Nurse–Patient/Relatives Conflict and Patient Safety Competence Among Nurses

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Abstract

Nurse–patient/relatives conflicts may adversely impact the well-being and work performance of nurses, which could prelude to the possibility of unwanted errors thereby threatening patient safety. This descriptive and cross-sectional study aimed to examine the association between nurses' perceived nurse–patient/family conflicts and their perceived patient safety (PS) competence. Nurse–patient/relatives conflicts are critical issues that may adversely impact the nurses' well-being, which could prelude to unwanted errors, thereby threatening PS. The study surveyed 320 nurses in Saudi Arabia using the "Healthcare Conflict Scale" and "Health Professional Education in Patient Safety Survey" from December 2019 to January 2020. The subscale "mistrust of motivations" was perceived to have the greatest conflict, whereas "contradictory communication" was rated as the lowest conflict. A significant difference was observed between the perceived conflict and the different hospital units where nurses worked. Saudi nurses reported higher nurse–patient/family conflicts than Filipino and Indian nurses. The highest PS competence was reported in "communicating effectively," whereas "working in teams with other health professionals" had the poorest safety competence. The nurses' perceived "mistrust of motivations" and "contradictory communication" were associated with poorer self-reported PS competence. Perceived conflicts between nurses and their patients/relatives had negative association with the perceived confidence of nurses in the difference patient safety competencies. The results can become the basis for formulating hospital policies geared toward the elimination of healthcare conflicts to help ensure the patient safety competence of nurses. Policies on mitigating conflicts between healthcare workers and patients/relatives must be created and implemented.

Keywords

healthcare conflict, patient safety, patient safety competence, nurses, workplace violence

Highlights

What is already known about this topic?
- Conflicts are pressing issues in organizations, particularly in healthcare settings where the staff continuously interacts with patients and their families.

How does your research contribute to the field?
- Nurse–patient/family conflicts had shown negative association with patient safety competence as perceived by the nurses.

What are your research's implications towards theory, practice, or policy?
- The study provides information to support the creation of hospital policies geared toward the elimination of healthcare conflicts to help ensure the patient safety competence of nurses.

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Introduction

A critical issue worldwide, healthcare conflict is a complex dysfunctional behavior in healthcare settings that affect diverse hospital human resources.[1] Healthcare conflicts range from dissimilarities to main disagreements that may lead to violence. Its negative effects include decreased quality of life, poor well-being, job dissatisfaction, decreased job performance, and increased turnover intentions among healthcare workers.[2,3] Moreover, healthcare conflicts can also result in poor quality of nursing care and less patient-centered care.[4,5]

Providing a competent, safe, and improved healthcare services has become a focal point of relevant policies in healthcare institutions in Saudi Arabia and around the globe.[6] Nurses, as the frontline staff in any healthcare institution and comprising the largest population of healthcare workers that provide direct patient care, are expected to possess high levels of competencies in nursing care and patient safety.[7] However, in countries such as Saudi Arabia that heavily rely on expatriate nurses to augment the chronic staff shortage, healthcare institutions are becoming culturally diverse.[8] Nurses have different values, beliefs, and clinical work ethics, which could affect interpersonal relationships with patients or relatives. Conflicts may become disruptive and threaten patient safety. Understanding the nurse–patients/relatives conflicts in healthcare settings and examining how these negative events impact patient safety are therefore critical.

Background

Conflicts are a pressing issue in organizations, particularly in healthcare settings where the staff continuously interacts with patients and their families. Marquis and Huston state that conflict is the result of individual experiences or disparities of visions, goals, objectives, ideas, attitudes, and beliefs, which can be positive or negative and healthy or apathetic within the workplace environment.[9] In healthcare settings, interpersonal conflicts may arise between doctors, nurses, other healthcare workers, and patients/relatives.[1] Conflict among healthcare workers is common and could be caused by the differences in professional values, roles, and expectations among healthcare workers.[10,11] However, conflicts may also arise between healthcare providers and patients/relatives, which and are also a cause of concern in the healthcare environment that needs to be focused.[12] Interpersonal relationships between nurses and patients/relatives are commonly sever due to uncivil and negative behaviors, such as unsupportive environments, bullying, and humiliation.[3] Conflicts between healthcare workers and patients/relatives often begin due to differences on expectations, opinions, and beliefs regarding what constitutes an effective and high-quality care.[12,13] Dissatisfaction of patients/relatives with the quality of care that they receive, and their overall hospital experience often leads to their unwarranted conflicts with healthcare providers.[12,13]

