**Prevalent Hospital Safety Issues**

**Name:**

**Institution:**

**Course:**

**Module:**

**Professor's Name:**

**Date:**

**Prevalent Healthcare Safety Issues**

Patient safety science aims to ensure that people who receive care are not harmed either physically or mentally.

Around 1 in every 10 patients in hospitals is harmed and more than 3 million deaths occur annually due to issues regarding safety. In low-to-middle income countries, as many as 4 in 100 people die from unsafe care.

**Key Features**

Inadequate Staffing.

COVID-19 effects on healthcare workers’ mental health.

Addressing patient safety with bias.

Drug therapy coverage gaps and errors.

Cognitive biases and diagnostic error.

Non ventilator healthcare-associated pneumonia.

Errors in operating healthcare telecommunication.

Supply chain disruptions.

Products subject to emergency use authorization.

**Sources of Patient Harm in Hospitals**

* **Medication Errors.**

Failure in medicinal treatment may result in harmful effects to patients. It's a major concern for hospital safety and can result in an increased risk of drug–drug interactions, elevate frequency in hospital admissions and outpatient visits, extended hospital stays, heavy cost on management and increase the mortality risk.

* **Surgical Errors.**

Over 300 million surgical procedures are performed each year worldwide. A surgical error is an unintentional, preventable injury occurring in the perioperative period that is not considered a known acceptable risk of surgery and could have been avoided by following appropriate procedure-specific training protocols. Surgical errors are a type of medical error and include retained foreign bodies, mislabelled surgical specimens, and wrong-site, wrong-procedure, and wrong-patient errors (WSPEs). Miscommunication, unnecessary or emergent procedures, insufficient training and burnouts state underlying causes of surgical error. Surgical errors are catastrophic, employ significant financial burden, and are likely under-reported.

* **Health care-associated infections-Bacterial Sepsis.**

With a global rate of 0.14% (increasing by 0.06% each year, Health care-associated infections (HCAIs) are infections that occur while receiving health care, developed in a hospital or other health care facility that first appear 48 hours or more after hospital admission, or within 30 days after having received health care.

Of all sepsis cases managed in hospitals, 23.6% were found to be health care associated, and approximately 24.4% of affected patients lost their lives as a result.

Bacterial Sepsis is a fatal condition that occurs when the body’s response to an infection injures its tissues and organs.

* **Diagnostic errors.**

Hospitals record diagnostic errors occurring in 5–20% of physician–patient encounters. Diagnostic error is the failure to establish an accurate and timely explanation of the patient’s health concerns and describe the concerns to the patient. The diagnosis needs to be on time and accurate so that appropriate treatment is initiated to enhance outcome on patients. Gaps found in the diagnostic process can lead to error.

* **Patient falls.**

Patient falls are the most frequent adverse issues in hospitals. Their rate of occurrence ranges from 3 to 5 per 1000 bed-days, and more than one third of these incidents result in injury, thereby reducing clinical outcomes and increasing the financial burden on systems. Hospital patients have numerous acute and chronic conditions which limit judgement and mobility, which makes difficult to navigate a new and unfamiliar environment. Staffing and unit design are critical factors. Short lengths of stay offer a brief window of time to conduct interventions, making strategies like exercise programs impractical. Thus, it is important to investigate fall prevention methodologies specific to the hospital setting.

* **Venous thromboembolism.**

Happens when a blood clot forms in a deep vein. Venous thromboembolism is provoked by factors like surgery, trauma, pregnancy, hospital stay or use of hormone for treatments.

* **Pressure ulcers.**

Hospital acquired pressure injuries are pressure ulcers during hospitalization. They have a significant impact on the mental and physical health of individuals, and their quality of life.

* **Unsafe Transfusion Practices.**

In hospitals Unnecessary transfusions and Unsafe transfusion practices happen frequently. Having millions of people at risk of Transfusion Transmissible Infections (TTIs). [Data](https://www.who.int/publications-detail-redirect/9789240051683) has shown adverse transfusion reactions during distribution of blood components.

* **Patient misidentification.**

Patient misidentification in hospitals is very common; it occurs during drug administration, blood transfusions, surgical interventions, and sample collection. Hand-over and other communication problems increase the risk of misidentification issues, in an instance where multiple healthcare providers and specialists are involved in caring for a patient. 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 effects, such as wrong-site surgery.

* **Unsafe injection practices.**

Injections are the most used medical devices in hospitals. Approximately 16 billion injections are given annually worldwide. Unsafe injection practices like needle and syringe reusage, along with unnecessary use of injections, are quite common. This places patients and health and care workers at risk of infectious and non-infectious effects. A study on a particular region estimated that, in a period time of 10 years, 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.

**Factors Leading to Patient Harm**

Patient harm in hospitals due to safety compromises is much prevalent, problematic. They occur in all settings and at all levels of health care provision. There are many factors that can lead to patient harm. Complexity of medical interventions, inadequate processes and procedures, disruptions in workflow and care coordination, resource constraints, inadequate staffing and competency development.

* **Technological factors:** Issues related to health information systems, such as problems with electronic health records or medication administration systems, and misuse of technology.
* **Human factors and behaviour**: Communication breakdown among health care workers, within health care teams, and with patients and their families, ineffective teamwork, fatigue, burnout, and cognitive bias.
* **Patient-related factors**: Limited health literacy, lack of engagement and non-adherence to treatment.
* **External factors**: Absence of policies, inconsistent regulations, economic and financial pressures, and challenges related to natural environment.

**Proactive Approach to Preventing Harm in Hospitals**

Practical strategies for hospital safety processes should be applied.

1. **Education and Training:** It is important for healthcare professionals to be educated about patient safety to reduce errors and harms on patients. Education and training should be multidisciplinary and multi -professional.
2. **Healthcare Organization Leadership in Patient Safety:** Effective, persistence, stable and well-balanced Organizational Leadership is necessary to lead hospitals down the path to establishing a culture of safety.
3. **A Fair and Just Culture:**  A system of shared accountability in which organizations are accountable for the systems they have designed and for responding to the behaviours of their employees in a fair and just manner. Employees are accountable for the quality of their choices and for reporting errors and system vulnerabilities.
4. **Patient Engagement:** Engaging patients and families is at the core of maintaining safe, reliable, and effective care.
5. **Effective use of data:** Collecting and analysing of data are central to quality improvement in a healthcare facility. Solid evidence in the form of data is required to support decision-making rather than isolated occurrences, assumptions or emotions.

**In Summary**

Hospital safety is much prevalent in our society which impacts health outcomes, increases costs related to patient harm, impairs system efficiency, discourages communities and causing them to lose trust in health care systems.

**References**

**World health Organization**

[**Patient safety (who.int)**](https://www.who.int/news-room/fact-sheets/detail/patient-safety#:~:text=Common%20adverse%20events%20that%20may%20result%20in%20avoidable,patient%20misidentification%2C%20unsafe%20blood%20transfusion%20and%20venous%20thromboembolism.)

**Oxford Academic.**

[**Introduction to patient safety | Oxford Professional Practice: Handbook of Patient Safety | Oxford Academic (oup.com)**](https://academic.oup.com/book/40138/chapter/341470780)

**Intech Open Journals**

[**Patient Safety: Preventing Patient Harm and Building Capacity for Patient Safety | IntechOpen**](https://www.intechopen.com/chapters/79011)