Spring 2024

Patient Safety and Its Role in Healthcare

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Acknowledgements

I can't thank my family, friends, and my previous WKCTC adviser, Mollie Bremer, enough for their guidance and encouragement. To my Aunt Monica who has assisted me in gathering various resources for the facts and statistics in this paper, resulting in the best themes and anecdotes listed. I express my heartfelt gratitude for the learning opportunities provided by my family and friends.

My project competition would not have been possible without the support of my fiancé, Adam, as well as the assistance of my parents. I'd like to thank my friends Jillian and Elizabeth Stuart for their supportive comments and prayers during this semester. Thank you for allowing

me to trust God and grow closer to him. I must extend my sincere gratitude to Maryville University for providing me with excellent studies on patient safety in connection with clinical care pertains to the measures made by clinical providers to minimize or prevent harm to the patient during treatment, as well as the necessity of developing plans to minimize risks to the patient's health. Regarding AMA I appreciate you letting me witness and comprehend the mental, physical, and emotional toll that significant medical errors take on doctors. I'd like to take a moment to convey how moving it felt to review the Patient Safety Movement program's stories about patients who have experienced complications and even medical errors, whether the error was an easy operation, a fall, miscommunication, or even receiving the incorrect medication. Nothing is more compelling than hearing about preventable patient damage firsthand from patients or their loved ones. The terrible stories represent only a portion of the major episodes of suffering and death caused by preventable medical errors that occur on a daily basis in your city and around the globe.

To my dearest friend, Tia Tucker, I thank you beyond words. You deserve the world and everything golden that comes with it. Tia is actually the one who pushed me to pursue my degree in healthcare administration. Thank you to everyone who has messaged me on my social media sites in order to get in touch with me despite not having my contact information. This means everything to me and gratitude is something I will forever cherish.

Finally, I want to thank my loving and caring children for pushing me to finish strong. They have made me the woman I am today, and they deserve everything and more. It gave me great comfort and relief to know that they understood my desire to offer a better life for them, and for that, I will be forever thankful.

Abstract

In the United States, medical errors are a major cause of death and a critical public health issue. Finding a reliable cause of mistakes and then offering a reliable, workable solution that reduces the likelihood of an ongoing issue are difficult tasks. Patient safety can be raised by acknowledging unfortunate events when they happen, acquiring knowledge about them, and striving to steer clear of them as well. Effectiveness in post-medical errors follow-up procedures is a pertinent and significant study topic for a number of reasons. In a hospital or maybe even a doctor's office, you may speak and engage with a receptionist, nurse, doctor, or maybe even a radiologist or another medical professional. However, behind the scenes, a health care administrator ensures that the organization operates effectively.

Ones desire to become a health care administrator may stem from a specific passion for the field, which allows them to have the ability to touch lives by assuring the finest patient experience. Also, being able to positively influence others is a goal of all healthcare administrators. Without a medical degree or prior experience providing direct patient care, individuals can make a difference from behind the scenes. The barriers and facilitators in utilizing best practices in follow-up actions after medical errors have the potential to be discovered and analyzed through research, along with the effectiveness and results of these actions in various settings and circumstances.

The development of consistent, open-minded, and ethical norms, rules, and standards for follow-up procedures may also benefit from such study. In conclusion, this research may help someone assist boost patient safety and the standard quality of

treatment while also encouraging an environment of responsibility, growth, and progress in the medical field.

Contents

Chapter 1: Patient Safety: The Why, What, Where, and How

Dan and Maria are husband and wife. Dan needs to go to the hospital for a scheduled surgery. Dan and Maria aren’t too concerned because hospitals are safe places, right? Unfortunately, not always. Ensuring patient safety is critical to providing excellent vital medical care. Determining patient safety grows more crucial as the field's intellectual history progresses. "To Err Is Human: Building a Safer Health System" is a pioneering study published in 1999 by the Institute of Medicine (IOM). According to this estimate, there are up to 98,000 avoidable medical errors that result in patient fatalities annually in U.S. hospitals. Each of these errors revealed serious weaknesses in patient safety and led to a profound change in the manner in which we provide healthcare. Twenty years later, patient safety is still a major worry. On a yearly basis, medical errors still cause adverse effects for thousands of individuals. Nonetheless, over this time, the patient safety movement has made a number of noteworthy advancements. Scholars started to question their various presumptions. Is there a method for handling patient safety? Is it a quality instead? What exactly is patient safety? Patient safety is a field that seeks to prevent and minimize risks, mistakes, and injuries that patients may sustain while receiving medical care. It entails fostering an atmosphere of safety inside healthcare facilities and putting policies in place that lessen the possibility and severity of infections, medical errors, and other unfavorable incidents that might have an influence on patients' health. On this point, existing definitions appeared to differ. Some believe it can be defined as "the absence of preventable harm to a patient and reduction of risk of unnecessary harm associated with health care to an acceptable minimum".

Accidents, infections, and other adverse outcomes can occasionally occur despite having the best medical care in prestigious medical institutions, but ultimately, patient safety serves as essential for both patients and healthcare facilities. Some believe patient safety is sensed as the cornerstone of medical care and is currently acknowledged as a significant and expanding worldwide public health concern. According to the book Advances in Patient Safety: their following definition of patient safety states, “Patient safety is a discipline in the health care sector that applies safety science methods toward the goal of achieving a trustworthy system of health care delivery. Recognizing the origins and effects of errors and events, as well as creating practical countermeasures to avoid or lessen them, are the main goals of safety science. It employs an approach that relies on data based on empirical studies and quantitative evaluation.

In a world that is becoming more international, safety science plays a critical role in defining protocols and creating a shared safety language. This is a continuous research project that requires well-defined procedures and measurements that are verifiable by other parties. In addition to focusing on "what went wrong," safety science also aims to make guarantee people adopt and apply more preventative safety measures. It entails using scientific instruments, research, as well as methodologies to comprehend, evaluate, and manage safety. By using safety science, we can improve workplace safety and fundamentally alter our perceptions of safety in general. Patient safety is also an attribute of health care systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events.” This definition recognizes patient safety as a newly developed field as well as a method for carrying out things. It focuses on the key components of patient safety. The field of patient safety in the medical field is fairly new. Currently, graduate degree programs are being created to acknowledge patient safety as a distinct field of study. It is a topic related to the caliber of healthcare. That being said, the majority of its

techniques are borrowed from fields other than medicine, specifically cognitive psychology, human factors engineering, and organizational management science. The healthcare industry must prioritize patient safety.

Patient safety aims for high dependability in high-risk situations. In the context of medical care, illness represents the initial risk factor. The second requirement, the therapeutic intervention, is related to patient safety. Overall, patient safety encompasses both the requirement for measures to minimize hazards to the patient's health throughout care and the efforts made by healthcare practitioners to decrease or eliminate harm that could be prevented. Efforts for patient safety focus on reducing harm that can be physical, psychological, or emotional while also protecting confidential patient data. These programs could involve communication and teamwork to reporting problems as they occur as well as procedures meant to avoid mishaps, negligence, or incorrect diagnoses that could unintentionally hurt the patient.

In what setting is patient safety implemented? The microsystem serves as the highest location for patient safety. The operating room, the emergency room, and other locations are examples of the immediate setting that occurs when care is provided. Patients are injured, patient-caregiver relations take place, safety lapses appear, as well as the "sharp end" is located within the microsystem. Safety lapses might have happened in a lot of blunt-end parts, and as was previously mentioned, occurrences are characteristics of parts of the system that collaborate. As a result, systems have an irreducible role in patient safety. Nevertheless, the microsystem is the location where the accomplishments or shortcomings of every system to guarantee safety meet, serving as the context in which the patient receives medical attention.

In what ways is patient safety ensured? Patient safety is achieved by a variety of techniques, one of which is high-reliability design. High-reliability design is a multifaceted

process which forms the core means of achieving patient safety. Consequently, the basic unit of patient safety administration is complicated; every element of the delivery of health care needs to be included within a system that can function as reliably as feasible in a variety of challenging circumstances. Complexity theory gives rise to a distinctive characteristic of high-reliability design: it states that chaotic or intrinsically unanticipated occurrences are bound to happen in accessible, interacting systems. Designs with an elevated level of stability can withstand unforeseen events.

Encouraging patient safety in healthcare continues to represent a major public health concern, regardless of advancements over the last 20 years. The development, study, and history of safety regulations have shown that this has become a more complicated problem than first thought and that it affects all healthcare environments. Consequently, solutions—especially in higher-risk sectors like surgery—must be handled at the systems level and complemented by a shift in safety culture. In order to achieve this, healthcare professionals across all degrees have begun to place a high priority on honing non-technical abilities like accountability, teamwork, and communication. This is evident in the creation of numerous checklists and safety initiatives. Implementing collaborative training initiatives that have worked well in other high-risk industries, like crew resource management (CRM), could help maintain this trend. Surgical teams can easily use these strategies, but their effective use is mostly dependent on the vigilante leadership and good judgment of individual surgeons.

Chapter 2: Medical Errors and its Impact on Patient Safety

Medical errors are a significant cause of death as well as a significant public health issue. Identifying a recurring source of errors and devising a reliable, practical solution that reduces the likelihood of a persistent issue are examples of challenging problems. In addition to improving

patient safety and treatment quality, beneficial research will assist the medical profession maintain its culture of innovation, development, and accountability. Many alternatives, like direct observation and reporting systems, have been proposed to improve patient safety, minimize, and eventually eliminate medical errors. Thus, by identifying a plausible cause for mistakes, a reliable and practical remedy may be proposed that lowers the likelihood of problems happening again. Medical errors are characterized by the inability to carry out an anticipated action as envisioned or by using the incorrect plan to accomplish a goal. Adverse medication events, incorrect transfusions, surgical wounds and wrong-site operations, suicides, injuries or deaths from restraints, falls, burns, pressure ulcers, and erroneous patient identities are a few of the issues that frequently arise when providing healthcare. The most common places for high error rates with catastrophic outcomes to happen are emergency rooms, surgical rooms, and critical care units. The complexity of medical knowledge is rising, and health care providers sometimes struggle to communicate concepts to patients because of a variety of issues, including lack of awareness, time restraints, the stress of multitasking, an excessive number of patients, staffing shortages, and the learning curve associated with health IT. It's possible that medical personnel are unaware of when a patient doesn't comprehend, and that patients don't ask their doctors to clarify difficult concepts. Types of medical errors are listed:

Diagnostic

Delay or mistake in diagnosis

Not using the recommended tests

Using antiquated diagnostic or therapeutic methods

Inaction in response to testing or monitoring results

Treatment

a mistake made when carrying out a process, activity, or test

Mistake in the way the treatment was given

error in the dosage or administration of a medication

Preventable postponement of therapy or reaction to an unusual examination

Unsuitable (not recommended) care

Preventing

Not administering preventative care

Insufficient treatment monitoring or follow-up

Other

Ineffective communication

Equipment malfunction

Additional system malfunction

Some Advances in Process Enhancement: Shi and Singh (2013)

Guidelines for Clinical Practice are a various professional associations, MCOs, and the government have started developing standardized practice standards in accordance with findings of minor area differences. Cost-Efficiency, which happens when the benefit outweighs the expense of delivering the service. Crucial Routes are multidisciplinary, outcome-based, and patient-centered case management technologies make it easier for many clinical departments and caregivers to coordinate patient care. Risk management, which is often centered on preventing medical malpractice, is a proactive attempt to prevent unfavorable outcomes connected to clinical care and facility operations.

