ORIGINAL RESEARCH

The path to patient safety in primary health care — A study of nurses' and general practitioners' perceptions in Sweden

Mesud Avdagic[1], Eric Carlström[2]

1. Carlanderska hospital, Gothenburg, Sweden. 2. University of Gothenburg, Gothenburg, Sweden.

Correspondence: Mesud Avdagic. Address: Carlanderska hospital, Gothenburg, Sweden.
Email: mesud.avdagic@carlanderska.se

Abstract

National reforms that give patients the autonomy to select physicians or health care units are considered to have an impact on patient safety. There is, however, a lack of research addressing its application to primary health care. Qualitative content analysis was conducted with 14 semi-structured interviews to identify district nurses' and general practitioners' perceptions of practices they perceived contribute to patients' safety. The DNs and GPs emphasized reciprocity, a holistic approach to patients' varying needs, empowerment, and improving the organization of the health care center as central to patient safety. In contrast to other studies, there was strong consensus among primary healthcare professionals' perceptions. The findings can be used to put focus on not just a holistic approach of reciprocity, but also on the organization and task oriented techniques in order to further increase the safety for the primary health care patient.

Key words
Patient safety, Primary health care, Sweden

1 Introduction

Currently, patient safety is receiving considerable attention as it is high on the health agendas of countries in the European region [1]. In the last decades, the focus of patient safety research and development has been mainly on hospital care, although in recent years safety in primary health care has also received attention [2]. This is important, as the majority of patients attain their health care in the primary health care system [3].

In Sweden, the Ministry of Health and Social Affairs states that health and medical services shall be conducted so as to meet the requirements for good care. In particular, this means that it must be of good quality and in accordance with the patient's need for safety in care and treatment [4].

To enhance patient safety, increase accessibility to the health industry, and strengthen the position of the patient, the Swedish government introduced a bill about changes in The Health and Medical Services (Act § 5) which was passed by the Parliament in 2008. New rules were introduced, such as the right to choose both doctor and health care units as well as the time for treatment. Another purpose of the act was to guarantee access to health care staff with several types of

competences in primary health care and to ensure continuity for the patients. The idea was considered to have effect on patient safety by ensuring a holistic approach to the needs of the patient in order to establish a continuum during the care process [5, 6]. Even if these measures were considered to contribute to increased patient safety, few studies have dealt with the application of the reform in primary health care [7].

1.1 Definitions of safety

There are several definitions of the concept safety. In nursing sciences it is common to define safety as a basic human need based on the theory of human motivation [8] as described by Maslow [9]. Another widely used definition is the division of the safety concept into three dimensions as: 1) a feeling, 2) an inner state, and 3) in interaction with the outside world [10-12]. The feeling of safety includes terms such as balance, harmony, and peace of mind. The second dimension is described as a capability to recognize personal abilities; a perception of inner weaknesses and self-confidence. It is suggested that this can be accomplished through experience, consciously processing situations of insecurity as well as by successful coping with crises. In contrast to the previous two dimensions, safety related to the outside world is the result of factors beyond the individual, such as material safety, environmental safety, and relations. It also includes resources of knowledge and control as means to understand, predict, manage and have power over one's own life, and to have the feeling of not being exposed to threats.

In medicine, patient safety is primarily associated with incident reporting and a low frequency of adverse medical events [2, 3, 13-17]. In a study of patient safety in emergency departments, patient safety was defined as: to minimize the risk of patient´s complications or early death as well as to identify the need for hospital care [18]. Adverse medical events are seen as a challenge to the quality of care, an avoidable cause of human suffering, and a high toll in financial loss [16]. It has been reported that the most common reasons for an unsafe health care in terms of adverse events are due to drug treatment, injuries due to medical devices, as well as surgical and anesthesia errors. Other common reasons for reduced medicine-related safety are health care-associated infections, unsafe injection practices, and unsafe blood products [14].

