the organization—from internal dynamics to external adaptation—toward meeting performance standards (**Saeidi et al., 2021**).

According to **Diabat et al. (2012)**, achieving a balance between effectiveness and efficiency is essential for an organization's sustainability. Their view is based on two assumptions: first, that decision-makers within organizations are rational actors pursuing clear objectives; and second, that these objectives must be realistic and well-defined so that organizational members can understand and work toward them (**Diabat et al., 2012**). This perspective, which equates effectiveness with goal

attainment, is one of the oldest and most commonly used frameworks in organizational evaluation **(Gomez & Bernet, 2019)**.

Organizational performance should not be judged solely through financial indicators. Other elements—such as corporate culture, employee capabilities, and investment in training—are equally vital to long-term success. Therefore, organizations should also consider non-financial aspects when assessing effectiveness **(Lai et al., 2019)**.

Chao et al. (2013) suggest a dual approach for evaluating organizational effectiveness. The "**hard performance**" dimension includes financial metrics like profit margins, business growth, and return on investment. On the other hand, "**soft performance**" covers non-financial outcomes such as service quality, employee satisfaction, and customer experience. This classification highlights the need to evaluate both tangible and intangible indicators to gain a complete picture of organizational success **(Kojima et al., 2019)**.

Risk Management

Risk is not an inevitable outcome but rather a matter of decision-making. Managing risk involves navigating between proactive and reactive options using limited organizational resources **(Nasrum, 2018)**. As global disasters and crises have evolved, the understanding of risk management has expanded beyond technical concerns to include managerial and socio-cultural dimensions **(Schandl & Foster, 2019)**. This has led scholars to explore both the objective nature of risk and constructivist views, which diverge based on how risk is conceptually defined. In today's complex business environment, organizations are vulnerable to numerous threats that may compromise their operational goals **(Joseph & Kibera, 2019)**.

With the expansion of globalization and advancements in technology, the failure of several large multinational corporations in recent years has highlighted the critical importance of effective risk management and internal oversight **(Yazid et al., 2012)**. According to **Lam (2005)**, enterprise risk

management (ERM) has evolved into both a recognized management discipline and a standard practice. **Zheng (2016)** describes risk as being universal, inherently harmful, variable, and unavoidable, while **Wang and Xu (2018)** point out that in hospitals, potential risks span areas such as financial operations, human resources, and institutional reputation.

Broder and Tucker (2011) note that risk involves unpredictability between actual outcomes and intended results. **Yang (2011)** emphasizes that risk management aims to analyze both causes and consequences of undesirable events. **Wu (2017)** adds that risk assessment focuses on both the severity of outcomes and the probability of their occurrence. In healthcare, the core objective of risk management is to thoroughly scrutinize operational procedures, thereby minimizing unexpected events and enabling managers to prioritize threats efficiently (**Saeidi et al., 2021**). As part of this process, governance models are being redesigned to strengthen accountability, optimize resource use, and improve institutional resilience (**Carter et al., 2019; Lai et al., 2019**).

Hospitals, given the inherent complexity and unpredictability of their functions, must approach risk with vigilance (**Koutoupis & Pappa, 2018**). According to the **World Health Organization (2019)**, patient safety must be integrated into the core of healthcare policy and organizational planning (**Yanka Perkasa & Fardinal, 2021**). Key goals of hospital risk management include:

1. Reducing the likelihood of harm to patients, staff, and infrastructure;
2. Preventing avoidable fatalities tied to service delivery or disease risks;
3. Enhancing clinical outcomes;
4. Preserving and managing healthcare resources efficiently;
5. Ensuring legal compliance and operational continuity.

The COVID-19 pandemic has further highlighted the essential role of effective risk management systems in mitigating large-scale crises (**Yanka Perkasa & Fardinal, 2021**).

Levy et al. (2010) define **risk culture** as the collective behavioral tendencies within an organization that influence how risk is perceived and managed, ultimately contributing to improved organizational performance. **Shahzad et al. (2012)** also underscore the significant impact of risk culture on employee performance outcomes. **Fraser and Henry (2007)** explored whether integrating risk management into corporate governance could improve organizational results and shareholder value, though many studies suggest that numerous firms still lack comprehensive ERM systems.

ERM influences organizational strategy by identifying and assessing enterprise-wide risks. **Beasley et al. (2009)** describe ERM as a strategic and effective approach to risk. Fong and Samad (2011) affirm that risk is a vital component of corporate governance. According to **COSO (2004)**, increasing global volatility has spurred growing interest in integrated risk management frameworks. Research by **Gordon et al. (2009)** shows that organizations employing enterprise-wide risk strategies often see notable gains in performance and decision-making capabilities (**Akpa et al., 2021**).

Organizational culture plays a critical role in shaping risk-related behavior. It serves as a daily guide for individual actions and gradually redefines how safety is perceived and enacted within the organization. **Cooper (1998)** described **safety culture** as the interplay of personal, organizational, and job-related attributes that shape overall safety performance. Later, **Cooper (2000)** clarified that safety culture is a distinct but integral dimension within the broader framework of organizational culture, and it significantly affects the safety behaviors and outcomes in any workplace (**Broder & Tucker, 2011**).

Internal Control

The concept of internal control originated in the early 20th century and gained substantial recognition in economic literature by the mid-1900s. A significant milestone in the development of modern internal control theory was the issuance of the **COSO Report** in 1992, followed by a 1994 supplement. Together, these reports established a foundational framework for internal control systems. According to **Njagi (2018)**, internal controls are structured processes endorsed by

management and are meant to be consistently followed by employees to ensure compliance and organizational stability.

Effective internal control frameworks embed the organization's structural influence and the mindset of both management and staff, cultivating a unified "control consciousness" (**Herz et al., 2017**). The COSO framework outlines four key objectives and five integrated components of internal control. **Schein (1996)** describes the control environment as a combination of elements that influence both the organizational culture and the perceptions of authority, rights, and duties—especially as they relate to human resource decisions. **Mulyadi (2016)** emphasizes that internal control includes guidelines aimed at safeguarding organizational assets, ensuring accounting accuracy, maintaining data integrity, and promoting adherence to company policies. Moreover, internal control effectiveness is shaped by leadership philosophy, decision-making style, and the overall corporate culture (**Joseph & Kibera, 2019**).

In healthcare institutions such as hospitals, internal audit functions drive the demand for improved governance and operational excellence (**Koutoupis & Pappa, 2018**). Hospital internal controls are developed using a **risk-based approach**, where minor risks may be streamlined, but high-priority risks necessitate robust procedures, defined systems, and specific control mechanisms. These systems rely heavily on a comprehensive risk assessment that evaluates both internal and external threats, facilitating strategic responses (**d'Ettorre et al., 2021**).

