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Patient Safety: Everyone's Life Matters

By Bachchu Kailash Kaini

Anglia Ruskin University

Abstract- Adverse events are still one of the major issues for healthcare organisations even though many initiatives have been launched in the past for patient safety. There are many reasons of patient safety incidents and avoidable harms to service users, such as human factors, medical factors, system wide problems, lack of technology, poor communication and teamwork. By developing and implementing proper system, effective teamwork, good communication channels and means, standardised procedural documents, patient safety training and education programme, healthcare professionals and institutions can deliver safe patient care and improve the quality of healthcare.

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Patient Safety: Everyone's Life Matters

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I. Introduction

Safe delivery of healthcare is a prime objective of everyone involved in the delivery of health services. Patient safety is influenced by a variety of factors, including the healthcare system, the environment and the individual service user. It encompasses the identification and reduction of risks to service users, as well as the promotion of safe and effective healthcare in any settings.[1]

According to Napier and Youngberg 'the purpose of patient safety is to provide a safe environment, to explore the possibility of failure, and to create defences that will change the current system of operation in order to reduce the potential for failure'. [2]

Patient safety can have a significant impact on the health and well-being of health service users. According to a report by House of Commons in the UK it is estimated that as many as 10% of patients admitted to hospital suffer some form of harm, much of which is avoidable.[3] This harm can range from minor injuries to death. Health service users who suffer from at least one adverse event are double as likely to die during their hospitalisation.[4]

A report '*The Economics of Patient Safety from Analysis to Action*' published by the Organisation for Economic Co-operation and Development highlights that over 10 per cent patients continue to be harmed from safety lapses during their care and unsafe care results in well over three million deaths each year globally.[5] The report further highlights that the health burden of harm is estimated at 64 million Disability-Adjusted Life Years (DALYs) a year, similar to that of HIV/AIDS and most of this burden is felt in low-to middle-income countries (LMICs). It further continues to estimate that as many as four in 100 people die from unsafe care in the developing world. This fact is alarming and highlights an urgent need to address by the health authorities around the world.

Patient safety is a costly issue, costing the global healthcare system billions of dollars each year. It is one of the major public health and hospital care problems.[6] World Health Organization (WHO) in its report '*The Conceptual Framework for the International Classification for Patient Safety*' published in 2009 defines that 'adverse healthcare-related events as incidents that occur during medical care and harm a patient, producing an injury, suffering, disability, or death'.[7]

Patient safety is not new to healthcare professionals and the health system. It is a critical and complex issue that affects service users, healthcare professionals and the healthcare system and requires multi-disciplinary approaches. The Institute of Medicine in the USA in its well-received report '*To Err is Human: Building a Safer Health System'* analysed wide ranges of patient safety issues and stated that there were many patient safety problems in every type of healthcare setting.[8] The report highlighted the need for improvement in healthcare delivery system to close gaps and save lives. Through the implementation of patient safety policies and improvement in healthcare systems, healthcare organisations are safer today than in the 1990s or before.[9]

The cost of adverse events and patient safety issues is not just financial. These issues can also have a significant impact on service users' quality of life by the harm of physical injuries, emotional distress, and financial hardship, amongst many others. To address these issues, healthcare organisations, authorities and professionals around the globe need to focus on developing proper systems, including appropriate technology, proper communication means or channel, great teamwork, standard procedural documents, education and training programme to mitigate the risk of avoidable harms to service users.

II. Healthcare System

The WHO has highlighted the importance of safe and effective delivery of healthcare around the world by developing systems and guidelines. This has

Author: PhD, SFHEA, FRSPH, MHA, MBA, LLB, PGCHE, BEd, Cert in Clinical Audit in Health and Social Care; Senior Lecturer of Healthcare Management and Leadership, Anglia Ruskin University, Faculty of Health, Medicine and Social Care, School of Allied Health and Social Care, Chelmsford, CM1 1SQ, UK. e-mail: Bachchu.Kaini@aru.ac.uk

been evident by creating 'The World Alliance for Patient Safety'[10], by developing 'WHO Patient Safety Curriculum Guide for Medical Schools'[11], publishing technical series on 'Safer Primary Care'[12], 'Surgical Site Checklist'[13], and developing 'Guidelines for Adverse Event Reporting and Learning Systems'[14], few important initiatives to highlight.

Another example is promotion of 'Universal Health Coverage' (UHC) which has emerged as a key theme and priority for the WHO. The UHC highlights the provision of accessible, safe and effective primary care is fundamental requirement to meet this important international policy goal by its member states.[15]

Patient safety incidents often occur when there are problems in the healthcare delivery system. Good examples of these kinds of problems are shortage of healthcare professionals or lack of adequate staff, no provision of regular or refresher training, miscommunication, lack of information, no protocols or guidance etc. Therefore, healthcare organisations, professionals and authorities responsible for healthcare delivery should focus on identifying and addressing the underlying causes of patient safety incidents. This approach helps to mitigate the risk of harm due to patient safety incidents which are often caused by factors within the healthcare delivery system.

