



The Arab American University
Faculty of Graduate Studies

**Strategic Human Rights-Based Approach for Understanding
Patient Safety in Selected Palestinian Hospitals
in North West Bank**

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Fundraising**

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Thesis Approval Form

Strategic HRBA for Understanding Patient Safety in Selected Palestinian Hospitals in North of West Bank

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Declaration

I am the undersigned Roaa Yaseen, holder ID Card No. (850644246). The work presented in this thesis, unless otherwise referenced, is based on my own work and has not been submitted elsewhere for any other degree or qualification.

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Dedication

I dedicate this great study to my great parents who instilled in me to trust myself and supported them to achieve my dreams no matter how hard the path is. I dedicate this achievement to myself, despite of the challenges and obstacles that I faced in my life. I would like also to give a special dedicate to a greatest human being Prof. Saleem Haj Yahia who is the source of optimism and positive energy in my life. My utter gratefulness goes to my beloved brother Eng. Amjad Yaseen, and everyone who supported and stood by me.

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Abstract

This study aimed to examine the level of understanding of patient safety in selected Palestinian hospitals in northern West Bank by employing a strategic HRBA by health professionals, considering the following axes: (Fairness, Equality, Respect, Dignity, Autonomy). A cross-sectional quantitative design was employed to achieve this aim. The researcher used the Arabic translated SOPS Hospital Survey 2.0 version (Survey Items and Composite Measures questionnaire) as a means of collecting the necessary data and polling for the study sample. The questionnaire created by the Agency for Healthcare Research and Quality (AHRQ) was employed in this study in 2019, whereby (481) questionnaires were distributed to health professionals in 6 government hospitals in the northern West Bank, including (Rafidia Hospital, Khalil Suleiman Hospital, Thabet Thabet Hospital, Tubas Turkish Hospital, Darwish Nazzal Hospital, Yasser Arafat Hospital). A total of (473) questionnaires were retrieved, with a response rate of (98%).

The researcher used the SPSS statistical program to analyze the data, and the results of the study showed an important and significant role in employing human rights principles in healthcare by health professionals in government hospitals in the north of west bank. The level of employing FREDIA principles by health professionals was moderate for all principles, noting that the level of employing the principle of fairness fared best of all with (70.8%) percentage compared to the other principles.

While the results showed that the level of patient safety assessment in government hospitals was (55.6%), the results also indicate that there are some factors that violate the patients' rights represented in the level of staffing and work pace by (56.3%), non- punitive response to errors by (64.7%), and the hospital administration support for patient safety (66%). On the other hand, the results showed that there is a correlation relationship between human rights principles and many

variables, but at a moderate rate like fairness factor is significant correlated with A6_1 Extent of agreement with statements about your unit/work area staffing and work pace (In this unit, staff feel like their mistakes are held against them). The study recommends by providing a supportive and encouraging environment by the hospital administration and the MoH through financial incentives and providing the necessary resources. There is a need to improve some areas of PS culture in Palestinian government hospitals to ensure enhanced PS. Allocating an adequate budget to the MoH in order to provide financial and human resources and medical equipment. Developing the patient rights' charter to ensure the patients' rights and healthcare providers in the government hospitals.

Index Words: HRBA, Patient Safety, Fairness, Equality, Respect, Dignity, Autonomy

LIST OF ACRONYMS

AAUP	Arab American University – Palestine
ACHPR	African Charter on Human and Peoples' Rights.
AHRQ	Healthcare Research and Quality
CDCs	Centers of Disease Control and Prevention
CRC	Convention on the Rights of the Child
ECHR	European Convention for the Protection of Human Rights and Fundamental Freedoms
FREDA	Fairness, Respect, Equality, Dignity, Autonomy
HSOPSC	Hospital Survey on Patient Safety Culture
HRBA	Human Right-Based Approach
IHI	The Institute for Healthcare Improvement
IoM	Institute of Medicine
ICHR	Independent Commission for Human Rights
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
JCI	Joint Commission International
MoH	Ministry of Health
MAPSAF	Manchester Patient Safety Assessment Framework
NPSF	The National Patient Safety Foundation
Opt	Occupied Palestinian Territory
OCHA	The United Nations Office for the Coordination of Humanitarian Affairs
PS	Patient Safety
PSCHO	Patient Safety Culture in Healthcare Organizations
PHC	Primary Healthcare
PCBS	Palestinian Center Bureau Statistics.
PPE	Personal Protective Equipment
PNA	Palestinian National Authorities
RTH	Right to Health.
SEM Factors	Social Ecological Model Factors
SOPS	Survey on Patient Safety
SDGs	Sustainable Development Goals
SAQ	Safety Attitudes Questionnaire
SOS	Safety Organizing Scale
SPSS	Statistical Package for the Social Sciences

UDHR	Universal Declaration of Human Rights
WHO	World Health Organization
WMA	World Medical Association

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DEFINITIONS OF TERMS

#	TERMS	DEFINITION
1	HRBA: Human Right-Based Approach	Is the process by which human rights are safeguard in clinical practices through adherence to the values underlying; Fairness, equality, respect, dignity, and autonomy. These principles are the fundamentals of good healthcare (Curtice and Exworthy, 2010). It focuses on the most marginalized and vulnerable people by analyzing and addressing discrimination and inequality aspects, and accountability of states and other parties to address growing global health disparities and facilitate equity of the right to health for victims of violations (London, 2008).
2	PS: Patient Safety	Defined as the avoidance and prevention of patient injuries or adverse events resulting from the processes of healthcare delivery (Arrieta, et al., 2017).
3	PS culture: Patient Safety culture	The product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization's health and safety management (Abu-El-Noor et al., 2019).
4	RTH: Right to Health	The RTH is that everyone has access to the health services they need, when and where they need them, without suffering financial hardship. The concept of the RTH has been mentioned in many international conventions and declarations that include the ICESCR, the Universal Declaration of Human Rights, and the

		Convention on Persons with Disabilities. There is controversy over the interpretation and application of the RTH, and the minimum level of the RTH has not been determined due to the different economic and political conditions in every country in the world (WHO, 2021) .
5	SEM: Social Ecological Model	The model was developed to enhance understanding of the dynamic interrelationships between various personal and environmental factors. The Centers for Disease Control and Prevention (CDC) used it to promote health and find sustainable solutions to violence and the problems that individuals and societies suffer from. The model includes four levels: Individual Relationships, Community, Societal (CDC, 2016) .
6.	Health professionals	WHO defined a HP is a person trained to work in health or health- related field who applying evidence- based practices. The team of health professional consist of (Physicians (General & Specialists), Pharmacists, Nurses, Midwives, Paramedicals). (MoH,2019)

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CHAPTER I

In this chapter, the researcher will explain the reason for conducting this study. It starts with a general description of the human rights-based approach and a patient safety background and then discusses the problem of the study, as well as the objectives of the study, the study of questions and hypotheses, and the significance of the study.

1.1 Introduction:

“All human rights are universal, indivisible, interdependent, interrelated” (Singh, et al., 2017), Making equal rights for all human beings available is the basis for freedom, justice, and peace in the world according to the Universal Declaration of Human Rights (UDHR) adopted by the United Nations General Assembly in 1948 (United Nations, 2006).

Member states of the United Nations have shown increasing interest in the concept of human rights and have developed a human rights-based approach (HRBA) as one of the foundations in the formulation of policies and programs. In the year 2003, the "United Nations Inter-Agency Understanding Statement on HRBA for Development Cooperation" was adopted, and human rights included civil, cultural, economic, political, and social rights (Gruskin et al., 2010), In the later, the right to health is an integral pillar.

Several studies indicated that HRBA focuses on the most marginalized and vulnerable people by analyzing and addressing discrimination and inequality aspects. Integrating HRBA into public health is a prerequisite for achieving health for all. Over the past years, global health management institutions have increasingly applied human rights to advance global health. Those institutions

aspired to coordinate between international organizations to implement human rights related to health and to reach a common understanding of universal human rights, HRBA includes accountability of states and other parties to address growing global health disparities and facilitate equity of the right to health for victims of violations (**London, 2008**).

HRBA is the mechanism by which human rights are safeguard in clinical practices through adherence to the values underlying; Fairness, equality, respect, dignity, and autonomy. These principles are the fundamentals of good healthcare (**Curtice and Exworthy, 2010**).

The integration of human rights into health and development process ensures that health policies lead to promote human rights. The right to health has been emphasized in international and regional human rights treaties, and in national constitutions around the world, Article 25 of the 1948 UDHR recognizes the right to health that: “Everyone has the right to a standard of living sufficient to guarantee health and well-being for himself and his family, especially at the level of food, clothing, housing and medical care” (**United Nations, 2006**).

Based on this notion, the concept of patient rights has developed around the world during the past decades, and there is a growing international consensus that all patients should have certain basic rights so that the patient is guaranteed access to all rights while obtaining basic health services. In other words, the patient is entitled to a certain amount of protection guaranteed by healthcare providers and the state, which has been codified in various societies and countries in the form of charters of patient rights. The concept of patient’s rights is defined as “the code of conduct between people who benefit from health services, health institutions and the individuals who provide them (**Akca et al., 2015**).

Respecting, protecting, and adhering to human rights can lead to improving health outcomes for patients. Providing appropriate working conditions in health institutions and centers, providing

safe, fair, timely appropriate and integrated health services reduce adverse events that may affect PS (**ICHR,2008**).

The WHO attaches great importance to PS as an integral part of the quality of healthcare to strengthen the health system, and it is one of the six national priorities identified by the Quality and disparities report (QDR), According to the report during 2017, 54% of healthcare quality measures showed improvement, nearly two-thirds of PS metrics were improving (**AHRQ, 2019**).

Monitoring the occurrence of medical errors is essential to raise awareness of the problem and recognize the responsibility to improve PS. Millions of patients around the world are still suffering from injuries or deaths caused by unsafe medical care, It is estimated that one out of every 10 patients in developed countries is injured while receiving hospital care, It is also estimated that the cost of adverse events associated with permanent disability, and the loss of life of affected people and their families amounts to trillions of dollars annually, in addition to the psychological adverse suffered by the patients and their families. It is also estimated that 15% of hospital expenditures in Europe are attributable to treatment of adverse events associated with PS (**WHO, 2017**). The role of the human factor in adhering to the application of laws is considered an important element in influencing health and commitment in providing the right service, and the belief in the citizen's right to health by all health workers and expressing it in word and practice. Studies show that patients should be considered human beings who are not allowed to experiment with or about. This perspective prevents endangering PS. Values, beliefs, and behavioral rules that health professionals share in hospitals towards patients are fundamental dimensions of PS culture.

Therefore, HRBA accreditation contributes to teaching them how to respect and protect patient rights, where safety and quality care are core elements. The process of placing patients and

their rights at the center of safety efforts ensures their participation and their families as decision-making partners (**Vaismoradi et al., 2011**).

1.2 Background & Significance

As a country of the South, Palestine recently started focusing on moving towards providing high-quality services in hospitals. The Palestinian Authority has worked since it took over the management of the health sector in 1994 to develop many legislations and provisions related to health. This provided a good legal environment governing health condition in Palestine.

It also laid down strategic plans to realize the right to health towards healthcare services improvements in Palestine. The Palestinian Authority adheres to the UDHR and the International Covenant on Human Rights as well as the Constitution of the WHO and therefore health is a right in Palestine. This right must translate across all systems and laws, mainly the Public Health Law and the Health Insurance Law. This right must also be reflected in the available health services, the quality of these services, and the public ability to access them (**ICHR, 2008**).

In 2009 the right to health was incorporated as a national priority in the work of the WHO in Palestine, and the organization focused on promoting a comprehensive health policy approach to support building the capacity of health partners in legal obligations and concepts such as gender mainstreaming and social determinants. The issues of gender equality, justice and human rights as well as considering the social determinants of health are considered important issues for sustainable development goals. The strategic approach to the right to health focused on ensuring the integration and implementation of human rights, gender, equality, and social determinants in all programs of WHO and MoH (**WHO, 2017**).

In developing the human rights law to promote public health through the United Nations, it is stated in the constitution of the WHO that “health is a state of complete physical, mental, and social well-being and not merely the absence of disease or disability, and that enjoying the highest attainable level of health is one of the major rights for every human being, without any distinction based on race, religion, political belief, economic or social condition” (Meier et al., 2018). From this starting point , the Ministry of Health seeks to work to strengthen the legal and regulatory environment in the health sector to ensure the sustainability of the health system and improve its performance through reviewing and developing various health laws and legislations according to needs, and ensuring the provision of comprehensive health services to all citizens in line with the third goal in sustainable development “Ensuring that all people enjoy healthy lifestyles and luxury at all ages” (WHO, 2017).

In the context of developing the right to health in Palestine, the Independent Commission for Human Rights worked on monitoring the reality of health in Palestine and define the basic concept of the RTH considering what is contained in international covenants, especially what was mentioned in the texts of the International Covenant of 1966 on Economic, Social and Cultural Rights. Article 12 clarified that it is the responsibility of the state to ensure that citizens enjoy the right to an appropriate level of health, and to ensure that none of its citizens is deprived from enjoying the RTH as a result of the actions of the state, It includes measures that state parties must take to ensure the right to health for all individuals in order to reduce child and maternal mortality rates, prevent and control epidemic diseases and create appropriate conditions for securing medical services and medical care for all ” (ICHR, 2008) .

According to the annual health report of the Ministry of Health for the year 2019, the death rate in the West Bank was 58.7%, and in Gaza 41.3% of all deaths in Palestine, and cardiovascular

disease was the first cause of death among Palestinian citizens, and the death rate reached 29.9%, followed by cancer as a second cause of death and amounted to 15.5% (MoH, 2020).

Adverse events in Palestinian hospitals are likely to occur 20 times higher than previously reported (Najjar et al., 2013), and therefore the hospital is responsible for providing operations that support patients and families' rights while receiving healthcare in terms of reducing physical, cultural barriers And respect for the patient's dignity, privacy and confidentiality of information, and work to inform patients about aspects of medical care and treatment decisions and other rights in order to reduce errors and preserve the safety of patients.

The outcome of this study helps to Improve understanding of the FREDA principles as the basis for the HRBA and providing reliable and accurate information about the application of HRBA to health as a strategic approach to understanding PS in government hospitals in Northern West Bank, also, identification of the areas of violation of patients' right to safety. This study will provide a guiding framework for planners and policies makers in the development process in the health field. Also, the findings of this study will contribute in understanding PS because of the lack of studies on strategic HRBA. The importance of scientific study is emphasized by enriching the theoretical framework for scientists and researchers in the health field, those interested in human issues, human rights workers, health services providers, and civil society organizations, where they can benefit from discussing the concept of a HRBA to health and the concept of PS, As a basic reference for future studies.

1.3 Study Problem

Human rights law has a significant effect on all facets of life and public services, but there is little awareness of the correct implementation of the concept of human rights law, and the generic concept of human rights has not developed from legal concepts to the principles on which decisions can be taken within organizations and provide a foundation to formulate policies, strategies, and programs. However, there was consensus on the need to have a human rights-based value system.

Whilst the principles of human rights are already based on good healthcare, the need remains to strengthen these values in the day-to-day working activities of health professionals or policymakers and planners. And this needs to be indirectly strengthened by the need to provide appropriate training and adequate resources for staff and organizations as a whole (**Exworthy and Curtice, 2010**).

In the Palestinian context, the level of interest in raising awareness and education in international human rights conventions in the Palestinian society is limited and modest despite its importance, so opportunities to obtain international and regional justice are often lost due to ignorance of the protection mechanisms, and the work to implement public health policies without seriously considering the human rights dimension may harm people and make politics ineffective (**Nashwan, 2011**). Especially because of the existence of the occupation, which indirectly affects the prevention of the RTH. The accessibility to health services due to the occupation and its practices in the West Bank and Gaza from obstacles and blockades makes it often impossible. (**ALbarsh, 2017**).

Regarding the commitment to the RTH, in terms of RTH realization requirements, the state of Palestine did best in the obligation to adopt appropriate legislation to achieve the RTH (**AlRifai,**

2013), but this legislation still needs to be further modernized to be in line with international health standards to reach the highest attainable level of health. There is a need to implement many aspects of legislation through the issuance of executive regulations such as the Public Health Law.

The Ministry of Health recently focused in its national health strategy on the urgent need to amend and develop the Public Health Law of 2004 in line with health and national developments (**MoH, 2017**), it did not specify the concept of RTH directly, but addressed the concept of health in several articles that guarantee the health rights of the Palestinian citizen and the most important thing in this law “is to give priority to the women and children's healthcare and to provide preventive, diagnostic, curative and rehabilitative services, disease control, health counseling and education (**ALbarsh, 2017**).

Violations or lack of attention to human rights and dignity can have serious health consequences, especially with the limitation of the Palestinian health institution's role in providing their services to the Palestinian citizen due to Israeli procedures and policies and their inability to move from the stage of responding to emergency needs to the stage of real health development, and this requires a clear vision and robust health system in order to achieve the implementation of the RTH.

The problem of the study lies in the lack of awareness for the health service providers and educating them about the rights and safety of patients in the Palestinian hospitals, and this leads to a violation in patients' RTH. Violation of human rights arises from deficiencies in the Ministry's organization and oversight function, which appears in the absence of institutional regulations incorporating the accountability measures in relation to the disclosure of patient information. Lack of a culture, awareness, and commitment to patient rights principles increases the occurrence of errors and adverse events that expose patients to health-related risks leading to a citizen's lack of

confidence in health services, and on the other hand there is a failure to educate the public about their rights with regard to healthcare (**AIRifai, 2013**).

Where In 2017, the Independent Commission for Human Rights received (48) complaints about the RTH, distributed among complaints about the availability of vaccinations and medicines, complaints about the lack of adequate health services and the demand for additional services for a region, and Complaints about responsibility for medical negligence (**ICHR, 2018**).

Threatened safety represents serious problems for patients, hospitals, and governments, in addition to the additional costs associated with facing harmful events, especially as Palestine has limited resources. Accordingly, improving PS requires to develop new methodologies to develop a health policy that works to integrate HRBA and make PS a high priority in national health plans and policies in order to face health challenges and crises based on inequality and discrimination, as the concept of PS culture is not clear to many of the participants in decision-making processes, hospitals and health policy makers in Palestine still lack evidence related to PS, and there is one out of every seven patients suffering harm in Palestinian hospitals (**Najjar et al., 2013**),so, there is more studies should be conducted on the subject of patients' rights that contribute to educating health professionals, patients and their families about the importance of patient rights and their commitment to protection from violations of PS principles or endangering them.

1.3 Scope of study

The study aims to know the level of understanding PS culture by the health professionals, and the extent of their adherence to the human rights principles in their clinical practices, and the relationship to improve PS in government hospitals. The researcher selected 6 government hospitals in north of West Bank as case study to assess PS culture through a non-random sample of (481) participants. A questionnaire has been distributed to targeted health professionals in August 2020 and study analysis of questionnaire has been conducted in 2021.

This study outline encompasses six chapters; chapter (1) introduction & background of the study, study problem, study questions, study objectives, study hypothesis. Chapter (2) literature review. Chapter (3) methodology. Chapter (4) analysis of data. Chapter (5) discussion of findings. chapter (6) conclusions and recommendations, and further research.

Therefore, according to the scope study above and outlines, the outcome of this study will be expected that: Improved understanding of the FRED A principles as the basis for the HRBA and identification of the areas of violation of patients' right and their safety. This is in order to and preventing the violation of patients' rights and their families while receiving the healthcare services within the healthcare sector.

1.5 Aim and Objectives

This study aimed to examine the level of health professionals' understanding of patient safety in selected Palestinian governmental hospitals in north west bank by employing a Strategic Human Rights Based Approach-HRBA.

To achieve this goal, the following objectives are set:

- To identify the level of employing the FREDA principles in healthcare by health professionals in government Palestinian hospitals in north of WB.
- To identify the level of understanding patient safety culture by health professionals in government Palestinian hospitals in north WB.
- To identify factors that affect the violation of patients' rights in Selected in government Palestinian hospitals in north WB.
- To understand the correlation among employing the principles of HRBA to healthcare and understanding patient safety in government Palestinian hospitals in north WB

1.6 Study Questions

The main study question of this study is “What is the level of health professionals’ understanding of PS employing the strategic HRBA utilizing FREDA – the five principles of this approach in six selected governmental hospitals?”

The problem of the study will be classified clearly through identifying the study sub-questions as follows:

- What is the level of employing the FREDA principles to healthcare by health professionals in government Palestinian hospitals in north WB?
- What is the level of understanding patient safety culture by health professionals in government Palestinian hospitals in north WB?
- What are the factors that affect the violation of patients' rights in government Palestinian hospitals in north WB?
- What is the correlation among employing the principles of HRBA to healthcare and understanding patient safety in government Palestinian hospitals in north WB?

1.7 Study Hypothesis

1. **H0-1:** There is no significant relationship at a level of 0.05 between fairness in providing health services to patient and patient safety in government Palestinian hospitals in north WB.
2. **H0-2:** There is no significant relationship at a level of 0.05 between equality in providing health services to patient and patient safety in government Palestinian hospitals in north WB.
3. **H0-3:** There is no significant relationship at a level of 0.05 between patient respect and patient safety in government Palestinian hospitals in north WB.
4. **H0-4:** There is no significant relationship at a level of 0.05 between patient dignity and patient safety in government Palestinian hospitals in north WB.
5. **H0-5:** There is no significant relationship at a level of 0.05 between patient autonomy and patient safety in government Palestinian hospitals in north WB.

CHAPTER II LITERATURE REVIEW

2.1 Introduction

This chapter presented literature reviews based on the study variables and their objectives mentioned in the first chapter. Covered by the researcher; In three main parts, the theoretical framework for the study concepts, the contextual framework, analytical framework, and for reviewing foreign and Arab field studies related to the current study.

The adoption of a strategic HRBA by health institutions contributes to improving medical practices and leads to quality healthcare to protect patients' rights and safety. Applying the concept of a HRBA is crucial in the health field, and adherence to the basic principles of this approach have a great impact on improving health outcomes for patients and working to deepen these principles in the daily practices of health workers, also needs to adopt other frameworks to guide health professionals to provide health services without taking measures that violate patients' rights.

Identifying the factors that drive health professionals to violations of rights, inequality, and discrimination, which makes health institutions intervene to address and prevent these violations. While there has been a recent increase in interest in PS theories and methodologies, and the concept of human rights, this approach has been integrated into health to implement the RTH to improve health outcomes. In connection with this study, the researcher analyzed and clarified the literature review by developing a study model from two main dimensions:

The HRBA which includes five main basic principles; (Fairness, Respect, Equality, Dignity, Autonomy), and PS Culture which includes 12 dimensions of (Teamwork, Staffing & Work Pace, Organizational Learning—Continuous Improvement, Response to Error, Supervisor, Manager, or

Clinical Leader Support for Patient Safety, Communication About Error, Communication Openness, Reporting Patient Safety Events, Hospital Management Support for Patient Safety, Handoffs and Information Exchange, Number of Events Reported, Patient Safety Rating), and the Socio-Ecological Model (SEM) Factors to be used as a framework in the study process.

2.2 Theoretical Framework

In this section, the researcher presented and addressed theoretical concepts and terms related to the study model that consists of a HRBA with a strategic approach and its elements; (fairness, respect, equality, dignity, autonomy), PS and its concepts, legal and legislative context for the RTH, the basic indicators of the RTH.

2.2.1 Human Rights-Based Approach

A health policy focused on human rights is necessary to tackle rising global health inequalities, the approach focuses on providing strategies to address inequality and non-discrimination-based practices to ensure the enjoyment all people of the right to health by adhering to many principles, the meaning associated with each of the principles of the HRBA will be clarified:

2.2.1.1 Equality and Fairness Principles

Many of the literature addressed the issue of health equity in recent years, and many international and non-governmental, and Governments organizations, have given broad attention to the issue of health equity in the world, in addition the human rights to equality, equal

opportunities, and the right to life have been recognized in numerous international and regional conventions and national constitutions. In the past 30 years, there have been significant improvements in public health worldwide, yet health inequalities persist and there is a need to review the evaluation of health justice (**Van Doorslaer et al., 2011**).

Awareness of equity and equality issues at each level is essential and important to ensure that policies work effectively, there are many aspects that overlap in the expression of the principle of equality, including equality of access, respect, treatment, and non-discrimination. A decision or action is discriminatory if there is no objective or logical justification for it, so when a particular case is described as unfair the reason must be examined, and the distinction occurs when people with a similar situation are treated differently (**Curtice and Exworthy., 2010**).

WHO has mentioned that everyone has a fair and equal opportunity to fully realize their health potential, and no one should be deprived of it. More equal societies are associated with better health outcomes and have less violence and discrimination between marginalized and poor groups, and an adequate social environment that contributes to the promotion of human rights. While unequal societies are associated with lower life expectancy rates, high prevalence rates of diseases and deaths, especially among infants, high obesity and mental illness, and increased rates of tobacco, alcohol, and other adverse health indicators (**Chapman, 2010**).

The term equality and non-discrimination refers to the access of every individual to his or her health rights and to the guarantee of an optimal health condition, which is equitable and affordable access to medical and healthcare, child and maternal care, education, housing, safe environment and other determinants that guarantee all individuals an adequate standard of living without discrimination; Based on race, religion, language, gender, socio-economic status, mental and physical disability, etc. (**Braveman et al., 2011**).

While Chapman defined the term fairness as a moral concept based on distributional justice principles that refer to justice or social justice. Paula Bravmann also shows that health equity is “the principle or goal that motivates efforts to reduce or eliminate health inequalities by improving the health of the economically and socially disadvantaged (**Chapman, 2010**).” In this regard, John Rawls, in "The Theory of Justice" referred to the necessity of disparity in medical treatment based on the principle of difference in needs, as he gave a justification for disparity, which is to bring the greatest possible benefit to the worst-off individuals, this is called in the human rights approach to positive discrimination of children, mothers, pregnant women and the elderly.

Jennifer Prah Roger, who is considered a right-to-health advocate in her book *Health and Social Justice, the Theory of Health Ability Paradigm*; “All people must have access to the right means to avoid early death and preventable diseases," she said. It called for reducing unnecessary health disparities in the world in order to realize the RTH by developing a comprehensive explanation of the basic drivers of health that included provision of potable water, fresh air, food, and preventive measures (**Ruger, 2004**).

Health disparities reflect differences in health and healthcare that adversely affect the health of socially disadvantaged individuals, as health differences indicate “an increase in the burden of illness, injury, disability, or death suffered by one group compared to another”. The disparity in healthcare is the differences between groups in their access to and utilization of health services and care, the provision of health services, coverage of health insurance for those groups, and the quality of healthcare. Many factors contributing to health disparities including individual, environmental, community, health system, and health service providers (**Artiga et al., 2016**).

Addressing health inequalities in health and healthcare is an important issue, not only from the perspective of equity but also important in improving the quality of healthcare and people's health,

since health inequalities lead to the denial of access to medical and healthcare for certain groups, especially the marginalized and poor. In addition to causing economic losses due to premature deaths, health-care disparities in the United States are estimated to cause economic losses of about \$309 billion per year (**Daniel et al., 2018**).

Although the level of medical care and disease prevention has improved, health disparities still exist and are increasing for cases of chronic diseases such as cardiovascular disease, cancer, and obesity. To improve and maintain people's health status, strategic planning is important in improving the equity of health services in hospitals and health centers (**Jamshidi et al., 2017**). The assessment of health justice is also important in determining whether national and international policy makers assess the impact and effectiveness of such policies on achieving social justice in health (**Braveman and Gruskin, 2003**), as well as at the level of clinical care, Communication between health professionals and patients can create or reduce health inequalities (**Perez-stable and El-Toukhy, 2018**).

The issue of equity in healthcare in the occupied Palestinian territories stands, as elsewhere, as a key issue in the current debate on reforms aimed at improving the efficiency of the health system while promoting equity in health (**Abu-Zaineh et al., 2011**). The Palestinian health sector is a skilled service sector that directly affects the lives of the Palestinian citizen, despite many challenges, the Palestinian Ministry of Health has paid great attention to the application of primary healthcare (PHC) principles since taking office in 1994; It has provided and developed health services, facilitated access for citizens, and equitable distribution among different groups of society, in various Palestinian governorates.