The origins of formal control theory can be traced back to **Taylor (1911)** and **Fayol (1916)**, with the latter identifying control as one of the core managerial functions. Reporting practices are also a critical component of internal control. According to **Willis (2000)**, transparent internal control disclosures enhance corporate governance and positively influence a firm's market value. **Ashbaugh (2009)** found that internal control strength varies based on systemic risk exposure, capital costs, and

structural deficiencies, while **Hogan (2008)** reported a direct relationship between the severity of internal control issues and increased audit expenses.

Internal control mechanisms function across all phases of enterprise growth, adapting to various types of organizational development. **Susanto (2017)** argues that such systems are essential for generating reliable financial data needed for strategic decision-making. **Schandl and Foster (2019)** advocate for continuous monitoring to improve the effectiveness of internal evaluations. **Arens et al. (2014)** further reinforce that internal control contributes significantly to the oversight and application of Good Corporate Governance (GCG).

To institutionalize ethical practices and accountability, organizations should establish behavioral benchmarks within their cultural framework. **Nasrum (2018)** notes that such benchmarks help align employee conduct with organizational values and ethical norms. A strong culture is also linked to long-term corporate sustainability (**Taylor, 2017**). **Manossoh (2016)** emphasizes the importance of harmonizing internal systems with external pressures in governance, where cultural values impact both individual and collective performance. Lastly, **Yanka and Fardinal (2021)** found a significant correlation between internal control quality and the effectiveness of accounting information systems.

Significance of the Study

This study holds critical significance as it explores the dynamic relationship between organizational culture and the effectiveness of risk management practices within a high-stakes healthcare setting. At King Faisal Specialist Hospital & Research Centre—a leading institution in Saudi Arabia known for its excellence in specialized medical care—understanding how cultural norms, values, and leadership influence safety protocols and risk awareness is essential. With increasing demands for patient safety, quality healthcare delivery, and institutional accountability, this research provides evidence-based insights into how fostering a positive and proactive culture can reduce adverse events, improve compliance with safety guidelines, and enhance workforce engagement in

risk prevention efforts. Furthermore, the study aligns with the goals of Saudi Vision 2030 by supporting healthcare transformation and strengthening institutional performance. By identifying cultural strengths and gaps, the findings can inform policy, training programs, and leadership strategies that promote a more resilient, responsive, and safety-driven hospital environment—ultimately improving both staff well-being and patient outcomes.

Study Purpose

The study aimed to assess how healthcare workers perceive the risk management culture within the institution and to evaluate the extent to which organizational culture impacts the implementation and success of risk-related practices. By benchmarking these findings against international standards, the study seeks to provide a comprehensive understanding of how culture shapes safety performance in one of the Middle East's most advanced healthcare institutions.

Research Objectives

1. To evaluate the awareness and understanding of risk management culture among healthcare staff at KFSHRC.
2. To examine the correlation between organizational culture dimensions and the effectiveness of risk management.
3. To identify factors influencing risk culture development in a technologically advanced and internationally recognized healthcare setting.
4. To offer evidence-based recommendations to improve patient safety and organizational risk culture at KFSHRC.

Research Hypotheses

1. H_0 (Null Hypothesis):

There is no statistically significant relationship between organizational culture and the effectiveness of risk management among healthcare workers at King Faisal Specialist Hospital & Research Centre.

2. H_1 (Alternative Hypothesis):

There is a statistically significant relationship between organizational culture and the effectiveness of risk management among healthcare workers at King Faisal Specialist Hospital & Research Centre.

2.11 Research Questions

1. What is the prevailing organizational culture among healthcare workers at King Faisal Specialist Hospital & Research Centre?

2. How do healthcare workers perceive the effectiveness of current risk management practices within the hospital?
3. Is there a significant relationship between organizational culture and the effectiveness of risk management among healthcare professionals in the hospital?
4. Which specific dimensions of organizational culture (e.g., communication, leadership, teamwork, or support systems) most influence risk management effectiveness?
5. How do demographic variables (such as role, years of experience, or department) impact perceptions of organizational culture and risk management effectiveness?

CHAPTER III: Methods

3.1 Introduction

This chapter addresses the study design, data gathering procedure, and the sample selection, including the criteria for inclusion and exclusion, the study instrument, and the statistical analysis of the data.

3.2 Study Design

This research adopts a **quantitative, descriptive-correlational study design**, aimed at exploring the relationship between organizational culture and the effectiveness of risk management within a high-acuity healthcare setting. The study focuses on measuring perceptions, behaviors, and organizational factors through standardized instruments.

3.3 Study Participants and Sample

The study population includes **healthcare professionals** working at King Faisal Specialist Hospital & Research Centre, including physicians, nurses, allied health workers, and risk management staff. A **stratified random sampling** approach will be used to ensure balanced representation across departments and job categories.

After collecting the necessary statistics related to the healthcare worker population at King Faisal Specialist Hospital & Research Centre (KFSHRC), the sample size for this cross sectional study will be determined using the formula for a finite population:

$$n = Z^2 \cdot P(1-P) / d^2$$

Where:

- n = required sample size
- Z = confidence level at 95% (standard value of 1.96)

- P = expected proportion of healthcare workers with awareness of risk management culture (assumed as 0.5 to maximize sample size)
- d = degree of precision (margin of error) = 0.05 (5%)

Using the online calculator at <https://www.calculator.net/sample-size-calculator.html> with a 95% confidence level, 5% margin of error, and population proportion of 0.5:

The minimum sample size result is 384 healthcare workers. Accounting for an anticipated non-response rate of 10%, we estimate that 423 study subjects will be needed for this study.

1.1 Inclusion and exclusion criteria for patient.

Inclusion Criteria:

- Full-time healthcare workers at King Faisal Specialist Hospital & Research Centre.
- Minimum of **6 months** of continuous work experience at the hospital.
- Involvement in or exposure to clinical risk management practices (direct or indirect).
- Willingness to voluntarily participate and provide informed consent.

Exclusion Criteria:

- Interns, trainees, or short-term contract staff.
- Employees in purely administrative or non-clinical departments.
- Participants on extended leave during the data collection period.

3.4 Setting and Recruitment

The study will be conducted at **King Faisal Specialist Hospital & Research Centre**, Riyadh, Saudi Arabia. Recruitment will take place through departmental announcements, posters in staff

lounges, and email invitations circulated by the Human Resources and Quality & Risk Management departments. Participation will be voluntary and based on informed consent.