Chapter 3: Teamwork and Communication in Patient Safety

. Hospitals are busy complex places where many talented and dedicated people do remarkable work and save lives every day. In hospitals with strong leadership and teamwork commitment, patient safety is a top priority. Strong teams can lead to low infection rates, put checks in places to prevent mistakes, and create strong lines of communication between hospital staff and patient's families. Experts in patient safety concur that good teamwork and communication are necessary for delivering high-quality medical treatment. There are innumerable opportunities for a patient safety incident to occur at any of the numerous points of contact that are required between healthcare professionals, patients, and family caregivers. The COVID-19 pandemic has presented the healthcare workers with previously unheard-of difficulties that call for quick thinking, ingenuity, and adaptability in order to cope with demanding and changing conditions on the front lines of patient care. One of the numerous functions that has changed during this time to achieve medical distance and respond to other developments is communication amongst providers. 2020 articles highlighted some effective communication strategies used in the wake of COVID-19.The need to recognize and give priority to the crucial role that communication still plays in the safe delivery of healthcare is necessary during a year where society has increasingly dedicated to reducing the amount of face-to-face interactions owing to the risk of COVID-19. The impact of various strategies to enhance communication among healthcare providers and patients, as well as takeaways from communication practices during the COVID-19 pandemic that may be applicable in other contexts, were all examined by scholars in 2020. Enhancing collaboration within the medical field has drawn a lot of attention. Inadequate communication can result in avoidable patient

injury on its own as well as be a contributing factor in other harms. In acute care settings, shift changes and other transitions of care present potential for communication breakdowns that could endanger patients. These include high-risk encounters when important details on the patient's condition and treatment plan may be misunderstood, resulting in therapy delays or improper prescriptions. According to a previous study, for instance, during the process of diagnosis in the emergency department (ED), 23% of the patients weren't provided with a clear description of the medical issue they were experiencing upon discharge, as well as 25% of those patients being unaware as to what to do if their health issue deteriorated or declined once leaving the emergency room (ED). Such disruptions in communication can have negative effects and negative outcomes. Patients' and caregivers' opinions regarding the treatment they receive can be significantly affected by efficient communication. According to a survey, one of the primary factors contributing to diagnostic inaccuracy is inadequate communication, according to patients. Health care teams can enhance patient happiness, avoid medical errors, improve efficiency, and improve patient outcomes when all clinical and nonclinical staff members work together efficiently. The American Organization of Nurse Executives (AONE) and the American Health Research & Educational Trust (HRET) of the American Heart Association (AHA) provide scientific proof of resources and tools for enhancing teamwork, cooperation, and communication, along with guidance and education on how to use these tools and materials and promote a safety culture. Patient involvement and safety are key to AONE's guiding principles. An evidence-based program called TeamSTEPPS®—Team Strategies and Tools to Enhance Performance and Patient Safety—aims to maximize productivity throughout health care teams to ensure that they can react rapidly and efficiently to any situation that may come up. All people make mistakes but

when there’s a good team in place, they can look out for each other. But unfortunately, some hospitals don’t have teams that work well together or good leadership.

When one person makes a mistake, and a team member can’t catch it, then the patient could suffer. Communication breaks down and patients get harmed. Patients could then experience dangerous complications, recovery is slower, and sometimes it could even be unnecessarily fatal. Encouraging patients and their families to participate is essential to enhancing collaboration and communication in healthcare. A growing body of research indicates a relationship between fewer incidents of harm and greater involvement among patients and their families. Patients' and families' comprehension of tests, procedures, and expected care outcomes—including a successful discharge—increases when their preferences for involvement in their care are established and they are subsequently included in the construction of their care plan.

To improve patient and family engagement, Attala, a small rural hospital in Mississippi, implemented an inpatient leadership rounding system. A Patient and Family Engagement Fellowship is available through the medical center's membership in the HRET Hospital Improvement Innovation Network. Effective communication and teamwork among healthcare providers lowers the possibility of error, improving patient safety and clinical outcomes. There are numerous situations in which proper communication of important data is required in order to perform clinical medicine effectively. Working as a team is vital. Patient safety is at danger when medical personnel fail to communicate effectively for a number of reasons, including incomplete or misinterpreted information, confusing telephone orders, and missed status updates.

Medical errors can happen in instances when there is a lack of communication. These mistakes run the risk of significantly harming patients or abruptly killing them. Medical errors

are a common issue in today's healthcare institutions, particularly those that result from a communication breakdown. From 1995 to 2004, the Joint Commission received reports of sentinel occurrences, and the most common underlying cause of those incidents was poor communication.

Respect, trust, and collaboration are traits of effective teamwork. According to one study, greater cooperation and communication are two of the most essential aspects in boosting clinical efficacy and satisfaction with employment within health care personnel. Nonetheless, the atmosphere of low standards that has grown in many health care settings has made numerous healthcare professionals accustomed to inadequate teamwork and communication. Errors arise from this culture of insufficient and incorrect information flow among healthcare workers, even among diligent professionals who often overlook warning signs and clinical inconsistencies. While ineffective communication can have disastrous results, good communication has the following beneficial effects: better information circulation, better-performing measures, enhanced security, higher staff morale, greater satisfaction from patients and their families, and shorter hospital stays.

In the patient care team, good communication between staff members fosters consistency and clarification as well as effective teamwork. When it works well, communication promotes cooperation, teamwork, and error prevention. The foundation of a patient security environment is communication, especially teamwork. Improved patient safety culture is correlated with both managers and employees communicating with greater regularity. But much like with provider-to-patient or caregiver-to-provider communication, errors in communication across providers are frequently the cause of unfavorable outcomes, especially during patient transitions. One systematic analysis, for example, discovered that there was little prompt communication of

discharge summaries between primary healthcare specialists and medical facilities physicians, and that nearly 10% of release reports were rarely communicated. Medication errors are just some of the unfavorable outcomes that are caused by this kind of poor communication during handoffs. Future-focused health care delivery aims to gain more knowledge about communication strategies and their applicability, effectiveness, and influence on safety results. In summary, a team's productivity is jeopardized when members are not actively and efficiently communicating. To enhance teamwork, it is imperative that all individuals have excellent communication skills.

Chapter 4: Medical Errors in Patient Safety

Medical errors are a serious public health concern and a leading cause of death in the United States. It's challenging to identify a dependable source of errors and then provide a dependable, practical fix that lessens the possibility of a persistent problem. Understanding the negative impacts of miscommunication, talking about organizations that promote preventative efforts, and learning about medical errors were some of the topics covered in the web pages and articles that provided the information. To lessen and eventually eradicate medical errors, a number of solutions have been put forth, such as reporting systems and direct observation. As a result, by determining a reasonable reason for errors, a trustworthy and workable solution may be put forth that reduces the possibility of reoccurring issues. Determining the definition of a medical error is one of key components in knowing where to start.

The definition of a medical error is described as an unintentional act or one that does not achieve its intended outcome using an incorrect plan to achieve a goal or a deviation from the method of care which could or might not cause harm to the patient. Medical errors can happen in any sector of the healthcare system, including clinics, hospitals, treatment centers, physician

locations, pharmacies, assisted living facilities, and patient homes. They can involve medications, surgery, diagnostics, equipment, or lab results, and they may have grave repercussions. Medication errors, anesthesia-related errors, hospital-acquired infections, missed or delayed diagnosis, avoidable treatment delays, inadequate follow-up after treatment, inadequate monitoring following a procedure, failing to act on test results, failing to take appropriate precautions, and technical medical errors are some of the most common types of medical errors. Medical errors pose a substantial threat to patient safety and the standard of care, making them a major global public health issue. In primary and outpatient care, medical errors cause injury to about 40% of patients. Errors in diagnosis and medicine damage millions of people and cost billions of dollars annually. Although medical errors can't always be avoided, patient safety can be enhanced, and their frequency greatly decreased.

It is imperative that a strong, global, and regional culture be established with the goal of reducing medical errors. Medical errors provide a substantial threat to patient safety and the standard of treatment, making them an important global public health concern. Medical errors cannot always be prevented, but they can be greatly decreased, and patient safety can be raised. One strategy for providers to encourage patient safety improvement is to put in place security procedures. Medical error threats can be decreased by developing safety norms and procedures. These procedures may involve actions like confirming someone’s identity, verifying medicine quantities, and making sure appropriate cleanliness standards are followed. Reducing medical errors is an essential component of maintaining patient safety also, which is a crucial feature of healthcare.

Enhancing patient safety might also involve responding to unfavorable events when they arise, taking lessons from them, and working to prevent them. For these reasons, the

effectiveness of post-medical error follow-up procedures is an important and relevant research subject. Inadequate safety in the medical field is a common problem. Without substantial reforms at the federal level, it won't go away on its own. Healthcare workers who have committed or experienced medical errors of any kind should be the first group addressed by officials looking to enhance solutions for medical errors since it is imperative to acknowledge and address the effects that these errors have on the involved healthcare providers. Ultimately, it is important to address the enduring safety problems and create systems that promote safety improvement rather than penalizing individuals for harm they have caused. Experts advise that the systems have features for noting noteworthy test findings, creating notifications (for example, regarding test receipt and evaluate, notifying patients, verifying recommendations), and incorporating security measures, according to the Canadian Medical Protective Association. These factors make the efficacy of follow-up protocols for medical errors a crucial and pertinent study topic.