However, with the tracking of health indicators on the reality of the RTH in the Palestinian territories, the health situation of the Palestinian population is very diverse and complex, given the

prevailing political conditions associated with the occupation procedures, and internal access in the West Bank is one of the main issues for Palestinian citizens. Isolating Palestinian areas from one another and preventing geographic contact with the Gaza Strip has deprived a large segment of Gaza's citizens of access to healthcare services and suffering from a shortage of medicines and medical supplies, which has a clear impact on the health and safety of patients, especially those suffering from chronic diseases such as cancer. Diabetes, epilepsy, and others (**Albarsh, 2017**), between 2000-2008, the Israeli human rights organization B'Tselem reported 66 deaths in the occupied Palestinian territories, directly related to the delay caused by limited movement (**Eklund, 2010**).

The State, which provides health services to the entire population without discrimination, contributes to reducing mortality rates and directly affects life expectancy at birth, which in turn affects economic development (**MAS, 2018**). The principle of justice must be applied both in the planning and evaluation of health services and in the daily personal practice of the medical profession. The resources at the disposal of physicians are almost limited, which means that health planners and policy makers must be aware of the ethical aspects and foundations of planning and evaluation of services. The principle of equitable distribution of health services to all patients must also be equitable .

There must also be fairness in the distribution of medical care provisions, but this is not done in Palestine, where medical resources and possibilities, including access to medical drugs, radiology services and laboratory tests in hospitals, are distributed through management interventions that discriminate and differentiate between patients motivated by the cronyism (**ICHR, 2016**).

A fair health-care system requires many considerations of accountability, transparency, and integrity to reduce corruption and promote good governance. A study centered on "The relationship between corruption and human rights in the Palestinian reality (RTH status model)" launched by the Coalition for Integrity and Accountability Safety in 2017 recommended the need to develop and adopt a new, comprehensive and equitable health insurance law to ensure the enjoyment of the RTH, and the need to legislate an independent law on medical errors, and It emphasized the need to harmonize the Public Health Act and the international human rights conventions to which Palestine is a party.

The study also found that the weakness of the health system consists in many aspects and forms of corruption, such as cronyism and bribes, in receiving numerous medical services, medicines and treatment, despite the good steps planned by the MoH towards immunizing the health system against corruption (**Aman, 2017**).

Another manifestation of inequality is the unequal access to health insurance services, which do not include all citizens and do not cover all their health-care needs, especially groups with special needs. Based on PCBS information in 2017 as reported by ICHR, the number of insured persons was 1,390,557 Palestinian citizens, 4,416,123, indicating that government insurance coverage does not exceed 31.5% of the population (**ICHR, 2018**). It also does not cover all medicines. The number of essential drugs in circulation was 526 in 2018 (**MoH, 2019**), and the lack of transparency in the provision of information, which prevents health insurance insurers from claiming their rights as recorded in the insurance contract.

Regarding medical referrals, in 2018, the number of medical transfers to non-governmental health institutions in Palestine and abroad increased, Government expenditures on medical transfers increased, as the percentage reached 25% of the general budget of the MOH, and 18% of

medicines and medical consumers (**MoH, 2019**), yet corruption in this area is by using influence to obtain medical transfers and treatment services not covered by health insurance abroad.

The health insurance system for 2004-2006 also requires a patient who benefits from medical transfers outside Palestinian health institutions to participate in the payment of a certain proportion of treatment costs, varying from case to case, on the other hand, excluding older groups(60 years old) from some medical services, even though they have a health insurance service such as liver transplant (**ICHR, 2018**), and public hospital patients are transferred to the private sector on unnecessary grounds for financial or personal benefit (**ICHR, 2016**).

This is accompanied by the lack of professional and ethical standards in the absence of regulations and instructions on the way staff provide services, the lack of guidelines for staff to ensure respect for patients' rights and treatment, the widespread misuse of the job position of some medical personnel for personal benefit and the use of public resources to serve patients who are able to pay private clinic fees, some physicians in the public sector are abusing medical drugs for personal benefit, or for the benefit of their friends and relatives, or for the purpose of returning.

There are disparities in medical practices and the provision of health services by private and public health providers that affect the RTH. Public confidence in public sector services is weak compared to the high quality of private sector health services, as well as attention and healthcare for patients in the private sector as opposed to the public sector. According to those advantages, physicians refer patients seeking healthcare from public facilities to their own clinics, paying far higher costs than services available in public facilities regardless of their ability to pay or satisfaction with the level of service.

Poor control systems for health providers and the absence of an accountability system to ensure that the perpetrator is prevented from practicing the profession before rehabilitation. Thus, poor supervision and control has created a gap in citizen confidence in the MoH (**Aman, 2017**).

In response, studies indicate that there are many complex factors affecting the violation of patients' RTH rights. The lack of financial resources associated with the Government's inability to raise employees' salaries causes physicians to seek alternative ways to secure their livelihood (**Zeina et al., 2013**).

In order to raise the level of healthcare for Palestinian citizens, achieve a more equitable health system, reduce maternal and child mortality rates, reduce the prevalence of chronic diseases and address violations of the Israeli occupation of the RTH, the State should commit itself to the RTH as one of the fundamental rights contained in the International Covenant on Economic, Social and International Rights through the obligation to provide human, financial and logistical resources. The State's non-discrimination obligation has nothing to do with the provision of resources, but rather with the inherent dignity of the human person. For example, laws must not deny women equal access to health services and prohibit discrimination at the level of actions and groups. The State must take a range of measures to facilitate and enable unhindered access to health-care facilities for persons with disabilities (**ICHR, 2019**).

2.2.1.2 Respect Principle

Experts recommend respecting human life, racial and ethnic minorities, different gender, age, and beliefs, socially and morally. It is wise that respect and self-respect are highly linked, that it is difficult to respect people if we do not respect ourselves (**Dillon, 2003**). The respect principle for human has received attention by policy makers, international organizations, law makers, and human rights activists (**Akhondi et al., 2012**).

Contemporary philosophers are interested in respect especially respect for persons. They see that all persons should be treated with respect because they are humans. Respect for persons is a major concept in a lot of ethical theories. The German philosopher, Immanuel Kant, in the 18th century, was the first Western philosopher to call for respect for human beings at the very center of moral theory (**Dillon, 2003**).

Respect for persons is a basic principle, grounded on the equal dignity of every person (**Seymour, 2010**). Now, it has become clear that respect must be based totally on dignity as it is strongly emphasized in the UN documents: (**Monteiro, 2014**). “The Preambles of the UN Charter and of the UDHR link human rights to human dignity.” “Human dignity is inviolable. It must be respected and protected”. “Article 3 - Human dignity and human rights: "Human dignity, human rights and fundamental freedoms are to be fully respected” (**UNESCO, 2013**).

Improving respect in clinical relations is important. The principle of respect in medical practice was interpreted to “recognize and respect the diverse needs, values, and circumstances of the patient, including race, religion, culture, gender, age, gender and any disability. They must take into account the patient’s opinions, desires, and feelings.” (**Curtice and Exworthy, 2010**).

Recent studies have reported that patients treated with respect responded better to treatment. Some ethicists argued that making patients feel respected or appreciated as a person is a multifaceted task that involves more than simply recognizing independence. A study reported on patients' opinions regarding respect, patients believe that respect for persons includes the following key elements: Empathy, Care, Independence, Provision of Information, Recognition of individuality, Dignity, and concern for needs independence (**Dickert and Kass, 2009**).

However, not all physicians follow these human values. Some of them violate these rights and thus disrespect their patients. Disrespect is a threat to PS because it limits relations and cooperation vital to teamwork, breaks morale, and disturbs implementing new practices. Disrespect increases dissatisfaction with work. Disrespectful behavior affects a lot of other sides of healthcare; quality decreases when physicians cannot work in teams, so, this behavior causes nurses to feel annoyed and then neglect or leave their work. Sometimes, patients suffer when physicians do not listen to them and care for their questions, so, physicians must involve them in their treatment process and respect their privacy (**Leape et al, 2012**).

Researchers suggested six categories of disrespectful behavior in this field: (disruptive behavior – humiliating: demeaning treatment of nurses, residents, and students - passive aggressive behavior - passive disrespect - dismissive treatment of patients - systemic disrespect): (**Leape et al., 2012**). This behavior with its several kinds represents a threat to patients' safety.

By reviewing the studies, it was noted that failure to respect and support for physicians by the hospital administration limits physicians' compliance with safe practices, and their non-compliance with rules, laws, procedures and regulations in the workplace.

To reach a high level of respect in the medical field, there must be institutional respect for all members of the medical field by providing a supportive environment, financial and human

resources. However, Palestinian physicians face many obstacles that prevent them from achieving full respect for their patients. As many medical workers retired and treatment services were reduced, this led to a severe and continuous crisis due to the great shortage of medicines, medical supplies, diagnostic equipment, and a shortage of medical staff, which affected the health status of patients.

For instance, hospitals in the Gaza Strip suffered from shortages of medicines, and the supply of new medical devices and laboratory materials needed to conduct tests for patients due to the Israeli restrictions imposed. In addition to the Palestinian Authority's curtailment of its health services by stopping the work of the coordination office of the MoH on coordination measures to transfer patients to receive treatment in West Bank hospitals in light of the spread of the Corona virus at the beginning 2020, which caused the deprivation of hundreds of patients who suffer from serious diseases, and their health conditions are unbearable any delay, especially for cancer patients (**PCHR, 2021**).

Their number in the Gaza Strip is estimated at about 14,000 patients. The deficit in medicines intended for cancer patients has reached more than 50% of the list of essential medicines, and this represents a serious threat to patients' lives and a violation of their right to access all health services. The Palestinian Center for Human Rights (PCHR) calls on the PA to fulfill its obligations towards the hospitals that have contracted with it in the Gaza Strip for the treatment of cancer patients, and to supply these hospitals with medical equipment and classes of medicines needed by cancer patients (**PCHR, 2021**).

On the other hand, the Palestinian health sector suffers a big lack of funding. In 2019, the total funds for medical supplies and equipment were about \$15.4 million. This modest sum cannot meet

the necessary medical needs for patients. These hard conditions cannot achieve the main requirements of respect for patients' rights (UNRWA, 2019).

Concerning training, there was no provision in the MoH budget for the necessary training and qualification of health staff, although the development and qualification of human staff was one of the objectives of the administrative and health governance program (ICHR, 2019). Lack of training resulted in many negative consequences. Lack of effective communication skills and training programs represents a barrier against improving patients' safety.

2.2.1.3 Dignity Principle

Multiple literature dealing with the concept of human dignity, the fundamental role of the concept as a human rights principle. Opinions also varied on this principle, especially about its source and dimensions. There was a consensus by many theorists about the lack of clarity of the concept and its dimensions, and it is not useful, and cannot be measured directly. There was argue about the principle of dignity as a broad concept, that its application is unclear in healthcare, and that it is useless in medical treatment, and that only dignity means respect the autonomy, even though many international conventions and constitutions recognize human dignity.

But it can be said that human dignity is an inherent value of all individuals as human beings, and it makes people feel equal with others, and human dignity contradict behaviors such as unfair degrading treatment, cursing and torture, which violate human rights and dehumanize human dignity, this is opposed what is stated in many human rights documents that dignity is inalienable (Killmister, 2010).

Dignity has been defined in many literatures as the right to have values and self-respect, and the right to be treated in an ethical manner. Dignity is the norm by which people must be seen and treated. "Dignity is not a commodity and it is inherent in all human beings, and everyone must be valued as a person." Dignity is respect for one's being human, regardless of one's identity, place, social role or position, and it is not only the way you treat it, but also how you treat others **(Papastavru et al., 2016)**. Human dignity is also defined as "the individual or group's sense of self-esteem, self-respect, physical and psychological integrity and empowerment" **(Ansari, 2019)**.

There are numerous theories that adhere to and recognize human dignity and its importance, and those that contradict the concept of human dignity: There are philosophical theories that view the concept of dignity as a secondary issue, Roberto Andorno stated that "the concept of dignity has not been explicitly defined in international human rights declarations, yet dignity in those declarations has been defined as inherent dignity in human beings, and that human beings are born free and equal in rights and dignity, and rights arise from the inherent dignity of human beings **(Andorno, 2009)**. Although the principle of dignity is the foundation of healthcare and a slogan for bioethics, Ruth Macklin noted "the concept of dignity is unhelpful and a reformulation of other values based on independence and respect for individuals" **(Macklin, 2003)**.

While some other philosophical theories show a difference in their view of the concept of dignity and its dimensions, which recognize and embrace the concept of dignity and adopt it in its constants: The concept of dignity has been clarified in Greek philosophy, specifically in Aristotle's philosophy and Sophocles "Tragedy Antigone, Aristotle argues that "dignity consists not in possessing honor, but in the consciousness that we deserve them". And he indicated that independence and rationality are the basis of dignity **(Morberg, 2016)**.

Immanuel Kant fully appreciated human dignity in its entirety as he sees that human beings are treated as end and not means, that human beings are not things that can be replaced and compared to something, but rather are people that must be respected. And this dignity is based on independence, that human beings do not enjoy dignity unless there is a commitment to morality, and therefore self-government is the foundation of human dignity (**Kant, 2017**).

Dignity has received considerable attention in many areas in societies such as philosophy, law, and medicine, where the setting of human dignity as a priority in the healthcare settings and medical treatment, and work to incorporate the principle of dignity into the ethical codes of health services providers (**Morberg, 2016**).

In the light of scientific and medical development, and following the introduction of human rights law, the principle of dignity has been applied in clinical practice, although conventions such as the European Convention on Human Rights have not addressed the concept of dignity in medical treatment, nor has it been explicitly mentioned in their clauses (**Curtice and Exworthy, 2010**).

The concept remains unclear in its application regarding the principle of medical ethics and respect for individuals such as the provision of informed consent by the patient, preservation the patient's privacy, the avoidance of degrading and inhuman treatment, equal treatment, and non-discrimination (**Macklin, 2003**). The principle of human dignity in medical practices has been interpreted as equal treatment in dignity for everyone. In other words, there should be no discrimination in treatment between patients based on gender, religion, age or ethnicity, and every patient deserves equal treatment and respect without discrimination. The other explanation is to respect the independence and decisions of people, and to obtain informed consent from the patient (**Morberg, 2016**).

The dignity of a patient in healthcare is violated by the effects of different attitudes on the patient by health professionals such as immoral and degrading treatment of the patient, disrespect for the patient, and poor communication, and the dignity of the patient is lost by the loss and omission of important patient-care information from health providers, and by the violation of patient privacy (**Papastavrou, et al. 2016**), as well as the dignity of the patient, are linked to health-care fundamentals such as assistance, eating and drinking, and a clean and safe health environment such as family hygiene (**Fenton and Mitchell, 2002**).

This was discussed by Rebecca Dresser in a study on “experiencing how to respect a patient’s dignity as an individual or not in clinical care”, which identified four areas in which a patient could be violated or enhanced by dignity: Communication, privacy, personal knowledge, and dependence (**Morberg, 2016**).

It can be said here that any event that violates a patient's safety, health or dignity leads to the loss of individual autonomy and identity, a sense of humiliation and loss of self-esteem, theorists (Benner 1984, Carper 1978, Maslow 1971) have referred to dignity as the basis and one of the requirements of self-esteem and comfort of the individual contained in the Maslow hierarchy of needs (**Fenton, and Mitchell, 2002**).

There is a dearth of studies that have addressed the concept of human dignity and its dimensions, and the dignity of patients in the Palestinian context. In 2010, a study was conducted to evaluate a tool to measure dignity and examine its impact on the health status of Palestinian refugees. The instrument consisted of four dimensions: autonomy, worthiness, self-esteem and self-respect. It was noted that there is a positive relationship between levels of dignity and the level of health of patients, and that patients who scored below the dignity scale were in poor health status (**Khatib and Armenian, 2010**).

Equality and dignity were emphasized in the goals of sustainable development (SDGs) as one of the basic principles for the enjoyment of human rights, including the enjoyment of the RTH. However, there is still a health gap as a result of political conflicts, occupation and violence, and the disparity in social determinants of health and high poverty rates that expose the Palestinian citizen to risks. Health issues such as high rates of non-communicable diseases and mental health **(Kitamura, et al., 2018)**, there is a need for an international response to provide fair solutions in order to preserve the dignity of the Palestinian citizen by providing financial aid and facing the current financial crisis facing the Palestinian government. As confirmed by the ICHR should be committed to protecting individuals from interference by other parties and protecting them from violating their rights by activating the tools of law against racial discrimination, developing policies, legislations, and laws, and amending them to protect the dignity of individuals, and enabling individuals to claim their rights to ensure equality and non-discrimination **(ICHR, 2020)**.

2.2.1.4 Autonomy Principle

The principle of autonomy is a basic ethical principle in healthcare, a complex and multifaceted concept, which relates to the ability of the patient to make decisions about his health and treatment based on clear and adequate information (**Seoane, 2013**). The Act on Rules of practice of 1983 states that "patients must be given the opportunity to participate in decision-making, planning, developing, and reviewing their treatment and care to ensure that it is presented in a suitable and effective manner" (**Curtice and ExWorthy, 2010**).

In recent years, there has been a need to extend the concept of autonomy of the patient beyond the independence and decision-making of therapeutic and medical intervention, including several dimensions: (Decision, executive, functional, informative, and narrative) (**Arrieta, 2019**). Medical ethics took care of the principle of respecting the autonomy of patients in clinical practices, and the principle of respect for autonomy was linked to many issues such as confidentiality, privacy, fidelity, telling the truth, and the right to informed consent of the patient (**Murgic et al., 2015**).

In order to achieve the autonomy of patients, physicians must adopt practices that promote open communication so that there is a common consensus between patients and physicians (**DZENG, 2019**), the autonomy of which is subject to three requirements: The patient makes a voluntary decision, without coercion from outside parties, to obtain adequate and accurate information regarding their health status and treatment to understand the potential benefits and risks of the proposed intervention, as well as the proposed alternatives for making the appropriate decision (**Sedig, 2016**). The ability of patients to implement the decision made and here is linked to the mental state; that is, their cognitive, emotional, and psychological ability to adhere to the

therapeutic plan, their ability to maintain and communicate effectively with others in an understandable way. This is what Beauchamp and Childress has pointed out to be two key conditions for independence as agreed in all theories of autonomy (Freedom and Power) (**Arrieta, 2019**).

Based on the theories of dignity and independence discussed in previous studies, many philosophers and authors have pointed out that independence is one of the dimensions of the principle of dignity, in which the dignity of individuals is described as able to make decisions and understand information that makes them feel psychological and physical well-being.

Dresser considered autonomy to be an essential ethical principle in empowering patients and avoiding them to reduce their value and themselves, yet patients still feel lost value during treatment (**Morberg, 2016**), and, in one important aspect of self-determination theory, independence is said to be a fundamental human right worthy of respect and protection (**Entitle et al., 2010; Hofmann and Lysdahl, 2008**).

There are many medical ethics charters, one of which was Hippocratic Oath, the first document to include physician-patient relations for 2500 years, and the World Medical Association (WMA) has taken the commandments of Hippocrates as a binding oath for all the world's physicians. The Hippocratic summary included "respect for the patient and concern for his interest, chastity and honesty, performing the profession with high morals, maintaining the privacy and confidentiality of information related to the patient, respecting teachers and colleagues" (**Parsa-Parsi, 2017**). Physicians must adhere to the Hippocratic oath when dealing with the concept of autonomy and self-determination to preserve the patient's life (**OTOO, 2019**). when supporting and understanding the autonomy of patients, their safety and dignity are protected (**Curtice and Exworthy, 2010**).

Meanwhile, the 1981 Lisbon Declaration addressed some of the fundamental rights of patients, as amended by WMA in 2015, which included the declaration "The right of the patient to freely choose a physician, the right to take care of the patient, and the acceptance or rejection of any treatment after receiving the necessary information about that treatment. The privacy of the patient and the right to die in dignity shall be preserved (**WMA, 2018**). As the Nuremberg Law and the UDHR have affirmed support for informed free consent principles, and avoidance of exploitation and harm in scientific experiments involving human beings (**Dhai, 2014**).

The independence of decisions is not limited to the patient only but is also related to the independence of the health care provider and his decision about the treatment of patients. Sometimes, a third party, i.e., the institution in which the health service provider works, intervenes with decisions to transfer patients, provide treatment to them, and withhold health insurance from them in a way that is inconsistent with the patient's interest. This is a flagrant violation of their health rights (**Cohen and Ezer, 2013**).

In Palestine, it has failed to put in place laws that protect patient rights, such as establishing legislations that incorporate accountability measures for violating PS rights and disclosing the privacy and confidentiality of medical information related to patients.

Sometimes the degree and extent of disclosure must be commensurate with the nature of the current clinical situation, the reasons for disclosure need to be assessed, and the reasons for disclosure must be balanced with the person's right to privacy and confidentiality. His treatment decisions, opinions and dignity must be respected, and the patient should be treated politely. Respect his or her needs, and the health professional give the patient a sense of appreciation.

For example, when converting cancer patients to receive chemotherapy, the decisions to transfer patients are made by the referral committee according to discriminatory non-professional considerations without considering the patient's choices or preferences. There is no protocol, guidelines, or standards to be followed in the decision-making process, and therefore this category is denied access to available service, in the sense that the individual is denied the right to freedom of choice (**AIRifai, 2013**).

To affirm the right of every patient to treatment at the highest attainable standard of health, the Palestinian Patients' Rights Charter of 1995 affirmed that "every patient has the right to choose or change the treated physician, healthcare provider or health facility within the permitted medical care system". "The citizen has the right to access information on his condition and healthcare, including information on the proposed medical procedure and treatment, potential medical risks, proposed medical alternatives to treatment, and his right to access medical records of his condition". "Every patient has the right to respect his or her privacy and confidentiality of his or her health information" (**Mas, 2011**). Legally, the Public Health Act No. 20 of 2004 stipulates in article 60 that every patient has the right to receive a clear explanation of his proposed treatment, to approve or reject treatment, and to lodge complaints against the health institution in case of violation of his right. The law also stipulates the right to respect the privacy, dignity, religious and cultural beliefs of the patient." (**Al Muqtafi, 2005**).

2.2.1.5 Summary

Regarding the principles of fairness and equality, there are no studies that separate these two concepts from each other, despite the wide difference between these two concepts, the principle of fairness is based on the principle of equitable distribution of services and resources according to the needs of individuals and priorities, which is the highest degree of the principle of equality in equity among individuals. The principle of equality refers to equal provision and access to services regardless of gender, religion, language, race, or socio-economic status as mentioned in international declarations and conventions.

The researcher noticed the correlation between the other three principles: Respect, dignity, and autonomy. The three principles are associated with respecting patient privacy, providing accurate and complete information, and informed consent. Autonomy and information privacy of the Patient are one of the dimensions of the principle of dignity. The principle of respect was also associated to respect for the dignity and independence of the patient in decision-making concerning treatment.

While the five Principles were linked to effective communication between health providers, colleagues in the workplace, patients, and their parents, the presence of communication skills has a significant impact on the equitable provision of healthcare to patients and reaching a joint decision between the patient and the physician to obtain the best treatment by providing proper and accurate information.

2.2.2 Patient Safety Dimensions

There is a growing global interest in PS theories and their application methodologies in the health field by many experts and specialists, as the issue of improving PS has become important in healthcare systems by international health organizations and healthcare providers. Since the publication of the report "To Err Is Human" of the IoM, important steps have been taken in developing PS practices by avoiding medical errors and providing a safe and healthy environment to the patient, but millions of patients still suffer from injuries or deaths due to the insecure healthcare. The IOM (1999) estimated that up to 98,000 people die in American hospitals every year due to preventable medical errors (**Dunsford, 2009**).

The IOM knows PS as "the avoidance and prevention of patient injuries or adverse events resulting from the processes of healthcare delivery" (**Rodziewicz and Hipskind, 2018**). WHO also defines PS as "The reduction of risk of unnecessary harm associated with healthcare to an acceptable minimum" (**Elmonsri et al., 2017**).

The importance of the concept of PS as a global health priority has been emphasized in WHO reports, and the conviction is growing that the ability of healthcare providers to avoid harm will be better achieved when a PS culture can be established (**Hellings, et al., 2007**), the PSC concept was determined according to AHRQ that "The safety of any institution is the product of individual and group values, attitudes, perceptions, competencies and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization's health and safety management." (**Arrieta et al., 2017**).

Providing safe care reduces death rates, illnesses, length of hospital stay and cost (**Abu-El-Noor et al., 2019**). The IOM recommended that to enhance PS, changes in the culture of the working environment are required and regular assessments of PS culture to identify areas of weakness and

strength in order to design interventions that enhance PS and reduce errors (**Hamdan and Saleem, 2018**). Evidence suggests that the rate of medical errors and harmful events is associated with the attitudes of health professionals toward the safety of patients in health-care determinants. The Centers for Disease Control and Prevention (CDC) estimates that 5,000 people are infected daily in hospitals, while the IOM estimates that 1.5 million patients suffer from medical errors annually (**Leape et al., 2012**).

2.2.2.1 The Reality of Patient Safety in Palestinian Health Sector

In Palestine, there is "one out of seven patients suffers harm in Palestinian hospitals", which can be avoided. In addition, the Global Trigger Tool has shown that adverse events in Palestinian hospitals are 20 times more likely to occur than in previous reports (**Najjar et al., 2013**).

Great efforts have been made to improve the quality and safety of patients in hospitals, and there has been an increasing interest in PS initiatives by health institutions, and hospitals accreditation certificates such as ISO certification. The issue of PS has become one of the priorities listed in the National Health Strategy 2014-2016 in 2011. In this regard, the Palestinian MoH joined the WHO PS Friendly Hospital Initiative (PSFHI) (**Hamdan and Saleem, 2013**). PSFHI, is an initiative launched by the WHO Regional Office for the Eastern Mediterranean in 2007 to understand and evaluate the level of safety in healthcare institutions. In 2014, the initiative began to be implemented by all governmental hospitals in the West Bank (**Siddiqi et al, 2012**). The PSFHI Handbook includes 140 standards, divided into three levels (20 critical, 90 core, and 30 developmental). Hospitals' compliance with these standards ensures that patient safety is a priority

in their strategic plans, and the best practices are guaranteed by hospital leaders and staff (**WHO, 2016**).

Governmental hospitals have achieved progress in critical and core standards, but no hospital has been accredited, nevertheless, many PS policies and procedures have been established, and quality teams have been trained on various PS issues. The MoH worked with partner organizations on initiatives to improve drugs safety, safe surgery, control infection and associated risks, and patient identification. Despite these developments, there is still a lack of research evidence on patient safety in general and the state of patient safety culture in hospitals in particular (**Hamdan and Saleem, 2018**).

Many Palestinian studies have been conducted on assessing PS culture to identify strengths and weaknesses and identify areas for improvement. Safety culture assessment should be part of the organizational learning and continuous improvement process. The literature shows that safety culture varies in hospitals and depends on the organization's experience, size, and function. In Palestine, understanding of safety culture and the factors affecting government hospitals is limited (**Elsous et al., 2016**).

Providing safe care is one of the fundamental challenges in many healthcare systems, where patients may be injured or die due to bad practices. Therefore, a culture of PS is a key factor of good healthcare systems. Despite the relentless efforts made by the MoH to improve the health sector. However, there are deficiencies in the health system with regard to assessing the infrastructure, which appear in the low level of medical equipment and the shortage of beds in many departments of governmental or private / private hospitals. In addition to the insufficient number of medical staff, which is the first line of defense for treating patients, and which increases

the high rates of medical referrals to hospitals outside the MoH, especially Israeli hospitals so that affects the PS (MAS, 2020).

2.2.3 Legal and Llegislative Context for the Right to Health

As medical science has evolved and patient expectations and requirements for patient quality and safety have increased, the importance of legal regulation and the protection of patients' rights has increased. The patient's rights include the whole of legal and social relationships that arise when citizens apply for medical care. Health protection is a set of measures of a political, economic, social, legal and health nature aimed at maintaining and promoting the physical and mental health of each person, maintaining his long-lasting life, providing the necessary medical services, and assistance in case for Health Loss (Gafurova and Babaev, 2019).

The RTH has been emphasized in many international and regional instruments and treaties and national constitutions as already mentioned, although the RTH is a fundamental and inalienable right, not all charters, covenants and constitutions have clearly described the content of the RTH, and the minimum enjoyment of RTH has not been established, whereby many countries have not been able, by virtue of their economic conditions, to provide the minimum level of the The RTH has been emphasized in many international and regional instruments and treaties and national constitutions as already mentioned, although the RTH is a fundamental and inalienable right, not all charters, covenants and constitutions have clearly described the content of the RTH, and the minimum enjoyment of RTH has not been established, whereby many countries have not been able, by virtue of their economic conditions, to provide the minimum level

of the RTH, such as vaccination services against diseases, maternity and child care services etc.. (Aman, 2017).