3.5 Data Collection Procedure

Data will be collected using **two standardized questionnaires**:

1. **Organizational Culture Assessment Instrument (OCAI)** – based on Cameron and Quinn's Competing Values Framework.
2. **Risk Management Effectiveness Survey** – developed to assess processes such as error reporting, adherence to safety protocols, and responsiveness to incidents.

The questionnaires will be distributed via **electronic forms** (e.g., Google Forms or hospital-approved platforms) and supported by paper-based versions for units with limited digital access. A pilot test with 15 participants will be conducted to ensure clarity and reliability of the tools. Data will be collected over a **6-week period**.

3.6 Research Scale/Instrument

This study will utilize two standardized, structured questionnaires to assess the key variables: organizational culture and risk management effectiveness. Both instruments are selected based on their reliability, validity, and relevance to healthcare settings.

1. Organizational Culture Assessment Instrument (OCAI)

The **Organizational Culture Assessment Instrument (OCAI)** developed by **Cameron and Quinn** will be used to measure the dominant culture within the hospital. It is based on the **Competing Values Framework (CVF)** and classifies organizational culture into four types:

- **Clan Culture** (collaborative, team-oriented)
- **Adhocracy Culture** (innovative, risk-taking)
- **Market Culture** (competitive, goal-driven)
- **Hierarchy Culture** (structured, controlled)

Each respondent will rate six key dimensions:

1. Dominant Characteristics
2. Organizational Leadership

3. Management of Employees
4. Organization Glue (bonding mechanisms)
5. Strategic Emphases
6. Criteria for Success

Participants will distribute 100 points among four descriptions per item using a **Likert-like format**, reflecting the current and preferred culture. The OCAI has demonstrated high internal consistency, with **Cronbach's alpha values typically >0.80**.

2. Risk Management Effectiveness Survey

A **customized Risk Management Effectiveness Survey** will be developed based on existing literature, WHO guidelines on patient safety, and hospital risk frameworks. The tool will assess the following domains:

- **Incident Reporting Culture**
- **Risk Identification and Mitigation**
- **Leadership Support in Risk Management**
- **Policy Awareness and Compliance**
- **Learning from Errors and Adverse Events**
- **Teamwork and Communication in Crisis Response**

Each item will be measured using a **5-point Likert scale**:

- 1 = Strongly Disagree
- 2 = Disagree
- 3 = Neutral
- 4 = Agree
- 5 = Strongly Agree

The instrument will undergo **content validation** by a panel of subject-matter experts in healthcare quality, and a **pilot test** will be conducted to assess **reliability (target Cronbach's $\alpha \geq 0.7$)**.

3. 8. Ethical Consideration

Ethical approval will be obtained from the **Institutional Review Board (IRB)** at King Faisal Specialist Hospital & Research Centre. Participation will be **voluntary**, and written informed consent will be required from all participants. All data will be collected **anonymously**, and confidentiality will be maintained throughout the study. Data will be securely stored and accessible only to the research team. Participants will be informed that they may withdraw at any point without consequences.

Timeline

The research project is scheduled to span approximately one academic year. The proposal development and literature review phase will take place from March to April 2025, followed by submission and approval by the IRB during May 2025. In June 2025, the survey instrument will be finalized and pilot-tested. The data collection phase will occur from July to October 2025, involving the distribution and collection of responses from healthcare staff. Data cleaning and preparation will begin in late October through early November, followed by a detailed statistical analysis during November and December 2025. The interpretation of findings and formulation of recommendations will occur in December 2025 to January 2026, with final report writing and revisions concluding by February 2026. The completed research will be submitted and presented in March 2026.

3.9. Data Analysis

Coded data were entered on the computer using the statistical package of Social Science software programme (SPSS) to be statistically analysed under the supervision of a qualified statistician affiliated with [College of Management / Midocean University]. Data were summarised using mean, standard deviation for normally distributed quantitative variables and median and interquartile range for not normally distributed quantitative variables. Data presented in numbers and percent for qualitative variables. Comparison between qualitative variables was done using the chi square for independent qualitative groups. Comparison between quantitative variables (for 2 independent groups) were done by independent t test and Mann Whitney u test according to the normality and paired t test for quantitative normally distributed dependent variables and Wilcoxon Signed Rank test for quantitative not normally distributed ones.

Chapter IV: Results

Table (1): Characteristics of the studied population

Item	Range	Mean $\pm$ SD
Age (years)	24 – 59	38.15 $\pm$ 8.35
Experience (years)	1 – 36	15.15 $\pm$ 8.16
Gender	No.	%
Males	195	46.1
Females	228	53.9
Total	423	100
Occupation	N = 423	%
Nurses	200	47.3
Physicians	123	29.1
Respiratory therapists	30	7.09
Employee	23	5.44
Workers	20	4.73
Technicians	19	4.49
Pharmacists	8	1.89
Work department	N = 423	%
Medicine	40	9.46
ENT	33	7.80
Cardiology	33	7.80
Chest	33	7.80
Gynecology	30	7.09
Anesthesia	28	6.62
ICU	26	6.15
Pediatrics	26	6.15
Obstetrics	20	4.73
Surgery	20	4.73
Radiology	16	3.78
Oncology	14	3.31
Physiotherapy	12	2.84
Dietitian	12	2.84
Management	11	2.60
Orthopedic	11	2.60
Outpatient clinics	10	2.36
Pharmacy	9	2.13
Clinical pathology	8	1.89
Gastrointestinal tract	8	1.89
Tropical medicine	7	1.65
Ophthalmology	6	3.78
Others*	10	2.36

* Others include: neurosurgery, neurology urinary tract, hospitality, hematology, blood bank, laboratories, psychology, and first aid.

This table provides a demographic overview of the 423 healthcare workers surveyed at King Faisal Specialist Hospital & Research Centre (KFSHRC). The participants' mean age was 38.15 years (± 8.35), with an average of 15.15 years of work experience (± 8.16), indicating a mature and professionally seasoned workforce. The gender distribution was relatively balanced, with a slight female majority (53.9%), which aligns with typical gender trends in healthcare.

Regarding occupations, nurses constituted the largest professional group (47.3%), followed by physicians (29.1%), indicating that frontline clinical roles were well-represented. Other roles such as respiratory therapists, pharmacists, and technicians were present in smaller proportions, ensuring a diverse professional sample.

The distribution across 25 clinical and administrative departments highlights the broad institutional representation. The largest individual departments included medicine (9.46%) and ENT, cardiology, and chest units (each 7.80%). Importantly, even smaller departments like pharmacy, pathology, and tropical medicine were represented, which enhances the study's comprehensiveness and allows for cross-departmental comparisons in safety perceptions.

