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Presenteeism in Relation to Maternity Nurses' Self-Reported Quality of Care, Decision Latitude and Patient Safety Culture

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Abstract: Background: Nurses are at risk for presenteeism, a growing occupational health issue that remains unnoticed despite its association with poor health and absenteeism due to illness.P**urpose:** The study aimed to examine the maternity nurses' perspective of presenteeism and its relation to self-reported quality of care, decision latitude & patient safety culture at the study settings. **Research Design**: Descriptive correlational research design was utilized. **Setting:** The study was conducted at maternity departments and maternity operation rooms at Shebin El-Kom University Hospital, Shebin El-Kom Teaching Hospital, El Shohdaa Hospital and Omoma Hospital, Menoufia governorate, Egypt. **Subjects:** All Staff nurses (95) at maternity departments and maternity operation rooms at the previous mentioned settings. **Instruments**: Data was collected using four standardized scales: (I): Stanford presenteeism scale, (II): Self-reported quality of patient care scale, (III): Decision latitude scale and (IV): Patient Safety Culture Scale. **Results:** The highest percentage of the studied nurses experienced presenteeism for better performance (60 %), high self-reported quality of patient care (56.8 %), the total decision latitude (70.1%) and very good perception toward patient safety culture (43.2 %). Conclusion: There was a highly statistically significant positive correlation among maternity nurses' perspective of presenteeism, self-reported quality of care, decision latitude and patient safety culture at the study settings. **Recommendations:** Nurse managers and supervisors should be familiar with the concept of presenteeism. Focus on presenteeism and not only absenteeism. Conduct further research among nurses to quantify presenteeism, identify its causes and consequences.

Keywords: *Presenteeism, Nurses, Self-reported quality of patient care, Decision latitude, Patient safety culture.*

Introduction

Nurses consider the larger part of the healthcare labor force and play a pivotal role in defending crises in healthcare organization and community health, incorporating the direct care provided to patients and their vulnerability to infectious diseases (Bhagavathula et al., 2020). Working night shifts, putting in extra hours, and showing up to work unwell are all part of what it takes to be a nurse. Majority of nurses prefer to attend and take responsibility for work even if suffering from low-efficiency physical or psychological problems rather in lieu of absenteeism to earn full salaries and maintain their employment, which is named the act of presenteeism (Ahmed et al., 2023).

Presenteeism poses a significant risk to patient safety and health as well as a major organizational burden (Critz et al., 2020). In literature, presenteeism has two types: job-stress presenteeism & sickness presenteeism and viewed conceptually, recently, and in a variety of ways as referring to professionals who continue to report to work while being physically or mentally ill. Presenteeism refers to the situation where employees don't have the necessary circumstances to be at work, need time off, and leave the workplace for a variety of causes (Ex., depression, illness, exhaustion, etc.) (Ahmed et al., 2023). It happens when nurses arrive at work when ill and are unable to function well as a result (Lohaus and Habermann, 2019).

One important element influencing the self-reported quality of care given by obstetric nurses is presenteeism. Presenteeism is seen as a serious concern as it is impossible to link a worker's poor performance to a health condition unless the person reports the issue to others. Consequently, presenteeism links the difficulties that impair job performance and cause productivity loss because of hidden health, psychological, or sickness concerns. This circumstance should draw the attention of obstetric healthcare providers and the potential impact of high presenteeism on the obstetric provided quality of care, their decision latitude and obstetric patients' safety (El-Kurdy et al., 2021).

Decision latitude is the ability to exercise control over one's job and career autonomy. There are two domains included in decision latitude known as decision authority & skill discretion. The term "decision authority" describes the daily democracy that exists in the workplace, specifically referring to the nurse's power to decide what has to be done and how. while the skill discretion domain relates to the nurse's capacity to acquire and use work-related skills and techniques (Lindahl Norberg & Falkstedt, 2023).

Additionally, presenteeism was greater among nurses having greater decision latitude. The higher latitude adjustment decreases the probability of absenteeism due to illness and increase persenteeism because workers may be able to modify work parameters to accommodate their temporarily impaired capacity, allowing them to work with less intensity even while they are ill. Actually, it is anticipated

that control of job will boost motivated, dedicated, as as positive work attitudes—all of which will motivate employees to go above and beyond the call of duty and work through illness (EA & HS, 2022).

Also, research has shown that, poor performance at work has major ramifications for patient safety in professions like nursing. An individual's or a group's values, attitudes, perceptions, competences, and behavioral patterns with regard to health and safety make up the patient safety culture (PSC) (Brborović et al., 2014).

Nursing presenteeism is especially important as it endangers patients through limiting the ability of nurses to deliver a high quality of care. The nursing workforce has very high presenteeism rates, and there is need to conduct further research to understand the nurses' presenteeism effects (Freeling et al., 2020).

Methods:

Purpose of the study:

This study was conducted to examine the maternity nurses' perspective of presenteeism and its relation to self-reported quality of care, decision latitude and patient safety culture at the study settings.

Research questions:

1) What are presenteeism levels from maternity nurses' perspective at the study settings?
2) What is the self-reported quality of care level from maternity nurses' perspective at the study settings?
3) What is the decision latitude level from maternity nurses' perspective at the study settings?
4) What is the patients' safety culture level from maternity nurses' perspective at the study settings?
5) What is the relation among presenteeism, maternity nurses' self-reported quality of care and patients' safety culture at the study settings?