Evidence suggests that conflicts between nurses and patient/relatives is widely experienced worldwide. For example, a study conducted in nursing homes in Canada reported 28 staff–family conflicts out of 124 daily diary calls (22.2%), with majority of the conflicts ranging from mild to moderate in severity.[14] In two studies conducted in Saudi Arabia, nurses report experiencing most of the uncivil behaviors from patients, their families, and visitors during hospital stays.[4,15] Ethno-cultural differences between the nurses and the patients/relatives, together with contextual and structural factors, can trigger such conflicts to arise.[12,16] For instance, an earlier study reported that conflicts that arise between nurses and the patient's family were hugely associated with the situation and organization of healthcare settings, such as pressure in time, vagueness of medical decisions, and limited visiting hours, which could alter meaningful communications and could lead to conflicts.[12] Overall, these conflicts can adversely affect the clinical work environment and likely lead to job dissatisfaction, decreased quality of life, and poor patient safety work performance of healthcare workers.

In Saudi Arabia, healthcare continues to evolve, and recent observations show substantial development in patient safety.[17] Ensuring and sustaining high levels of patient safety competence is vital in diminishing medical errors and improving quality patient care. The World Health Organization has defined patient safety as "the absence of preventable harm to a patient during the process of healthcare and reduction of risk of unnecessary harm associated with healthcare to an acceptable minimum."[18] In this study, patient safety competence is defined as the nurses' confidence in the patient safety competencies along six domains, namely "working in teams with other health professionals, communicating effectively, managing safety risks, understanding human and environmental factors that influence patient safety, recognizing and responding to adverse events, and culture of safety."[19] Assessing the patient safety competence among nurses and other healthcare workers is thus a popular research topic because of the importance of ensuring safe patient care. Ensuring such competence requires a committed, positively engaged, and empowered nurses in a supportive and cooperative working environment. However, nurses encounter several work-related factors (i.e., problematic teamwork, faulty communication, and negative behaviors toward nurses) and nurse-related (i.e., inadequate patient safety education, clinical experience, and critical thinking) challenges in attaining high levels of patient safety competence.[15,20]

Conflicts promote a culture of disrespect, which can be a potential obstacle to patient safety.[21] Patient safety depends on collaborative relationships within the healthcare setting. Communication and teamwork are essential to patient safety.[22] Communication failure is included as a "root cause" of reported sentinel events according to the latest report of the Joint Commission.[23] A lot of these failures in communication in the healthcare are caused by conflicts.[24] Furthermore, effective nurse–patient relationships are fundamental in ensuring patient safety.[22] A good nurse–patient relationship was reported to be associated with improved general care and

better healing results. By contrast, poor relationship between the nurse and the patient leads to poor communication and interaction with patients.[25] Conflicts that arise between nurses and patient/relative can sever the nurse–patient relationship. A previous study argued that conflicts involving family members cause more stress to nurses compared with other members of the healthcare team due to their direct and constant interaction with the patients and their family.[26] The same study reported that nurses vented their concern that they may cause harm and suffering to patients due to conflicts with the family.[26] Moreover, healthcare conflicts can cause adverse effects on the nurses' work performance and lead to unwanted errors, which in turn threaten patient safety.[27] These negative effects of workplace conflicts on the well-being and work performance of nurses are a prelude to the possibility that these negative events may also pose risks to patient safety. However, although previous studies have suggested the negative impacts that conflicts have on patient care quality,[5,27] the impact of nurse–patient/family conflicts on patient remains unexplored. As conflicts are a daily issue in the workplace and creates negative consequences if inadequately attended to, examining this critical issue as perceived by nurses is essential. Examining how these nurse–patients'/relatives' conflicts are associated with the patient safety competence of nurses can provide knowledge on how to improve such competence in healthcare settings. The study hypothesized that these is an association between nurse–patient/relatives conflicts and the nurses' confidence in the difference patient safety competencies.

Aim

This study aims to assess self-reported nurse and patients/relatives conflicts among nurses and investigate its association with the nurses' confidence in patient safety competencies.

Methods

This descriptive and cross-sectional investigation presents the association between nurse–patients/relatives conflicts and the nurses' confidence in patient safety competencies.

Setting and Sample

This investigation was conducted at the King Saud University Medical City (KSUMC) in Riyadh City, Saudi Arabia. The university hospital is a tertiary level hospital and has 1351 beds. KSUMC is a multi-facility and has multi-disciplinary administration with different practice areas such as the Emergency Rooms (ER), Out-patient Department (OPD), Medical Department, Surgical Department, Intensive Care Units (ICU) (adult, pediatric, and post-anesthetic), Maternity Department, Pediatric Department, and Operating Rooms. The university hospital is a leading hospital in the country and delivers acute care services to the inhabitants of Riyadh City and neighboring cities.