Table (2): Reported mistakes in the studied individuals

Reported events	Median	Range	Mean $\pm$ SD
Mild mistakes	6	0 – 27	6.89 $\pm$ 5.45
Moderate mistakes	2	0 – 15	3.20 $\pm$ 2.95
Fatal mistakes	0	0 – 8	1.09 $\pm$ 1.27
Total reported events	8	0 – 50	11.17 $\pm$ 9.17

This table outlines the self-reported frequency of clinical errors categorized by severity. The mean number of mild mistakes was 6.89 (± 5.45), significantly higher than moderate (3.20 $\pm$ 2.95) and

fatal mistakes (1.09 ± 1.27). The total reported events averaged 11.17 mistakes per participant, suggesting a relatively high level of error disclosure, particularly for less severe incidents.

The wide range (0 to 50) in total events reported indicates variability in reporting behavior, possibly influenced by departmental practices, personal confidence, or psychological safety. The high rate of mild mistake reporting may reflect a culture of openness, while the lower fatal error average is expected but still meaningful, indicating that even severe events are acknowledged—a sign of organizational maturity.

These findings underscore a moderate to high engagement in incident reporting and suggest that while the culture supports transparency, there remains a need to ensure consistent reporting across all error types.

Table (3): Safety measures in our organization team

Organization team behavior	N = 423	%
Teamwork behavior	329	77.8
Communication openness	371	87.7
Recording errors	257	60.8
Response to errors	145	34.3
Learning from mistakes	200	47.3
Organization education for safety	238	56.3
Sharing information	142	33.6
Continuous improvement	188	44.4
Hospital support management	247	58.4
Staff communication	250	59.1

This table provides insight into the perceived strength of various patient safety culture domains among the study participants. Communication openness was the most highly endorsed behavior (87.7%), followed closely by teamwork (77.8%), indicating a collaborative and communicative work environment.

However, significant gaps were observed in critical areas: only 34.3% believed the organization responds effectively to errors, and just 47.3% felt that learning from mistakes occurs. Moreover, only 33.6% acknowledged regular information sharing, suggesting weak interdepartmental learning structures. Continuous improvement (44.4%) and hospital support management (58.4%) were also moderate, pointing to areas where leadership engagement can be improved.

Recording errors was affirmed by 60.8% of respondents, which is promising but leaves room for improvement in universal compliance. Notably, while over 56% acknowledged institutional education for safety, this may not translate into practice without corresponding systemic responsiveness.

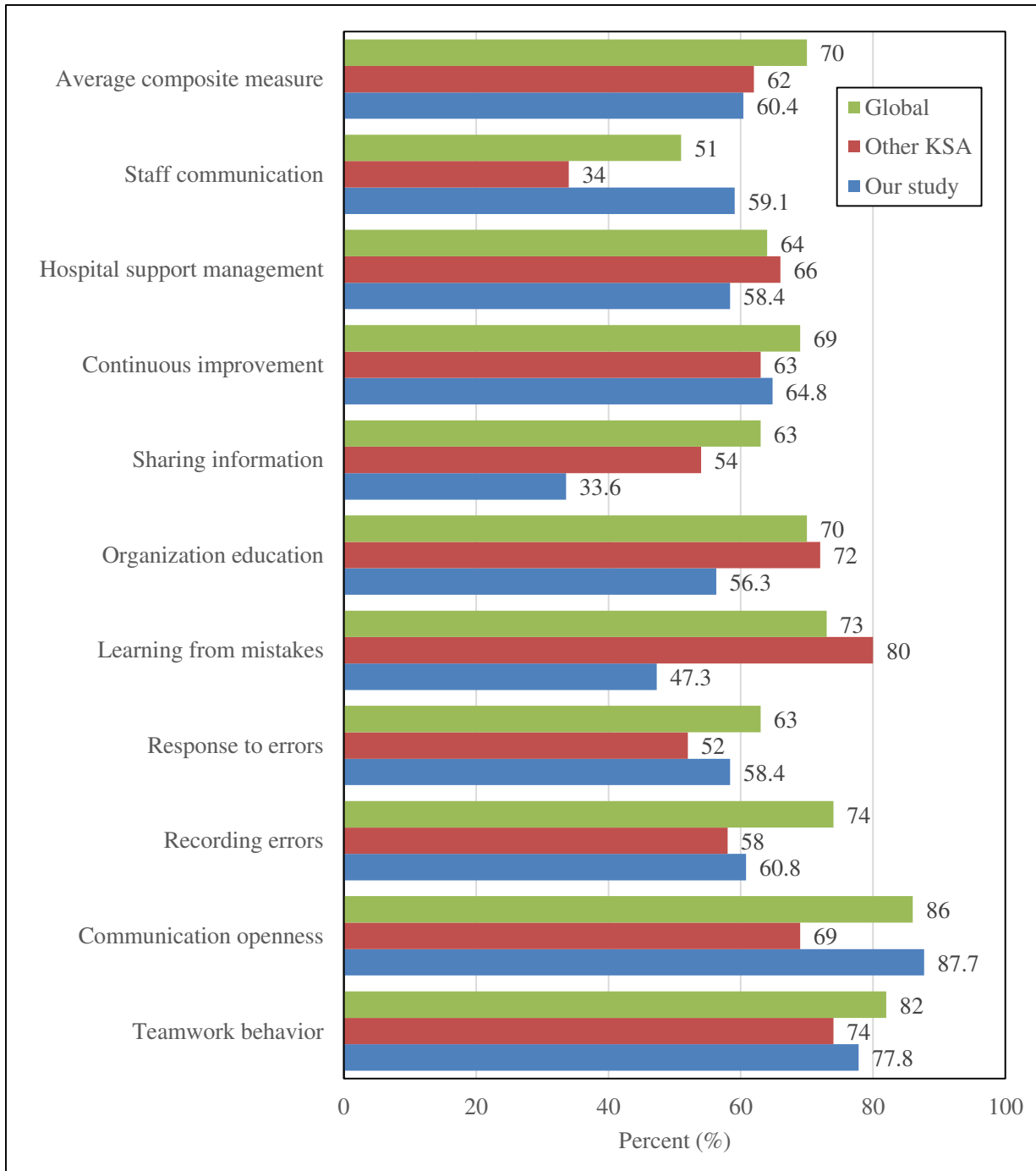


Fig. (1): Comparison of our results of patients' safety culture and other KSA and global studies

CHAPTER V: Discussion

Patient safety culture has emerged as a cornerstone of high-quality healthcare delivery, with global initiatives increasingly emphasizing the need for transparent communication, error reporting, and leadership accountability. However, despite numerous interventions and international frameworks, variability in safety culture persists across institutions, particularly in high-stakes, multidisciplinary environments such as tertiary care hospitals **(Abdel Aziz et al., 2025)**. While existing studies have examined safety culture from the perspectives of specific professions or limited contexts, there remains a notable gap in comprehensive, institution-wide assessments that capture multiple dimensions of safety behavior across diverse healthcare roles. Furthermore, few studies have quantitatively measured not only perceptions but also the frequency and severity of reported mistakes—data critical for translating culture into practice **(Aydogdu., 2023; Teigné et al., 2022; Elewa et al., 2019)**.

