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The Effect of Organizational Culture and Leadership on Nurse Safety: Nurses' Perceptions

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Dedication

I dedicate this work to my mother, whose unwavering support has been the foundation of my strength throughout my life. Her love, wisdom, and constant encouragement have guided me through challenges and empowered me to reach my goals.

I also extend my heartfelt gratitude to my father, my family, friends, and colleagues. Their steadfast support and belief in me have been a continual source of motivation, pushing me to pursue excellence in everything I do. I am deeply honored and humbled by their impact on my journey and their contributions to the broader community.

Mohammed Waheed muhamad aleabyat

Declaration

I certify that this thesis which is submitted to the Deanship of Graduate Studies to get the degree of master in on filed Nursing Management, this is my own research and my own work and it doesn't submit to any other universities or any institutions.

Signed: ..... 

Mohammed Waheed muhamad aleabyat

Date: 16/8/2025

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In addition, I wish to extend my heartfelt thanks to the nurses who participated in my study. Your valuable contributions and openness in sharing your experiences have greatly enriched this research. It has been an honor to collaborate with such committed professionals, and your input has provided essential insights into the realities and opportunities within the nursing field. Your dedication to advancing patient care is truly commendable, and I am thankful for your support.

Mohammed Waheed muhamad aleabyat

Abstract

Background: Nursing managers and leaders must fight to retain nurses in hospitals by constructing an inviting organizational climate that is attractive to work in, not toxic. The organizational climate is primarily affected by employees' internal work environment and behavior. Hence, nursing managers and leaders must implement effective strategies to increase nurses' intention to stay by address the organizational climate.

Aim: This study examined nurses' perceptions, feelings, and views about their work experiences in hospital settings, focusing on leadership, unit-level organizational culture, and the significance of workplace illnesses and injuries. Secondly, it examines how nurses perceive the influence of organizational culture and leadership on their health and safety. Third, the study investigates whether certain leadership behaviors are believed to negatively impact nurse safety. Finally, it identifies perceived leadership and organizational practices that support nurses in providing safe, high-quality patient care while minimizing the risk of illness and injury.

Design: A cross-sectional study design was utilized using a self-administered questionnaire of 304 nurses working governmental and private hospitals in the southern region of west Bank, Palestine.
Methods: Data were gathered between May and June 2025 using a scale that measured nurses' perceptions of structural factors associated with organizational culture, leadership, and safety culture affecting nurse safety and health. The analysis involved descriptive statistics, inferential statistics, and correlation analyses.

Results: The results indicated that collaboration and a supportive work environment positively affect nurses' job satisfaction. To promote nurse safety, unit leaders should emphasize safety protocols, cultivate a culture focused on safety, and promote safe practices among staff. Regarding perceptions of Unit Organizational Culture, the overall mean score was 3.41, indicating a good rating. The specific dimension of Unit Organizational Culture scored 3.71, and the nurses' perceptions of their current unit scored 3.15, both of which were also considered good. Correlation coefficients indicating a strong positive relationship between variables, were found in the Illness and Injury Management & Return to Work ($r = .832$, $p < .001$). A strong positive correlation means that as one variable increases, the other tends to increase as well

Recommendation. These findings may also aid healthcare institutions in enhancing or maintaining their organizational culture, leadership practices, and overall safety culture through the involvement of nursing staff.

***Keywords*:** Registered nurse, occupational safety and health, healthcare, nursing, hospitals, nurse safety, nurse injuries

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Chapter One

1.1. ntroduction

Nurses are highly skilled healthcare professionals who perform duties that expose them to various occupational hazards across different settings such as hospitals, clinics, nursing homes, and community environments (Wunderlich et al., 1996). In hospital settings, nurses often work under pressure, manage significant workloads in confined spaces, and operate diverse medical equipment within limited areas (Mullen et al., 2013). Consequently, they are frequently at risk of work-related health problems, including musculoskeletal disorders, psychological stress, sharp-object injuries, sleep disturbances, burnout, fatigue, and workplace violence (Medeiros et al., 2021; Mullen et al., 2015; Nixon et al., 2015; Samur & Intepeler, 2017; Stone & Gershon, 2006). These types of injuries are prevalent throughout the healthcare sector.

Despite increasingly difficult working conditions, particularly those exacerbated by the COVID-19 pandemic, which have led to a rise in occupational injuries, illnesses, absenteeism, burnout, turnover, and stress, nurses continue to provide high-quality care (Labrague & de Los Santos, 2020; Marceau et al., 2021). Often, healthcare organizations may overlook the health and safety concerns arising from these working conditions (Medeiros, 2021). However, a strong organizational safety culture significantly impacts nurses' job satisfaction and performance, potentially reducing stress, illness, and injury while improving safety and overall work quality (Hammer et al., 2019; Samur & Intepeler, 2017). Furthermore, the organization's role in shaping the work environment is crucial, as it directly influences occupational safety. By fostering a culture that promotes autonomy, responsibility, professional development, safe staffing levels, and effective communication, organizations can empower nurses and enhance their work conditions (Squires et al., 2010).

1.2. Organizational Culture

Organizational culture encompasses a company's core beliefs, values, traditions, and shared behaviors (Casida & Pinto-Zipp, 2008; Hyun & Eun-Kyung, 2021; Sproat, 2001). Closely related to this is the concept of organizational climate, which reflects how employees perceive the organization's characteristics that stem from its culture (Stone & Gershon, 2006). While some elements of organizational culture can positively influence staff motivation, attitudes, and

performance, others may contribute to ineffective leadership, increased overtime, higher turnover among nurses, and limited professional development opportunities (Gifford et al., 2002).

According to Gifford et al. (2002), the design and structure of an organization play a key role in influencing nurse retention and commitment, which in turn enhances patient care, job performance, and employee satisfaction. Conversely, organizational challenges can result in unsafe practices, increasing the risk of medication errors, nurse injuries, compromised patient safety, and reduced job satisfaction (Nixon et al., 2015). Both safety culture and safety climate are rooted in the broader organizational culture and environment. Emphasizing safety within an organization promotes better communication, effective staffing and leadership, and a unified focus on health and safety goals (Almost et al., 2018; Sherwood, 2015).

Safety culture refers to the collective beliefs, attitudes, and perceptions that individuals and teams hold about occupational safety and health practices (Harris, 2013; O'Donovan et al., 2019; Saleh et al., 2015). Closely tied to this is the safety environment, which reflects the group's shared perceptions of workplace safety (Clarke, 2006; Hyun & Eun-Kyung, 2021). Both organizational and safety cultures influence the work environment and can be linked to workplace safety issues. Samur and Intepeler (2017) emphasize that a supportive and positive work atmosphere is vital for nurses to perform effectively, achieve organizational goals, ensure quality care, and maintain their health and safety.

A strong safety culture not only improves working conditions but also reduces illness and injury rates, boosts employee morale, enhances retention, and drives improvements in patient care quality (Harris, 2013). A safe and healthy work environment lowers the likelihood of accidents and occupational illnesses. Thus, organizational culture plays a significant role in shaping nurses' health and safety outcomes (Hammer et al., 2019). Leadership is crucial in promoting preventive measures and fostering a culture of safety and health. Effective leadership can transform organizational culture and improve overall performance (Sproat, 2021). Strong leadership is essential to achieving organizational goals and influencing how health and safety are managed within the workforce (Cooper, 2015; Olawoyin, 2018). Moreover, leadership decisions can positively shape employee behaviors, reduce workplace injuries and illnesses, and cultivate a culture that values staff well-being (Cooper, 2015).

1.3. Leadership

Leadership and organizational culture are two key elements that significantly influence organizational performance (Casida & Pinto-Zipp, 2008). Because the term "leadership" applies across various disciplines, its definition can vary depending on the context. Generally, leadership is understood as the process by which managers guide and influence employee behavior to achieve set goals (Kleinman, 2004; Saleh et al., 2018).

In healthcare, effective leadership is vital for ensuring high-quality patient care, minimizing medical errors, and maintaining a safe and positive work environment for staff (Farag & Gedney-Lose, 2019; Mattson et al., 2019; Saleh et al., 2018). Studies show that leaders play a central role in shaping workplace safety, with their decisions and actions directly impacting safety outcomes (Cooper, 2015; Durta et al., 2021; Farag et al., 2018; Mattson et al., 2019).

Nurse leaders, especially those at the frontline, help build both the organizational and safety cultures, which leads to higher engagement among nursing staff and improved safety performance

(Sherwood, 2015). Research highlights several important leadership qualities, such as showing genuine concern for staff well-being and safety (Cooper, 2015), influencing motivation and job performance (Olawoyin, 2018), and actively contributing to safety enhancement (Hammer et al., 2019).

In nursing, leadership typically follows either a transformational or transactional style (Cooper, 2015; Farag & Gedney-Lose, 2019; Hammer et al., 2019; Stanley, 2008). However, Dirik and Intepeler (2017) note that there are gaps in how leadership's impact on workplace safety is conceptually defined and empirically measured.

1.4. Transformational Leadership

Transformational leaders are known for their positive, people-centered approach, motivating employees to reach or exceed their potential while also promoting their overall health and well-being (Cooper, 2015; Dirik & Intepeler, 2017; Farag & Gedney-Lose, 2019; Hammer et al., 2019). These leaders actively engage with their teams, focusing not only on achieving the organization's goals but also on supporting their staff's needs.

Research indicates that transformational leadership is linked to better health and safety outcomes, including reduced rates of workplace illness and injury and increased employee involvement in safety initiatives (Farag & Gedney-Lose, 2019; Mattson et al., 2019). This leadership style relies on empowering employees to improve organizational performance. It has shown particular value in nursing and other caregiving professions (Stanley, 2008).

However, transformational leadership has faced criticism for lacking depth in both theory and practice, especially given the complexity of healthcare organizations and their leadership structures (Dirik & Intepeler, 2017).

1.5. Statement of the Problem

Nurses operate in diverse environments that significantly impact their health and safety. Due to the high levels of risk and injury associated with nursing, ongoing research is focused on identifying effective strategies to improve workplace health and safety. To ensure the continued delivery of safe, high-quality patient care, it is essential for nurses to work within organizations that provide strong leadership and a supportive culture that promotes safety and reduces the risk of occupational illnesses and injuries.

Studies have identified organizational culture and leadership as key factors influencing nursing performance, safety practices, and overall productivity. However, when these elements are lacking or poorly managed, they can negatively affect job satisfaction, increase the likelihood of illness and injury, and hinder organizational outcomes. Despite these findings, there is still a need for further investigation into which leadership approaches and styles nurses believe are most effective in enhancing organizational culture and workplace safety.

1.6. Significance of the study

Nurses are consistently exposed to occupational hazards, including musculoskeletal injuries, psychological conditions, needlestick injuries, sleep disturbances, burnout, stress, fatigue, and workplace violence (Dressner & Kissinger, 2018; Gamma et al., 2015; NBCI, 2022; OSHA, 2013; U.S. Bureau of Labor Statistics, 2021, 2022; Wunderlich et al., 1996). Research has identified

several contributing factors to these health risks, with organizational culture and leadership within healthcare units being key influences.

Organizational culture plays a crucial role in shaping the workplace environment, which can either support or hinder employee motivation, attitudes, and safety behaviors. Leadership is a core component of this culture and may be embodied by a single leader or a group. Leaders are instrumental in establishing and maintaining the values and practices that define the organization, thereby influencing overall workplace safety and goal achievement. The leadership style adopted can strengthen or weaken the existing culture. In the nursing field, transformational and transactional leadership styles are most common, each with distinct characteristics that may positively or negatively affect organizational culture.

While numerous studies have examined the individual impact of either organizational culture or leadership on nurse safety (Casida & Pinto-Zipp, 2008; Collins et al., 2020; Hyun & Lee, 2021; Lui & Johnston, 2019; McFadden et al., 2015; Stone & Gershon, 2006; Sproat, 2001), there is a lack of research that explores the combined effect of both. Gaining insight into how these two elements interact could help healthcare professionals and institutions identify gaps in their systems. Ultimately, this understanding could lead to improved safety practices, reduced occupational injuries and illnesses, and a reversal of concerning trends in nurse health outcomes.

1.7. Purpose of the Study

This study explores nurses' perceptions, feelings, and views about their work experiences in hospital settings, focusing on leadership, unit-level organizational culture, and the significance of workplace illnesses and injuries. Secondly, it examines how nurses perceive the influence of organizational culture and leadership on their health and safety. Third, the study investigates whether certain leadership behaviors are believed to negatively impact nurse safety. Finally, it identifies perceived leadership and organizational practices that support nurses in providing safe, high-quality patient care while minimizing the risk of illness and injury.

1.8Research Objectives

- To determine the nurses' perception about structural factors related to unit organizational culture, leadership, and safety culture that impacts nurse safety and health?
- To explore the nurses' perception regarding the factors that positively and negatively impact the safety and health of a nurse?
- To identify the nurses' perception regarding practices that aim to prevent adverse safety and health events
- To compare the nurses' perceptions domains among nurses by demographic variables?
- To find out the correlation between the nurses' perceptions domains?

1.9. Research Questions

The research questions are:

- What is nurses' perception about structural factors related to unit organizational culture, leadership, and safety culture that impacts nurse safety and health?
- What is the nurses' perception regarding the factors that positively and negatively impact the safety and health of a nurse?
- What is the nurses' perception regarding practices that aim to prevent adverse safety and health events?
- Is there a significant difference in the nurses' perceptions domains by demographic variables?

1. Is there a correlation between the nurses' perceptions domains?

1.11 Research Hypothesis:

- There are no significant differences in hospital-based nurses' perceptions by demographic variables about:
  - structural factors related to unit organizational culture, leadership, and safety culture that impacts nurse safety and health?
  - experienced-related factors that positively and negatively impact the safety and health of a nurse?
  - practices that deter adverse safety and health events?
- There is no correlation between the different the nurses' perceptions domains.

1.13. Definition of Terms

Nursing: Encompasses autonomous and collaborative care for individuals of various ages, groups, and communities; promotes health and prevention of illness; cares for the ill, disabled, and dying (World Health Organization, n.d.).

Organizational Climate: Measurable properties of the work environment based on the perceptions of the individuals and their behavioral response (Hoy, 1990).
Organizational Culture: A system of beliefs shared by the members of the organization that distinguishes the organization from other organizations (Hoy, 1990).
Post-Anesthesia Care Unit (PACU): A unit in the hospital where nurses observe postoperative patients whose physical and mental functions are different from other patients (Guo et al., 2022).
Registered Nurse: A licensed healthcare professional who practices professional nursing (Casper, 2018).
Safety: The condition of safety from undergoing or causing hurt, injury, or loss (Merriam-Webster, n.d.).
Safety Climate: Employees' shared perceptions about the importance of safety within their organization are associated with workplace safety (Hyun & Hyun, 2021).

Safety Culture: Common set of beliefs, assumptions, and behaviors that influence how workers think and act with regard to safety (Harris, 2013).

Transformational Leadership: Set of transformative actions promoted by the leader over their followers; to raise awareness about the importance of the activities performed and the well-done work; acting in defense of the institution's mission; and the reach of its goals (Ferreira et al., 2020).

Transactional Leadership: Transactional leaders emphasize work standards using reward or discipline-based methods to influence the worker's performance (Olawoyin, 2018).

Chapter 2

.2.1. Literature

2.2. Review Introduction

Nurses' health and safety are significantly influenced by the physically demanding and high-risk nature of their profession (Dutra et al., 2021; Labrague, 2021; Marceau et al., 2022; Stone & Gershon, 2006). Historically, nurses have experienced higher-than-average rates of workplace-related illnesses and injuries (Dressner & Samuel, 2018), a situation that has been further exacerbated by the COVID-19 pandemic (Qureshi et al., 2022). Common health issues faced by nurses include burnout, stress, and fatigue (Samur & Intepeler, 2017; Siami et al., 2023), musculoskeletal injuries such as strains and sprains (Almost et al., 2018; Hopcia et al., 2012; Medeiros et al., 2021; Mullen et al., 2015), as well as injuries from needle sticks and other sharp instruments (Kim & Moon, 2021; Persaud & Mitchell, 2021; Stone & Gershon, 2006; Wang et al., 2003).