Adverse medical events in primary health care are reported to vary from 5 to 80 per 100,000 consultations [3, 13]. In Sweden, the exact numbers are yet to be studied. It is, however, known that adverse events occur frequently in hospitals and consume a substantial amount of the available hospital resources [3]. A national study based on a review of 1,967 medical records shows that 8.6% of the patients in Swedish hospitals had experienced preventable adverse events. When extrapolated to the 1.2 million annual admissions the results correspond to 105,000 preventable adverse events and 630,000 days of hospitalization [15].

1.2 Predictors of patient safety

Several hospital-oriented studies conducted in various countries have identified nurse-related predictors of patient safety. These studies suggest improvements in nurse staffing and education to enhance patient safety [19-24]. Furthermore, there is a bond between professional commitment [23], experience, emotional stability, and patient safety [22, 24]. Committed and professional nurses enhanced patient safety by reducing the number of medication errors, incomplete or incorrect documentation, and delayed care activities. In addition, professional commitment also improved patient-perceived care quality in terms of responsiveness and empathy [23].

In a study partly aimed at providing a better understanding of how safety can be transformed from concept to action, attention was given to hospital inpatients' views on what attitudes and actions of medical staff are desirable for patients to achieve greater safety [10]. Some patients expected doctors and nurses to be kind and patient, to show interest, and to be accommodating. Others emphasized the feeling of being taken seriously and listened to. Patients also expected adequate medical care and good nursing care, that is, literacy, accuracy, and consistency of the care provided. They stressed the importance of getting information and explanations in a way that could be understood. Requests were made that staff must turn directly to the patient and speak loud and clear, avoid jargon, and encourage questions to show that they are open to the patient's concerns. The same study also demonstrated that although scientific definitions of patient safety were available, they were difficult to apply in health care delivery [10].

In contrast to previous reports, a recent study—aimed at exploring what doctors and nurses in primary health care perceive as patient safety—provided somewhat different and new insights. The results indicate that medication safety (e.g., the prescribing and monitoring of medication and polypharmacy) and culture of professionalism are important variables. In addition, a number of mostly organizational items were mentioned (e.g., telephonic and physical accessibility of the practice) as important to achieve patient safety [2]. The same study also identified a need to align the definition of patient safety between researchers and primary care workers for implementation purposes.

The aim of this study was to identify district nurses' and general practitioners' perceptions of practices they believe contribute to primary health care patients' safety in a Swedish health care center context. Mapping how this is done may help identify previously unknown aspects of patient safety and how it can be improved.

2 Methods

A qualitative, descriptive approach [25] using semi-structured interviews was used in order to identify the perceptions of district nurses (DNs) and general practitioners (GPs). Eight central as well as rural health care centers mainly located in, and in the vicinity of, the city of Gothenburg were chosen as setting (see Table 1). The ambition was to ensure a reasonably good spread regarding practice size and difference in the visiting patients' socio-economic background. Even though some of the clinics were situated in affluent areas and others in disadvantaged and segregated areas, they were all visited by patients with different ethnicities and socio-economic backgrounds.

Table 1. Participants

Interviewed DNs & GPs	Gender	Place of Practice	Practice size	Years of experience as a DN/GP
DN 1	Female	Suburb	12 857	17
DN 2	Female	Suburb	12 857	25
DN 3	Female	Suburb	7 430	16
DN 4	Female	Suburb	13 471	13
DN 5	Female	City	20 341	15
DN 6	Female	City	20 341	27
DN 7	Female	Suburb	8 760	7
GP 1	Male	City	11 350	5
GP 2	Male	City	11 350	18
GP 3	Male	City	11 350	8
GP 4	Male	City	11 350	3
GP 5	Male	Rural	1 587	11
GP 6	Female	Rural	1 587	30
GP 7	Female	Suburb	10 763	7

A purposeful sample of eight DNs and equally as many GPs of both sexes were invited to participate. One from each profession eventually declined to take part. All informants who had over three years of professional experience within their specialty and were willing to take part in the study were eligible for inclusion. Those who recently had completed their specialist training and had limited clinical experience were excluded. The sample size was selected from a saturation and variability perspective [26]. A key issue was to generate enough in-depth data that could illuminate the patterns, categories, and dimensions of the studied practices [27].

