Introduction

Safety is a condition or state of being resulting from the modification of human behavior and/or designing of the physical environment to reduce hazards, thereby reducing the chance of accidents ***(Khatab, 2005)***. Patient safety is defined as the prevention of harm to patients "Emphasis is placed on the system of care delivery that prevents errors; ***(Aspden et al., 2010)***. Patient safety also defined as the prevention of harm: "freedom from accidental or preventable injuries produced by medical care" ***(Agency for Healthcare Research and Quality, 2009)***.

Understanding safety is very important process, it helps in developing an effective system to reduce or prevent the adverse events and errors occur in healthcare delivery. Safety is not the responsibility of a person, device or department; it emerges from the interaction of components of a system (individuals, equipments, departments, etc...) Therefore, if an environment is safe, the risk of accident is lower. Making environment safe means monitoring the process of care to reduce defect in the process or avoid the way things should have been done. Thus, ensuring patient safety involves the establishment of operational system and processes that increase the reliability of patient care, ***(Dohaldson, 2007)***.

The Institute of Medicine (IOM) estimated that 98,000 preventable deaths occur each year due to medical errors, with no significant improvement in 5 years due to failure to improve patient safety. Since the IOM report, organizations have struggled to develop effective programs for improving safety ***(Health care Risk control, 2009)***.

Safety culture surveys are useful for measuring organizational conditions that can lead to adverse events and patient harm in the healthcare organization. In addition, these surveys can be used to raise awareness about patient safety issues and track changes over time. The ultimate goal, to develop a positive culture of safety, has tremendous potential to benefit patients ***(Garayon, 2007)***.

The Agency Health Care Research and Quality (AHRQ) presents an evidence report on patient safety practices, and define five factors related to the presence of adverse event that affect patient safety. When those factors are controlled it plays a role in reducing the adverse outcomes resulting from exposure to the health care system. These factors refer as working conditions; the evidence report claim that working conditions are an important influence on patient safety, therefore they deserve to have attention by healthcare professionals and be assessed in the work place in order to protect the patient from being harmed ***(Hickman, 2008)***.

These factors include: Workforce Staffing refers to staffing shortage, mandatory nurse-patient ratio (nurse - resident ration) competency and experience, work schedule, and job satisfaction; Physical environment includes air, light, toxic exposure, temperature and humidity, and aesthetics; Personal Social Factors refers to the personal, professional, and social aspects of the healthcare work environment; Workflow design includes the activities of health care workers; it looks at what tasks are accomplished, where and how, the interactions among workers, the work complexity, and transfer responsibilities and Organizational Factors include how work is performed by team members,

organizational culture, beliefs and values that affect' the worker behavior ***(Evans, 2009)***.

Staff perception of the quality of care they provide patient is an important aspect. Nurses are committed professionals in a unique role to advocate for patient safety and contribute to the overall efforts to reform healthcare. Nurses are the largest group of healthcare providers in the nation and are regarded by the public as the most highly ethical and honest group of professionals ***(American Nursing Association, 2007)***.

The law Nursing Association reports that, nurses are extremely well positioned to improve patient safety because they represent the largest number of workers in the nation's health care system, but more importantly, because of nursing critical role in providing ongoing surveillance of patients safety studies support the key role of nurses in ensuring patient safety ***(American nurses Association of Critical Care, 2005)***.

Due to patient safety is important for preventing injuries, accident and improving patient safety in health care organization. The institute of medicine reports, keeping patient safety transforming the work environment of nurses, conducted that poor working conditions for nurses and inadequate nurse staffing levels increase the risk for errors thus ensuring patient safety protect and safe patient from errors, mistakes or near misses that result from medication, surgery or accidental injuries ***(Rogers , 2004)***. So that this study was conducted to assess perception of nursing staff toward factors related to working conditions affecting patient safety at Benha University Hospital.