Ongoing research seeks to better understand the causes behind these health problems and to find effective strategies to reduce their prevalence. Many studies have identified weak organizational culture—particularly poor safety culture—and ineffective leadership as key contributors to nurses' illness and injury rates. Scholars such as Harris (2013), Lee et al. (2021), Robertson et al. (2021), and Weiner (2009) suggest that an absence of a supportive safety culture can negatively affect nurses' well-being. Similarly, research by Casida & Pinto-Zipp (2008), Labrague (2021), McFadden et al. (2015), and Rouse (2009) links inadequate leadership to increased rates of illness and injury among nurses.

Weiner (2009) notes that organizational culture can have both positive and negative consequences for a workplace, which directly influences employee performance (Casida & Pinto-Zipp, 2008; Gifford et al., 2002). A lack of commitment to safety within an organization can significantly undermine safety outcomes (Lee et al., 2021). Achieving safety goals also requires leadership that is genuinely committed to maintaining a safe work environment (Hammer et al., 2019; Olawoyin, 2018). In nursing, a range of leadership styles is observed, including authentic, transformational, transactional, and laissez-faire approaches.

However, studies suggest that transformational and transactional leadership are the most widely applied styles in nursing contexts (Casida & Pinto-Zipp, 2008; Cooper, 2015; Collins et al., 2020; Farag & Gedney-Lose, 2019; Hammer et al., 2019; Kahn et al., 2018; Magbity & Wilson, 2020; Stanley, 2008). Each of these leadership styles has unique effects on nurses' health and safety as well as on the broader organizational culture.

To enhance both patient and nurse safety, it is essential to understand how leadership and organizational culture influence nurses' well-being. Nurses who are unwell or injured may not be able to provide the safe, effective care patients require. A safer, healthier work environment—achieved by recognizing the impact of illness and injury and implementing effective interventions—can lead to improved outcomes for both patients and healthcare staff.

.1.3 Historical Background of Occupational Safety and Health

The tragic Triangle Shirtwaist Factory fire, which occurred in New York City on March 25, 1911, resulted in the deaths of 146 individuals (Sanchez, 2006). The disaster was marked by a series of preventable failures—such as low water pressure that hindered firefighting efforts, doors that opened inward trapping people inside, and locked exits that left workers with no choice but to jump or succumb to the flames (Sanchez, 2006). This event marked a pivotal moment in workplace safety history, prompting the formation of the American Society of Safety Engineers (ASSE), now known as the American Society of Safety Professionals (ASSP), on October 14, 1911 (Greer, 2001). The organization was dedicated to advancing safety engineering and accident prevention and played a key role in raising national awareness about workplace safety, influencing both the White House and Congress (Greer, 2001).

A major legislative milestone followed on December 29, 1970, when President Richard Nixon signed the Occupational Safety and Health Act (OSH Act) into law, establishing the Occupational Safety and Health Administration (OSHA) (Bartel & Thomas, 1985; Goldstein, 1971; Michaels & Barab, 2020). Described as a groundbreaking and transformative piece of legislation, the OSH Act aimed to ensure safe and healthy working conditions for employees in the U.S. and to reduce occupational hazards (Currie, 1976). Through the OSH Act, OSHA gained the authority to enforce safety regulations, aiming to prevent workplace injuries and save lives (Michaels & Barab, 2020; Thompson & Scicchitano, 1985).

As outlined in Appendix A (Occupational Safety and Health, 1970), the primary purpose of the OSH Act is to ensure that all workers have access to safe and healthy job conditions. OSHA has significantly advanced worker protection by enforcing laws that require employers to provide a hazard-free work environment (McPhaul, 2021). The Act emphasizes the development and enforcement of federal occupational health and safety standards (Goldstein, 1971; Thompson & Scicchitano, 1985). However, ultimate responsibility for maintaining safe workplaces lies with employers (Bartel & Thomas, 1985; McPhaul, 2021; Persaud & Mitchel, 2021).

Healthcare workers, including nurses, face a wide range of occupational hazards that can affect their physical and mental well-being. These include exposure to infectious agents and bloodborne pathogens, contact with hazardous chemicals and pharmaceuticals, inhalation of anesthetic gases, respiratory threats, ergonomic risks from repetitive movements and heavy lifting, radiation exposure, risks associated with laser use, laboratory hazards, and incidents of workplace violence ("Healthcare," n.d.). Nurses may encounter chemicals such as formaldehyde, ethylene oxide, glutaraldehyde, and peracetic acid, which are commonly used in sterilization and preservation

procedures ("Healthcare," n.d.). These exposures have been identified as major contributors to workplace injuries and illnesses among hospital nurses. The healthcare industry continues to report some of the highest rates of occupational injury and illness.

To help address these risks, OSHA offers educational materials and training programs aimed at reducing workplace injuries in healthcare settings. However, the responsibility for creating a safe work environment ultimately falls on employers. Research suggests that healthcare organizations must take proactive steps to better protect nurses' health and safety (Almost et al., 2018; Farag & Gedney-Lose, 2019; Kao et al., 2021; O'Donovan et al., 2019). Improving working conditions can lead to significant benefits for nurses' well-being and safety (Dutra et al., 2021; Labrague, 2021; Marceau et al., 2022; Stone & Gershon, 2006).

2.4 The Nursing Profession

Florence Nightingale is widely regarded as the founder of modern nursing and a key figure in advancing public health during the 19th century (Strickler, 2017; Winkelstein, 2009). Born on May 12, 1820, in Florence, Italy, to a wealthy British family, she would go on to revolutionize healthcare (History.com Editors, 2009).

During her time, nursing was not seen as a reputable profession. Nevertheless, in 1851, she defied her family's expectations and went to Kaiserwerth, Germany, to pursue nursing studies (Strickler, 2017). After two months of training there, she continued her education in Paris for six months (Strickler, 2017). Upon returning to England, she began working at a hospital in London and was soon promoted to Head of Nursing. In that role, she significantly improved hygiene standards, leading to a major reduction in patient mortality (History.com Editors, 2009).

When the Crimean War broke out in October 1853, lasting until 1856, the British and Russian empires clashed over control of the Ottoman Empire (History.com Editors, 2009). Reports in British newspapers exposed dire hospital conditions, including overcrowding, poor sanitation, inadequate care, and even sewage contaminating living quarters (Strickler, 2017; Winkelstein, 2009). As a result, nearly 42% of British soldiers died due to these conditions (Dossey, 2010). In response, the Secretary of War, Sir Sidney Herbert, invited Nightingale in 1854 to assemble a team of nurses to improve military hospital care. She departed for Crimea with over 30 nurses.

Upon arrival, Nightingale and her team implemented major sanitary reforms—ensuring patients were clean and properly clothed, ventilating hospital wards, and organizing the use of clean linens (History.com Editors, 2009; Strickler, 2017; Winkelstein, 2009). She also introduced a patient library and a special kitchen that provided nutritious meals tailored to specific dietary needs (History.com Editors, 2009). A skilled statistician, Nightingale meticulously documented hospital data, revealing that within six months, the death rate had decreased from 42% to 2% (Dossey, 2010; Strickler, 2017; Winkelstein, 2009).

Florence Nightingale's legacy of compassion and dedication continues to serve as a model for nursing practice today (Bradshaw, 2017; Currie & Carr-Hill, 2013). However, the definition of nursing and what it means to be a nurse has evolved over time (Currie & Carr-Hill, 2013; Marshall, 1988; Wilson, 2005). Today, a registered nurse (RN) is someone who has completed an accredited program, met the necessary qualifications, and passed a licensing exam (Currie & Carr-Hill, 2013; Daly et al., 2009).

Scholars offer various perspectives on the key attributes of nursing. While wording may vary, these definitions consistently highlight the core values and responsibilities expected of nurses. According to Wilson (2005), nursing involves promoting health, preventing illness and injury, alleviating suffering, and advocating for the care of individuals, families, and communities. This definition underscores the holistic nature of nursing care.

Similarly, Wilson (2005) describes nursing as a field focused on minimizing harm, enhancing well-being, and advocating for patient care, emphasizing the vital role nurses play in improving individual and public health. Currie & Carr-Hill (2013) define nursing as a profession that provides care independently and collaboratively across all age groups and health conditions, whether in wellness or illness, in various settings. Their definition also includes health education, research, policy advocacy, and system management.

These definitions reflect the complexity and diversity of nursing as a profession, requiring a broad set of skills, knowledge, and values to deliver quality patient care.

Many of Florence Nightingale's core principles remain central to nursing today, especially the commitment to delivering safe, high-quality care (Olans et al., 2022; Samur & Intepeler, 2017; Seo & Lee, 2022). Numerous studies have emphasized the expectations placed on nurses to maintain high standards of care (Basahel, 2021; Farmsworth et al., 1994; Hammer et al., 2019; Hopcia et al., 2012; Kim & Jung, 2019; Marceau et al., 2022; Mullen et al., 2015).

2.5 .Relevancy of Illness and Injury Among Nurses

Hospital-based nurses face numerous occupational hazards that can lead to illness and injury due to the nature of their work (Goldstein & Benoit, 1975; Wunderlich et al., 1996). Because nurses provide continuous, around-the-clock patient care, they are particularly vulnerable to work-related health risks (Lannon & Reichelt, 1998). In 1993, the healthcare industry—especially hospitals and long-term care facilities—was one of the largest employers in the United States, with over half of its workforce based in these settings (Wunderlich, 1996).

That same year, private industry reported 6.7 million cases of work-related injuries and illnesses, with an incidence rate of 8.5 per 100 employees. Approximately 6.3 million of these cases led to time away from work, and hospitals alone accounted for 2 million of those cases—making up 30% of all reported injuries and ranking as the second-highest industry for such incidents, with more than 100,000 annually (Wunderlich, 1996).

Between 1983 and 1993, injury rates in hospitals rose to over 12 cases per 100 workers, while rates in other private industries either remained steady or declined (Lannon & Reichelt, 1998; Wunderlich, 1996). In 2001, hospitals continued to rank second among eight major industries, again reporting more than 100,000 illnesses and injuries (Stone & Gershon, 2006). That year, the injury and illness rate for nurses in the private sector was 13.5 per 100 workers, significantly higher than the national average of 1.8 (Stone & Gershon, 2006).

By 2016, there were approximately 3 million registered nurses employed across various sectors, with 61% working in hospitals. That year, 19,790 cases of illness or non-fatal injury resulted in at least one missed workday, translating to a rate of 104.2 incidents per 10,000 employees (Dressner & Kissinger, 2018). In May 2019, the private sector employed nearly 3 million nurses, recording

20,150 injury or illness cases and a rate of 102.1 per 10,000 workers (U.S. Bureau of Labor Statistics, 2021).

As of May 2020, nearly 3 million nurses were working in the private sector. Alarmingly, 78,740 cases of illness or injury were reported that year, with an incidence rate of 390.6 per 10,000 workers—each resulting in at least one missed workday (U.S. Bureau of Labor Statistics, 2022). These consistently high and rising rates reflect the ongoing occupational risks in nursing, with a significant spike in 2020 attributed to COVID-19 infections (U.S. Bureau of Labor Statistics, 2021).

Historically, hospital staff—particularly nurses—have experienced higher-than-average rates of workplace illness and injury (Dressner & Samuel, 2018). Data shows these rates have continued to rise over time. While researchers are still working to understand the root causes and effective prevention strategies, studies suggest that weak organizational culture—especially poor safety culture (Harris, 2013; Lee et al., 2021; Robertson et al., 2021; Weiner, 2009)—as well as a lack of strong leadership (Casida & Pinto-Zipp, 2008; Labrague, 2021; McFadden et al., 2015; Rouse, 2009) may significantly contribute to the high incidence of illness and injury among nurses.

Summary

Chapter 2 reviews literature on nurses' health and safety, highlighting their heightened risk of illness and injury due to the demanding nature of their work. Common issues include stress, fatigue, musculoskeletal injuries, and needle-stick accidents, with rates escalating during the COVID-19 pandemic. Research links weak organizational and safety culture, along with poor leadership, to these risks, while transformational and transactional leadership are noted as the most influential in promoting safety. The chapter also traces the history of occupational safety, from the 1911 Triangle Shirtwaist fire to the 1970 OSH Act and OSHA's role in enforcing workplace protections. It further outlines Florence Nightingale's foundational contributions to nursing and evolving definitions of the profession. Finally, statistics reveal persistently high and rising injury and illness rates among nurses, underscoring the urgent need for stronger leadership and organizational commitment to safety in healthcare.

Chapter Three

3.1. Methodology

3.2. Introduction

The purpose of this exploratory study was to examine the perspectives, feelings, and opinions hospital-based nurses have about their experiences within the hospital encompassed around unit organizational culture, leadership, and the prominence of illness and injury. Using a descriptive quantitative cross-sectional method design, the study aimed to determine the perceived effects of organizational culture and leadership on the safety and health of nurses; determine if a specific practice of leadership negatively influences the safety of nurses; and identify organizational and leadership practices that can allow nurses to provide quality and safe patient care while not at significant risk of illness and injury for themselves. The safety and health of nurses is an ongoing concern in the nursing profession and has been discussed for years; however, it is crucial to investigate what factors currently contribute to the deficiencies or improvement of the safety and health of nurses.

3.3. Study setting and participants

The study was conducted in the southern region of the West Bank, Palestine, involving nursing staff from four hospitals—two governmental and two private—located in Bethlehem and Hebron. Nurses were grouped according to their main assignments in various hospital units, including ICU, NICU, PICU, MICU, Critical Care Unit, Emergency Department, Labor and Delivery, Medical-Surgical, Oncology, Operating Room, and Psychiatric units.

3.4. Study Design

This study employed a descriptive cross-sectional research design, enabling the collection of quantitave data that will be analyzed and interpreted to offer a thorough understanding of the subject under investigation.

Population and Sampling

This study focused on Palestinian nurses employed across various departments in selected hospitals located in the southern West Bank, who formed the accessible population. A convenience sampling method was used—a non-probability approach frequently applied in health research due to its practicality and cost-effectiveness (Etikan et al., 2016). This technique allowed researchers to efficiently select and recruit an adequate number of nurses working in different wards from both governmental and private hospitals. Additionally, it facilitated the collection of a suitable and representative sample of nurses from the southern region of the West Bank.

3.5. Sample Size

The sample size for this study was calculated using Rawsoft software, with a "population size of 1020, a response distribution of 50%, a margin of error of 5%, and a confidence level of 95%". Based on these parameters, the minimum required sample size was set at 280 participants. To account for the possibility of attrition or non-response 10%, the target sample size was increased to 320 participants. Ultimately, 304 participants completed the questionnaires.

Eligibility Criteria

This study was adhered to the following inclusion and exclusion criteria:

3.6. Inclusion Criteria

- Nurses who agreed to participate in the study.
- Nurses working full-time in different wards
- Nurses with one year of experience or more.

Exclusion Criteria

- Nurses who refused to participate in the study.
- Nurses working part-time, volunteer and nursing students.
- Nurses who were on leave or who were unable to participate.

Study Instruments

A questionnaire was developed to align with the research questions. The questionnaire consists of two parts:

Part one: includes the demographic variables.

Part two: includes questions using a 4-Point Likert Scale about:

- Perceptions on Safety Culture (Safe Work Procedures, Reporting, Illness and Injury Management & Return to Work),
- Perceptions on Unit Organizational Culture and
- Perceptions on Leadership.

