Okasha A, J Pub Health Issue Pract 2018, 2: 122
https://doi.org/10.33790/jphip1100122

Journal of Public Health Issues and Practices

Creating a Culture of Patient Safety: The Role of Leadership

Ahmad Okasha

Department of Environmental Health Sciences, Canadian University of Dubai, United Arab Emirates

Article Details

Article Type: Mini Review
Received date: 28th May, 2018
Accepted date: 6th September, 2018
Published date: 18th October, 2018

***Corresponding Author:** Ahmad Okasha, Department of Environmental Health Sciences, Canadian University of Dubai, United Arab Emirates. E-mail: a.okasha@cud.ac.ae

Citation: Okasha A (2018) Creating a Culture of Patient Safety: The Role of Leadership. J Pub Health Issue Pract 2: 122. doi: https://doi.org/10.33790/jphip1100122.

Abstract

There are alarming stories about medical mistakes. Medical errors are a worldwide problem. For instance, a patient is admitted to a hospital and the wrong kidney, which is healthy, is being removed. Another patient, complaining of a chest pain, is given a clean sheet and sent home after a routine investigation only to discover from a subsequent examination from a different hospital that he was in the early stages of a heart attack, requiring immediate surgery.

News reports have also alerted us of several other instances in the region. Doctors in one of the Middle Eastern countries have been found to be administering oral dehydration solutions improperly to babies. According to the Al Sharq Al Awsat daily , a young girl, admitted to a Middle Eastern hospital, was administered HIV infected blood. The daily also stated that several patients have died in the recent past because of a lack of basic hygiene and transfusions of infected blood. According to another report, an infant was fed expired formula milk in a hospital. These are only a few cases of medical mistakes that have been reported from the Middle East countries, but in no way is the problem limited to the region alone.

There are no robust published data on medical errors in the Middle East, however, the issue is widely studied and documented by studies in the US and worldwide. In fact, the World Health Organization (WHO) indicates that 10 per cent of hospital admissions results in some sort of harm to patients.

Traditionally, hospitals have addressed the patient safety issue by establishing infectious control committees. Although the presence of an infection control committee inside a hospital is a basic requirement of a patient safety program, it's not enough to reduce the alarming number of patient safety violations.

I believe that leadership and building a culture of safety are the main factors toward building a comprehensive patient safety program. Although an online survey has indicated that implementing of electronic medical record solutions across the middle east hospitals have improved healthcare outcomes, many errors still occur due to certain endemic organizational and leadership issues.

Leadership

The first role of a leader of an organization is to articulate the vision of an organization and strive to build a culture with articulated and practiced values. For healthcare organizations, the emphasis of the healthcare culture is firstly on patient safety and "do no harm to patients". To build a culture of patient safety, there must be an acknowledgement that there is a problem and an acceptance to solve it. Most clinicians likely agree that medical care is not as safe as it should be, although some might still disagree that errors occur frequently. Recognising that clinical care can be unsafe shakes physicians' belief that they are doing all they can for patients and, certainly, that they are not harming their patients.

Physicians, who are leading the care of the patients are viewed unfairly by society. Physicians are viewed by society as heroes or super heroes who do not make mistakes. Dr. Hassan Farah of Qatif's Central Hospital in the Eastern Province of Saudi Arabia who studied medical errors said: "Getting doctors to admit they have committed a medical error is the biggest challenge."

Many physicians are reluctant to report their mistakes or declare them. If we need to do no harm to patients, then we need to identify and analyse mistakes to arrive at their root causes. Medical directors or physician leaders inside hospitals must first acknowledge that physicians are reluctant to share their own mistakes with their peers and the hospitals. Second, medical directors and hospital directors need to build a model that encourages and motivates transparency with regards to medical errors. Physician leaders and hospital managers have roles to build a culture of accepting that we make mistakes. This will help hospitals to study them and prevent their occurrence in the future. Involvement of all physicians in the patient safety program is essential. Usually, physicians are efficient leaders and can make or break the program depending on whether they are involved or not.