What exactly assists physicians when making a significant medical error? In accordance with the American Medical Association, researchers previously questioned 61 physicians the same question and condensed their expertise into an essential set of suggestions in physician training courses. The article "Physicians discuss medical errors" by the American Medical Association's staff news writers covers everything from learning how to deal with imperfection to becoming an expert on their mistakes, preventing recurring mistakes and improving teamwork, and finally helping others and teaching about it. What I read focused most of my attention on the portion about forgiveness. Based on the report, "Some physicians took time to forgive themselves after committing an error, a process that requires self-acceptance and awareness." To prevent being overly harsh on oneself and making mistakes in the future, this step is essential. According to the study, doctors claimed that having moral standards—such as

strong humanism, spiritual teachings, or professional codes of conduct—helped them know how to "do the right thing" after making a medical error. Some doctors claimed their mentors helped them remember vital ideals. It is vital to learn from making a mistake and use it to improve patient care. Physicians, doctors, and/or nurses who can do the right thing play an important role in preventing future medical errors.

In the healthcare industry, miscommunication may also result in detrimental effects. deterioration of the doctor-patient relationship, misdiagnoses, medication errors, lower quality of care, negative outcomes for patients, adverse effects on staff and satisfaction with care, decreased wellbeing of patients, and other medical errors that can easily result in preventable morbidity and mortality are just a few of the consequences that can arise from it. Verbal communication problems are one systemic factor that increases the likelihood of a medical error, according to a National Institutes of Health study. Disruptive behavior, noise issues related to the surroundings, cultural differences between patients and caregivers, problems with hierarchy, and providers functioning as independent agents are risk factors for mistakes in language. Increasing communication is essential to enhancing patient safety. Shared decision-making and patient-centered care depend on effective communication between healthcare professionals, as well as between healthcare professionals and patients or family caregivers. Encouraging communication between patients and family caregivers is crucial to ensuring their effective participation in the health care system, including during diagnosis, treatment, and transitions.

Unfavorable work environments can significantly contribute to medical errors. Medical carelessness, an excessive workload, a lack of encouragement groups, anxiety, and inadequate training, poor teamwork, and a failure to follow safety protocols are just some of the factors thought to be responsible for these medical errors. Critical care nurses with poor mental and

physical wellness indicated significantly more medical errors than nurses in healthier states, according to a study from The Ohio State University College of Nursing. Additionally, the research discovered that "nurses were twice as likely to have better physical health if they felt that their worksite was very supportive of their well-being." Institutions in the legal, medical, and government sectors must cooperate to eliminate the blame culture while maintaining accountability. Within the framework of just culture, medical errors might be categorized as simple human error, or recklessness. Consolation, risk-awareness coaching, and punishment are suggested treatments for these errors. "Enterprise liability" is a suggested legal theory that makes healthcare companies liable for the actions of their practitioners. Collaboration is one of the key elements in reducing medical errors. Each team member has a responsibility for their behavior, outlook, and continuous learning. When considering collaboration, it is critical to remember the organizations that work together to improve patient safety and reduce medical errors.

Several groups advocate for the prevention of medical errors. NCC MERP is a nonprofit organization made up of 27 national organizations that work alongside and together to solve the root problems of pharmaceutical mistakes and promote drug safety. JCAHO is a further significant partner that has stepped up to the plate to improve patient safety. Thousands of patient safety investigation and execution initiatives have been funded by AHRQ in order to prevent and reduce medical errors. It is critical to recognize that medical errors and avoidable negative effects are a worldwide issue. The initial step toward enhancing patient safety is gaining a thorough awareness of the many forms of medical errors as well as the healthcare procedures that lead to medical errors throughout healthcare delivery.

Chapter 5: Patient Stories of Medical Errors

Nothing is more compelling as hearing about preventable patient damage firsthand from patients or their loved ones. We can't solve a matter that we don't know exists. Because of a lack of transparency in healthcare, most people are unaware of the large number of individuals that suffer needless medical injury. Patient testimonies about their experiences with medical blunders are important, especially in terms of raising awareness. However, you can also read of celebrities who have access to cutting-edge care in top medical facilities becoming victims of avoidable harm and death. Medication errors, hospital-acquired infections, sepsis, pressure ulcers, communication errors, hospital-acquired pneumonia, and falls are among the most common causes of avoidable patient injury. While patient safety statistics frequently focus on mortality rates, millions of people throughout the world survive a medical error only to have their lives significantly altered, if not cut short, as a result of the impairment. Medical errors also have an impact on the patient's family and loved ones, who are frequently forced to grieve and adjust to a fatal conclusion. Patient Safety Movement Foundation was given access to the personal accounts of two moms who had lost their young children in 2013. Furthermore, they illuminated the significance of patient and family involvement in the care process as they brought 34 additional patient accounts to life. Nothing is more effective than getting firsthand knowledge about avoidable patient harm from patients or their loved ones. The horrific stories which precede are only a small sample of the numerous major occurrences of injury and fatalities brought on by avoidable medical mistakes that occur on a daily basis in your community and throughout the globe. Ridley Barron's son died as a result of a medical error. The Patient Safety Movement is helping to keep his story alive. Barron goes on to say, "It only took a matter of moments for my world to fall part apart that Spring Day."

Barron and his family were returning home after a family vacation when a car ran a stop sign and collided with their vehicle. Unfortunately, his wife of twelve years was killed instantaneously. EMTs informed him that day that he had witnessed Sarah's final breath. Josh, his seventeen-month-old son, was thrown out of their minivan as it crashed down onto the roadway at the same moment, his seat belt snapping. About fifty feet from where their van had stopped, volunteers discovered Josh fastened into his car seat. Josh was brought to a small hospital in Southwest Georgia and then transported via helicopter to a larger hospital in Savannah, Georgia. Josh's family hoped to move past the loss of his mother, Sarah, and spent the following four days keeping an eye on him and praying for him to keep getting better. Although Josh had sustained a serious brain injury, his doctor told Ridley on day four that he had made steady progress while under their care. Ridley was shocked when he received that phone call on early morning of day five. Physicians were requesting that he and his loved ones leave everything behind and head to the hospital as soon as we could. For them, that would be a two-and-a-half-hour journey that would seem endless. When they arrived, he reported that they were greeted by physicians and officials who wanted them to meet in a conference room before being allowed to return to Josh's room. It was in that meeting room that the collapse of my neat little world would reach its pinnacle. He and his family were notified that a pharmacist's error had caused a medication error. His son had been given five times the recommended dose of phenytoin treating cerebral seizures. FIVE TIMES! He was led into the chamber and there witnessed his death on that particular day. He watched as physicians tried a final time to save his life but were unsuccessful. Ridley had made two decisions that day. His son's death was not going to be in vain; God was going to give him the opportunity to accomplish something positive with the loss of his two family members. And he was willing to do anything he could with his

narrative to help others avoid the unnecessary suffering he had felt that day. Accidents transpire, and he understands that. Personnel in the healthcare industry are human. Yet accidents do not have to affect those we love. Ridley believes that those around them should do whatever in their ability to ensure each preventable misstep is long gone. Every life is valuable; every half-second counts!

Anna Edwards, who resides within the gorgeous countryside of Kent, England, has always been a nature enthusiast, according to the Patient Safety Movement. Wildlife was always a part of her life, whether it be on peaceful walks throughout rural areas or cool strolls along the seaside. Leading NHS England's national staff retention program, Anna is a key member of the organization's professional team. Nevertheless, Anna's life hasn't always been easy. When she was just 19 years old, her Crohn's disease diagnosis was first characterized as a "mild inconvenience." However, the next twenty-five years showed differently. Her journey through life became characterized by numerous major procedures and the difficulties that came with them. Anna and her spouse set out on a mission to become parents six years ago. Though there were many obstacles in the way, it was a ray of optimism for the pair. Anna had a considerable amount of scar tissue in her pelvis from her long surgery history, which complicated the IVF process. At first, she received instructions to remain indoors despite her cries and assertions of something that seemed off. Anna followed her feelings and went to the doctor, where she was given a bleak prognosis that her survival depended on her kidneys failing.

Thankfully, Anna got the required care right on schedule thanks to the involvement of a committed urologist. Even if the IVF cycles did not result in a fruitful pregnancy, destiny had other ideas. A gorgeous baby boy that Anna and her husband adopted has since become their entire world. Anna underlines the significance of listening to patients as she reflects on what she

has experienced. Ultimately, patients are collaborators in their care journey. Overlooking individuals cry out can result in unsuccessful attempts to improve the efficacy of treatment and save lives. Their insights and feelings are priceless. Ultimately, Anna's tale serves as a tribute to tenacity, faith, and the conviction because occasionally life finds a way to direct us toward our intended course.

People typically associate medical errors with taking the incorrect medication, falling patients, botched surgical procedures, or even a nurse administering the incorrect dosage of medication. Not everyone considers carelessness or the absence of someone who need constant monitoring and aid. A woman's son passed away in the hospital as a result of hospital employees' incompetence. The nurses did not watch after him since they were sleeping. He suffered from paranoid schizophrenia. When they finally realized he wasn't in bed, one of the three patients who had gone to the bathroom unattended at the same time had hung himself. It was already too late.

The family of Juwan and Sha-Asia expressed excitement that they were expecting a child in 2020. During Sha-Asia's normal stress test at Woodhull Medical Center on July 2, 2020, her blood pressure was found to be excessively high. They were preparing to induce her given that she was already a few days over her estimated due date. Juwan was prompted to leave the area since she was about to receive an epidural. The family was receiving texts from Sha-Asia that said, "They're getting ready!" Before the family realized it, Juwan had witnessed them carrying her into a separate room. The family continually heard the phrase "code blue" as he trailed them beyond the doors. Upon noticing that Sha-Asia's grandma, Juwan and Jasmine's grandmother, also worked at a hospital, they asked her, "What does that mean?" "That indicates that an individual is dying," she informed them. After half an hour, they removed the newborn.

However, their initial thought was, "Where's Sha-Asia?" They sought to ensure that she was okay, but the healthcare professionals simply stated that they were working on her. She was unsuccessfully resuscitated more than thirty times. Juwan was forced to see her there, motionless and covered in blood. Afterwards, they discovered that the anesthesiologist had essentially killed her. He place the epidural too deeply into her spine, over three times the recommended amount. She went into cardiac arrest as a consequence of the fluid getting to her heart. That anesthesiologist should not have had a job, Juwan stated. He had a history of medical blunders and injured several patients. He then lost his license and will never be able to practice in the United States again, but he should not have stayed. Sha-Asia's family believes she should not have had to go through a tragic event like this.

