Patient safety assessment: USA and Slovak hospitals

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Original Articles

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Abstract:

It is the priority of all health care organizations to promote patient safety. All over the world, numerous people suffer from hospital acquired infections and other adverse events day in and day out. The goal of this study was to verify whether there were any disparities in the way patient safety issues are handled in the United State and the Slovak Republic. This article also explores the types of adverse event and errors and their causes, some universal strategies to minimize safety issues, and some basic steps involved in incident reporting. It was concluded that there was a wide difference in the number of adverse events that are reported in both countries.

Introduction

Patients are likely to be exposed to some degree of risk during the delivery of care. Patient safety was defined by the Institute of Medicine (IOM) "as the prevention of harm to patients" with emphasis being placed on the system of care delivery that (1) prevents errors, (2) learns from the errors that do occur, (3) and is built on a culture of safety that involves healthcare professionals, organizations, and patients.

According to the Institute of Medicine, at least 48,000 people and as many as 98,000 people die from medical errors each year and these errors are known to be preventable. Total cost of preventable errors per year in hospitals nationwide was estimated to be between $17 billion and $29 billion (Institute of Medicine; To Err Is Human, 1999). The healthcare system in the United States has not achieved its desired level of safety likewise that of the Slovak Republic and any other country in the world. But major efforts are being made to improve patient safety and the quality of care delivered.

What Constitute an Adverse Event and Medical Errors

An adverse event is defined as the injury caused by medical management rather than the underlying condition of a patient whilst medical error is the failure of a planned action to be completed as intended (Institute of Medicine). Common types of adverse events and medical errors are: foreign objects found in a patient after surgery; surgery done on the wrong part of the body; medication errors; patient falls; injuries from electric shock; surgery on the wrong patient; pressure ulcers; wrong surgical procedure; nosocomial infections/HAIs; mistakes in communication; missing standards or guidelines and many more. Some of these errors are mandatory reportable and some are voluntarily reportable.

In a study done by the Office of the Inspector General, which reports adverse events in hospitals among Medicare beneficiaries, reveals that an estimated 13.5% of Medicare beneficiaries experienced adverse event during their hospital stay that resulted in temporary harm. Physician's reviewers also determined that 44% of these adverse events were known to be preventable. Care associated with adverse events and temporary harm events cost Medicare an estimated $324 million in October, 2008. Based on their findings, they recommended that AHRQ and CMS broaden their patient safety efforts to include all kinds of adverse events and should enhance their efforts to identify adverse events (OIG, 2010).

In a recent study, researchers surveyed three different hospitals with a sample size of 1,787 hospital staff in the Trnava Region of the Slovak Republic. Their aim was to identify the perception of healthcare workers with regards to the safety of patients in the workplace. The study revealed that team work across hospital units and hospital management support for patient safety issues were very weak with a 35% and 39% survey results respectively. Hospital staff also admitted to the fear of reporting adverse events. Physicians and nurses also had different perceptions on communication; adverse event reporting and staffing in the hospitals surveyed for this study (Veronika *et.al*, 2012).

In a similar study on the distribution of the number of adverse events reported both in the United States and the Slovak Republic, the result shows that 80% of healthcare workers in the Slovak Republic never reported any adverse event that occurred as opposed to 52% in the United States. Those who reported one or two events when they occurred were 11% and 28% for the Slovak Republic and the United States respectively. Again, 8% of healthcare workers in Slovak Republic reported three to five events, whilst 13% of healthcare workers in the United States reported three to five events when they occurred. This shows there was under-reporting of adverse events and medical errors in the Slovak Republic and the reason for this was the fear of adverse event reporting; the fear of losing one's job; being punished (Viera Rusnáková *et.al*, 2010).

Causes of Adverse Events and Medical Errors

Fragmented nature of healthcare delivery system; negligence; task complexity and the availability and use of protocols; inadequately trained personnel and staffing levels; excessive workload; administrative and managerial support problems; problems associated with skill mix; equipment failure or malfunction; poor verbal and written communication; and poor leadership and supervision.

Preventive Strategies

- Encourage information sharing and promote good team work.
- All healthcare facilities must make sure they have sufficient personnel's to provide patient care.
- They must always take into consideration the ratio of patients to healthcare staff.
- There must be policies and procedures in place to check that.
- Care and consideration should be given when hiring and assigning jobs to healthcare personnel.
- Patients should be involved in their care. They should be allowed to ask questions.
- Suitable working environment which is free from harm should be provided at all times.
- There should be transparency in the delivery of care.
- Patient safety lies in our hands; therefore, promoting a culture of safety is a must.

Conclusion

All healthcare workers should be involved in safeguarding the health and safety of the patient. Research reveals that there is a wide disparity in the number of adverse events that are reported in both the United States and the Slovak Republic. Therefore, healthcare workers should be encouraged to report adverse events and errors as soon as they occur because it is the only way the healthcare facility can address the issue and come up with a solution. Errors are very costly; a lot of people are losing their lives due to preventable errors. There is also the lack of trust in the system and a decreased satisfaction by both patients and healthcare professionals. Patient safety can be enhanced by allowing patients to ask questions and involving them in their care; putting in a lot of consideration in hiring and assigning task to employees; and by promoting transparency in the delivery of care and allowing open communication.

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