International instruments include several laws that include the RTH as a fundamental human right (United Nations, 2006):

1. The Universal declaration of 1948 (art. 25).
2. The International Covenant on Economic, Social and Cultural Rights of 1966 (art. 12).
3. The International Convention on the Elimination of All Forms of Racial Discrimination of 1965 (CERD) (art. 5 (e) (iv)).
4. The Convention on the Elimination of All Forms of Discrimination against Women of 1979 (articles 11.1 (f) and 12).
5. The Convention on the Rights of the Child of 1989 (art. 24).
6. Convention on the Rights of Persons with Disabilities (art. 225).

Regional human rights instruments also recognize the right to health in several laws and regulations:

1. The European Social Charter of 1961 as revised (art. 11).
2. The African Charter on Human and Peoples 'Rights of 1981 (art. 16).
3. The Commission on Human Rights, the Vienna Declaration and Programme of Action of 1993.
4. The Arab Charter on Human Rights (art. 39) to which Palestine is a signatory.

The SDGs also focused on the RTH in the third goal on ensuring a healthy life for all at all ages, emphasizing the importance of comprehensive health coverage without discrimination and considering the economic conditions of all individuals, especially marginalized and poor groups.

Human rights provide a set of performance standards against which governments and other actors can be held accountable. In a HRBA, human rights define the relationship between individuals, groups (rights holders), and governmental and non-governmental actors (responsible actors). Consequently, human rights institutions use a model to protect, respect and fulfill the commitment to human rights as a tool for accountability, accountability, and oversight.

According to General Comment No. (14), the right to health includes four basic elements. Together, these elements provide an important analytical framework for measuring the level of enjoyment of the RTH, in addition to the social determinants of health. This framework is used to examine criteria for transparency, integrity, and accountability in the RTH, as shown in the figure **(Ubri and Artiga, 2016; WHO, 2017)**:

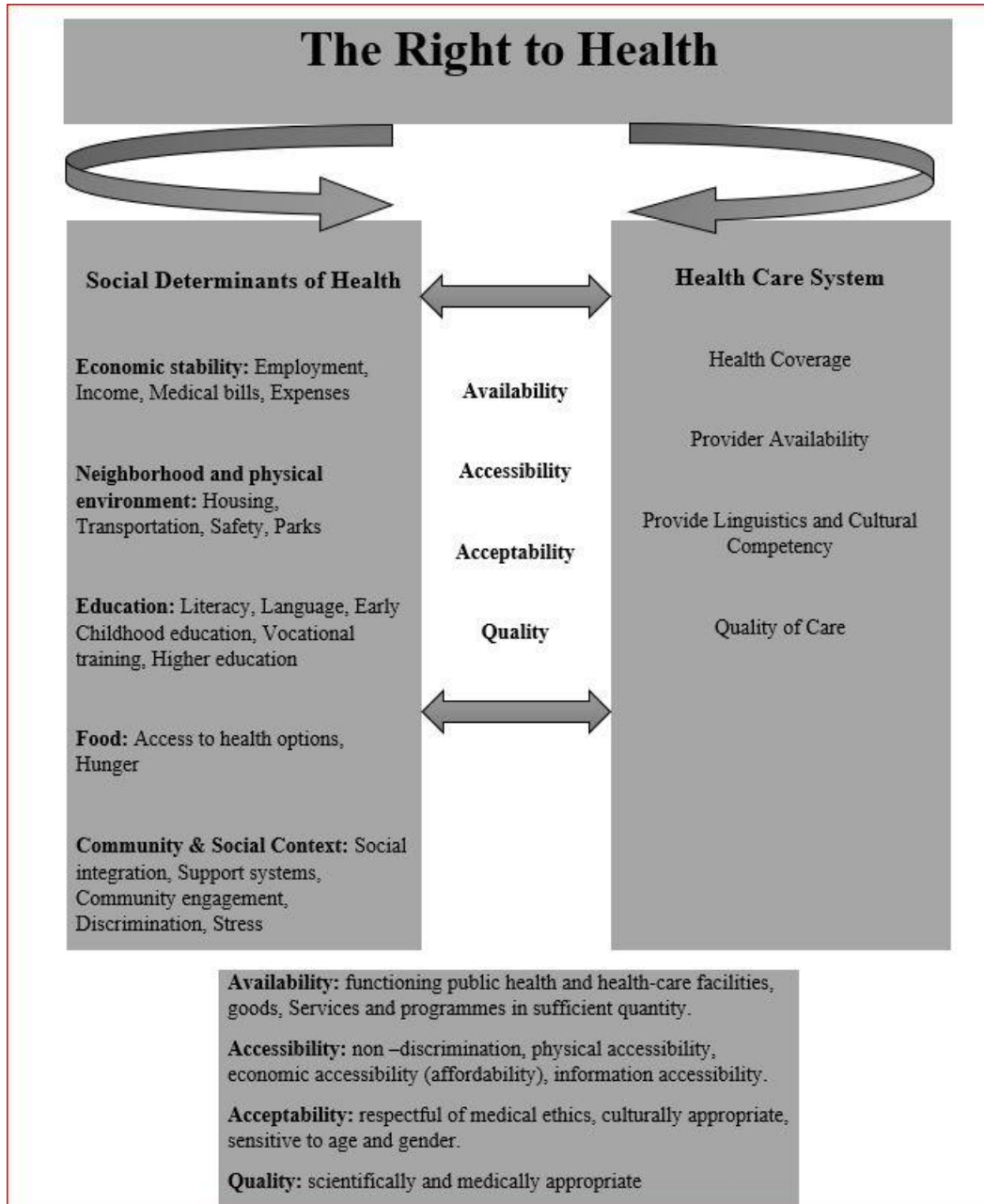


Figure (1): The Right to Health

The above framework illustrates that the RTH is not limited only to health services and care but includes a wide range of social and economic factors that promote conditions in which people can live healthy lives and extends to basic determinants of health such as food, housing, access to safe drinking water and adequate sanitation, safe and healthy working conditions, and a safe

environment. Non-discrimination is the prerequisite and imperative, and it prohibits discrimination in access to healthcare and the underlying determinants of health on multiple factors, including race and gender, language, religion, national origin, physical or mental disability, health status, gender, civil, political, social, and other status.

The RTH concept clarifies the four basic elements of the right that form the second pillar of this framework. Health-care facilities, goods, services, and social determinants of health must be accessible, accessible, acceptable and of good quality. It means **availability**: Adequate quantities of public health and health-care facilities and goods and service irrespective of the level of development of the country. **Accessibility**: Includes a range of factors determining access, including discrimination, physical access, economic affordability, and information accessibility. **Acceptance**: Healthcare requires attention to standards of medical ethics, culture, gender, age-related sensitivity, and confidentiality of personal medical data. **Quality**: Means good quality health facilities, goods and services and their appropriate science.

2.2.3.1 Legislation and Laws Related to the RTH in the Palestinian Context

The State of Palestine joined many international charters, treaties and conventions and became a party to them, after the Palestinian Declaration of Independence document for the year 1988 stipulated Palestine's commitment to the UDHR. The Palestinian Authority adhered to the decisions of the Arab summits and the decisions of the League of Arab States, as it was the first country to sign the Arab Charter on Human Rights (ACHR), it also committed itself to the constitution of the WHO, and the International Covenant on Economic, Social and Cultural Rights (ICESCR).

The MoH seeks to develop and ensure access to PHC. health is a right in Palestine and must be reflected in all laws and regulations, in particular the Health Insurance Act and the Public Health Act. It must also be reflected through the available health services, given that the MoH is the main provider to them, with the law giving it the oversight role for the Palestinian health sector (**Aman, 2017**). Since the establishment of the Palestinian National Authority (PNA) in 1994, legislation and provisions related to the provision of an adequate standard of health have been included in the following laws (**ICHR, 2008**):

1. Health-related provisions of the Basic Law of 2003, such as those relating to medical trials, social insurance, and the right to a clean environment.
2. Palestinian Medical Council Law of 2006.
3. Insurance Law of 2005.
4. Anti-Smoking Law in 2005.
5. Public Health Law of 2004.
6. Children's Law of 2004.
7. Water Law of 2002.
8. Labor Law for the year 2000.
9. Disability Rights Law of 1999.
10. Environment Law of 1999.

These legislations have provided a good legal environment governing the health conditions in the Palestinian territories. However, these legislations still need to be further updated to be consistent with international health standards to achieve the highest attainable standard of health, and they still need to be implemented in many aspects by issuing the necessary implementing regulations.

2.3 Contextual Framework

In this section, the researcher addressed empirical reviews that related to the dimensions of this study and the correlation of these reviews to the study; the Human right -based approach, PS culture. So, the researcher presented a summary for each previous study encompasses the title of the study, the aim of the study, design of the study, the conclusion, the recommendation.

Mohammed et, al. (2017) have done a study to "assess the patients' awareness of their rights, the predictors of knowledge of patients' rights and the degree of adherence to these rights by the medical team from the patients 'perspective". A cross-sectional study was conducted with a total 514 patients in Minia University Hospital in Egypt in 2017. Data was gathered using survey form to inquire about their knowledge of the patients 'rights, and degree of practicing these rights according to patients' views. the results were that 76% of patients didn't know about patients' rights charter. And the study indicated that the health services providers had to focus on raising the patients' awareness about their rights and engaging them in taking decisions related to the treatment's choices, where 98.1% of patients mentioned that the healthcare professionals didn't report them about the treatment choices.

The other researchers **Saifan et al. (2016)** presented a study about "The perspective of Palestinian physicians and nurses about the do-not-resuscitate order for terminally ill patients". The purpose of this study was to investigate whether healthcare professionals' consent to legalize DNR order in Palestine and whether their religious beliefs, culture or both affect their DNR order decision. The findings of this study indicate that the majority of the participants favor legalizing the DNR in Palestine and they expressed that their attitudes toward DNR were significantly influenced by their cultural background. Where about 64% of the participants (physicians & nurses) indicated their fear that the patients 'families will sue them if their family members are not

revived, and this is reflected in the absence of an effective medical law in Palestine, 88% of the participants would like to better understand about legal implications about Do-Not-Resuscitate order DNR. Also, 88% of respondents would like to know more about patients' rights.

Akca et al. (2015) assessed knowledge and attitudes of nurses working in Corum/Turkey regarding patient rights. A descriptive and cross-sectional approach was conducted in this study. No sample was selected, but the sample formed of nurses with a total of (939) who participated voluntarily in this study. data was collected through questionnaire design which includes two parts: questions about the nurses' characteristics, questions about patients' rights. the results revealed that 92% of nurses received education about patients 'rights, Nurses have shown that patients should receive healthcare services in a safe environment, regardless of religion, race, gender, economic or social status, or political opinion. In addition, respect and attention must be shown to patients. Also, studies should be conducted targeting to train the health workers and patient relatives on patient rights and to raise awareness of the patient rights culture.

Zeina et al. (2013) conducted a study to “examine the awareness, source of knowledge, and practices related to patients' rights in one of the general hospitals in South Egypt”, across sectional study was conducted, the population of the study included the health services providers, a group of patients and their companions in at Beni Suef University Hospital, with a total of 72 physicians and 48 nurses, 292 patients, and their companions. Data were collected using a two structured questionnaire. Of the results, concluded that three quarters of the patients and companions did not know about the list of patients' rights, compared to about half of the health services providers. So, this study indicated that most patients face difficulties in obtaining health services, as most of them are unable to face problems or harm in the hospital due to lack of awareness of their rights. The hospital manager mentioned in an interview there are complex interaction factors hinder respecting

the patients' rights especially in governmental hospitals such as bad working conditions, low salaries, and inadequate supervision supportive.

Joolae et al. (2008) examined the Factors affecting patients' rights practice in a central teaching hospital in Tehran, the study aimed to “know the perceptions and lived experiences of Iranian physicians and nurses of respecting patients' rights”. the study used the qualitative method in selecting eight nurses and five physicians working in a central teaching hospital in Tehran were interviewed during 2005–2006. The study recommended that the policymakers and managers have to develop legislation for protecting and promoting patients' rights, where there are factors that negatively affect patients' rights and act as obstacles: awareness of rights, availability resources, and accountability.

Researchers conducted several studies that covered the topics of PSC in many hospitals and healthcare centers in the world. The researchers **ELZoghbi et al. (2018)** evaluated the effect of quality improvement training, accreditation, and PS training on the improvement of the PS culture at the Primary Healthcare Corporation-Qatar. A descriptive cross-sectional study carried out in 2012 and 2015, The SOPS questionnaires were distributed in 21 health centers to assess PSC, and a total of 2,689 staff working in these centers had been selected. The questionnaire includes of 38 items for measuring the 10 dimensions included (“Teamwork, patient care follow-up, organizational learning, overall perceptions of PS and quality, staff training, owner/managing partner/leadership support for PS, communication about error, communication openness, office processes and standardization, and work pressure and pace”).

The study discovered that the survey was a good tool to raise awareness on the PS and quality in the PHC center. in addition, the PS rating as excellent/very good was 62% in 2015 in comparison

with 43% in 2014. Hence, the executing of the accreditation program, the training on quality improvement, and training on PS helped the institution improve its PSC.

Also, **Najjar et al. (2018)** explored the relationship between PS culture and prevalence of adverse events and assessed PS in eight medical departments in two Palestinian hospitals in 2009 and 2010. They used the Arabic HSOPSC questionnaire to measure the perceptions of health professionals to assess PS. and therefore the study sample was 428 health-care employees. The HSOPSC consists of 42 items for measuring 12 dimensions (“Teamwork within units, Organizational learning, supervisor expectations and actions promoting PS, Communication openness, communication about error, non-punitive response to error, Staffing, management support for PS, Teamwork across hospital units, Hospital hand-offs and transitions, Overall safety perceptions, Frequency of event reporting”). The study showed that the adverse events were associated negatively with PSC. So, to boost the PS, policymakers and managers should allocate resources, communication on errors, hospital management support, teamwork, supervisor actions, on- punitive response, and organizational learning.

Other researchers **Elmonsri et al. (2017)** conducted a study to find out the PS culture status in Arab countries based on the results of the English and Arabic HSPSC questionnaire, they performed electronic searches of the 18 previous Arabic studies that focused on PSC included 54,117 participants. The study summarized that there is a need to promote a PSC as a strategy to improve PS by policymakers and healthcare organizations in the Arab world. The studies agreed that the dimensions that were categorized as strength included teamwork, management support, organizational learning while the non- punitive response to error, and communication openness required further improvement according to the participant’s perceptions in these studies. The lowest score of the non- punitive response to error was scored respectively in Palestine, Saudi

Arabia, Egypt (17%, 16%, 19.5%), and this considered a serious problem on safety, as the blame culture still exists, and errors are not reported.

In addition, **Hellings et al. (2010)** measured PS culture in five Belgian general hospitals (three private and one public hospital) in 2005 and 2007 based on HSOPSC questionnaire. quantitative approach was used to measure PSC, and the study adopted a non-random sample to select the participants. 12 dimensions were used as the same as Najjars' study to evaluate the perceptions of hospitals staff about PSC and reporting to errors. 3,940 and 3,626 participants responded to the first and second surveys respectively. the study resulted that there is need to improve PS because of decreasing some dimension's scores, as an improvement was observed in some dimensions, such as (hospital management support for PS, supervisor expectations and actions promoting safety, and the teamwork within hospital units was high scores. On another hand, the lowest scores were the non-punitive response to error, and staffing, hospital transfers and transitions.

While the researchers **Bodur and Filiz (2010)** identified the HSOPS reliability and validity in improving the PSC, and the study aimed to assess the perceptions of physicians and nurses about PS in all government hospitals in the Turkish city of Konya and compared the results with the hospital in the United States. The Turkish version of the HSOPS questionnaire was used and distributed to 309 physicians and nurses. 10 dimensions were adopted in this study included ("Teamwork within units, Management Expectations, Teamwork across units and Management support, Organizational learning, Overall perceptions of safety, communication openness about the error, Frequency of events reported, Staffing, Handoffs and transitions, Non-punitive response to error"). The study concluded that the PS degree is 44%, which is less than the standard score, so the highest scores were teamwork within the hospital 70%, and the lowest scores are the

frequency of the reported incidents. while the study stated that the HSOPS tool is good for raising awareness of the PS culture in Turkey.

Hamdan and Saleem (2013) conducted a study to evaluate the PS culture in 11 Palestinian public hospitals in the west bank. A cross-sectional quantitative design and an Arabic translated version of the HSOPSC questionnaire was adopted. The population of the study was clinical and non- clinical staff with a total 1,460 person. PSC was assessed by using 42 items for measuring 12 dimensions. This study concluded that the highest scores were teamwork within units 71%, and the non- punitive response to error was the lowest scores 17%. also, there was low reporting of adverse events, insufficient management support, and lack of communication openness are core obstacles for enhancing PS, but the comparison to the previous year, the PS rating was excellent /very good 63.5%.

This study is the first in the Palestinian context in terms of integrating the HRBA to patient safety. There are no studies that have touched on the topic of HRBA in connection to patient rights including safety. On the other hand, there are few foreign and Arabic studies related to the attitudes and perceptions of health service providers and patients to the patients' rights (**Akca et al., 2015; Zeina et al., 2013; Joolae et al., 2008**) while Many Arab and foreign studies have been done about the issue of patient safety in hospitals without linking it to HRBA (**ELZoghbi et al., 2018; Najjar et al., (2018); Elmontsri et al., 2017; Hellings et al., 2010; Bodur and Filiz, 2010; Hamdan and Saleem, 2013**). Given the importance of patient rights, this study will state some studies regarding the patients' attitudes to the rights' patients being an essential element in informing them about aspects of medical care, treatment decisions, and other rights.

The literature review began in defining the concepts of HRBA and patient safety (**Curtice and Exworthy, 2010; Kohn et al., 2000**). Where it focused on raising the public awareness to the healthcare professionals regarding to the patients 'rights, and explained the factors impacting on violation the patients' rights during received them the healthcare services in the hospitals as well as clarified the dimensions of the patient safety culture and their relationship in improving patient safety and low the adverse events during the medical practices. In addition, it expressed how adherence to the patient rights and the development of legislation will help to provide the safe and healthy environment to the patients. On the other hand, the previous studies didn't address the FREDA principles as a one of the fundamental of HRBA to measure the level of commitment of health services providers of the principles of patients' rights. also, the previous studies didn't adopt any theory related for preventing violations of individuals rights in the hospitals. So, this study will be different, and it will a value added through integrating the FREDA principles as one of the fundamentals of the HRBA that adopted from Martin J. Curtice, Tim Exworthy in 2010 (**Curtice and Exworthy, 2010**), and the Social-Ecological Model: A Framework for Prevention adopted from Helse, l., Ellsber, m., & Gottemoeller, M (1999) (**CDC, 2015**) as a comprehensive framework to measure the PS in the Palestinian government hospitals in the north of west bank.

On the other hand, the strategic planning is involved in many areas of life in general, in the medical field. The topic of this study connected to the strategic planning, and the process of planning here lie in the first phase of situational analysis. Which means analyzing the current situation and studying all issues related to violation of the patients' rights and safety (weaknesses and strengths) in the Palestinian government hospitals so that put in place strategic interventions contribute to enhance the public health. The below picture illustrates the strategic planning process (**Nathy.B, 2017**):



Figure (2): Strategic Planning Process

2.4 Framework for Analysis

Socio-ecological model was used in several revisions and adoptions to reflect multi-level approaches to fields such as promotion of public health, prevention of violence, healthy college campuses. The SEM was first developed by Urie Bronfenbrenner in the 1970s as a conceptual model for understanding human development, and later formalized in the 1980s as a theory (Kilanowski, 2017).

The model states that health is affected by the interaction between the characteristics of the individual, society, and the environment, which includes the physical, social, and political components. The Centers for Disease and Prevention (CDC) have adapted SEM to promote health

and find sustainable solutions to the problems experienced by individuals and societies. By understanding many factors that influence harmful behavior exposed to violence, this model considers the complex interaction between individual factors, relationship, community, and societal factors. The Social-Ecological Model: A Framework for Prevention adopted from Helse, I., Ellsber, M., & Gottemoeller, M (1999) (**CDC, 2015**).

In our study, SEM theory will be adopted to study and understand the multifaceted effects of personal and environmental factors, and how the model can be used to frame discussion of PS and health interventions. SEM factors directly affect health providers' practices and adherence to patient rights principles that are reflected as behaviors in PS improvement practices.

The study will adopt the FREDA principles as one of the fundamentals of the HRBA, and adopted from Martin J. Curtice, Tim Exworthy (2010) (**Curtice and Exworthy, 2010**). There is an interrelationship between these principles and cannot be considered segregate because the HRBA includes all these values that are applied to a particular issue.

The figure below illustrates the conceptual framework for understanding the set of factors that expose patients to a violation of the RTH or protect them from exposure to violence, adherence to FREDA principles and their impact on PS, and includes 6 levels:

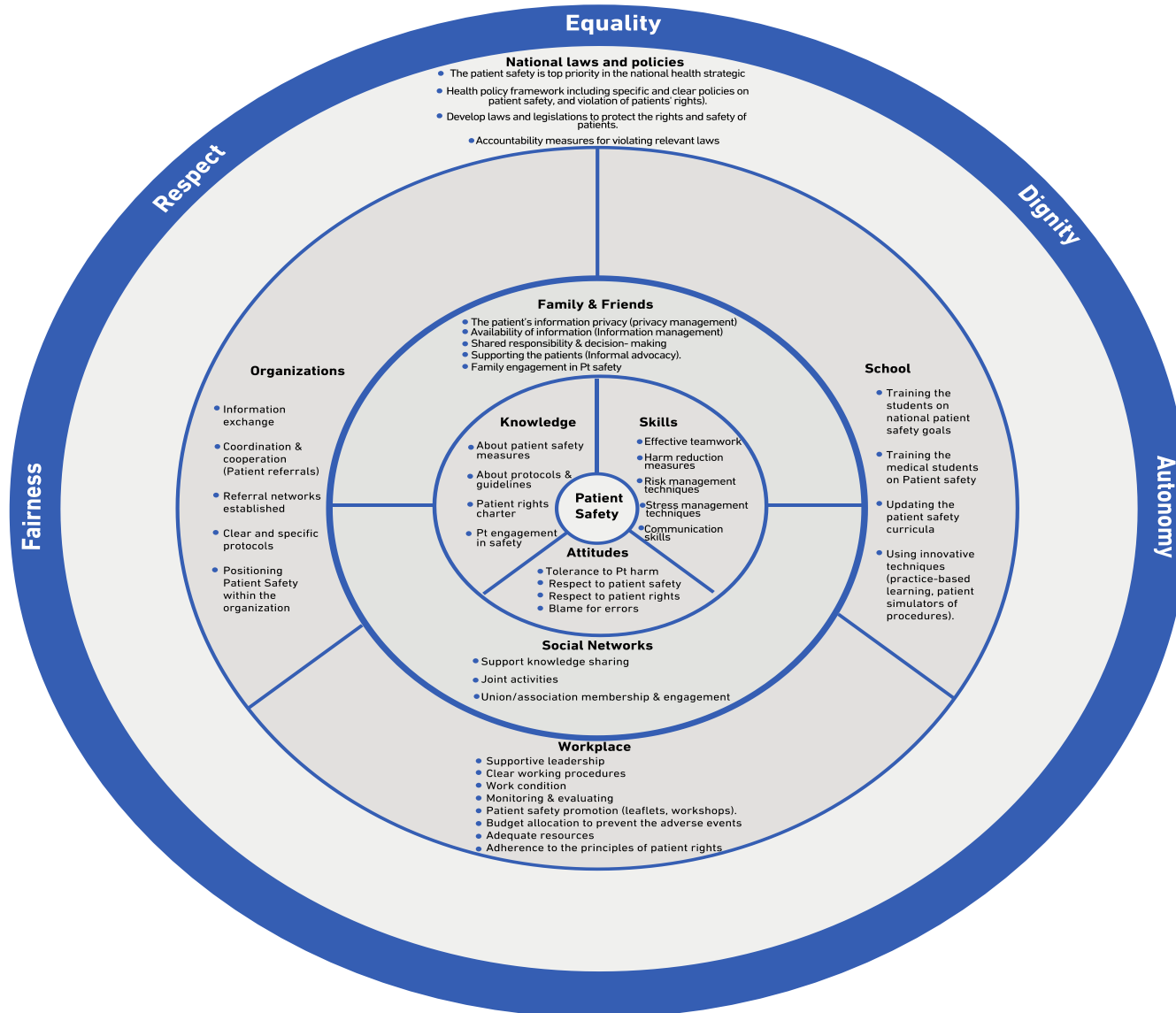


Figure (3): Application of the Socio-Ecological Model (SEM) & FREDa Principles to Enhance PS

First level

Patient safety: This aspect revolves around prevention reduction, reporting and analysis of error or unnecessary harm that patients may be exposed to when receiving healthcare because of medical errors, infection resulting from healthcare facilities and other consequences, and there is no doubt that concern for the patient’s safety is to ensure the RTH of patients and stop violating their rights, and this requires an understanding of the factors that influence violence. In our study, the researcher adopted HSOPSC survey to measure PS culture, PS culture has 12 dimensions of (Teamwork, Staffing & Work Pace, Organizational Learning—Continuous Improvement, Response to Error, Supervisor, Manager, or Clinical Leader Support for Patient Safety, Communication About Error, Communication Openness, Reporting Patient Safety Events, Hospital Management Support for Patient Safety, Handoffs and Information Exchange, Number of Events Reported and Patient Safety Rating) (AHRQ, 2019). The below table illustrates HSOPSC Survey Composite Measures and Definitions (AHRQ, 2018):

Table (1): HSOPSC Survey Composite Measures and Definitions

#	HSOPSC Survey Composite Measures	Definition
1.	Teamwork	The department has a culture of teamwork, mutual respect, and close working relationships among staff and providers.
2.	Staffing and Work Pace	There are enough staff and providers to handle the patient load, and the department work pace is not hectic.
3.	Organizational Learning – Continues Improving	The department has a learning culture that facilitates making changes in work processes to improve the quality of patient care and evaluates changes for effectiveness
4.	Response to Error	Staff are willing to report mistakes they observe and do not feel like their mistakes are held against them

5.	Supervisor/Manager /clinical Leader Support for Patient Safety	Leadership takes consideration staff suggestions seriously to improve the patient safety, the quality of patient care is more important than getting more work done, work processes are good at preventing mistakes, and mistakes do not happen more than they should.
6.	Communication About Error	Providers and staff talk openly about work problems and how to prevent errors from happening.
7.	Communication Openness	Providers in the work are open to staff ideas about how to improve work processes, and staff are encouraged to express alternative viewpoints and do not find it difficult to voice disagreement
8.	Reporting Patient Safety Events	Frequency reporting of events, whether when the error is caught and corrected before the patient's arrival or when the error reaches the patient and nearly harms him, but did not
9.	Hospital Management Support for Patient Safety	leadership actively supports quality and PS, places a high priority on improving patient care processes, does not overlook mistakes, and makes decisions based on what is best for patients
10.	Handoffs and Information Exchanging	Patient care information is not lost during the transfer of patients from one department to another or during the shifts changing.

Second Level

Individual: Represents the first element of SEM theory, this level determines the characteristics and personality of an individual that affect a person's behavior and increase the likelihood of becoming a perpetrator of violence, some of these factors are age, educational level, gender and economic status, and these factors are important to consider when building public health strategies where Beliefs and attitudes that prevent violations of rights are reinforced through daily training and skills.

Third Level

Relationships: This level examines social relationships and networks. Personal relationships from families and friends play a major role in influencing the behavior of health service providers in terms of treatment or intervention, patient support or privacy violations regarding disclosure of patient information. Prevention strategies at this level include strengthening health relationships to thwart violence and focus on health education and awareness programs.

Level Four

Community: This level focuses on the relationships between institutions, organizations, and schools that make up the larger community. These elements play a major role in developing behaviors by imposing regulations and restrictions that define behavior, disseminating knowledge and transforming information about safe health practices that either lead to a violation of patient rights or improve patient safety.

Level Five

Societal: This level focuses on factors that create an environment in which violence is encouraged and supported or prevented, health policies laws and regulations at the national level play a major role in influencing large numbers of people, setting an appropriate budget to prevent harmful events, combat infectious diseases, promote cultural programs regarding to rights and PS, prevent violence, and work to integrate the patients' rights and PS into national plans and policies as part of national goals contribute to achieving equality and non-discrimination in accessing health services for all patients.

Sixth Level

FREDA principles: The final level in the framework includes several elements that include fairness, respect, and equality in providing health services, maintaining patient dignity, autonomy, and patient right to make treatment decisions regarding their medical care. Consequently, working across multiple levels of this model at the same time helps prevent violation of patient rights in health institutions.

