**PREVALENT HOSPITAL SAFETY ISSUES**

**NAME:**

**INSTITUTION:**

**COURSE:**

**MODULE:**

**LECTRURE’S NAME:**

**Prevalent Healthcare Safety Issues Key Features:**

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

Adverse events that may result in avoidable patient harm are medication errors, unsafe surgical procedures, health care-associated infections, diagnostic errors, patient falls, pressure ulcers, patient misidentification, unsafe blood transfusion and venous thromboembolism.

A conventional system is needed to standardize and track events to measure particularly when healthcare workers are working between and within different professional backgrounds. The core terms are as described below.

* **Sentinel Event:** A patient safety event (not primarily related to the natural course of the patient’s illness or underlying condition) that reaches a patient and results in any of the following: death; permanent harm; severe temporary harm. The Sentinel Event Policy explains how The Joint Commission partners with hospitals that have experienced a serious patient safety event to protect the patient, improve systems, and prevent further harm.
* **Safety Patient Events:** An event incident, or condition that could have resulted or did result in harm to a patient. A patient safety event can be, but is not necessarily, the result of a defective system or process design, a system breakdown, equipment failure, or human error.
* **Adverse Events:** Any untoward or unfavourable medical occurrence in a human subject, including any abnormal sign (for example, abnormal physical exam or laboratory finding), symptom or disease temporally associated with the subject’s participation in the research.
* **Near Miss, Near Hit, Close Call or Nearly a Collision:** An unplanned event that has the potential to cause, but does not actually result in human injury, environmental or equipment damage, or an interruption to normal operation. Near misses also may be referred to as close calls, near accidents, accident precursors, injury-free events and, in the case of moving objects, near collisions.
* **A No-Harm Event**: A patient safety event that reaches the patient but does not cause harm. A close call (or “near miss” or “good catch”) is a patient safety event that did not reach the patient. Unsafe conditions are hazards that have the potential to cause injury or death to an employee. Some of these hazards include erroneous safety procedures, malfunctioning equipment or tools, or failure to utilize necessary safety equipment.

**Sources of Patient Harm in Hospitals**

* **Medication Errors.**

A medication error is failure in drug therapy that may result in harmful effects to patients. It is a serious concern and can result in an increased risk of drug–drug interactions, elevate the frequency of hospital admissions and outpatient visits, prolong the length of hospital stay, increase the management cost, and elevate 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). An analysis of these errors over the last few decades has revealed their cause is often multifactorial. However, miscommunication, unnecessary or emergent procedures, insufficient training, and provider burnout represent common causes of surgical error. Surgical errors can be potentially catastrophic, carry a significant financial burden, and are likely under-reported. Despite awareness of adverse effects, surgical errors continue to occur at a high rate.

* **Health care-associated infections.**

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.

* **Bacterial Sepsis.**

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 life-threatening condition that arises when the body’s response to an infection injures its tissues and organs. Sepsis has recently been re-defined as life-threatening organ dysfunction caused by a dysregulated host response to infection. Further widespread use of antibiotics and the discovery of endotoxin suggested the pathophysiology of sepsis is far more complex.

* **Diagnostic errors.**

These occur in 5–20% of physician–patient encounters. Diagnostic error is the failure to (a) establish an accurate and timely explanation of the patient’s health problem(s) or (b) communicate that explanation to the patient. Diagnosis is an iterative process that solidifies as more information becomes available. The diagnosis needs to be timely and accurate so that appropriate treatment is initiated to optimize the patient’s outcome. Any gaps that arise in the diagnostic process can lead to error.

* **Patient falls.**

Patient falls are the most frequent adverse events 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. Although there is a growing body of research on fall prevention in community dwelling elderly, findings from these studies are not necessarily generalizable to the hospital environment. Hospital patients have numerous acute and chronic illnesses which limit judgement and mobility, and they must navigate a new and unfamiliar environment. Staffing and even unit design considerations may play into fall risk. Short lengths of stay offer a brief window of time to conduct interventions, rendering some strategies (e.g. exercise programs) impractical. The unique organizational culture and leadership structures of hospitals require specific implementation strategies. Thus, it is imperative to examine fall prevention intervention strategies specific to the hospital setting.

* **Venous thromboembolism.**

Known majorly as blood clots, venous thromboembolism is a highly burdensome and preventable cause of patient harm and is associated with a high degree of morbidity and mortality, which contributes to one third of the complications attributed to hospitalization.

* **Pressure ulcers.**

Pressure ulcers are injuries to the skin or soft tissue. If not promptly managed, they can have fatal complications. Pressure ulcers affect more than 1 in 10 adult patients admitted to hospitals despite being highly preventable, they have a significant impact on the mental and physical health of individuals, and their quality of life.

* **Unsafe transfusion practices.**

Unnecessary transfusions and Unsafe transfusion practices can put millions of people at risk of Transfusion Transmissible Infections (TTIs). [Data](https://www.who.int/publications-detail-redirect/9789240051683) 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. Transfusion associated infections continue to be a big threat globally.

* **Patient misidentification.**

Major areas where patient misidentification occurs include drug administration, blood transfusions, surgical interventions, and sample collection.[9](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7276410/#ref9) Hand-over and other communication problems increase the risk of misidentification issues, particularly when 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 adverse effects, such as wrong-site surgery.

* **Unsafe injection practices.**

Injections are the most used medical devices in health care settings. Approximately 16 billion injections are given annually worldwide, most of them for therapeutic purposes and a very few for immunizations. 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 adverse events. 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 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:

* **System and organizational factors**: The 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.

## **Building capacity to Change and proactive approach to Preventing Harm**

A coordinated and practical strategy in which systemwide safety processes are applied across entire healthcare fields through collaboration among diverse stakeholders has been proven to provide the best outcomes.

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 lays at the core of the framework for safe, reliable, and effective care. Safe and reliable organizations’, patients and families are as much members of the care team as clinicians and other health care staff.
5. **Effective use of data:** Collecting and analyzing of data are central to quality improvement at all levels. Solid evidence in the form of data is required to support decision-making rather than isolated occurrences, assumptions or emotions.

**Conclusion**

Investing in **Hospital Safety** positively impacts health outcomes, reduces costs related to patient harm, improves system efficiency, and helps in reassuring communities and restoring their trust in health care systems

**References**

[**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.)

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

[**National Center for Biotechnology Information (nih.gov)**](https://www.ncbi.nlm.nih.gov/)