As they grieve Sha-Asia's death, they reflect on how she would have made an excellent mother as well as how it is tragic that she will not be able to meet her first daughter. She had never gotten to hug her. They solely recognize that something needs to be put in place in order and done. You go to the hospital to deliver a baby, and you're excited. No one should have to lose their life in order to save another. The family believes that hospitals must do better so that dads, mothers, and other family members do not have to endure the pain they have experienced.

Chapter 6: Common Sources of Patient Harm

Any physical, psychological, or health-related harm to an individual, including both transient and lifelong damage, is commonly referred to as patient harm. It is interchangeable with unfavorable medical occurrences. Patient harm has been defined as unexpected, unplanned events (such as patient injuries, problems from care, or death) which arise directly from the treatment given instead of from the underlying illness of the patient. Legally, hospitals and other

healthcare facilities must notify state regulating bodies of these occurrences. Medical errors, surgical procedures, infections related to healthcare, sepsis, incorrect diagnosis, patient injuries such as falls, pressure ulcers, hazardous transfusion practices, patient misidentification, and dangerous injection practices are prominent causes of patient harm. According to studies on patient harm in healthcare, about 3 million fatalities per year are attributed to hazardous care, and about one in ten patients experience harm while receiving treatment. In fact, up to 4 out of every 100 deaths in low-to middle-income nations are related to unsafe care.

One in every thirty individuals receiving medical care experiences medication-related injury, with over 25% of these cases being classified as serious or life-threatening. Medication-related harm is half of all preventable harm in healthcare. Another further major source of harm to patients is surgical error. Worldwide, more than 300 million surgical procedures are carried out yearly. Even with knowledge of the potential consequences, surgical errors nevertheless happen frequently; 10% of avoidable patient harm in healthcare was recorded in surgical settings, with the majority of the ensuing bad events happening before and after operation. infections related to healthcare cause prolonged hospital admissions, permanent impairment, enhanced resistance to antibiotics, additional financial strain on patients, families, and health systems, and preventable deaths. Their global rate is 0.14%, rising by 0.06% annually. A severe illness known as sepsis results from the body's immune system reacting excessively to a viral infection. Tissues as well as organs of the human body suffer harm as a result of the body's response. Roughly 24.4% of patients with sepsis who were treated in hospitals died as a result, with 23.6% of instances being linked to health treatment. Between five and twenty percent of doctor-patient visits result in diagnostic mistakes. Doctor reviews indicate that at least 0.7% of adult admissions had detrimental diagnostic mistakes. The absolute most significant harmful

occurrence within medical facilities is patient falls. They occur three to five times per thousand bed-days, and over one-third of these accidents lead to damage, which worsens the medical results and puts more financial strain on the infrastructure. Venous thromboembolism, or blood clots as they are more commonly called, is a very costly and avoidable cause of patient injury that accounts for one-third of hospitalization-related adverse effects Medical records pertaining to a patient are referred to as patient data. It contains details regarding their prior medical conditions, courses of treatment, etc. Damage to the skin or soft tissues are known as pressure ulcers. gradually, they arise from pressure applied to specific bodily areas. Fatal complications may arise if they are not handled swiftly. Although being largely preventable, pressure ulcers cause over 10% of adolescent hospital admissions and can have a substantial negative influence on patients' mental and physical well-being as well as their quality of life. Patients are at risk for major adverse transfusion reactions and infections that can spread to others through unnecessary transfusions and poor transfusion practices. A standard deviation of 12.2 major responses per 100,000 dispersed blood components are reported in data on adverse transfusion reactions from 62 different countries. Inaccurate patient identification can be the source of numerous issues and have a major impact on the delivery of healthcare. It may result in disastrous side effects, if the procedure is performed on the incorrect place. Among 3326 instances (12.3%) between 2014 and 2017, 409 sentinel events of patient identification were found in a Joint Commission report issued in 2018.Over 16 billion injections are given globally, and patients as well as medical professionals are at risk of both infectious and non-infectious adverse effects due to hazardous injection methods. A research that used mathematical modeling found that from 157 592 and 315 120 hepatitis C virus infections, from 16 939 and 33 877 HIV infections, and 1.67 million

hepatitis B infections caused by viruses over a ten-year period were linked to risky injecting practices.

Chapter 7: Elements Leading to Patient Harm

In order to guarantee patient safety, it is critical to identify and acknowledge the factors that can cause harm to patients. Patient injury in healthcare being a result of safety lapses is widespread, troubling, and can happen in all contexts and at all levels of the delivery of healthcare. Patient harm can result from a variety of connected reasons. One important component of patient harm is organizational and systemic variables. The intricacy of medical interventions, insufficient protocols and guidelines, disturbances in the coordination of care and efficiency, limited resources, insufficient staffing, and skill building all have a significant impact. The next category is technological elements or challenges pertaining to health-related data systems, including technological misuse and issues with electronic health records or medication management programs. Human conduct and circumstances are another component. The following factors can cause communication breakdowns in the healthcare industry: poor teamwork, exhaustion, feelings of burnout, and mental bias; patient-related issues such as inadequate health literacy, disengagement, and treatment non-adherence; and finally, external factors. Lack of rules, uneven economic and financial pressures, and environmental concerns are all factors. In order to address the problem and guarantee improved safety procedures, it is essential to comprehend and be conscious of these primary components of patient harm.

Health care facilities are paying closer attention to the patient safety concept in an effort to strengthen the safety culture. Several studies have explored patient safety attitudes among doctors and nurses, shedding light on their perceptions and experiences. One of the key findings was Negative Perceptions. Both physicians and nurses tend to harbor negative attitudes related to

patient safety. These include low perceptions of teamwork climate and management domains. The purpose of this study was to look into how doctors and nurses feel about patient safety as well as see if workloads, unfavorable situations, and knowledge are related to patient safety attitudes. The Turkish version of the Safety Attitudes Questionnaire and a descriptive cross-sectional design were employed in the study. 73 physicians and 246 nurses from two private hospitals in Northern Cyprus were among the participants. All patient safety domains were perceived negatively by the participants. Among the participants, the safety climate domain had the lowest overall perception rating and the work conditions domain the highest positive impression rate. When it came to job happiness, stress acknowledgment, and judgments regarding leadership domains, nurses outperformed doctors in these areas. The overall mean scores of patient safety attitudes, workloads, unpleasant occurrences, and encounters all showed substantial variations. By encouraging health care providers to choose better decisions across a range of safety attitudes, policymakers and directors can enhance patient safety and quality of treatment. Hospitals must increase patient safety by implementing organizational rules, management support, and in-service training.

The prevention of related unfavorable outcomes or injuries resulting from medical treatment is known as patient safety. Patient safety is a top priority when providing healthcare, according to the idea of "first, do no harm," which is entwined with fundamental ethical concepts and human rights. The National Patient Safety Foundation claims that it established the significance of patient safety in businesses and ignited a worldwide movement to guarantee that all patients receive proper care and are not injured.

According to a World Health Organization report, there has been a notable global rise in adverse health outcomes linked to hazardous patient care. According to projections, one in ten

patients in wealthy nations have injuries while in the hospital. Medical errors rank as the third leading contributing factor to fatality in the US. An estimated 6.3 million patient incidents involving medical care were projected to have cost $19,571 million in total. According to a report by Sweden's National Board of Health, over 9% of patients receiving somatic care experienced avoidable errors. The likelihood of unfavorable events is significantly higher in developing nations than in industrialized ones. For instance, there are around 4.4 million adverse events in the Eastern Mediterranean Region each year, and unfavorable events account for 18% of inpatient admissions. These occurrences are linked to a high death and lifetime impairment rate. One in every seven individuals transferred to hospitals experienced medical errors, and 59.3% of these errors might have been avoided, according to yet another study done in Palestinian hospitals. These numbers show that in order to enhance patient outcomes and lower the expenses and complications associated to patients, health care workers' patient safety expertise needs to be confirmed and the rate of adverse events needs to be decreased.

According to Patient Safety 2030, one of the biggest obstacles to delivering health care is failing to ensure patient safety. Throughout the next fifteen years, the analysis suggested improving health care providers' patient care procedures, patient safety knowledge, and patient safety attitudes. Human ideas and actions that influence choices and mold behavior are collectively referred to as attitudes. Understanding the attitudes of healthcare professionals toward patient safety, therefore, can make it easier to pinpoint interventions meant to improve attitudes and foster improved clinical results and capacity for organization. Accordingly, assessing attitudes toward safety makes safety factors more visible and can improve a medical environment where mistakes are acknowledged and appropriately addressed. Improvements in patient empowerment and improved patient outcomes are linked to patient education about

safety. When health care professionals' attempts to improve safety are combined with positive patient attitudes about taking responsibility for their own welfare, there can be mutually beneficial effects.

Physicians and nurses showed poor attitudes toward patient safety, according to several studies that evaluated their attitudes. These attitudes included poor assessments of management domains and the collaborative environment. In a cross-sectional, quantitative, qualitative investigation carried out in Portugal, the participants expressed unfavorable opinions about the safety culture of patients. Strong leadership dedication was seen important to improve patent safety and establish a safety culture, according to participants in a Swedish survey of healthcare professionals working in emergency departments. A recent study carried out in Turkey with 290 operating room personnel—including physicians and nurses—found that communication was essential and the hospital's "safety culture" needed to be strengthened. According to a nationwide research conducted in Northern Cyprus, creating a suitable safety culture is essential to guaranteeing patient safety. "Healthcare managers and decision-makers should foster patient safety culture through in-service education, management support, institutional regulations, and updated guidelines," according to a different study conducted in Northern Cyprus. Therefore, a key element of safe treatment is creating an organizational culture that prioritizes patient safety and encouraging healthcare professionals to adopt proper attitudes and behaviors. While many hospitals attempt to enhance their patient safety policies, a number of obstacles, including workload, unfavorable occurrences, and experience, stand in the way of improvement and lower healthcare performance-related patient safety.

Adverse events represent a critical component of hospital quality that reveal details about inadequate care. Unfavorable incidents that occur during the provision of healthcare are linked to

an increase in morbidity and mortality as well as a negative correlation with the safety attitudes of medical professionals. Workload and health care providers are significantly correlated, according to earlier research. Healthcare services are greatly impacted by workload since it is linked to issues with staffing, including adverse events, mortality, and burnout and turnover. Another element that can be connected to views about patient safety is experience. Numerous research revealed that compared to fewer-experienced healthcare practitioners, experienced healthcare providers have stronger attitudes toward patient safety.

