Patient Safety Culture in the Healthcare Workplace- Reflective Paper

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Patient safety is the primary determinant of the quality of healthcare throughout the world. In the United States, it is a documented fact, that poor quality of healthcare has remained a leading cause of death. Another feature of a poor healthcare environment remains the cases of injuries at the workplace and illness the healthcare workers dwell, which ultimately affects the patient's health safety. It is for such reasons that patient and worker safety are considered inter-relatedd and complimentary for each other. The report published by the Institution of Medicine in 1999 revealed some eye opening facts about the patient safety (Liang & Brach, 2017). It stated that around 44,000 to 98,000 people lose their lives as the outcome of the medical errors. The primary reason the report cites is that such injuries are not the consequence of patient conditions, rather the environment they interact with in the healthcare institution.

In addition to some disturbing facts, the report suggested some ways for creating conditions that can benefit in the safety of workers along with creating a safe work related environment. It also includes a lack of awareness among people who don't consider this a cultural and systematic issue. The health care workers become the recipients of viruses because of the lapses in infection control, faulty equipment, and exhaustion (“Safety and Health Topics | Healthcare—Organizational Safety Culture—Linking patient and worker safety | Occupational Safety and Health Administration,” n.d.). The only way, a health care worker, can efficiently perform his duty is the absence of threat and confidence over the health care mechanism at the workplace. The report went on to emphasize the worst aspect of failure in such systems and the benefits which can arise from limiting such errors. It concludes by referring to a critically linked aspect, which is the reduction in medical error with the benefits of preventing workers related injuries.

In addition to the 1999 report, many other studies reasoned the organizational faults as the primary predictor death in health care institutions (Liang & Brach, 2017). Studies show that both patients and the health care workers tend to comply with the standard precautions if the institution shows a strong will to comply with the safety and standard precautions. Health care workers also show confidence when they experience interventions focused on improving the organizational support for employees. The organizational safety culture also suggests that non- compliance with the safety and control guidance by the healthcare workers contributes to expanded infections and new problems in healthcare. The Centers for Disease Control and Prevention's Healthcare Infection Control Practices Advisory Committee suggested that increased measures of safety are linked with the adherence to the healthcare precautions by both the patients and the healthcare workers (Joyce, Kuhar, & Brooks, 2015). For them, the organizational characteristics, adherence to personal healthcare, and hospital-based safety settings remain the primary drivers for creating a safety culture.

Despite the release of various reports concerning patient care and the safety of the health care workers, there has been no significant improvement in the safety mechanism adopted by the health care institutions. The safety and health management systems in hospitals suggest that workplace hazards should be comprehensive and proactive in nature (Morgan, Wenzel, & Bearman, 2017). It can be achieved by reducing the associated costs and improving the quality of care. Similarly, the OSHA's voluntary protection program distinguishes the employers and workers from the private and federal industry who remain the initiators of effective safety and health management. The IOM report, in this regard, stresses the need for laying a comprehensive strategy that should be enacted by federal or state governments. Similar to this, the Lucia Leape Institute focuses on the need for identifying and transforming the vital framework of patient and worker health care safety (Morgan et al., 2017). Lastly, the paper titled healthcare without harm, improving patient and worker safety: Opportunities for synergy, collaboration and innovation, and the NORA health care and social assistance sector council talks about how to achieve sustained improvements in workplace practices.

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