This study used a convenience sampling technique and included 320 nurses that fit the following criteria: (1) registered nurse in Saudi Arabia; (2) employed in the university hospital for at least 6 months; (3) provides direct care to patients; and (4) consents to participate. During the data collection, the population of nurses in the setting was 2125. Using the sample size calculator http://www.raosoft.com/samplesize.html, the required sample size was 326 at 5% margin of error and 95% confidence level. A total of 400 nurses were included in the study to ensure adequate sample size. However, 326 were retrieved, and six were excluded due to missing data. Hence, the response rate was 80.0%.

Ethical Consideration

Ethical approval was secured from the Institutional Review Board of King Saud University (Ref. No.: KSU-HE-19-263). This study adheres to the highest ethical standards in conducting surveys. The respondents are properly informed regarding the following: (a) purpose, significance, benefits, and possible risks; (b) expected participation; (c) right for voluntary participation; (d) right to withdraw participation; and (e) assurance of no harm in participation or non-participation. The researcher ensured the protection of respondent anonymity and data confidentiality by (1) foregoing the name of respondents in the survey, (2) asking respondents to place the answered questionnaire in a white blank envelope (provided by the researcher) and sealing it themselves, and (3) instructing the respondents to place the sealed envelope in a drop box. During this research and the dissemination of our findings, no individual personal information is presented; all data are presented collectively. No incentive is offered for participation.

Instrument

The data gathering method utilize a pen-and-paper survey questionnaire containing adapted scales and a demographic and work-related information sheet. This report includes data for the variables (1) demographic and work-related information; (2) healthcare conflicts, specifically between nurse–patients/relatives; and (3) patient safety competence. The demographics are age, sex, nationality, marital status, and education. Work-related variables include the current hospital unit of assignment, length of professional experience as a clinical nurse, and length of professional experience in the country, hospital, and current work area.

Nurses' perceptions of nurse and patients/relatives conflicts are assessed using the "Healthcare Conflict Scale" (HCS) of Forbat et al.[13] HCS assesses the conflict between clinicians and patients/relatives using seven items with three factors: "Mistrust of motivation" (4 items), "Threatening language or actions" (2 items), and "Contradictory communication" (1 item). HCS is used in the surveillance of hospital conflicts and is designed for staff use. The tool asks the respondents to rate the

items from 1 (strongly disagree) to 10 (strongly agree). High scores denote many perceived conflicts in the healthcare setting. HCS has an acceptable Cronbach's alpha (.75) and excellent stability reliability with ICC values above .90 for all seven items.[13] The Principal Component Analysis, conducted by Forbat and colleagues, supports the three-factor solution with explained total variance of 70.2%.[13] The dimension "Mistrust of motivation" contributed 34.4% of the total variance, whereas "Threatening language or actions" and "Contradictory communication" contributed 19.3% and 16.5% of the total variance, respectively. This indicate the acceptable factorial validity of the HCS and its dimension.[13] In the present sample, the overall Cronbach's alpha was .85. For the subscales "Mistrust of motivation" and "Threatening language or actions," the computed Cronbach's alpha was .80 and .72, respectively. Internal consistency for "Contradictory communication" cannot be computed because this subscale comprises of 1 item only.

Patient safety competence is quantified using the "Health Professional Education in Patient Safety Survey" (H-PEPSS) of Ginsburg et al.[19] H-PEPSS assesses the health professionals' perceived level of patient safety competence in six socio-cultural areas, namely, "working in teams with other health professionals, communicating effectively, managing safety risks, understanding human and environmental factors that influence patient safety, recognizing and responding to adverse events, and culture of safety." Thus, patient safety competence in this study is operationally defined as the nurses' confidence in the six socio-cultural areas of patient safety measured by the H-PEPSS. This scale measures the individual's confidence on patient safety competencies in the classroom and clinical areas.[19] For this study, only the clinical component is assessed. H-PEPSS uses a 5-point Likert scale and the means are calculated for each area of patient safety competence. High mean values indicate high confidence in patient safety competence. This scale is valid and reliable.[19] The computed Cronbach's alphas for the dimensions of the scale are as follows: "working in teams with other health professionals" (.81), "communicating effectively" (.85), "managing safety risks" (.85), "understanding human and environmental factors" (.84), "recognizing and responding to adverse events" (.81), and "culture of safety" (.84).[19] The confirmatory factor analysis supported a good model fit for the six dimensions of the scale.[19]

Data Collection

The researcher met with potential respondents during work breaks in the hospital to present the study details and discuss their rights. Data collection was conducted in various staff shifts. Respondents who agreed to partake were requested to affix their signature to the informed consent form, and then were provided the questionnaires in white blank envelopes. Respondents were also instructed to place and seal the filled-out questionnaire in the envelopes then drop these in boxes

installed in the nursing stations. The sealed envelopes were collected from the boxes at the end of each week from December 2019 to January 2020.