Research design:

The design used in this study was a descriptive correlational research design.

Subjects:

All Staff nurses (95) at maternity departments and maternity operation rooms at the previous mentioned settings.

Setting:

The current study was implied at maternity departments and maternity operation rooms at Shebin El-Kom University Hospital (34), Shebin El-Kom Teaching Hospital (13), El Shohdaa Hospital (16) and Omoma Hospital (32) , Menoufia governorate, Egypt.

Instruments:

The data for this study were gathered using four standardized measures that were first created in English. These scales were translated into Arabic utilizing the translation and back-translation method because the study was carried out in Egypt. (Brislin, 1970).

Instrument one: Stanford presenteeism scale-6 (SPS-6):

It measures people's self-rated job performance while they are impacted by presenteeism and was created by Koopman et al. (2002). It consists of six items. It has two dimensions: "Avoiding Distraction" (items 1, 3, and 4) refers to one's ability to focus when there is a circumstance that promotes presenteeism, and "Completing Work" (items 2, 5, and 6) relates to the quantity of work completed while being ill.

Scoring system:

A Likert-type scale with five response options—strongly disagree, disagree, neutral, agree, and strongly agree—was used to quantify it. The score has a range of 6 to 30. Lower scores (6–18) indicate reduced performance on work-related tasks and presenteeism. Higher scores (19–30) indicate better performance at work in spite of health issues.

Instrument two: Self-reported quality of patient care Scale:

De Oliveira et al. created it (2013). There are five items about the measurement in it, in the previous year or less, of the self-reported level of patient care. The nurses reported the perceived quality of care on a 5-point Likert-type scale response (never, once, a couple of times, multiple times, often).

Scoring system: score ranges between 5 and 25. Lower scores (5-15) mean low self-reported quality of care. Higher scores (16-25) mean high self-reported quality of care.

Instrument three: The decision latitude scale:

it was developed by Karasek (1979) and included three dimensions; skill discretion (6 items), decision authority (3 items), and psychological job demand (5 items). This scale is used to measure decision latitude on a 5-point Likert-type scale response (strongly disagree, disagree, neutral, agree, strongly agree).

Scoring system: scores range with 14 as minimum and 70 as maximum Decision latitude was expressed as "low" (14-42) and "high" (43-70).

Instrument four: Patient Safety Culture scale:

this measure was created by Westat et al., (2018) database report in the Agency for Healthcare Research and Quality (AHRQ) in to evaluate patient safety culture among nurses. It consists of 42 items divided into the following twelve domains; Teamwork within units (4items), supervisors' expectations and action promoting patient safety (4items), organizational learning continuous improving (3items), management support for patient safety (3items), feedback and communication about error (3items), communication openness (3items), overall perceptions of patient safety (4items), frequency of events reported (3items), teamwork across unit (4items), staffing (4items), handoffs and transitions (4items), and

nonpunitive response to errors (3items).

Scoring system:

The Likert scale was utilized to rate nurses' responses on 5 points scale ranged from (one for strongly disagree) to (five for strongly) agree for all items, except items of two domains (error's communication and feedback and communication openness) were ranging from 1 for never to 5 for always. Higher ratings signify an increased positive perception of patients' safety culture. Prior to computing total scores, items with negative direction were reversed coded. The entire score was calculated and divided into the following five levels: poor 60 %, good 60->75%, very good (75- > 85%), and excellent ≥85% ((AHRQ, 2019)

Reliability:

a) Stanford presenteeism scale-6 (SPS-6):

The internal consistency coefficient alpha of the instrument, which was (0.80), was used to assess its reliability.

b) Self-reported quality of patient care Scale:

The internal consistency coefficient alpha, which measured the instrument's reliability, was (0.71).

c) The decision latitude scale:

The internal consistency coefficient alpha, which measured the instrument's reliability, was (0.85).

d) Patient Safety Culture scale:

The internal consistency coefficient alpha of the instrument, which was (0.94), was used to test its reliability.

Validity:

Five multilingual specialists were chosen to evaluate the instruments' face validity and content. The panel comprised of a pair of experts from the department of nursing administration, a pair of experts from the departments of medical surgical nursing, and one expert from the department of community health nursing at Menoufia University's Faculty of Nursing. The researcher asked the panel to critique the instrument as a whole, including identifying areas of concern and reviewing the construction, flow and grammar. The panel examined the following criteria: relevant to the purpose of the study, clear and simple wording of research questions, instruments are easy to be understood, comprehensiveness of questions, appropriate length of the instruments and of each question, appropriate ordering of questions, unbiased, and no redundancy in questions. Necessary modifications and deleting of some questions were done to reach the final valid version of the instruments. The instruments were finally valid from the experts' perspective.

Pilot study

After reviewing of instruments by experts, the researchers conducted a pilot study of the developed instruments before administering the final questionnaires. 10% of the entire

sample was used in the pilot study by the researchers. (10 nurses) to ascertain the study instruments' applicability and clarity, as well as to identify any possible obstacles during data collection. Estimating the amount of time required to complete the form—which roughly ranged from 20:25 minutes—also proved helpful. No adjustments were made to the instruments based on the pilot's results. The final sample had the piloted participants.