2.4.1 Study Variables

The conceptual framework model was developed after reviewing many of the literature related to this study, the variables are considered as a blueprint for the research process, the researcher has developed a conceptual framework integrated between HRBA principles and the factors related to the social ecological model to enhance PS. This framework was analyzed in detail in its own section of the study.

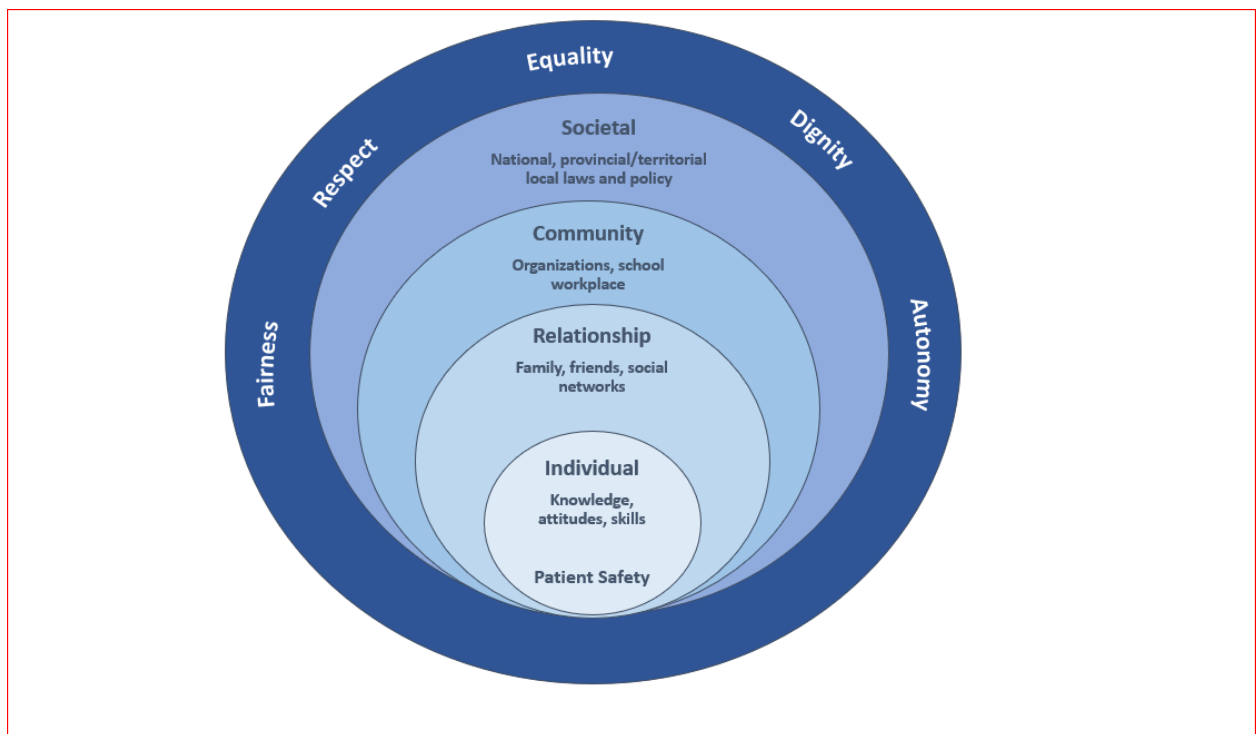


Figure (4): Study Conceptual Model Based on the Socioecological Theory

The figure above presents the nested loops in the model that show how factors at one level affect another and the relationships between them, which include 6 levels:

First level: PS is the dependent variable and it's affected by the FREDA principles and the SEM factors.

The first four level: There are four basics factors and their elements related to SEM theory, it was adopted in this study to help in understanding the multifaceted effects of personal and environmental factors, and these levels take into account the complex interaction between individual factors, relationship, community, and societal factors.

Last level: There are five independent variables, which are namely FREDA principles (Fairness, Respect, Equality, Dignity and Autonomy), they effect on PS, and the same time affected by the SEM factors.

Chapter III

Study Methodology

This chapter describes the methods and procedures followed by the researcher of how she conducts the task of this study. This chapter addressed the study population and the sample size, explaining the scientific steps and procedures that were followed in building and describing the study tool, then explaining the study design scheme and its variables, method of data collection, as well as the statistical treatments used in the analysis of the results.

3.1 Study Design

The study has adopted the analytical descriptive approach to have the results. A cross-sectional quantitative design is adopted to examine the hypotheses of the study and answer questions. Based on the literature review, the researcher used the Arabic translated **SOPS** Hospital Survey 2.0 version (Survey Items and Composite Measures questionnaire) to collect data, this questionnaire released by Agency for Healthcare Research and Quality (AHRQ) in 2019, the study used it to measure the perceptions of health professionals to assess PS and measure their level of adherence to the principles of FREDA regarding to the patients' rights in the Palestinian government hospitals in Northern West Bank (AHRQ, 2019).

The data were then analyzed and processed statistically to extract and compare the results. So, the research approach of this study is containing from one phase: Phase I: In this phase the researcher will conduct an empirical study that will use a questionnaire as the study instrument in order to examine the hypothesized study conceptual Model.

3.2 Study settings and population

The study population consists of all health professionals (Physicians general and specialist), Pharmacists, Nurses, Midwives and, Paramedical) in six governmental Palestinian hospitals of (Rafidia, Nablus, Tulkarem (Thabet Thabet), Salfit (Yaser Arafat), Tubas Turkish Hospital, Jenin (Khalil Suliman) and Qalqilia (Darwish Nazal) hospitals in North of West Bank. IN total, these health facilities collectively comprise (1511) health professionals (MoH, 2018).

3.3 Sample Size

This study adopted non-random sampling technique to draw the sample from health professionals who are the study population. The estimated sample size is (384) based on statistical formula (Taherdoost, 2017), which is a simplified formula to calculate sample size that takes consideration for sampling error and suits for a large ,targeted population.

Table (2): Sample Size Indicator

Items for sample size	Value used
Estimation	Proportions
Variance of the population (p)	%50
Marginal error (e)	5%
level of confidence (95%)	1.96

In calculating the sample size of this study using the formula below, the researcher used the confidence level of (95%) and a precision level (Margin of error) of (0.05) is being selected because the population is too large. Therefore, the sample size of the study is:

Unlimited population: sample size (n)

$$n = \frac{P * (1 - P) * z^2}{(e)^2}$$

$$\frac{0.5 * (1 - 0.5) * 1.96^2}{(0.05)^2} = 384$$

The table below illustrates the calculation of the size of the total study sample:

A proportional sampling was taken for each hospital (Health Professional no., Staff%, Health Professional Sample). To determine the percentage of non-response for the individuals of this study sample. Based on the PSOHS user's guided, the expected response rate was at least 50% to determine the sample size of the study (**Sorra at al., 2016**). And by reviewing the PCBS publications, for example, the methodology of designing a sample survey of the impact of Covid 19 was obtained from the PCBS in 2020, and it was mentioned that the anticipated response rate when designing the sample amounted to 80%, which means that the percentage of estimated non-response rate was 20% (**PCBS, 2021**). The same argument was adopted in the completion of this study. Accordingly, the total sample size was calculated as (481), which were distributed to health professionals in the selected government hospitals on a proportionate to size bases to obtain accurate and reliable results.

Table (3): Proportionate to Size Sample Calculation & Distribution

S. No.	Hospital	Type of Hospital	Health Professional no.	Staff%	Health Professional Sample
1	Rafidia -Nablus	Governmental	434	29%	138
2	Tulkarem (Thabet Thabet)	Governmental	276	18%	88
3	Salfit (Yaser Arafat)	Governmental	164	11%	52
4	Tubas Turkish	Governmental	135	9%	43
5	Jenin (Khalil Suleiman)	Governmental	339	22%	108
6	Qalqiliya (Darwish Nazzal)	Governmental	163	11%	52
Total			1,511	100%	481

An (481) questionnaires distributed to respondents, and about (8) questionnaires have been excluded due to for the lack of seriousness in the answers by the respondent, So, some of questionnaires were empty and another contain missing data. The number of questionnaires returned (473).

3.5 Data Collection Methods

3.5.1 Data Collection Source:

The researcher used two sources of information :

3.5.1.1 Primary data: Data were collected by the study sample participants by filling structured (HSOPS) questionnaire to investigate the level of understanding patient safety and the level of adherence the healthcare professionals to HRBA principles in the Palestinian Hospitals, in Northern of West Bank. The variables will rate by using a 5 Likert scale from 5= strongly agree, to 1= strongly disagree.

3.5.1.2 Secondary data: Data were collected through a desk review from published and grey literature which includes Arabic and foreign academic research, reports, articles, and credible internet websites.

3.5.2 Data Collection Technique

The study tool used by the researcher is prepared to investigate the level of understanding patient safety in Selected Palestinian Hospitals in North of West Bank by employing the strategic HRBA. The study adopted Arabic translated SOPS Hospital Survey 2.0 questionnaire: Items and Composite Measures for collecting data to dealing with the same subject for achieving the study purpose. The questionnaire consists of 12 dimensions of (Teamwork, Staffing & Work Pace, Organizational Learning—Continuous Improvement, Response to Error, Supervisor, Manager, or Clinical Leader Support for Patient Safety, Communication About Error, Communication Openness, Reporting Patient Safety Events, Hospital Management Support for Patient Safety, Handoffs and Information Exchange, Number of Events Reported and Patient Safety Rating). The questionnaire consists of (41) statements.

3.5.2.1 Questionnaire Design

The study model consists of three components: FREDA principles, social ecological model (SEM), and PS. In order to cover the three elements and verify the five main hypotheses of the study, the original HSOPSC consists of 42 items on 12 dimensions: two outcome dimensions and 10 safety dimensions. Respondents address these 42 items by means of a five-point Likert scale of which the labels vary throughout the dimensions; 1 = ‘strongly disagree’ to 5 = ‘strongly agree’, or, 1 = ‘never’ to 5 = ‘always. The HSOPSC questionnaire is composed of three main parts:

Part One: This part includes the introduction, several elements which emphasize the target of the study, kind of data that the researcher needs to collect from the study sample in addition to a paragraph aiming at encouraging the targeted individuals to respond frankly on the study questions after satisfying the tested health professionals that the information will remain highly confidential and will not be used except for the scientific research only.

Part Two: This part includes general information characteristics of participants, which is including the variables: Staff position, Hospital name, Unit/Work area.

Part Three: This part includes 8 sections that measure patient safety issues/ patient protect in the hospitals, which embodies the third elements of the study model as following:

Section A: This section composed of 14 closed short statements by using multiple Likert Scales (from 1=strongly disagree, to 5=strongly agree) that captured “Your unit/ work area”.

Section B: This section composed of 3 closed short statements by using multiple Likert Scales (from 1=strongly disagree, to 5=strongly agree) that captured “Supervisor, Manager, or Clinical Leader”.

Section C: This section composed of 7 closed short statements by using multiple Nominal Scales (Never, Rarely, Sometimes, most of the Time, Always) that captured “Communication”.

Section D: This section composed of 3 closed short questions, first two questions using multiple Nominal Scales using (Never, Rarely, Sometimes, Most of the Time, Always), and the third short question using choices that captured “Reporting Patient Safety Events”.

Section E: This section composed of one closed short question by using multiple Nominal Scales (Poor, Fair, Good, Very Good, Excellent) that captured “Reporting Patient Safety Events”.

Section F: This section composed of 6 closed short statements by using multiple Likert Scales (from 1=strongly disagree, to 5=strongly agree) that captured “Your Hospital”.

Section G: This section composed of 4 closed short questions that captured “Background Questions”.

Section H: This section involves opening statement about how things are done or could be done in hospital that might affect patient safety that captured “Your Comments”.

3.6 Validity of Questionnaire

To verify the validity of the questionnaire, there are validated studies that exist that adopted this tool as a standard tool, this form was presented to the supervisor after it was translated into the Arabic language for verification.

3.7 Reliability of Questionnaire

The stability of the tool was achieved by conducting the internal consistency test and extracting the stability coefficient (Cronbach alpha) on the entire sample of the study, where the stability coefficient of the tool (72 %) was a good stability factor.

3.8 Study Procedures

In order to carry out the study, the study carried out the following research procedures:

- A structured questionnaire was adopted based on literature review to identify the opinions of health professionals and their perceptions on patient safety/protection issues, medical errors and events reports within the six governmental hospitals in northern of West Bank- Palestine. In addition to investigate the level of understanding patient safety and the level of adherence to HRBA principles by healthcare professionals in the government Hospitals.
- A questionnaire was presented to the academic supervisor at Arab American University to take her view on the validity of the study tool and based on her guidance some fields related to administrators have been excluded in the first and second sections of the form (your staff position, your unit/ work area) because of our study targets only the health professionals. Regarding to the " your staff position" section, some cells listed under the nursing field have been excluded because they are not accredited in the state of Palestine and are not on the occupational ladder in Palestinian hospitals. In addition, minor modifications were added in the first two sections of the questionnaire, by placing the cells in each section without listing them under each heading as in the original English SOPS survey to ensure ease of understanding.
- The study population was identified to achieve the aim and objectives of the study by reviewing the studies relevant to the topic of this study, which included a sample of (Health professionals in 6 governmental hospitals in north of west bank).
- 481 questionnaires were distributed on field to the study sample. The distribution period began on 4-8-2020 to 18-8-2020, and the number of questionnaires returned (473).
- The study emptied the responses and extracted the results using statistical treatments.

3.9 Statistical Processes

After gathering the responds, they were codified, entered the computer, and statically processed by using the statistical package for social science (SPSS).

The statistical procedures used in the study are :

1. Cronbach Alpha formula to measure the creditability of the study.
2. Frequencies, means, standard deviations and percentages to achieve the four study objectives of (identifying the level of employing the principles of HRBA to healthcare by health services providers in Selected Palestinian Hospitals in North of West Bank, identifying the level of understanding PS culture by health services providers in Selected Palestinian Hospitals in North of West Bank, identifying factors that affect the violation of patients' rights in Selected Palestinian Hospitals in North of West Bank, and to understand the correlation among employing the principles of HRBA to healthcare and understanding patient safety in Selected Palestinian Hospitals in north of west bank.
3. Factor analysis was conducted to identify the measures for each statement that reflect each of the human values in the model adopted in the FREDA principles study.

3.10 Ethical Consideration

Ethical considerations will include the following:

1. Ethical clearance was obtained through getting official letter from faculty of graduate studies at Arab American university to MoH and hospitals to start the study.
2. Verbal consent by MoH was approved for distributing the questionnaire to the targeted sample in this study.

3.11 Limitations

- There was cooperation from the quality coordinators in the targeted hospitals in order to facilitate the process of distributing the forms to the target group, but the researcher faced a very great difficulty when distributing the forms, the sample size was very large and it took a great time and effort to complete the task, in addition, the high cost of transportation to the cities to reach those hospitals. On the other hand, the process of completing the forms by the target sample was carried out in two stages, especially in hospitals that have large number of participants, and also, some questionnaires were missing due to the neglect of some participants, so the researcher had to continue to hand out the questionnaire again until fitted the study sample size due to the large number of the study sample.
- Scarcity of relevant research in the region and locally. There are a few Arab and local studies related to the perception of healthcare providers of the patients' rights, especially in relation to PS. Moreover, since HRBA is a new subject, there are no such literature reviews covering this topic and its related or impacts on PS, specifically, the lack of Arabic reviews especially in Palestine that entitled the topic of employing FREDA principles in the health institutions.

CHAPTER IV DATA ANALYSIS AND RESULTS

In this chapter, the researcher presented and analyzed the finding results of this study that collected from study sample which was (473) participants with (98%) respondent rate, the chapter divided into three sections, which are: Participants Profile, Research Questions analysis, and Testing Hypothesis.

4.1 Participants Profile:

4.1.1 Characteristics of the General Information of the Participants:

The tables below presented the characteristics of the general information of the participants regarding to their: Staff position, hospital name, unit/work area, the period of work in the hospital, the period of work in unit/work area, working hours variable, direct interaction or contact with patient.

1. Staff Position Variable:

Table (4)
Distribution of the Study Sample by the Staff Position

	Frequency	Percent
Registered Nurse (RN)	177	37.4
Practical Nurse	32	6.8
Specialist Physician	48	10.1
Resident, Intern	62	13.1
Pharmacist, Pharmacy Technician	27	5.7
Dietitian	3	.6

Physical, Occupational, or Speech Therapist	17	3.6
Technologist, Technician (e.g., EKG, Lab, Radiology)	50	10.6
Other	57	12.1
Total	473	100.0

The data in the table above shows distribution of the sample by staff, as follows: 37.4% were answered Registered Nurse (RN), 6.8% were answered Practical Nurse, 10.1% were answered Specialist Physician, compare to 13.1% were answered Resident, Intern. And the lowest percentage of respondents are .6% were answered Dietitian, 3.6% were answered Physical, Occupational, or Speech Therapist, while 10.6% of respondents are Technologist, Technician (e.g., EKG, Lab, Radiology), and 12.1% others.

2. Hospital Name Variable

Table (5)
Distribution of the Study Sample by Hospital Name

		Frequency	Percent
Valid	Darwish Nazzal	50	10.6
	Khalil Suleiman	107	22.6
	Rafidia	135	28.5
	Thabet Thabet	86	18.2
	Tubas Turkish	43	9.1
	Yaser Arafat	52	11.0
	Total	473	100.0

The data in the table above shows distribution of the sample by hospital name, as follows: 10.6% of health staff are in Darwish Nazzal hospital (Qalqiliya), and the ratio of health staff in Khalil Suleiman hospital (Jenin) was 22.6%, and the largest ratio of targeted sample was in

Rafidia hospital (Nablus) by 28.5%, while the ratio of health staff in Thabet Thabet hospital (Tulkarem) was 18.2% of the study sample, the lowest ratio of health staff was in Tubas Turkish hospital with 9.1%, and 11.0% of them in Yaser Arafat hospital (Salfit).

3. Your unit/ Work Area Variable

Table (6)
Distribution of the Study Sample by the Your unit/ Work area

	Frequency	Percent
Valid	12	2.5
Many different hospital units, No specific unit	38	8.0
Internal medicine	38	8.0
Surgical unit	62	13.1
Labor & Delivery, Obstetrics & Gynecology	42	8.9
Pediatrics (including NICU, PICU)	46	9.7
Emergency Department	32	6.8
ICU (All Adult Types)	18	3.8
Rehabilitation, Physical Medicine	14	3.0
Pharmacy	27	5.7
Pathology, Lab	38	8.0
Radiology, Imaging	22	4.7
Anesthesiology	13	2.7
Other	71	15.0
Total	473	100.0

The data in the table above shows distribution of the sample by unit/ work area, as follows: 8.0% of the respondents were answered Many different hospital units, no specific unit, Internal medicine, and Pathology, Lab. 13.1% were answered Surgical unit, 8.9% were answered Labor & Delivery, Obstetrics & Gynecology, 9.7% were answered Pediatrics (including NICU, PICU), 6.8% were answered Emergency Department, 3.8% were answered ICU (All Adult Types), 3.0% were answered Rehabilitation, Physical Medicine, 5.7% were answered Pharmacy, 4.7% were answered Radiology, Imaging, 2.7% were answered Anesthesiology, while 15.0% were answered working in other units.

4. The Period of Work in the Hospital Variable

Table (7)
Distribution of the Study Sample by the Period of Work in the Hospital

		Frequency	Percent
Valid	Less than 1 year	64	13.5
	1 to 5 years	141	29.8
	6 to 10 years	108	22.8
	11 or more years	156	33.0
	Total	469	99.2
Missing	System	4	.8
Total		473	100.0

The data in the table above shows distribution of the sample by How long have you worked in this hospital, as follows: 13.6% were answered Less than 1 year, compare to 30.1% were answered 1 to 5 years, while 23.0% were answered 6 to 10 years, and 33.3% for 11 or more years.

5. The Period of Work in Unit/Work Area Variable

Table (8)
Distribution of the Study Sample by the Period of Work in Unit/Work Area

		Frequency	Percent
Valid	Less than 1 year	80	16.9
	1 to 5 years	183	38.7
	6 to 10 years	92	19.5
	11 or more years	114	24.1
Total		469	99.2
Missing	System	4	.8
Total		473	100.0

The data in the table above shows distribution of the sample by the period of work in Unit/Work Area in this hospital, how long have you worked in your current unit/work area as follows: 17.1% were answered Less than 1 year, compare to 39.0% were answered 1 to 5 years, while 19.6% were answered 6 to 10 years, and 24.3% for 11 or more years.

6. Working Hours Variable

Table (9)
Distribution of the Study Sample by the Working Hours

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Less than 30 hours per week	25	5.3	5.3	5.3
	30 to 40 hours per week	260	55.0	55.0	60.3
	More than 40 hours per week	188	39.7	39.7	100.0
Total		473	100.0	100.0	

The data in the table above shows distribution of the sample by how many hours per week do you work in these hospitals follows: 5.3% were answered Less than 30 hours per week, compare to 55.0% were answered 30 to 40 hours per week, while 39.7% were answered More than 40 hours per week.

3. Direct Interaction or Contact with Patient Variable

Table (10)

Distribution of the Study Sample by the Direct Interaction or Contact with Patient

		Frequency	Percent
Valid	YES, I typically have direct interaction or contact with patients	429	90.7
	NO, I typically do NOT have direct interaction or contact with patients	40	8.5
	Total	469	99.2
Missing	System	4	.8
Total		473	100.0

The data in the table above shows distribution of the sample by do you typically have direct interaction or contact with patients as follows: 91.5% were answered YES, I typically have direct interaction or contact with patients, compare to 8.5% were answered NO, I typically do NOT have direct interaction or contact with patients.

4.2 Study Questions:

This study sought to investigate the level of understanding patient safety in selected Palestinian hospitals in North of West Bank by employing the strategic HRBA. So, the study looked at the effect role of HRBA (FREDA principles) regarding the five constructs of the survey questionnaire: Fairness, Equality, Respect, Dignity, Autonomy. To answer the main and sub-questions of the study, the researcher used the arithmetic mean and standard deviation based on the Likert scale to judge the level of each item.

The following distribution of items has been adopted in the process of correcting the paragraphs of the study tool, as follows (Diebe and Iriqat, 2019):

Table (11): Likert scale

Strongly Agree	Agree	Sometimes	Disagree	Strongly Disagree
5	4	3	2	1

Thus, the level is low when the mean (1-2.33), whereas it is moderate when the mean (2.34-3.66), and the level is high when the mean (3.67-5), as shown in the table below (Diebe and Iriqat, 2019):

Table (12): Assessing data level of Likert scale

Mean	Degree
5 - 3.67	High
3.66 - 2.34	Moderate
2.33 - 1	Low

In order to answer the four sub-questions, the tables will be presented at the bottom, which includes the arithmetic mean and standard deviation of the 12 dimensions of the PS culture, then after that each sub-question will be answered through the analysis of those tables. We deal

with negatively worded items during the analysis as reversal analysis. Whereby disagreeing or responding never to a negatively worded item indicates a positive response. We revised the codes of negatively worded items so that a higher score always reflected a more positive response.

Table (13): Teamwork indicators

#	Statement	Mean	Std. Deviation	%	Level
1	How much do you agree or disagree with the following statements about your unit/work area? (In this unit, we work together as an effective team)	3.991	.9553	79.8	High
2	How much do you agree or disagree with the following statements about your unit/work area? (During busy times, staff in this unit help each other)	3.701	1.0369	74.0	High
3	How much do you agree or disagree with the following statements about your unit/work area? (There is a problem with disrespectful behavior by those working in this unit)	2.138	1.1009	42.8	Low
4	Teamwork	3.2786	.57674	65.6	High

It is clear from the results of the previous table of the Teamwork indicators that the paragraph that states (In this unit, we work together as an effective team) obtained a high value of Mean reached (3.991), from other hand we see that the paragraph that states (There is a problem with disrespectful behavior by those working in this unit) Obtained a low value of Mean reached (2.138), this indicates that working in collective teams affects the quality of work and health services provided to patients.

Table (14): Staffing and Work Pace indicators

#	Statement	Mean	Std. Deviation	%	Level
1	How much do you agree or disagree with the following statements about your unit/work area? (In this unit, we have enough staff to handle the workload)	2.699	1.1711	54.0	Moderate
2	How much do you agree or disagree with the following statements about your unit/work area? (Staff in this unit work longer hours than is best for patient care)	3.394	1.1054	67.9	Moderate
3	How much do you agree or disagree with the following statements about your unit/work area? (This unit relies too much on temporary, float, or PRN staff)	2.374	1.1141	47.5	Moderate
4	How much do you agree or disagree with the following statements about your unit/work area? (The work pace in this unit is so rushed that it negatively affects patient safety)	2.748	1.2274	55.0	Moderate
5	Staffing and Work Pace	2.8140	.65228	56.3	Moderate

As in results of the previous table of Staffing and Work Pace indicators that the paragraph that states (Staff in this unit work longer hours than is best for patient care) obtained a high value of Mean reached (3.394), from other hand we see that the paragraph that states (How much do you agree or disagree with the following statements about your unit/work area? (This unit relies too much on temporary, float, or PRN staff) Obtained a low value of Mean reached (2.374).

Table (15): Organizational Learning—Continuous Improvement Indicators

#	Statement	Mean	Std. Deviation	%	Level
1	How much do you agree or disagree with the following statements about your unit/work area? (This unit regularly reviews work processes to determine if changes are needed to improve patient safety)	3.703	.9283	74.1	High
2	How much do you agree or disagree with the following statements about your unit/work area? (In this unit, changes to improve patient safety are evaluated to see how well they worked)	3.525	1.0601	70.5	Moderate
3	How much do you agree or disagree with the following statements about your unit/work area? (This unit lets the same patient safety problems keep happening)	2.472	1.0834	49.4	Moderate
4	Organizational Learning—Continuous Improvement	3.2364	.59160	64.7	Moderate

The results of the previous table of **Organizational Learning—Continuous Improvement indicators** shows that the paragraph that states (This unit regularly reviews work processes to determine if changes are needed to improve patient safety) obtained a high value of Mean reached (3.703), from other hand we see that the paragraph that states (How much do you agree or disagree with the following statements about your unit/work area? (This unit lets the same patient safety problems keep happening) Obtained a low value of Mean reached (2.472).

Table (16): Response to Error Indicators

#	Statement	Mean	Std. Deviation	%	Level
1	How much do you agree or disagree with the following statements about your unit/work area? (In this unit, staff feel like their mistakes are held against them)	3.458	1.0740	69.2	Moderate
2	How much do you agree or disagree with the following statements about your unit/work area? (When an event is reported in this unit, it feels like the person is being written up, not the problem)	3.167	1.1449	63.3	Moderate
3	How much do you agree or disagree with the following statements about your unit/work area? (When staff make errors, this unit focuses on learning rather than blaming individuals)	3.271	1.1897	65.4	Moderate
4	How much do you agree or disagree with the following statements about your unit/work area? (In this unit, there is a lack of support for staff involved in patient safety errors)	3.037	1.1280	60.7	Moderate
5	Response to Error	3.2341	.65026	64.7	Moderate

The results of the previous table of **Response to Error indicators** shows that the paragraph that states (In this unit, staff feel like their mistakes are held against them) obtained a high value of Mean reached (3.458), from other hand we see that the paragraph that states (How much do you agree or disagree with the following statements about your unit/work area? (In this unit, there is a lack of support for staff involved in patient safety errors) Obtained a low value of Mean reached (3.037).

Table (17): Supervisor, Manager, or Clinical Leader Support for Patient Safety**Indicators**

#	Statement	Mean	Std. Deviation	%	Level
1	How much do you agree or disagree with the following statements: My supervisor, manager, or clinical leader seriously considers staff suggestions for improving patient safety	3.665	1.0834	73.3	Moderate
2	How much do you agree or disagree with the following statements: My supervisor, manager, or clinical leader wants us to work faster during busy times, even if it means taking shortcuts	2.672	1.1126	53.4	Moderate
3	How much do you agree or disagree with the following statements: My supervisor, manager, or clinical leader takes action to address patient safety concerns that are brought to their attention	3.789	.8893	75.8	High
4	Supervisor, Manager, or Clinical Leader Support for Patient Safety	3.3774	.70000	67.5	Moderate

As shown in the results of the previous table of **Supervisor, Manager, or Clinical Leader Support for Patient Safety indicators** that the paragraph that states (My supervisor, manager, or clinical leader takes action to address patient safety concerns that are brought to their attention) obtained a high value of Mean reached (3.789), from other hand we see that the paragraph that states (How much do you agree or disagree with the following statements about your unit/work area? (My supervisor, manager, or clinical leader wants us to work faster during busy times, even if it means taking shortcuts) Obtained a low value of Mean reached (2.672).