To improve understanding of patient safety and raise the standard of healthcare, more research on attitudes toward safety and related aspects is required. Examining physicians' and nurses' attitudes toward patient safety was the main goal of the study. The following questions from the study followed the additional objective of examining relationships between workload, unfavorable incidents, and experience with patient safety attitudes:

What perspectives do physicians and nurses have on patient safety?

Do physicians and nurses have different ideas about safety?

Exist correlations between adverse events, experience, workload, and attitudes toward patient safety?

Chapter 8: Supplies and Procedures

A cross-sectional and descriptive design was employed in the course of the study. Two Northern Cyprus private medical centers hosted the research project. One is a sizable educational facility with over 200 residential beds, 13 inpatient units, 5 critical care units, and 8 surgical suites. There are almost 150 beds in the additional one, distributed among various units. Patient safety attitude surveys were distributed to 450 medical professionals working in both institutions (112 physicians and 338 nurses); 73 physicians and 246 registered nurses completed the study,

representing a 75% percentage of those who responded. Physicians and nurses who were registered met the admission requirement. Students, new employees, and bearers of diplomas did not take into account the study. The Safety Attitudes Questionnaire (SAQ) as well as an analytical collection instrument were used to gather data. A descriptive data tool created by the team of investigators was used to collect participant demographic information, including age, gender, job titles, education levels, facility category, working modifications, as well as security training and educational background.

Sexton et al. created the first version of the SAQ, and this has been applied in a variety of contexts to evaluate medical providers' attitudes toward safety throughout safety competencies and identify domains in demand for development. The Turkish version was employed as a data gathering instrument in this present investigation. The range of values of the Cronbach alpha was 0.66 to 0.77. Thirty of the 59 initial components of the safety attitudes questionnaire were used in the Turkish version for the SAQ. Six domains make up the scale: the working environment (4 items), perceptions of management (4 items), fulfillment with work (5 items), security environment (7 items), and collaboration atmosphere (6 things). Two items (item number 2 for partnership and item 4 for safe culture) on the two-scale variables received negative scores. In response to the inquiry, "How many errors have you reported in the past 12 months?" volunteers were given notice about the list of potential mistakes included including patient injury, surgical mistakes, incorrect dosage and treatment omissions, lost records, falls, and incorrect patient selection. The accuracy of the instrument was evaluated in this study using Cronbach's α, which came out at 0.74.

Using a the form of self- approach, the surveys were distributed throughout May and July of 2019. Prior to administering the questionnaire, the researchers gave an explanation of the

purpose of the research and required everyone who participated to sign a written consent document in order to participate. They were also told that being involved was entirely optional and confidential. They could leave the study at any moment, and the findings would not affect their yearly assessments. Prior to being entered into the Statistical Package for the Social Sciences (Version 22.0, SPSS Inc., Chicago, IL, USA), the information's contents were reviewed. For the purpose of analyzing demographic data, statistical indicators (average, the rate, and percentile) were calculated. A 5-point Likert scale was used to rate statements about the safety of patients behaviors that are with values spanning from strongly opposing them to strongly supporting them. Using a scale with a score of 100, the Likert scale values were plotted as (1 = 0, 2 = 25, 3 = 50, 4 = 75, and 5 = 100). The threshold of scores have been determined by adding up all of the strongly agreeing with responses, dividing the total amount with the total number of those surveyed, and then multiplying the result by 100%. A favorable answer was given if the overall percentage was greater than or equal to 75; a negative response was indicated if it was less than 75. In reference to unfavorable reactions, reverse-coding negatively interpreted items to show a favorable opinion (completely oppose, somewhat differ). On data with normal distributions, parametric tests (mean SD, independent sample t-tests, and ANOVA) have been conducted to look at correlations amongst all two categories and connections between variables that were classified. A threshold of significance of $p < 0.05$ has been selected.

55.3% of the individuals in either group are female. The average age of healthcare professionals was 27.3 ± 6.4 while that of physicians was 30.7 ± 8.1. In terms of qualifications, 48.9% of physicians had between six and ten years' worth, whilst 49.4% of healthcare professionals had between one and five years' worth. The two thirds of those surveyed had a 33–48 hour work week. In the previous years, the majority of participants in both categories had not

reported any problems. Regarding each participant's demographics, there weren't any quantitatively noteworthy variations. (Table 1)

Table 1. Demographic Characteristics of the Participants (N = 319).

Demographic Characteristics	Doctors		Nurses		Total		*p* Value *
	N	%	N	%	N	%	
Hospital							
First hospital	50	81.5	177	83.4	227	82.1	0.5
Second hospital	23	18.5	69	16.6	92	17.9	
Gender							
Male	33	44.7	103	46.8	136	45.7	
Female	40	55.3	143	53.2	138	54.3	0.9
Age							
20–25 years	22	34.4	127	50.9	149	42.6	
26–30 years	33	46.2	77	35.7	110	40.9	0.8
>31 years	18	19.4	42	13.4	60	16.5	
Mean	30.7 ± 8.1		27.3 ± 6.4				
Years of experience							
1–5 years	13	18.4	120	49.4	133	33.9	
6–10 years	35	48.9	72	33.8	107	41.4	0.27
>11 years	25	32.7	54	16.8	79	24.7	
Workload							
16–32 h/w	12	7.2	10	6.6	22	6.9	
33–48 h/w	50	85.8	195	83.1	200	84.5	0.18
>48 h/w	11	7.0	41	10.3	52	8.6	
Event report within the last year							
No events	66	96.9	210	86.4	276	91.7	
1–2 events	5	2.3	23	8.7	28	5.5	0.12
3 more events	2	0.8	13	4.9	15	2.8	
Total	73	100	246	100	319		

* $p < 0.05$, frequencies test; chi-squared test.

Among the six dimensions of the SAQ, the work conditions dimension received the highest positive rate (64.2%), followed by job satisfaction and teamwork climate dimensions

The working environment aspect within the SAQ had the greatest affirmative percentage (64.2%) across the six categories, next to the categories of job satisfaction and teamwork climate (63.9% and 62.4%, correspondingly). The SAQ's emphasize awareness and leadership categories were shown to have poor views, with favorable rates of 56.4% and 55.8%, correspondingly. Table 2 shows that the SAQ's security atmosphere component had the lowest positive percentage (49.7%).

(63.9%, 62.4%), respectively. A weak perception of the stress recognition and perceptions of management dimensions of the SAQ was found, with a positive rate of (56.4%, 55.8%) respectively. Safety climate dimension of the SAQ had the lowest positive rate (49.7%) (Table 2).

Table 2. Positive Response Percentages of the Participant.

	Positive Responses (>75%) *
Job Satisfaction	63.9
I receive appropriate feedback about my performance	54.7
Hospital management does their job well	66.8
This hospital is a good place to work	60.1
Working in this hospital is like being part of a large family	68.6
This hospital deals constructively with problem personnel	67.5
In this hospital, the moral of the nurses is valued	61.6
I am proud to work at this hospital	56.3
The medical equipment in this office is adequate	62.6
The levels of staffing in this hospital are sufficient to handle the number of patients	63.1
Decision making in this hospital utilizes input from relevant personnel	65.1
I am provided with adequate, timely information about events in the hospital that might affect my work	58.7
Teamwork Climate	62.4
While the patient is undergoing care, other employees help me teamwork	64.1
It is easy for personnel in this hospital to ask questions when there is something that they do not understand	62.5
In this hospital, ethical values are high	59.8
During emergencies, I can predict what other personnel are going to do next	65.7
Disagreements in this hospital are resolved appropriately	57.8
Employees who are really professional do not reflect their personal problems	69.2
In this hospital, teamwork and cooperation are supported among employees	66.1
I am encouraged by my colleagues to report any patient safety concerns I may have	61.5
The culture in this hospital makes it easy to learn from the errors of other	58.9
I saw other staff making mistakes that could harm the patient	62.8
I know the proper channels to direct questions regarding patient safety in this hospital	64.6
The physicians and nurses here work together as a well-coordinated team	66.7

Table 2. *Cont.*

Stress Recognition	56.4
Fatigue impairs my performance during emergency situations **	61.3
When my workload becomes excessive, my performance is impaired **	52.0
Stress caused by personal problems negatively affects performance **	55.6
I am less effective at work when fatigued **	49.3
In this hospital, it is difficult to speak up if I perceive a problem with patient care **	57.6
Working Conditions	64.2
In this hospital, the communication disorders that cause the disruption of the service are widespread **	64.4
Employees often do not care about rules and procedures established in this hospital **	58.4
I am disappointed in my work **	59.6
All employees, including doctors in this unit, do their job well	69.3
I feel exhausted in my work **	67.1
In this hospital, nursing education is appropriately supported	62.9
Safety Climate	49.7
In this hospital, information about event reports is used to ensure the patient safety	51.2
In this hospital, safety reporting systems, patient safety development is utilized	45.1
In this hospital, follow clinical guidelines and evidence-based criteria for patient safety	59.8
In this hospital, we know how to report medical errors when necessary	52.4
In this hospital, patient safety is always considered as priority	48.7
Perceptions of Management	55.8
I would feel safe being treated here as a patient	42.3
In this hospital, medical errors are handled appropriately	51.2
This hospital does a good job of training new personnel	45.1
All personnel in this unit take responsibility for patient safety	59.8
Hospital management does not knowingly compromise the safety of patients	52.4
Hospital management supports my efforts to ensure patient safety	48.7
All information about diagnosis and treatment decisions is routinely given to me	51.9

* Positive Responses of Safety Attitudes Questionnaire; ** Negative statements.

Regarding patient safety attitudes of the doctors and nurses, results revealed that the total positive frequencies for both participant groups were beneath the positive score (>75%), which indicates the overall perceptions of both participant groups were negative toward patient safety (62.9 ± 22.4; 58.6%). Although not significant statistically, nurses had higher total positive perceptions (63.3%) than doctors (54.3%). There were statistically significant differences between positive responses of the nurses and doctors in terms of job satisfaction, stress recognition, and perceptions of management domains. Nurses showed higher positive perceptions (69.3%) than doctors (58.1%) in terms of the job satisfaction domain

The findings concerning the views of nurses and physicians for patient safety showed that each of the audience populations' overall favorable frequencies fell below the positive score (>75%), indicating that both categories' general assessments concerning patient safety were unfavorable (62.9 ± 22.4; 58.6%). Despite not being significant in statistical terms, nurses' overall positive impressions were greater (63.3%) than doctors' (54.3%). The favorable reactions of the doctors and nurses differed statistically significantly in terms of job satisfaction, stress recognition, and leadership domain judgments. Regarding the job fulfillment domain, nurses' favorable evaluations were greater (69.3%) than doctors' (58.1%) ($p < 0.05$). Nurses had more favorable impressions (57.4%) than doctors (55.4%) in the stress awareness category ($p < 0.05$). In regards to opinions regarding the leadership area, nurses also shown more favorable impressions (68.3%) than doctors (45.4%); this difference was statistically significant ($p < 0.05$).