The procedures were in accordance with Swedish law [28] and the principles of the Declaration of Helsinki from 1975—as revised in 2008 [29]. Participants who met the inclusion criteria were sent an introductory letter which described the overall purpose of the study and the main features of the design. It also contained information regarding participation stating that

it was voluntary and at any time, without reprisal, possible to withdraw consent. Participants were assured of strict confidentiality and secure data storage.

The interviews, held in Swedish, were conducted face to face in the DNs' and GPs' offices and were introduced by a briefing in which the purpose of the interview was clarified. The informants were initially asked if they had any questions. In the dialogue, the authors related to an interview guide (see Table 2) which structured the course of the interview [30].

Table 2. Interview guide

Main and subsidiary questions
Could you briefly tell me about your professional background?
• How long have you worked at this job?
• Can you tell me about this health care center?
What can contribute to a feeling of insecurity for those patients who are treated in primary health care?
• Causes that can be traced to the patient?
• Causes that can be traced to the patient's own context?
• Causes that can be traced to the health care center and primary health care in general?
How could such insecurity be prevented?
Can you tell me about a situation when you felt that you made a patient feel safe who initially felt unsafe?
Can you tell me about a situation when you felt that you failed to make a patient feel safe who felt unsafe?
• What do you think the reason/reasons were for this?
With the study's purpose in mind, is there anything else you think I should know?

Combinations of introductory, specifying, and direct questions were posed as a means to yield spontaneous and rich descriptions [30]. As some of the interviewees expressed general statements, attempts were made to get more precise descriptions by asking specifying and direct questions, for instance: "Can you tell me about a situation when you felt that you made a patient feel safe who initially felt unsafe?", "What do you think the reason/reasons were for this?" These inquiries were usually postponed until the latter part of the interview; after the informants spontaneously had described which aspects of the studied practices were central to them. Silence and mere nods were employed as a strategy to obtain further elaboration. The initial briefing was followed up with a debriefing and then the interview was rounded off, usually by asking if the interviewees had anything else they would like to bring up. The interviews lasted approximately 45-60 minutes and were recorded digitally and transcribed verbatim by the first author, leaving out pauses, emphases in intonation, and emotional expressions like laughter and sighing.

A qualitative content analysis of the manifest content was then used [25, 31]. First, the units of meaning were identified, then condensed into core contents, and thereafter abstracted into codes. These were later sorted, grouped, re-sorted, and re-grouped, until three main categories describing DNs' and GPs' way of work emerged. At a point where no new information and codes novel in substance were observed in the data, a decision not to proceed any further was taken.

3 Results

In total, 15 codes were identified in the unit of analysis. The codes were ordered into three developed categories: a holistic approach, patient empowerment, and organization of the health care center. They are described below in more detail, in rank order from most to least discussed. All codes except three are derived from perceptions of both professions.

3.1 A Holistic approach

Staff from several health care centers emphasized the importance of displaying sincere interest in the patient to induce a feeling of safety. A sincere interest involved attentiveness to the patient's general needs, and not just the symptoms that were the stated reason for the visit. The majority of the interviewed DNs and GPs claimed that as often as they could, and in spite of a tight time schedule, they took time to carefully listen to what the patients were troubled by—even though they

almost immediately had a hypothesis about what actually was wrong. The staff's intention was to react immediately when the patient called for their attention. They also took the initiative and posed various exploratory questions—a strategy aimed to contribute to the feeling of well-being and safety. Well-chosen and carefully prepared questions about aspects related to the underlying causes of symptoms were posed in an effort to reduce patients' uncertainty about the staff's intentions and willingness to help. It was a way of showing that they were willing to do more than merely cover up the symptoms with a drug.

> I try to see the whole person in front of me, not only the high blood pressure. I also try to talk to the person and ... show an interest and ask: Are you out walking now as we talked about, what medications do you take, do you take what is written here or have you changed anything? How are things around you and so on? (DN)

Another technique sometimes used was to verbally summarize topics the patient accounted for. The summarizing technique provided an overview of achieved common understanding. It demonstrated that the DN and the GP listened actively. It contributed to a common ground.