Table (18): Communication About Error Indicators

#	Statement	Mean	Std. Deviation	%	Level
1	How often do the following things happen in your unit/work area? (We are informed about errors that happen in this unit)	3.626	1.0896	72.5	Moderate
2	How often do the following things happen in your unit/work area? (When errors happen in this unit, we discuss ways to prevent them from happening again)	3.841	1.0375	76.8	High
3	How often do the following things happen in your unit/work area? (In this unit, we are informed about changes that are made based on event reports)	3.790	.9843	75.8	High
4	Communication About Error	3.7432	.89458	74.9	High

It is clear from the results of the previous table that the paragraph that states (When errors happen in this unit, we discuss ways to prevent them from happening again) obtained a high value of Mean reached (3.841), from other hand we see that the paragraph that states (How much do you agree or disagree with the following statements about your unit/work area? (We are informed about errors that happen in this unit) Obtained a low value of Mean reached (3.626).

Table (19): Communication Openness Indicators

#	Statement	Mean	Std. Deviation	%	Level
1	How often do the following things happen in your unit/work area? (In this unit, staff speak up if they see something that may negatively affect patient care)	3.682	1.0757	73.6	Moderate
2	How often do the following things happen in your unit/work area? (When staff in this unit see someone with more authority doing something unsafe for patients, they speak up)	3.317	1.2133	66.3	Moderate
3	How often do the following things happen in your unit/work area? (When staff in this unit speak up, those with more authority are open to their patient safety concerns)	3.215	1.1511	64.3	Moderate
4	How often do the following things happen in your unit/work area? (In this unit, staff are afraid to ask questions when something does not seem right)	2.659	1.1433	53.2	Moderate
5	Communication Openness	3.2308	.72045	64.6	Moderate

It is clear from the results of the previous table that the paragraph that states (In this unit, staff speak up if they see something that may negatively affect patient care) obtained a high value of Mean reached (3.682), from other hand we see that the paragraph that states (In this unit, staff are afraid to ask questions when something does not seem right) Obtained a low value of Mean reached.

Table (20): Reporting Patient Safety Events Indicators

#	Statement	Mean	Std. Deviation	%	Level
1	When a mistake is caught and corrected before reaching the patient, how often is this reported?	3.361	1.1852	67.2	Moderate
2	When a mistake reaches the patient and could have harmed the patient, but did not, how often is this reported?	3.480	1.0949	69.6	Moderate
3	Reporting Patient Safety Events	3.4143	1.01872	68.3	Moderate

It is clear from the results of the previous table of **Reporting Patient Safety Events indicators** that the paragraph that states (When a mistake reaches the patient and could have harmed the patient, but did not, how often is this reported) obtained a high value of Mean reached (3.480), from other hand we see that the paragraph that states (When a mistake is caught and corrected before reaching the patient, how often is this reported) Obtained a low value of Mean reached (3.361).

Table (21): Hospital Management Support for Patient Safety Indicators

#	Statement	Mean	Std. Deviation	%	Level
1	How much do you agree or disagree with the following statements about your hospital? (The actions of hospital management show that patient safety is a top priority)	3.661	.9213	73.2	Moderate
2	How much do you agree or disagree with the following statements about your hospital? (Hospital management provides adequate resources to improve patient safety)	3.115	1.0611	62.3	Moderate
3	How much do you agree or disagree with the following statements about your hospital? (Hospital management seems interested in-patient safety only after an adverse event happens)	3.108	1.0563	62.2	Moderate
4	Hospital Management Support for Patient Safety	3.2987	.69055	66.0	Moderate

It is clear from the results of the previous table that the paragraph that states (The actions of hospital management show that patient safety is a top priority) obtained a high value of Mean reached (3.661), from other hand we see that the paragraph that states (Hospital management seems interested inpatient safety only after an adverse event happens) Obtained a low value of Mean reached (3.108).

Table (22): Handoffs and Information Exchange Indicators

#	Statement	Mean	Std. Deviation	%	Level
1	How much do you agree or disagree with the following statements about your hospital? (When transferring patients from one-unit to another, important information is often left out)	2.366	1.0661	47.3	Moderate
2	How much do you agree or disagree with the following statements about your hospital? (During shift changes, important patient care information is often left out)	2.2632	.99053	45.3	Low
3	How much do you agree or disagree with the following statements about your hospital? (During shift changes, there is adequate time to exchange all key patient care information)	3.3890	1.06831	67.8	Moderate
4	Handoffs and Information Exchange	2.6724	.69522	53.4	Moderate

The results of the previous table (**Handoffs and Information Exchange**) that the paragraph that states (During shift changes, there is adequate time to exchange all key patient care information) obtained a high value of Mean reached (3.389), from other hand we see that the paragraph that states (During shift changes, important patient care information is often left out) Obtained a low value of Mean reached (2.2632).

Table (23): Respondents by Number of Events Reported

In the past 12 months, how many patients' safety events have you reported?		
#		Valid Percent
1	None	49.2
2	1 to 2	28.3
3	3 to 5	12.6
4	6 to 10	4.2
5	11 or more	5.7
6	Total	100.0

The results of the previous table (**Number of Events Reported**) that the paragraph that states (**In the past 12 months, how many patient safety events have you reported?**), 49.2% of participants were answered that they didn't report any event, compare to 28.3% who reported 1 to 2 patient safety incidents, while 12.6% were answered from 3 to 5 events, 4.2% were answered from 6 to 10 events, and 5.7% were answered from 11 or more. This means that there is a need for a supportive environment to encourage reporting of errors to prevent their recurrence in the future

Table (24): Respondents by their Patient Safety Rating

How would you rate your unit/work area on patient safety?		
#		Valid Percent
1	Poor	3.2
2	Fair	8.7
3	Good	32.6
4	Very Good	40.0
5	Excellent	15.6
6	Total	100.0

The results of the previous table (**Patient Safety Rating**) that the paragraph that states (**How would you rate your unit/work area on patient safety?**). We see that 32.6% of participants rated the level of PS in their units/hospitals as ‘Good’, from other hand we see that 55.6% of respondents rated the level of PS in their units/hospitals as ‘Very Good/ Excellent’.

4.2.1 Regarding to the five constructs of the questionnaire which answer the study

question of: The level of employing the FRED A principles in healthcare

by health professionals in government Palestinian hospitals in north west bank.

Table (25): Respondents by Construct level of Fairness

#	Statement	Mean	Std. Deviation	%	Level
1	How much do you agree or disagree with the following statements about your unit/work area? (Staff in this unit work longer hours than is best for patient care)	3.39	1.11	67.9	Moderate
2	How much do you agree or disagree with the following statements about your unit/work area? (This unit regularly reviews work processes to determine if changes are needed to improve patient safety)	3.70	.93	74.1	High
3	How much do you agree or disagree with the following statements about your unit/work area? (In this unit, staff feel like their mistakes are held against them)	3.46	1.07	69.2	Moderate
4	How much do you agree or disagree with the following statements about your unit/work area? (In this unit, changes to improve patient safety are evaluated to see how well they worked)	3.52	1.06	70.5	Moderate
5	How much do you agree or disagree with the following statements: My supervisor, manager, or clinical leader seriously considers staff suggestions for improving patient safety	3.67	1.08	73.3	Moderate

6	How much do you agree or disagree with the following statements about your hospital? (The actions of hospital management show that patient safety is a top priority)	3.66	.92	73.2	Moderate
7	How much do you agree or disagree with the following statements about your hospital? (During shift changes, there is adequate time to exchange all key patient care information)	3.39	1.07	67.8	Moderate
8	Fairness	3.5426	.53794	70.8	Moderate

It is clear from the results of the previous table that the paragraph that states (**This unit regularly reviews work processes to determine if changes are needed to improve patient safety**) obtained a high value of Mean reached (3.70), from other hand we see that the paragraph that states (**Staff in this unit work longer hours than is best for patient care**) obtained a low value of Mean reached (3.39). The average arithmetic mean, where it was equal to (3.54), from this we can be explained the average of **fairness**. The researcher concluded that the level of employing the fairness principle to healthcare by health professionals in government Palestinian hospitals is moderate.

Table (26): Respondents by Construct level of Equality

#	Statement	Mean	Std. Deviation	%	Level
1	How much do you agree or disagree with the following statements about your unit/work area? (In this unit, we have enough staff to handle the workload)	2.70	1.17	54.0	Moderate
2	How much do you agree or disagree with the following statements about your unit/work area? (During busy times, staff in this unit help each other)	3.70	1.04	74.0	High
3	How much do you agree or disagree with the following statements about your unit/work area? (The work pace in this unit is so rushed that it negatively affects patient safety)	2.75	1.23	55.0	Moderate
4	How much do you agree or disagree with the following statements: My supervisor, manager, or clinical leader wants us to work faster during busy times, even if it means taking shortcuts	2.67	1.11	53.4	Moderate
5	How much do you agree or disagree with the following statements about your hospital? (Hospital management provides adequate resources to improve patient safety)	3.12	1.06	62.3	Moderate
6	Equality	2.9869	.58185	59.7	Moderate

It is clear from the results of the previous table that the paragraph that states (**During busy times, staff in this unit help each other**) obtained a high value of Mean reached (3.7), from other hand we see that the paragraph that states (**My supervisor, manager, or clinical leader wants us to work faster during busy times, even if it means taking shortcuts**) obtained a low value of Mean reached (2.67). The average arithmetic mean, where it was equal to (2.98), from this we can be explained the average of **equality**. The researcher concluded that the level of employing the equality principle to healthcare by health professionals in government Palestinian hospitals is moderate.

Table (27): Respondents by Construct level of Respect

#	Statement	Mean	Std. Deviation	%	Level
1	How much do you agree or disagree with the following statements about your unit/work area? (In this unit, we work together as an effective team)	3.99	.96	79.8	High
2	How much do you agree or disagree with the following statements about your unit/work area? (There is a problem with disrespectful behavior by those working in this unit)	2.22	2.19	44.4	Low
3	How much do you agree or disagree with the following statements about your unit/work area? (When staff make errors, this unit focuses on learning rather than blaming individuals)	3.27	1.19	65.4	Moderate
4	How often do the following things happen in your unit/work area? (In this unit, we are informed about changes that are made based on event reports)	3.79	.98	75.8	High
5	Respect	3.3191	.74458	66.4	Moderate

It is clear from the results of the previous table that the paragraph that states (**In this unit, we work together as an effective team**) obtained a high value of Mean reached (3.99), from other hand we see that the paragraph that states (**There is a problem with disrespectful behavior by those working in this unit**) obtained a low value of Mean reached (2.22). The average arithmetic mean, where it was equal to (3.31), from this we can be explained the average of **Respect**. So, the researcher concluded that the level of employing the respect principle to healthcare by health professionals in government Palestinian Hospitals is moderate.

Table (28): Respondents by Construct level of Dignity

#	Statement	Mean	Std. Deviation	%	Level
1	How much do you agree or disagree with the following statements about your unit/work area? (When an event is reported in this unit, it feels like the person is being written up, not the problem)	3.17	1.14	63.3	Moderate
2	How much do you agree or disagree with the following statements about your unit/work area? (This unit lets the same patient safety problems keep happening)	2.47	1.08	49.4	Moderate
3	How much do you agree or disagree with the following statements: My supervisor, manager, or clinical leader takes action to address patient safety concerns that are brought to their attention	3.79	.89	75.8	High
4	How often do the following things happen in your unit/work area? (We are informed about errors that happen in this unit)	3.63	1.09	72.5	Moderate
5	How often do the following things happen in your unit/work area? (When errors happen in this unit, we discuss ways to prevent them from happening again)	3.84	1.04	76.8	High
6	How much do you agree or disagree with the following statements about your hospital? (Hospital management seems interested in-patient safety only after an adverse event happens)	3.11	1.06	62.2	Moderate
7	Dignity	3.3310	.51552	66.6	Moderate

It is clear from the results of the previous table that the paragraph that states (**When errors happen in this unit, we discuss ways to prevent them from happening again**) obtained a high value of Mean reached (3.84), from other hand we see that the paragraph that states (**This unit lets the same patient safety problems keep happening**) obtained a low value of Mean reached (2.47). The average arithmetic mean, where it was equal to (3.33), from this we can be explained the average of **Dignity**. The researcher concluded that the level of employing the dignity principle to healthcare by health professionals in government Palestinian hospitals is moderate.

Table (29): Respondents by Construct level of Autonomy

#	Statement	Mean	Std. Deviation	%	Level
1	How much do you agree or disagree with the following statements about your unit/work area? (This unit relies too much on temporary, float, or PRN staff)	2.37	1.11	47.5	Moderate
2	How much do you agree or disagree with the following statements about your unit/work area? (In this unit, there is a lack of support for staff involved in patient safety errors)	3.04	1.13	60.7	Moderate
3	How much do you agree or disagree with the following statements about your hospital? (When transferring patients from one unit to another, important information is often left out)	2.37	1.07	47.3	Moderate
4	How often do the following things happen in your unit/work area? (In this unit, staff speak up if they see something that may negatively affect patient care)	3.68	1.08	73.6	Moderate
5	How often do the following things happen in your unit/work area? (When staff in this unit see someone with more authority doing something unsafe for patients, they speak up)	3.32	1.21	66.3	Moderate
6	Autonomy	2.9576	.56814	59.2	Moderate

It is clear from the results of the previous table that the paragraph that states (**In this unit, staff speak up if they see something that may negatively affect patient care**) obtained a high value of Mean reached (3.68), from other hand we see that the paragraph that states (**This unit relies too much on temporary, float, or PRN staff**) and (**When transferring patients from one unit to another, important information is often left out**) obtained a low value of Mean reached (2.37). The average arithmetic mean, where it was equal to (2.95), from this we can be explained the average of **Autonomy**. The researcher concluded that the level of employing the autonomy principle to healthcare by health professionals in government Palestinian hospitals is moderate.

4.2.2 **Regarding to the five constructs of the questionnaire which answer the study question of:** The level of understanding patient safety culture by health professionals in government Palestinian hospitals in north west bank.

Table (30): Level of Patient Safety Rating

How would you rate your unit/work area on patient safety?		
#		Valid Percent
1	Poor	3.2
2	Fair	8.7
3	Good	32.6
4	Very Good	40.0
5	Excellent	15.6
6	Total	100.0

It is clear from the results of the previous table that the paragraph that states (**How would you rate your unit/work area on patient safety?**), we see that 32.6% of participants rated the level of PS in their units/hospitals as ‘Good’, from other hand we see that 55.6% of respondents rated the level of PS in their units/hospitals as ‘Very Good/ Excellent’. So, the researcher concluded that there is a need to improve some areas of patient safety culture in Palestinian government hospitals to ensure enhanced patient safety. The composite score for the indicator is: Handoffs and Information Exchange 53.4%, Staffing and Work Pace 56.3%, Organizational Learning—Continuous Improvement and Response to Error 64.7%, Communication Openness 64.6%, Teamwork 65.6%, Hospital Management Support for Patient Safety 66%, Supervisor, Manager, or Clinical Leader Support for Patient Safety 67.5%, Reporting Patient Safety Events 68.3%, Communication About Error 74.9%.

4.2.3 Regarding to the five constructs of the questionnaire which answer the study question of: The factors that affect the violation of patients' rights in government Palestinian hospitals in north west bank.

Table (31): Staffing and Work Pace Factors

#	Statement	Mean	Std. Deviation	%	Level
1	How much do you agree or disagree with the following statements about your unit/work area? (In this unit, we have enough staff to handle the workload)	2.699	1.1711	54	Moderate
2	How much do you agree or disagree with the following statements about your unit/work area? (Staff in this unit work longer hours than is best for patient care)	3.394	1.1054	67.9	Moderate
3	How much do you agree or disagree with the following statements about your unit/work area? (The work pace in this unit is so rushed that it negatively affects patient safety)	2.748	1.2274	55	Moderate
4	Staffing and Work Pace	2.814	0.65228	56.3	Moderate

As in results of the previous table of Staffing and Work Pace indicators, 54% of the participants indicated to the sufficiency of the number of employees to deal with work pressure, 55% showed that they work very quickly, and 67.9% of the participants indicated that they work long hours. We notice that these factors effect on patient rights and their safety negatively.

Table (32): Response to Error Factor

#	Statement	Mean	Std. Deviation	%	Level
1	How much do you agree or disagree with the following statements about your unit/work area? (In this unit, staff feel like their mistakes are held against them)	3.458	1.074	69.2	Moderate
2	Response to Error	3.2341	0.65026	64.7	Moderate

As in results of the previous table of **Response to Error Factor** that the paragraph that states (In this unit, staff feel like their mistakes are held against them) by 69.2%. The researcher concludes that staff feel like their mistakes are held against them leads to motivation of others not to report the errors due to fear of exposure to legal accountability and creates a feeling of mistrust between team members and the leadership.

Table (33): Hospital Management Support for Patient Safety Factors

#	Statement	Mean	Std. Deviation	%	Level
1	How much do you agree or disagree with the following statements about your hospital? (Hospital management provides adequate resources to improve patient safety)	3.115	1.0611	62.3	Moderate
2	How much do you agree or disagree with the following statements about your hospital? (Hospital management seems interested in-patient safety only after an adverse event happens)	3.108	1.0563	62.2	Moderate
3	Hospital Management Support for Patient Safety	3.2987	0.69055	66	Moderate

As in results of the previous table of **Hospital Management Support for Patient Safety** that the paragraphs that illustrate that 62.3% of participants indicate “Hospital management provides adequate resources to improve patient safety” and 62.2% of respondent’s state that “Hospital management seems interested in-patient safety only after an adverse event happens. So, the researcher concluded that the insufficient administrative support represents a major challenge for the safe care of patients in government hospitals.

4.2.4 Regarding to the five constructs of the questionnaire which answer the study question of: The correlation among employing the principles of HRBA to healthcare and understanding patient safety in in government Palestinian hospitals in north of west bank.

In order to answer this question, the researcher used the factor analysis method to analyze the five principles (hypotheses) that target to interpret the data and describe the relationship between the interrelated variables. The factor analysis aims to identify the variables most closely related to each factor. Factor analysis will be presented dimensions’ factor analysis- results through showing the tables for each factor: KMO and Bartlett's Test, Total Variance Explained, Rotated Component Matrix.

4.2.4.1 Dimensions Factor Analysis-Results

A. Fairness Factor

The first dimension contains 7 variables as follows:

Table (34): Fairness Factor Analysis

#	Fairness Factor Analysis
A3	How much do you agree or disagree with the following statements about your unit/work area? (Staff in this unit work longer hours than is best for patient care)
A4	How much do you agree or disagree with the following statements about your unit/work area? (This unit regularly reviews work processes to determine if changes are needed to improve patient safety)
A6	How much do you agree or disagree with the following statements about your unit/work area? (In this unit, staff feel like their mistakes are held against them)
A12	How much do you agree or disagree with the following statements about your unit/work area? (In this unit, changes to improve patient safety are evaluated to see how well they worked)
B1	How much do you agree or disagree with the following statements: My supervisor, manager, or clinical leader seriously considers staff suggestions for improving patient safety
F1	How much do you agree or disagree with the following statements about your hospital? (The actions of hospital management show that patient safety is a top priority)
F6	How much do you agree or disagree with the following statements about your hospital? (During shift changes, there is adequate time to exchange all key patient care information)

The first attempt of the factor analysis for this dimension shows the following results:

For the correlation matrix some of the correlation was higher than 0.3 as the first condition of the factor analysis.

For the second condition related to Kaiser-Meyer-Olkin Measure of Sampling Adequacy, the test was significant with p value 0.000 and equal to 0.767.

Table (35): KMO and Bartlett's Test

KMO and Bartlett's Test		
Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.767
Bartlett's Test of Sphericity	Approx. Chi-Square	519.85
	Df	4
	Sig.	.000

Concerning the third condition which related to the partial sampling adequacy MSA which is calculated in the anti-image table, all the variable has correlation higher than 0.5 which is the third condition of the factor analysis.

The fourth condition concerning the communalities, the analysis shows that the variable/ the question” How much do you agree or disagree with the following statements about your unit/work area? (In this unit, staff feel like their mistakes are held against them)’ has a communality less than 0.5 so it should be eliminated from the analysis and be considered as basic variable in this dimension and re-do the analysis without it.

So, in the second attempt all the communalities are higher than 0.5.

By looking at the total variance explained table and the eigenvalues larger than 1 it seems like we have 2 components.

Table (36): Total Variance Explained

Total Variance Explained										
Component	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings			
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	
dimension	1	2.353	39.215	2.353	39.215	39.215	2.337	38.949	38.949	
	2	1.274	21.228	1.274	21.228	60.443	1.290	21.493	60.443	
	6	.436	7.263	100.000						
Extraction Method: Principal Component Analysis.										

Table (37): Rotated Component Matrix^a

#	So now we have to find which variables related to wich component by looking at the rotated component matrix. Rotated Component Matrix^a	Component	
		1	2
A3.1	How much do you agree or disagree with the following statements about your unit/work area? (Staff in this unit work longer hours than is best for patient care)	.018	.796
A4.1	How much do you agree or disagree with the following statements about your unit/work area? (This unit regularly reviews work processes to determine if changes are needed to improve patient safety)	.769	.062
A6.1	How much do you agree or disagree with the following statements about your unit/work area? (In this unit, staff feel like their mistakes are held against them)	.038	.791
A12.1	How much do you agree or disagree with the following statements about your unit/work area? (In this unit, changes to improve patient safety are evaluated to see how well they worked)	.798	-.100
B1.1	How much do you agree or disagree with the following statements: My supervisor, manager, or clinical leader seriously considers staff suggestions for improving patient safety	.773	.043
F1.1	How much do you agree or disagree with the following statements about your hospital? (The actions of hospital management show that patient safety is a top priority)	.713	-.122

The first component as shown above we have 4 variables so we will choose the variable with the highest variance explained which is A4_1 “How much do you agree or disagree with the following statements about your unit/work area? (In this unit, changes to improve patient safety are evaluated to see how well they worked).

For the second component we have 2 variables so we will choose the variable with the highest variance explained which is A3_1 “How much do you agree or disagree with the following statements about your unit/work area? (Staff in this unit work longer hours than is best for patient care)” to represent the second component.

So, in summery for this fairness dimension, we have three variables that should represent this dimension:

1. A6_1 Extent of agreement with statements about your unit/work area **Staffing and Work Pace** (In this unit, staff feel like their mistakes are held against them).
2. A4_1 Extent of agreement with statements about your unit/work area **Organizational Learning—Continuous Improvement** (In this unit, changes to improve patient safety are evaluated to see how well they worked).
3. A3_1 Extent of agreement with statements about your unit/work area **Response to Error** (Staff in this unit work longer hours than is best for patient care).

B. Equality Factor

The second dimension contains 5 variables as follows:

Table (38): Equality Factor Analysis

#	Equality Factor Analysis
A2_2	How much do you agree or disagree with the following statements about your unit/work area? (In this unit, we have enough staff to handle the workload)
A8_2	How much do you agree or disagree with the following statements about your unit/work area? (During busy times, staff in this unit help each other)
A11_2	How much do you agree or disagree with the following statements about your unit/work area? (The work pace in this unit is so rushed that it negatively affects patient safety)
B2_2	How much do you agree or disagree with the following statements: My supervisor, manager, or clinical leader wants us to work faster during busy times, even if it means taking shortcuts
F2_2	How much do you agree or disagree with the following statements about your hospital? (Hospital management provides adequate resources to improve patient safety)

The first attempt of the factor analysis for this dimension shows the following results:

For the correlation matrix some of the correlation was higher than 0.3 as the first condition of the factor analysis.

For the second condition related to Kaiser-Meyer-Olkin Measure of Sampling Adequacy, the test was significant with p value 0.000 and equal to 0.554.

Table (39): KMO and Bartlett's Test

KMO and Bartlett's Test		
Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.554
Bartlett's Test of Sphericity	Approx. Chi-Square	184.255
	Df	10
	Sig.	.000

Concerning the third condition which related to the partial sampling adequacy MSA which is calculated in the anti-image table, all the variable has correlation higher than 0.5 which is the third condition of the factor analysis.

The fourth condition concerning the communalities, the analysis shows that the variable/ the question” How much do you agree or disagree with the following statements about your unit/work area? (During busy times, staff in this unit help each other)’ has a communality less than 0.5 so it should be eliminated from the analysis and be considered as basic variable in this dimension and re-do the analysis without it.

So, in the second attempt all the communalities are higher than 0.5. By looking at the total variance explained table and the eigenvalues larger than 1 it seems like we have 2 components.

Table (40): Total Variance Explained

Total Variance Explained										
Component	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings			
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	
dimension0	1	1.541	38.534	38.534	1.541	38.534	38.534	1.391	34.780	34.780
	2	1.223	30.577	69.111	1.223	30.577	69.111	1.373	34.331	69.111
	3	.680	17.009	86.120						
	4	.555	13.880	100.000						

Extraction Method: Principal Component Analysis.

So now we have to find which variables related to which component by looking at the rotated component matrix.

Table (41): Rotated Component Matrix^a

#	Rotated Component Matrix ^a	Component	
		1	2
A2_2	How much do you agree or disagree with the following statements about your unit/work area? (In this unit, we have enough staff to handle the workload)	.009	.838
A11_2	How much do you agree or disagree with the following statements about your unit/work area? (The work pace in this unit is so rushed that it negatively affects patient safety)	.822	-.071
B2_2	How much do you agree or disagree with the following statements: My supervisor, manager, or clinical leader wants us to work faster during busy times, even if it means taking shortcuts	.839	-.025
F2_2	How much do you agree or disagree with the following statements about your hospital? (Hospital management provides adequate resources to improve patient safety)	-.107	.816

The first component as shown above we have 2 variables so we will choose the variable with the highest variance explained which is B2_2 “How much do you agree or disagree with the following statements: My supervisor, manager, or clinical leader wants us to work faster during busy times, even if it means taking shortcuts” to represent the first component.

For the second component we have 2 variables so we will choose the variable with the highest variance explained which is A2_2 “How much do you agree or disagree with the following statements about your unit/work area? (In this unit, we have enough staff to handle the workload)” to represent the second component.

So, in summery for this equality dimension, we have three variable that should represent this dimension:

1. A8_2 Extent of agreement with statements about your unit/work area **teamwork** (During busy times, staff in this unit help each other).
2. B2_2 Extent of agreement with statements about your unit/work area **Staffing and Work Pace** (My supervisor, manager, or clinical leader wants us to work faster during busy times, even if it means taking shortcuts).
3. A2_2 Extent of agreement with statements about your unit/work area **Supervisor, Manager, or Clinical Leader Support for Patient Safety** (In this unit, we have enough staff to handle the workload).

C. Respect Factor

The third dimension contains 5 variables as follows:

Table (42): Respect Factor Analysis

#	Respect Factor Analysis
A1_3	How much do you agree or disagree with the following statements about your unit/work area? (In this unit, we work together as an effective team)
A9_3	How much do you agree or disagree with the following statements about your unit/work area? (There is a problem with disrespectful behavior by those working in this unit)
A10_3	How much do you agree or disagree with the following statements about your unit/work area? (When staff make errors, this unit focuses on learning rather than blaming individuals)
C3_3	How often do the following things happen in your unit/work area? (In this unit, we are informed about changes that are made based on event reports)

The first attempt of the factor analysis for this dimension shows the following results:

For the correlation matrix some of the correlation was higher than 0.3 as the first condition of the factor analysis.

For the second condition related to Kaiser-Meyer-Olkin Measure of Sampling Adequacy, the test was significant with p value 0.000 and equal to 0.654.

Table (43): KMO and Bartlett's Test

KMO and Bartlett's Test		
Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.654
Bartlett's Test of Sphericity	Approx. Chi-Square	146.728
	Df	6
	Sig.	.000

Concerning the third condition which related to the partial sampling adequacy MSA which is calculated in the anti-image table, all the variable has correlation higher than 0.5 which is the third condition of the factor analysis.

The fourth condition concerning the communalities, the analysis shows that the variable/ the question” How much do you agree or disagree with the following statements about your unit/work area? (There is a problem with disrespectful behavior by those working in this unit)’ has a communality less than 0.5 so it should be eliminated from the analysis and be considered as basic variable in this dimension and re-do the analysis without it.

So, in the second attempt all the communalities are higher than 0.5.

By looking at the total variance explained table and the eigenvalues larger than 1 it seems like we have component.