Data Collection Technique

Before beginning data collection, ethical approval was obtained from the research ethics committee (Approval No. RESC/2025-92), as well as from the authorized personnel at each participating hospital and the Ministry of Health (MOH).

Questionnaires served as the primary data collection tool, involving the participation of all eligible nurses. Data were collected during hospital visits, where the researcher first introduced the study, confirmed participants' eligibility, and obtained their informed consent. For nurses who had difficulty reading or understanding the questionnaire, trained research assistants read the questions aloud and accurately recorded their responses.

Each data collection session lasted approximately 15–20 minutes per participant, with breaks provided if needed. To maintain confidentiality, participants were assigned random numerical codes, and no identifying personal information was recorded. Data quality was ensured through routine monitoring and techniques such as data imputation to address any missing responses. The study strictly followed ethical guidelines, particularly in safeguarding confidentiality and securing informed consent.

3.7.Data Analysis:

- Once the data collection process is completed, a thorough cleaning process was undertaken to ensure the data is free of errors, inconsistencies, or duplications. This involved a series of meticulous steps, including verifying data accuracy, correcting discrepancies, and removing duplicates.
- Following data cleaning, the analysis begins. The researcher created a data subset of items from the results of the quantitative data, using descriptive statistical techniques to summarize the nurses' perspectives, feelings, and opinions.
- Data was summarized in the text to examine overall perceptions of the respondents. Results were organized by research questions.
- Independent samples t test and One Way ANOVA were used to do the comparison between the study participants by demographic variables, in addition to the Pearson correlation coefficient.

3.8. Confidentiality and Data Security:

- Before nurses take part in the questionnaire, the researcher secured approval from the ethical committee at Al-Quds University as well as from the involved institutions. Participant information will be kept confidential and shared only with the researcher and their advisor on a need-to-know basis.
- Each participant required to provide informed consent prior to receiving the questionnaire.
- Participants are instructed not to include any personal identifiers such as their name, email, or phone number on the questionnaire, even if they are open to further contact by the researcher.

CHAPTER 4

4.1. RESULTS

4.2 INTRODUCTION

The main aim of this study was to explore the perspectives, emotions, and opinions of registered nurses within the hospital environment. Specifically, it sought to uncover the key factors that affect nurses' safety and well-being, with a particular focus on the role of organizational culture and leadership within hospital units. A mixed-methods design was employed, incorporating a structured questionnaire administered to registered nurses across various hospital units to gather quantitative data. The results offer meaningful insights for healthcare institutions and policymakers, supporting the development of strategies to enhance nurse safety, job satisfaction, and overall well-being. Ultimately, the study strives to support the broader goal of fostering a safe, supportive, and healthy workplace for nurses in the healthcare sector.

Summary of Procedures

A total of 320 structured self-administered questionnaires were distributed to nurses across various units of the selected hospitals using a convenience sampling method. Out of these, 310 questionnaires were returned completed. However, after reviewing the responses, some were found to be incomplete. Following data cleaning, 300 valid questionnaires were retained for the final analysis, yielding a response rate of 94%.

4.3 Demographic characteristics of the participants

As shown in Table 4.2, the majority of surveyed nurses were female, accounting for 185 (61.7%), while 115 (38.3%) were male. In terms of age distribution, the largest group of participants fell within the 25–34 age range, making up 139 (46.3%) of the sample, followed by those aged 35–44 at 102 (34.0%). The smallest age group was 18–24, comprising only 17 (5.7%) of respondents.

Regarding educational background, most participants (n = 202, 67.3%) held a bachelor's degree as their highest qualification, indicating that a substantial proportion had completed undergraduate nursing education. Job titles were categorized into nurse manager, staff nurse, midwife, and other roles, with the majority (254 nurses, 84.7%) identified as staff nurses.

The respondents also varied in terms of work experience. Nearly half had over 10 years of experience (n = 138, 46.0%), and 70 nurses (23.3%) had worked for 21 years or more. About one-fifth of the sample had between 1–3 years and 7–10 years of experience (n = 40, 13.3%).
In terms of unit distribution, the highest number of responses came from the Intensive Care Unit (ICU) with 65 nurses (21.7%), followed by the Emergency Room/Emergency Department with 62 nurses (20.7%), and the medical unit with 56 nurses (18.7%). Smaller proportions were drawn from other units, totaling 37 respondents (12.3%), as detailed in Table 4.2.

Table (4.1): Demographic characteristics of the Respondents

Characteristic	Numbers	Percentages (%)
Gender		
Male	115	38.3
Female	185	61.7
Age-group		
18-24	17	5.7
25-34	139	46.3
35-44	102	34.0
more than 44	42	14.0
Qualification		
Diploma	85	28.3
Bachelor	202	67.3
Master	13	4.3
Job Title		
Head nurse	16	5.3
Staff nurse	254	84.7
Midwife	25	8.3
Others	5	1.7
Experience		
1-3	40	13.3
4-6	52	17.3
7-10	70	23.3
more than 10	138	46.0
Working Unit		
Emergency	62	20.7
ICU	65	21.7
Pediatric	39	13.0
Medical	56	18.7
Surgery	41	13.7
Others	37	12.3

4.4.Research Question One

The initial research question examined hospital-based nurses' perceptions regarding how structural elements affect their health and safety, with a particular emphasis on the roles of organizational culture, leadership, and safety practices.

4.5. Nurses' Perceptions About the Effects of Organizational Culture and Leadership On Nurse Safety

Overall, nurses' perceptions of the safety culture were rated as good, with an average score of 3.21. Specifically, the dimension of Safe Work Procedures received a good rating with a mean score of 3.39, and Reporting also scored well at 3.61. However, the dimension of Illness and Injury Management & Return to Work was rated as adequate, with a lower mean score of 2.25.

Regarding perceptions of Unit Organizational Culture, the overall mean score was 3.41, indicating a good rating. The specific dimension of Unit Organizational Culture scored 3.71, and the nurses' perceptions of their current unit scored 3.15, both of which were also considered good. Lastly, nurses' perceptions of leadership were rated as good, with a mean score of 3.31 (Table 4.3).

Table 4.2: Nurses' Perceptions About the Effects of Organizational Culture and Leadership On Nurse Safety

Dimension	N	Mean	Std. Deviation
Perceptions on Safety Culture	300	3.21	0.52
Safe Work Procedures	300	3.39	1.05
Reporting	300	3.61	0.67
Illness and Injury Management & Return to Work	300	2.25	0.64
Perceptions on Unit Organizational Culture	300	3.41	0.55
Unit Organizational Culture	300	3.71	0.86
My current unit	300	3.15	0.72
Perceptions on Leadership	300	3.31	0.55

4.6. Safety Culture

Nurses were presented with several questions to explore their perceptions of workplace safety. A significant majority, 74.1% (n = 222), reported that they prefer to seek help when unsure rather than attempting to navigate procedures on their own. Similarly, 77.0% (n = 231) indicated that they tend to push themselves before requesting assistance. About two-thirds (68.0%, n = 204) stated that they continue delivering patient care even when they are sick or injured. Additionally, 74.1% (n = 222) admitted to continuing patient care even in the absence of personal protective equipment (PPE). On a more positive note regarding safety adherence, 61.3% (n = 184) disagreed or strongly disagreed with the notion of skipping safety procedures to provide better

patient care, as detailed in Table 4.4.

Table 4.3: Perception on Safety Culture: Safe Work Procedures (n=300)

Question	N	Mean(SD)	Strongly disagree/ disagree	Neutral	Strongly agree/agree
When I am faced with a strenuous task, I tend to push myself before asking for help.	300	3.50(1.15)	69(23.0)	39(13.0)	192(64.0)
I tend to skip safety procedures to effectively provide patient care.	300	3.43(1.26)	184(61.3)	33(11.0)	83(27.7)
If I am unsure of workplace procedures, I ask for help rather than figure it out on my own.	300	3.33(1.33)	95(31.7)	22(7.3)	183(61(.0)
When PPE is not readily available, I continue to provide patient care.	300	3.43(1.22)	78(26.0)	47(15.7)	175(58.4)
If I am ill and/or injured, I continue to provide patient care.	300	3.28(1.26)	96(32.0)	43(14.3)	161(53.7)

4.7. Perceptions on Safety Culture: Reporting

Table 4.5 presents nurses' perceptions regarding safety-related reporting in the workplace, offering insights into their experiences with reporting hazards and safety concerns. Nearly three-quarters of the participants (72.6%, n = 218) agreed or strongly agreed that their workplace has an effective process for reporting such issues, and 72.0% (n = 216) emphasized the importance of reporting safety concerns. Additionally, 66.3% (n = 199) felt comfortable reporting safety issues, while 57.7% (n = 173) believed that leadership makes efforts to identify the root of the problem.

However, 64.0% (n = 192) disagreed or strongly disagreed with the notion that leadership tends to blame individuals after safety issues are reported.

Overall, the findings suggest that while a considerable number of nurses feel confident in the reporting system and recognize its value, concerns remain regarding how leadership handles safety reports—particularly around perceptions of blame—indicating potential areas for improvement.

Table 4.4: Perceptions on Safety Culture: Reporting

Question	N	Mean(SD)	Strongly disagree/ disagree	Neutral	Strongly agree/agree
After reporting safety issues, leadership blames people.	300	3.47(1.02)	61(20.3)	47(15.7)	192(64.0)
I feel comfortable reporting safety issues to my organization.	300	3.77(1.17)	56(18.7)	45(15.0)	199(66.3)
Reporting workplace safety concerns is important to my organization.	300	3.68(1.01)	50(16.6)	34(11.3)	216(72.0)
My workplace has an effective reporting process for hazards and/or safety concerns.	300	3.79(1.30)	69(23.0)	13(4.3)	218(72.6)
After reporting safety issues, leadership tries to find the problem.	300	3.34(1.34)	95(31.7)	32(10.7)	173(57.7)

4.8. Perceptions on Safety Culture: Illness and Injury Management & Return to Work

Nurses were asked a series of questions (Table 4.6) to understand their views on managing illness and injury, as well as their experiences with the return-to-work process. A significant majority, 70.7% (n = 212), agreed or strongly agreed that they notify their leadership when they experience illness or injury while on the job. More than half of the respondents (65.3%, n = 196) disagreed or strongly disagreed with the notion that their leaders expect them to continue working despite being ill or injured. Similarly, 60.3% (n = 181) disagreed or strongly disagreed that their leaders make them feel guilty for taking time off due to illness or injury.

Table 45: Perceptions on Safety Culture: Illness and Injury Management & Return to Work

Question	N	Mean(SD)	Strongly disagree/ disagree	Neutral	Strongly agree/agree
If I become ill and/or injured at work, my leaders expect me to continue work.	300	2.35(.97)	196(65.3)	51(17.0)	53(17.7)
My leaders make me feel bad for calling out/off when I am ill and/or injured.	300	2.25(.88)	181(60.3)	97(32.3)	22(7.3)
I ensure leadership knows if I have experienced an illness and/or injury while on duty.	300	2.14(1.06)	41(13.6)	47(15.7)	212(70.7)

4.9. Organizational Culture

Nurses responded to a set of questions designed to capture their perceptions of their respective units. Just over half (55.0%, n = 165) agreed or strongly agreed that communication within their unit was effective. A similar proportion (55.4%, n = 166) felt their unit offered opportunities for personal and professional development, while 59.4% (n = 148) agreed that their unit encouraged collaboration among colleagues. Additionally, 37.3% (n = 112) believed their unit had effective policies and procedures, and 68.0% (n = 151) felt their unit helped them understand the organization's values, beliefs, and goals.

A smaller percentage (37.7%, n = 113) agreed that leadership within their unit was visible and accessible, and 60.5% (n = 178) felt their unit had clear organizational goals. About half (50.6%, n = 152) agreed or strongly agreed that their unit was influential. When asked whether their unit was free from workplace politics, the majority—75.0% (n = 225)—disagreed or strongly disagreed, as shown in Table 4.7.

Table 4.6: Perceptions on Unit-Organizational Culture

Question	N	Mean(SD)	Strongly disagree/ disagree	Neutral	Strongly agree/agree
Has good communication.	300	3.56(1.26)	76(25.3)	59(19.7)	165(55.0)
Has opportunities for me to better myself.	300	3.56(1.21)	71(23.6)	63(21.0)	166(55.4)
Has opportunities for collaboration.	300	3.41(1.27)	76(25.3)	76(25.3)	148(59.4)
Has effective policies and procedures.	300	3.09(1.25)	98(32.7)	90(30.0)	112(37.3)
Has leaders that are visible and accessible.	300	3.07(1.18)	87(29.0)	100(26.7)	113(37.7)
Is free of workplace politics.	300	1.99(.95)	225(75.0)	48(16.0)	27(9.0)
Has clear organizational goals	300	3.07(1.13)	105(35.0)	43(14.3)	152(50.6)
Ensures I have understanding of the organizations' values, beliefs, and goals.	300	3.60(1.16)	63(21.0)	33(11.0)	151(68.0)
Is influential.	300	2.98(1.16)	125(41.7)	28(9.3)	147(49.0)

4.10. Transformational and Transactional Leadership

Table 4.8 presents nurses' perspectives on leadership, with a focus on characteristics of transformational and transactional leadership styles. A large majority (78.3%, n = 235) agreed or strongly agreed that their leaders emphasize maintaining workplace standards. Furthermore, 60.6% (n = 182) felt that leadership challenges themselves and/or nurses to prioritize safety, and 60.0% (n = 180) agreed that leadership effectively communicates the importance of practicing safety.

More than half (62.7%, n = 187) agreed or strongly agreed that leadership tends to prioritize daily operations over safety practices. Similarly, 57.0% (n = 171) believed that leadership encourages

staff to advocate for safety, while 44.3% (n = 133) reported that leadership uses corrective feedback when unsafe practices are observed. Over half (57.0%, n = 171) felt that leadership promotes safe behavior within their units, and 61.7% (n = 185) agreed that leaders motivate themselves and others to engage in safe practices. Additionally, 63.0% (n = 189) of nurses agreed or strongly agreed that leadership is supportive and responsive to their safety concerns.

In contrast, only 41.4% (n = 124) agreed or strongly agreed that leadership provides negative feedback when safety practices are not followed. A majority (69.0%, n = 207) disagreed or strongly disagreed that leadership offers rewards or incentives for safe behavior, and an even larger majority (76.7%, n = 230) rejected the idea that leadership punishes staff for violating safety protocols. Around 37.7% (n = 113) disagreed or strongly disagreed that leadership helps them improve their safety goals. Finally, 63.3% (n = 190) agreed or strongly agreed that leadership monitors their safety behavior to ensure compliance with safety standards.