Statistical Analysis

The researcher analyzed the data using SPSS version 22.0. Descriptive statistics were used to analyze the demographic and work variables. The mean and standard deviation were conducted for the overall and dimension score of HCS and H-PEPSS. Inferential statistics, including t-tests, one-way ANOVA, and Pearson's correlations, were carried out to examine the associations of and differences on perceived nurse and patients/relatives conflicts according to demographics and work variables. Tukey HSD tests were performed for multiple comparisons if ANOVA revealed significant findings. The researcher also conducted a multiple linear regression analysis for each dimension of patient safety competence as dependent variables with demographics, work, and HCS dimensions as predictor variables. Before conducting the multiple linear regression analyses, the variance inflation factor (VIF) values were examined. The VIF values were ranging from 1.19 to 8.69. According to Plichta et al,[28] VIF values more than 10 indicate multicollinearity problem. The VIF values in this study were less than 10; thus, ruling out multicollinearity problem.

Results

Table 1 shows that the age range was 25–60, with an average of 36.19 (SD = 7.87). More than three-fourths of the respondents were females (87.8%), while two-thirds were married (66.9%) and had a baccalaureate degree in nursing (71.3%). Most of the respondents were Filipinos (60.3%), and the remaining participants were Saudis (13.4%) and Indians (26.3%). In terms of work variables, most of the respondents were assigned in the Medical Department (26.9%), followed by OPD/ER (25.3%). The least number of respondents were assigned to the AKU (2.5%) and the Psychiatric Department (2.5%). The average years of professional experience as a clinical nurse, in Saudi Arabia, KSUMC, and at the present unit were 12.78 (SD = 7.16), 8.61 (SD = 6.18), 7.02 (SD = 5.89), and 6.03 (SD = 5.33), respectively.

Nurse and Patients/Relatives Conflicts and Its Associated Factors

Supplementary Table 1 shows the descriptive findings on the nurses' perceived nurse and patients/relatives conflicts. The overall HCS score was 3.48 (SD = 1.91), indicating the low degree of perceived conflict in the workplace. The highest mean was recorded in the item "The patient and/or family has been aggressive or has made physical or verbal threats" (M =

Table 1. Demographic and work variables (n = 320).

Variable	n	%
Gender		
Male	39	12.2
Female	281	87.8
Nationality		
Saudi	43	13.4
Filipino	193	60.3
Indian	84	26.3
Marital status		
Single	106	33.1
Married	214	66.9
Education		
Diploma	77	24.1
Baccalaureate	228	71.3
Graduate program	15	4.7
Unit		
Out-patient department/Emergency department	81	25.3
Medical department	86	26.9
Surgical department	57	17.8
Intensive care units	43	13.4
Obstetric department	37	11.6
Others (artificial kidney unit, psychiatric department)	16	5.0
	Mean (SD)	Range
Age	36.19 (7.87)	25.00–60.00
Total years of experience	12.78 (7.16)	1.00–39.00
Total years of experience in KSA	8.61 (6.18)	.50–37.00
Total years of experience in the hospital	7.02 (5.89)	.50–29.00
Total years of experience in the unit	6.03 (5.33)	.50–29.00

4.19, SD = 3.07), while the lowest was recorded in the item "The language used by members of the clinical team to describe the patient or medical situation has been perceived as insensitive or offensive by the patient and/or family" (M = 2.73, SD = 2.73). The subscale "mistrust of motivations" was perceived to have the greatest conflict (M = 3.53, SD = 2.02), followed by "threatening language/action" (M = 3.46, SD = 2.19). The subscale "contradictory communications" (M = 3.32, SD = 2.42) was rated as the lowest conflict among the three subscales.

Table 2 shows the results for associations and differences between nurse and patients/relatives conflicts, demographics, and work variables. Saudi nurses (M = 4.19, SD = 1.78) reported higher conflicts than Filipino (M = 3.41, SD = 1.79, P = .039) and Indian (M = 3.29, SD = 2.17, P = .031) nurses. Significant differences were also revealed between different hospital units where nurses worked. Those in the Medical Department (M = 4.11, SD = 1.82), Surgical Department (M = 4.09, SD = 2.18), and OPD/ER (M = 3.61, SD = 1.64) perceived greater conflict than those in the Obstetric Department (M = 2.71, SD = 1.74), ICUs (M = 2.42, SD = 1.51), and others (M = 1.96, SD = 1.44). Small negative correlations were revealed between nurse and patients/relatives conflicts

and age ($r = -.13$, P = .018), total years of professional nursing experience ($r = -.19$, P = .001), and years of nursing experience in Saudi Arabia ($r = -.13$, P = .020).

