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Review Article

Looking at the Future for Patient Safety

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Abstract

We are looking for a high reliable person-centered and safe care with some imagination we can redesign the processes of care to be compassionate and safe.

The health care delivery system has inherent risk and that the focus of patient safety should be on the proactive management of that risk. So, a total redesign of the system is the way we need to go as we move to the future.

And to achieve a safe system, we will need to address some fundamental issues that we have accepted as the norm.

Keywords: *Person-Centered; Safe Care; Health Care; Patient Safety*

Introduction

Our vision for the future is to achieve a Zero harm?!!

But does it realistic, due to the complexity of health care system the concept of zero harm is a mirage.

Complex Adaptive System:

The hospital are a complex organization, so don't operate like predictable and static machines in which input A and B predictably leads to result C the elements of complex adaptive system.

- Unpredictability
- Codependency
- Non linearity "small things can lead to big effects"

But instead we need hospitals as complex fast-moving environment.

Figure A

So that we should actively adopt patient safety initiatives to improve outcomes and minimize risk. We should redesign the system from the hospital at the center to the hospital as the facilitator of health within a system of care delivery which is focused closer to the home, and this will require a relocation of resources to primary care and a change of health care to health.

People will still be harmed; however, the degree of harm will be different to the current situation.

As we redesign services to be safer in the future, we will need a vision that sees beyond the current challenge and plans for an integrated service of care focused on health rather than disease.

Discussion

Steps for the future changes:

1. **Develop the language and culture of safety**

   Culture defines our belief and in turn how we behave.

   And usually language reflects culture. So, if we want to develop safety culture then we will need to critically analyze the terminology we use.

   Health Care → Health

   Patient safety and risk management but in reality it doesn't managing risk but rather managing incident that had occurred.

   But management of risk is a proactive activity which should happened at all times, not only when there is an incident.

   Near miss, "ambiguity" instead "good catch"

   - Leadership for safety will be the foundation of future work in patient safety.
   - To realign the budget to facilitate change and courage to make the changes against the resistance that the past ways will present.
   - Politicians need to invest in health while funding healthcare.
   - The health care workforce will require an education that enables them to deliver health as well as manage disease safely.

2. **Promote psychological safety**

   - Psychological safety is the foundation for providing safe care for individuals.
   - Edmondson defines psychological safety as shared belief held by members of a team that the team is safe for interpersonal risk-taking. The ability to take risks and feel able to challenge in order to promote safe practices is one of the major challenges we will face going forward.

     (Avoid strict hierarchical constructs) (resilience).

Authority Gradient: Is the psychological distance between a worker and a supervisor.

And the overall steepness of gradient is referred as **hierarchy.**

Figure B

- Also we need a program to prevent burnout of clinical staff because stressed clinicians are unable to deliver safe care.

Burnout is due to multifactorial reasons like (education, hierarchies, technology, and overall design of the service).

Therefore, all people working in the healthcare setting need to be supported to be safe and to proactively work to their own safety from a psychological and physical perspective. The safety of the people for who they care will then follow.

3. **Design for health and for safety**
    - Invest in health rather than health care.
    - Co-produce safety with people not with patient (in which people are part of the solution rather than part of the problem).
    - Place people in charge of their health, not their disease.
    - Use human factors and ergonomics to address complexity.

    Human factors: The interrelationship between:

    - Humans.
    - The tools and equipment they use in the work place.
    - And the environment in which they work.

    Human factors engineering: Modifying system design to better aid people.
4. Social determinants of patient safety
    - Health outcomes can be predicted depending on the influences of the social determinant: poverty, housing, education, literacy and nutrition.

      So, the poorer the one is, the worse is the clinical outcome.

      So social determinant of health has an impact on the risk of harm.

      And if you add ethnicity, gender, language and status like refugee then the outcome is likely to be even worse.

      In the future, the social determinants of Patient safety (SDPS) will be as important in understanding how to prevent harm as are the methods and interventions we use to mitigate against adverse events.
5. Harnessing technology for the future
    - Digital health for safety: But the challenge is to not replace old errors with new ones.
    - Empowering people using technology.
    - Understand the advantages and risks of artificial intelligence “AI”.

Conclusion

Patient safety in the future will not be about the interventions needed but rather about the people who work in the system, the people who receive care, and how we can design systems to support them in the delivery of reliable and safe care.

If we need zero harm as a concept:

1. Redesign our systems of care through co-production and partnership.
2. To address the challenges of:
    - Social determinants
    - Hierarchical culture
    - IT [1-3].

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