



### Patient Safety

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#### Editorial

Now a day's health-care context is more complex. Health care is usually delivered during a pressurized and fast-moving environment, involving a huge array of technology and, daily, many individual decisions and judgments by health-care professional staff the matter of adverse events in health care isn't new. Studies as early because the 1950s and 1960s reported on adverse events, but the topic remained largely neglected.

A body of evidence began to emerge within the primary 1990s with the publication of the results of the Harvard practice Study in 1991. Various studies have investigated the extent of adverse events. The Harvard study found that 4% of patients suffer some quite harm in hospital; 70% of the adverse events end in short-lived disability, but 14% of the incidents cause death.

The Institute of drugs (IOM) report estimated that "medical errors" cause between 44 000 and 98 000 deaths annually in hospitals within the USA, quite car accidents, carcinoma or AIDS.

Things in developing countries and countries in economic transition merits particular attention. The poor state of infrastructure and equipment, unreliable supply and quality of medicine, shortcomings in waste management and infection control, poor performance of personnel because of low motivation or insufficient technical skills, and severe under financing of essential operating costs of health services make the probability of adverse events much above in industrialized nations.

Safety could even be fundamentals of patient care and a critical component of quality management. Its improvement demands a sophisticated system wide effort, involving a broad range of actions in performance improvement, environmental safety and risk management, including infection control, safe use of medicines, equipment safety, safe clinical practice and safe environment of care.

Enhancing the security of patients includes three complementary actions: preventing adverse events; making them visible; and mitigating their effects once they occur. This requires: Increased ability to seek out from mistakes, through better reporting systems, skillful investigation of incidents and

responsible sharing of data.

- a. Greater capacity to anticipate mistakes and probe systemic weaknesses which can cause an adverse event.
- b. Identifying existing knowledge resources, within and out of doors the health sector.
- c. Improvements within the health-care delivery system itself, so as those structures are reconfigured, incentives are realigned, and quality is placed at the core of the system.

The creation of a world alliance for patient safety could also be a big step within the search to reinforce the safety of health care altogether Member States. At this, no single player has the expertise, funding or research and delivery capabilities to tackle the whole range of patient questions of safety on a worldwide scale.

Outdated approaches to defining, organizing, and operating quality assurance functions are not any more suitable. More and more, health care organization are becoming devoted that improving quality needs a comprehensive approach.

Continuous quality improvement of all kinds improves performance through reducing poor quality delivery of service rather than through trying to repair the results after service delivered.

Once a year thousands of patients within the suffer and die from an infection they quarried despite the particular fact within the hospital. Reducing the danger of infection, also as other potential.

Supposing an accurate identification and impeccable execution of a given treatment, also creates a patient safety issue. Root cause Analysis in my opinion the only technique should be used to identify tendencies and assess possibility and risk which can be used whenever human error is doubted with the understanding that system, rather than individual factors.

Root cause analysis approach will improve and solve most problems. LEAN methodology also will improve wide arrays of health care quality issues by identifying the source of process waste and discrepancy.

This achieves a stronger process that not only improves efficiencies but also eliminates the possibilities for errors. This leads to better-quality patient safety and clinical quality.

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