Factors Associated with the Nurses' Patient Safety Competence

Supplementary Table 2 shows that the item means ranged from 4.03 (SD = .99; "encouraging team members to speak up, question, challenge, advocate and be accountable as appropriate to address safety issues") to 4.34 (SD = .81; "effective verbal and nonverbal communication abilities to prevent adverse events"). The highest patient safety competence was reported in the dimension "communicating effectively" (M = 4.32, SD = .81), followed by "managing safety risks" (M = 4.29, SD = .79), "recognize, respond to immediate risks" (M = 4.28, SD = .83), "understanding human and environmental factors" (M = 4.25, SD = .79), "culture of safety" (M = 4.23, SD = .79), and "working in teams with other health professionals" (M = 4.07, SD = .83).

Table 3 summarizes the multiple regression analysis conducted on each dimension of the H-PEPSS. The six regression models were significant with the explained

Table 2. Results of tests of association between healthcare conflict and demographic and work variables (n = 320).

Variable	Mean	SD	Statistical Test	p
Gender				
Male	3.84	1.91	$t = 1.24$	.215
Female	3.43	1.91		
Nationality[a]				
Saudi	4.19	1.78	$F = 3.60$	.029*
Filipino	3.41	1.79		
Indian	3.29	2.17		
Marital status				
Single	3.73	1.88	$t = 1.62$	.106
Married	3.34	1.92		
Education				
Diploma	3.19	2.04	$F = 2.81$	.062
Baccalaureate	3.52	1.86		
Graduate program	4.43	1.76		
Unit[b]				
Out-patient department/Emergency department	3.61	1.64	$F = 10.32$	<.001***
Medical department	4.11	1.82		
Surgical department	4.09	2.18		
Intensive care units	2.42	1.51		
Obstetric department	2.71	1.74		
Others (artificial kidney unit, psychiatric department)	1.96	1.44		
Age			$r = -.13$	.018*
Total years of experience			$r = -.19$	.001**
Total years of experience in KSA			$r = -.13$	.020*
Total years of experience in the hospital			$r = -.09$	.118
Total years of experience in the unit			$r = -.10$	.062

Note. [a]Saudi > Filipino (P = .039), Saudi > Indian (P = .031);
[b]Out-Patient Department/Emergency Department > Intensive Care Units (P = .006), Out-Patient Department/Emergency Department > Others (P = .010), Medical > Intensive Care Units (P < .001), Medical > Obstetric (P = .001), Medical > others (P < .001), Surgical > ICUs (P < .001), Surgical > Obstetric (P = .004), Surgical > others (P < .001).
*Significant at .05, **Significant at .01, ***Significant at .001.

variances of 18.3%, 24.7%, 26.8%, 15.9%, 20.4%, and 20.1% for Dimensions 1, 2, 3, 4, 5, and 6, respectively. A one-point increase in the "mistrust of motivations" scores corresponds to .17 (P < .001), .13 (P < .001), .17 (P < .001), .11 (P < .001), .12 (P < .001), and .13-point (P < .001) decrease in the scores of Dimensions 1, 2, 3, 4, 5, and 6 of patient safety competence, respectively. Similarly, a point increase in the "contradictory communications" scores was associated with a decline of .05 (P = .019), .07 (P = .005), and .06 (P = .023) points in the scores of Dimensions 3, 4, and 5, respectively. Filipino nurses reported better competence on Dimensions 2 (ß = .27, P = .035), 3 (ß = .29, P = .018), and 5 (ß = .29, P = .036) than Saudi nurses. Nurses who completed a graduate program reported higher competence on Dimension 1 than those with bachelor's degrees (ß = .51, P = .024). A 1-year increase on the total professional nursing experience was associated with a .04-point (P = .013) decrease on the Dimension 6 scores. Nurses assigned in the Medical Department had higher scores by .28 points in Dimensions 1 (P = .024) and 6 (P = .019) than nurses assigned in the OPD/ER.

Discussion

This investigation examined the association between nurse and patients/relatives conflict and nurses' confidence in the different patient safety competencies. The tool used in this study focuses on the conflict between staff and patients/relatives.[13] The findings show low degrees of conflict between nurses and patients/relatives, as indicated by the mean score of 3.48 from 10. This result is unexpected, considering the differences on cultural and religious backgrounds between most nurses and patients. As shown in the findings, the majority of the surveyed nurses are non-Saudis (Filipinos and Indians). In multicultural healthcare settings, expatriate nurses are often on the receiving end of negative behaviors due to differences in cultural backgrounds, cultural conflicts, language barriers, and discrimination.[29] However, an ethnographic study on the contributing factors to healthcare conflicts show no direct association with cultural variations, but rather originate from varying concepts of "good care"; patient families perceived "good care" in a holistic concept

Table 3. Results of the multiple regression analyses on the patient safety competence dimensions (n = 320).

