Patients' safety as an endemic concern

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Recognizing that medical error affects approximately 10% of the patients around the world, the world health care referred to patients’ safety as an endemic concern. Safety health care and medical errors have emerged as a powerful healthcare discipline built on the basis of the immature scientific framework that is fast developing. Increased access to information regarding the number of cases of medical errors has helped improve this discipline (Hurwitz & Sheikh, 2009).

The impacts and magnitude of medical errors were unappreciated until in the 1990s when there were several reported incidences in the United States of America. The Institute of Medicine (IOM) of the National Academy of Sciences published a report ‘ Building a Safe Health System’ in 1999 in recognition of the trend of human error in health care systems. In the report, the IOM urged for a broad national effort including the establishment of a patient safety center, safety programs development in health care institutions, expansion of reporting of adverse effects and urged healthcare purchasers, regulators and professional societies to pay attention to this fact. Within two weeks of the publishing of the report, the president of the United States of America ordered a study to be carried out to establish the feasibility of the implementation of the report’s recommendations. Health Grades, in July 2004, released a study namely ‘ Patient Safety in American Hospitals’ that showed that there were over 1, 000, 000 adverse impacts associated with healthcare systems during 2000-2002 which resulted in more than 190, 000 deaths per year in US healthcare institutions (Wilson, Runciman, Gibberd, Harrison, Newby & Hamilton, 1995). This experience is much similar to other countries around the world. According to a ten-year

study in Australia, there were over 17, 000 deaths annually that resulted from medical errors, for instance, medical dosing error. The Canadian adverse effects study revealed that there were adverse effects in more than 6. 9% hospital admissions and 9000-24, 000 die per year due to unavoidable medical errors (Baker & Norton 2004).

Medical errors emanate from a number of factors like physician stresses, the process of care factors, patient-related factors, and physician’s characteristics like lack of prerequisite knowledge. Some of the problems may also result from the quality of services and equipment, access to and financing of healthcare (Peters & Peters, 2007). To err is to human and errors will always happen despite the level of care practiced in health care facilities. Physicians, patients and health care staff errors are common in many hospitals and therefore necessary systems must be implemented to prevent or absorb them. Sometimes the errors may be as a result of negligence on the part of the patient or the physician, but others are unavoidable. Most of the errors result from the overly complex processes but are preventable according to Hatlie & Youngberg (2006). To reduce such medical errors, a culture of incidence reporting should be developed that includes clearly distinguishing between blameworthy and blameless errors. Systems should be put in place to absorb a degree of some of the errors and the health care institutions should be dynamic to adapt in emergency situations.