Journal of Research in Nursing and Midwifery Vol. 10(5)
Available online @https://www.interesjournals.org/research-nursing-midwifery.html

Commentary

Indeed patient safety has emerged as a distinct healthcare discipline supported by an immature yet developing scientific framework

Carolynn Thomas*

Department of Clinical Nursing at the Ohio State University, Columbus USA

***Corresponding Author's** Email: thomascarolynn18@edu.usa

ABSTRACT

Patient safety work product includes any data, reports, records, memoranda, analyses (such as root cause analyses), or written or oral statements (or copies of any of this material), which are assembled or developed by a provider for reporting to a PSO and are reported to a PSO; or are developed by a Patient Safety Organization for the conduct of patient safety activities; and which could result in improved patient safety, health care quality, or health care outcomes; or which identify or constitute the deliberations or analysis, or identify the fact of reporting pursuant to a patient safety evaluation system However, patient safety work product does not include a patient's medical record, billing and discharge information, or any other original patient or provider records; nor does it include information that is collected, maintained, or developed separately, or exists separately, from a patient safety evaluation system. Patient safety work product must not be disclosed, except in very specific circumstances and subject to very specific restrictions. Safety is the condition of a "steady state" of an organization or place doing what it is supposed to do.

Keywords: Health care, pediatric nursing, adult nursing, public health nursing, critical care.

INTRODUCTION

Patient safety is a discipline that emphasizes safety in health care through the prevention, reduction, reporting and analysis of error and other types of unnecessary harm that often lead to adverse patient event. The frequency and magnitude of avoidable adverse events, often known as patient safety incidents, experienced by patients was not well known until the 1990s, when multiple countries reported significant numbers of patients harmed and killed by medical errors. Recognizing that healthcare errors impact 1 in every 10 patients around the world, the World Health Organization (WHO) calls patient safety an endemic concern. Millennia ago, hippocrates recognized the potential for injuries that arise from the well-intentioned actions of healers. Greek healers in the 4th century BC drafted the hippocratic oath and pledged to "prescribe regimens for the good of my patients according to my ability and my judgment and never do harm to anyone. Since then, the directive premium non nocere ("first do no harm") has become a central tenet for contemporary medicine. However, despite an increasing emphasis on the scientific basis of medical practice in Europe and the United States in the late 19th century, data on adverse outcomes were hard to come by and the various studies commissioned collected to adverse events. Use of effective communication can aid in the prevention of adverse events, whereas ineffective communication can contribute to these incidences. If ineffective communication contributes to an adverse event, then better and more effective communication skills must be applied in response to achieve optimal outcomes for the patient's safety. There are different modes in which healthcare professionals can work to optimize the safety of patients which include both verbal and nonverbal communication, as well as the effective use of appropriate communication technologies.

SAFETY CULTURE

As is the case in other industries, when there is a mistake or error made people look for someone to blame. This may seem natural but it creates a blame culture where who is more important than why or how. A just culture also sometimes known as no blame or no fault, seeks to understand the root causes of an incident rather than just who was involved. Mostly anecdotal events. In the United States, the public

and the medical specialty of anesthesia were shocked in April 1982 by the ABC television program 20/20 entitled. The deep sleep presenting accounts of anesthetic accidents the producers stated that every year 6,000 Americans die or suffers brain damage related to these mishaps. In 1983, the british royal society of medicine and the harvard medical school jointly sponsored a symposium on anesthesia deaths and injuries, resulting in an agreement to share statistics and to conduct studies. Attention was brought to medical errors in 1999 when the institute of medicine reported that about 98,000 deaths occur every year due to medical errors made in hospitals.

EFFECTIVE AND INEFFECTIVE COMMUNICATION

The use of effective communication among patients and healthcare professionals is critical for achieving a patients optimal health outcome. However scientific patient safety research by Annegret, among others has shown that ineffective communication has the opposite effect as it can lead to severe patient harm. Communication with regards to patient safety can be classified into two categories: Prevention of adverse events and responding. Methods of effective verbal and nonverbal communication include treating patients with respect and showing empathy, clearly communicating with patients in a way that best fits their needs, practicing active listening skills being sensitive with regards to cultural diversity and respecting the privacy and confidentiality rights of the patient. To use appropriate communication technology, healthcare professionals must choose which channel of communication is best suited to benefit the patient. Some channels are more likely to result in communication errors than others, such as communicating through telephone or email (missing nonverbal messages which are an important element of understanding the situation). It is also the responsibility of the provider to know the advantages and limitations of using electronic health records, as they do not convey all information necessary to understanding patient needs. If a health care professional is not practicing these skills, they are not being an effective communicator which may affect patient outcome.