Predictor Variables	Dimension 1[a]		Dimension 2[b]		Dimension 3[c]		Dimension 4[d]		Dimension 5[e]		Dimension 6[f]	
	β (SE)	p	β (SE)	P	β (SE)	p	β (SE)	p	β (SE)	p	β (SE)	p
Age	.01 (.01)	.352	−.01 (.01)	.418	−.00 (.01)	.943	.00 (.01)	.905	−.01 (.01)	.666	.01 (.01)	.565
Gender	.08 (.14)	.570	−.07 (.13)	.575	.03 (.13)	.815	.04 (.14)	.779	.14 (.14)	.322	.20 (.13)	.138
Nationality (reference group: Saudi)												
Filipino	.06 (.14)	.647	.27 (.13)	.035*	.29 (.12)	.018*	.19 (.13)	.160	.29 (.14)	.036*	.18 (.13)	.157
Indian	−.15 (.24)	.531	−.05 (.22)	.834	.08 (.21)	.714	−.02 (.23)	.931	.00 (.24)	.998	−.17 (.22)	.444
Marital status	−.08 (.11)	.477	.02 (.10)	.876	.09 (.10)	.348	.01 (.10)	.944	.06 (.11)	.553	.05 (.10)	.654
Education (reference group: Baccalaureate)												
Diploma	.28 (.23)	.210	.38 (.21)	.072	.21 (.20)	.287	.15 (.22)	.482	.22 (.22)	.329	.25 (.21)	.235
Graduate	.51 (.22)	.024*	.32 (.21)	.120	.30 (.20)	.137	.25 (.22)	.255	.38 (.22)	.085	.29 (.21)	.162
Total years of experience	−.03 (.02)	.113	−.02 (.02)	.334	−.03 (.02)	.100	−.01 (.02)	.418	−.02 (.02)	.229	−.04 (.02)	.013*
Total years of experience in KSA	.02 (.02)	.426	.03 (.02)	.099	.03 (.02)	.083	.00 (.02)	.842	.02 (.02)	.239	.03 (.02)	.151
Total years of experience in the hospital	.03 (.02)	.134	.01 (.02)	.636	.01 (.02)	.799	.03 (.02)	.118	.03 (.02)	.224	.02 (.02)	.218
Total years of experience in the unit	−.02 (.02	.245	−.02 (.01)	.183	−.01 (.01)	.564	−.02 (.02)	.198	−.02 (.02)	.175	−.01 (.01)	.464
Unit (reference group: Out-patient department/Emergency department)												
Medical department	.28 (.13)	.024*	.12 (.12)	.285	.17 (.11)	.129	.15 (.12)	.205	.20 (.12)	.101	.28 (.12)	.019*
Surgical department	.12 (.14)	.380	.06 (.13)	.641	.19 (.12)	.128	.05 (.13)	.693	.22 (.14)	.109	.16 (.13)	.235
Intensive care units	−.03 (.16)	.860	.08 (.15)	.597	.16 (.14)	.263	.14 (.15)	.349	.07 (.15)	.666	.17 (.15)	.239
Obstetric department	.09 (.16)	.598	.01 (.15)	.929	.09 (.14)	.527	−.04 (.16)	.810	−.10 (.16)	.519	.12 (.15)	.424
Others	.33 (.23)	.149	.27 (.21)	.199	.21 (.20)	.308	.21 (.22)	.341	.23 (.22)	.303	.55 (.21)	.010*
Mistrust of motivations	−.17 (.03)	<.001***	−.13 (.03)	<.001***	−.17 (.03)	<.001***	−.11 (.03)	.001**	−.12 (.03)	<.001***	−.13 (.03)	<.001***
Threatening language/actions	.01 (.03)	.701	−.04 (.03)	.146	.02 (.03)	.563	.01 (.03)	.658	−.03 (.03)	.358	−.02 (.03)	.561
Contradictory communications	−.04 (.03)	.123	−.04 (.02)	.101	−.05 (.02)	.019*	−.07 (.02)	.005**	−.06 (.03)	.023*	−.04 (.02)	.098
R² (Adjusted R²)	.231 (.183)		.291 (.247)		.312 (.268)		.209 (.159)		.251 (.204)		.249 (.201)	

Note. The dependent variables are [a]Working in teams with other health professionals,
[b]Communicating effectively,
[c]Managing safety risks,
[d]Understanding human and environmental factors,
[e]Recognize, respond to immediate risks,
[f]Culture of safety.
β is the unstandardized coefficients; SE-b is the Standard error.
*Significant at .05, **Significant at .01, ***Significant at .001.