($p < 0.05$). In the stress recognition domain, nurses showed higher positive perceptions (57.4%) than doctors (55.4%) ($p < 0.05$). Nurses also showed higher positive perceptions (68.3%) than doctors (45.4%) in terms of perceptions of the management domain, which was statistically significant ($p < 0.05$) (Table 3).

Table 3. Attitudes of participants related to patient safety.

Safety Attitudes Domains	Doctors	Positive Response	Nurses	Positive Response	Total Mean (SD)	Total Positive Responses (>75%) *	*p* Values **
	Mean (SD)	(>75%)	Mean (SD)	(>75%)			
Teamwork Climate	66.2 ± 11.9	57.6	68.1 ± 12.1	65.4	67.1 ± 9.1	62.4	0.44
Job satisfaction	69.3 ± 28.4	58.1	74.7 ± 21.1	69.3	71.5 ± 15.4	63.9	0.01
Work Conditions	60.4 ± 30.8	66.4	64.0 ± 27.4	62.0	62.2 ± 25.7	64.2	0.21
Stress Recognition	59.5 ± 28.4	55.4	56.0 ± 29.7	57.4	57.4 ± 21.3	56.4	0.04
Perceptions of Management	49.3 ± 32.0	45.4	53.6 ± 34.2	68.3	50.3 ± 30.6	55.8	0.0
Safety Climate	65.0 ± 27.4	42.9	71.0 ± 26.4	55.8	67.5 ± 22.8	49.7	0.14
Total	61.6 ± 21.4	54.3	64.5 ± 23.6	63.3	62.9 ± 22.4	58.6	0.19

* The comparisons were made between the positive responses. ** Independent sample *t*-tests $p < 0.05$;

Table 4 compares the participants' patient safety attitudes values with the workload, adverse events, and experience. There were statistically significant differences between experiences, workloads and adverse events, and total patient safety attitudes mean scores of the participants ($p < 0.05$). In terms of years of experience, nurses who have 1–5 experience years showed lower patient safety attitudes mean scores (54.7 ± 7.5) than the other age groups ($p < 0.05$). The doctors and nurses who work >48 h/w and 3 more adverse events showed lower patient safety attitudes mean scores than the other groups, which was statistically significant ($p < 0.05$).

Table 4. Comparison of the Participants' Patient Safety Attitudes perceptions with Workload, Adverse events, and Experience.

Descriptive Characteristics	Doctors		Nurses		Total SAQ Mean Score ± SD	*p*-Value *
	Total SAQ Mean Score ± SD	*p*-Value	Total SAQ Mean Score ± SD	*p*-Value		
Years of experience						
1–5 years	55.4 ± 9.1		54.7 ± 7.5		54.0 ± 5.1	
6–10 years	57.1 ± 7.3	0.11	59.9 ± 4.4	0.03	55.8 ± 4.5	0.01
>11 years	61.9 ± 10.3		60.7 ± 3.8		60.1 ± 5.2	
Workload						
16–32 h/w	45.3 ± 9.2		53.9 ± 2.1		49.8 ± 3.8	
33–48 h/w	41.3 ± 5.7	0.03	52.1 ± 9.1	0.00	46.7 ± 7.2	0.001
>48 h/w	40.1 ± 7.4		50.6 ± 3.1		45.9 ± 4.9	
Adverse events within the last year						
No events	55.4 ± 5.1		51.3 ± 1.1		52.9 ± 3.1	
1–2 events	51.6 ± 3.2	0.006	49.2 ± 2.7	0.00	50.0 ± 2.2	0.00
3 more events	50.2 ± 2.4		49.0 ± 7.5		49.3 ± 5.7	

* ANOVA.

Multiple linear regression analysis was carried out to determine the contribution of

Patient safety viewpoints and principles of those surveyed are compared with the workload, adverse events, and knowledge in Table 4.

The participants' average scores for overall patient safety views, their workloads, negative occurrences, and observations varied quite significantly ($p < 0.05$). Nurses with 1-4 years of experience had mean ratings of 54.7 ± 7.5 for patient safety views, which was considerably lower than the standard deviation of the scores of the other age groups ($p < 0.05$). There was a statistically significant difference ($p < 0.05$) in the mean ratings of patient safety attitudes between the groups of doctors and nurses who work more than 48 hours per week and who have three or more adverse occurrences.

cluded. The overall model was statistically significant and identified two variables (gender, age) explained 16.1% of the variance in the patient safety attitude with F (2, 134) = 9.174 ($p < 0.001$) (Table 5).

Table 5. Multiple linear regression analysis results: factors associated with patient safety attitude questionnaire score.

	Patient Safety Attitude		
	ΔR2	**β**	***p***
Hospital type		0.159	0.06 *
Gender		0.124	0.002 *
Age	0.161	0.111	0.001 **

* $p < 0.05$; ** $p < 0.01$ Multiple linear regression.

In order to evaluate physicians' and nurses' opinions of patient safety attitudes and investigate connections between the amount of work, unfavorable occurrences, and prior experience and patient safety attitudes, this study was carried out among medical professionals in

two hospitals in Northern Cyprus. The results of this study will help healthcare facilities identify patient safety-related issues that require addressing as well as their strengths and weaknesses. The results of the research showed that physicians' and nurses' views toward patient safety were generally unfavorable. One plausible reason for the unfavorable impression could be because, in comparison to prior studies, our individuals possessed less experience and less education. Staff members with greater knowledge and skills are held accountable for patient safety in a matured and ethical way. They have a greater understanding of complications and are more conscious of problems with care quality.

The results of this study are in line with studies done on healthcare professionals in Saudi Arabia, which showed negative views toward all secure areas and made it difficult to establish a safety culture. All respondents in a different study exhibited negative views about every safety attitude component. Health care providers demonstrated a negative attitude toward safety in several international research. Adverse sentiments have the potential to impede actions and care quality enhancements in healthcare facilities that support patient safety.

In accordance with Tunçer and Harmanci, healthcare professionals demonstrated a greater overall favorable attitude toward patient safety than physicians, despite this difference not being statistically significant. It's possible that nurses have a more favorable attitude toward patient safety than doctors do since they interact with patients more extensively and frequently coordinate patient care. Physicians may have a smaller involvement in everyday patient treatment or a lack of patient safety instruction in several medical university curricula, which could account for their less favorable conclusions about patient safety. Remarkably, in multiple investigations, physicians' attitudes toward patient safety were more positive than nurses'. Patient safety may be impacted by differences in the cultures of organizations and medical specialties.

With the highest perception rate was a category of work environments. While the number was below the favorable the threshold, the outcome exceeded benchmarks. This represents an intriguing discovery since multiple research studies have indicated that healthcare personnel frequently expressed dissatisfaction with their working environments. Respondents in the most recent poll appeared to be generally content with their ergonomics, which is technical and logistical help, and aid for new hires, based on the superior response in this category. Research has shown that improved working circumstances can be achieved by therapeutic and diagnostic information maintenance, proper staffing, training, and supervision.

Work satisfaction is important because it affects employee morale, motivation, and overall job fulfillment in hospitals. Job satisfaction had the second-highest favorable rating in the current study. The outcomes aligned with the findings of other investigations. The sense of pride and morale among coworkers boosts nurses' and doctors' job happiness. On the other hand, adverse events and drug errors are more common in institutions due to overwork and shortages.

Regarding a positive rating, the field of atmosphere of cooperation ranked third. Between nurses and doctors, there occurred statistically negligible variations. The results of this study did not support those of other research. An inadequate collaboration level is caused by issues with expressing out, the perception that asking questions when something is unclear is frowned upon, and improper resolution of conflicts. A happy workplace is crucial because it improves the quality of care and fosters a safer atmosphere for patients when combined with sufficient personnel. A number of treatments are being suggested to enhance treatment, lower errors, and enhance the work atmosphere. Among these measures are ways to enhance the climate of cooperation by fostering better physician-nurse interaction and working together, as well as having the capacity to ask questions in order to learn from mistakes.

In this study, stress recognition scored somewhat higher than in previous investigations, although it had a lower positive perception rate overall. In line with earlier studies, caregivers' favorable opinion was more favorable than doctors'. The idea that an individual is incapable of making wise decisions when under stress is untrue. People perform worse and are more prone to mistakes when they are overly tired, under pressure, or working too much. It will need multiple interventions to improve this circumstance. They involve setting regulations for managing stress, controlling the equilibrium between job and leisure time, and enhancing healthy lives by means of wellness initiatives.

Aspects associated with administrative assistance and personnel management are included in the perception of the management domain. When it came to their opinions of the leadership in the area, nurses outperformed physicians in the sense of positivity. This outcome matched findings from other investigations. Staff shortages can result in workloads, unpleasant environments, and errors in choices made by management pertaining to policies. Therefore, open dialogue, shared accountability, and an appropriate staff-to-patient ratio are priorities for legislators. Between nurses and physicians, the security climate domain had the lowest perception percentage. The numerical insignificance of the disparity observed indicates the minimal influence of the safety atmosphere on medical professionals within their respective establishments. Research carried out in underdeveloped nations has demonstrated that medical practitioners' perceptions of the safety environment were unfavorable. It's possible that participants find it difficult to talk about mistakes and don't have enough support. In order to reduce patient injuries and foster a safety culture among the personnel, Robello et al. suggested that recognizing mistakes, learning from them, and minimizing safety dangers are critical elements.

Contrary to earlier studies, individuals with less years of medical experience had statistically significant differences and fewer points on the average for safeguarding patients attitudes. Research has shown that views of patient safety rise with knowledge. Stress related to practicing impacts recent graduates as well as inexperienced healthcare providers, making them more prone to mistakes and influencing how safe they believe their patients are. An abundance of employees who lack expertise and show little regard for patient safety pose a risk to other medical professionals and patient care. Similar to other investigations, the healthcare workers in the current research who reported a greater number of incidents and worked longer hours also had lower optimistic views about patient safety.

