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HEALTHCARE SAFETY CULTURE: BUILDING A SAFER AND MORE RELIABLE SYSTEM

***Dr. M. Padmaja**

India.

***Corresponding Author: Dr. M. Padmaja**
India.

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ABSTRACT

"First, do no harm" stands as the core principle of all health care services. No one should suffer harm in health care; nonetheless, substantial evidence indicates a significant prevalence of preventable patient harm worldwide in both developed and developing health care systems. This carries significant human, moral, ethical, and financial consequences. Ensuring patient safety in healthcare is a crucial aspect designed to prevent harm and minimize risks associated with medical care. It encompasses numerous strategies to ensure that healthcare systems and providers deliver safe and effective services. This involves cultivating a safety culture, implementing robust safety protocols, and continuously improving practices to reduce errors and adverse events. Important elements of patient safety in healthcare involve upholding a clean and sterilized environment to avoid infections and cross-contamination, guaranteeing that well-equipped emergency services are readily available for managing urgent situations, healthcare professionals must be sufficiently trained and qualified to deliver safe and capable care, access to contemporary and well-maintained medical equipment is vital for precise diagnosis and effective treatment, and enforcing rigorous infection control measures is essential to inhibit the transmission of infections within healthcare facilities. Involving patients in their treatment and motivating them to communicate any issues or mistakes is essential for enhancing safety. Establishing strong systems for overseeing and upholding health information technology is crucial. Safeguarding healthcare professionals from workplace dangers is a vital component of patient safety.

INTRODUCTION

Patient safety is *freedom from accidental injury*. World Health Organization (WHO) has developed a Global Patient Safety Action Plan to address the global challenge of avoidable harm in healthcare. The plan aims to eliminate avoidable harm in healthcare and improve patient safety through policy actions, implementation of recommendations, and alignment of strategic instruments. The plan also provides a framework for countries to develop their own national action plans on patient safety. By focusing on these key areas and implementing comprehensive patient safety strategies, healthcare systems can significantly reduce the risk of harm to patients and create a safer environment for all. Safety systems in health care organizations seek to prevent harm to patients, their families and friends, health care professionals, contract-service workers, volunteers, and the many other individuals whose activities bring them into a health care setting. Safety is one aspect of quality, where quality includes not only avoiding preventable harm, but also making appropriate care available—providing effective services to those who could benefit from them and not providing ineffective or harmful services.

Health care consists of a vast array of interconnected systems—paramedicine, emergency services, outpatient care, inpatient services, and home health care; diagnostic and imaging labs; pharmacies; among others—that are linked in loosely connected yet complex networks of people, teams, processes, regulations, communication, equipment, and devices operating under decentralized management in a fluctuating and unpredictable setting. Doctors in community practice might be linked so loosely that they do not perceive themselves as members of a care system. They might view the hospitals where they are staff as venues for their efforts. Through these and numerous other methods, the unique cultures of medicine (and various health professions) contribute to the peculiar nature of health care within high-risk industries.

Approximately 1 in 10 patients experiences harm in healthcare, resulting in over 3 million fatalities each year from unsafe treatment. In countries with low to middle income, around 4 out of every 100 individuals die due to inadequate care.[1] More than 50% of damage (1 in every 20 patients) can be avoided; half of this damage is linked to medications.[2,3] Certain estimates indicate that

approximately 4 out of 10 patients experience harm in primary and outpatient settings, and up to 80% (23.6–85%) of this harm is preventable.[4] Frequent adverse events that could lead to preventable patient harm include medication mistakes, risky surgical interventions, infections linked to health care, diagnostic inaccuracies, falls among patients, pressure sores, patient identification errors, unsafe blood transfusions, and venous thromboembolism.