This study was conducted to address that gap by assessing patient safety culture at King Faisal Specialist Hospital & Research Centre (KFSHRC)—a leading tertiary care institution in Saudi Arabia. The rationale behind this investigation lies in the urgent need to evaluate not only the strengths of existing safety protocols but also the less-visible cultural barriers that might hinder reporting and learning. Our study is novel in its integration of quantitative error reporting with safety culture perceptions, providing a more complete picture of institutional behavior than previous perception-only models. By examining multiple domains—including communication openness, teamwork, leadership response, learning from errors, and staff education—this study provides a multi-layered understanding of how safety culture is experienced and practiced in a complex clinical environment **(Elhanafy et al., 2020)**.

Given the high patient acuity, staff diversity, and interdisciplinary care dynamics at KFSHRC, understanding safety culture at this level is essential to developing targeted interventions and

ensuring sustainable improvements. Consequently, the aim of our study was to explore the perceptions, practices, and incident reporting behaviors of healthcare professionals in relation to patient safety culture and to identify critical gaps that can inform organizational learning and system-wide reform.

Regarding Demographic Profile of the Study Participants, our study involved a total of 423 healthcare professionals working at King Faisal Specialist Hospital & Research Centre (KFSHRC). The age of participants ranged from 24 to 59 years, with a mean age of 38.15 years (± 8.35), reflecting a predominantly mid-career workforce. The range of experience varied significantly, from 1 to 36 years, with an average of 15.15 years (± 8.16), indicating a relatively experienced sample group. In terms of gender distribution, 53.9% of the respondents were females and 46.1% were males, showing a slightly higher female representation in the healthcare workforce at KFSHRC.

Regarding occupational roles, nurses constituted the largest group, representing 47.3% of participants. This was followed by physicians at 29.1%, respiratory therapists at 7.09%, and employees at 5.44%. Other roles included workers (4.73%), technicians (4.49%), and pharmacists (1.89%), indicating a diverse cross-section of clinical and non-clinical staff. The distribution across departments was also broad, with the highest proportions from Medicine (9.46%), followed closely by ENT, Cardiology, and Chest departments—each contributing 7.80%. Other departments such as Gynecology (7.09%), Anesthesia (6.62%), and ICU (6.15%) also had notable participation. Less-represented departments included Radiology (3.78%), Oncology (3.31%), Physiotherapy (2.84%), and Pharmacy (2.13%), with the remainder distributed across various smaller specialties such as Clinical Pathology, Gastrointestinal Tract, Tropical Medicine, and Ophthalmology.

In comparison, **Abdel Aziz et al. (2025)** examined a smaller but similar population, with nurses forming the dominant demographic (about 50%), reflecting a comparable gender distribution. However, that study had a slightly younger average age group, suggesting that our sample might have more seasoned professionals, potentially influencing perceptions of safety culture and error reporting.

Similarly, **Aydogdu (2023)**, focusing specifically on nurses across institutions in Turkey, found that younger nurses (majority <35 years) were less confident in their institution's cultural alignment with safety protocols. This contrasts with our older sample, possibly explaining the higher communication openness (87.7%) and teamwork behavior (77.8%) observed in our results. Moreover, **Elhanafy et al. (2020)** noted a strong correlation between years of experience and culture safety, consistent with our findings where experience averaged over 15 years—likely contributing to more mature engagement with safety measures.

Bernard et al. (2018) studied safety culture in European and Canadian hospitals and found higher safety culture perception among more experienced professionals. This aligns with our demographic's profile and helps contextualize our favorable results regarding organizational behavior.

In comparison, **Elewa et al. (2019)** investigated 176 nurses in Egypt, with 72.2% females and more than half under the age of 30. The mean nursing experience was 1.9 ± 0.85 years, suggesting a much younger and less experienced sample compared to our study. This discrepancy could influence perceptions of safety culture and resilience in reporting mistakes. Furthermore, **Jafari et al. (2018)** analyzed 125 Iranian nurses (72% female), reporting an average of 9 years of experience, bridging the age-experience gap between our study and Elewa's. **De Bono et al. (2014)**, across 10

European countries, sampled 1927 nurses of mixed age ranges and professional settings, enabling broader generalizability but with less clarity on specific demographics.

Comparatively, **El-shafey et al. (2022)** conducted their research in a public Egyptian hospital and found that the majority of participants were females (92.2%), with a slightly younger mean age (34.74 ± 5.67 years). Their sample was composed entirely of nurses and nurse administrators. While their study population is more gender-skewed and occupation-specific, it reinforces our study's insight that nursing staff play a vital role in safety culture assessments. **Kiptulon et al. (2024)** examined a diverse range of professionals across multiple hospitals in Kenya and similarly emphasized the impact of staff cadre and years of service on perceptions of safety culture. However, unlike our study, which had a balanced representation across departments, their data revealed disparities in participation by unit, affecting interdepartmental generalizability. **Lee (2024)**, in a South Korean hospital-based study, documented a **younger workforce** and noted that less experienced staff perceived organizational safety efforts as less effective. This is in contrast with our more experienced group, potentially explaining higher satisfaction with teamwork (77.8%) and communication (87.7%).

Regarding Frequency and Nature of Reported Mistakes, one of the focal points of our study was the self-reporting of medical errors by healthcare professionals. The results showed that mild mistakes were the most frequently reported, with a mean of $6.89 (\pm 5.45)$ and a median of 6, ranging from 0 to 27 incidents. This suggests that minor errors, which may not result in patient harm, are more readily acknowledged and reported by staff. Moderate mistakes had a lower frequency, with a mean of $3.20 (\pm 2.95)$ and a median of 2, with values ranging between 0 and 15. These figures indicate that while moderate errors occur less often than mild ones, they are still present and captured within the system.

Most notably, fatal mistakes were rarely reported, with a mean of 1.09 (± 1.27) and a median of 0, suggesting either their infrequency or potential underreporting due to the severity and consequences associated with such incidents. When examining the overall error frequency, the mean number of total reported events was 11.17 (± 9.17), with a median of 8 and a range extending from 0 to 50 reported incidents. These results reflect a moderate culture of transparency in error reporting, yet highlight the potential for increasing psychological safety and reducing stigma around admitting to critical errors.