Table 4.7: Perceptions on Leadership

Question	N	Mean(SD)	Strongly disagree/ disagree	Neutral	Strongly agree/agree
Promotes positive safety behavior.	300	3.29(1.02)	73(24.4)	42(14.0)	185(61.7)
Motivates myself and/or other nurses to practice safety.	300	3.53(1.02)	57(19.0)	59(19.7)	184(61.3)
Communicates to practice safety.	300	3.26(1.11)	70(23.3)	50(16.7)	180(60.0)
Challenges myself and/or other nurses to practice safety.	300	3.56(1.40)	90(30.0)	28(9.3)	182(60.6)
Supports and listens to my safety concerns and/or needs.	300	3.75(1.35)	82(27.3)	29(9.7)	189(63.0)
Encourages me to advocate to others about safety.	300	3.47(1.28)	84(28.0)	45(15.0)	171(57.0)
Helps me improve on my safety goals.	300	3.13(1.26)	113(37.7)	65(21.7)	122(40.6)
Offers me rewards or incentives for practicing safety.	300	2.29(1.23)	207(69.0)	38(12.7)	55(18.3)
Uses corrective criticism if I am unsafe.	300	3.19(1.41)	120(36.7)	57(19.0)	133(44.3)
Provides negative feedback if I don't practice safety.	300	3.09(1.24)	111(37.0)	65(21.7)	124(41.4)
Monitors my safety behavior to see if I am following safety rules.	300	3.69(1.28)	81(27.0)	29(9.7)	190(63.3)
Punishes me and/or other nurses if safety rules are not followed.	300	2.12(1.01)	230(76.7)	33(11.0)	37(12.3)
Focuses more on daily operations rather than safety practices.	300	3.65(1.14)	60(20.0)	52(17.3)	187(62.7)
Emphasizes workplace standards.	300	4.01(1.22)	54(18.0)	11(3.7)	235(78.3)

4.11. Illness and/or Injury Experienced on the Job

Table displayed the percentage of nurses who reported experiencing each type of illness or injury. Nurses could select all illnesses and injuries that applied, and the percentage corresponding to each ailment is calculated based on the total number of nurses (n = 300). The findings showed that nurses are exposed to a wide range of occupational hazards. Stress, being the most commonly reported hazard, was cited by 90.0% (n = 270) of respondents. Fatigue and burnout were also commonly reported by 83.3% (n = 250) and 70.0% (n = 110) of the respondents, respectively. Additionally, over half of the nurses (59.3%, n = 178) reported experiencing soreness and pain while performing their duties. Apart from these hazards, over half 160(53.3&) of nurses reported overexertion in lifting or lowering, and 186(62.0%) bruises or contusions. The data in Table 4.9 highlight that nurses encounter several other occupational hazards that can lead to various illnesses and injuries. Musculoskeletal injuries were reported by 22.7% (n = 68) of the nurses. Other illnesses and injuries, such as strains and sprains caused by sudden or forceful movements, slip, trip or fall incidents, and sharps injuries and needle sticks, occurred less frequently but can have serious consequences.

Table 4.8: Illness and/or Injury Experienced on the Job

Question	**n**	**%**
I have encountered this illness and/or injury while working as a nurse within the past year.		
Musculoskeletal	68	22.7
Burnout	210	70.0
Strain and Sprains	42	14.0
Slips, Trips, and Falls	28	9.3
Sharps Injury and Needle Sticks	31	10.3
Stress	270	90.0
Illness (i.e., Influenza, etc.)	140	46.7
Fatigue	250	83.3
Mental Health Related	104	34.7
Struck by Object or Equipment	60	20.0
Overexertion in Lifting or Lowering	160	53.3
Bruises, Contusions	186	62.0
Soreness, Pain	178	59.3
Intentional Injury by Other Person	61	20.3
No answer chosen	10	3.3

4.12. Perceptions on Unit-Organizational Culture: Organizational Practices

Table 4.10 provides a summary of nurses' perceptions regarding organizational practices aimed at preventing adverse safety and health incidents. The survey sought to understand how nurses view

their unit's commitment to safety. The results showed that nearly two-thirds (65.0%, n = 195) agreed or strongly agreed that their unit promotes safety and safe work practices. A majority (63.3%, n = 190) also agreed or strongly agreed that safety-oriented training is provided in their workplace, and 77.6% (n = 233) felt their unit actively works to reduce risks affecting nurse safety and health.

Additionally, 54.0% (n = 162) of nurses agreed or strongly agreed that their unit invests in measures to protect their safety and well-being, while 59.3% (n = 178) believed that their unit responds promptly to safety-related issues. Just over half (53.0%, n = 159) felt that their unit is committed to employee well-being, and 55.3% (n = 166) agreed or strongly agreed that they are encouraged to voice concerns about staff well-being.

However, more than half (57.3%, n = 172) disagreed or strongly disagreed that their unit ensures adequate staffing levels.

Table 4.9: Perceptions on Unit-Organizational Culture: Organizational Practices (n=300)

Question	N	Mean(SD)	Strongly disagree/ disagree	Neutral	Strongly agree/agree
My unit tries to reduce factors that impact nurse safety and health.	300	4.32(1.07)	29(9.7)	38(12.7)	233(77.6)
My unit tries to reinforce safety and safe working practices.	300	3.92(1.26)	60(20.0)	45(15.0)	195(65.0)
My unit reacts quickly to solve safety-related problems.	300	3.87(1.23)	53(17.6)	69(23.0)	178(59.3)
My unit invests in workplace safety.	300	3.60(1.53)	106(32.0)	42(14.0)	162(54.0)
My unit is committed to employee wellbeing.	300	3.67(1.33)	74(24.7)	67(22.3)	159(53.0)
My unit encourages me to speak up about issues regarding employee well-being.	300	3.68(1.27)	68(22.7)	66(22.0)	166(55.3)
My unit ensures we are well-staffed.	300	2.65(1.65)	172(57.3)	38(12.7)	90(30.0)
My unit has training that focuses on safety in the workplace.	300	3.96(1.39)	73(24.3)	37(12.3)	190(63.3)

4.13. Comparison of the nurses' perception of Organizational Culture and Leadership by demographic variables

The independent samples t-test indicated that there were no statistically significant differences in the mean scores for overall perceptions of safety culture and its various dimensions between male and female staff members ($p > 0.05$). Likewise, gender did not have a significant impact on employees' average perceptions of unit organizational culture ($p = 0.547$) or on leadership among nurses ($p = 0.122$). Consequently, the null hypotheses were retained (refer to Table 4.11).

Table 4.10: Relationship between nurses' sociodemographic characteristic (gender) and the nurses' perception of Organizational Culture and Leadership (n = 300)

Domain	Gender	N	Mean(SD)	t-statistics(df)	P-value
Perceptions on Safety Culture	male	115	3.20(.49)	-.29(298)	.773
	female	185	3.22(.55)		
Safe Work Procedures	male	115	3.35(1.02)	-.59(298)	.557
	female	185	3.42(1.06)		
Reporting	male	115	3.64(.59)	.68(298)	.498
	female	185	3.59(.71)		
Illness and Injury Management & Return to Work	male	115	2.22(.63)	-.60(298)	.547
	female	185	2.26(.64)		
Perceptions on Unit Organizational Culture	male	115	3.40(.58)	-.40(298)	.691
	female	185	3.42(.53)		
Unit Organizational Culture	male	115	3.77(.93)	.91(298)	.363
	female	185	3.67(.83)		
My current unit	male	115	3.07(.71)	-1.54(298)	.123
	female	185	3.20(.72)		
Perceptions on Leadership	male	115	3.25(.58)	-1.55(298)	.122
	female	185	3.35(.53)		

A One-Way ANOVA was conducted to determine whether nurses' overall perceptions of safety culture varied by age group. As presented in Table 4.12, a statistically significant difference was identified in the overall perceptions of safety culture ($p = 0.038$). However, no significant differences were found in the perceptions of safety culture dimensions of safety culture, as all p-values were greater than 0.05. Similarly, age group did not significantly affect perceptions of unit organizational culture or leadership. Therefore, the null hypothesis was accepted for all variables across age groups, except for the overall perceptions of safety culture.

Table 4.11: Relationship between nurses' sociodemographic characteristic (age-group) and the nurses' perception of Organizational Culture and Leadership (n = 300)

Domain	Age-group	N	Mean(SD)	F-statistics(df)	P-value
Perceptions on Safety Culture	18-24	17	3.01(.46)	2.85(3)	.038
	25-34	139	3.23(.55)		
	35-44	102	3.15(.51)		
	more than 44	42	3.38(.50)		
Safe Work Procedures	18-24	17	3.07(1.03)	1.70(3)	.168
	25-34	139	3.46(1.02)		
	35-44	102	3.27(1.06)		
	more than 44	42	3.59(1.04)		
Reporting	18-24	17	3.39(.76)	2.43(3)	.066
	25-34	139	3.61(.61)		
	35-44	102	3.55(.60)		
	more than 44	42	3.83(.59)		
Illness and Injury Management & Return to Work	18-24	17	2.27(.64)	.25(3)	.860
	25-34	139	2.21(.61)		
	35-44	102	2.27(.62)		
	more than 44	42	2.28(.76)		
Perceptions on Unit Organizational Culture	18-24	17	3.20(.45)	1.92(3)	.127
	25-34	139	3.39(.57)		
	35-44	102	3.42(.56)		
	more than 44	42	3.55(.46)		
Unit Organizational Culture	18-24	17	3.75(.80)	.41(3)	.744
	25-34	139	3.68(.87)		
	35-44	102	3.69(.93)		
	more than 44	42	3.84(.69)		
My current unit	18-24	17	2.71(.48)	2.87(3)	.037
	25-34	139	3.13(.76)		
	35-44	102	3.19(.70)		
	more than 44	42	3.30(.67)		
Perceptions on Leadership	18-24	17	3.40(.52)	.77(3)	.513
	25-34	139	3.27(.51)		
	35-44	102	3.31(.56)		
	more than 44	42	3.40(.64)		

Table 4.13 showed that there were no statistically significant differences in nurses' overall perceptions of safety culture, its dimensions, perceptions of unit organizational culture and its dimensions, or perceptions of leadership based on educational level. As a result, the null hypothesis was retained across all dimensions, indicating that educational level does not significantly impact perceptions related to emotional intelligence or leadership behavior.

Table 4.12: Relationship between nurses' sociodemographic characteristic (Education) and the nurses' perception of Organizational Culture and Leadership (n = 300)

Domain	Education	N	Mean(SD)	F-statistics(df)	P-value
Perceptions on Safety Culture	Diploma	85	3.30(.49)	1.50(2)	.224
	Bachelor	202	3.18(.54)		
	Master	13	3.17(.53)		
Safe Work Procedures	Diploma	85	3.54(1.01)	1.15(2)	.317
	Bachelor	202	3.33(1.05)		
	Master	13	3.40(1.20)		
Reporting	Diploma	85	3.67(.73)	.47(2)	.624
	Bachelor	202	3.59(.65)		
	Master	13	3.54(.47)		
Illness and Injury Management & Return to Work	Diploma	85	2.27(.68)	.20(2)	.815
	Bachelor	202	2.24(.61)		
	Master	13	2.15(.74)		
Perceptions on Unit Organizational Culture	Diploma	85	3.45(.57)	1.77(2)	.172
	Bachelor	202	3.41).54)		
	Master	13	3.15(.52)		
Unit Organizational Culture	Diploma	85	3.72(.86)	.39(2)	.676
	Bachelor	202	3.71(.85)		
	Master	13	3.50(1.06)		
My current unit	Diploma	85	3.22(.68)	1.62(2)	.201
	Bachelor	202	3.14(.74)		
	Master	13	2.84(.59)		
Perceptions on Leadership	Diploma	85	3.41(.53)	4.22(2)	.016
	Bachelor	202	3.29(.55)		
	Master	13	2.96(.50)		

A One-Way ANOVA was performed to examine whether nurses' overall perceptions of safety culture differed by job title. As shown in Table 4.14, a statistically significant difference was observed in the overall safety culture perceptions ($p = 0.021$), as well as in the Reporting dimension ($p = 0.001$). However, no significant differences were found in the Safe Work Procedures and Illness and Injury Management & Return to Work dimensions, with p-values exceeding 0.05. Similarly, job title did not significantly influence overall perceptions of unit organizational culture or its related dimension. In contrast, significant differences were identified in the "My Current Unit" dimension and perceptions of leadership ($p < 0.05$).

Therefore, the null hypothesis was rejected for overall safety culture perception, the Reporting dimension, "My Current Unit," and leadership. It was retained for Safe Work Procedures, Illness and Injury Management & Return to Work, and perceptions of unit organizational culture.

Table 4.13: Relationship between nurses' sociodemographic characteristic (Education) and the nurses' perception of Organizational Culture and Leadership (n = 300)

Domain	Job title	N	Mean(SD)	F-statistics(df)	P-value
Perceptions on Safety Culture	Head nurse	16	2.94(.35)	3.29(3)	.021
	staff nurse	254	3.25(.51)		
	midwife	25	3.04(.70)		
	others	5	2.95(.40)		
Safe Work Procedures	Head nurse	16	3.12(1.04)	2.03(3)	.110
	staff nurse	254	3.44(1.01)		
	midwife	25	3.24(1.36)		
	others	5	2.48(.42)		
Reporting	Head nurse	16	3.32(.55)	5.29(3)	.001
	staff nurse	254	3.65(.64)		
	midwife	25	3.25(.80)		
	others	5	4.20(.45)		
Illness and Injury Management & Return to Work	Head nurse	16	2.00(.57)	2.47(3)	.062
	staff nurse	254	2.26(.63)		
	midwife	25	2.35(.61)		
	others	5	1.67(.85)		
Perceptions on Unit Organizational Culture	Head nurse	16	3.24(.50)	.89(3)	.448
	staff nurse	254	3.43(.54)		
	midwife	25	3.33(.63)		
	others	5	3.32(.66)		
Unit Organizational Culture	Head nurse	16	4.12(.83)	1.63(3)	.183
	staff nurse	254	3.69(.85)		
	midwife	25	3.57(1.04)		
	others	5	3.98(.70)		
My current unit	Head nurse	16	2.46(.63)	6.24(3)	<.001
	staff nurse	254	3.20(.71)		
	midwife	25	3.12(.63)		
	others	5	2.73(.92)		
Perceptions on Leadership	Head nurse	16	3.01(.65)	2.71(3)	.046
	staff nurse	254	3.33(.55)		
	midwife	25	3.22(.46)		
	others	5	3.67(.47)		

A One-Way ANOVA was carried out to assess whether nurses' overall perceptions of safety culture differed based on years of experience. As shown in Table 4.15, there was no statistically significant difference in overall safety culture perceptions ($p = 0.097$). Likewise, no significant differences were observed across the dimensions of safety culture, with all p-values exceeding 0.05. Additionally, experience had no significant impact on perceptions of unit organizational culture or leadership. Consequently, the null hypothesis was accepted for all variables across levels of experience.

Table 4.14: Relationship between nurses' sociodemographic characteristic (Experience) and the nurses' perception of Organizational Culture and Leadership (n = 300)

Domain	Experience	N	Mean(SD)	F-statistics(df)	P-value
Perceptions on Safety Culture	1-3	40	3.20(.62)	2.12(3)	.097
	4-6	52	3.07(.50)		
	7-10	70	3.31(.51)		
	more than 10	138	3.22(.52)		
Safe Work Procedures	1-3	40	3.44(1.17)	.86(3)	.463
	4-6	52	3.23(.93)		
	7-10	70	3.53(1.01)		
	more than 10	138	3.38(1.04)		
Reporting	1-3	40	3.49(.75)	1.61(3)	.187
	4-6	52	3.51(.73)		
	7-10	70	3.73(.53)		
	more than 10	138	3.62(.67)		
Illness and Injury Management & Return to Work	1-3	40	2.32(.74)	1.73(3)	.161
	4-6	52	2.07(.57)		
	7-10	70	2.24(.53)		
	more than 10	138	2.29(.67)		
Perceptions on Unit Organizational Culture	1-3	40	3.26(.59)	2.31(3)	.077
	4-6	52	3.36(.53)		
	7-10	70	3.53(.55)		
	more than 10	138	3.42(.53)		
Unit Organizational Culture	1-3	40	3.43(.82)	1.73(3)	.160
	4-6	52	3.79(.83)		
	7-10	70	3.78(.92)		
	more than 10	138	3.72(.85)		
My current unit	1-3	40	3.11(.69)	2.12(3)	.098
	4-6	52	2.97(.83)		
	7-10	70	3.30(.65)		
	more than 10	138	3.15(.71)		
Perceptions on Leadership	1-3	40	3.33(.58)	.42(3)	.741
	4-6	52	3.28(.49)		
	7-10	70	3.26(.47)		
	more than 10	138	3.34(.60)		

A One-Way ANOVA was conducted to assess whether nurses' overall perceptions of safety culture varied by department. As indicated in Table 4.16, there was a statistically significant difference in overall safety culture perceptions ($p < 0.001$), as well as in the Reporting and Safe Work Procedures dimensions ($p < 0.05$). However, no significant differences were found in the Illness and Injury Management & Return to Work dimension, as the p-values exceeded 0.05. Similarly, the department did not significantly impact overall perceptions of unit organizational culture ($p = 0.342$). In contrast, significant differences were found in the "My Current Unit" and Unit Organizational Culture dimensions ($p < 0.05$). No significant difference was observed in perceptions of leadership ($p = 0.276$).