Table (44): Total Variance Explained

Total Variance Explained							
Component		Initial Eigenvalues			Extraction Sums of Squared		
		Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
dimension0	1	1.645	54.838	54.838	1.645	54.838	54.838
	2	.724	24.129	78.967			
	3	.631	21.033	100.000			
Extraction Method: Principal Component Analysis.							

So, now we have to find which variables related to which component by looking at the rotated component matrix.

Table (45): Component Matrix^a

#	Component Matrix ^a	
		Component
		1
A1_3	How much do you agree or disagree with the following statements about your unit/work area? (In this unit, we work together as an effective team)	.756
A10_3	How much do you agree or disagree with the following statements about your unit/work area? (When staff make errors, this unit focuses on learning rather than blaming individuals)	.762
C3_3	How often do the following things happen in your unit/work area? (In this unit, we are informed about changes that are made based on event reports)	.702
Extraction Method: Principal Component Analysis. a. 1 components extracted.		

Only one component was extracted as shown above we have 3 variables so we will choose the variable with the highest variance explained which is B2_2 “How much do you agree or

disagree with the following statements about your unit/work area? (When staff make errors, this unit focuses on learning rather than blaming individuals)” to represent this component.

So, in summary for this respect dimension, we have two variables that should represent this dimension:

1. A9_3 Extent of agreement with statements about your unit/work area **Teamwork** (There is a problem with disrespectful behavior by those working in this unit)'
2. A10_3 Extent of agreement with statements about your unit/work area **Response to Error** (When staff make errors, this unit focuses on learning rather than blaming individuals).

D. Dignity Factor

The fourth dimension contains 6 variables as follows:

Table (46): Dignity Factor Analysis

#	Dignity Factor Analysis
A7_4	How much do you agree or disagree with the following statements about your unit/work area? (When an event is reported in this unit, it feels like the person is being written up, not the problem)
A14_4	How much do you agree or disagree with the following statements about your unit/work area? (This unit lets the same patient safety problems keep happening)
B3_4	How much do you agree or disagree with the following statements: My supervisor, manager, or clinical leader takes action to address patient safety concerns that are brought to their attention
C1_4	How often do the following things happen in your unit/work area? (We are informed about errors that happen in this unit)
C2_4	How often do the following things happen in your unit/work area? (When errors happen in this unit, we discuss ways to prevent them from happening again)
F3_4	How much do you agree or disagree with the following statements about your hospital? (Hospital management seems interested inpatient safety only after an adverse event happens)

The first attempt of the factor analysis for this dimension shows the following results:

For the correlation matrix some of the correlation was higher than 0.3 as the first condition of the factor analysis

For the second condition related to Kaiser-Meyer-Olkin Measure of Sampling Adequacy, the test was significant with p value 0.000 and equal to 0.668.

Table (47): KMO and Bartlett's Test

KMO and Bartlett's Test		
Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.668
Bartlett's Test of Sphericity	Approx. Chi-Square	356.792
	Df	15
	Sig.	.000

Concerning the third condition which related to the partial sampling adequacy MSA which is calculated in the anti-image table, all the variable has correlation higher than 0.5 which is the third condition of the factor analysis.

The fourth condition concerning the communalities, the analysis shows that the variable/ the question” How much do you agree or disagree with the following statements about your hospital? (Hospital management seems interested inpatient safety only after an adverse event happens)’ has a communality less than 0.5 so it should be eliminated from the analysis and be considered as basic variable in this dimension and re-do the analysis without it.

So, in the second attempt all the communalities are higher than 0.5.

By looking at the total variance explained table and the eigenvalues larger than 1 it seems like we have 2 components.

Table (48): Total Variance Explained

Total Variance Explained										
Component	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings			
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	
dimension0	1	2.120	42.409	42.409	2.120	42.409	42.409	1.957	39.132	39.132
	2	1.118	22.369	64.778	1.118	22.369	64.778	1.282	25.646	64.778
	3	.728	14.565	79.343						
	4	.637	12.744	92.087						
	5	.396	7.913	100.000						
Extraction Method: Principal Component Analysis.										

So, now we have to find which variables related to which component by looking at the rotated component matrix.

Table (49): Rotated Component Matrix^a

#	Rotated Component Matrix ^a	Component	
		1	2
A7_4	How much do you agree or disagree with the following statements about your unit/work area? (When an event is reported in this unit, it feels like the person is being written up, not the problem)	.017	.836
A14_4	How much do you agree or disagree with the following statements about your unit/work area? (This unit lets the same patient safety problems keep happening)	-.221	.722
B3_4	How much do you agree or disagree with the following statements: My supervisor, manager, or clinical leader takes action to address patient safety concerns that are brought to their attention	.687	-.214
C1_4	How often do the following things happen in your unit/work area? (We are informed about errors that happen in this unit)	.852	.032
C2_4	How often do the following things happen in your unit/work area? (When errors happen in this unit, we discuss ways to prevent them from happening again)	.842	-.126
Extraction Method: Principal Component Analysis. Rotation Method: Varimax with Kaiser Normalization. a. Rotation converged in 3 iterations.			

The first component as shown above we have 3 variables so we will choose the variable with the highest variance explained which is C2_4 “How often do the following things happen in your unit/work area? (We are informed about errors that happen in this unit)” to represent the first component.

For the second component we have 2 variables so we will choose the variable with the highest variance explained which is A7_4 “How much do you agree or disagree with the following statements about your unit/work area? (When an event is reported in this unit, it feels like the person is being written up, not the problem)” to represent the second component.

So, in summary for this dignity dimension we have three variables that should represent this dimension:

1. F3_4 Extent of agreement with statements about your unit/work area **hospital management support for patient safety** (Hospital management seems interested inpatient safety only after an adverse event happens)’
2. C2_4 Extent of agreement with statements about your unit/work area **communication about error** (We are informed about errors that happen in this unit).
3. A7_4 Extent of agreement with statements about your unit/work area **response to error** (When an event is reported in this unit, it feels like the person is being written up, not the problem)”

E. Autonomy Factor

The fifth dimension contains 5 variables as follows:

Table (50): Autonomy Factor Analysis

Autonomy Factor Analysis	
A5_5	How much do you agree or disagree with the following statements about your unit/work area? (This unit relies too much on temporary, float, or PRN staff)
A13_5	How much do you agree or disagree with the following statements about your unit/work area? (In this unit, there is a lack of support for staff involved in patient safety errors)
F4_5	How much do you agree or disagree with the following statements about your hospital? (When transferring patients from one unit to another, important information is often left out)
C4_5	How often do the following things happen in your unit/work area? (In this unit, staff speak up if they see something that may negatively affect patient care)
C5_5	How often do the following things happen in your unit/work area? (When staff in this unit see someone with more authority doing something unsafe for patients, they speak up)

The first attempt of the factor analysis for this dimension shows the following results:

For the correlation matrix some of the correlation was higher than 0.3 as the first condition of the factor analysis.

For the second condition related to Kaiser-Meyer-Olkin Measure of Sampling Adequacy, the test was significant with p value 0.000 and equal to 0.533.

Table (51): KMO and Bartlett's Test

KMO and Bartlett's Test		
Kaiser-Meyer-Olkin Measure of Sampling Adequacy.		.533
Bartlett's Test of Sphericity	Approx. Chi-Square	250.508
	Df	10
	Sig.	.000

Concerning the third condition which related to the partial sampling adequacy MSA which is calculated in the anti-image table, all the variable has correlation higher than 0.5 which is the third condition of the factor analysis.

The fourth condition concerning the communalities, the analysis shows that the variable/ the question A13_5” How much do you agree or disagree with the following statements about your unit/work area? (In this unit, there is a lack of support for staff involved in patient safety errors)’ has a communality less than 0.5 so it should be eliminated from the analysis and be considered as basic variable in this dimension and re-do the analysis without it.

So, in the second attempt all the communalities are higher than 0.5.

By looking at the total variance explained table and the eigenvalues larger than 1 it seems like we have 2 components.

Table (52): Total Variance Explained

Total Variance Explained										
Component		Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings		
		Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
dimension	1	1.673	41.822	41.822	1.673	41.822	41.822	1.625	40.616	40.616
	2	1.190	29.754	71.576	1.190	29.754	71.576	1.238	30.960	71.576
	3	.766	19.138	90.714						
	4	.371	9.286	100.000						
Extraction Method: Principal Component Analysis.										

So, now we have to find which variables related to which component by looking at the rotated component matrix.

Table (53): Rotated Component Matrix^a

#	Rotated Component Matrix ^a	Component	
		1	2
A5_5	How much do you agree or disagree with the following statements about your unit/work area? (This unit relies too much on temporary, float, or PRN staff)	.002	.793
F4_5	How much do you agree or disagree with the following statements about your hospital? (When transferring patients from one unit to another, important information is often left out)	-.081	.774
C4_5	How often do the following things happen in your unit/work area? (In this unit, staff speak up if they see something that may negatively affect patient care)	.895	-.103
C5_5	How often do the following things happen in your unit/work area? (When staff in this unit see someone with more authority doing something unsafe for patients, they speak up)	.904	.010
Extraction Method: Principal Component Analysis. Rotation Method: Varimax with Kaiser Normalization. a. Rotation converged in 3 iterations.			

The first component as shown above we have 2 variables so we will choose the variable with the highest variance explained which is C5_5 “How often do the following things happen in your unit/work area? (When staff in this unit see someone with more authority doing something unsafe for patients, they speak up)” to represent the first component.

For the second component we have 2 variables so we will choose the variable with the highest variance explained which is A5_5 “How much do you agree or disagree with the following statements about your unit/work area? (This unit relies too much on temporary, float, or PRN staff)” to represent the second component.

So, in summary for this autonomy dimension, we have three variables that should represent this dimension:

1. A13_5 Extent of agreement with statements about your unit/work area **Staffing and Work Pace** (In this unit, there is a lack of support for staff involved in patient safety errors)’.

2. C5_5 Extent of agreement with statements about your unit/work area **communication openness** (When staff in this unit see someone with more authority doing something unsafe for patients, they speak up).
3. A5_5 Extent of agreement with statements about your unit/work area **Staffing and Work Pace** (This unit relies too much on temporary, float, or PRN staff).

4.3 Summary:

This chapter explained in detail the results and findings of the study. Characteristics of the general information of the participants was presented; Staff position, hospital name, unit/work area, the period of work in the hospital, the period of work in unit/work area, the numbers of working hours, direct interaction or contact with patient. The presentation is connected to the research objectives and covers on the level of understanding PS by employing strategic HRBA (Fairness, Equality, Respect, Dignity, Autonomy) health professionals.

The findings show that; there is a significant role of employing FREDa in the healthcare by health professionals in government hospitals. Moreover, there is a need to improve some areas of patient safety culture in Palestinian government hospitals to ensure enhanced patient safety.

The findings also prove that, staffing and work pace indicators, response to error indicators, and hospital Management Support for PS are the most factors that affect the violation of patients' rights in government Palestinian hospitals.

On the other hand, the results showed that there is a relationship between the factors (FREDa) and many variables (indicators), but it was found that the relationship is moderate.

The results indicate that there is a correlation between the fairness factor and the dimensions of PS culture:

1. A6_1 (In this unit, staff feel like their mistakes are held against them).
2. A4_1 (In this unit, changes to improve patient safety are evaluated to see how well they worked).
3. A3_1 “How much do you agree or disagree with the following statements about your unit/work area? (Staff in this unit work longer hours than is best for patient care).

There is a correlation between the equality factor and the dimensions of PS culture:

1. A8_2 (During busy times, staff in this unit help each other).
2. B2_2 (My supervisor, manager, or clinical leader wants us to work faster during busy times, even if it means taking shortcuts).
3. A2_2 (In this unit, we have enough staff to handle the workload).

There is a correlation between the respect factor and the dimensions of PS culture:

3. A9_3 (There is a problem with disrespectful behavior by those working in this unit).
4. A10_3 (When staff make errors, this unit focuses on learning rather than blaming individuals).

There is a correlation between the dignity factor and dimensions of PS culture:

1. F3_4 (Hospital management seems interested inpatient safety only after an adverse event happens).
2. C2_4 (We are informed about errors that happen in this unit).
3. A7_4 (When an event is reported in this unit, it feels like the person is being written up, not the problem).

There is a correlation between autonomy factor and PS culture dimensions:

1. A13_5 (In this unit, there is a lack of support for staff involved in patient safety errors).

2. C5_5 (When staff in this unit see someone with more authority doing something unsafe for patients, they speak up).
3. A5_5 (This unit relies too much on temporary, float, or PRN staff).

CHAPTER V

Discussion of Findings

This chapter describes the discussion of the study results and findings. It commences with the discussion of each research question; the researcher will match the finding and results of the study with other literature findings mentioned in chapter two on the role of HRBA (FREDA principles) to understanding the PS.

5.1 Discussion

In this part, the researcher will thematically discuss the study findings guided by the previous literature review completed in chapter two:

- 1) **The level of employing the FREDA principles to healthcare by health professionals in government Palestinian hospitals in north west bank.**

Regarding the first statement, employing the principles of HRBA to healthcare by health professionals in government Palestinian hospitals in North of West Bank:

The researcher found in the previous chapter (4) **table (25) “Fairness”** that there is a moderate level of employing of fairness principle in the healthcare by health professionals in government Palestinian hospitals. This obviously found in the mathematical mean and standard deviation in the high mean value and low SD value of fairness construct level, which reflect

government hospitals' participants attitudes and perceptions. The results indicate that the 70.8% of respondents are neutral about employing the principle of fairness. This is refer to the most important items that engagement in providing the health services fairly, whereby 74.1% of participants in the sample were answered that "this unit regularly reviews work processes to determine if changes are needed to improve patient safety", 73.3% of them were answered "My supervisor, manager, or clinical leader seriously considers staff suggestions for improving patient safety", and 73.3% of them were answered "The actions of hospital management show that patient safety is a top priority".

This indicates the existence of a supportive work environment for medical staff by directors of departments in government hospitals, which in turn promotes equity in health and the provision of health services to patients without discrimination in government hospitals.

Looking at the previous ratios, it seems that there is an improvement in the culture of PS with positive responses about these dimensions compared to previous studies. A rise in positive responses to organizational education and continuous improvement was observed by 64.7%, compared to previous studies, which reached 62.7% of responses related to this dimension. Previous studies also showed that 66.2% of respondents indicated that “: My supervisor, manager, or clinical leader seriously considers staff suggestions for improving patient safety”. There are also 55.6% of the responses about “the actions of hospital management show that patient safety is a top priority.” (**Hamdan and Saleem, 2018**). However, health reports and indicators have proven that there is a failure to provide a sufficient number of human and financial resources and the number of beds that enhance patient safety. The principle of justice must be applied both at the level of planning and evaluation of health services, or at the level of personal daily practice of the medical profession. The resources at the physicians’ disposal are almost limited, as medical resources and capabilities are distributed, including access to medical drugs, radiology services, and laboratory tests in hospitals, with administrative

interventions that distinguish and differentiate between patients motivated by favoritism and nepotism **(ICHR, 2016)**.

There is a disparity in access to health insurance services, as it does not include all citizens and does not cover all their healthcare needs. There is also a disparity in benefiting from medical referrals outside the institutions of the MoH, which leads to depriving vulnerable and marginalized groups from benefiting from them.

Table (26) “Equality” shows the equality dimension, from which we find that the level of employing the equality principle in healthcare by health professionals in government Palestinian hospitals is moderate. The results indicate that the 59.7% of respondents are neutral about employing the principle of equality. So, we find that the highest percentage was awarded to the statement by 74.0%: (During busy times, staff in this unit help each other) with mean 3.70, and this indicated from the results that although the medical staff cooperating with each other during busy time within the departments in providing healthcare to patients, and the positive responses of most of the health professional participants in the study sample regarding the "Hospital management provides adequate resources to improve patient safety" by 62.3%, however, the percentage is considered low in order to achieve the principle of equality and ensure that all patients obtain their health rights equally without discrimination. Whereas the shortage of medical staff by 54% in contrast to the high number of patients in hospitals leads to depriving some patients, especially the socially and economically marginalized groups, in obtaining healthcare equally without the other groups.

And this is consistent with the data of the MoH report in 2019, the lack of beds in government hospitals with the overcrowding of patients, especially Corona patients, which caused a real crisis in the health sector, and deprived many patients of receiving treatment, as there is a large percentage of occupancy in many departments Government hospitals which have exceeded 100% since 2018 **(MOH, 2020)**.

In addition to the insufficient number of medical staff, which is the first line of defense for treating patients, which increases the rates of medical referrals to hospitals outside the MoH, especially Israeli hospitals. On the other hand, the Palestinian government is facing financial challenges in providing health services, especially covering medical referrals. Millions of money are wasted on medical referrals. The budget allocated to the MoH has maintained relative stability during the previous years and did not meet health needs and population growth or develop the health sector and improve the quality and quality of health services (MAS, 2020). The percentage of spending on the health sector in 2019 reached 11%, which makes Palestine a backward country compared to other countries in terms of health spending indicators (AMAN, 2019).

Table (27) “Respect” shows the respect dimension, from which we find that that the level of employing the respect principle in healthcare by health professionals in government Palestinian hospitals is moderate. The results indicate that the 66.4% of respondents are neutral about employing the principle of equality. So, we find that the highest percentage was awarded to the statement by 79.8%: (In this unit, we work together as an effective team) with mean 3.99, followed by statement (4): (In this unit, we are informed about changes that are made based on event reports) with mean 3.79, and this indicated from the results that although the medical staff work effectively with each other and the mutual respect among them, and they are informed about changes that are made based on event reports, but the culture of blame still exists when errors occur, as the percentage of responses for participants about "When staff make errors, this unit focuses on learning." rather than blaming individuals " is 65.4%.

This is due to the need to create a supportive work environment by managers within the hospital that encourages reporting of errors that protects the privacy of staff who report errors and enhances learning from mistakes to avoid their recurrence in the future. Consequently, the lack of institutional respect for employees is reflected in their behavior in dealing with patients

in a humiliating and inhuman manner. Accordingly, a study indicated that teamwork efforts depend on communication openness and focused on the importance of training programs on teamwork and open communication, so that different medical specialties are linked in medicine to improve team performance. In addition, the success and failure of teamwork is linked to effective leadership. Team structure is vital in influencing patient health outcomes. **(Elmontsri et al., 2017)**. Lack of respect is a threat to patient safety. Absence of respect reduces the teamwork needed to improve practice. Dissatisfaction with work and pressures experienced by health professionals, especially nurses, make them suffer from fatigue and resignation from work in hospitals, which leads to a lack of respect for patients embodied in not hearing physicians have them and their opinions, complain about their questions, and not involve them in the decision-making process related to treatment, or fail to find an explanation for alternative treatment options for patients, in addition to not respecting patients' privacy.

Regarding error reporting of a blame-free culture, a report by the AHRQ on culture surveys conducted in 1,052 hospitals showed that more than half (56%) of respondents did not feel safe to report an error. In large hospitals, the rate was above 60%. However, many other industries Like airlines have succeeded in creating supportive and satisfying work environments despite production pressures and complex regulatory and documentation requirements **(Leape et al., 2012)**.

Table (28) "Dignity" shows the dignity dimension, from which we find that that the level of employing the dignity principle in healthcare by health professionals in government Palestinian hospitals is moderate. The results indicate that the 66.6% of respondents are neutral about employing the principle of equality. So, we find that the highest percentage was awarded to the statement (5) by 76.8%: (When errors happen in this unit, we discuss ways to prevent them from happening again) with mean 3.84, followed by statement (3) by 75.8%: (My supervisor,

manager, or clinical leader takes action to address patient safety concerns that are brought to their attention) with mean 3.79.

It appears from the results that there is follow-up to prevent keep happening the same patient safety problems by the departments' managers in the hospitals, and there is a high interest by the medical staff to discuss ways to prevent errors, but sometimes when an event is reported in this unit, it feels like the person is being written up, not the problem. Which creates an emotional behavior for the employee and reduces the morale and reflects negatively on the patient in the treatment or the way he is given the treatment, in addition, Loss of trust between team members and leadership. Also, the hospital administration's concern with the patient's safety problems after the occurrence of an error or incidents violates the patient's safety.

This is due to the hospital's policy and management, that indicates the administration's neglect and negligence, and the administration's lack of commitment to preventive measures to avoid safety problems.

As the patient's dignity in healthcare is violated according to the effects of different situations on the patient by health professionals, such as degrading and inhumane treatment of the patient, creating a communication gap with the patient, which leads to a misunderstanding of his true needs, violation of patient privacy, or loss and omission of important information related to patient care by health staff. This is what correspond with mentioned in a study that the patient dignity is linked to the basics of healthcare, such as aiding, eating and drinking, and having a clean and safe healthy environment such as family hygiene, or washing hands to prevent the spread of infection, whether among health workers or patients (**Papastavrou et al. 2016**). So, failure to support and respect the physicians' efforts by the hospital administration leads to the physicians' failure to comply with and adhere to safe practices and procedures related to patient safety. Disrespectful of patient dignity is a barrier to improving patient safety.

Table (29) “Autonomy” shows the autonomy dimension, from which we find that that the level of employing the autonomy principle in healthcare by health professionals in government Palestinian hospitals is moderate. The results indicate that the 59.2% of respondents are neutral about employing the principle of equality. So, we find that the highest percentage was awarded to the statement (4) by 73.6%: (In this unit, staff speak up if they see something that may negatively affect patient care) with mean 3.68. And this indicated from the results the ability of employees to speak freely within departments when they see something that affects the PS negatively, and their ability to express their opinions freely if a person with higher authority does something unsafe for patients, this falls under the dimension of "communication openness" by 53.3%. Nevertheless, the percentage is considered moderate at a time when the issue of communication openness is considered a crucial issue of concern to many healthcare professionals in the Arab world (**Elmontsri et al., 2017**). Effective communication between the members of the medical team and the patient contributes to reaching a joint decision related to the patient's health condition and the proposed or alternative treatment.

The independence of the staff and their reporting of any medical event or error without fear helps to save the patient's health life from being exposed to danger. On the other hand, the results illustrate that the employee who commits any error that affects the PS does not find support and protection from the hospital administration. This is due to the failure to activate the medical safety protection law and to establish a fund to compensate accident victims and medical errors in the government hospitals (**ICHR, 2018**). The success or failure of the work of medical teams in health institutions is linked to effective leadership, in order for medical teams to work effectively and safely, and to ensure effective communication. The structure must be vital, and leaders must create a supportive environment in health institutions while ensuring accountability while avoiding blame.

A study indicated that in order to achieve the independence of patients, physicians must adopt practices that promote open communication so that there is a common consensus between patients and physicians (**Dzeng, 2019**). For example, interference by third parties in the independence of the healthcare provider and his decision about treating patients contrary to the patient's interest is a violation of his rights to enjoy the highest level of health, and affects health outcomes, such as government interference in decisions to transfer patients and provide treatment to them and withholding health insurance from them constitutes A flagrant violation of patients' rights (**Cohen and Ezer, 2013**).

2) The level of understanding patient safety culture by health professionals in government Palestinian hospitals in north west bank.

For the second statement, it measures the level of understanding patient safety culture by health professionals in government Palestinian hospitals in North of West Bank as showed in **table (30)**. We see that 55.6% of respondents rated the level of PS in their units/hospitals as 'Very Good/ Excellent'. So, the researcher concluded that there is a need to improve some areas of patient safety culture in Palestinian government hospitals to ensure enhanced patient safety. Based on the indicators in this table, the researcher concludes that there is a lack of clarity in understanding the safety culture of most health service providers in Palestinian governmental hospitals, in addition to the lack of awareness of patients' rights by health professionals, which leads to the occurrence of errors and medical accidents that affect the health and safety of patients.

The results indicate the necessity of improving safe healthcare and respecting and protecting patients' rights by paying attention to employing a sufficient number of efficient employees to bear work pressure, improving communication openness and exchanging

information between employees and other departments through training work teams on communication skills to reduce misunderstanding between individuals and patients that may effect on patient care, the hospital administration and the MoH's interest in providing financial resources and in terms of improving infrastructure, working to support hospital management for physicians' efforts, setting laws, regulations and supporting systems to encourage employees in hospitals to implement medical error reporting systems, ensuring a non-punitive response to errors in a free environment from blame, and promote learning from mistakes to avoid their occurrence in the future.

There is a need to improve the employ of human rights principles in health institutions to ensure safe practices for patient safety, given that the role of the human factor in complying with laws is an important element in influencing health and commitment to providing the right service. The process of placing patients and their rights at the center of safety efforts ensures their participation and their families as partners in decision making.

The values, beliefs, and behavioral rules shared by health professionals in hospitals towards patients are essential dimensions of PS culture. Failure to support these beliefs and values from leadership at the hospital or ministry level affects the level of health professionals' commitment to human rights principles, which contributes to violating patients' rights and safety. Behaviors in five human rights principles. The results show the level of employing of human rights principles by health professionals in their daily practices in the of healthcare settings: Fairness Dimension 70.8%, Equality Dimension 59.7%, Respect Dimension 66.4%, Dignity dimension 66.6%, Autonomy Dimension 59.2%.

This is consistent with a Palestinian study carried out in 2018, that the implementation of quality improvement strategies, including accreditation in hospitals, is positively associated with patient safety. The results of the Palestinian public hospitals survey reveal that employees feel less positive about the PS culture within their organization. There is a need to improve

many dimensions of PS culture, particularly those related to developing an effective incident reporting system and establishing a non-punitive culture, allocating more staff and adequate working hours and ensuring hospital management support for PS (**Hamdan and Saleem, 2018**).

3) The factors that affect the violation of patients' rights in government Palestinian hospitals in north west bank.

Table (31) shows staffing and work pace factors that could violate on patients' rights and their safety. So, the researcher concluded that there are three composite measures effect negatively on patient rights and their safety. at a time when Palestinian governmental hospitals suffer from a shortage of medical staff, in addition to the great workload, the high number of patients and the shortage of beds, employment is a problem and one of the factors that violate the patient's safety and right to healthcare (composite grade 56.3%). The insufficient number of employees causes great pressure, which makes them work long hours and increases the possibility of committing medical errors that lead to negative results on the health of patients, as 55.0% of the participants were answered that they work 30 to 40 hours per week, while 39.7% were answered that they work more than 40 hours per week. To provide patients with high-quality healthcare, the number of working hours must be adequate and the provision of an adequate number of employees.

This is consistent with a study that showed that in order to improve PS, there is a need to allocate more staff and adequate working hours (**Hamdan and Saleem, 2018**). This was confirmed by a study issued by the (MAS) Research Institute on evaluating the performance of the Palestinian health sector, that in order to know the adequacy of

health workers in Palestine, the WHO set a standard for that. The organization suggested that the minimum number of physicians should be one for 1000 people, and for per1000 people for nurses and midwives. The number of physicians exceeds the minimum to reach 1.1 per 1000 inhabitants, while the number of nurses and midwives has decreased to 95.1 per thousand people.

There is a paradox between the West Bank and Gaza Strip, the data showed that there is a decrease in these limits in the West Bank, which calls for an increase in the number of physicians in the West Bank and an increase in the number of nurses and midwives at the level of Palestine. In addition, there is a shortage of physicians in all specialties in Palestine compared to other countries such as Turkey, Italy, and Greece. In this regard, this deficiency causes shortcomings in dealing with the most mortality diseases such as chronic diseases, in addition to the expansion of medical referrals for treatment outside Palestinian hospitals (MAS, 2020).

Table (32) shows response to error factor that could violate on patients' rights and their safety. So, the researcher concluded that there is one composite measure effect negatively on patient rights and their safety. from which we find that 69.2% of respondents were answered to the phrase: (In this unit, staff feel like their mistakes are held against them).

As we mentioned in previous in the chapter (4), the researcher concluded that staff feel like their mistakes are held against them leads to motivation of others not to report the errors due to fear of exposure to legal accountability, and this creates a feeling of mistrust between team members and the leadership.

In addition to the employee's feeling of anxiety and refusal to take any action to treat other patients for fear of making another mistake that endangers the patients' lives,

which prevents the patient from obtaining fair healthcare. This illustrates the prevailing culture of non-punitive response to errors (composite score 64.7%), and the culture of blame that prevents them from reporting incidents in government hospitals. Noted that the non-punitive response to the error is the most important for improving patient safety in Palestinian hospitals. So, there is a need for regulations and legislation to be provided by policy makers to encourage hospitals to implement patient safety incident reporting systems that help identify risks to patients, as well as help hospitals learn from mistakes and not repeat them in the future (Alfaqawi et al.,2020).