Ethical consideration:

An official letter of approval was filed to the Nursing College Dean before any attempt was made to collect data from the previously indicated study settings. The letter included the study's title, purpose, and data gathering procedures. The Menoufia University Faculty of Nursing's Research and Ethics Committees (January 2023) no (918) granted permission to carry out the planned study. Furthermore, the hospitals' official granted formal approval for the study to be carried out in their facilities. The nature and purpose of the research study were explained to every nurse. The study's participants were free to leave at any moment, the researchers stressed, and participation was entirely voluntary. After then, a consent form had to be signed by those who had decided to take part in the study. Additionally, the data was coded to ensure anonymity and secrecy.

Procedure:

Following the verification of the instruments' clarity, the researcher conducted daily individual or small-group interviews with staff nurses who worked morning, evening, and night shifts. It took 20 to 25 minutes for each participant to complete the self-reporting surveys. Operating room of obstetrics and gynecology and inpatient department of obstetrics and gynecology provided the data. Between May 2023 and July 2023, data were gathered.

Statistical analysis

With the use of SPSS version 20 (Statistical Package of Social Science, Inc., Chicago, Illinois, USA), data were gathered, calculated, and analyzed statistically. Whereas data that was qualitative were shown as percentages and figures, and data that was quantitative were shown as the mean, standard deviation (SD), range, and so on. The data was shown to have a normal distribution using the Shapiro-Wilk test. A comparison between two non-normally distributed quantitative variables was performed using the Mann Whitney test (U). When comparing more than two groups with quantitative data that was not normally distributed, the Kruskal Wallis test (k) was employed. To corroborate quantitative variables, Spearman's correlation (r) was utilized. A P-value of less than 0.05 was deemed statistically significant.

Results

Table (1): This table shows that the highest percentage of the study sample regarding working hospital was from Menoufia university hospital with percent (35.8 %) and the lowest

working at Menoufia teaching hospital with percent (13.7 %) and more than half of them working at operating room of obstetrics and gynecology (53.7 %). In terms of duration of work in the current unit the highest percentage was working from 1 to 5 years (42.1 %) and the lowest percentage working from 21 years and more (2.1 %). As regards working hours per week (38.9 %) working 20 – 39 hours / week and (3.2 %) working 100 or more hours / week.

Table (2): This table shows that mean and mean % of presenteeism among the studied group. The mean score % for completing work dimension was (66.2 %), while the mean score % for avoiding distractions was (64.9 %). The total mean score % for overall presenteeism perception was (62 %).

Figure (1): this figure illustrates the total presenteeism level among the studied group. The highest percentage was for better performance (60 %) and the lowest percentage was for reduced performance (40 %).

Table (3): This table shows that mean and mean % of self-reported quality of patient care data among the studied group. The highest mean % was for " I make mistakes with negative consequences to patients" (94 %) and the lowest was for "I do not have enough time or attention for my patients" (26.8 %).

Figure (2): this figure illustrates the total self-reported quality among the studied group. The total self-reported quality of care among the study participants was high (56.8 %).

Table (4): This table shows the mean, mean % and ranking of hospital survey on patient safety culture among the studied group. The highest mean % was for "Frequency of events reported" dimension (84.7 %) and the lowest was for "Nonpunitive response to errors" (40.6 %). The total mean % for hospital survey on patient safety culture among the studied group was (79.4 %).

Figure (3): this figure illustrates the number of events reported in the past 12 months among the studied group. The highest percentage was for no events reported (49.4 %) and the lowest percentage was for (11 – 20) events reported (1.1%).

Figure (4): this figure illustrates the overall grade of patient safety among the studied group. The overall grade of patient safety among the studied group was very good (43.2 %).

Table (5): This table shows the mean, mean % and ranking of decision latitude among the studied group. The highest mean % was for "Skill discretion" dimension (77.3 %) and the lowest was for "Decision authority" (61.4 %). The total mean % for decision latitude among the studied group was (70.1%).

Table (6): This table shows the correlation among presenteeism, quality of care, patient safety culture and decision latitude among the studied group. There was a highly statistically significant correlation among presenteeism and quality of care, patient safety culture and decision latitude among the studied group as (p-value < 0.01).

Table (7): This table shows the relation between presenteeism and self-reported quality of care, and Socio

demographic data of the studied group. There was no significant correlation between presenteeism and all socio-demographic data of the studied group as (p-value > 0.05), except in relation to working hospital there was a highly statistically significant correlation as (p-value < 0.01). Moreover, there was no significant correlation between self-reported quality of care and socio-demographic data of the studied group in relation to working department and duration of work in the current unit as (p-value > 0.05), in relation to working hospital there was a highly statistically significant correlation as (p-value < 0.01), and in relation to working hours per week there was only a statistical significant correlation as (p-value < 0.05).

Table (8): This table shows the relation between patient safety culture and decision latitude, and Socio-demographic data of the studied group. There was there was a highly statistically significant correlation between patient safety culture and all socio-demographic data of the studied group as (p-value < 0.01), except in relation to duration of work in the current unit there was only a statistically significant correlation as (p-value < 0.05) and in relation to working department there is no significant correlation as (p-value > 0.05). Moreover, there was there was a highly statistically significant correlation between decision latitude and all socio-demographic data of the studied group as (p-value < 0.01), except in relation to duration of work in the hospital there was only a statistically significant correlation as (p-value < 0.05) and in relation to duration of work in the current unit there is no significant correlation as (p-value > 0.05).