In addition, leading an organisation that is committed to providing safer care requires overcoming the common traps in thinking about errors, such as blaming employees, ignoring the underlying systems factors, and blaming the bureaucracy of the organisation. Leadership must occur first at the governing level. Strong, determined leadership that sets the tone, makes tools available, and nurtures an environment for open communication and action to improve patient safety is essential.

The hospital board holds the ultimate responsibility for medical quality and patient safety. The board must hold the hospital directors accountable for defining and meeting the goals of safety plan. Sponsorship is required from hospital leaders such as CEOs and medical directors and the chairmen for private hospitals; and CEOs, ministry of health directors, or department of health directors for public hospitals.

Chairman sponsorships and approvals are essential in private

hospitals in case there are some expenses required for implementing a patient safety program. CEOs' sponsorships are vital. CEOs will make sure that all the care team and staff that get in contact with patients are trained, empowered, and accountable for not making harm to patients. CEOs will be also responsible for putting in the right infrastructure to support patient safety programs.

Building a culture of safety

Although change sometimes shakes core beliefs, physicians must agree to implement the change. Even though there is no consensus about what to change, what to change to, and how to accomplish the change, the lack of focus and lack of planning contribute to the slow pace of change in patient safety. In a Harvard Business Review article "Fixing Healthcare from the Inside Today" published September 2005, S. J. Spear, a senior fellow at Institute for Healthcare Improvement, describes why the root causes of preventable errors are deeply embodied in the traditional culture and practice of healthcare. Healthcare professionals are resistant to the standardisation of safe practice and mandatory checklists, which typically are accepted practices in other complex industries such as air transportation.

On an individual level, patient safety is about dignity and respect and cannot be separated from employees, visitors, and caregivers safety. Safety is safety. Period.

Consider the "straightforward" issue of handwriting legibility, if we were to view legible handwriting as indicative of our dignity and respect towards others, would hospitals be able to tackle this problem today, rather than waiting for technologies to mature and allow for universal electronic health records?

In other words, if we consider that an illegible order to another caregiver is one that could compromise his or her ability to properly treat a patient on our behalf, that we have placed both the caregiver and patient at risk, could we correct this problem now? We believe that the answer is yes.

Building an effective safety culture will enable the hospital to overcome the following scenario: let us consider a patient who receives a prescription with a wrong dose by his or her physician. If the pharmacist detects the error and gives the patient the proper dose, then no harm was made to the patient. On the other hand, if there is no system to detect such an error and no proper adjustment was made, the patient stands the risk of being harmed.

Giving recently advances in medical technologies and information technologies, we have improved the outcomes of patient and some errors such as medications errors are being reduced. However, strong leaderships at both the medical organization and the hospital management are essential to significantly improve patient safety at our hospitals.

References

1. Brennan TA, Leape LL, Laird NM, Hebert L, Localio AR, et al. (1991) Incidence of adverse events and negligence in hospitalised patients. Results of the Harvard Medical Practice Study I. New England J Med 324: 370-376.
2. Vincent C, Knox E (1997) Clinical risk modification, quality, and patient safety: interrelationships, problems, and future potential. Best Pract Benchmark Health 2: 221-226.
3. Kohn LT, Corrigan J, Donaldson MS (2000) To Err Is Human: Building a Safer Health System. Institute of Medicine (U.S.) Committee on Quality of Health Care in America.
4. Leape LL, Brennan TA, Laird N, Lawthers AG, Localio AR, et al. (1991) The nature of adverse events in hospitalized patients. Results of the Harvard Medical Practice Study II. New England J Med 324: 377-384.
5. Leape LL (1994) Error in medicine. JAMA 272: 1851-1857
6. The worst health care in the nation (1994) The Washington Times.
7. Bauman R (1993) The VA's war on health. Wall Street J A14.