Therefore, the null hypothesis was rejected for overall safety culture, the Reporting and Safe Work Procedures dimensions, as well as for "My Current Unit" and Unit Organizational Culture. It was retained for Illness and Injury Management & Return to Work, overall Unit Organizational Culture perceptions, and Leadership perceptions.

A. Table 4.15: Relationship between nurses' sociodemographic characteristic (Department) and the nurses' perception of Organizational Culture and Leadership (n = 300)

Domain	Department	N	Mean(SD)	F-statistics(df)	P-value
Perceptions on Unit Organizational Culture	emergency	62	3.19(.58)	4.98(5)	<.001
	intensive care unit	65	3.42(.45)		
	Pediatric	39	3.28(.43)		
	Medical	56	3.01(.62)		
	surgery	41	3.07(.47)		
	others	37	3.28(.41)		
Safe Work Procedures	emergency	62	3.24(1.04)	5.39(5)	<.001
	intensive care unit	65	3.81(.90)		
	Pediatric	39	3.59(1.10)		
	Medical	56	3.12(1.16)		
	surgery	41	2.97(.89)		
	others	37	3.60(.93)		
Reporting	emergency	62	3.75(.75)		.002
	intensive care unit	65	3.71(.98)		
	Pediatric	39	3.59(.52)		
	Medical	56	3.29(.78)		
	surgery	41	3.61(.54)		
	others	37	3.69(.40)		
Illness and Injury Management & Return to Work	emergency	62	2.17(.65)	3.80(5)	.342
	intensive care unit	65	2.28(.54)		
	Pediatric	39	2.25(.64)		
	Medical	56	2.35(.59)		
	surgery	41	2.32(.72)		
	others	37	2.07(.73)		
Perceptions on Unit Organizational Culture	emergency	62	3.52(.49)	1.65(5)	.147
	intensive care unit	65	3.37(.48)		
	Pediatric	39	3.54(.67)		
	Medical	56	3.39(.54)		
	surgery	41	3.34(.55)		
	others	37	3.27(.59)		
Unit Organizational Culture	emergency	62	4.02(.75)	3.27(5)	.007
	intensive care unit	65	3.42(.76)		
	Pediatric	39	3.74(1.05)		
	Medical	56	3.68(.83)		
	surgery	41	3.73(.85)		
	others	37	3.67(.94)		
My current unit	emergency	62	3.08(.77)	3.27(5)	.017
	intensive care unit	65	3.33(.56)		
	Pediatric	39	3.35(.84)		
	Medical	56	3.14(.63)		
	surgery	41	3.00(.73)		
	others	37	2.91(.78)		

B. Table 4.15: Relationship between nurses' sociodemographic characteristic (Department) and the nurses' perception of Organizational Culture and Leadership (n =300)

Perceptions on Leadership	emergency	62	3.24(.52)	1.27(5)	.276
	intensive care unit	65	3.37(.42)		
	Pediatric	39	3.27(.64)		
	Medical	56	3.29(.49)		
	surgery	41	3.22(.64)		
	others	37	3.47(.66)		

Pearson correlation coefficients between the study variables

Correlation coefficients (r) greater than 0.7, indicating a strong positive relationship between variables, were found in the Illness and Injury Management & Return to Work ($r = .832$, $p < .001$). A strong positive correlation means that as one variable increases, the other tends to increase as well (Table 4.17).

Correlation coefficients (r) around 0.5, which indicate a moderate and statistically significant positive relationship, were observed between Reporting and leadership ($r = .557$, $p < .001$).

Additionally, weaker but still statistically significant positive relationships (with r values around 0.2) were found in the following: Staff satisfaction and rater Illness and Injury Management & Return to Work ($r = .321$, $p < .001$), Perceptions on Unit Organizational Culture and leadership ($r = .211$, $p < .001$), Perceptions on Unit Organizational Culture ($r = .234$, $p < .001$), My current unit and leadership ($r = .383$, $p <.001$), and finally, Perceptions on Leadership and all other dimensions ($r = .204$, $p < .001$). But no statistically significant relationship between Unit Organizational Culture and leadership ($r = -.076$, $p = .191$).

Table 4.16: Pearson correlation coefficients between the study variables

Correlations									
		1	**2**	**3**	**4**	**5**	**6**	**7**	**8**
1- Perceptions on Unit Organizational Culture	Pearson Correlation	1							
	Sig. (2-tailed)								
2-Illness and Injury Management & Return to Work	Pearson Correlation	.832**	1						
	Sig. (2-tailed)	.000							
3- Reporting	Pearson Correlation	.557**	.096	1					
	Sig. (2-tailed)	.000	.096						
4-Illness and Injury Management & Return to Work	Pearson Correlation	.321**	.064	-.019	1				
	Sig. (2-tailed)	.000	.268	.740					
5- Perceptions on Unit Organizational Culture	Pearson Correlation	.211**	.132*	.119*	.186**	1			
	Sig. (2-tailed)	.000	.023	.040	.001				
6- Unit Organizational Culture	Pearson Correlation	-.076	-.044	-.054	-.056	.717**	1		
	Sig. (2-tailed)	.191	.450	.351	.333	.000			
7- My current unit	Pearson Correlation	.383**	.235**	.228**	.327**	.669**	-.039	1	
	Sig. (2-tailed)	.000	.000	.000	.000	.000	.501		
8- Perceptions on Leadership	Pearson Correlation	.204**	.127*	.161**	.102	.204**	.012	.279**	1
	Sig. (2-tailed)	.000	.028	.005	.079	.000	.832	.000	
**. Correlation is significant at the 0.01 level (2-tailed).									
*. Correlation is significant at the 0.05 level (2-tailed).									

Chapter 5

5.1. Discussion

5.2. Introduction

This study explored nurses' perspectives, experiences, and opinion concerning unit organizational culture and leadership, and how these elements affect their safety and well-being. Given the diverse and often high-risk environments in which nurses work, their health and safety are frequently compromised due to the demands of the profession. As such, it is crucial to identify professional practices that can mitigate these risks and promote a safer, healthier workplace.

To gather relevant data, the study utilized a structured questionnaire administered to nurses in four hospitals located in the southern region of the West Bank. A total of 300 completed responses were collected. The research was guided by the following key questions:

- How do nurses perceive the structural aspects of organizational culture, leadership, and safety culture that influence their safety and health?
- What are nurses' views on the factors that either support or hinder their safety and health?
- What are nurses' perceptions of the strategies used to prevent safety and health-related incidents?
- Are there notable differences in nurses' perceptions based on demographic characteristics?
- Is there a relationship between the various domains of nurses' perceptions?

The findings aim to inform best practices that enhance safety measures and reduce the occurrence of illness and injury among nurses. Continuous assessment and improvement of organizational procedures are vital for ensuring the health and safety of healthcare professionals.

5.3. Research Question One

The first research question explored nurses' perceptions of structural factors that affect their safety within healthcare settings. The investigation was structured around three core themes: organizational culture, leadership, and safety culture—each selected due to its significance in supporting nurse safety in hospitals.

The organizational culture component addressed elements that influence the nursing work environment, such as collaboration, communication, and job satisfaction. The researcher analyzed

responses from both the questionnaire and interviews to assess how these factors impact nurse safety.
Finally, the leadership component examined the role of nurse leaders in fostering a culture of safety within their units. Nurses' responses to the questionnaire offered important insights into how they perceive leadership behaviors that support health and safety.

5.4. Organizational Culture

Positive aspects were found in this study that highlight the importance of teamwork, collaboration skills, and a positive organizational culture that supports nurses'
well-being. Nurses have good communication practices and share skills and knowledge with colleagues. Collaboration among healthcare professionals is present in these units, which is vital for reducing the potential risks to injury while providing patient care.
Nurses' understanding of the organization's values, beliefs, and goals enables them to deliver high-quality care. Overall, the study suggests that there is effective communication, collaboration, and professional development among nurses. These aspects are important for ensuring workplace safety and delivering high-quality healthcare.
The results showed that nurses have good communication practices and share their skills and knowledge with colleagues, which is essential for their professional development. Collaboration promotes a supportive work environment, creating a positive work culture that fosters safety, learning, and development. The recent study by Robertson et al. (2021) highlights the significance of establishing a well-defined framework for employee involvement in program implementation, which aligns with the findings of the current research. To ensure successful program outcomes, organizations should emphasize the development of teamwork and collaborative abilities among staff members. Similarly, Lee et al. (2021) explored the influence of organizational culture on employee health and safety, emphasizing that a positive and supportive workplace culture plays a vital role in enhancing employee well-being. Such a culture not only boosts nurses' job satisfaction and motivation but also supports both nurse and patient safety.
In the present study, nurses generally expressed positive views about their work environment, citing strengths in communication, professional development opportunities, teamwork, policy implementation, leadership, clarity of organizational goals and values, and their ability to influence their units. Although one quantitative item revealed concerns about workplace politics, the qualitative responses suggested that teamwork focused on patient care and safety often takes precedence over personal or political concerns within the unit.

5.6. Leadership

The findings from the survey show that both transformational and transactional leadership styles are present within nursing units. However, leaders could do more to emphasize safety and foster a stronger culture of safety. Nurses expressed the need for more leadership involvement in guiding the implementation of safety protocols. The study highlights several key findings:

- Both leadership styles are evident, yet improvements are needed in how they support nurses' safety and well-being.
- Transformational Leadership Insights:
- Many nurses reported that their leaders encourage safe practices and emphasize their importance.

- Around half of the participants agreed that their leaders advocate for safety, encourage safe behavior within the unit, motivate nurses to work safely, and are responsive to their concerns.

Transactional Leadership Insights:

- Most nurses said their leaders emphasize compliance with workplace standards.
- Slightly more than half felt that leaders focus more on day-to-day operations than on safety.
- Fewer than half agreed that leaders actively monitor safety behaviors.
- Most nurses do not feel punished for unsafe practices, but over half indicated leaders use corrective feedback when safety lapses occur.
- Recognition or rewards for safe behavior are rare.
- Effective communication, active listening, and leader engagement are crucial elements in building a safety-focused environment.

The study confirms the presence of both leadership approaches—transformational, which inspires creativity, growth, and collaboration; and transactional, which centers on performance and task completion. However, the research suggests that leaders are not fully leveraging these styles to promote safety. There is an opportunity for leaders to:

Emphasize safety in daily operations.

Provide regular feedback and recognize safe practices.

Engage with staff to monitor and encourage safety behavior consistently.

Importantly, lower-level leaders—those in more direct, day-to-day roles—are especially influential in promoting safety. Through open communication, support, and involvement, they can significantly shape a unit's safety culture.

Previous research (Cooper, 2015; Farag & Gedney-Lose, 2019; Hammer et al., 2019; Stanley, 2008) confirms that transformational and transactional leadership dominate the nursing field. This study echoes that conclusion but notes that neither style is dominant or fully effective on its own.

For leadership to be effective in nursing, it must combine clear communication, industry knowledge, and a strong commitment to safety. As Olawoyin (2018) noted, effective leaders motivate staff by setting clear goals, offering recognition, and providing constructive feedback. Hammer et al. (2019) emphasized that leaders should proactively identify hazards, implement safety measures, and foster a blame-free reporting environment.

Despite some existing efforts, there is room for growth in creating safer workplaces. Leaders must view safety as a critical part of daily practice, not a secondary concern.

- To enhance safety culture, leaders should:
- Recognize and reward safe behavior through formal programs.
- Promote accountability by regularly monitoring adherence to safety protocols.
- Foster open, transparent communication, encouraging feedback on safety concerns and responding appropriately.

Research by Hutchinson and Jackson (2013) and James (2015) shows that when leaders acknowledge and reward safe behaviors, employees are more motivated and perform better. Encouraging accountability and a shared sense of responsibility enhances overall safety. Lastly, as Almost et al. (2018) suggest, integrating structured safety systems and cultivating a proactive safety culture within organizations are key to improving workplace health and safety outcomes.

In conclusion, this study reveals that while transformational and transactional leadership styles are both present in hospital nursing units, leaders must further prioritize safety to develop a robust culture of protection. By emphasizing safety practices, recognizing safe behaviors, engaging

lower-level leadership, and establishing open communication, leaders can ensure both employee well-being and patient safety remain central to healthcare delivery.

5.7. Safety Culture

The data gathered on nurses' perceptions of workplace safety culture offers a comprehensive understanding of their beliefs, attitudes, and behaviors related to safety. Safety culture, as a vital component of organizational culture, plays a critical role in protecting nurses' health and well-being.

The study revealed several key findings:

- Nurses often push themselves to continue working rather than ask for assistance, which may compromise their safety.
- Nurses commonly seek clarification from colleagues when uncertain about procedures—an encouraging sign of their dedication to maintaining safety standards.
- Encouraging open communication in the workplace is essential to ensure that nurses feel comfortable asking for help when needed.

The study also found that, in some cases, nurses proceed with patient care even in the absence of proper personal protective equipment (PPE), exposing themselves to potential health risks. This highlights the importance of consistently providing adequate PPE to all staff to ensure a safe work environment.

Nurses recognize the significance of clear policies and procedures in promoting safety for both patients and staff. They also depend on their colleagues and supervisors for support in maintaining safety standards. However, issues such as staff shortages and high patient-to-nurse ratios often force nurses to overextend themselves, as reflected in Table 4.6. These demands can negatively affect nurses' health and performance both immediately and over time (Mullen et al., 2015).

To address these issues, healthcare institutions must regularly review and update safety policies and ensure they align with organizational values. Previous research (Lee et al., 2021) emphasizes that communication from leadership is critical to improving workplace safety. A lack of communication can lead to confusion, disengagement, and reduced commitment to safety practices.

Improving managed systems and cultivating a strong safety culture within healthcare organizations can significantly enhance workplace safety and staff well-being (Almost et al., 2021).

In summary, this study provides meaningful insights into nurses' views and behaviors related to safety. It highlights the importance of a strong safety culture as a key element of organizational culture in protecting nursing staff. The findings point to a continued need for efforts focused on sustaining a safe and supportive working environment for nurses.

5.8. Research Question Two

Research Question Two aimed to explore the various experiential factors that significantly influence nurses' health and safety—both positively and negatively. The study revealed several important findings:

- Nurses are exposed to multiple occupational hazards in the course of their duties, which can have serious physical and psychological consequences.
- Inadequate staffing levels remain a major issue, limiting the ability to provide comprehensive support for all nursing staff.

Survey results identified stress as the most frequently reported occupational hazard. Contributing factors included extended work hours, excessive workloads, challenging interactions with patients or colleagues, and limited access to necessary resources. Stress was linked to serious outcomes such as burnout, anxiety, depression, and other health-related issues. Fatigue and burnout were also common themes in nurses' responses, often attributed to long shifts, insufficient rest, emotional strain, and the high demands of the job. These conditions can increase the likelihood of medical errors, reduce patient safety, and contribute to absenteeism and high turnover rates—all of which undermine the quality of care provided.

One of the most pressing concerns raised was the impact of staffing shortages. Nurses emphasized how working under-resourced and managing high patient loads directly affect their safety and well-being. These challenges often lead to physical exhaustion, emotional strain, and a higher risk of error, all of which jeopardize nurse health and patient outcomes.