The GPs' experience was that some patients have a hidden agenda, that is, an unspoken reason for paying a visit to the doctor. To contribute to these patients' safety, doctors devoted themselves to explore the possible underlying causes of the visits.

> In my calendar it may say stomach ache but maybe it really isn´t so, maybe the patient seeks help because of general fear of cancer because a loved one might be the one that is sick. (GP)

DNs and GPs reported that every week they met patients who felt unsafe, anxious, or were on the verge of depression. This was something that partly was attributed to physical or mental illness, and partly to individual lifestyle factors such as unemployment and drug and alcohol abuse. They emphasized the importance of always acknowledging and never trivializing any of the patients' symptoms—even if they often sought care for symptoms that could not be linked to any known treatable disease.

> It is much easier to break a leg and get plaster and clarity ... than to be told that you have chronic pain in the muscles that comes from high tension, which in turn is due to mental illness. It is not possible to measure, image, or diagnose because there are not even names for these conditions. (GP)

Several GPs pointed out the importance of dealing with issues alike; particularly when encountering patients who display symptoms impossible to classify within established frames of references. A superior principle was to not question patients' experiences based on the idea that there may be explanations that are still unknown. In respect to this principle, the GPs strived to be firm, followed a track of established knowledge and experience, and avoided to openly indicate any doubtful solution. Indecisiveness concerning diagnosis and treatment was perceived as harmful and as something that only would add to the confusion and insecurity the patient may experience.

3.2 Patient empowerment

DNs and GPs also perceived themselves to contribute to primary health care patients' safety through involving them in their own care process. To provide enough information was believed to be a key element. According to one DN, it is important to increase patients' knowledge about what is happening in the current situation and what is on the agenda. Her experience was that a patient who has not been informed of what will happen, risks losing control and, as a consequence, uncertainty and insecurity can arouse. Therefore, the staff regularly explained what was being done, and what was to come, to create a more structured and predictable situation.

> It is important that you give clear information: Now, I have done this and we'll proceed with this, we'll take blood samples, we'll schedule you for a return visit in so many weeks, in the meantime I will get the results, and so on. (DN)

Scrupulous information, for example regarding severe and lethal diseases, sometimes hindered patients from absorbing all given information at once. In these cases, a common technique was to reduce the information to a level adjusted to the patient's ability to absorb. This was done by initially giving brief information and at a later stage providing a more detailed follow-up, preferably in company with a relative.

> I never leave highly detailed information without any relatives around ... because I believe only then will you truly face someone who is taking it in. (GP)

Information in moderate portions and at the right time was seen as a necessary component for building a therapeutic relationship and increase patient participation and perceived safety. Despite lack of time, GPs sometimes scheduled counseling sessions in order to give the patients and their relatives an opportunity to ask questions.

> They can't be allowed to walk away from a doctor's appointment with unspoken questions which they might go to the next doctor for, or to an emergency a week later ... because they ended up in a rush and felt misunderstood. (GP)

The primary health care workers were aware that they were in a superior position in relation to the patients who often played a passive role in care and treatment. Therefore several DNs and GPs stressed the importance of shared decision making. This meant that they gave patients control over some aspects of care and treatment. Instead of giving clear directives and decide for themselves, staff provided the necessary information so patients could decide how they wanted to proceed. They did, in a way, adopt an assisting role in relation to the patients' quest for independence and recovery.

3.3 Organization of the health care center

Well-functioning collegial cooperation within the health care center was widely considered as crucial in order to contribute to primary health care patients' safety. It was defined as working together in a joint intellectual effort. When patients' needs were complex, an interdisciplinary collaboration with, for example, counselors and psychiatrists was perceived as necessary and frequently undertaken. By collaborating, the personnel considered themselves better equipped to meet patients' multifaceted needs. However, staff reported that it was necessary at times to take a step back and let another colleague take over. DNs as well as GPs believed that such an approach—that is, for staff to be humble and not act superior to one another—increased the likelihood for patients to feel safe in care and treatment.

