



Open the door to complexity

– safety climate and work processes in the operating room

av

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Akademisk avhandling

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Abstract

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A complex adaptive system such as the operating room (OR), consists of different safety cultures, sub-cultures and ways of working. When measuring, a strong safety climate has been associated with lower rates of surgical complications. Teamwork is an important factor of safety climate. Discrepancies among professionals' perceptions of teamwork climate exists. Hence it seems crucial to explore if diversity exists in the perception of factors related to safety climate and between managers and front-line staff in the OR. Complex work processes including multitasking and interruptions are other challenges with potential effect on patient safety. However, multitasking and interruptions may have positive impact on patient safety, but are not well understood in clinical work. Despite challenges a lot of things go well in the OR. Thus, the overall aim of this thesis was to evaluate an instrument for assessing safety climate, to describe and compare perceptions of safety climate, and to explore the complexity of work processes in the OR.

To evaluate the Safety Attitudes Questionnaire-operating room (SAQ-OR) version and elicit estimations of the surgical team a cross-sectional study design was used. How work was done was studied by observations using the Work Observation Method by Activity Timing and by group interviews with OR professionals.

The results show that the SAQ-OR is a relatively acceptable instrument to assess perceptions of safety climate within Swedish ORs. OR professionals' perceptions of safety climate showed variations and some weak areas which cohered fairly well with managers' estimations. Work in the OR was found to be complex and consisting of multiple tasks where communication was most frequent. Multitasking and interruptions, mostly followed by communication, were common. This reflects interactions and adaptations common for a complex adaptive system. Managing complexity and creating safe care in the OR was described as a process of planning and preparing for the expected and preparedness to be able to adapt to the unexpected.

Keywords: patient safety, operating room, complexity, safety climate, psychometrics, cross-sectional, observations and qualitative

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