Table (33) shows hospital management support factor for PS that could violate on patients 'rights and their safety. So, the researcher concluded that there are two composite measures effect negatively on patient rights and their safety. from which we find that 62.3% of respondents were answered to the phrase: (Hospital management provides adequate resources to improve patient safety), and 62.2% of them were answered to the phrase: (Hospital management seems interested in-patient safety only after an adverse event happens).

As we mentioned in previous, the researcher concluded that the insufficient administrative support represents a major challenge for the safe care of patients in government hospitals. It is clear that there are deficiencies in the health system in terms of infrastructure, which appear in the insufficient number of medical staff and the increase in the number of working hours with the high workload given the employment indicator previously. Effective leadership is important in improving patient safety, and hospital leadership is responsible for how patients are handled. There is a need to know and understand leadership at the MoH and hospital level for the rights of patients and their families and hospital responsibilities as defined in regulations and laws. Hospital

management requires strenuous efforts to raise job satisfaction through adequate employment in government hospitals, provision of financial resources, employee training, in addition to incentives and promotions and reducing workload to ensure safe practices and improve patient safety. This is compatible with (Elsous et al., 2016) study who stated, the main factors affecting PS are: effective leadership, adequate staffing, teamwork, and evidence-based practices. There is a need to understand health workers' attitudes towards behaviors related to patient safety to ensure that a safe and positive climate is maintained.

4) The correlation among employing the FREDA principles to healthcare and understanding patient safety in government Palestinian hospitals in north west bank.

The fourth statement measures the correlation among employing the principles of HRBA to healthcare and understanding patient safety in government Palestinian hospitals in North of West Bank. Factor analysis is used to test the hypotheses, the results showed that there is a relationship between the FREDA factors and many variables, but it was found that the relationship is moderate. In this part, the researcher will discuss the study hypothesis with the previous literature review that mentioned in chapter two to answer the fourth question:

1. **H0-1: There is no significant relationship at a level of 0.05 between fairness in providing health services to patient and patient safety in government Palestinian hospitals in North of West Bank.**

The results indicate that there is a correlation between the fairness factor and the dimensions of PS culture (A4_1, A3_1, A6_1). The testing results hypothesis showed that there is a significant role of employing the fairness principle in healthcare by health professionals in government Palestinian hospitals in North of West Bank. This is consistent with the study (**Braveman and Gruskin, 2003**) that the assessment of health equity is important in determining whether policy makers evaluate the impact and effectiveness of those policies in achieving social justice in health. The principle of justice must be applied both at the level of planning or evaluating services, or at the level of personal practice of the medical profession, and there must be justice in distributing the time for the physicians' work to ensure justice among patients.

However, according to the report of the ICHR, it is indicated that there is a disparity in the distribution of medical resources and capabilities in Palestine with regard to obtaining medicines, conducting laboratory tests, medical referrals and others, with administrative interventions that distinguish between patients motivated by nepotism and favoritism (**ICHR, 2016**). A state that provides health services to the entire population without discrimination contributes to reducing mortality rates, which directly affects the average life expectancy at birth, which in turn affects economic development. Health equity is also achieved by working on the social determinants of health that affect health (Chapman, 2010). From all above the researcher concluded that Fairness principle is an important factor in improving patient safety and protect their rights.

2. **H0-2: There is no significant relationship at a level of 0.05 between equality in providing health services to patient and patient safety in government Palestinian hospitals in north of west bank.**

The results indicate that there is a correlation between the equality factor and the dimensions of PS culture (A8_2, B2_2, A2_2). The testing results hypothesis showed that there is a significant role of employing the equality principle in healthcare by health professionals in government Palestinian hospitals in North of West Bank.

Working in collective teams affects the quality of work and health services provided to patients. Cooperation is necessary for teamwork, creates team spirit and increases the effectiveness of communication between team members and with patients and their families, ensuring equality in providing services and healthcare for all without discrimination or neglect. This result in concur with the study (**Pérez-Stable and El-Toukhy, 2018**) that confirm communication between health professionals and patients can create or reduce health disparities. Health service providers play a major role in shaping health inequalities by creating barriers that hinder communication with patients, whether linguistic or cultural (**Ubri and Artiga, 2020**). As mentioned in the principle of justice and equality, the lack of consideration of the ethical aspects in the process of distributing resources, whether human or financial resources, or equality in the procedures that are taken by health service providers in order to provide services to all patients without discrimination, or accountability in medical services from during the enactment of laws and regulations. This leads to disparities in medical practices, misuse of the job position of many medical staff for personal benefits, and the spread of nepotism, favoritism, and corruption. So, the researcher emphasize that equality

principle is a significant affected indicator on patient safety and their rights in government Palestinian hospitals in North of West Bank.

3. **H0-3: There is no significant relationship at a level of 0.05 between patient respect and patient safety in government Palestinian hospitals in north west bank.**

The results indicate that there is a correlation between the respect factor and the dimensions of PS culture (A9_3, A10_3). The testing results hypothesis showed that there is a significant role of employing the respect principle in healthcare by health professionals in government Palestinian hospitals in North of West Bank. This is combatable with the study (**Leape et al., 2012**) that showed absence of respect is a threat to organizational culture and patient safety, because it prevents the fellowship and cooperation necessary for teamwork, creates communication gap, undermines morale, and prevents compliance with laws, regulations, and safe practices.

Disrespectful behavior is rooted in characteristics of the individual, such as insecurity or aggressiveness. The main contributor to disrespectful behavior is the stressful healthcare environment, such as unnecessarily long working hours, high stressful workloads, physical risks, psychological intimidation, and the need to see many patients. From the researchers' point of view, the principle of respect affects significantly on the safety and well-being of patients and healthcare workers in government Palestinian hospitals in North of West Bank.

4. **H0-4: There is no significant relationship at a level of 0.05 between patient dignity and patient safety in government Palestinian hospitals in north west bank.**

The results indicate that there is a correlation between the dignity factor and dimensions of PS culture (F3_4, C2_4, A7_4). The testing results hypothesis showed that there is a significant role of employing the dignity principle in healthcare by health professionals in government Palestinian hospitals in North of West Bank. This corresponds to what was previously explained, whereby the patient's dignity in healthcare is violated according to the effects of different situations on the patient by health professionals, such as degrading and inhumane treatment of the patient, creating a barrier in communication with the patient, which leads to a misunderstanding of his true needs, violation of patient privacy, or loss and omission of important information related to patient care by health staff. and this agreement with a study (**Curtice and Exworthy, 2010**) that the patient dignity is linked to the basics of healthcare, such as aiding, eating and drinking, and having a clean and safe healthy environment such as hygiene, or washing hands to prevent the spread of infection, whether among health workers or patients. So, this requires the hospital administration's commitment to preventive measures to avoid safety problems.

Moreover, it is in line with (**Morberg, 2016**) that the dignity in medical practices is linked to the equal treatment of each person with dignity, and the provision of treatment to all equally without discrimination. It is also linked to respecting patient autonomy in treatment decisions and obtaining informed consent. From researcher point view that dignity principle has a significant impact on patient safety in government Palestinian hospitals in North of West Bank.

5. **H0-5: There is no significant relationship at a level of 0.05 between patient autonomy and patient safety in government Palestinian hospitals in north west bank.**

The results indicate that there is a correlation between the autonomy factor and dimensions of PS culture (A13_5, C5_5, A5_5). The testing results hypothesis showed that there is a significant role of employing the autonomy principle in healthcare by health professionals in government Palestinian hospitals in North of West Bank.

This is consistent with the study (Sedig, 2016) that the relationship between the physician and the patient is the basis for preserving the rights of the patient, and that the patient responds to treatment better when the physician cares about the patient and respects his independence more than prescribing the treatment itself. The principle of respecting autonomy has been linked to many issues such as confidentiality and privacy, sincerity, telling the truth and obtaining informed consent from the patient (Murgic et al., 2015). In order to achieve patient independence, physicians must adopt practices that promote communication openness so that there is mutual agreement between patients and physicians (Dzeng, 2019). On the other hand, (Cohen and Ezer, 2013) stressed that interference with the independence of the healthcare provider by other parties, such as government interference in decisions to transfer patients, provide treatment for them and withhold health insurance from them, constitutes a flagrant violation of patients' rights.

This was confirmed by the ICHR report that the harm caused by medical error leads to financial and moral losses to the patient, his family, and the health institution, in addition to the complications that the patient suffers in the long run. According to the complaints submitted by many citizens to the commission. In Palestine, medical errors

were represented in allegations about the patient's failure to receive a clear explanation about his health condition or the proposed treatment, or an error in the diagnosis, or the delay of the competent physician in treating the patient, or the mistreatment of the patient by the medical staff, interference with the patient's privacy and other medical incidents that cause complications or death of the patient (MAS, 2011). The State of Palestine has failed to establish regulations incorporating accountability measures regarding violations of patient safety rights and disclosure of privacy and confidentiality of medical information related to patients (AIRifai, 2013). Therefore, the researcher confirms that the patient's independence is affected by medical error, which loses trust between the patient and the physician, interference with the decisions of health professionals, and creating a communication gap affects the health outcomes of patients. The dignity of individuals is achieved by their ability to make decisions and understand information that makes them feel psychologically and physically comfortable. Therefore, the researcher believes that the principle of autonomy has a significant impact on patient safety in government Palestinian hospitals in Northern West Bank.

CHAPTER VI

Conclusions & Recommendations

Introduction

This chapter presents the most important points of the conclusions and recommendations about investigate the level of understanding patient safety in selected Palestinian hospitals in North of West Bank by employing the strategic HRBA, based on the statistical questionnaire survey tests, and list some points about future studies will be presented, which will complement our study.

6.1 Conclusions

The researcher summarized the finding results of this study as below:

1. The absence of a system of motivation for health workers in government hospitals by the hospitals administration or at the MoH level impedes progress in patient safety and improving the quality of health services.
2. The non-punitive response to the error with a culture of blame among employees is still one of the obstacles to progress in safety in government hospitals.
3. High workload, large number of patients, inadequate of beds and staffing represent some of the most common problems and factors that violate patient safety and the right to health care.
4. The lack of a charter of patients' rights in the facilities of government hospitals to ensure the patients' rights and prevent their violation.

6.2 Recommendations

The findings of the study confirm the key role of employing strategic HRBA in understanding PS regarding: Fairness, Equality, Respect, Dignity, Autonomy. So based on the above, the researcher elicited a number of recommendations related to the study which are the following:

1. Providing a supportive and encouraging environment by the hospital administration and the MoH through financial incentives and providing the necessary resources (staffing, medical equipment) to improve the performance of their work and raise the level of staff appreciation and respect for each other, which ensures the physical and psychological safety of the employee and patients alike.
2. There is a need to improve some areas of PS culture in Palestinian government hospitals to ensure enhanced PS (Handoffs and Information Exchange, Staffing and Work Pace, Response to Error, Hospital Management Support for Patient Safety).
3. Allocating an adequate budget to the MoH in order to provide financial and human resources and medical equipment that contribute to improving PS and reducing adverse events.
4. Education and awareness of patient rights among service providers and beneficiaries alike through developing the patient rights' charter to ensure the patients' rights and healthcare providers in the government hospitals.
5. Develop laws and legislations to protect the right and safety of patients.

6.3 Further Research

Based on the findings from the conclusions and the recommendations above, further research should be explored the following aspects:

1. This study targeted one group related to health professionals in order to investigate the level of employing HRBA by them in the government hospitals and the factors that affect the violation of patients' rights, so future studies are invited to target the patients to know their perspectives to patients 'rights by using another research tool such as interview or focus group.
2. This study used anew analysis tool" Factor analysis" that aimed to data explanation and data (variables) reduction, so, future studies could be building on it to design a new questionnaire with a new variable.
3. Future studies should be conducted that aim at educating health workers, patients and their relatives about patient's rights, and focus on HRBA (FREDA principles) to ensure patient safety and enjoyment of the highest standard of health.

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Appendix (1) English Version of Questionnaire



الجامعة العربية الأمريكية
Arab American University

FACULTY OF GRADUATE STUDIES

Evaluation of Patient Safety Culture in Hospitals of Ministry of Health

Dear Participant.

The researcher is conducting a study entitled "Strategic Human Rights-Based Approach for Understanding Patient Safety in Selected Palestinian Hospitals in the Northern West Bank" as one of the requirements for a master's degree in strategic planning and fund raising from the Arab-American University. The information you provide to the researcher will help to better understand the human rights principles concerning to patients' rights, and their relationship to improve patient safety in government hospitals.

This research aims to identify your views and perspectives on patient safety/protection issues within the hospital. The culture of the safety or protection of patients in the hospital can be defined by the ideas and concepts shared by the members of the institution, which they consider to be important and valuable collectively. The questionnaire consists of certain statements and opinions about patient safety issues, medical errors, and accident reports in your hospital. For each saying / sentence there are five possible answers, please choose the answer that matches your opinion of misleading the appropriate box. If you do not want to answer a question, or if the question does not apply to you, please highlight the box that falls under Not applicable, or I do not know. It takes 10-15 minutes to answer this questionnaire. To fill out this questionnaire, please focus on the way the hospital works in general with regard to patient safety from your own point of view, which you touched or experienced through your work. It is important to point out that your participation in the study is critical to obtain an accurate picture of the culture of patient safety in your hospital, and that the accuracy of this research depends on the rate of participation and answers of the staff in the hospital. This questionnaire is distributed to all health workers in the hospital, including those with no direct contact or contact with patients.

Finally, we would like to point out the complete confidentiality of the identity of the person who filled out the questionnaire is guaranteed in this search. We would like to inform you that neither

Hospital Survey on Patient Safety (Version 2.0)

Instructions

This survey asks for your opinions about patient safety issues, medical error, and event reporting in your hospital and will take about 10-15 minutes to complete. If a question does not apply to you or your hospital or you don't know the answer, please select "Does Not Apply or Don't Know."

- **"Patient safety"** is defined as the avoidance and prevention of patient injuries or adverse events resulting from the processes of healthcare delivery.
- A **"patient safety event"** is defined as any type of healthcare-related error, mistake, or incident, regardless of whether or not it results in patient harm.

Your Staff Position

1. What is your position in this hospital?

Select ONE answer.

Nursing

- a Registered Nurse (RN)
- b Patient Care Aide, Hospital Aide, Nursing Assistant
- c Licensed Practical Nurse (LPN)
- d Specialist Physician
- e Resident, Intern
- f Pharmacist, Pharmacy Technician

- g Dietitian
- h Secretary, Office Staff
- i Psychologist
- j Physical, Occupational, or Speech Therapist
- k Technologist, Technician (e.g., EKG, Lab, Radiology)
- l Supervisor, Manager, Department Manager, Clinical Leader, Administrator, Director

Other

- m Other, please specify:

Your Unit/Work Area

2. Think of your "unit" as the work area, department, or clinical area of the hospital where you spend most of your work time. What is your primary unit or work area in this hospital?

Hospital Name.....

Select ONE answer.

- | | | |
|--|--|---|
| <input type="checkbox"/> a Many different hospital unit,
No specific unit | <input type="checkbox"/> g ICU (All Adult Types) | <input type="checkbox"/> l Radiology, Imaging |
| <input type="checkbox"/> b Internal Medicine Unit | <input type="checkbox"/> h Psychiatry, Behavioral Health | <input type="checkbox"/> m Anesthesiology |
| <input type="checkbox"/> c Surgical Unit | <input type="checkbox"/> i Rehabilitation, Physical Medicine | Other |
| <input type="checkbox"/> d Labor & Delivery, Obstetrics
& Gynecology | <input type="checkbox"/> j Pharmacy | <input type="checkbox"/> n Other, please specify: |
| <input type="checkbox"/> e Pediatrics (including NICU,
PICU) | <input type="checkbox"/> k Pathology, Lab | <div style="border: 1px solid black; width: 150px; height: 25px; margin-left: 10px;"></div> |
| <input type="checkbox"/> f Emergency Department,
Observation, Short Stay | | |

SECTION A: Your Unit/Work Area

How much do you agree or disagree with the following statements about your unit/work area?

Think about your unit/work area:	Strongly Disagree ▼	Disagree ▼	Neither Agree nor Disagree ▼	Agree ▼	Strongly Agree ▼	Does Not Apply or Don't Know ▼
1. In this unit, we work together as an effective team.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 9
2. In this unit, we have enough staff to handle the workload	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 9
3. Staff in this unit work longer hours than is best for patient care.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 9
4. This unit regularly reviews work processes to determine if changes are needed to improve patient safety	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 9
5. This unit relies too much on temporary, float, or PRN staff.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 9
6. In this unit, staff feel like their mistakes are held against them	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 9
7. When an event is reported in this unit, it feels like the person is being written up, not the problem.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 9
8. During busy times, staff in this unit help each other	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 9
9. There is a problem with disrespectful behavior by those working in this unit	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 9
10. When staff make errors, this unit focuses on learning rather than blaming individuals.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 9
11. The work pace in this unit is so rushed that it negatively affects patient safety	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 9
12. In this unit, changes to improve patient safety are evaluated to see how well they worked.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 9
13. In this unit, there is a lack of support for staff involved in patient safety errors	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 9
14. This unit lets the same patient safety problems keep happening	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 9

SECTION B: Your Supervisor, Manager, or Clinical Leader

How much do you agree or disagree with the following statements about your immediate supervisor, manager, or clinical leader?

	Strongly Disagree ▼	Disagree ▼	Neither Agree nor Disagree ▼	Agree ▼	Strongly Agree ▼	Does Not Apply or Don't Know ▼
1. My supervisor, manager, or clinical leader seriously considers staff suggestions for improving patient safety	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 9
2. My supervisor, manager, or clinical leader wants us to work faster during busy times, even if it means taking shortcuts	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 9
3. My supervisor, manager, or clinical leader takes action to address patient safety concerns that are brought to their attention	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 9

SECTION C: Communication

How often do the following things happen in your unit/work area?

Think about your unit/work area:	Never ▼	Rarely ▼	Sometimes ▼	Most of the Time ▼	Always ▼	Does Not Apply or Don't Know ▼
1. We are informed about errors that happen in this unit	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 9
2. When errors happen in this unit, we discuss ways to prevent them from happening again...	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 9
3. In this unit, we are informed about changes that are made based on event reports	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 9
4. In this unit, staff speak up if they see something that may negatively affect patient care	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 9
5. When staff in this unit see someone with more authority doing something unsafe for patients, they speak up	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 9
6. When staff in this unit speak up, those with more authority are open to their patient safety concerns	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 9
7. In this unit, staff are afraid to ask questions when something does not seem right.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 9

SECTION D: Reporting Patient Safety Events									
	Never ▼	Rarely ▼	Some- times ▼	Most of the Time ▼	Always ▼	Does Not Apply or Don't Know ▼			
Think about your unit/work area:									
1. When a mistake is <u>caught and corrected before reaching the patient</u> , how often is this reported?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 9			
2. When a mistake reaches the patient and <u>could have harmed the patient, but did not</u> , how often is this reported?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 9			
3. <u>In the past 12 months</u> , how many patient safety events have <u>you</u> reported?									
<input type="checkbox"/> a. None									
<input type="checkbox"/> b. 1 to 2									
<input type="checkbox"/> c. 3 to 5									
<input type="checkbox"/> d. 6 to 10									
<input type="checkbox"/> e. 11 or more									
SECTION E: Patient Safety Rating									
1. How would you rate your unit/work area on patient safety?									
Poor ▼	<input type="checkbox"/> 1	Fair ▼	<input type="checkbox"/> 2	Good ▼	<input type="checkbox"/> 3	Very Good ▼	<input type="checkbox"/> 4	Excellent ▼	<input type="checkbox"/> 5
SECTION F: Your Hospital									
How much do you agree or disagree with the following statements about your hospital?									
	Strongly Disagree ▼	Disagree ▼	Neither Agree nor Disagree ▼	Agree ▼	Strongly Agree ▼	Does Not Apply or Don't Know ▼			
Think about your hospital:									
1. The actions of hospital management show that patient safety is a top priority	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 9			
2. Hospital management provides adequate resources to improve patient safety	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 9			
3. Hospital management seems interested in-patient safety only after an adverse event happens	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 9			
4. When transferring patients from one unit to another, important information is often left out	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 9			
5. During shift changes, important patient care information is often left out	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 9			
6. During shift changes, there is adequate time to exchange all key patient care information ...	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 9			

SECTION G: Background Questions

1. How long have you worked in this hospital?

- a. Less than 1 year
- b. 1 to 5 years
- c. 6 to 10 years
- d. 11 or more years

2. In this hospital, how long have you worked in your current unit/work area?

- a. Less than 1 year
- b. 1 to 5 years
- c. 6 to 10 years
- d. 11 or more years

3. Typically, how many hours per week do you work in this hospital?

- a. Less than 30 hours per week
- b. 30 to 40 hours per week
- c. More than 40 hours per week

4. In your staff position, do you typically have direct interaction or contact with patients?

- a. YES, I typically have direct interaction or contact with patients
- b. NO, I typically do NOT have direct interaction or contact with patients

SECTION H: Your Comments

Please feel free to provide any comments about how things are done or could be done in your hospital that might affect patient safety.

Thank you for completing this survey.

Appendix (2) Arabic Version of Questionnaire



الجامعة العربية الأمريكية
Arab American University

كلية الدراسات العليا

دراسة تقييم ثقافة سلامة المرضى في مستشفيات وإدارة الصحة

عزيزي/عزيزتي المشارك في هذه الدراسة

تحية طيبة و بعد،

تجري الباحثة دراسة بعنوان "النهج الإستراتيجي القائم على حقوق الإنسان لفهم سلامة المرضى في مستشفيات فلسطينية مختارة في شمال الضفة الغربية" كأحد متطلبات الحصول على درجة الماجستير في التخطيط الإستراتيجي وتجنيد الأموال من الجامعة العربية الأمريكية. ستساعد المعلومات التي تقدمها للباحثة في فهم مبادئ حقوق الانسان المتعلقة بحقوق المرضى بشكل أفضل وعلاقتها في تحسين سلامة المرضى في المستشفيات الحكومية.

يهدف هذا البحث الى التعرف على آرائكم و وجهات نظركم حول قضايا سلامة/حماية المرضى داخل المشفى. ان ثقافة سلامة او حماية المرضى في المشفى يمكن تعريفها بما يتبادلته اعضاء المؤسسة فيما بينهم من افكار ومفاهيم، و ما يعتبرونه هاما و ذا قيمة هامة بشكل جماعي.

تتكون الاستبانة من بعض المقولات والآراء حول قضايا سلامة المرضى والأخطاء الطبية وبلغات الحوادث في مشفاكم. لكل مقولة/جملة هناك خمسة أجوبة ممكنة، الرجاء اختيار الاجابة التي تتوافق مع رأيك الخاص بتظليل المربع المناسب. إذا كنت لا ترغب في الإجابة عن سؤال ما، أو إذا كان السؤال لا ينطبق عليك، الرجاء تظليل المربع الذي يندرج تحت لاينطبق أو لا أعرف. تستغرق اجابة هذه الاستبانة من ١٠ - ١٥ دقيقة. لتعبئة هذه الاستبانة نرجو التركيز على طريقة عمل المشفى بشكل عام فيما يخص سلامة المرضى من وجهة نظرك الخاصة والتي قمت بلمسها او تجربتها من خلال عملك. ومن المهم ان نشير الى ان مشاركتكم في الدراسة تعتبر بالغة الاهمية للحصول على صورة دقيقة لثقافة سلامة المرضى في مشفاك، وان دقة هذا البحث تعتمد على نسبة مشاركة واجابات الموظفين

و أخيرا فالتنا نود ان نلوه الى السرية التامة حول هوية الشخص الذي قام بتعبئة الاستبانة مضمونة في هذا البحث. هذا والتنا نود اعلامكم باننا لا إدارة المشفى ولا الأشخاص الذين سيقومون بمعالجة البيانات يمكنهم معرفة أسماء المشاركين في البحث، حيث سيتم معالجة المعلومات بشكل عام وليس بشكل خاص.

شكرا جزيلاً لتعاونكم

الباحثة

رؤى ياسين



HOSPITAL SURVEY ON PATIENT SAFETY CULTURE

دراسة ثقافة سلامة/حماية المرضى في المشفى

تعليمات

هذه الاستبانة تهدف الى التعرف على آرائكم حول قضايا سلامة/ حماية المرضى والاطباء الطبية وبلادات الحوادث في مشفاكم. قد تستغرق اجابتها حوالي ١٠ الى ١٥ دقيقة.

- "سلامة/حماية المرضى": هو ما يعرف بحماية المريض من الاذى ومنع وقوع اي اذى له بما في ذلك اي نتائج سلبية قد تحدث جراء تقديم الرعاية الصحية له.
- "حوادث سلامة المرضى": أي نوع من الأخطاء، أو الحوادث، أو ما لم يتم تفيدته بشكل صحيح، أو الانحراف عن الوضع السليم، بعض النظر عما إذا سببت بايذاء المريض أم لا.

موقعك الوظيفي

1. ما هو مسمالك الوظيفي (ما هو عملك) في هذا المشفى ؟ اختر اجابة واحدة فقط تمثل أفضل مسمى وظيفي لك.

- | | |
|--|---|
| <input type="checkbox"/> a. ممرض قانوني/ قابلة قانونية | <input type="checkbox"/> g. أخصائي/ فني تعدي |
| <input type="checkbox"/> b. ممرض مساعد | <input type="checkbox"/> h. كاتب قسم/سكرتيرة |
| <input type="checkbox"/> c. عامل صريض | <input type="checkbox"/> i. معالج نفسي |
| <input type="checkbox"/> d. طبيب اختصاص | <input type="checkbox"/> j. فني علاج طبيعي او وظيفي |
| <input type="checkbox"/> e. طبيب متزيب/ طبيب معقم | <input type="checkbox"/> k. فني (تخطيط قلب، مختبر أشعة) |
| <input type="checkbox"/> f. صيدلاني | <input type="checkbox"/> l. إداري/ إدارة |
| | <input type="checkbox"/> m. وظيفة أخرى حدده من فضلك: |

القسم / مكان العمل

2. في هذه الاستبانة، يعتبر القسم/ الوحدة التي تعمل بها هي أكثر متان تقضي فيه وقت عمل او تقدم فيه خدمات مباشرة او غير مباشرة للمرضى

اسم المستشفى.....:

في اي قسم تعمل؟ اختر اجابة واحدة بتضمين المربع.

- g. أقسام متعددة / ليس هناك قسم محدد
- a. الأجنة
- b. الباطنية
- c. الجراحة
- d. التوليد
- e. الأطفال
- f. الطوارئ
- g. وحدة العناية المكثفة
- h. النفسية
- i. التأهيل والعلاج الطبيعي
- j. الصيدلية
- k. المخبر
- l. الأجنة
- m. التصوير
- n. أخرى الرجاء التحديد

القسم الاول (A): القسم / مكان العمل

ما مدى موافقتك او رفضك للجمل التالية فيما يتعلق بالقسم الذي تعمل به؟ اختر اجابتك بتضمين الدائرة.

#	استنادا للقسم الذي تعمل به.....	معارض			موافق		لاينطبق / لا أعرف
		بشدة	معارض	محايد	موافق	بشدة	
1.	في هذا القسم ، نعمل معًا كفريق فعال	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
2.	في هذا القسم لدينا كادر كاف للقيام بأعباء العمل	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
3.	يعمل كادر القسم لساعات طويلة مما قد يؤثر على سلامة المرضى	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
4.	يقوم هذا القسم بمراجعة إجراءات العمل بانتظام لتحديد ما إذا كانت هناك حاجة لإجراء تغييرات لتحسين سلامة المرضى	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6

- | | | | | | | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 5. يعصد قسمنا بشكل كبير على الموظفين المؤقتين أو من أقسام أخرى مما قد يؤثر على سلامة المريض |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 6. يشعر الموظفون ان أخطاءهم تسجل ضدهم |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 7. عندما يكتب تقرير حادثة ، فإنه يسود شعور بان التقرير عن الشخص وليس عن المشكلة |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 8. عندما يشغل جزء من القسم فان الآخرون يساعدونهم |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 9. لا يحترم جميع افراد قسمي بعضهم البعض |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 10. عندما يرتكب الموظفون أخطاء ، يركز قسمنا على التعلم بدلا من إلقاء اللوم على الأفراد |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 11. ان سرعة العمل في قسمنا مستعجلة لدرجة انها تؤثر سلبا على سلامة المرضى |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 12. يتم تقييم التعبيرات لتحصين سلامة المرضى في قسمنا لمعرفة مدى نجاحها |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 13. في هذا القسم لا يوجد دعم للكاثر المشارك في الأخطاء المتعلقة بسلامة المرضى |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 14. في هذا القسم يكرر حدوث نفس المشاكل المتعلقة بسلامة المريض |

القسم الثاني (B): رئيسك المباشر/ مديرك

ما مدى موافقتك أو رفضك للجمل التالية فيما يتعلق بمشرفك المباشر أو مديرك ؟ اختر إجابتك بتضمين الدائرة.

