Title: What are the barriers in achieving a shared understanding of the patient safety concept between organisational hierarchy and frontline staff-How important is establishing this symbiotic relationship to Patient Safety?

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Keywords: High Performing Organisations, Patient Safety, Policy and Practice Gap, Organisational hierarchy,

I. Abstract Body (up to 229 words)

The Patient Safety concept has now become widely embraced and embedded into the broader healthcare organisational psychic and structures in Australia and other developed nations' health care organizations over the last two decades (Waring, Allen, Braithwaite, & Sandall, 2016). The motivating factors that continue to drive the uptake of the Patient Safety concept are as variable as the phases, methodologies and anticipated benefits of implementation between health care jurisdictions. It has to be pointed out that integration of the Patient Safety concept has been gradual, with progress being largely dependent on bridging the knowledge gap between clinical and managerial leadership and cultural sensitivity to patient safety issues (Gaw, Rosinia, & Diller, 2018). Senior healthcare leadership and senior managers have invariably developed a much greater appreciation of the key tenets of patient safety programs.

For any program to succeed within healthcare, however, greater investment has to be directed towards the people who are ultimately responsible for the implementation, frontline healthcare staff are ultimately responsible for the actual delivery of the Patient Safety program (Russell & Dawda, 2014) (Godlock, Miltner, & Sullivan, 2017).

This presentation explores the challenges in developing a shared understanding of the Patient Safety concept capable of transcending hierarchical structures, with a hypothesis that a critical mass of frontline staff is vital to the success of the Patient Safety concept. If a shared understanding by a critical mass of frontline health care staff does not exist, neither will any Patient Safety program succeed in achieving the desired levels of harm minimization (The IOM medical errors report: 5 years later, the journey continues., 2005)

II References

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III. Biography:

Abraham Mahachi completed a Graduate Certificate in Qualitative Health Research at the University of Sydney, Australia, in 2015, prior to this, he had completed a Master of Health Leadership and Management in 2012 at the University of Wollongong in Australia. He has held several Nursing management roles prior to joining Clinical Governance in 2013 in one of the largest public healthcare organisations in Australia, Western Sydney Local Health District. Abraham has been in his current role as a Patient Safety Analyst at the Clinical Excellence Commission in Sydney, Australia since August 2018.

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