To address these issues, collaboration between frontline and upper-level leadership is essential. Leaders at all levels must work together to develop sustainable solutions that protect nurse well-being. This study calls on healthcare organizations and stakeholders to recognize and act on the urgent need to improve working conditions for nurses.

Existing research (Casida & Pinto-Zipp, 2008; Nixon et al., 2015; Robertson et al., 2021; Stone & Gershon, 2006; Weiner, 2009) consistently supports the idea that nurses rely on leadership to cultivate a supportive workplace culture—one that prioritizes their safety, health, and professional needs. By doing so, organizations can establish a stable and healthy work environment that minimizes risk, fosters positive relationships, and encourages safe, effective care.

5.9. Research Question Three

Research Question Three explored key strategies for reducing health and safety risks among nurses. The study findings revealed nurses' levels of trust in their organization's efforts to address safety-related issues. The responses reflected a shared responsibility between nurses and leadership in cultivating a strong safety culture. When nurses operate in a supportive environment, they are more likely to follow safety protocols and deliver higher-quality patient care.

Key findings from the study include:

- Nurses identified that adequate staffing levels play a vital role in preventing workplace injuries and illnesses.
- Nursing units were generally described as collaborative and supportive, which helps mitigate occupational health risks.
- Nurses offered several practical suggestions to improve workplace safety.

Nurses not only focus on delivering quality care but also look out for one another's well-being. Elements such as teamwork, clear communication, and joint decision-making were highlighted as essential for maintaining a positive work environment and enhancing safety outcomes. Supporting nurses through adequate resources, training, and organizational backing can build resilience and effectively address workplace hazards.

Nurses proposed a variety of recommendations to strengthen safety in their work settings. These included:

- Hiring more nursing staff
- Ensuring access to high-quality personal protective equipment (PPE)
- Providing additional support to current staff
- Improving nurse-to-patient ratios and compensation

- Standardizing clinical procedures
- Utilizing technology to enhance care delivery and safety
- Implementing these recommendations would help create a safer, more supportive workplace for nurses, ultimately leading to improved care for patients and better outcomes for healthcare systems overall.

5.10. Conclusions of the Study

This study explored several factors that influence nurses' safety and health, with a particular focus on organizational culture, leadership, and safety culture. It provided a detailed analysis of how these elements impact nurses in the workplace and underscored the importance of teamwork and a supportive environment. The findings indicated that nurses working within teams that foster mutual support and encouragement are more likely to experience greater job satisfaction and improved performance. Conversely, workplace politics can negatively affect job satisfaction and productivity in some units.

The study's results suggest that nurse unit leaders can use these insights to identify areas that need improvement and implement strategies to enhance the work environment. Emphasizing safety practices and cultivating a culture of safety can help create conditions that support nurses' physical and mental health. Although both transformational and transactional leadership styles were found to be present in nursing units, the study indicates that there is room for leaders to place greater emphasis on promoting safety.

Additionally, the study highlighted the critical role of safety culture in protecting nurses' well-being. Establishing a strong safety culture is essential for maintaining a secure workplace. Leaders can adopt several strategies to support this, such as:

- Recognizing and rewarding safe practices
- Regularly monitoring safety compliance
- Encouraging open, honest communication
- Offering support and guidance
- Actively engaging with frontline nursing staff

The research also emphasized the important role of lower-level leadership in influencing safety behaviors, as they work closely with staff on the ground. However, it also recognized that upper-level leadership has a significant responsibility in shaping policies and addressing key structural issues—such as staffing levels and patient ratios—that directly affect nurses' safety and well-being.

Ultimately, the findings call for collaborative action across all leadership levels to improve staffing conditions, promote safety, and ensure a healthier, more supportive environment for nurses.

5.11. Recommendations of the Study

The health and safety of nurses are essential components that directly influence the quality of patient care. To ensure nurses can operate in a secure and supportive environment, healthcare organizations must prioritize organizational culture, effective leadership, and a strong safety culture. Based on the findings, the researcher recommends that hospital administrators use insights

from the survey and interviews to identify areas needing improvement and implement targeted strategies to enhance nurses' work conditions.

2.12. Key Recommendations to Improve Nurse Workplace Safety:

1. Emphasize Safety Practices and Build a Safety-Oriented Culture:

Leaders who actively support safety initiatives and promote a safety-first mindset can play a crucial role in improving nurses' well-being. While both transformational and transactional leadership styles are evident in nursing units, there is room for stronger emphasis on safety and minimizing workplace politics. Leaders should take practical steps such as rewarding safe behavior, routinely monitoring safety compliance, fostering open communication, offering guidance, and staying engaged with frontline staff. Additionally, lower-level leaders, who work directly with nurses, are instrumental in encouraging teamwork and maintaining a supportive work environment that reinforces safety.

2. Reinforce the Importance of a Strong Safety Culture:

A robust safety culture is vital within healthcare settings, where the protection of nursing staff is critical. Leaders must maintain ongoing efforts to strengthen this culture by addressing nurse concerns, improving communication, and encouraging collaboration. Doing so can enhance job satisfaction and performance while contributing to higher-quality patient care.

3. Tackle the Issue of Staffing and Nurse-to-Patient Ratios:

The research highlights the urgent need to address inadequate staffing and high patient ratios, which have a direct impact on nurse safety and health. While lower-level leaders influence day-to-day safety through direct support, upper-level leadership must also take responsibility by engaging in long-term planning, resource allocation, and policy development. Strategic efforts from senior leaders are essential to ensure appropriate staffing levels that support both nurse well-being and effective patient care.

4. Listen to and Act on Nurses' Concerns:

Nurses shared valuable suggestions for improving safety, such as increasing staffing levels and refining organizational practices. By fostering a positive and supportive work environment and implementing their feedback, healthcare institutions can improve safety outcomes for nurses. Continuously addressing the factors that influence job satisfaction and performance is crucial to maintaining a safe, healthy, and productive workforce and ensuring consistent, high-quality care for patients.

In conclusion, prioritizing nurse safety requires collaborative efforts across leadership levels, a commitment to ongoing communication and support, and responsiveness to the needs and insights of nursing professionals.

5.13. Recommendations for Future Research

1. **Exploring nurses' experiences across diverse work environments**, including both hospital and non-hospital settings, can provide insight into the challenges, gaps, and factors

affecting their health and safety. Analyzing elements such as workload, staffing ratios, and access to resources in these different contexts may help identify effective strategies for supporting nurses' well-being.

2. **Conducting an in-depth analysis of the role of leadership in nurse safety** is essential. This involves assessing the influence of leaders at all levels—from frontline supervisors to senior hospital administrators—on workplace safety practices and outcomes.
3. **Examining healthcare leaders' perspectives on nurse health and safety** could offer valuable understanding of how leadership prioritizes these issues. This line of research may uncover the specific actions leaders take to promote nurse safety and reveal opportunities for improving leadership engagement and support in creating a safer work environment.
4. **Comparing the education of nurse safety in academic settings with its application in clinical practice** would help evaluate the alignment between what is taught and what is actually implemented. Identifying any inconsistencies can assist educators and healthcare organizations in bridging gaps between theory and practice, ensuring that nurses are adequately prepared and supported in real-world settings.

References

- 19 pandemic. *Stress and Health, 39*(2), 404-413. https://doi.org/10.1002/smi.3192
- 236. https://doi:10.1177/21650799211007446
- *58*(10), 49-55.
- 648–657. https://doi.org/10.2307/258070
- Abd-El Aliem, S. M. F., & Abou Hashish, E. A. (2021). The relationship between transformational leadership practices of first-fine nurse managers and nurses' organizational resilience and job involvement: A structural equation model. Worldviews on Evidence-Based Nursing, 18(5), 273–282. https://doi.org/10.1111/wvn.12535
- Aghaei, H., Sadat Asadi, Z., Mirzaei Aliabadi, M., & Ahmadinia, H. (2020). The relationships among occupational safety climate, patient safety climate, and safety performance based on structural equation modeling. Journal of Preventive Medicine and Public Health = Yebang Uihakhoe chi, 53(6), 447–454. https://doi.org/10.3961/jpmph.20.350
- Allen, I. E., & Seaman, C. A. (2007, 07). Likert scales and data analyses. Quality Progress, 40, 64-65.
- Almost, J., Van Den Kerkhof, E., Strahlendorf, P., Caicco Tett, L., Noonan, J., Hayes, T., Van Hulle, H., Adam, R., Holden, J., Kent-Hillis, T., McDonald, M., Paré, G. C., Lachhar, K., & Silva E Silva, V. (2018). A study of leading indicators foroccupational health and safety management systems in healthcare. BMC Health Services Research, 18(1), 296-296. https://doi.org/10.1186/s12913-018-3103-0
- Bartel, A. & Thomas, L. (1985). Direct and indirect effects of regulation: A new look at
- Basahel, A. M. (2021). Safety leadership, safety attitudes, knowledge, and motivation toward safety-related behaviors in electrical substation construction projects. *International Journal of Environmental Research and Public Health, 18*(8), 4196. https://doi.org/10.3390/ijerph18084196
- Bass, B. (1990). Bass & Stogdill's handbook of leadership: Theory, research, and managerial application (3rd ed.). New York: Free Press.
- Bass, B., Avolio, B., & Atwater, L. (1996). The transformational and transactional leadership of men and women. *Applied Psychology: An International Review, 45*(1), 5–34. https://doi.org/10.1111/j.1464-0597.1996.tb00847.x
- Bass, B., Avolio, B., Jung, D., & Berson, Y. (2003). Predicting unit performance by assessing transformational and transactional leadership. *Journal of Applied Psychology, 88*(2), 207- 218. https://doi.org/10.1037/0021-9010.88.2.207
- Beus, J., Payne, S., Bergman, M., & Arthur, W. (2010). Safety climate and injuries: An examination of theoretical and empirical relationships. *Journal of Applied Psychology, 95*(4), 713-727. https://doi.org/10.1037/a0019164

- Bishop, P. A., & Herron, R. L. (2015). Use and misuse of the Likert item responses and other ordinal measures. *International Journal of Exercise Science, 8*(3), 297–302.
- Bradshaw, A. (2017). What is a nurse? The Francis report and the historic voice of nursing. *Nursing Inquiry, 24*(4), e12190-n/a. https://doi.org/10.1111/nin.12190
- Bushnell, P. T., Pana-Cryan, R., Howard, J., Quay, B., & Ray, T. K. (2022). Measuring the benefits of occupational safety and health research with economic metrics: Insights from the National Institute for Occupational Safety and Health. *Am J Ind Med 65*(5), 323–342. https://doi.org/10.1002/ajim.23347
- Bycio, P., Hackett, R. D., & Allen, J. S. (1995). Further assessments of Bass's (1985) conceptualization of transactional and transformational leadership. *Journal of Applied Psychology, 80*(4), 468-478. https://doi.org/10.1037/0021-9010.80.4.468
- Carter, N., Bryant-Lukosius, D., DiCenso, A., Blythe, J., & Neville, A. (2014). The use of triangulation in qualitative research. *Oncology Nursing Forum, 41*(5), 545-7. https://www-proquest-com/scholarly-journals/use-triangulation-qualitativeresearch/docview/1559261620/se-2
- Casida, J., & Pinto-Zipp, G. (2008). Leadership-organizational culture relationship in nursing units of acute care hospitals. *Nursing Economic, 26*(1), 7-15.
- Casper, C. (2018). What is a nurse? *Colorado Nurse, 118*(4), 3.
- Castro, F., Kellison, J., Boyd, S., & Kopak, A. (2010). A methodology for conducting integrative mixed methods research and data analyses. *Journal of Mixed Methods Research, 4*(4), 342–360. https://doi.org/10.1177/1558689810382916
- Chiang, H., Hsiao, Y. & Lee, H. (2017). Predictors of hospital nurses' safety practices. *Journal of Nursing Care Quality, 32*(4), 359-368. https://doi.org/10.1097/NCQ.0000000000000240
- Clarke, S. (2006). The relationship between safety climate and safety performance: A meta-analytic review. Journal of Occupational Health Psychology, 11(4), 315- 327. https://doi.org/10.1037/1076-8998.11.4.315
- clinical information systems implementation in hospitals. *Journal of the Association forInformation Systems, 12*(2), 1–40.
- Collins, E., Owen, P., Digan, J., & Dunn, F. (2020). Applying transformational leadership in nursing practice. Nursing Standard (Royal College of Nursing (Great Britain): 1987), 35(5), 59–66. https://doi.org/10.7748/ns.2019.e11408
- consortium. *Diabetic Medicine, 38*(5), [e14498].
- Cooper, D. (2015). Effective safety leadership: Understanding types & styles that improve safety performance. Professional Safety, 60(2), 49–53.
- Creswell, J. W., & Creswell, J. D. (2017). Research design: Qualitative, quantitative, and mixed methods approaches. Sage Publications.
- Currie, D. (1976). OSHA. American Bar Foundation Research Journal, 1(4), 1107–1160.
- Currie, E. J., & Carr-Hill, R. A. (2013). What is a nurse? Is there an international consensus? International Nursing Review, 60(1), 67-74. https://doi.org/10.1111/j.1466-7657.2012.00997.x
- Curtis, E. A., de Vries, J., & Sheerin, F. K. (2011). Developing leadership in nursing: Exploring core factors. British Journal of Nursing, 20(5), 306–309.
- Daly, J., Speedy, S., & Jackson, D. (2009). Contexts of nursing: An introduction. Chatswood, NSW, Australia: Elsevier.

- Denny, E., & Weckesser, A. (2022). How to do qualitative research? Qualitative research methods. BJOG: An International Journal of Obstetrics and Gynaecology, 129(7), 1166-1167. https://doi.org/10.1111/1471-0528.17150
- Dinnesen, M. S., Olszewski, A., Breit-Smith, A., & Guo, Y. (2020). Collaborating with an expert panel to establish the content validity of an intervention for preschoolers with language impairment. *Communication Disorders Quarterly, 41*(2), 86-99. https://doi.org/10.1177/1525740118795158
- Dirik, H., & Seren Intepeler, S. (2017). The influence of authentic leadership on safety climate in nursing. *Journal of Nursing Management, 25*(5), 392–401.
- docview/1831706711/se-2
- Dossey, B. M. (2010). Florence nightingale: A 19th-century mystic. *Journal of Holistic Nursing, 28*(1), 10-35. https://doi.org/10.1177/0898010109356474
- Dressner, M. & Kissinger, S. (2018) *Occupational injuries and illnesses among registered nurses. Monthly Labor Review*, U.S. Bureau of Labor Statistics, November 2018. https://doi.org/10.21916/mlr.2018.27
- Dunlap, E., Basford, B., & Smith, M. (2019). Remodeling Heinrich: An application for modern safety management. *Professional Safety, 64*(5), 44–52.
- Dutra, C. K. D. R., & Guirardello, E. B. (2021). Nurse work environment and its impact on reasons for missed care, safety climate, and job satisfaction: A cross-sectional study. *Journal of Advanced Nursing, 77*(5), 2398-2406. https://doi.org/10.1111/jan.14764
- Echevarria, I. M., Patterson, B. J., & Krouse, A. (2017). Predictors of transformational leadership of nurse managers. *Journal of Nursing Management, 25*(3), 167–175. https://doi.org/10.1111/jonm.12452
- Emerson, R. (2017). Likert scales. *Journal of Visual Impairment & Blindness, 111*(5), 488-488. https://doi.org/10.1177/0145482X1711100511
- Esposito, C. L., Contreras Sollazzo, L., & DeGaray, C. (2021). Nurses' unions can help reduce stress, burnout, depression, and compassion fatigue during the COVID-19 pandemic, part 3. *Journal of the New York State Nurses Association, 48*(1), 30– 51.
- Evans, J., & Mathur, A. (2005). The value of online surveys. *Internet Research, 15*(2), 195-219. https://doi.org/10.1108/10662240510590360
- Farag, A., Lose, D., & Gedney-Lose, A. (2019). Nurses' safety motivation: Examining predictors of nurses' willingness to report medication errors. *Western Journal of Nursing Research,41*(7), 954–972. https://doi.org/10.1177/0193945918815462
- Farag, A., Tullai-McGuinness, S., Anthony, M., & Burant, C. (2017). Do leadership style, unit climate, and safety climate contribute to safe medication practices? *The Journal of Nursing Administration, 47*(1), 8-15.
- Farnsworth B., Cox T., Cox S., & Ferguson E. (1994). Managing health and safety in hospitals. *British Journal of Nursing, 3*(16), 831–836.
- Ferreira, V., Amestoy, S., Silva, G., Trindade, L., Santos, I., & Varanda, P. (2020). Transformational leadership in nursing practice: Challenges and strategies. *Revista Brasileira De Enfermagem, 73*(6), 1-7. https://doi.org/10.1590/0034-7167-2019-0364
- Forde, R., Arente, L., Ausili, D., De Backer, K., Due-Christensen, M., Epps, A., Fitzpatrick, A., Grixti, M., Groen, S., Halkoaho, A., Huber, C., Iversen, M. M., Johansson, U. B., Leippert, C., Ozcan, S., Parker, J., Paiva, A. C., Sanpetreanu, A., Yoldi, C. (2021). The impact of the COVID-19 pandemic on people with diabetes and diabetes services: A

pan-European survey of diabetes specialist nurses undertaken by the Foundation of European Nurses in Diabetes survey