Table (1): Socio demographic data of the studied group (N=95):

Studied variables	No.	%
Hospital		
Menoufia university hospital	34	35.8
Menoufia teaching hospital.	13	13.7
Omooma hospital	32	33.7
Elshohada hospital	16	16.8
Duration of work in hospital		
< 1 year	11	11.6
1 – 5 years	37	38.9
6 – 10 years	21	22.1
11 – 15 years	17	17.9
16 – 20 years	4	4.20
21 or more	5	5.30
Department		
Operating room of obstetrics and gynecology	51	53.7
Department of obstetrics and gynecology	44	46.3
Duration of work in the current unit		
< 1 year	11	11.6
1 – 5 years	40	42.1
6 – 10 years	23	24.2
11 – 15 years	13	13.7
16 – 20 years	6	6.30
21 or more	2	2.10

Working hours per week		
< 20 hours / week	7	7.40
20 – 39 hours / week	37	38.9
40 – 59 hours / week	26	27.4
60 – 79 hours / week	12	12.6
80 – 99 hours /week	10	10.5
100 or more hours / week	3	3.20

Table (2): Mean and Mean % of presenteeism among the studied group (N=95):

Studied variables	Mean	SD	Min	Max	Mean %
Completing Work	9.93	2.46	6.00	15.0	66.2%
Avoiding Distraction	9.74	2.97	6.00	15.0	64.9%
Total	18.6	4.20	12.0	30.0	62%

Figure (1): Total presenteeism level among the studied group (N=95)

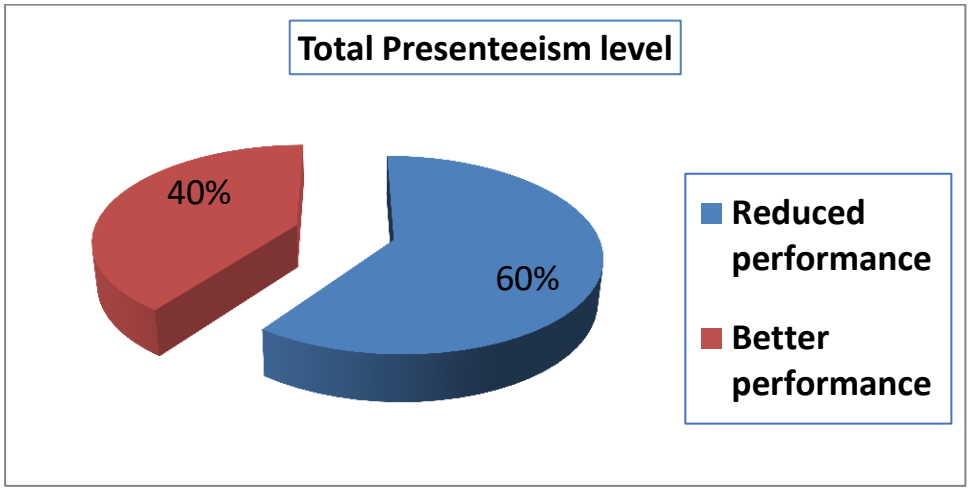

Table (3): Mean and Mean % of Self-reported quality of patient care among the studied group (N=95):

Self-reported quality of patient care dimensions	Mean	SD	Min	Max	Mean %
I make mistakes without negative consequences to patients	1.71	0.73	3.00	5.00	34.2%
I perform procedures without appropriate training	1.45	0.66	3.00	5.00	29.0%
I make mistakes with negative consequences to patients	4.70	0.52	3.00	5.00	94.0%
I fall short in the quality of care I provide to my patients	4.57	0.67	3.00	5.00	91.4%
I do not have enough time or attention for my patients	1.34	0.56	3.00	5.00	26.8%
Total self-reported quality of patient care	17.1	2.21	5.00	25.0	68.0%

Figure (2): Total self-reported quality among the studied group (N=95)

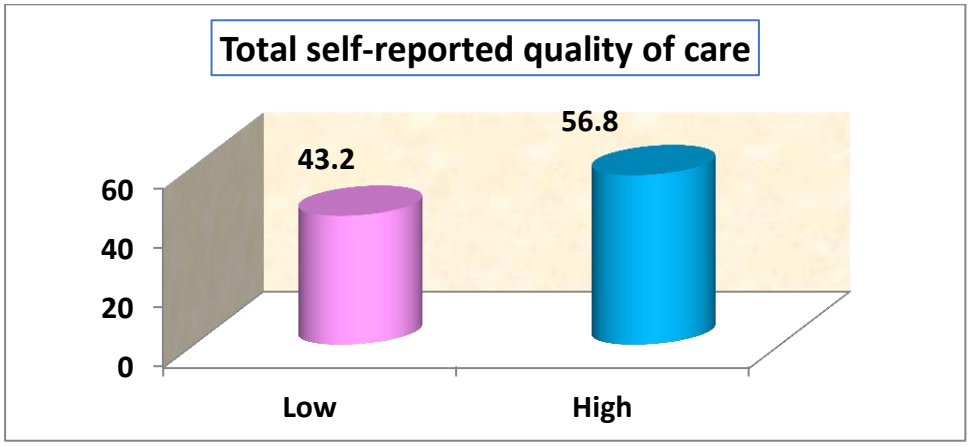

Table (4): Mean, Mean % and Ranking of Hospital Survey on Patient Safety Culture among the studied group (N=95):

