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Health Care Safety as First Consideration in Middle Income

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Abstract

Safe environmental conditions and the availability of standard precautions are important to prevent and treat infections in health care facilities (HCF) and to achieve the Sustainable Development Goals (SDGs) on health, water and sanitation. Baseline estimates of HCF coverage must still be formed for the SDG. And there is little evidence that there is inequality in coverage. To address this, we have developed a first estimate of the coverage of environmental conditions and standard care elements in HCF in low- and middle-income countries (LMICs). We examined factors associated with low coverage. Data from surveillance reports and peer-reviewed literature were systematically collated. Information about terms, service levels and tabular differences. We used logistic regression to identify factors associated with low coverage.

Keywords: Clinics; Environmental health; Hospitals; Hygiene

Introduction

The concept of "doing no harm at first" is taught to all medical and nursing students. Unfortunately, we know that many patients are injured by medical care. The World Health Organization (WHO) states that up to 10% of patients in high-income countries have such "adverse events" or "serious incidents," that is, events or incidents that could have harmed and avoided them [1]. It is estimated that it has been damaged by. There are many costs associated with harm-pain, discomfort or distress to the patient, financial costs to the patient (eg, due to more frequent visits) and to the health care system due to the patient being hospitalized longer. Financial costs and / or more (and different) treatment is needed. As more patients sue hospitals and clinicians after a serious incident, legal costs also incur [2]. Due to the large number of injured patients and the resulting costs, it is very important to focus on patient safety. There are two ways to tackle patient safety.

1. Prevent serious incidents.

2. Learn from the critical incidents that have occurred and modify the steps to prevent this from happening again.

This focuses on loss prevention. It involves introducing processes and procedures that reduce the risk of harm to the patient. For example; people who perform surgery change clothes and wash their hands to prevent harm. Washing hands ("scrubbing") and changing clothes before surgery reduces the risk of passing the infection to the patient [3, 4]. Another example of precautionary measures is the WHO Checklist for Safe Surgical Procedures, which aims to ensure that the right patients are performing the right surgery using the right methods. (Provides a formal way to verify), staff, manufacture All equipment is regularly maintained, equipment is sterilized, etc. Two important elements of these procedures are that they are routine (ie, done by everyone at each event) and that they can be documented (eg, for patients who have completed the WHO Safety Surgery Checklist). It is linked to the medical record). This can indicate that the procedure has been performed [5]. They are not very effective if the procedures and protocols are intermittently followed only by some people. A good example of this is staff hygiene practices. This is different in many hospitals and has been shown to expose patients and staff to the transmission of the infection [6, 7].

Even the best clinics and hospitals can sometimes harm patients. It is important for medical staff to learn from a serious incident and take action to prevent the same incident from recurring (and thus prevent further patients from being injured) [8]. One of the important principles for learning from harm is "no blame". Our usual reaction when something goes wrong is trying to find someone who is responsible. However, there are often broader issues that lead to errors or incidents. Understanding the reasons for the errors will help hospitals implement procedures and protocols to prevent them from recurring [9, 10]. In this example, it may have been necessary to ensure that a certain number of employees were in the ward on the day of surgery. Or it was double checked by the surgeon and OR staff before the IOL power was inserted into the eye. Effective leadership is needed for staff to learn from mistakes and make hospitals safer [11, 12]. You need to have a system in place to investigate the adverse events and find out why they occurred. Investigations should be conducted in collaboration with the entire ophthalmology team, as solutions that reduce the likelihood of serious future events usually require different behavior than people. When employees see the reason for the change, they are more likely to adopt it. Blame them instead of investigating the problem that caused the case can lead to a culture of fear that people try to hide the problem and not report a serious case [13].