According to the information available, there is a strong correlation between a spike in adverse events and a higher workload. An excessive workload has a negative impact on the treatment of patients, services knowledge, and medical professionals. If such problems with workload persist for a long time, the hospital may suffer significant consequences and have fewer options for improving staff health and patient care.

Advantages and disadvantages of this research are that the large sample size and excellent participation rate from health care professionals in a variety of departments and facilities were the study's key strengths and because the study was conducted in just two hospitals, it is difficult to generalize the findings. To gain an improved comprehension of and raise the standard of healthcare services, more research employing various designs, such as qualitative approaches, is required to look at patient safety attitudes toward healthcare professionals.

The degree to which nurses and physicians in Northern Cyprus view patient safety attitudes is revealed by this survey. The findings show that all patient safety domains are viewed

negatively, which helps to identify areas that need to be improved and things that are getting in the way of creating a safety culture. Among participants, the safety atmosphere sector had the lowest perception rate while the work environment sector received the most positive impression rating. Those with a shorter period of experience had mean ratings for patient safety attitudes that were lower than those of those with more years of experience.

Chapter *9:* What and Who is PSO?

In order to promote an atmosphere of assurance, raise patient safety, and enhance the quality of health care, a Patient Safety Organization (PSO) works in conjunction with healthcare professionals. Patient safety involves a team effort, and institutions play a big part in making the healthcare system safer for everyone. With the goal to increase patient safety, a number of organizations are essential. Using Common Formats to ensure uniform reporting of patient safety occurrences, PSOs facilitate the gathering, examination, exchange, and education of information regarding mishaps, close calls, and hazardous situations. With the goal to stop medical errors from happening in the future, the data gathered aids in identifying the specific mistakes that are taking place and the reason. In reaction to the Institute of Medicine study To Err Is Human, Congress created the federal Patient Safety and Quality Improvement Act of 2005 in July of that year. On November 21, 2008, the final Patient Safety Rule was approved, and on January 19, 2009, it went into force. The Patient Safety Rule is managed by the Department of Health and Human Services' eleventh division, the Agency for Healthcare Research and Quality.

Clinicians as well as other medical professionals who proactively and confidentially communicate health-related details to designated PSOs are protected under the Patient Safety Act and the Patient Safety Rule, which also serve as PSO frameworks. The approach purposefully

sets PSO work apart from the majority of legal and mandated reporting requirements. The nation's fifth officially authorized PSO was the Center for Patient Safety in 2008. The Center for Patient Safety PSO's mission is to ascertain the cause and manner of events, as well as to educate healthcare professionals and others on preventative measures that might be taken. According to the website, The Center for Patient Safety (CPS), founded in 2005, serves as an self-sufficient, charitable organization committed towards eliminating needless damage. At CPS, they are dedicated to understanding medical errors, what causes them to take place, and what they can do to reduce patient harm. The organization emphasize the significance of culture in developing safe systems of care. Their yearly internal strategy review, which incorporates high-achieving program advice such as the Malcolm Baldrige Criteria, ensures that CPS maintains a medical company of distinction and specialist in patient safety and cultural enhancement. Continuous process improvement operations discover new customer needs and service innovations according to client input as well as market trends, allowing CPS to present our clients with the most current and pertinent data. A culture of safety that promotes and permits medical professionals to confidentially disclose while exchanging data pertaining to risks inside the health care sector is strengthened by the Patient Safety Act and the Patient Safety Rule. Under the Act, inquiries and evaluations carried out by a PSO or a healthcare organization in their specific patient safety evaluation system (PSES) and information developed by a PSO for the conduct of patient safety activities are all entitled to privacy and privileged status security measures, except for knowledge gathered for another reason.

Numerous federal agencies, institutions and healthcare systems, accreditation bodies, associations, foundations, patient advocacy groups—the list goes on—are among the numerous institutions in the US which concentrate towards patient safety. Just like the Center for Patient

Safety The World Health Organization, in particular, is a large organization with a significant impact on patient safety. WHOs website states that they work to provide individuals with medical treatment, reduce disease, encourage health, and supervise global responses to medical crises. Prominent authorities in public health from around the globe, including physicians, researchers in epidemiology, researchers, and supervisors, make up an organization of over 8000 people. They work to ensure that all people have equal chances for a safe and healthy life by providing countries, individuals, and partners with reliable scientific facts. There are 194 member states that make up WHO. The Director-General, who guides the organization in accomplishing its objectives for global health, is chosen by the Member States. The WHO's flagship program, patient safety, attempts to raise the standard and safety of medical care provided globally. The program entails empowering and involving policymakers, medical experts, and patients' relatives in order to work together while exchanging knowledge and experience. In addition, the effort promotes learning and creativity while establishing worldwide goals and standards for patient safety. The World Health Organization (WHO) serves as a United Nations branch of government formed in 1948. As stated in the organization's charter, WHO's broad duty is to "act as the directing and coordinating authority on international health work" within the United Nations system. It has 194 member states. The organization has been instrumental in a variety of previous worldwide health achievements, including the Alma-Ata Declaration on Primary Health Care (1978), the eradication of smallpox (formally recognized in 1980), the Framework Convention on Tobacco Control (adopted in 2003), and the 2005 revision of the International Health Regulations (IHR), an international agreement that determines what is required in creating for as well as adjusting to worldwide health crises.

The Texas Hospital Association (THA), established in 1930, is the leading group and primary advocate representing Texas's hospitals and medical facilities. THA, headquartered in Austin, plays a significant part for building the organization's capacities to enhance the accessibility, quality, and cost-effectiveness of health care for all Texas residents. Some essential aspects of THA include their mission, vision, and values. THA's objective is to serve Texas hospitals as a reliable source and collective voice in promoting quality in medical services among all Texans. THA seeks to drive change by assisting all Texas hospitals in providing accessible, affordable, and high-quality health care. The Texas Hospital Association values service, integrity, and teamwork. Service for them is characterized as anticipating other people's requirements while providing a high-quality, consistent, and personalized experience. Integrity refers to displaying accountability, openness, and ethics via acts. Teamwork implies acknowledging each other's perspectives and opinions through efficient interaction and collaborative effort. The organization's objective is to be an effective advocate for local and national legislative, regulatory, and judicial initiatives that promote affordable, high-quality health care. Emphasize integration, community health, and equitable funding, as well as offer educational goods and activities to help members navigate market obstacles and migrate to combined, community-based delivery models. THA's seasoned team has gained a reputation among Texas hospitals as the go-to resource and thought leader on hospital-related topics. Another example of a patient safety organization would be the A&M Rural and Community Health Institute Patient Safety Organization (PSO #79). Hospitals, physicians, and other healthcare professionals can use the A&M Rural and Community Health Institute Patient Safety Organization to be an instrument to enhance patient safety and quality of healthcare. Their mission aims to aid healthcare professionals in lowering or doing away with the potential

dangers related to providing patient care. Participation in monitoring is free and open, and all data is kept private. In order to identify developments and trends and ascertain the causes behind them, the PSO compiles safeguards against events. Additional credible data on how to enhance patient safety and quality is made possible by this regular aggregation. The PSO makes use of the common formats provided by the Agency for Healthcare Research and Quality (AHRQ). PSOs must gather and examine data in a consistent manner.

In 1999, a major Institute of Medicine report, "To Err Is Human: Building a Safer Health System," raised much-needed awareness for patient safety. According to the report, up to 98,000 individuals die in US hospitals each year as a result of preventable errors. Today, medical error is the third greatest cause of death in the United States, with estimates ranging as high as 200,000 per year. Globally, the figure is as much as 3 million, more than the total yearly death toll from malaria, TB, and HIV. This issue impacts everyone, regardless of gender, age, ethnicity, geographic region, or socioeconomic level. People without the finances or access to adequate care are more vulnerable to unnecessary damage in healthcare settings. The Patient Safety Movement Foundation offers an integrated strategy to prevent preventable patient harm. The organization pulls together a varied interdisciplinary collection of patient safety specialists who are committed to discovering successful approaches to eliminate needless patient suffering. Their movement pulls together patients, physicians, healthcare organizations, payers, and legislators to tackle the complexities associated with healthcare in a methodical way. The Patient Safety Movement Foundation has a programed called Project ZERO which brings together healthcare organizations worldwide to implement evidence-based practices. Healthcare organizations can benefit from the most effective blueprints and the application of science, which encourages physicians to prioritize safety measures. This effort supports our objective of

promoting standardized procedures throughout international healthcare systems. The organization works with patients, families, and groups to create healthcare systems that prioritize the needs of patients and their families throughout the process. They possess the expertise to achieve ZERO preventable patient harm, but this can only be accomplished within a healthcare facility with a safety culture and the essential Actionable Evidence-Based Practices. Pharmaceutical mistakes, infections acquired in the hospital, sepsis, ulcers caused by pressure, mistakes in communication, pneumonia acquired in the hospital, and falls are among the most common causes of avoidable patient injury. While safety for patients statistics tend to concentrate on death rates, millions of individuals throughout worldwide survive a medical error only to have their lives drastically changed, if not cut short, as a result of the impairment. Medical errors additionally have an impact on the patient's family and loved ones, who are frequently forced to grieve and cope with a fatal conclusion. To eliminate avoidable patient injury, awareness, advocacy, and action are all necessary. To provide safe care for all patients, the healthcare community and society must build a culture of safety, commit to a culture of transparency, and implement evidence-based safety procedures. Furthermore, establishing resiliency during obstacles, implementing novel approaches, and campaigning for medical staff security all contribute to reducing the complexity of healthcare systems. The Patient Safety Foundation states, “Our ultimate goal is to promote humanity and diversity in healthcare. We cannot hope for ZERO, we must plan and execute.” The Patient Safety Movement Foundation and the organizations listed above embrace numerous key beliefs and work together to enhance the healthcare system as a whole. They tackle existing difficulties, devise realistic tactics, and execute systemic reforms to create a more secure healthcare system, and they share the six ideals listed below. The partnership and concerted endeavor to strengthen and promote the voices of

patients in the greater political dialogue draws on their shared knowledge, best practices, available technologies, and collective compassion to achieve the greatest possible patient results. Their ultimate goal is to get to the point where Care provides security, dependable, and egalitarian, patient-centered care, use of evidence-based procedures, transparency of care and data, care prioritizes value and quality, and it protects the well-being of healthcare providers.

