

Chapter 3

Patient Safety and Medical Errors: Building Safer Healthcare Systems for Better Care

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ABSTRACT

Patient Safety is considered to be the most important parameter of quality that every contemporary healthcare system should be aiming at. The terms “Patient Safety” and “Medical Errors” are directly linked to the “Safety Culture and Climate” in every organization. It is widely accepted that medical errors constitute an index of insufficient safety and are defined as any unintentional event that diminishes or could diminish the level of patient safety. This chapter indicates that a beneficial safety culture is essential to enhance and assure patient safety. Furthermore, health care staff with a positive safety culture is more probable to learn openly and successfully from errors and injuries.

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INTRODUCTION

The adverse events in healthcare constitute a major issue of global interest since they could be traced in the healthcare systems of every country regardless of their level of development. Worldwide, millions of patients suffer or get injured and die annually due to the provision of unsafe care and treatment. Hospital infections, inadequate diagnosis, delays in treatment, adverse drug events and omissions of surgical procedures make up the most common root causes of medical errors or adverse events that may be avoided.

Donabedian (1980) suggested the evaluation of healthcare quality and linked it directly to the patient safety. Moreover, he suggested that the assessment of quality should be applied according to the structure (resources and administration), the process (culture and professional co-operation) and outcome (competence development and goal achievement). Twenty years after the Donabedian's model, the managers of healthcare services adopted the principles of Total Quality Management (TQM) from Deming's work. TQM promotes not only the team spirit and the coordination but also the clarification of the procedures, the commitment to the goals of the organization and the change, ultimately aiming at the constant pursuit and assurance of quality services. In healthcare, the Continuous Quality Improvement (CQI) has been considered as interdependent with the integrated implementation of a program which is based on a trustworthy risk management policy aimed at minimizing the chances of further instance of a preventable medical error (Donabedian, 1980). According to McFadden, Stock and Gowen (2014) although CQI initiatives are extremely associated with improved process quality, they are also connected with higher hospital-acquired condition rates, a measure of patient safety (McFadden, Stock, & Gowen, 2014).

Within the discussion framework about medical error prevention, European and non-European Organizations keep talking about methods and tools, which will effectively contribute to the assurance of a safe and high quality healthcare environment. According to Nix, Coopey and Clancy (2006) the quality tools include websites, protocols, data bases, newsletters, guidelines and other mechanisms in order to help healthcare professionals, legislators in the healthcare sector and patients to create, promote and cultivate quality conditions in healthcare organizations or in their daily lives. The significance of the above methods in CQI and patient safety is obvious (Nix, Coopey, & Clancy, 2006).

The main objectives of this chapter are first of all, the description of "safety" as a parameter of healthcare quality as well as the categorization of concepts regarding the "patient safety". Secondly, the clarification of the terms "patient safety"

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