

Address a Patient Safety Issue

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The primary concern of the healthcare industry is patient safety where cure, well-being and security of lives directly align to safe care. In this context, healthcare professionals try their level best to deliver impeccable medical services to gain the desired goals regarding health. However, the complexity of the system and fast-paced demands may lead to various errors that create safety threats. So, addressing the patients' safety issue has become crucial to reducing harm, improving the quality of healthcare and maintaining trust in the system. Contrary to that, the consequences and implications of such errors and mistakes become manifold if not properly addressed. So, a deeper understanding of safety issues is mandatory for handling the safety of patients in a well-mannered way. Such understanding may encompass the identification of potential safety issues and respective impacts by considering all the stakeholders. However, this paper will explore a safety issue, i.e., medication error in alliance with the imperative of risks, results of non-addressing the issue, the role of multiple regulatory agencies in this context along with multiple evidence-based tools and strategies to tackle the said threats effectively.

Health Care Safety Imperative

The identified potential safety threat from the available list is medication error which is solely the incorrect administration of any medicine to the particular patient. The multiple dimensions of medication error may include a selection of the wrong medicine due to any reason, incorrect dose, incorrect route for medicine administration or delivery dosage of medicine to the wrong patient (Sutherland et al., 2020). For example, a nurse administers an anti-hypertensive medicine to patient B which is actually for patient A. Patient B was admitted with different conditions compared to patient A, but their names were similar which led to confusion during dosage administration. In this case, the concerned nurse did not utilize a verification system and relied on her memory which intensified the said situation.

However, medication errors may lead to severe implications. The foremost consequence of such medication error is harm to the patient. Such incorrect administration may cause worse conditions for the patient, even life-threatening outcomes. Another result would be the legal consequences which the concerned patient or family may face against the healthcare facility. Such legal action will lead to reputational damage, financial loss and several impositions on healthcare units according to law. Similarly, such incidental errors of medication rupture the trust of patients and clients in the healthcare system, staff and officials. This result is observable during follow-up treatments and even in future times when patients are reluctant to take any medicines. In addition, several other consequences would be impositions of penalties by regulatory bodies, decreased morale of the staff and tarnished reputation of a particular healthcare facility in the long run. However, addressing medication errors is crucial to

prevent above-said impacts.

Risks If Threats Are Not Addressed

Multiple risks are aligned to situations where patient safety threats are not addressed in healthcare systems. Such risks may be severe and leave multiple impacts on various stakeholders. For example, the most risk lies in a patient who is the most vulnerable in such medication error cases. Adverse medication reactions may lead to life-threatening situations sometimes and the life of the patient is kept in danger. Such risks to the lives of patients become severe if the safety threat is not addressed as first priority. Similarly, another stakeholder under the blanket of risk is employees. All the healthcare professionals including physicians, the nursing community, support staff, and physicians have to bear multiple risks. These may include emotional distress, augmented stress and job loss in alliance. In addition, unaddressed patient safety threat poses severe risks and implementations for the organizations. These include risks of legal impacts, fines, reputation loss and low turnover in future along with bans by regulatory agencies.

However, in such cases of medication error, the healthcare imperative emphasizes that the leading purpose of healthcare operations would be safety. It implies following medication administration protocols, the emergence of a safe environment, and the usage of modern technology and techniques. By adhering to safety imperative, medication error may be minimal to the maximum extent. In addition, various regulatory bodies and agencies are working in the country to oversight patient safety issues. The list comprises CMS (Centers for Medicare & Medicaid Services), The Joint Commission, FDA (Food and Drug Administration), and AHRQ (Agency for Healthcare Research and Quality) along with multiple State Health Departments, etc.

Regulatory Agency Role and Impact

In healthcare organizations, regulatory authorities play a crucial role in enforcing patient safety standards. They aim to ensure that healthcare facilities are providing patient safety and quality care as a priority. For example, concerning medication error, NPSGs (Joint Commission's National [Patient Safety Goals](#)) outline particular areas to improve patient safety by correct identification of patients and prevention of infections. Hence, the regulatory authorities have significant impacts on safety programs as well. All healthcare facilities are mandatory to comply with the enacted rules and regulations for accreditation purposes, reimbursement of funds from the government and to avoid any legal penalties. Resultantly, the respective organizations align their initiatives to the guidelines enacted by regulatory agencies.