Patient safety refers to the prevention of avoidable harm to a patient and minimizing the risk of unnecessary harm related to healthcare to an acceptable level. It is a structure of structured actions that forms cultures, processes, procedures, behaviors, technologies, and settings in health care that consistently and sustainably minimize risks, decrease the frequency of preventable harm, lessen the likelihood of errors, and mitigate the effects of harm when it happens. Harm related to medication impacts 1 in 30 patients within healthcare, with over a fourth of this harm classified as severe or potentially life-threatening. Fifty percent of the preventable damage in healthcare is associated with medications.[3] More than 300 million surgeries are conducted annually across the globe.[6] Even with knowledge of negative consequences, surgical mistakes still happen frequently; 10% of avoidable patient harm in healthcare was noted in surgical environments,[2] with the majority of adverse incidents taking place before and after surgery.[7]

Health care-associated infections, with a worldwide rate of 0.14% (rising by 0.06% annually), lead to longer hospital stays, persistent disabilities, heightened antimicrobial resistance, extra financial strain on patients, families and health systems, as well as preventable deaths.[8] Among all sepsis cases treated in hospitals, 23.6% were identified as health care associated, and about 24.4% of those patients died due to the condition.[9] Diagnostic mistakes happen in 5–20% of doctor-patient interactions.[10,11] Based on physician evaluations, harmful diagnostic mistakes were identified in at least 0.7% of adult hospital admissions.[12] Patient falls are the most common negative incidents in hospitals.[14] The frequency of these events varies between 3 and 5 for every 1000 bed-days, with over a third of these occurrences leading to injuries,[15] which ultimately diminishes clinical results and elevates the economic strain on systems.[16]

Unnecessary transfusions and unsafe transfusion practices expose patients to the risk of serious adverse transfusion reactions and transfusion-transmissible infections. Data on adverse transfusion reactions from a group of 62 countries show an average incidence of 12.2 serious reactions per 100 000 distributed blood components. Failure to correctly identify patients can be a root cause of many problems and has serious effects on health care provision. It can lead to catastrophic adverse effects, such as wrong-site surgery. A report of the Joint Commission published in 2018 identified 409 sentinel events of patient identification out of 3326 incidents (12.3%) between 2014 and 2017.

Each year, 16 billion injections are administered worldwide, and unsafe injection practices place patients and health and care workers at risk of infectious and non-infectious adverse events. Using mathematical modelling, a study estimated that, in a period of 10 years (2000–2010), 1.67 million hepatitis B virus infections, between 157 592 and 315 120 hepatitis C virus infections, and between 16 939 and 33 877 HIV infections were associated with unsafe injections.[20]

Patient harm in health care due to safety breaks is pervasive, problematic and can occur in all settings and at all levels of health care provision. There are multiple and interrelated factors that can lead to patient harm, and more than one factor is usually involved in any single patient safety incident. Most of the mistakes that lead to harm do not occur as a result of the practices of one or a group of health and care workers but are rather due to system or process failures that lead these health and care workers to make mistakes. Understanding the underlying causes of errors in medical care thus requires shifting from the traditional blaming approach to a more system-based thinking. In this, errors are attributed to poorly designed system structures and processes, and the human nature of all those working in health care facilities under a considerable amount of stress in complex and quickly changing environments is recognized. This is done without overlooking negligence or misbehaviour from those providing care that leads to substandard medical management.

CONCLUSION

A secure health system implements essential strategies to prevent and lessen harm through structured efforts, which include: securing leadership dedication to safety and cultivating a culture that prioritizes safety, guaranteeing a secure work environment along with the safety of procedures and clinical processes, enhancing the skills of health and care professionals and fostering teamwork and communication, involving patients and families in policy shaping, research, and collaborative decision-making, and creating mechanisms for reporting patient safety incidents for learning and ongoing enhancement. Allocating resources to patient safety enhances health results, lowers expenses associated with patient injuries, boosts system efficacy, and aids in reassuring communities while rebuilding their confidence in health care systems. Acknowledging patient safety as a worldwide health priority and a crucial factor in enhancing health systems to achieve universal health coverage, the Seventy-second World Health Assembly passed resolution WHA72.6 on “Global action on patient safety” in May 2019. The resolution urged the Director-General to prioritize patient safety as a fundamental strategic focus in WHO’s efforts related to universal health coverage, supported the creation of

World Patient Safety Day to be celebrated every year on 17 September, and called on WHO's Director-General to formulate a global patient safety action plan involving WHO Member States, partners, and other pertinent stakeholders.

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21. Dr. M. Padmaja, HOD & Assistant Professor, Department of Home Science, Ch. S. D. St. Theresa's College for Women (Autonomous), Eluru. Mail ID: dr.padmaja@stcelr.ac.in