Hospital Survey on Patient Safety Culture dimensions	Mean	SD	Min	Max	Mean %	Rank
Teamwork within units (4items)	15.2	3.13	7.00	20.0	76.0%	2
Supervisors' expectations and action promoting patient safety(4items)	12.4	2.90	6.00	20.0	62.0%	6
Organizational learning continuous improving (3 items)	10.6	1.57	6.00	15.0	70.6%	3
Management support for patient safety(3items)	9.08	2.05	3.00	15.0	60.5%	8
Feedback and communication about error(3items)	10.4	2.66	5.00	20.0	52.0%	10
Communication openness(3items)	8.27	1.99	5.00	20.0	41.4%	11
Overall perceptions of patient safety(4items)	9.22	2.25	5.00	15.0	61.5%	7
Frequency of events reported (3items)	12.7	2.16	5.00	15.0	84.7%	1
Teamwork across unit(4items)	11.4	1.76	8.00	20.0	57.0%	9
Staffing(4items)	13.4	3.06	6.00	20.0	67.0%	4
Handoffs and transitions(4items)	9.82	2.17	4.00	20.0	49.1%	10
Nonpunitive response to errors(3items)	8.13	1.57	5.00	20.0	40.6%	12
Total	131.1	14.5	101.0	165.0	79.4%	

Figure (3): Number of events reported in the past 12 months among the studied group (N=95).

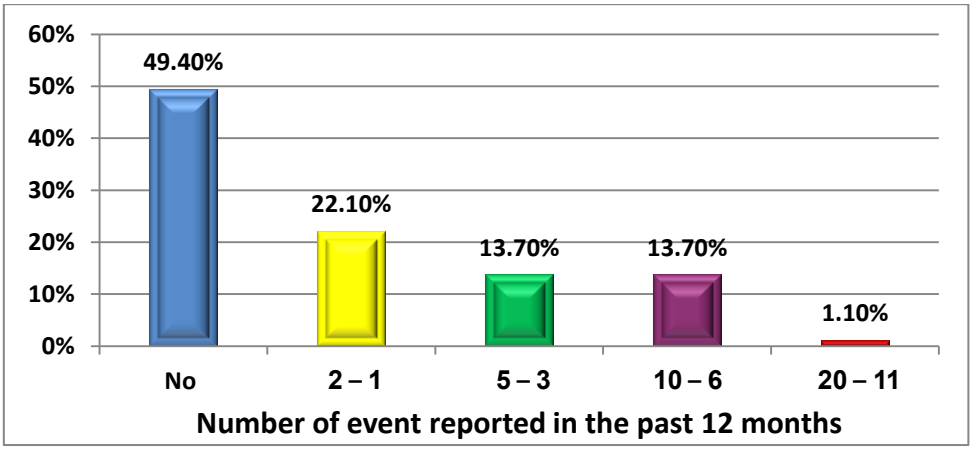

Figure (4): Overall grade of patient safety among the studied group (N=95)

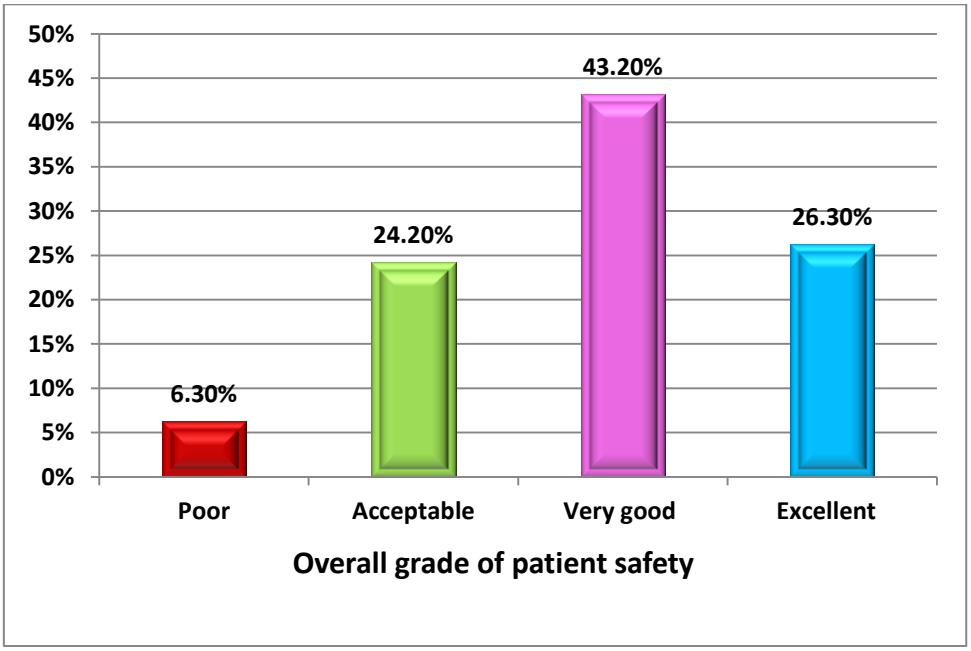

Table (5): Mean, Mean % and Ranking of Decision latitude among the studied group (N=95):

Decision latitude dimensions	Mean	SD	Min	Max	Mean %	Rank
Skill discretion (6 items)	23.2	4.27	12.0	30.0	77.3%	1
Decision authority (3 items)	9.22	1.96	4.00	15.0	61.4%	3
Psychological job demand (5 items)	16.6	2.12	12.0	25.0	66.4%	2
Total	49.1	6.65	32.0	70.0	70.1	