#	استنادا للقسم الذي تعمل به.....	معارض			موافق		لا ينطبق / لا أعرف
		بشدة	معارض	محايد	موافق	بشدة	
1.	يأخذ رئيسي المباشر/ منبري مقترحات الموظفين على محمل الجد لتحسين سلامة المرضى	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
2.	كلما زاد ضغط العمل فإن رئيسي المباشر يطلب منا العمل بسرعة، حتى وإن أدى ذلك للإحصار (في الاجراءات مثلا)	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
3.	يقوم رئيسي المباشر/ منبري بالعمل على معالجة مشاكل سلامة المرضى التي تلفت انتباههم اليها	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6

القسم الثالث (C): الإتصالات/ طرق توصيل المعلومة بين العاملين

كم يتكرر حدوث الأشياء التالية في مكان عملك / قسمك ؟ اختر إجابتك بملء المربع

#	استنادا للقسم الذي تعمل به.....	لا يحدث	نادرا	أحيانا	غالبا	دائما	لا ينطبق / لا أعرف
		<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	
1.	يتم إعلامنا عن الأخطاء التي تحدث في القسم	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
2.	عند حدوث أخطاء في هذا القسم، نناقش طرق منع حدوثها مرة أخرى	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
3.	في هذا القسم، يتم إعلامنا بالتعبيرات التي تم إجراؤها بناء على تقارير الإبلاغ عن الأحداث	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
4.	يحدث الموظفون بحرية إذا رأوا ما يؤثر سلبا على العناية بالمرضى	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
5.	يحدث الموظفون بحرية في هذا القسم عندما يرون شخصا ذو سلطة عليا يفعل شيئا غير آمن للمرضى	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6

6. عندما يحدث الموظفون، اصحاب السلطة العليا يهتمون بما يقوله فيما يتعلق بسلامة المرضى
7. في هذا القسم ، يخوف الموظفون من طرح الأسئلة عندما يبدو امر ما غير صحيحا

القسم الرابع (D): الإبلاغ عن أحداث سلامة المرضى

كم يتكرر الإبلاغ عن الأحداث التي ترتب فيها اخطاء في مكان عملك / قسمك ؟ حده إجابتك بتضمين المربع

- | # | استنادا للقسم الذي تعمل به..... | لا يحدث | نادرا | أحيانا | غالبا | دائما | لا ينطبق / لا أعرف | |
|----|--|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--|
| 1. | عندما يتم ضبط الخطأ وتصحيحه قبل أداء المريض: هل يتم عادة الإبلاغ بذلك؟..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2. | عندما يصل الخطأ إلى المريض كان سيؤدي المريض: ولكن لم يحدث له أذى ، هل يتم عادة الإبلاغ بهذا؟..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3. | خلال آخر 12 شهر ، كم عدد أحداث سلامة المرضى التي أبلغت عنها ؟
بعض النظر عما إذا كان هذا الحادث او الضرر قد وصل إلى المريض أو لا | <p>a. <input type="checkbox"/> لم أبلغ عن أي حدث</p> <p>b. <input type="checkbox"/> 1-2</p> <p>c. <input type="checkbox"/> 3-5</p> <p>d. <input type="checkbox"/> 6-10</p> <p>e. <input type="checkbox"/> 11 حدث أو أكثر أبلغ عنها</p> | | | | | | |

القسم الخامس (E): تقييم مستوى سلامة المرضى

كيف يقيم قسمك / مكان عملك سلامة المرضى؟

- | ضعيفة | مقبولة | جيدة | جيدة جدا | ممتازة |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

القسم السادس (F): المشفى الذي تعمل به

ما مدى موافقتك أو عدم موافقتك على العبارات التالية حول المستشفى الخاص بك؟

#	استنادا للقسم الذي تعمل به.....	معارضن		موافق		لا ينطبق / لا أعرف
		بشدة	معارض	محايد	بشدة	
1.	تظهر إجراءات إدارة المستشفى أن سلامة المرضى هي أولوية قصوى	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 6
2.	عوفر إدارة المستشفى الموارد الكافية لتحسين سلامة المرضى	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 6
3.	يظهر إهتمام إدارة المشفى بسلامة المرضى فقط عند وقوع اي حدث سلبي	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 6
4.	عند نقل المرضى من قسم إلى آخر ، عائلاً ما يتم ضياع المعلومات المهمة	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 6
5.	خلال تجديد الورديات ، عائلاً ما يتم ضياع المعلومات المهمة لرعاية المرضى	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 6
6.	خلال تجديد الورديات ، يتوفر الوقت الكافي لتبادل جميع معلومات رعاية المرضى الرئيسية	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 6

القسم السابع (G): معلومات عامة

1. منذ متى وانت تعمل في هذا المشفى؟

- a. أقل من عام واحد
b. 1-5 أعوام
c. 6-10 أعوام
d. 11 عام فأكثر

2. كم هي المدة التي امضيتها وأنت تعمل في هذا القسم من المشفى؟

- a. أقل من عام واحد
b. 1-5 أعوام
c. 6-10 أعوام
d. 11 عام فأكثر

3. عادة ، كم ساعة تعمل أسبوعيا في هذا المشفى؟

a. أقل من 30 ساعة أسبوعيا

b. 30-40 ساعة في الأسبوع

c. 40 ساعة فأكثر في الأسبوع

4. بحكم وظيفتك ، هل تتعامل مباشرة مع المرضى ؟

a. نعم، عادة يكون لي إتصال أو إحتكاك مباشر مع المرضى

b. لا، عادة لا يكون لي إتصال أو إحتكاك مباشر مع المرضى.

القسم الثامن (H): أية ملاحظات أخرى/ تعليقاتك

يرجى إضافة ملاحظاتك وتعليقاتك حول الإبلاغ عن سلامة/حماية المرضى، أو الأخطاء أو الحوادث في المشفى التي تعمل فيه

شكرا جزيلا على تعاونكم

Appendix (3)

English Patient Safety Culture Dimensions & FREDA Principles

SOPS Hospital Survey 2.0: Items and Composite Measures:

1. Teamwork

A1. In this unit, we work together as an effective team.

A8. During busy times, staff in this unit help each other.

A9. There is a problem with disrespectful behavior by those working in this unit.
(Negatively worded)

2. Staffing and Work Pace

A2. In this unit, we have enough staff to handle the workload.

A3. Staff in this unit work longer hours than is best for patient care. (Negatively worded)

A5. This unit relies too much on temporary, float, or PRN staff. (Negatively worded)

A11. The work pace in this unit is so rushed that it negatively affects patient safety.
(Negatively worded)

3. Organizational Learning—Continuous Improvement

A4. This unit regularly reviews work processes to determine if changes are needed to improve patient safety.

A12. In this unit, changes to improve patient safety are evaluated to see how well they worked. A14. This unit lets the same patient safety problems keep happening.
(Negatively worded)

4. Response to Error

A6. In this unit, staff feel like their mistakes are held against them. (Negatively worded)

A7. When an event is reported in this unit, it feels like the person is being written up, not the problem. (Negatively worded)

A10. When staff make errors, this unit focuses on learning rather than blaming individuals.

A13. In this unit, there is a lack of support for staff involved in patient safety errors.
(Negatively worded)

5. Supervisor, Manager, or Clinical Leader Support for Patient Safety

B1. My supervisor, manager, or clinical leader seriously considers staff suggestions for improving patient safety.

B2. My supervisor, manager, or clinical leader wants us to work faster during busy times, even if it means taking shortcuts. (Negatively worded)

B3. My supervisor, manager, or clinical leader takes action to address patient safety concerns that are brought to their attention.

6. Communication About Error

C1. We are informed about errors that happen in this unit.

C2. When errors happen in this unit, we discuss ways to prevent them from happening again.

C3. In this unit, we are informed about changes that are made based on event reports.

7. Communication Openness

C4. In this unit, staff speak up if they see something that may negatively affect patient care.

C5. When staff in this unit see someone with more authority doing something unsafe for patients, they speak up.

C6. When staff in this unit speak up, those with more authority are open to their patient safety concerns.

C7. In this unit, staff are afraid to ask questions when something does not seem right.
(Negatively worded)

8. Reporting Patient Safety Events

D1. When a mistake is caught and corrected before reaching the patient, how often is this reported?

D2. When a mistake reaches the patient and could have harmed the patient, but did not, how often is this reported?

9. Hospital Management Support for Patient Safety

- F1. The actions of hospital management show that patient safety is a top priority.
 F2. Hospital management provides adequate resources to improve patient safety.
 F3. Hospital management seems interested in-patient safety only after an adverse event happens. (Negatively worded)

10. Handoffs and Information Exchange

- F4. When transferring patients from one unit to another, important information is often left out. (Negatively worded)
 F5. During shift changes, important patient care information is often left out. (Negatively worded)
 F6. During shift changes, there is adequate time to exchange all key patient care information.

11. Number of Events Reported

(None, 1 to 2, 3 to 5, 6 to 10, 11 or more)

- D3. In the past 12 months, how many patients' safety events have you reported?

12. Patient Safety Rating

(Poor, Fair, Good, Very Good, Excellent)

- E1. How would you rate your unit/work area on patient safety?

Statements that reflect each of the human values in the model adopted in the study (FREDA Principles):

➤ FAIRNESS

- A3. Staff in this unit work longer hours than is best for patient care. (Negatively worded)
 A4. This unit regularly reviews work processes to determine if changes are needed to improve patient safety
 A6. In this unit, staff feel like their mistakes are held against them. (Negatively worded)

A12. In this unit, changes to improve patient safety are evaluated to see how well they worked. A14. This unit lets the same patient safety problems keep happening. (Negatively worded)

B1. My supervisor, manager, or clinical leader seriously considers staff suggestions for improving patient safety.

F1. The actions of hospital management show that patient safety is a top priority.

F6. During shift changes, there is adequate time to exchange all key patient care information.

➤ **EQUALITY**

A2. In this unit, we have enough staff to handle the workload

A8. During busy times, staff in this unit help each other.

A11. The work pace in this unit is so rushed that it negatively affects patient safety. (Negatively worded)

B2. My supervisor, manager, or clinical leader wants us to work faster during busy times, even if it means taking shortcuts. (Negatively worded)

F2. Hospital management provides adequate resources to improve patient safety.

➤ **RESPECT**

A1. In this unit, we work together as an effective team.

A9. There is a problem with disrespectful behavior by those working in this unit. (Negatively worded)

A10. When staff make errors, this unit focuses on learning rather than blaming individuals.

C3. In this unit, we are informed about changes that are made based on event reports.

➤ **DIGNITY**

A7. When an event is reported in this unit, it feels like the person is being written up, not the problem. (Negatively worded).

A14. This unit lets the same patient safety problems keep happening. (Negatively worded)

B3. My supervisor, manager, or clinical leader takes action to address patient safety concerns that are brought to their attention.

C1. We are informed about errors that happen in this unit.

C2. When errors happen in this unit, we discuss ways to prevent them from happening again.

F3. Hospital management seems interested in-patient safety only after an adverse event happens. (Negatively worded).

➤ **AUTONOMY**

A5. This unit relies too much on temporary, float, or PRN staff. (Negatively worded)

A13. In this unit, there is a lack of support for staff involved in patient safety errors. (Negatively worded)

F4. When transferring patients from one unit to another, important information is often left out. (Negatively worded)

C4. In this unit, staff speak up if they see something that may negatively affect patient care.

C5. When staff in this unit see someone with more authority doing something unsafe for patients, they speak up.

Appendix (4)

Arabic Patient Safety Culture Dimensions & FREDA Principles

SOPS Hospital Survey 2.0: Items and Composite Measures:

13. العمل الجماعي

- A1 في هذا القسم ، نعمل معًا كفريق فعال
 A8 عندما ينشغل جزء من القسم فإن الآخرون يساعدونهم
 A9 لا يحترم جميع افراد قسمي بعضهم البعض

14. التوظيف ووتيرة العمل

- A 2 في هذا القسم لدينا كادر كاف للقيام بأعباء العمل
 A3 يعمل كادر القسم لساعات طويلة مما قد يؤثر على سلامة المريض
 A5 يعتمد قسمنا بشكل كبير على الموظفين المؤقتين أو من أقسام أخرى مما قد يؤثر على سلامة المريض
 A11 ان سرعة العمل في قسمنا مستعجلة لدرجة انها تؤثر سلبا على سلامة المرضى

15. التعلم المؤسسي

- A 4 يقوم هذا القسم بمراجعة إجراءات العمل بانتظام لتحديد ما إذا كانت هناك حاجة لإجراء تغييرات لتحسين سلامة المرضى
 A12 تم تقييم التغييرات لتحسين سلامة المرضى في قسمنا لمعرفة مدى نجاحها
 A14 في هذا القسم يتكرر حدوث نفس المشاكل المتعلقة بسلامة المريض

16. الاستجابة الغير عقابية للاخطاء

- A6 يشعر الموظفون ان أخطاءهم تسجل ضدهم
 A7 عندما يكتب تقرير حادثة ، فإنه يسود شعور بان التقرير عن الشخص وليس عن المشكلة
 A10 عندما يرتكب الموظفون أخطاء، يركز قسمنا على التعلم بدلا من إلقاء اللوم على الأفراد
 A13 في هذا القسم لا يوجد دعم للكادر المشارك في الأخطاء المتعلقة بسلامة المرضى

17. دعم المشرف والرئيس المباشر لسلامة المرضى

- B1 يأخذ رئيسي المباشر/ مديري مقترحات الموظفين على محمل الجد لتحسين سلامة المرضى
- B2 كلما زاد ضغط العمل فان رئيسي المباشر يطلب منا العمل بسرعة، حتى وان ادى ذلك للإختصار (في الاجراءات مثلا)
- B3 يقوم رئيسي المباشر/ مديري بالعمل على معالجة مشاكل سلامة المرضى التي تلفت انتباههم اليها

18.التواصل بشأن الخطأ

- C1 يتم اعلامنا عن الأخطاء التي تحدث في القسم
- C2 عند حدوث أخطاء في هذا القسم، نناقش طرق منع حدوثها مرة أخرى
- C3 في هذا القسم، يتم إعلامنا بالتغييرات التي تم اجراؤها بناء على تقارير الإبلاغ عن الأحداث

19.انفتاح التواصل

- C4 يتحدث الموظفون بحرية اذا رأوا ما يؤثر سلبا على العناية بالمريض
- C5 يتحدث الموظفون بحرية في هذا القسم عندما يرون شخصا ذو سلطة عليا يفعل شيئا غير أمن للمرضى
- C6 عندما يتحدث الموظفون، اصحاب السلطة العليا يهتمون بما يقولونه فيما يتعلق بسلامة المرضى
- C7 في هذا القسم ، يتخوف الموظفون من طرح الأسئلة عندما يبدو امر ما غير صحيحا

20.تكرار الإبلاغ عن الاحداث

- D1 عندما يتم ضبط الخطأ وتصحيحه قبل ابداء المريض، هل يتم عادة الإبلاغ بذلك؟.....
- D2 عندما يصل الخطأ إلى المريض كان سيؤذي المريض، ولكن لم يحدث له أذى ، هل يتم عادة الإبلاغ بهذا؟.....

21.دعم ادارة المستشفى لسلامة المرضى

- F1 تظهر إجراءات إدارة المستشفى أن سلامة المرضى هي أولوية قصوى
- F2 توفر إدارة المستشفى الموارد الكافية لتحسين سلامة المرضى
- F3 تظهر إهتمام إدارة المشفى بسلامة المرضى فقط عند وقوع اي حدث سلبي

22.تبادل المعلومات والتحوللات

- F4 عند نقل المرضى من قسم إلى آخر ، غالبًا ما يتم ضياع المعلومات المهمة
- F5 خلال تبديل الورديات ، غالبًا ما يتم ضياع المعلومات المهمة لرعاية المرضى

F6 خلال تبديل الورديات ، يتوفر الوقت الكافي لتبادل جميع معلومات رعاية المرضى الرئيسية

23. عدد الاحداث المبلغ عنها

(لم أبلغ عن أي حدث، 2-1، 3-5، 6-10، 11 حدث أو أكثر أبلغ عنها)

D3 خلال آخر 12 شهر، كم عدد أحداث سلامة المرضى التي أبلغت عنها؟

24. تقييم سلامة المرضى

(ضعيفة، مقبولة، جيدة، جيدة جدا، ممتازة)

E1 كيف يقيم قسمك / مكان عملك سلامة المرضى؟

العبارات التي تعكس كل قيمة من القيم الانسانية في النموذج المتبنى في الدراسة FREDa

➤ العدالة

- A3 يعمل كادر القسم لساعات طويله مما قد يؤثر على سلامة المريض
- A 4 يقوم هذا القسم بمراجعة إجراءات العمل بانتظام لتحديد ما إذا كانت هناك حاجة لإجراء تغييرات لتحسين سلامة المرضى
- A6 يشعر الموظفون ان أخطاءهم تسجل ضدهم
- A12 يتم تقييم التغييرات لتحسين سلامة المرضى في قسمنا لمعرفة مدى نجاحها
- B1 يأخذ رئيسي المباشر/ مديري مقترحات الموظفين على محمل الجد لتحسين سلامة المرضى
- F1 تظهر إجراءات إدارة المستشفى أن سلامة المرضى هي أولوية قصوى
- F6 خلال تبديل الورديات ، يتوفر الوقت الكافي لتبادل جميع معلومات رعاية المرضى الرئيسية

➤ المساواة

- A 2 في هذا القسم لدينا كادر كاف للقيام بأعباء العمل
- A8 عندما ينشغل جزء من القسم فان الآخرون يساعدونهم
- A11 ان سرعة العمل في قسمنا مستعجلة لدرجة انها تؤثر سلبا على سلامة المرضى
- B2 كلما زاد ضغط العمل فان رئيسي المباشر يطلب منا العمل بسرعة، حتى وان ادى ذلك للإختصار
- (في الاجراءات مثلا)
- F2 توفر إدارة المستشفى الموارد الكافية لتحسين سلامة المرضى

➤ الإحترام

- A1 في هذا القسم ، نعمل معًا كفريق فعال
- A9 لا يحترم جميع افراد قسمي بعضهم البعض
- A10 عندما يرتكب الموظفون أخطاء، يركز قسمنا على التعلم بدلًا من إلقاء اللوم على الأفراد
- C3 في هذا القسم، يتم إعلامنا بالتغييرات التي تم إجراؤها بناء على تقارير الإبلاغ عن الأحداث

➤ الكرامة

- A7 عندما يكتب تقرير حادثة ، فإنه يسود شعور بان التقرير عن الشخص وليس عن المشكلة
- A14 في هذا القسم يتكرر حدوث نفس المشاكل المتعلقة بسلامة المريض
- B3 يقوم رئيسي المباشر/ مديري بالعمل على معالجة مشاكل سلامة المرضى التي تلفت انتباههم اليها
- C1 يتم اعلامنا عن الأخطاء التي تحدث في القسم
- C2 عند حدوث أخطاء في هذا القسم، نناقش طرق منع حدوثها مرة أخرى
- F3 تظهر إهتمام إدارة المشفى بسلامة المرضى فقط عند وقوع اي حدث سلبي

➤ الإستقلالية

- A5 يعتمد قسمنا بشكل كبير على الموظفين المؤقتين أو من أقسام أخرى مما قد يؤثر على سلامة المريض
- A13 في هذا القسم لا يوجد دعم للكادر المشارك في الأخطاء المتعلقة بسلامة المرضى
- F4 عند نقل المرضى من قسم إلى آخر ، غالبًا ما يتم ضياع المعلومات المهمة
- C4 يتحدث الموظفون بحرية اذا رأوا ما يؤثر سلبيًا على العناية بالمريض
- C5 يتحدث الموظفون بحرية في هذا القسم عندما يرون شخصا ذو سلطة عليا يفعل شيئًا غير آمن للمرضى

Appendix (5)

Introduction to Factor Analysis

With the tangible progress in specialized programs for statistical analysis, and as a result of the development of factor analysis and the expansion of its use in the social sciences, factor analysis has become a matter of particular importance. In educational research, factor analysis is a statistical method for analyzing multiple data that are related to each other with different degrees of correlation in the form of independent classifications based on the theoretical foundations of classification.

Objectives of Factor Analysis

- A. It summarizes the variables in a smaller number of the main factors that can explain the phenomenon.
- B. Highlight the difficult-to-reveal latent set of underlying elements that can play a role in explaining the relationships between a large number of variables.
- C. Obtaining a new set of variables (factors) with a smaller number to partially or completely replace the original set of variables.
- d. To Identify the variables that have important statistical significance and that require further analysis, such as regression.

General Concepts

Principal component's method:

It is one of the most widely used and accurate factor analysis method. Due to the accuracy of its results compared to other methods. This method has several advantages, including that it leads to accurate saturations (loadings), and each factor extracts the maximum amount of variance, and it leads to the least possible amount of residuals, and the correlation matrix is reduced to the smallest number of orthogonal unrelated factors.

varimax rotation:

varimax rotation is used to simplify the expression of a particular sub-space in terms of just a few major items each. The actual coordinate system is unchanged, it is the orthogonal basis that is being rotated to align with those coordinates. There are many practical ways to rotate in an attempt to present a mathematical solution to simple construction. perhaps the most famous of which is Kaiser's Varimax method, which accepts the idea of simple construction while preserving the perpendicularity between the factors.

Eigenvalue:

It measures the size of the variances in all the variables that are calculated on a single factor, the value of the latent root is not a ratio to interpret the variance but rather a measure of the size of the variance used for the purposes of comparison, according to Kaiser's rule, the factor in which the value of Eigen is greater than one is accepted, but if the value of Eigen is less than one, the factor is rejected.

Communalities:

It is the sum of the square of the factor loads on the different variables that were extracted in the factor matrix, that each variable contributes in different sizes to each of the factors, and

the sum of the squares of these contributions or the loading in the factors is the value of the communalities and its value must be greater than 0.5.

Extraction:

The factor extraction process relates to choosing a group of variables that explain the largest possible amount of total variance, and this is what constitutes the first factor, then the program selects the set of variables that explain the largest possible amount of the remaining variance after extracting the first factor, and this is what constitutes the second factor and so on.

Loadings:

Factor loadings is the degree of correlation of each variable with a particular factor, and the concept of factor loadings is very important, as many calculations are processed from the factor loadings table, so if the loading of a particular factor is greater than 0.5, then the variable related to it helps in describing it well. Factor loadings that are less than 0.5 can be neglected.

KMO and Bartlett's Test of Sphericity:

By marking the field KMO and Bartlett's test of sphericity, we get through measuring the KMO on the adequacy of the number of individuals in the sample and its value must be greater than (0.5) for the sample to be sufficient and this is a prerequisite that must be achieved. For the relationship between the variables, the level of significance for this relationship must be less than 0.05, so that we can confirm that this relationship is statistically significant.

Factor Analysis Plan

In this part, the analysis plan will be defined, which is summarized in the following steps:

-Factor analysis of the variables for each dimension will be applied.

- It should be noted that the variables that are omitted from the factor analysis in the first attempt of the analysis will remain as basic variables, as they are not related to other variables and should not be removed from the analysis at a later stage.
- In addition, it should be noted that the analysis plan was based on several factors, the most important of which is the size of the sample, according to the recommendations of the application of factor analysis, the recommended number for each analysis is 5-10 questionnaire for each variable.

Appendix (6) Mission Letter

Arab American University
Faculty of Graduate Studies



الجامعة العربية الأمريكية
كلية الدراسات العليا

5-5-2020

حضرة الدكتورة أمل أبو عوض المحترمة،
مدير عام التعليم الصحي
وزارة الصحة الفلسطينية-رام الله

تسهيل مهمة بحثية

تحية طيبة وبعد،

تهديكم كلية الدراسات العليا في الجامعة العربية الأمريكية أطيب التحيات، وبالإشارة إلى الموضوع أعلاه، تشهد كلية الدراسات العليا في الجامعة أن الطالبة روى عبد الجبار محمد ياسين والتي تحمل الرقم الجامعي 201720244 هي طالبة ماجستير في الجامعة العربية الأمريكية تخصص تخطيط استراتيجي وتحتد اموال، وتعمل على رسالة بحثية " النهج الاستراتيجي القائم على حقوق الإنسان لهم سلامة المرضى في مستشفيات فلسطينية منقده في شمال الضفة الغربية" تحت إشراف د. عائشة الزقاني، نأمل من حضرتكم الإيعاز لمن يلزم لمساعدتها في توزيع الاستمارات على المهنيين الصحيين في المستشفيات الحكومية للحصول على المعلومات اللازمة للدراسة، طمأن أن المعلومات المستخدمة لعلية البحث فقط وسيتم التعامل معها بغيرة السرية، وقد أعطيت هذه الرسالة بنهاية على طلبها.

وتفضلوا بقبول فائق الاحترام

د. رانية شقيرات

مساعدة عميد كلية الدراسات العليا



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ملخص الدراسة

هدفت هذه الدراسة إلى فحص مستوى فهم سلامة المرضى في مستشفيات فلسطينية منتقاة في شمال الضفة الغربية بتوظيف النهج الإستراتيجي القائم على حقوق الإنسان من قبل المهنيين الصحيين، من خلال دراسة المحاور التالية: (العدالة، المساواة، الإحترام، الكرامة، الإستقلالية). ولتحقيق هذا الهدف استخدم الباحث نسخة استبيان SOPS Hospital 2.0 المترجمة إلى اللغة العربية (استبيان عناصر المسح والمقاييس المركبة) لجمع البيانات اللازمة واستطلاع الرأي لعينة الدراسة، هذا الاستبيان صادر عن وكالة أبحاث الرعاية الصحية والجودة (AHRQ) في عام 2019. تم توزيع (481) استبيان على المهنيين الصحيين في 6 مستشفيات حكومية في شمال الضفة الغربية شملت (مستشفى رفيديا، مستشفى خليل سليمان، مستشفى ثابت ثابت، مستشفى طوباس التركي، مستشفى درويش نزال، مستشفى ياسر عرفات)، تم استرداد (473) استبيان أي بمعدل استجابة (98%).

وقد قامت الباحثة باستخدام البرنامج الاحصائي SPSS لتحليل البيانات، وأظهرت نتائج الدراسة ان هناك دور مهم وكبير في توظيف مبادئ حقوق الانسان في الرعاية الصحية من قبل المهنيين الصحيين في المستشفيات الحكومية في شمال الضفة الغربية، تبين أن مستوى التوظيف متوسط لكل المبادئ علما ان مستوى توظيف مبدأ العدالة كان يمثل بنسبة (70.8%) كأعلى نسبة مقارنة مع المبادئ الأخرى. بينما أظهرت النتائج ان مستوى تقدير سلامة المرضى في المستشفيات الحكومية (55.6%)، ان هناك عدة عوامل تنتهك حقوق المرضى تمثلت، في عدد الموظفين وسرعة العمل بنسبة (56.3%)، والاستجابة للأخطاء بنسبة (64.7%)، دعم إدارة المستشفى لسلامة المرضى (66%)، من جانب آخر، أظهرت النتائج بوجود علاقة ارتباط بين مبادئ حقوق الانسان والعديد من المتغيرات ولكن بنسبة متوسطة؛ مثل عامل الإنصاف يرتبط ارتباطاً وثيقاً بالمتغير (A6_1) مدى الاتفاق مع البيانات حول الوحدة / منطقة العمل الخاصة بك والتوظيف وسرعة العمل (في هذه الوحدة، يشعر الموظفون أن أخطائهم تقع ضدهم).

وقد خلصت الدراسة إلى توفير بيئة داعمة ومشجعة من قبل إدارة المستشفى ووزارة الصحة من خلال الحوافز المالية وتوفير الموارد اللازمة. هناك حاجة إلى تحسين بعض مجالات ثقافة سلامة المرضى في المستشفيات الحكومية الفلسطينية لضمان تعزيز PS. تخصيص ميزانية كافية لوزارة الصحة لتوفير الموارد المالية والبشرية والمعدات الطبية. تطوير ميثاق حقوق المريض لضمان حقوق المرضى ومقدمي الرعاية الصحية في المستشفيات الحكومية.

الكلمات الدالة: النهج القائم على حقوق الإنسان، سلامة المرضى، العدالة، المساواة، الإحترام، الكرامة، الإستقلالية.