- Forero, R., Nahidi, S., De Costa, J., Mohsin, M., Fitzgerald, G., Gibson, N., McCarthy,S., & Aboagye-Sarfo, P. (2018). Application of four-dimension criteria to assess rigour of qualitative research in emergency medicine. *BMC Health Services Research, 18*(1), 120. https://doi.org/10.1186/s12913-018-2915-2
- Gaines, K. (2017, February 28). *Where am I going? The list of hospital unit acronyms every nurse should know.* Industry. https://nurse.org/articles/hospital-unitacronyms/
- Gaines, K. (2022, October 26). *ICU nurse*. Guide.
- Gifford, B., Zammuto, R., & Goodman, E. (2002). The relationship between hospital unit culture and nurses' quality of work life. *Journal of Healthcare Management, 47*(1), 13-25. https://doi.org/10.1097/00115514-200201000-00005
- Gillet, N., Fouquereau, E., Bonnaud-Antignac, A., Mokounkolo, R., & Colombat, P. (2013). The mediating role of organizational justice in the relationship between transformational leadership and nurses' quality of work life: A cross-sectional questionnaire survey. *International Journal of Nursing Studies, 50*(10), 1359–1367. https://doi-org./10.1016/j.ijnurstu.2012.12.012
- Goldstein, D. (1971). The occupational safety and health act of 1970. *The American Journal of Nursing*, *71*(8), 1535–1538. https://doi.org/10.2307/3421832
- Goldstein, D., & Benoit, J. (1975). Occupational safety and health. *The American Journal of Nursing*, *75*(10), 1759–1759. https://doi.org/10.2307/3423560
- Gomaa, A., Tapp, L., Luckhaupt, S., Vanoli, K., Sarmiento, R., Raudabaugh, W., & Sprigg, S. (2014). Occupational traumatic injuries among workers in health care facilities - United States, 2012-2014. *MMWR. Morbidity and Mortality Weekly Report*, *64*(15), 405–410.
- Gorli, R. (2018). A new approach for employee safety in industries with IoT. *IManager's*
- Greer, M. E. (2001). 90 Years of progress in safety. *Professional Safety*, *46*(10), 20.
- Guo, L., Yin, X., Zeng, X., Tang, L., & Zhang, D. (2022). Nursing practice combined with scene simulation teaching mode in standardized training and teaching for newly recruited nurses in post anesthesia care unit. *Iranian Journal of Public Health, 51*(4), 831-838. https://doi.org/10.18502/ijph.v51i4.9244
- Hammer, L., Truxillo, D., Bodner, T., Pytlovany, A., & Richman, A. (2019). Exploration of the impact of organisational context on a workplace safety and health intervention. *Work and Stress, 33*(2), 192-210.
- Harris, S. (2013). Safety culture in healthcare: The $13 billion case. *Professional Safety*,
- Hartley, J. (2014). Some thoughts on Likert-type scales. *International Journal of Clinical and Health Psychology*, *14*(1), 83-86. https://doi.org/10.1016/S1697-2600(14)70040-7
- History.com Editors. (2009). *Florence Nightingale – biography, Facts & Nursing*.
- History.com. Retrieved May 7, 2023, from
- Hopcia, K., Dennerlein, J. T., Hashimoto, D., Orechia, T., & Sorensen, G. (2012). Occupational injuries for consecutive and cumulative shifts among hospital registered nurses and patient care associates: A case-control study. *Workplace Health & Safety*, *60*(10), 437–444. https://doi.org/10.1177/216507991206001005
- Hoy, W. (1990). Organizational climate and culture: A conceptual analysis of the school workplace. *Journal of Educational & Psychological Consultation*, *1*(2), 149-168.
- http://www.jstor.org/stable/828003

- https://doh.wa.gov/public-health-healthcare-providers/healthcare-professions-andfacilities/healthcare-associated-infections/hai-reports/types-hospital-units
- https://doi.org/10.1007/s10869-019-09658-3
- https://doi.org/10.1080/02678373.2018.1496159
- https://doi.org/10.1097/EDE.0b013e3181935ad6
- https://doi.org/10.1097/HMR.0000000000000006
- https://doi.org/10.1097/NNA.0000000000000430
- https://doi.org/10.1108/01409171111136211
- https://doi.org/10.1111/dme.14498
- https://doi.org/10.1111/j.1365-2850.2011.01701.x
- https://doi.org/10.1111/jonm.12480
- https://doi.org/10.1177/1527154406297896
- https://doi.org/10.1186/1472-6963-11-98
- https://doi.org/10.1186/s12912-022-01123-6
- https://doi.org/10.1207/s1532768xjepc0102_4
- https://doi.org/10.1308/003588413X13511609956372
- https://doi.org/10.3390/ijerph16081425
- https://doi/10.1097/NNA.0000000000000690.
- https://nurse.org/resources/intensive-care-unit-nurse-career-guide/
- https://uscode.house.gov/view.xhtml?path=/prelim@title29/chapter15&edition =
- https://www.bls.gov/iif/snapshots/osn-registered-nurses-2015-19.htm
- https://www.bls.gov/iif/snapshots/osn-registered-nurses-2016-20.htm
- https://www.history.com/topics/womens-history/florence-nightingale-1
- https://www.osha.gov/sites/default/files/1.2_Factbook_508.pdf
- https://www-proquest-com./scholarly-journals/what-isleadership/
- Hutchinson, M., & Jackson, D. (2013). Transformational leadership in nursing: Towards a more critical interpretation. *Nursing Inquiry, 20*(1), 11-22. https://doiorg./10.1111/nin.12006
- Hyun, Y., & Hyun, L. (2021). Safety climate, nursing organizational culture and the intention to report medication errors: A cross-sectional study of hospital nurses. *Nursing Practice Today, 8*(4), 284–292
- Ivankova, N., & Wingo, N. (2018). Applying mixed methods in action research: Methodological potentials and advantages. *The American Behavioral Scientist (Beverly Hills), 62*(7), 978-997. https://doi.org/10.1177/0002764218772673
- James, K. (2015). Leadership particular interest group: What is leadership? *Canadian Oncology Nursing Journal = Revue Canadienne De Nursing Oncologique, 25*(1), 114-115. https://www-proquest-com/trade-journals/leadership-special-interestgroup-what-is/docview/1768623050/se-2
- Jogulu, U., & Pansiri, J. (2011). Mixed methods: A research design for management doctoral dissertations. *Management Research News, 34*(6), 687-701.
- Jones, R., Jimmieson, N., & Griffiths, A. (2005). The impact of organizational culture and reshaping capabilities on change implementation success: The mediating role of readiness for change. *Journal of Management Studies, 42*(2), 361- 386. https://doi.org/10.1111/j.1467-6486.2005.00500.xlang–en/index.htm.
- Jones, T., Baxter, M., & Khanduja, V. (2013). A quick guide to survey research. *Annals*

- *Journal on Information Technology, 7*(2), 22-29. https://doi.org/10.26634/jit.7.2.14650
- Kao, K., Thomas, C. L., Spitzmueller, C., & Huang, Y. (2021). Being present in enhancing safety: Examining the effects of workplace mindfulness, safety behaviors, and safety climate on safety outcomes. *Journal of Business and Psychology, 36*(1), 1-15.
- Kasaoka S. (2017). Evolved role of the cardiovascular intensive care unit (CICU). *Journal of intensive care, 5*, 72. https://doi.org/10.1186/s40560-017-0271-7
- Kelly, L. A, Wicker, T. L., & Gerkin, R. D. (2014). The relationship of training and education to leadership practices in frontline nurse leaders. *JONA: The Journal of Nursing Administration, 44*(3), 158-163. https://doi.org/10.1097/nna.0000000000000044
- Kettles, A., Creswell, J., & Zhang, W. (2011). Mixed methods research in mental health nursing. *Journal of Psychiatric and Mental Health Nursing, 18*:535-542.
- Khan, A. R., Rosenthal, C. D., Ternes, K., Sing, R. F., & Sachdev, G. (2022). Time spent by intensive care unit nurses on the electronic health record. *Critical Care Nurse, 42*(5), 44–50. https://doi.org/10.4037/ccn2022518
- Khan, B., Quinn Griffin, M., & Fitzpatrick, J. (2018). Staff nurses' perceptions of their nurse managers' transformational leadership behaviors and their own structural empowerment. *JONA: The Journal of Nursing Administration, 48*(12), 609-614.
- Kim, B., & Jung, S. (2019). The mediating role of job strain in the transformational Leadership⁻ Safety behavior link: The buffering effect of self-efficacy on safety. *International Journal of Environmental Research and Public Health, 16*(8), 1425.
- Kim, N., & Moon, K. (2021). Factors affecting patient safety culture in terms of compliance with preventing bloodborne pathogens among general hospital nurses. *BMC Nursing, 20*(1), 5. https://doi.org/10.1186/s12912-020-00529-4
- Kleinman, C. (2004). The relationship between managerial leadership behaviors and staff nurse retention. *Hospital Topics, 82*(4), 2–9. https://doi.org/10.3200/HTPS.82.4.2-9
- Kuhnert, K., & Lewis, P. (1987). Transactional and transformational leadership: A constructive/developmental analysis. *The Academy of Management Review, 12*(4),
- Labrague, L. (2021). Influence of nurse managers' toxic leadership behaviours on nursereported adverse events and quality of care. *Journal of Nursing Management, 29*(4), 855-863. https://doi.org/10.1111/jonm.13228
- Lannon, B., & Reichelt, P. (1998). Nurse managers' role in injury prevention. *Nursing*
- leadership as vital enhancers of personal hope and resilience during the COVID-
- leadership. *Professional Safety, 63*(8), 41-47. Manuele, F. (2011). Reviewing Heinrich dislodging two myths from the practice of safety. *Professional Safety, 56*(10), 52–61.
- Lee, D., Halleck, J., & Lee, H. (2023). The impact of union membership on nursing turnover and job satisfaction. *The Journal of Nursing Administration, 53*(6), 353-360. https://doi.org/10.1097/NNA.0000000000001296
- Lee, E., Zheng, H., Aung, H., Seidmann, V., Li, C., Aroor, M., Lwin, M., Ho, S., & Theng, Y. (2021). Examining organizational, cultural, and individual-level factors related to workplace safety and health: A systematic review and metric analysis. *Health Communication, 36*(5), 529-539. https://doi.org/10.1080/10410236.2020.1731913
- Lee, M., Jeong, M., Park, S., & Kim, E. (2021). Occupational safety and health officials' perception of safety and health education for business owners. *Turkish Journal of Computer and Mathematics Education, 12*(5), 392-400.

https://www.proquest.com/scholarlyjournals/occupational-safety-health-officialsperception/docview/2623049183/se-2

- Lichtman, M. (2006). *Qualitative research in education: A user's guide*. Thousand
- Magbity, J., Ofei, A., & Wilson, D. (2020). Leadership styles of nurse managers and
- *Management, 29*(8), 70-72. https://doi.org/10.1097/00006247-199808000-00020
- Marceau, M., Ledoux, I., Lavoie, S., Benyamina Douma, N., Mailhot-Bisson, D., & Gosselin, É. (2022). Exploration of the occupational and personal dimensions impacted by the COVID-19 pandemic for nurses: A qualitative analysis of survey responses. *Journal of Advanced Nursing, 78*(7), 2150-2164. https://doi.org/10.1111/jan.15167
- Marshall, F. (1988). What is a nurse: Perceptions of baccalaureate nursing students. *The Journal of Nursing Education, 27*(4), 185-186. https://doi.org/10.3928/0148-4834-19880401-12
- Mattson Molnar, M., Von Thiele Schwarz, U., Hellgren, J., Hasson, H., & Tafvelin, S. (2019). Leading for safety: A question of leadership focus. *Safety and Health at Work, 10*(2), 180–187. https://doi.org/10.1016/j.shaw.2018.12.001
- McFadden, K., Stock, G., & Gowen, C. (2015). Leadership, safety climate, and continuous quality improvement: Impact on process quality and patient safety. *Health Care Management Review, 40*(1), 24-34.
- McPhaul, K. (2021) OSHA and NIOSH turn 50. *Workplace Health & Safety, 69*(5): 236-
- Medeiros, C., Coropes, V., Silva, K., Shoji, S., Souza, N., Souza, M., & Nascimento, S. (2021). Occupational damage to nurses in primary health care. *Rev Rene, 22*(1), 1-7. https://doi.org/10.15253/2175-6783.20212260056
- Merriam-Webster. (n.d.) Safety. In Merriam-Webster.com dictionary. Retrieved December 12, 2022, from https://www.merriam-webster.com/dictionary/safety
- Michaels, D., & Barab, J. (2020). The occupational safety and health administration at 50: Protecting workers in a changing economy. *American Journal of Public Health, 110*(5), 631–635. https://doi.org/10.2105/AJPH.2020.305597
- Molina-Azorin, J. (2016). Mixed methods research: An opportunity to improve our studies and our research skills. *European Journal of Management and Business Economics, 25*(2), 37-38. https://doi.org/10.1016/j.redeen.2016.05.001
- Mullen, K., Gillen, M., Kools, S., & Blanc, P. (2015). Hospital nurses working wounded: Motivations and obstacles to return to work as experienced by nurses with injuries. *Work (Reading, Mass.), 50*(2), 295-304. https://doi.org/10.3233/WOR-131800
- Mykhnyuk, M., & Abiltarova, E. (2020). Instilling safety culture into future occupational health and safety specialists. *IOP Conference Series.Materials Science and Engineering, 753*(8) https://doi.org/10.1088/1757-899X/753/8/082029
- National Association of Neonatal Nurses. (n.d.) *Is a career in neonatal nursing right for you?* http://nann.org/about/what-is-neonatal-nursing
- Nixon, A., Lanz, J., Manapragada, A., Bruk-Lee, V., Schantz, A., & Rodriguez, J. (2015). Nurse safety: How is safety climate related to affect and attitude? *Work and Stress, 29*(4), 401-419. https://doi.org/10.1080/02678373.2015.1076536
- Northouse P. (2021). Leadership theory and practice (Ninth). *SAGE Publishing*.
- *Nursing Administration, 46*(4), 215-220. https://doi.org/10.1097/NNA.0000000000000330

