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**Patient Safety Culture and Nurse-Reported Adverse Patient Events
in Outpatient Hemodialysis Facilities**

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Aims: Patient safety culture is an important quality indicator in health care facilities and has been associated with key patient outcomes in hospitals. The purpose of this analysis was to examine relationships between patient safety culture and nurse-reported adverse patient events in outpatient hemodialysis facilities.

Methods: A cross-sectional correlational, mailed survey design was used. The analytic sample consisted of 422 registered nurses who worked in outpatient dialysis facilities in the United States. The Handoff and Transitions and the Overall Patient Safety Grade scales of the Agency for Healthcare Research and Quality's (AHRQ) Hospital Patient Safety Survey were modified and used to measure patient safety culture in outpatient dialysis facilities. Nurse-reported adverse patient events was measured as a series of questions designed to capture the frequency with which nurses report that 13 adverse events occur in the outpatient dialysis facility setting.

Results: Handoff and transitions safety during patient shift change in dialysis centers was perceived negatively by a majority of nurses. On the other hand, a majority of nurses rated the overall patient safety culture in their dialysis facility as good to excellent. All relationships between patient safety culture items and adverse patient events were in the expected direction. Negative ratings of handoffs and transitions safety were independently associated with increased odds of frequent occurrences of vascular access thrombosis and patient complaints. Negative ratings of overall patient safety culture in dialysis units independently associated with increased odds of frequent occurrences of medication errors by nurses, patient hospitalization, vascular access infection, and patient complaints.

Conclusion: Findings from this analysis indicate that patient safety culture is important for patient outcomes in dialysis units.

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