Table (6): Correlation among presenteeism, quality of care, patient safety culture and decision latitude among the studied group (N=95):

Studied variables	Presenteeism		Quality of care		Patient safety culture		decision latitude	
	R	P value	R	P value	r	P value	R	P value
Presenteeism	-	-	-0.420	**0.001***	0.635	**0.001***	0.485	**0.001***
Quality of care	-0.420	**0.001***	-	-	-0.565	**0.001***	-0.333	**0.001***
Patient safety culture	0.635	**0.001***	-0.565	**0.001***	-	-	0.544	**0.001***
Decision latitude	0.485	**0.001***	-0.333	**0.001***	0.544	**0.001***	-	-

Table (7): Relation between presenteeism, self-reported quality of care, patient safety culture, decision latitude and Socio demographic data of the studied group (N=95):

Studied variables	presenteeism	Test of sig P value	Self-reported quality of care	Test of sig
	Mean ±SD		Mean ±SD	P value
Hospital				
Menoufia university hospital	19.1 ±2.58	K	7.97 ±2.15	K
Menoufia teaching hospital.	19.6 ±2.75	57.7	8.00 ±1.95	28.9
Omooma hospital	25.8 ±2.02	**0.001***	6.15 ±0.84	**0.001***
Elshohada hospital	23.1 ±2.98		9.37±2.50	
Duration of work in hospital				
< 1 year	23.5 ±3.47		6.47 ±1.63	
1 – 5 years	21.6 ±3.44		7.45 ±1.86	
6 – 10 years	23.8 ±3.86	K	7.91 ±2.61	K
11 – 15 years	21.2 ±4.97	10.5	7.25 ±1.25	14.7
16 – 20 years	21.5 ±2.38	0.060	7.20 ±1.78	**0.012***
21 or more	19.0 ±2.34		8.58 ±1.54	
Department				
Operating room of obstetrics and gynecology	22.8 ±4.01	U 1.88 0.060	7.60 ±2.04	U 0.148 0.882
Department of obstetrics and gynecology	21.2 ±3.63		7.59 ±2.31	
Duration of work in the current unit				
< 1 year	23.5 ±3.47		7.36 ±1.96	
1 – 5 years	21.9 ±3.26		7.50 ±1..86	
6 – 10 years	22.8 ±4.24	K	7.82 ±3.05	K
11 – 15 years	21.6 ±5.60	6.47	7.92 ±1.75	4.55
16 – 20 years	19.5 ±2.34	0.263	7.83 ±1.32	0.473
21 or more	20.0 ±2.82		5.50 ±0.70	
Working hours per week				
< 20 hours / week	21.2 ±3.54		8.43 ±2.63	
20 – 39 hours / week	21.6 ±3.49		7.85 ±1.46	
40 – 59 hours / week	21.4 ±3.27	K	7.66 ±1.55	K
60 – 79 hours / week	21.8 ±4.40	10.5	7.60 ±2.16	12.8
80 – 99 hours /week	25.9 ±5.17	0.062	6.84 ±1.75	**0.024***
100 or more hours / week	25.0 ±0.01		6.40 ±1.34	

Table (8): Relation between patient safety culture and decision latitude and Socio demographic data of the studied group (N=95):

Studied variables	Patient safety culture	Test of sig P value	Decision latitude	Test of sig
	Mean ±SD		Mean ±SD	P value
Hospital				
Menoufia university hospital	125.1±11.5	**K**	22.4±4.15	**K**
Menoufia teaching hospital	120.6±16.3	**44.1**	21.6±2.92	**15.6**
Omooma hospital	144.8±8.62	**0.001***	25.1±5.13	**0.001***
Elshohada hospital	124.9±7.15		22.3±1.62	
Duration of work in hospital				
< 1 year	142.1±12.2		26.1±6.43	
1 – 5 years	128.7±14.8		22.8±3.39	
6 – 10 years	139.4±12.9	**K**	23.9±4.60	**K**
11 – 15 years	123.4±11.2	**23.5**	22.0±3.64	**12.8**
16 – 20 years	124.0±6.68	**0.001***	22.7±4.57	**0.025***
21 or more	121.2±8.04		21.2±3.03	
Department				
Operating room of obstetrics and gynecology	132.5±15.5	U 1.00	24.7±4.15	U 3.90
Department of obstetrics and gynecology	129.4±13.3	0.313	21.4±3.73	**0.001***
Duration of work in the current unit				
< 1 year	140.5±12.8		25.4±6.40	
1 – 5 years	128.2±15.2		23.3±3.34	
6 – 10 years	136.9±12.2	K	22.9±4.36	K
11 – 15 years	128.0±14.9	14.2	22.9±4.97	8.95
16 – 20 years	121.7±7.03	**0.014***	20.1±2.85	0.111
21 or more	119.0 ±1.41		24.0±0.01	
Working hours per week				
< 20 hours / week	133.0±12.4		24.4±3.55	
20 – 39 hours / week	126.4±10.8		21.6±3.18	
40 – 59 hours / week	130.9±15.4	**K**	22.8±4.31	**K**
60 – 79 hours / week	131.1±10.4	**15.0**	23.9±5.19	**21.3**
80 – 99 hours /week	140.9±21.7	**0.010***	26.3±4.42	**0.001***
100 or more hours / week	154.0±0.01		30.0±0.01	

Discussion:

The term "presenteeism" refers to the practice of nurses reporting to work despite experiencing a physical or mental health issue. In these situations, the level of the work produced may be compromised, leading to a loss of productivity and resulting in harm to the hospitals where the nurses work, the society, and the health of the nurses themselves. It was also regarded as a predictive measure for future disability and sick leave payments. Therefore, research into it was necessary because, with a greater understanding of it, strategies, and measures to lessen its incidence can be developed. (Kigozi et al., 2017). The current study was conducted to examine maternity nurses' perspective of presenteeism and its relation to self-reported quality of care, decision latitude and patient safety culture at the study settings.