> Well, you should not say something you know nothing about. I think you should be honest and say: We must talk to a colleague about this, because it is not part of my training, which patients sometimes believe. We should perhaps call a more experienced colleague to take care of this? (DN)

To be accessible by telephone and visits was a priority for both DNs and GPs. Access to primary health care staff was considered to correlate with the perceived safety of the patient. Some of the staff reported negative experiences from delayed consultations. The longer the patients had to wait for a phone call or a visit, the more worried, anxious, and upset they appeared to be. A common way to try to prevent this was to offer generous visiting hours and make a telephone call the same day patients sought help. However, accessibility within a reasonable time was a reoccurring problem—especially when colleagues were on leave or ill. Therefore, DNs as well as GPs did their utmost to compensate for the long waiting times for visits; for example, by directly after a visit offer a return appointment and/or by leaving their card and informing patients that they were welcome to contact them at any time.

> If I know I'm booked several weeks ahead, I do what I can to convey that I'm still reachable. First, by planning for the next visit, and also by giving out my card which shows the different ways the patient can contact me, when I'm on duty, or when the health care center is closed. (DN)

Several primary health care workers noticed that patients increasingly claimed their rights from the primary health care, most likely because of the changes in The Health and Medical Services (Act § 5). Concretely, this meant that they invoked

their freedom to either choose a particular DN or GP for regular visits or cancel the contact and visit someone else. The personnel seemed unanimous in that high quality health care is based on continuity. Staff should be familiar to the patient and vice versa. In accordance with this principle, some health care centers had developed procedures for referral management and booking of appointments which staff followed.

> If the patient is a frequent visitor, there is an agreement to arrange an appointment to a person the patient has met before. The same applies for incoming referrals which are sorted according to current memo that states that patients, if possible, should be called for a visit to the GP or DN as agreed on; unless they expressed otherwise. (DN)

The staff was convinced that continuity contributed to patient safety because patients in an established relationship dared to mention sensitive topics such as drug and alcohol abuse. Familiarity was believed not only to benefit patients but also health care production because it made work more effective. They did not have to introduce themselves yet again but could immediately go to the essentials. The resulting additional time could instead be used for patients with more extensive needs or trailing administrative tasks.

4 Discussion

4.1 Principle findings

The results of this study represent DNs' and GPs' efforts to enhance primary health care patients' safety. The strategies used by DNs and GPs are mainly reciprocal, such as providing a listening ear, ongoing support, and information. They were keen to undertake comprehensive investigations—alone or together with co-workers—which could provide the information needed to assist patients to find a feeling of, and an inner state of, safety. Well-functioning collegial cooperation, satisfactory accessibility to health care services, and continuity in care and treatment, were other components perceived to contribute to patient safety.

Research shows that perceived or actual illness, hospitalization, as well as social, physical, and economic loss can cause a disturbance and make patients feel unsafe [10, 32, 33]. The experiences of the interviewed staff suggest similar reasons for unsafe patients in primary health care. In relation to these findings, a holistic approach to patients' varying needs-frequently undertaken by DNs and GPs in this study-form the basis for therapeutic relations and concrete actions that may help patients cope with situations of insecurity.

Primary health care staff perceived themselves to contribute to patient safety by supporting patient participation. By providing detailed and personalized information about patients' status and available treatment options, DNs and GPs seemed to strive for patient empowerment and increased sense of control. Such actions have been shown to enable patients to better understand and manage their current situation by reducing anxiety related to the unpredictability of illness and the threat it poses [9, 10].

The main findings regarding the organization of the health care center-relating to factors patients have no or limited control over-are supported by research linking professional collaboration [2, 3, 10], accessibility and continuity [2, 5, 6] with patient safety. However, none of the interviewed professionals specifically mentioned staffing, prescribing and medication monitoring systems, actions to prevent adverse medical events, or incident reporting in order to enhance patient safety. Neither were experience and emotional stability given any importance. This is a relevant finding as these variables have the potential to significantly improve patient safety [2, 3, 19, 21, 22, 24]. It seems like staffing, computerized systems, and incident reporting still have a potential in the development of safe health care centers. Furthermore, these findings may also suggest a closed culture where staff is reluctant to openly discuss personal flaws in relation to incidents that affect patient safety.