The Global Interprofessional Patient Safety Fellowship, established in August 2021, offers medical professionals worldwide an extraordinary chance to learn about patient safety theory and practice. The Patient Safety Movement Foundation provides an exceptional chance for learning within the manner of the Global Interprofessional Patient Safety Fellowship. It seeks to provide healthcare workers around the world with understanding of patient security theory and practice. Here's everything you should know regarding such a peculiar program. They offer Education and Training. The fellowship program incorporates a year-long curriculum developed by patient safety professionals and every few months online learning meetings. Participants attend monthly live virtual classroom courses on essential patient safety subjects. Hands-On Improvement Project that enables Each fellow completes a practical improvement project relevant to patient safety in their professional environment. This project enables individuals to investigate and address real-world patient safety issues in their own communities and occupations. Monthly readings and reflections which allows fellows to be asked to read from the selections issued monthly basis. These texts broaden their perspective and encourage thoughtful deliberation on patient safety issues. Passionate Participants are what the fellows are motivated by a strong desire to ensure patient safety, which is often fueled by their own involvement with patient-related occurrences. Their devotion stretches to enhancing care outcomes in their particular settings. Lastly, they have a diverse faculty respected professors who lead the fellows

on this remarkable experience. It also includes a direct growth project that addresses safety concerns for patients in each fellow's professional environment.

Chapter 10: Patient Safety Fellows Have an Impact

Recently for the purpose to find out the extent to which the fellowship program has impacted how they work to enhance patient safety in their native nations, the program followed up with each of the four fellows from its original cohort. World Patient Safety Day was commemorated for the very first time in the healthcare ministry's history, according to Dr. Ebikapaye Okoyen, the program coordinator for patient safety and quality of care at the Ministry of Health in Yenagoa, Nigeria. A rally was held in Yenagoa as part of the compliance, and awareness-raising interviews on TV and radio were also made. In addition, he has made strides in five hospitals' frontline healthcare staff' patient safety education and advocacy. For her fellowship assignment, Samar Khaled Hassan—a senior accreditation officer for the Health Care Accreditation Council in Jordan—focused with the problem of the resistance to antibiotics. Her attempts to connect with medical professionals and officials in order to pinpoint regions for development as well as potential impediments to implementing changes across a variety of health providers in her country have been aided by the experience she obtained as a PSMF fellow. We are quite happy that we have an outstanding team of fellows actively disseminating their understanding in order to improve patient safety on all of them in the long run.

Dr. Elizabeth Namugaya Igaga, who is also based in Africa, was capable of to progress in her profession by using the expertise that she acquired from the fellowship. Halfway of the year-long fellowship course, Dr. Igaga, an anesthesiologist and critical care intensivist from Kampala, Uganda, was employed by Smile Train, a globally recognized charity that performs cleft

operations, as the Director of Safety and Quality for Medical Programs. She saw it as the ideal chance to work for a company whose commitment to providing high-quality care and its aim to assist others matched her own.

Following his fellowship, Dr. Luis Torres Torija Arguelles maintains a strong connection with the Patient Safety Movement Foundation as their ambassador in Mexico, where he practices medicine and specializes in excellence in clinical treatment. He attributes his ability to collaborate with others and take contextual considerations into consideration to the fellowship. This is particularly pertinent to his attempts to comprehend the many elements required in fostering a culture of safety, particularly in situations where plenty of individuals are unfamiliar with the idea of patient safety.

The Iraqi Pharmacovigilance Center was founded and is run by Manal Younus, PhD. She has been on numerous regional and international committees and has over 20 years of expertise in pharmacy practice, pharmaceutical surveillance, and medicine regulation. Melanie Whitfield works for an NHS Trust in London as a Trust Patient Safety Specialist and Associate Director of Patient Safety, Clinical Governance, and Risk Management. She maintains a Masters of Science in patient safety, 25 years of work background, and is a professionally trained midwife.

Anesthesiologist Dr. Frank Gitonga works at the Isiolo Regional Military Hospital in Kenya. Along with training in echocardiography and hemodynamic monitoring, he has finished a fellowship in critically ill kidneys from the European Society of Intensive Care Medicine. On the other hand in São Paulo, Brazil, Natalia Camargo works as a certified nurse and specializes with healthcare management of quality. Having worked in several healthcare facilities for a total of nine years, she oversaw the Public Healthcare Unit at the Patient Safety Center of São Paulo.

In the background, the Patient Safety Movement Foundation works all year long to support elected representatives, legislative bodies, and legislators in the advancement of new federal and state laws and services that will have the biggest potential to save lives of patients. This year, the Centers for Medicare and Medicaid Services (CMS) was advised to examine the impact of a patient safety care oversight model with aligned incentives. The proposed law, cautiously known as the "Value-Based Patient Safety Model Act," would mandate that the Center for Medicare & Medicaid Innovation (CMMI), under the direction provided by the Secretary of Health and Human Services, create and execute a model that illustrates the implications of tying Medicare payment incentives and penalties to patient safety.

Chapter 11: Patient Safety Leadership Association

The Patient Safety Leadership Association was founded by the Patient Safety Movement Foundation as an answer to the year 2023 President's Council of Advisors on Science and Technology's suggestion to integrate scientifically proven procedures within the health care system. This global network of healthcare thought leaders tackles the complicated problems of implementing excellent patient safety standards across all parts of the medical industry. The Patient Safety Movement Foundation created this platform to build confidence and take part by allowing members to disclose critical adverse occurrences and get guidance from world-renowned patient safety experts, medical professionals, and scholars. This forum will enable these catalysts for change to contribute existing knowledge and create transformational healthcare approaches grounded in actionable evidence-based practices and implementation science. Attendees see directly how data transparency may save lives while making choices based on data, as well as the worldwide impact of sharing patient outcome data. To be eligible for affiliation, applicants must possess the title of Chief Quality Officer, Patient Safety Officer,

or be an upper management position in a healthcare company with duties related to patient safety, quality, and excellence. Members get access to exclusive educational workshops, webinars, and an annual conference reserved for members only. They will also attend the Patient Safety Movement Foundation's biennial World Patient Safety, Science, and Technology Summit as a VIP guest of the Chief Executive Officer

Chapter 12: Executive Leadership Council

Dr./Professor Carol Peden served in positions in safety and quality assurance at national levels in both the US and UK. She has worldwide experience in patient safety, quality enhancement, and medical device innovation. Dr. Peden holds appointments as an assistant professor of medical anesthesia at the Universities of Pennsylvania and Southern California, USA; he also serves as an adjunct instructor in health system development and enhancement at the University of Bath Business School, UK; and a senior associate tutor at the University of Oxford. Her scholarly work has mostly concentrated on applying methods of implementation to improve patient safety and quality, especially in perioperative medicine.

At the Johns Hopkins University School of Medicine, Brandyn Lau is a clinical assistant professor of radiology with an MPH. At the Johns Hopkins College of Medicine, Brandyn Lau lectures radiology as well as radiographic science as a research assistant professor. She is also an associate faculty member of the Armstrong Institute for Patient Safety and Quality. His main areas that fascinate him regarding studies include how to enhance patient safety, clinical education, and the quality of care using data from electronic health records. In terms of clinical practice, venous thromboembolism, or VTE, avoidance, detection, and therapy are the main areas of emphasis for him. In addition to being the author or coauthor of over 50 peer-reviewed

articles, he has been awarded over $5 million in extramural research funding to investigate and enhance the application of medical technology for institutional enhancements in quality. Dr. David Stockwell Pediatric intensive care unit specialist at Johns Hopkins Children's Center in Baltimore. Pediatric ICU physician Dr. Stockwell practices at Johns Hopkins Children's Center in Baltimore, Maryland. His professional life has concentrated on patient safety, quality improvement, and physician administration as opposed to his medical duties. He is just another CMO at the Children's Center, having taken up the role in 2021 at the Johns Hopkins Children's Center. At the Johns Hopkins School of Medicine, Dr Stockwell teaches urgent care health and anesthesiology as a clinical professor. His research has mostly concentrated on developing an accepted monitoring method that uses the electronic health record to reliably identify safety occurrences. The medical facilities at which he was employed have also profited from this research because better and more consistent changes are made possible by the consistent identification of safety events. In addition, Dr. Stockwell is the Chief Clinical Officer of the patient safety organization Pascal Metrics.

Conclusion

In conclusion, patient safety is a worldwide problem in the healthcare system. Healthcare professionals are human. Human error will inevitably occur. Systems are in place in the healthcare industry to reduce errors, however they are insufficient to completely prevent errors. Nobody ever intends to hurt patients when they work. Medical error are not limited to the critically ill or injured. It tells the story of the unfortunate hundreds who died because they put their trust in the healthcare system. There are several strategies to avoid medical errors to ensure

patient safety, including speaking up, improving, and even educating ourselves. It is crucial to preserve a culture that is focused on identifying safety issues and putting workable solutions in place. By doing these medical errors will be prevented and help with enhancing patient safety

Quality healthcare is built on a solid basis of patient safety. In addition to safeguarding patients from harm, patient safety also entails the use of PSOs (Patient Safety Organizations), such as the Federal Patient Safety and Quality Improvement Act of 2005, the Center for Patient Safety established in 2008, the Center for Patient Safety at the World Health Organization, the Patient Safety Organization (PSO #79) at the Community Health Institute, and the Global Interprofessional Patient Safety Fellowship, which was launched in August 2021, to name a few. Safeguarding patient information is just as crucial as ensuring their physical well-being. Medical records pertaining to a patient are referred to as patient data. It is researched all around the world, and the findings are frequently put into practice. Patient care and safety are influenced by a nurse's education, abilities, and attitudes. Overemphasizing personal expertise and abilities can lead to mistakes and obstacles that compromise patient safety. The adage "human is to err" serves as proof of these kinds of chances. Patient safety, which involves taking precautions to keep patients safe, is essentially the cornerstone of high-quality healthcare. Ensuring the physical safety of patients should not take precedence over protecting their data. Recall that patient safety is the cornerstone of high-quality healthcare, and it is critical to safeguard patient information as well as physical safety. To guarantee patient safety, healthcare facilities have to choose nursing care models carefully. We may offer high-quality care and protect patients from injury by following relevant laws and policies, such as those pertaining to fall preventive measures. Reaching this objective requires awareness, cooperation, and active participation. Encouraging efficient teamwork is essential to guaranteeing patient safety in medical environments. When

medical staff work together harmoniously, patient results get much better. Recall that cooperation saves lives. To sum up, patient safety is the cornerstone of high-quality medical care. Actions taken to keep patients safe are referred to as patient safety. Safeguarding patient information is just as crucial as ensuring their physical well-being. Therefore, when selecting nursing care models, healthcare facilities should exercise caution

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