III. Technology

Technologies such as automated decision-making support systems, telehealth, electronic patient record and automatic data capture technology could make substantial improvements to care.[4] It can be used to communicate between healthcare professionals and service users in many ways and provides real-time feedback to service users, healthcare professionals and institutions. Moreover, technology helps to prevent patient safety incident.[5,13] It was found that digital health platforms such as Clinical Decision Support (CDS) and Result Notification Systems (RNS) tools help to reduce diagnostic error and improve diagnosis in exploratory and validation studis.[16]

In the context of developing nations, telehealth is widely used to provide regular and follow up health services where health services are not easily accessible. The WHO's report 'Safer Primary Care' highlights that effective and safe delivery of primary care should be priority of every nation and healthcare authorities around the world.[12]

IV. Teamwork

Avoidable adverse events are common in healthcare organisations. It is suggested that avoidable adverse events are good to look at and tackle to achieve quality improvement targets through teamwork and patient safety initiatives.[4]

Teamwork is essential for safe and effective delivery of healthcare. It is an underlying element of safety culture and essential for ensuring that service users receive the care they need. If healthcare professionals and workers understand and apply the principles of teamwork, work as a great team and provide reliable care, it is assumed that it helps to deliver safe and effective patient care.[17] It was reported that there were reductions in adverse events such as hospital acquired infections (HAIs) because of teamwork.[16]

There are many benefits to teamwork in healthcare settings. Some of the most important benefits include improved communication, increased awareness of risks, reduced errors and improved patient outcomes.[18,19]

There are many ways to promote teamwork in healthcare settings for the safe and effective delivery of healthcare. Some of the most important ways to improve teamwork include creating a culture of safety, providing training on teamwork, creating opportunities for teamwork, recognising and rewarding teamwork, and being clear about roles and responsibilities in a team. By promoting teamwork, healthcare organisations can create a safer environment for service users, healthcare professionals and improve patient outcomes.

V. Communication

Different levels and categories of healthcare professionals have different levels and types of knowledge, skills and expertise. Each member of the healthcare team should feel comfortable communicating with each other, even if they have different levels of experience or expertise. They also should treat each other with respect, even when they disagree.

It found that studies of simulation-based education curricula for doctors and nurses report improvements in clinical safety process and clinical outcome measures in healthcare organisations.[16] One study by Leonard et al highlighted that the effective and good communication between healthcare professionals, service users and carers is one of the important factors for providing safe healthcare. [17]

VI. Standardised Procedural Documents

Standardised approach to care is very important for better clinical outcome, safe delivery of healthcare and improving patient experience.[5,20] Procedural documents such as standard operating protocols (SOPs), guidance, policies, guidelines and procedures provide guidance to healthcare professionals for standardised approach to care. The use of procedural documents in healthcare settings

reduce errors, increase efficiency and improve communication.

Procedural documents should be easy to understand and follow, concise and clear. Moreover, they should be reviewed and updated to reflect the most recent practices or guidance and to ensure that they are accurate and up to date. By developing and implementing procedural documents, healthcare professionals and institutions can deliver safe patient care and improve quality of healthcare.

VII. Human Factors and Patient Safety

Healthcare professionals are human being. Human beings live with their emotions. Emotions are integral, important and powerful parts of human beings. Human errors are natural while working in any set up and it is more important when healthcare professionals work for sick and unwell patients around the clock in difficult circumstances.

Human factors and errors are a major cause of adverse events and harm in healthcare settings. They can occur at any stage of the patient care process in healthcare settings, from diagnosis to treatment to discharge.

Hallinan in his book 'Why We Make Mistakes', examined various factors that contribute to human errors and explained why errors in any setting continue to occur. Some of the points Hallinan highlighted are distractions, interruptions, fatigue, shortcut we take in the delivery of services etc.[21]

There are many different types of medical errors that can lead to patient harm. Some of the most common types of errors include medication errors, diagnostic errors, communication errors and surgical errors.[22]

Human errors can have a devastating impact on health service users and their families. They can lead to pain, suffering, disability, and even death. There are several things that can be done to reduce human errors and improve patient safety. Some of the most important things include training, standardised procedures, use of appropriate technology and promotion of safety culture.

VIII. Measures to Minimise Risks

Reducing adverse incidents in healthcare and action to improve quality of care by focusing on patient safety require transparency, accountability, great leadership, effective communication, political will, investment, technology and a strong health system.[1,4,5]

According to Ankowicz 'understanding and accepting our humanness and how it affects our work environment is an important step in understanding our ability to apply solutions to prevent unintentional patient harm'.[23]

Healthcare institutions and healthcare professionals can take many initiatives to improve patient safety and to prevent unintended harm to service users. Some of the examples of great initiatives with little resources are implementing safety checklist, developing protocols and guidance, staff training on patient safety, implementing adverse incident reporting and learning system, creating a safety culture, use of technology, improving patient engagement, empowering service users etc.[2, 6, 14, 13]

By continuously improving health services and taking steps to prevent adverse events and incidents, healthcare professionals and institutions can create a safer environment for patients and improve patient outcomes. Health service users can also play an important role in their own safety and wellbeing by asking questions, being involved in their care, and reporting any concerns they have. Sometimes by following simple steps and preventive tips, patient safety incidents can be reduced in healthcare settings.

IX. Summary

The issue of patient safety is getting more attention in developing nations in recent years. Safe delivery of healthcare should be a priority for everyone in the healthcare delivery system. Healthcare professionals, institutions, patients, their families, carers, healthcare managers and administrators have a role to play in preventing patient safety incidents or avoidable harms and to ensure that service users receive the highest quality of care. There are many ways to minimise patient safety risk and harm to service users. Collaborative approaches between healthcare professionals, service providers, service users and carers are required to improve quality of care, which includes safe delivery of care, clinical effectiveness and improving patient experience. Everyone's life matters in the healthcare delivery system and everyone deserves to receive safe, effective and highest quality of care.

Conflict of Interest: None

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