Although the interviewed staff had varying lengths of clinical experience, belonged to different professions, and worked at independent health care centers, a strong consensus can be seen regarding their perceptions of which practices contribute to patient safety. This is an interesting finding because it contradicts the scope of patient safety in primary health care perceived by physicians and nurses as very broad [2].

However, some differences in the perceptions of staff were noticed. For instance, GPs thought that consistency and a formalistic approach in dealing with difficult issues contributed to patient safety. DNs did not express this view. They displayed a more integrative and social approach in the relationship to the patient. This can possibly be explained by the fact that nurses tend to be more inductive, that is, more social and relationship-oriented compared to physicians—who rather have an investigative profile and value individual responsibility [34, 35]. Deductive reasoning has proven to be the imperative of the medical services provided by physicians, but can have a negative impact on patient safety if communication with the patient is limited [34].

Effects of the Swedish primary health care reform, such as new health care centers and round the clock opening hours, have generally led to greater access to health care [7, 36]. The introduction of market economy and competition seems to influence DNs' and GPs' practice, which can explain why they appear customer-oriented and tend to focus more on social interaction and good service than on systematic identification and prevention of medical errors. This comes as a paradox since the causes of errors often are multiple and related to interaction between various factors such as drug dosing and poor communication and co-ordination between health care providers [3, 36].

4.2 Strengths and weaknesses of the study

This study highlights the current situation in Swedish primary health care and provides an insight into the work of DNs and GPs in order to contribute to patient safety. As the participation rate was reasonably good, one can assume that doctors and nurses were genuinely interested in patient safety. To evaluate the presented research findings and the trustworthiness of the study, they must be evaluated in relation to the procedures used to generate the findings [31]. This involves looking at the credibility, dependability, confirmability, and transferability of the study [37].

Several measures were taken in order to increase trustworthiness. A qualitative, descriptive approach using semi-structured interviews seemed like the most appropriate method for data collection and analysis as the intention was to identify the perception of primary health care staff. The method is described as suitable when focusing on the manifest content of verbal data since it is the least interpretive method of the qualitative analysis approaches in that there is no mandate to re-present the data in any other terms but their own [25]. To choose participants with various experiences, genders, and ages, as applied in this study, increases the possibility of shedding light on the research question from a variety of aspects, further increasing the trustworthiness [31].

During the analysis, the transcripts were divided into shorter meaning units to avoid too broad texts that can be difficult to manage since they are likely to contain various meanings [31]. Construction of meaning units, condensations, and abstractions were developed and illustrated by relevant and concise quotations. However, it must yet again be repeated that all interviews were conducted in Swedish, and the presented quotations are English translations made by the authors themselves. As translation is an interpretive act, some of the meaning may get lost in the translation process [38]. Lastly, in view of the small sample size, specific context, and methodological decisions in this study, caution is advised when transferring the results to similar settings or groups. As Lincoln and Guba noted, the author's responsibility is to provide sufficient descriptive data so consumers themselves can evaluate the applicability of the data to other contexts [37].

5 Conclusion

The results of this study highlight important aspects of practice in Swedish primary health care aimed to contribute to the multidimensional and dynamic nature of patient safety. In contrast to similar research, a strong consensus is seen in the

perceptions of staff which suggests that a holistic approach to patients' varying needs, patient empowerment, and the organization of the health care center, are important strategies. The fact that organizational aspects such as staffing, computerized medication monitoring systems, and incident reporting were not mentioned in the interviews calls for further analysis. The findings can be used to put focus not just on a holistic approach of reciprocity but also on the organization and task oriented techniques in order to further increase the safety for the primary health care patient.

Competing interest statement

The authors declare that there are no competing interests. The authors alone are responsible for the content and writing of the paper.

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