while healthcare providers view "good care" as a biomedical care model.[30] Similar findings are observed in the present study. Nurses perceive the greatest conflicts on the theme "mistrust of motivations," which denotes the patients/relatives' perceptions that the decisions made were not for their best interest.[13] As such, nurses believe that most of their conflicts with patients/relatives stem from the loss of trust of the latter, who may view that the hospital's resources and nurses' competence to provide quality care are inadequate. This finding is similar to that of Alshehry et al[4] that most of the workplace incivility experiences of nurses in Saudi Arabia were from patients/visitors due to their frustrations regarding the poor quality of care they were receiving and the unsatisfactory environment-related factors. This finding can also support the present results on the negative correlations between the perceived healthcare conflict and length of professional experience. Lesser experience as a nurse is associated with greater perceived healthcare conflict with patients/relatives. Nurses with less years of experience in the profession are often vulnerable in receiving uncivil treatment from patients and families due to their unfamiliarity to the work environment and protocols, and due to lower levels of competency compared with experienced nurses.[4,31]

In this study, Saudi nurses perceive greater healthcare conflicts than non-Saudi nurses, similar to findings in previous studies.[4,15] Alshehry et al[4] posit that this may be due to the lower competence of Saudi nurses than the non-Saudi nurses. However, this assumption is rejected given that competency level is not measured in their study. Thus, future studies can focus on examining the influence of nurses' competency on their experiences of negative behaviors from patients/relatives. Alquwez presents a plausible explanation that the higher experiences of uncivil acts of Saudi nurses are due to cultural influences.[15] Alquwez discussed that a person's cultural background plays a critical role on how negative behaviors are perceived, resulting in differences in incivility tolerance thresholds.[15] This suggestion means that Saudi nurses have a lower threshold in terms of uncivil behaviors, which lead to their sensitivity in experiencing workplace conflicts with patients/relatives. The cultural aspect can also explain the present findings that nurses who have greater nursing experiences in the country perceive relatively lesser conflicts than those with lesser experience. Exposed to the Saudi Arabian culture and the organizational culture of the hospital, seasoned nurses have a higher tolerance of conflicts with patients/relatives than newer nurses.

Furthermore, differences on perceived healthcare conflicts are found between nurses in different clinical units. Interestingly, nurses working in the Medical Department, Surgical Department, and OPD/ER report greater perceived healthcare conflicts than those in other clinical units. Similar findings are obtained in previous studies, where greater experiences on uncivil behavior from patients/relatives are reported by nurses assigned to the OPD/ER report than those working in ICUs,[15] and those working in Medical Department than those in ICUs and Obstetric Department.[4] Literature also supports the varying degrees of workplace conflicts between healthcare staff and patients/families in different units in the hospital, but which unit has greater or lower conflict experiences remains inconclusive.[13] Thus, future studies can examine the factors affecting the conflicts experienced in different clinical units.

The findings indicate good patient safety competence as reported by the nurses, with the item means ranging 4.03–4.34. This figure is higher than the reported competence among nurses in South Korea,[32,33] but lower than that among nurses in Canada.[30] Comparing the results with previous studies carried out in Saudi Arabia, the findings are higher compared than those reported among nurses in Riyadh, and the regular nursing students and bridging students in the country.[15,34,35] The nurses in the study report the highest level of competence on the dimension "Communicating effectively," which implies that the nurses are highly confident in communicating clearly and consistently with patients and colleagues using effective verbal and nonverbal communication skills to avoid the occurrences of adverse events. This finding is coherent with the results of Alquwez, who believe that a possible reason is the multilingual skills of nurses in the country.[15] The nurses are exposed to different languages in hospital settings and are encouraged to learn the Arabic language in addition to others spoken by their colleagues from other countries. The exposure of nurses to people from various cultural and linguistic backgrounds may have enhanced their communication skills with patients and colleagues. Nonetheless, effective communication is a critical healthcare component that ensures the provision of quality and safe healthcare to patients.[36] Effective communication and teamwork are interrelated and are essential in ensuring patient safety within the healthcare setting.[37] However, the nurses in this study reported working in teams as their weakest dimension of patient safety competence. This result was also evident in a previous study conducted in the country, where nurses have the poorest competence in working in collaboration with other healthcare workers.[15] Hence, hospital managers and leaders must consider this finding, because an ineffective teamwork in healthcare settings not only impact patient outcomes (i.e., poor quality and safety of care, dissatisfied patient experience), but also affect staff and organization outcomes.[38]