The results will be discussed in the following order: (1) level of presenteeism as perceived by nurses, level of maternity nurses' self-reported quality, level of decision latitude and level of patient safety culture as perceived by nurses. (2) Relation between presenteeism, maternity nurses' self-reported quality, decision latitude and patient safety culture.

Concerning Nurses' presenteeism level, the current study showed that the highest percentage of the studied subjects experienced presenteeism and that the highest percentage was for better performance (60 %) and the lowest percentage was for reduced performance (40 %). (This answered the 1st research question). According to the researchers, this might be related to highly demanding occupations such as nursing occupations usually involve great responsibilities, high workloads, and inflexible nurses experience pressure to meet deadlines. Because of this, nurses were more likely to work when ill and to miss work due to excessive job expectations which may lead to high risk of presenteeism.

These findings were consistent with those of Min et al. (2021), who noted that healthcare workers typically have a strong sense of duty, which can compel them to report to work even while ill, particularly when staffing shortages occur. High rates of sick presenteeism (SP) have been documented among nurses, which is concerning because it has been connected to patient safety and the quality of care.

The current study's findings aligned with those of Elsherbiny et al. (2022), who investigated nurse presenteeism and potential contributing factors. Their findings indicated that 100% of ICU nurses and the comparison group at MUH reported having presenteeism. This was in line with the findings of Shan et al. (2021), who discovered that 94.25% of Chinese nurses reported presenteeism.

The findings of MosteiroDíaz et al. (2020) on presenteeism among nurses—a comparative analysis of Spanish, Portuguese, and Brazilian nurses—correspond with this, since they found a mean overall SPS-6 score of 20.23±4.44. Additionally, it aligned with the findings of Brborović et al. (2014), who conducted a cross-sectional study on nurse presenteeism and patient safety culture and reported that nurses' mean total SPS-6 score was 22.53±4.32, respectively.

This result was in line with the findings of Dhaini et al. (2016), who noted that irrespective of the setting they work in, healthcare workers—including registered nurses and nurse assistants—frequently exhibit high rates of presenteeism. For instance, 44% of Swedish health sector employees reported a regular persenteeism in 2005. According to Critz et al. (2020), there is a significant presenteeism rate among nurses globally. Furthermore, Mdziniso (2016) discovered that 80.7% of nurses report to work even when they are sick. In this respect, Santos etal., (2018) confirmed that the high rate of presenteeism among nursing workers. Agreed with the current study, Al-Mutairi etal., (2022) The study's

findings indicated that presenteeism had a high mean value.

Compared to the results of that study, a study done in Norway in 2013 by Linnerud revealed a comparatively lower prevalence rate of presenteeism. Furthermore, the results of this study differed from those of Mosteiro-Díaz et al. (2020) in Portugal, who reported a significantly lower prevalence rate of presenteeism.

The mean score for "completing work" was significantly higher among maternity nurses. Elsherbiny et al. obtained the same outcome in 2022. Furthermore, Silva-Costa et al. (2020) found that at a Brazilian public hospital, the mean score for completing work was 12.43 ± 2.97. The worker had less difficulty completing his or her tasks the higher this score was (Silva et al., 2019). Also, the mean "avoiding distraction" dimension score was significantly lower for maternity nurses. This was consistent with the findings of the Elsherbiny et al., (2022) study, which showed a mean score of (avoid distraction) 9.3 ± 3.4. Furthermore, Silva-Costa et al. (2020) found that the mean score of avoid distraction was 8.65 ± 3.78; Paschoalin et al., (2013) stated the lower this score, the more focused and psychologically well-adjusted the person was at work.

In terms of maternity nurses' self-reported quality, the current study noticed that there was high self-reported quality of patient care by nurses, and this answered the 2nd research question.

This finding was consistent with den Breejen-de Hooge et al (2021) who studied association between leadership of nurses and nurse-reported quality of care and found that nurses rated quality of care as moderate.

In the same line, Letvak,et al (2012) who studied Nurses' Presenteeism and Its Effects on Self-Reported Quality of Care and Costs and found nurses reported an average quality-of-care . On the other side of the coin, this result was contradicted with Kakemam etal., (2021) which indicated that self-reported quality of patient care was assessed and found as being poor. Also, this result was contrasted with Nantsupawat et al., (2016), Poghosyan et al., (2010), and Sulaiman et al., (2017).

Regarding decision latitude, the current study indicated that nurses reported high decision latitude. This finding was agreed on by Elsherbiny etal., (2022) who study presenteeism among nursing staff of intensive care units and found high decision latitude.