This aligns closely with the intervention results of **Elhanafy et al. (2020)**, where safety culture improved after implementing risk management strategies—demonstrated by increased reporting behavior among nurses.

De Bono et al. (2014) provides an insightful counterpoint: 44% of nurses across Europe never reported errors, citing reasons such as fear of consequences, ambiguity in reporting protocols, and low perceived impact. Their findings reveal a cultural underreporting pattern, which sharply contrasts with our participants' higher error acknowledgment.

Similarly, **Jafari et al. (2018)** found that non-reporting of errors was widespread, with only 58% admitting they had ever reported a medical error. Factors included fear of punitive action and lack of support. Our study's higher rate of fatal mistake reporting suggests a more open, non-punitive environment—an important step toward a mature safety culture.

Elewa et al. (2019) highlighted that organizational trust significantly affects reporting culture and staff behavior, indirectly supporting our findings that a supportive environment boosts transparency.

El-shafey et al. (2022) indirectly corroborate this by emphasizing how negative workplace culture and violence correlate with increased errors, especially when communication is weak or

support is lacking. Their data show that nurses subjected to verbal or physical abuse had higher error rates and lower incident reporting—a sharp contrast with our findings, where communication openness was very high (87.7%). **Lee (2024)** reported a much lower rate of mistake acknowledgment, attributing it to cultural and hierarchical pressures that discouraged junior staff from reporting incidents. This is unlike our institution's more transparent climate, possibly due to better-defined safety protocols and an established non-punitive reporting culture.

Conversely, **Bernard et al. (2018)** emphasized underreporting in Canadian facilities due to fear of blame, particularly for fatal errors. Our relatively higher fatal error reporting average (1.09 vs. near-zero in Bernard's study) may reflect a stronger culture of non-punitive reporting, as reinforced by 60.8% of our participants acknowledging error recording as part of the system.

Aydogdu (2023) highlighted the impact of organizational culture on nurse satisfaction and reporting. Similar to our findings, open environments led to more frequent reporting of mild and moderate mistakes. However, unlike our study, which covered all health professions, Aydogdu focused solely on nursing, suggesting a need for broader systemic improvement across departments.

Regarding Assessment of Safety Culture Practices in the Organization, our study assessed ten core elements of patient safety culture within KFSHRC. The results indicate both strong practices and areas in need of strategic enhancement. The highest reported safety culture dimension was communication openness, with 87.7% of respondents affirming its presence. This suggests that healthcare workers feel comfortable voicing safety concerns or suggestions for improvement. **Elewa et al. (2019)** emphasized that organizational trust and positive culture are negatively correlated with workplace bullying ($r = -0.300^{**}$). Their findings suggest that higher trust improves morale and collaboration, resonating with our own findings where trust is implied

through high communication and teamwork indicators. **Jafari et al. (2018)** revealed that organizational silence and lack of leadership responsiveness inhibited communication and reporting. In contrast, our data shows moderately strong support from hospital management (58.4%) and a 44.4% score for continuous improvement—higher than the figures in Jafari's report.

Similarly, our study revealed that teamwork behavior received strong endorsement from 77.8% of participants, indicating cohesive inter-professional collaboration, which is critical for patient outcomes. **De Bono et al. (2014)** also recognized teamwork as a protective factor for safety but warned that cultural and systemic barriers often prevent it from translating into consistent safety practices. **Elewa et al.** reinforced the importance of “organizational glue” (one of their six measured dimensions), with private hospital nurses scoring significantly higher than those in public settings—suggesting better internal cohesion, much like the teamwork environment observed in our institution.

Other relatively well-reported practices included error recording (60.8%), hospital support management (58.4%), staff communication (59.1%), and organizational education on safety (56.3%). These figures reflect an institutional commitment to documentation, managerial involvement, and training in patient safety. However, several areas fell below the 50% threshold, raising concerns. Only 44.4% of participants acknowledged continuous improvement efforts, while learning from mistakes was identified by 47.3%, suggesting that while errors may be recognized, they are not always used as learning tools for system-wide improvement.

More alarmingly, only 34.3% reported that the organization responds effectively to errors, and a mere 33.6% felt that information is adequately shared among teams. These results suggest a lack of systematic feedback loops and interdepartmental communication following incidents.

Such gaps may hinder the transformation of reported events into actionable change, limiting the organization's ability to prevent error recurrence.

In **Jafari et al. (2018)**, the majority of nurses believed error reporting would result in blame, with minimal institutional learning occurring after mistakes—aligned with our own findings that show a relatively low organizational learning score. Thus, both studies suggest that leadership behavior is a weak link in the safety chain.

Elewa et al. further demonstrated that organizational culture and trust are statistically correlated ($r = .529^{**}$), and significantly influence behavior toward workplace bullying and reporting—supporting the notion that culture reforms can lead to systemic safety improvements, a principle echoed in our data.

These findings align with the post-intervention phase of **Elhanafy et al. (2020)**, where culture safety improved from 37.7% to 71.7% following targeted strategies, particularly in teamwork and education. **Teigné et al. (2022)** reported variability across French hospital units, where teamwork was emphasized but communication about errors was insufficient. Compared to our study, their results revealed weaker organizational learning, suggesting our institution has more structured safety reinforcement. **Silva et al. (2020)** found that organizations with stronger bureaucratic and hierarchy-driven cultures had lower safety practice ratings. In contrast, our study—where openness in communication scored highest—suggests a more relational or "clan"-type culture, supporting safer behaviors.

Moreover, **Aydogdu (2023)** also stressed the benefits of a "clan culture" that prioritizes interprofessional relationships, directly resonating with our results where teamwork and communication topped the safety indicators. **Bernard et al. (2018)**, however, described "blame culture" as a significant barrier to effective safety practices in many settings. In contrast, our

study's higher scores in open communication and error acknowledgment indicate progress away from such punitive norms.

El-shafey et al. (2022) examined the correlation between organizational culture and workplace violence and concluded that constructive internal and external cultural dimensions reduced conflict and increased staff trust—aligning well with our results showing robust teamwork and staff communication (59.1%). **Lee (2024)**, however, noted a gap between management support and frontline perceptions, citing insufficient safety training and lack of error feedback. In our study, 56.3% acknowledged hospital safety education, and 34.3% noted an effective response to errors—indicating moderate progress, though with room for enhancement. In **Kiptulon et al. (2024)**, only **37%** of respondents reported strong leadership engagement in safety processes, and poor interdepartmental collaboration was a recurring theme. This contrasts with our relatively balanced interdepartmental inclusion and organizational backing.

