**MEDICAL NEWS**

## WHO Health Topic: Are we practice a safe health care?

All health care providers are dedicating themselves to provide a good health care to their patient with no harm, but remains the fact that patients are harmed daily in the course of receiving health care all over the world. Patient safety is a serious global public health issue. Estimates show that in developed countries as many as 1 in 10 patients is harmed while receiving care.

Patient safety has received increased attention in recent years, but mostly with a focus on the epidemiology of errors and adverse events, rather than on practices that reduce such events. Therefore, we need to address this fact and do our best to correct the problems that leads to unsafe practice, as all patients have a right to effective, safe care at all times. WHO considered patient safety as a fundamental principle of health care. Every point in the process of care-giving contains a certain degree of inherent unsafety. Adverse events may result from problems in practice, products, procedures or systems. Patient safety improvements demand a complex system-wide effort, involving a wide range of actions in performance improvement, environmental safety and risk management, including infection control, safe use of medicines, equipment safety, safe clinical practice and safe environment of care.

Recently, the solutions for insuring patient safety offer a more constructive approach; one important solution is the work of the caregivers together as a team, how effectively they communicate with one another and with patients, and how carefully the care delivery processes and supporting systems of care are designed. With the growing recognition of safety problems in health care, it is now time to create and disseminate “Solutions” for patient safety. WHO stated some guidelines on patient safety in some health practices, it is under the following headings:

- Best practices for injections and related procedures toolkit
- Blood donor selection
- Natural ventilation for infection control in health-care settings
- Screening donated blood for transfusion-transmissible infections: recommendations
- Towards 100% voluntary blood donation

- WHO guidelines on hand hygiene in health care

Not only that but also WHO published a Patient Safety Curriculum Guide under the title "The Multi-professional Patient Safety Curriculum Guide" It was released in October 2011and it promotes the need for patient safety education. The comprehensive guide assists universities and schools in the fields of dentistry, medicine, midwifery, nursing and pharmacy to teach patient safety. It also supports the training of all health-care professionals on priority patient safety concepts and practices.

The World Health Organization launched the World Alliance for Patient Safety and identified six action areas in 2005. One of these action areas is the development of "Solutions for Patient Safety". In the same year, the Joint Commission and Joint Commission International were designated as a WHO Collaborating Centre for Patient Safety Solutions, to initiate and coordinate the work of developing and disseminating solutions for patient safety. The output from this component of the World Alliance will be delivered to the global health-care community as "Patient Safety Solutions". Within the foregoing context, the term "Patient Safety Solution" is defined as: Any system design or intervention that has demonstrated the ability to prevent or mitigate patient harm stemming from the processes of health care.

Inaugural Patient Safety Solutions:

1. Look-Alike, Sound-Alike Medication Names
2. Patient Identification
3. Communication During Patient Hand-Overs
4. Performance of Correct Procedure at Correct body site
5. Control of Concentrated Electrolyte Solutions
6. Assuring Medication Accuracy at Transitions in Care
7. Avoiding Catheter and Tubing Mis-Connections
8. Single Use of Injection Devices
9. Improved Hand Hygiene to Prevent Health Care-Associated Infection

International patient safety goals:

- Identify patient correctly
- Improve effective communication
- Improve the safety of high alert medication
- Eliminate wrong site, wrong patient and wrong procedure surgery
- Reduce the risk of health care acquired infection
- Reduce the risk of patient harm resulting from fall

Fortunately, authorities in many countries are reforming health care in terms of higher quality and the elimination or correction of practices that are known to be unsafe or wasteful. Also let us not to forget the role of patients and their families in improving the patient safety, they are becoming increasingly skilled in accessing information to make personal health care decisions about treatments and their choice of providers, and demanding safer care as well. Health-care practitioners are also becoming more proficient at incorporating evidence-based knowledge into their clinical decision-making practices. One of the role of patients and their families in improving the safety is the patient advocates use past experiences to change the future, and here is an example of a lady who lost her son and she dedicated herself to advocate patient safety. When visiting a doctor, patients expect a listening ear, an accurate diagnosis and timely treatment. This woman encountered the opposite, a flawed health system that lacked the capacity to respond to her 21

years old son deteriorating health. His personality changed. He was moody and constantly tired. He consulted a doctor for persistent bone pain. Tests revealed high calcium levels and a plasma creatinine level indicating kidney failure. The results required immediate referral, which did not happen. Symptoms continued for another 2 years without action. On his last visit to his doctor, tests showed critically high levels of calcium in his blood, levels later described by peer reviewers as "inconsistent with life". The results were communicated by telephone and written on a post-it note by a nurse, who believed that the patient had hypercalcaemia. Ignoring the nurse's diagnosis, the doctor omitted any reference to calcium and only included results in his referral letter that supported the incorrect diagnosis. The post-it note was stuck to the back of the referral letter and was not seen by the hospital until 6 weeks after the patient death. Unaware of his high calcium levels, the patient was diagnosed with nephritis and transferred to another hospital for treatment. Because it was a weekend, on-call senior personnel were not advised of the patient's condition and an aggressive treatment plan was not started. Hours later, the patient suffered a heart attack and could not be resuscitated. His cause of death was primary hyperparathyroidism, multi-organ failure and hypercalcaemia. Calcium was being channelled into the patient's blood stream instead of his bones, putting strain on his heart. A simple surgery, with a 96% success rate, would have saved his life.

"Adverse events happen to real people," the mother says. "my son was more than a statistic; he was more than a medical condition. He was a real person, a young man, full of life. But above all, he was my beautiful boy."

In 2004, WHO launched a patient safety programme to develop policies and practices aimed at preventing harm to patients worldwide. Because the patient voice is essential to advocating for change, WHO also formed Patients for Patient Safety (PFPS) – a patient-lead, global network of patients and patient organizations who advocate for patient safety.

"Because patients and caregivers see things that busy health-care workers do not, it's essential for us to include them at the center of all the work we do."

"The patient is the single entity which is present throughout the full continuum of care," stresses Margaret. "A variety of professionals dip in and out of the care pathway, but the patient is the one constant and a useful resource in relation to diagnosis and treatment. Importantly, the patient is the individual with the greatest vested interest in the outcome."