Meanwhile, healthcare organizations incorporate the guidelines of regulatory agencies to develop and investigate best practices. These practices ensure patient safety standards like the implementation of an incident report system. Through such system, employees report adverse incidents, mishaps and

concerns of patients. Such a system should be non-rigid and non-disciplinary to promote a culture of open discussion, where the concerned staff should report any error, safety issue and wrong practices without any fear. Similarly, to incorporate agencies' guidelines, health organizations should establish concrete investigation protocols to analyse any reported incident or issue. These protocols may involve the identification of root causes, conduction of thorough reviews, devising corrective actions and the implantation of various checks to prevent such incidents in future. In such a manner, healthcare organizations may overcome risks and enhance patient safety up to the maximum extent.

However, the consequences would be drastic for employees, patients and even organizations if the respective hospitals fail to rectify threats. Patients may suffer from complications to life threats while employees may experience job dissatisfaction along with issues in future careers. Similarly, the organizations may experience penalties, fines, cancellation of registrations and less flow of patients. However, the hospitals have concrete options to prioritize their patient safety and incorporate regulatory agencies' regulations in the system to avoid any discrepancy.

Role of the Patient Safety Officer

Patient safety officers play a crucial role in implementing patient safety plans in healthcare organizations. They develop and oversee strategies like collaboration with all stakeholders, conduction of training, and evaluate overall safety initiatives. They also tend to establish a culture where errors can be reduced. In this way, their main responsibilities revolve around the identification of safety issues like medication errors, devising plans and implementing them according to a policy of the organization. Mulac et al., (2021) concluded that patient safety officers reduce patient safety threats by checking medication errors as they formulate and devise the particular mechanism that leaves lasting impacts.

Evidence-Based Best Practice Tools

For elimination and lessening the patient safety threats, the employment of evidence-based practice tools and techniques become mandatory. Currently, multiple recommendations in this regard play a significant role in posing lasting impact. These practice tools include "Medication Barcoding Systems" which reduce medication error through scanning applications. Kuitunen et al. (2021) concluded that barcode scanning has ability to reduce the medication error up to about half of the extent. Similarly, "Medication Reconciliation" is another tool recommended by AHRQ (Agency for Healthcare Research and Quality). In addition, other tools may be "Team Training and Communication", "Incident Reporting and Root Cause Analysis", and "Standardized Protocols and Checklists" which reduce medication errors significantly.

Moreover, to reduce patient safety threats, a five-point plan is of grave importance. The first point is the implantation of a barcoding system on a priority basis. Meanwhile, during patient transitions of

care, the reconciliation process for standardised medication is the second point. The third point relates to team training sessions on a regular basis to improve collaboration and prevention of errors. Similarly, the fourth point is the propagation of a culture to report any incident and consider root-cause analysis for reducing threats in future cases. Finally, the fifth point is the development and adoption of standardized procedures like abiding by the safety checklist during the medication process.

Furthermore, various process considerations can be helpful in eliminating patient safety threats. For example, responding to ensure appropriate actions as well as to feedback. Similarly, regular rounds by the senior to get any potential threats may be helpful. Another consideration may be the usage of technology for detecting and alerting the healthcare system about any threat would be beneficial. In addition, reporting of the ongoing situation with discussion-based suggestions is significant. And finally, operation considerations like allocation of wise-full resources, taking initiatives, adoption of new procedures and use of modern technology can reduce patient safety threats.

Conclusion

From the above discussion, it can be concluded that patient safety issues are of grave importance in the healthcare system. Medication errors pose severe effects on the health and life of patients, the overall morale of employees and the business model of concerned hospitals. However, the healthcare imperative emphasizes healthcare organizations to address safety issues to relinquish any discrepancy. In this context, the role of regulatory agencies and the role of safety officers are pivotal in alliance with the implantation of evidence-based practice tools and various considerations. All such measures are significantly helpful in reducing and eliminating patient safety threats to make healthcare organizations more safe, secure and productive.

References

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