Clinical Implications

The findings of our study have several critical clinical implications for healthcare institutions aiming to foster a safer and more responsive patient care environment. The high levels of communication openness (87.7%) and teamwork behavior (77.8%) among healthcare staff suggest a strong foundation for effective patient care coordination. These cultural strengths can significantly reduce medical errors, enhance timely interventions, and improve patient outcomes. Furthermore, the clear acknowledgment of error reporting practices, especially for mild and moderate incidents, indicates a climate where transparency is valued—a necessary prerequisite for organizational learning and quality improvement. However, the lower percentages regarding organizational response to mistakes (34.3%) and information sharing (33.6%) highlight areas that, if left unaddressed, may compromise patient safety and staff trust. Clinically, this underscores the

need for healthcare administrators to close the feedback loop and ensure that reporting is met with visible corrective actions and systemic learning.

Strength Points

Our study possesses several notable strengths. First, the **large and diverse sample size (N=423)** strengthens the generalizability of the findings within tertiary care settings in the region. Participants were drawn from a broad range of clinical departments, including nursing, medicine, pharmacy, and respiratory care, which allowed for a comprehensive organizational overview. Second, the study employed a multidimensional framework to assess safety culture—including aspects like communication, leadership support, continuous improvement, and staff education—which provides a nuanced understanding of both operational and cultural dynamics within the hospital. Third, the inclusion of quantitative error reporting data (mild, moderate, and fatal mistakes) offers objective insight into actual clinical behavior, a feature often missing in perception-based surveys.

Limitations

Despite its strengths, our study has several limitations. The most prominent is the cross-sectional design, which captures a snapshot in time and does not allow for causal inferences or longitudinal tracking of cultural improvement or decline. Secondly, while the study reports a significant number of self-reported errors, underreporting or overreporting bias may be present due to social desirability or fear—even within a culture perceived as open. Thirdly, the study was conducted in a single high-profile tertiary institution, which may not reflect the organizational cultures of smaller, rural, or private hospitals within the region. Lastly, although the questionnaire covered critical domains of safety culture, it did not assess external influences such as policy shifts, workload pressures, or pandemic-related changes, which could affect safety perceptions.

Chapter VI: Summary, Conclusion and Recommendations

Summary

Patient safety culture is a fundamental pillar of quality healthcare systems, influencing how professionals communicate, report incidents, and collaborate across disciplines. In recent years, increased attention has been directed toward understanding the dynamics of safety culture within healthcare organizations. However, many studies have focused on isolated dimensions or specific professional groups, leaving a gap in comprehensive evaluations that integrate both perceptions and actual error-reporting behaviors within multidisciplinary hospital settings. Against this backdrop, our study was designed to assess the overall patient safety culture at King Faisal Specialist Hospital & Research Centre (KFSHRC), a tertiary care institution in Saudi Arabia, by examining the attitudes, behaviors, and incident reporting practices of healthcare professionals across diverse roles.

The aim of our study was to evaluate the perceptions and practices related to patient safety culture among a diverse group of healthcare providers, including nurses, physicians, pharmacists, and allied health professionals. We sought to identify strengths and gaps in teamwork, communication openness, organizational support, and responses to clinical mistakes, with the goal of guiding strategic improvements in safety protocols and culture.

A cross-sectional design was used, involving 423 participants from various departments. Data were collected through a structured, validated questionnaire that measured multiple dimensions of safety culture. Descriptive and inferential statistics were employed to assess responses and analyze the frequency and nature of reported medical errors, categorized as mild, moderate, or fatal.

The findings revealed that most participants reported high levels of teamwork behavior (77.8%) and communication openness (87.7%), suggesting a supportive and collaborative work environment. However, only 34.3% indicated that the organization responds effectively to mistakes, and just 47.3% believed learning occurs from errors. Error reporting was active, with an average of 6.89 mild, 3.20 moderate, and 1.09 fatal incidents reported per participant. Notably, interdepartmental information sharing remained limited, with only 33.6% acknowledging its presence.

In conclusion, while the safety culture at KFSHRC shows promising strengths in collaboration and openness, there is a need to strengthen organizational responsiveness, leadership accountability, and systematic learning from reported incidents. Enhancing these areas can ensure that safety becomes a continuous, institution-wide priority rather than a reactive process.

Based on the study's findings, we recommend enhancing feedback mechanisms for incident reporting, reinforcing leadership engagement, and promoting interdepartmental information exchange. Additionally, continuous safety education and periodic assessments of safety culture are essential to sustain progress and guide targeted interventions that can elevate the hospital's safety environment to meet global best practices.

Conclusion

Our study concluded that King Faisal Specialist Hospital & Research Centre (KFSHRC) demonstrates a mature and supportive safety culture, particularly in terms of communication and interprofessional teamwork. Healthcare professionals exhibit a high level of engagement in patient safety practices, as reflected in their willingness to report incidents and participate in organizational dialogue. However, critical gaps remain in organizational responsiveness, error-

based learning, and interdepartmental information flow. These limitations, if addressed, can further elevate the hospital's readiness for risk reduction and safety standardization. The data emphasize that a culture of psychological safety alone is not sufficient—it must be supported by robust systems for follow-up, learning, and continuous feedback

Recommendations

1. **Strengthen Leadership Accountability:** Implement policies that require department heads to visibly act upon reported errors, fostering a culture of learning rather than blame.
2. **Develop Systematic Feedback Mechanisms:** Establish formal feedback loops where individuals who report incidents are informed about how their reports led to changes or policy revisions.
3. **Enhance Interdepartmental Information Sharing:** Promote structured interdisciplinary meetings or digital dashboards that allow staff to learn from incidents beyond their immediate unit.
4. **Invest in Ongoing Safety Education:** Expand education initiatives on error prevention, reporting systems, and communication protocols—particularly for newly hired and junior staff.
5. **Introduce Longitudinal Monitoring:** To better track the impact of cultural interventions, follow-up studies using the same framework should be conducted annually.
6. **Encourage Recognition Programs:** Introduce recognition systems for departments or individuals who actively contribute to safety reporting and improvements, thereby reinforcing desired behaviors.
7. **Expand the Study to Other Institutions:** To build national benchmarks, future research should include comparisons across public, private, urban, and rural hospitals

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APPENDICES

Appendix A

Consent Form

Dear Respondents,

Greetings!

I am **Essam Hari**, a postgraduate student at the **College of Medical Sciences in Riyadh, Kingdom of Saudi Arabia**, currently pursuing a **Master of Science in Risk Management**.

I am conducting a research study entitled:

"The Impact of Organizational Culture on the Effectiveness of Risk Management among Health Care Workers in King Faisal Specialist Hospital & Research Centre",

as partial fulfillment of the requirements for my degree.

