OPEN ACCESS Freely available online

Medical Safety & Global Health

Perspective

Impact of Health Care Errors on Patient Safety

Hue Xin*

Department of Medicine, Nankai University, Tianjin, China

DESCRIPTION

Patient safety is a discipline that places an emphasis on health care safety through the prevention, mitigation, reporting, and analysis of mistakes and other types of needless harm that frequently result in negative patient events. Before the 1990s, when numerous nations reported sizable numbers of patients hurt and killed by medical errors, the frequency and scale of preventable adverse events, also known as patient safety incidents, experienced by patients were not well understood. According to the World Health Organization (WHO), patient safety is a widespread problem because medical errors affect one in every ten patients globally. Patient safety has in fact become a separate healthcare field, underpinned by a young but developing scientific framework. There is a significant trans disciplinary body of theoretical and research literature that informs the science of patient safety.

Causes of healthcare error

The simplest definition of a health care error is a preventable adverse effect of care, whether or not it is evident or harmful to the patient. Errors have been, in part, attributed to;

Human factors: Variations in the education and experience of healthcare providers, as well as exhaustion, despair, and burnout.

- Diverse patients, strange environments, and time constraints.
- A failure to recognise the incidence and gravity of medical mistakes.
- Increasing the number of hours that healthcare workers work.
- Incorrectly classifying or failing to label specimens with stress and distress.
- Medical difficulty.
- Complex technology, potent medications.
- Protracted hospitals stay with intensive care.
- Systemic issues.
- Dangerous communication.
- Lines of authority between doctors, nurses, and other healthcare professionals are unclear. As the patient to nurse staffing ratio rises, complications rise as well.
- Hospital reporting systems are fragmented and disconnected, resulting in errors and a lack of coordination as a result of the frequent patient handoffs.
- Drug names with similar spellings or pronunciations.
- The feeling that other organisations inside the institution are acting.
- Reliance on automated systems to prevent error.
- Analysis of contributing reasons and improvement methods are hampered by inadequate channels for sharing information about errors.
- Hospitals' cost-cutting efforts in reaction to reductions in payment.

Design elements and the environment: In times of emergency, patient care may be given in locations not ideal for secure monitoring. Concerns regarding the secure planning and development of healthcare facilities have been raised by the American Institute of Architects.

Infrastructure break down: The WHO estimates that 50% of medical equipment in poor nations is only partially functional because there aren't enough competent operators or parts. As a result, it is impossible to carry out diagnostic procedures or therapies, which results in inadequate care.

According to The Joint Commission's 2007 Annual Report on Quality and Safety, more than half of significant adverse events at recognized hospitals were the result of poor communication between healthcare professionals or between those professionals and patients and family members. Inadequate evaluations of the patient's condition and subpar training or leadership were some of the other significant causes.

Common misconceptions about adverse events are; "Bad apples" or unskilled healthcare professionals are frequently to blame." Many of the mistakes aren't the consequence of bad judgment or carelessness, but rather ordinary human slips or mistakes.

"High risk medical specialty or procedures are to blame for the majority of preventable adverse outcomes." Errors occur at all levels of treatment; however some mistakes, like those that occur during surgery, are simpler to spot. Negative results are frequently caused by the severity of the condition being treated

Correspondence to: Hue Xin, Department of Medicine, Nankai University, Tianjin, China; E-mail: Hxin46@hotmailcom

Received: 28-Mar-2022, Manuscript No. MSGH-22-20401; **Editor assigned:** 30-Mar-2022, PreQC No: MSGH-22-20401 (PQ); **Reviewed:** 15-Apr-2022, QC No: MSGH-22-20401; **Revised:** 21-Apr-2022, Manuscript No: MSGH-22-20401 (R). **Published:** 29-Apr-2022; DOI: 10.35248/2574-0407.22.11.157.

Citation: Xin H (2022) Impact of Health Care Errors on Patient Safety. Med Saf Glob Health. 11:157.

rather than the complexity of the process, even if complex procedures carry a higher risk. However, according to USP, drug errors that occur during surgical procedures are three times more likely to injure a patient than errors that happen during other medical care procedures. "A mistake has been made if a patient gets an unfavourable outcome while receiving care." Most medical procedures have some level of risk, and they may result in problems or side effects, often unanticipated ones, depending on the underlying ailment or the course of therapy.