



PATIENT SAFETY: ERROR REDUCTION IN HEALTH CARE

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Article Received on 23/06/2019

Article Revised on 13/07/2019

Article Accepted on 03/08/2019

ABSTRACT

Patient safety is a top priority. Strong health care teams reduce infection rates, put checks in place to prevent mistakes and ensure strong lines of communication between hospital staff, patients and families. As many as 440,000 people die every year due to hospital errors, injuries, accidents, and infections. Every year, 1 out of every 25 patients develops an infection while in the hospital—an infection that didn't have to happen. A Medicare patient has 1 in 4 chance of experiencing injury, harm or death when admitted to a hospital. Today alone, more than 1000 people are dying because of a preventable hospital error. It's important to remember that most hospital errors can be prevented. Hospitals need to work hard every day to protect their patients from errors, injuries, accidents, and infections. To ensure safe care, it is important to be an active member of the health care team. One of the most significant problems with today's health care system is the failure to make safety and quality information available to the public. But public deserves this information so they can make informed choices about where to receive care.

KEYWORDS: Patient safety, health care team, error, injury, quality.

INTRODUCTION

Healthcare is a team effort. Each healthcare provider is like a member of the team with a special role like doctors or technicians who help diagnose disease, experts who treat disease or care for patients' physical and emotional needs. Healthcare team members include doctors, physician assistants, nurses, pharmacists, dentists, technologists and technicians, therapists and rehabilitation specialists, emotional, social and spiritual support providers, administrative and support staff, community health workers and patient navigators. Patient safety is an important element of an effective, efficient health care system where quality prevails.

Delivering safer care in complex, pressurized and fast-moving environments is one of the greatest challenges facing health care today. In such environments, things can often go wrong. The most important challenge in the field of patient safety is how to prevent harm, particularly 'avoidable harm', to patients during treatment and care. All preventable errors can and should be, avoided. But in order to provide high quality health services, the safety of each and every patient deserves to be given the highest priority.

Ensuring the safety of patients is a high visibility issue for those delivering health care - not just in any single country, but worldwide. The safety of health care is now a major global concern. Services that are unsafe and of

low quality lead to diminished health outcomes and even to harm. The experience of countries that are heavily engaged in national efforts clearly demonstrates that, although health systems differ from country to country, many threats to patient safety have similar causes and often similar solutions. Treating and caring of people in a safe environment and protecting them from health care-related avoidable harm should be a national and international priority, calling for concerted international efforts.

Patient safety is a fundamental principle of health care. A number of patients are harmed during health care, either resulting in permanent injury, increased length of stay in health care facilities, or even death. According to a study, medical errors are the third leading cause of death in the United States. In the United Kingdom, recent estimations have shown that on average, one incident of patient harm is reported every 35 seconds. Similarly, a combination of numerous unfavourable factors such as understaffing, inadequate structures and overcrowding, lack of health care commodities and shortage of basic equipment, and poor hygiene and sanitation, contribute to unsafe patient care. A weak safety and quality culture, flawed processes of care, and disinterested leadership teams further weaken the ability of health care systems and organizations to ensure provision of safe health care.

Every year, an inadmissible number of patients suffer injuries or die because of unsafe and poor quality health care. Most of these injuries are avoidable. The burden of unsafe care broadly highlights the magnitude and scale of the problem. It is commonly reported that around 1 in 10 hospitalized patients experience harm, with at least 50% preventability. In a study on frequency and preventability of adverse events, across 26 countries, the rate of adverse events was around 8%, of which 83% could have been prevented and 30% led to death. It is estimated that 421 million hospitalizations take place in the world annually, and approximately 42.7 million adverse events occur in patients during those hospitalizations.

It is estimated that the cost of harm associated with the loss of life or permanent disability, which results in lost capacity and productivity of the affected patients and families, amounts to trillions of rupees every year. Furthermore, the psychological cost to the patient and their family, associated with the losing a loved one or coping with permanent disability, is significant though more difficult to measure. Studies on direct medical costs associated with poor care show that additional hospitalization, litigation costs, infections acquired in hospitals, lost income, disability and medical expenses have cost between Rs. 6 billion and Rs.29 billion per year. Loss of trust in the system and loss of reputation and credibility in health services are additional forms of collateral damage caused by unsafe health care.

Medical errors occur right across the spectrum, and can be attributed to both system and human factors. The most common adverse safety incidents are related to surgical procedures (27%), medication errors (18.3%) and health care-associated infections (12.2%). Yet, in many places, fear around the reporting of errors is manifested within health care cultures, impeding progress and learning for improvement and error prevention. The global need for quality of care and patient safety was first discussed during the World Health Assembly in 2002, and resolution WHA55.18 on 'Quality of care: patient safety' at the Fifty-fifth World Health Assembly urged Member States to "pay the closest possible attention to the problem of patient safety". Since then, there have been several international initiatives, which have brought the importance of the matter to the attention of policy-makers in many countries.

However, there have been limited systemic improvements in the safety of health care globally, and in some situations efforts made have been unsustainable and uncoordinated. In many countries, health services, where they are available, are of poor quality, thus endangering the safety of patients, compromising health outcomes, and this leads to lack of trust of the population in health services. Clear policies, organizational leadership capacity, data to drive safety improvements, skilled health care professionals and effective involvement of patients in their care, are all needed to

ensure sustainable and significant improvements in the safety of health care.

CONCLUSION

Patient safety is the cornerstone of high-quality health care. In some hospitals, patient safety is a top priority. Strong health care teams reduce infection rates, put checks in place to prevent mistakes, and ensure strong lines of communication between hospital staff, patients, and families. But some hospitals don't have teams that work well together, or good leadership to ensure that patient safety is the number one priority. When one person makes a mistake, there isn't a good team ready to catch that mistake. Patients can experience dangerous complications, recovery is slower, and some patients even die unnecessarily.

Much of the work defining patient safety and practices that prevent harm have focused on negative outcomes of care, such as mortality and morbidity. Health care team is critical to the surveillance and coordination that reduce such adverse outcomes. Much work remains to be done in evaluating the impact of health care team on positive quality indicators, such as appropriate self-care and other measures of improved health status.

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