Regarding nurses' patient safety culture, the present study highlighted that a majority of the nurses who were studied had very good perception about patient safety culture, while the highest perception was for frequency of events reported domain followed by teamwork within units and lowest perception was for non-punitive response to errors domain followed by communication openness. This good perception toward patient safety culture may be due to nurses had training program related aspect of patient safety culture or nursing mangers create nursing work environment that empowers staff nurses, enhance nurses' autonomy, and

providing nurses with opportunities for professional development. Nursing managers also share their views on the importance of safety, fidelity and accountability, and agreed trust in the effectiveness of preventive measures.

This result was consistent with Ibrahim and Abo Habieb (2020) who found that a majority of the nurses who were studied had good or moderate perception (66%) toward patient safety culture. In the same line El-Sherbiny et al., (2020) reported that the lowest score was for communication openness. Moreover, Ghobashi et al, (2014) reported that the studied nurses had poor culture less than 50% related the non – punitive response to errors, on the other hand, teamwork among the center's units and organizational learning were the highest positive dimension. This result was in the same line with a study conducted Hadad etal., (2021) that showed that the highest percentage of staff nurses have high total scores regarding patient safety culture for the dimensions "frequency of event reporting" "teamwork within units" and "organizational learning continuous improvement".

Also, in the same context the study of Ricklin et al., (2019) and Ali et al. (2018), the nurses under study evaluated the overall patient safety culture as very good. These results were in conflict with the findings of Abdi et al, (2015) indicated none of the patient safety culture domains achieved a positive culture and all the domains need improvements. It also disagreed with El-Sherbiny et al., (2020) reported that the degree of patient safety is poor.

concerning the relation between presenteeism and self-reported quality of care, the results of the present study demonstrated a high correlation between self-reported quality of care and presenteeism. Letvak et al. (2012) verified this finding by indicating a significant correlation between nursing-sensitive quality-of-care indicators and nurses' presenteeism. More specifically, lower self-reported quality of care was linked to perenteeism among studied nurses.

Regarding relation between presenteeism and decision latitude, according to the current findings, presenteeism was significantly higher among nurses who had a high degree of decision latitude. Elsherbiny et al., (2022) was consistent with this study findings who concluded that nurses who had high decision latitude exhibited significantly higher presenteeism. In the studies they conducted, Miraglia and Johns (2016) concurred with their findings. They proposed that a high adjustment latitude lowers the probability of sick absenteeism (SA) in preference for sickness presenteeism because workers may be able to work less intensively even when they are feeling ill because of their ability to modify job requirements to fit their temporary limitations.

Concerning the relation between presenteeism and safety culture: the results of the study demonstrated a statistically significant positive correlation between presenteeism and patient safety culture. According to the researchers, this unexpected finding

may be explained by the fact that nurses who have a high patient safety culture—a set of values they uphold—tend to show up for work even when they feel their performance is below average or in comparison to others, whereas nurses who have a low patient safety culture—on the other hand—tend to skip work. Our results also suggest that PSC was not an accurate measure of patient safety when it came to presenteeism since, even if it were, it wouldn't positively correlated with poor performance or sick work.

This result go hand with hand with Brborović and Brborović (2017) who reported that Higher PSC nurses are more likely to experience presenteeism, whereas lower PSC nurses are more likely to have absences from work.

This result was congruent with Rainbow etal., (2020) who found that a strong relationship was found between presenteeism and safety culture, indicating that addressing presenteeism is crucial for enhancing patient safety practices. On the other side of the coin, this result was contradicted with Zanon etal., (2021) who indicated that a statistically significant negative correlation existed between presenteeism and patient safety culture. Also, this result was opposed to Baldonedo-Mosteiro et al., (2020) who found that presenteeism has been linked to decreased patient safety by professionals suffering from it.

Conclusion

It was concluded that, there was a highly statistically significant positive correlation among maternity nurses' perspective of presenteeism, self-reported quality of care, decision latitude and patient safety culture at the study settings.

Recommendations

The following recommendations have been put in light of the study's findings and reviewing the literature:

1) Nurse managers and supervisors should be familiar with the concept of presenteeism. A significant number of managers and supervisors have neglected to pay attention to this variable, which has important consequences for patient safety, quality, and the health and welfare of nurses.

2) Pay attention to presenteeism as well as absenteeism. Supervisors who only concentrate on absenteeism run the risk of undervaluing the contribution which presentist employees provide to their organization.

3) Clearly define the rules around attendance at work and prohibit people from coming to work when sick, especially if they have an infectious disease.

4) Encourage nurses to talk about their illnesses or health issues without worrying about negative consequences.

5) Provide full pays to nurses for time missed due to illness.

6) Define appropriate nurse staffing ratios and guarantee prompt replacement in the event that a coworker becomes ill.

7) Establish measurable organizational goals for workers' health and welfare.

8) Establish a transparent communication and feedback mechanism on errors to avert recurrence and mitigate adverse consequences for nurses, patients, and healthcare institutions.
9) Handoffs and information exchange standards should be achieved to prevent lack of information that important for patient safety.
10) Nursing managers should constantl y
observe and assess many aspects of the patient safety culture among nu rses in order to create a safe and healthy environment for patients,
11) Hospital management should concern with continuous training programs for nurses that enhances their culture regarding patient safety in addition to improving quality of patient care.
12) Carry out additional research on nurses to measure presenteeism and determine its origins, effects and consequences.

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