The findings suggest that nurse and patients/relatives conflict seem to have a negative association with nurses' patient safety competence. Specifically, the dimension "mistrust of motivations" was negatively associated with the nurses' competence on the 6 patient safety areas. Moreover, the dimension "contradictory communication" was negatively associated with the nurses' competency on "managing safety risks," "understanding human and environmental factors," and "recognize, respond to immediate risks." A previous study in Sweden found that healthcare conflicts can threaten the quality of patient care, specifically on the timeliness of care provision, dissatisfactory patient-centered

care, and less efficient and safe care.[5] The negative impact of workplace incivility from patients/relatives on the nurses' professional quality of life and quality of nursing care are also reported.[2,4] The negative association between nurse–patients/relatives conflicts and the patient safety competence of nurses may be explained by understanding similar effects on the quality of patient care. Teamwork and communication are important in delivering safe and effective nursing care.[37,39] However, healthcare conflicts can sever teamwork and communication, which can eventually lead to uncooperative and unmotivated staff and uncoordinated communication within the healthcare system,[40] thus causing poor patient safety competence. Furthermore, patient cooperation and compliance are critical in achieving the effective outcomes of interventions, which can only be achieved if patients/relatives trust the nurses. In the present findings, the contradicting information provided to patients (i.e., "contradictory or unclear advice from different members of the clinical team on the patient's prognosis or treatment") may lead to their mistrust of nurses. Thus, patients/relatives become uncooperative. Such scenario could result to nurses being incompetent in working with teams, communication, managing safety issues, knowing the different factors associated with patient safety, and recognizing and responding to risks.

Limitations

First, the design of this study enables a deeper investigation of the variable healthcare conflicts, but future studies can employ mixed methods to have a richer examination of the study variables. Also, the design of the study was correlational, which only allow testing the association between the variables and not causal relationships. Second, the study used self-report in the variable "patient safety competence." To the researcher's knowledge and based on the literature search conducted by the researcher, no available evidence exists to support that perceived patient safety competence translate to the actual patient safety competence among nurses. Thus, research consumers are cautioned in interpreting and using the findings. Third, this study was limited to nurse–patients'/relatives' conflicts. Future studies should examine other types of conflict and examine their impact on patient safety competence. Fourth, the study's focused was to examine how nurse–patient/relatives conflicts influence the nurses' self-report patient safety. The relationship between the two variables maybe reversed. Thus, future study may consider examining how patient safety competence of nurses lead to nurse–patient/relative conflict in the healthcare. Fifth, the convenience sampling technique and the limited setting of the study constrains the generalizability of the findings.

Conclusions

The study examined the association between nurse–patient/relative conflicts and the nurses' patient safety competence. Healthcare conflicts between nurses and their patients/relatives had a negative association with the competence of nurses to provide safe nursing care. The patient or family's loss of trust is the most common conflict perceived by the nurses, while contradictory communications are perceived as the least-occurring healthcare conflict. The perceptions of healthcare conflicts among nurses are associated with nationality, hospital unit, age, and nursing experience. The nurses perceived their patient safety competence as high, with the highest scores in communication and lowest in working with other members of the healthcare team.

Ensuring patient safety is the topmost concern for any healthcare facility. Nurses, as the frontline staff of care, are anticipated to possess high levels of competencies in providing safe and quality care to every patient. However, findings show that healthcare conflicts, specifically between nurse–patients/relatives, may jeopardize patient safety by negatively impacting nurses' patient safety competence. Recognizing the importance of patient safety, this study provides valuable findings that can be used to improve the patient safety competence of nurses. The results can become the basis for formulating hospital policies geared toward the elimination of healthcare conflicts to help ensure the patient safety competence of nurses. Hospital administrations should create an environment where respect and understanding are ensured. Policies on mitigating conflicts between healthcare workers and patients/relatives must be created and implemented. Given that most conflicts arise from the differences on the concept of "good care" between nurses and patients/relatives, open communication must be advocated to reach an understanding and a common ground in terms of providing holistic nursing care to ensure patient satisfaction and trust. Continuous education must also be provided to the nurses to ensure the highest level of competence when caring for patients. Nurses can be trained on recognizing and understanding conflicts with patients/relatives, and on effectively responding and managing such conflicts. The findings also implicate the creation of a communication system in the hospital to provide accurate information to patients to avoid contradictory communication conflicts.

Author's Contributions

Made substantial contributions to conception and design: ASA Acquisition of data: ASA Analysis and interpretation of data: ASA Involved in drafting the manuscript: ASA Revising the manuscript critically for important intellectual content: ASA Given final approval of the version to be published: ASA

Ethical Approval

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Disclaimer

Agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved: ASA

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Supplemental Material

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