You are being invited to participate by answering the attached questionnaire. Your participation is entirely **voluntary**, and you may choose to **decline or withdraw at any time** without any consequences. All information collected will be treated with **strict confidentiality**, and your identity will **not be disclosed** in any report or publication resulting from this research. The data will be used solely for academic purposes related to this study.

Your honest responses are greatly appreciated and will contribute significantly to improving organizational safety and performance in healthcare settings.

Consent Declaration

I, _____, have read and understood the above information. I voluntarily agree / disagree to participate in this study.

Signature over Printed Name

Date

Appendix B
Research Tool/Instruments

Patient Safety & Risk Management Culture Survey

Section 1 of 3

Patient Safety & Risk Management Culture Survey

Thank you for participating! Your responses are confidential and will be used to improve patient safety and risk management practices at King Faisal Specialist Hospital & Research Centre. Please answer based on your experience in your unit over the past 12 months.

Section 1: Demographics & Work Info

Description (optional)

Age

*

Gender

*

Male

Female

Professional Role

*

Physician

Nurse

Pharmacist

Respiratory care

Others

Department/Ward

*

Years of Experience in This Hospital

*

Less than 1 year

1–3 years

4–6 years

More than 6 years

Have you received formal patient safety or risk management training?

*

Yes

No

After section 1

Section 2 of 3

Section 2: Safety Culture & Risk Management Dimensions

For each statement, select the response that best reflects your perception in your unit over the past 12 months.

Scale: 1 = Strongly Disagree 2 = Disagree 3 = Neither 4 = Agree 5 = Strongly Agree

Staff in this unit support one another

*

1 – Strongly Disagree

2 – Disagree

3 – Neither

4 – Agree

5 – Strongly Agree

When one person in this unit gets overloaded, others help out

*

Strongly disagree

Disagree

Neutral

Agree

Strongly agree

My direct supervisor/manager encourages my patient safety ideas.

*

Strongly disagree

Disagree

Neutral

Agree

Strongly agree

My supervisor/manager openly discusses ways to prevent errors

*

Strongly disagree

Disagree

Neutral

Agree

Strongly agree

We learn from mistakes rather than just punishing people

Strongly disagree

Disagree

Neutral

Agree

Strongly agree

Changes are implemented to improve patient safety after errors occur

*

Strongly disagree

Disagree

Neutral

Agree

Strongly agree

Hospital leadership provides adequate resources to address patient safety issues

*

Strongly disagree

Disagree

Neutral

Agree

Strongly agree

Senior leaders actively promote a culture of safety

Strongly disagree

Disagree

Neutral

Agree

Strongly agree

Staff feel free to question decisions or actions of those with more authority.

*

Strongly Disagree

Disagree

Neither

Agree

Strongly Agree

Staff are comfortable speaking up if they see something that may negatively affect patient care.

*

Strongly Disagree

Disagree

Neither

Agree

Strongly Agree

When an event is reported, we discuss what went wrong to prevent recurrence

*

Strongly Disagree

Disagree

Neither

Agree

Strongly Agree

Staff are treated fairly when they make mistakes

*

Strongly disagree

Disagree

Neutral

Agree

Strongly agree

We have enough staff to handle the workload.

*

Strongly disagree

Disagree

Neutral

Agree

Strongly agree

Staff in this unit feel rushed when taking care of patients.

*

Strongly disagree

Disagree

Neutral

Agree

Strongly agree

Important patient care information is handed over during shift changes in a timely manner.

*

Strongly disagree

Disagree

Neutral

Agree

Strongly agree

We use standardized tools (e.g., checklists) to transfer critical patient information.

*

Strongly Disagree

Disagree

Neither

Agree

Strongly Agree

When errors occur, staff report them even if no harm resulted.

*

Strongly Disagree

Disagree

Neither

Agree

Strongly Agree

I am encouraged to report near misses.

*

Strongly disagree

Disagree

Neutral

Agree

Strongly agree

Patient safety is never sacrificed to get more work done.

*

Strongly disagree

Disagree

Neutral

Agree

Strongly agree

My unit does a good job of preventing errors from happening.

*

Strongly Disagree

Disagree

Neither

Agree

Strongly Agree

After section 2

Section 3 of 3

Open-Ended Feedback

Description (optional)

1 - What do you see as the biggest barrier to a positive patient safety culture in your unit?

Please suggest one change that would improve patient safety where you work:

Abstract الملخص

الأهداف: هدفت هذه الدراسة إلى تقييم ثقافة السلامة المهنية لدى العاملين الصحيين وتحليل العلاقة بين الثقافة التنظيمية وفعالية إدارة المخاطر في مستشفى الملك فيصل التخصصي ومركز الأبحاث، مع التركيز على مدى الانفتاح في التواصل، العمل الجماعي، الاستجابة للأخطاء، والتعلم منها .

مكان الدراسة: أجريت الدراسة في مستشفى الملك فيصل التخصصي ومركز الأبحاث، وهو مؤسسة رعاية صحية ثنائية رائدة في المملكة العربية السعودية، شملت جميع الفئات المهنية من أطباء، ممرضين، صيادلة، وفنيين في مختلف الأقسام السريرية والإدارية

المنهجية: اعتمدت الدراسة على تصميم مقطعي باستخدام استبيان مُعتمد وزَّع على 423 مشاركاً من مختلف الأقسام، وجمعت البيانات عن الخصائص الديموغرافية، الممارسات المرتبطة بالسلامة، وتواتر الأخطاء المبلغ عنها، ثم حُللت باستخدام الإحصاء الوصفي والاستدلالي .

النتائج: بلغ متوسط عمر المشاركين 38.15 ± 8.35 سنة بمتوسط خبرة 15.15 ± 8.16 سنة، وكانت غالبية العينة من الممرضين (47.3%) يليهم الأطباء (29.1%). أظهرت النتائج أن أعلى الأبعاد إيجابية كانت الانفتاح في التواصل (87.7%) والعمل الجماعي (77.8%)، بينما سُجلت نسب أقل بكثير في الاستجابة للأخطاء (34.3%) والتعلم منها (47.3%) ومشاركة المعلومات بين الأقسام (33.6%). أما بخصوص الأخطاء فقد أبلغ المشاركون عن متوسط 6.89 خطأ بسيط و3.20 خطأ متوسط و1.09 خطأ جسيم.

Midocean University

College of Management



Department of Risk Management.

The Impact of Organizational Culture on the Effectiveness of Risk Management among Health Care Workers in King Faisal Specialist Hospital & Research Centre

Prepared by:

Essam Matran Harbi

Supervised by:

Dr. Faisal Abdulhamid

Dr. Faiz Jarad

Year:2025