Healthcare system

A mature health system takes into account the increasing complexity in health care settings that make humans more prone to mistakes. For example, a patient in hospital might receive a wrong medication because of a mix-up that occurs due to similar packaging [14, 15]. In this case, the prescription passes through different levels of care starting with the doctor in the ward, then to the pharmacy for dispensing and finally to the nurse who administers the wrong medication to the patient. Had there been safe guarding processes in place at the different levels, this error could have been quickly identified and corrected. In this situation, a lack of standard procedures for storage of medications that look alike, poor communication

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between the different providers, lack of verification before medication administration and lack of involvement of patients in their own care might all be underlying factors that led to the occurrence of errors [16]. Traditionally, the individual provider who actively made the mistake (active error) would take the blame for such an incident occurring and might also be punished as a result. Unfortunately, this does not consider the factors in the system previously described that led to the occurrence of error (latent errors). It is when multiple latent errors align that an active error reaches the patient. To err is human, and expecting flawless performance from human beings working in complex, high-stress environments is unrealistic. Assuming that individual perfection is possible will not improve safety.

Environment cleanliness

Humans are guarded from making mistakes when placed in an error-proof environment where the systems, tasks and processes they work in are well designed. Therefore, focusing on the system that allows harm to occur is the beginning of improvement, and this can only occur in an open and transparent environment where a safety culture prevails [17]. This is a culture where a high level of importance is placed on safety beliefs, values and attitudes and shared by most people within the workplace.

Every year, millions of patients suffer injuries or die because of unsafe and poor-quality health care. Many medical practices and risks associated with health care are emerging as major challenges for patient safety and contribute significantly to the burden of harm due to unsafe care. Below are some of the patient safety situations causing most concern [18, 19].

Causes of harm leading to healthcare damage

Medication errors are a leading cause of injury and avoidable harm in health care systems: globally, the cost associated with medication errors [20]. Health care-associated infections occur in 7 and 10 out of every 100 hospitalized patients in high-income countries and low- and middle-income countries respectively. Unsafe surgical care procedures cause complications in up to 25% of patients. Almost 7 million surgical patients suffer significant complications annually, 1 million of whom die during or immediately following surgery. Unsafe injections practices in health care settings can transmit infections, including HIV and hepatitis B and C, and pose direct danger to patients and health care workers; they account for a burden of harm estimated at 9.2 million years of life lost to disability and death worldwide (known as Disability Adjusted Life Years (DALYs)). Diagnostic errors occur in about 5% of adults in outpatient care settings, more than half of which have the potential to cause severe harm. Most people will suffer a diagnostic error in their lifetime. Unsafe transfusion practices expose patients to the risk of adverse transfusion reactions and the transmission of infections. Data on adverse transfusion reactions from a group of 21 countries show an average incidence of 8.7 serious reactions per 100 000 distributed blood components. Radiation errors involve overexposure to radiation and cases of wrong-patient and wrong-site identification. A review of 30 years of published data on safety in radiotherapy estimates that the overall incidence of errors is around 15 per 10 000 treatment courses. Sepsis is frequently not diagnosed early enough to save a patient's life. Because these infections are often resistant to antibiotics, they can rapidly lead to deteriorating clinical conditions, affecting an estimated 31 million people worldwide and causing over 5 million deaths per year. Venous thromboembolism (blood clots) is one of the most common and preventable causes of patient harm, contributing to one third of the complications attributed to hospitalization. Annually, there are an estimated 3.9 million cases in high-income countries and 6 million cases in low- and middle-income countries.

Conclusion

Current knowledge suggests ways to collaborate with others to improve health outcomes for socially disadvantaged populations. At a minimum, appreciation of some of the social factors that influence health-related behaviors and health status itself can help clinical providers develop more effective treatment plans. Clinical and public health practitioners can strengthen routine procedures to assess and respond to social needs through referrals and/or on-site social and legal services. Public health workers and clinicians also can develop health-promotion strategies that reach beyond individual clinical and social services to communities, to influence living and working conditions that are generally the strongest determinants of whether people are healthy or become sick in the first place. They can participate in or promote research adding to the understanding of the mechanisms by which social factors influence health, and test which strategies appear most effective and efficient. Finally, clinicians and public health practitioners can be key resources for local, state, and national policy makers on the crucial issue of health equity for all Americans, including those facing the greatest social obstacles.

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