- O'Connor, S., & Carlson, E. (2016). Safety culture and senior leadership behavior: Using negative safety ratings to align clinical staff and senior leadership. *The Journal of*
- O'Donovan, R., Ward, M., De Brún, A., & McAuliffe, E. (2019). Safety culture in health care teams: A narrative review of the literature. *Journal of Nursing Management, 27*(5), 871-883. https://doi.org/10.1111/jonm.12740
- Oaks: Sage Publications. Lincoln, Y. S., & Guba, E. G. (2007). But is it rigorous? trustworthiness and authenticity in naturalistic evaluation. *New Directions for Evaluation*, (114), 15-25. https://doi.org/10.1002/ev.223
- Occupational Safety and Health Administration. (2013). *Caring for our caregivers: Facts about hospital worker safety.*
- Occupational Safety and Health Administration. (n.d.) *Healthcare*. Retrieved September 28, 2023, from https://www.osha.gov/healthcare
- Occupational Safety and Health Administration. (n.d.) *OSH Act of 1970.* Retrieved May 27, 2023, from https://www.osha.gov/laws-regs/oshact/completeoshact
- Occupational Safety and Health Administration. (n.d.) *OSHA's 30th Anniversary*. Retrieved May 27, 2024, from www.osha.gov/aboutosha/30-years
- Occupational Safety and health, 29 U.S. Code § 651 (1970).
- *of Nursing Administration, 31*(11), 524-526.
- *of the Royal College of Surgeons of England, 9*5(1), 5–7.
- Olans, R. D., Olans, R. N., & DeMaria, A., Jr (2022). Florence Nightingale and Antimicrobial Stewardship. *Florence Nightingale journal of nursing*, *30*(1), 106–108. https://doi.org/10.5152/fnjn.2022.21141
- Olawoyin, R. (2018). Emotional intelligence: Assessing its importance in safety
- Olawoyin, R. (2018). Emotional intelligence: Assessing its importance in safety leadership. *Professional Safety, 63*(8), 41-47.
- OSHA's impact. The Journal of Law & Economics, 28(1), 1–25. http://www.jstor.org/stable/725463
- Persaud, E., & Mitchell, A. (2021). Needlestick injuries among healthcare workers administering COVID-19 vaccinations in the United States. *New Solutions, 31*(1), 16-19. https://doi.org/10.1177/10482911211001483
- prelim
- Probst, T., Brubaker, T., & Barsotti, A. (2008). Organizational injury rate underreporting: The moderating effect of organizational safety climate. *Journal of Applied Psychology, 93*(5), 1147-1154. https://doi.org/10.1037/0021-9010.93.5.1147
- Qureshi, S., Bookey-Bassett, S., Purdy, N., Greig, M., Kelly, H., & Neumann, W. (2022). Modelling the impacts of COVID-19 on nurse workload and quality of care using process simulation. *PloS one, 17*(10), e0275890. https://doi.org/10.1371/journal.pone.0275890
- Richards, A. (2020) Exploring the benefits and limitations of transactional leadership in healthcare. *Nursing Standard, 35*(12), 46-50. https://doi.org/10.7748/ns.2020.e11593
- Rivard, S., Lapointe, L., & Kappos, A. (2011). An organizational culture-based theory of
- Robertson, M., Tubbs, D., Henning, R., Nobrega, S., Calvo, A., & Murphy, L. (2021). Assessment of organizational readiness for participatory occupational safety, health and well-being programs. *Work, 69*(4), 1317–1342. https://doi.org/10.3233/WOR-213552

- Rouse, R. (2009). Ineffective participation: Reactions to absentee and incompetent nurse leadership in an intensive care unit. *Journal of Nursing Management, 17*(4), 463- 473. https://doi.org/10.1111/j.1365-2834.2009.00981.x
- Sackmann, S. (1992). Culture and subcultures: An analysis of organizational knowledge. *Administrative Science Quarterly*, *37*(1), 140–161.
- Sakuda, H., Ogushi, A., & Sakaguchi, M. (2020). Structure of nursing practice of flight nurses. *Journal of Japan Academy of Nursing Science, 40,* 252–259. https://doi.org/10.5630/jans.40.252
- Saleh, A., Darawad, M., & Al-Hussami, M. (2015). The perception of hospital safety culture and selected outcomes among nurses: An exploratory study. *Nursing & Health Sciences, 17*(3), 339-346. https://doi.org/10.1111/nhs.12196
- Saleh, U., O'Connor, T., Al-Subhi, H., Alkattan, R., Al-Harbi, S., & Patton, D. (2018). The impact of nurse managers' leadership styles on ward staff. *British Journal of Nursing, 27*(4), 197-203. https://doi.org/10.12968/bjon.2018.27.4.197
- Samur, M., & Intepeler, S. S. (2017). Factors influencing nurses' perceptions of occupational safety. *Archives of Environmental & Occupational Health, 72*(1),45-52. https://doi.org/10.1080/19338244.2016.1156045
- Sanchez, T. R. (2006). The Triangle Fire: A simulation-based lesson. *Social Studies*, *97*(2), 62–68. https://doi-org./10.3200/TSSS.97.2.62-68
- Schneider, B. (1975). Organizational climates: An essay. *Personnel Psychology, 28*(4), 447-479. https://doi.org/10.1111/j.1744-6570.1975.tb01386.x
- Seago, J. A., Spetz, J., Ash, M., Herrera, C., & Keane, D. (2011). Hospital RN job satisfaction and nurse unions. *The Journal of Nursing Administration, 41*(3), 109-114. https://doi.org/10.1097/NNA.0b013e31820c726f
- Seo, J., & Lee, S. (2022). Mediating roles of patient safety knowledge and motivation in the relationship between safety climate and nurses' patient safety behaviors: A structural equation modeling analysis. *BMC nursing*, *21*(1), 335.
- Sharma H. (2022). How short or long should be a questionnaire for any research? Researchers dilemma in deciding the appropriate questionnaire length. *Saudi Journal of Anaesthesia, 16*(1), 65–68. https://doi.org/10.4103/sja.sja_163_21
- Sherwood, G. (2015). Perspectives: Nurses' expanding role in developing safety culture: Quality and safety education for nurses – competencies in action. *Journal of Research in Nursing, 20*(8), 734-740. https://doi.org/10.1177/1744987115621142
- Siami, S., Gorji, M., & Martin, A. (2023). Psychosocial safety climate and supportive
- Silva, A. (2016). What is leadership? *Journal of Business Studies Quarterly*, *8*(1), 1-5.
- *snapshot; Registered Nurses, 2015-2019.*
- Sproat, S. (2001). Using organizational artifacts to Influence Change. *JONA: The Journal*
- Squires, M., Tourangeau, A., Spence-Laschinger, H., & Doran, D. (2010). The link between leadership and safety outcomes in hospitals. *Journal of Nursing Management, 18*(8), 914-925. https://doi.org/10.1111/j.1365-2834.2010.01181.x
- Stanley, D. (2008). Congruent leadership: Values in action. *Journal of Nursing Management, 16*(5), 519-524. https://doi.org/10.1111/j.1365-2834.2008.00895.x
- Stanton, P., Bartram, T., & Bamber, G. J. (2022). The role of nurses' unions in workplace innovation in Australian and Canadian hospitals: Analysing union strategies. *Industrial Relations Journal*, *53*(5), 484–500. https://doiorg.reddog.rmu.edu/10.1111/irj.12378

- Stone, P., & Gershon, R. (2006). Nurse work environments and occupational safety in intensive care units. *Policy, Politics & Nursing Practice*, *7*(4), 240-247.
- Strickler, J. (2017). Florence Nightingale: Lighting the way for the future of nursing. *Nursing (Jenkintown, Pa.)*, *47*(12), 43-45. https://doi.org/10.1097/01.NURSE.0000526887.95058.3b
- Tamers, S., Streit, J., Pana-Cryan, S., Tapas, R., Syron, L., Flynn, M., Castillo, D., Roth, G., Geraci, C., Guerin, R., Schulte, P., Henn S., Chang, C., Felknor, S., & Howard, J. (2020). Envisioning the future of work to safeguard the safety, health, and well-being of the workforce: A perspective from the CDC's national institute for occupational safety and health. *American Journal of Industrial Medicine*, *63*(12), 1065–1084. https://doi.org/10.1002/ajim.23183
- Tavakol, M., & Dennick, R. (2011). Making sense of Cronbach's alpha. *International Journal of Medical Education*, 2, 53–55. https://doi.org/10.5116/ijme.4dfb.8dfd
- Thompson, F. & Scicchitano, M. (1985). State implementation effort and federal regulatory policy: The case of occupational safety and health. *The Journal of Politics*, *47*(2), 686–703. https://doi.org/10.2307/2130903
- Tsai, Y. (2011). Relationship between organizational culture, leadership behavior and job satisfaction. *BMC Health Services Research, 11*(1), 98-98.
- turnover intention. *Hospital Topics*, *98*(2), 45–50. https://doiorg./10.1080/00185868.2020.1750324
- U.S. Bureau of Labor Statistics. (2021). *Employer-reported workplace injuries and illnesses-2020.* https://www.bls.gov/news.release/pdf/osh.pdf
- U.S. Bureau of Labor Statistics. (2021). *Injuries, illnesses, and fatalities: Occupational*
- U.S. Bureau of Labor Statistics. (2022). *Injuries, illnesses, and fatalities: Occupational snapshot; Registered nurses, 2016-2020.*
- UAB Medicine. (n.d.). *Neurosciences intensive care unit (NICU).* https://www.uabmedicine.org/web/careers/nursing/browse-nursingunits/neuroscience-services/neurosciences-intensive-care-unit
- Vatani, J., Arami, M., Khanikosarkhizi, Z., Shahabi Rabori, M. A., Khandan, M., Dehghan, N., Aminizadeh, M., Poursadeqiyan, M., & Jafari, M. (2021). Safety climate and related factors in rehabilitation nurses of hospitals in Iran. *Work*, *68*(1), 189–196. https://doi.org/10.3233/WOR-203368
- Wang, H., Fennie, K., He, G., Burgess, J., & Williams, A. (2003). A training programme for prevention of occupational exposure to bloodborne pathogens: impact on knowledge, behaviour and incidence of needle stick injuries among student nurses in Changsha, People's Republic of China. *Journal of Advanced Nursing*, *41*(2),187–194. https://doi.org/10.1046/j.1365-2648.2003.02519.x
- Washington State Department of Health. (n.d.). *Types of hospital units*.
- Weiner, B. (2009). Theory of organizational readiness for change. *Implementation Sci, 4*(67). https://doi.org/10.1186/1748-5908-4-67
- Weng, R., Huang, C., Chen, L., & Chang, L. (2015). Exploring the impact of transformational leadership on nurse innovation behaviour: A cross-sectional study. *Journal of Nursing Management, 23*(4), 427-439. https://doi.org/10.1111/jonm.12149
- Wilson, C. (2005). Said another way. my definition of nursing. *Nursing Forum (Hillsdale), 40*(3), 116-118. https://doi.org/10.1111/j.1744-6198.2005.00016.x

- Winkelstein, W. (2009). Florence Nightingale: Founder of modern nursing and hospital epidemiology. *Epidemiology (Cambridge, Mass.)*, *20*(2), 311-311.
- World Health Organization (n.d.). *Nursing and midwifery.* https://www.who.int/health-topics/nursing#tab=tab_1
- Wunderlich, G., Sloan F., Davis C. (1996). *Institute of Medicine (US) Committee on the adequacy of nursing staff in hospitals and nursing homes; Nursing staff in hospitals and nursing homes: Is it adequate? Washington (DC): National Academies Press (US); 1996*. 7, Staffing and Work-Related Injuries and Stress. Available from: https://www.ncbi.nlm.nih.gov/books/NBK232675/
- Wynne-Jones, J., Martin-Babin, M., Hayward, B., & Villa, L. (2020). Patient safety leadership walk rounds: Lessons learned from a mixed-methods evaluation. *Kai Tiaki Nursing Research*, *11*(1).https://link.gale.com/apps/doc/A646895625/AONE?u=anon~688903f6&sid=googleScholar&xid=44670109
- Zohar, D. (1980). Safety climate in industrial organizations: Theoretical and applied implications. *Journal of Applied Psychology, 65*(1), 96-102. https://doi.org/10.1037/0021-9010.65.1.96
- Zohar, D. (2000). A group-level model of safety climate: Testing the effect of group climate on microaccidents in manufacturing jobs. *Journal of Applied Psychology, 85*(4), 587-596. https://doi.org/10.1037/0021-9010.85.4.587
- Zohar, D. (2002). The effects of leadership dimensions, safety climate, and assigned priorities on minor injuries in work groups. *Journal of Organizational Behavior,23*(1), 75–92. http://www.jstor.org/stable/4093686
- Zohar, D. (2003). Safety climate: Conceptual and measurement issues. In J. C. Quick &L. E. Tetrick (Eds.), *Handbook of Occupational Health Psychology* (pp. 123–142). American Psychological Association. https://doi.org/10.1037/10474-006

تأثير الثقافة التنظيمية والقيادة على سلامة الممرضات: تصورات الممرضات

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الملخص

الهدف: تستكشف هذه الدراسة تصورات الممرضات ومشاعرهن ووجهات نظرهن حول تجاربهن العملية في المستشفيات، مع التركيز على القيادة، والثقافة التنظيمية على مستوى الوحدة، وأهمية الأمراض والإصابات في مكان العمل. ثانيًا، تبحث الدراسة في كيفية إدراك الممرضات لتأثير الثقافة التنظيمية والقيادة على صحتهن وسلامتهن. ثالثًا، تبحث الدراسة فيما إذا كان يُعتقد أن بعض سلوكيات القيادة تؤثر سلبًا على سلامة الممرضات. وأخيرًا، تحدد الدراسة ممارسات القيادة والتنظيم المتصورة التي تدعم الممرضات في تقديم رعاية آمنة وعالية الجودة للمرضى مع تقليل مخاطر المرض والإصابة.

التصميم: استُخدم تصميم دراسة مقطعية باستخدام استبيان ذاتي شمل 300 ممرضة يعملن في مستشفيات حكومية وخاصة في المنطقة الجنوبية من الضفة الغربية – فلسطين.

المنهجية: جُمعت البيانات بين مايو ويونيو 2025 باستخدام مقياس لقياس تصورات الممرضات للعوامل الهيكلية المرتبطة بالثقافة التنظيمية والقيادة وثقافة السلامة التي تؤثر على سلامة الممرضات وصحتهن. شمل التحليل إحصاءات وصفية، وإحصاءات استدلالية، وتحليلات ارتباطية.

النتائج: أشارت النتائج إلى أن التعاون وبيئة العمل الداعمة يؤثران إيجابًا على رضا الممرضات عن وظائفهن. ولتعزيز سلامة الممرضات، ينبغي على قادة الوحدات التأكيد على بروتوكولات السلامة، وغرس ثقافة تركز على السلامة، وتعزيز ممارسات السلامة بين الموظفين. وفيما يتعلق بتصورات ثقافة الوحدة التنظيمية، بلغ متوسط الدرجات الإجمالي 3.41، مما يشير إلى تقييم جيد. وسجل البعد المحدد لثقافة الوحدة التنظيمية 3.71، وسجلت تصورات الممرضات لوحدتهن الحالية 3.15، وكلاهما يُعتبر جيدًا أيضًا. وُجدت معاملات ارتباط تشير إلى وجود علاقة إيجابية قوية بين المتغيرات في إدارة المرض والإصابة والعودة إلى العمل (r = 832.، .(001. > pويعني الارتباط الإيجابي القوي أنه مع زيادة أحد المتغيرات، يميل الآخر إلى الزيادة أيضًا.

الكلمات المفتاحية: ممرضة مسجلة، السلامة والصحة المهنية، الرعاية الصحية، التمريض، المستشفيات، سلامة الممرضات، إصابات الممرضات.