"WHAT IS PATIENT SAFETY?"

By

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Abstract

The Institute of Medicine Report *to Err is Human* in 1999 generated tremendous public and media attention, setting the stage for unprecedented efforts and activities to improve patient safety. Patient Safety is developed as a health care discipline that is associated with the evolving complexity in health care systems and deals with in tern increased load and burden of patient harm in health care facilities. Patient safety has emerged with an aim of avoiding, preventing and reducing the risks of potential and preventable errors and resultant harm that occur to patients during provision of health care.

The quality and patient safety are the buzz words in the health care management. As compared to other developed countries the concept of patient safety is new and does not have a considerable understanding amongst the health care providers and patients in India.

The paper has its aim to explain the meaning and concepts of patient safety and its importance in providing the quality health services and for better patient outcomes to the health care providers and the stake holders. The author has also explained in detail the benefits of patient safety to owners and management of health care settings, health care providers, and direct the beneficiaries like patients and their care takers or family members. The paper in the last also throws light on the barriers and challenges in the implementation of patient safety in the various healthcare settings.

Keywords: Patient safety, Quality, Healthcare services, errors, adverse events, patient harm

Introduction:

Health care services also become complex, involving higher technology and hence much complicated and costly. Complexity of diseases and also of healthcare services pose increased risk and cost. In this context, healthcare institutions, and professionals are exploring innovative approaches and methods that reduce preventable medical errors, improve patient care and safety and decrease healthcare costs. Here cost mainly focuses on cost of stress and extra efforts of health care providers as well as cost patient's sufferings along with operational costs.

Patient Safety is developed as a health care discipline that is associated with the evolving complexity in health care systems and deals with in tern increased load and burden of patient harm in health care facilities. Patient safety has emerged with an aim of avoiding, preventing and reducing the risks of potential and preventable errors and resultant harm that occur to patients during provision of health care. A cornerstone of the discipline is continuous improvement based on developing a proper system with good quality structure, and well documented and implemented processes, Standard Operating Procedures, check points in areas of potential risks, training and development, documentation and records management, effective communication amongst healthcare providers, incident reporting as well as learning from errors, near misses and adverse events.

It is evident that with increased knowledge and technology the healthcare become more complex as well as complicated and poses significant risks to patients. The healthcare delivery system today takes into account the growing complexity in health care organizations that make humans more prone to errors and commit mistakes. (3) Millions of patients are injured or die because of unsafe and poor-quality health care every year. Many of the medical practices and other processes associated with health care have in built risks. They contribute significantly to the burden of harm due to unsafe care are emerging as major challenges for patient safety. This associated risk and potential harm has become a major concern and need to be monitored and addressed continually. This is focus or scope of Patient safety. It includes a variety of reasons and range of types from risk associated with infrastructure, equipment, patient transporting and

other systems failure, errors of judgement, diagnosis, prescription by physician medication use, drug administration, diagnostic and therapeutic procedures, Lac of

correct identification of patient and his therapeutic plan-medicine or surgical procedure/intervention, identification of correct side and site of surgery , inaccurate surgical procedures or leaving any material in the patient body, surgical site infection, others Hospital Acquired Infections , to errors of communication, poor coordination of healthcare providers during patient transfer etc which are proven to be the most detrimental to risk associated with potential temporary or permanent harm to patient's life or limb.

The aim of Patient Safety is an appropriate application of medical knowledge with due regard to the balance between the hazard inherent in every medical intervention and the benefits expected from it (10) The patient safety policies and procedures helps providing and standard operating procedures as well as keeping checks at potentially risky points during provision of health care services.

This paper tends to understand the basics of patient safety, areas of preventable and potential patient harm, how patient safety helps avoiding or reducing the patient harm and how it can be effectively implemented

Review of Literature and Gap identified

The detailed and in-depth review of the literature relevant to the inquiry of the present study was done. Its purpose was to reveal the most appropriate and suitable knowledge about patient safety concepts and practices used in the various hospitals and health care organizations Started by dealing with in depth detailing the main approach undertaken to identify relevant literature, including search terms, databases reviewed. The findings from the literature review were then presented under sub topics or the themes related to the research objectives addressed in this study: 1) Introduction provides the brief idea about the term concepts and applicability the current study. 2) What is Patient safety 3)Why patient safety , it discusses about magnitude of burden of preventable patient harm which demands for or shows need of patient safety .5) Importance of Organizational Culture for nurturing patient safety and effective implementation of patient safety practices for fruitful gains for recipients as well as providers of healthcare services.6) Benefits of patient safety initiatives for patients, healthcare providers and healthcare organizations or healthcare settings

This paper is based on secondary research data. In undertaking the literature review, an integrative approach was adopted and approach were based on the four stages Tranter et al.(2012), Whittemore and Knafl (2005) (108), .

The identification of relevant articles about patient safety and safety culture in healthcare in general, in the English language and published between 1999 and 2021, by the searching at the well-recognized sources and databases; WHO, AHRQ, HNS, ISQUA, NABH, JCAHO Medline, PubMed Sci, Web of Science, Google scholar and Shodhganga. The research articles
, Ph.D. thesis and papers were screens systematically on a criteria whether they were directly giving the relevant information about what is patient safety and its basics or was linked to patient safety and patient safety practices or patient safety culture in hospitals. . The articles, paper or other literature material which was most suitable and appropriate for the topic was filtered for the foundation of the study. This included the qualitative as well as quantitative studies and primary research database as well as secondary researches. Started with 2880 articles papers and studies or materials from different websites, duplications were filtered and remained with 1420 articles. With further filters about relevance and applicability 268 articles were there. With further inclusion and exclusion criteria of holistic concept of patient safety 43 articles were included in the literature review.

The researcher has done a thorough review of literature that has defined and explained various definitions ,aspects of patient safety, patient safety culture, errors near misses and adverse reactions and resultant patient during the provision of healthcare services causes of sentinel events etc. These studies either qualitative or quantitative have thrown light on different areas of incidents anf patient harms and effective patient safety solutions for it However for a person naïve to the Health care Service quality and coined term of patient safety the researcher has made an effort to help understand the concept and meaning of patient safety in a very simple way and basic concepts covered under it. This also helps him and other healthcare providers in minimizing the risks and thus preventing and reducing the potential patient harm by effective implementation of patient safety practices in his healthcare organization.

The paper also shows the benefits of patient safety initiatives like improved quality of

health services & patient outcomes , increased patient satisfaction, increased patient turnover and patient database, reduced operating costs, stronger financial performance and raised profitability , reduced employee stress and burnouts , greater employee motivation and engagement, organizational development of the healthcare organization, better image and branding

Objectives

The objectives of this paper areas follows

I. To study the definition and meaning of Patient safety
II. To understand risks, errors, near misses and sentinel/adverse events
III. To understand the different areas and categories of risk of potential patient harm
IV. To understand the different patient safety practices to avoid, prevent or reduce the patient harm
V. To study the benefits of patient safety initiatives for patients, healthcare staff and healthcare organizations or healthcare settings

What is Patient Safety

Patient Safety is recognized and accepted as an issue of utmost importance and is being paid heed at global level. The countries and nations have undertaken the manifolds of initiatives, standard or tailormade at different levels.

There are many definitions and meanings of Patient safety given by different organizations and authors. The most simple and easy to understand definition of patient safety is the prevention of errors and adverse effects to patients associated with health care. (29) Health care is though become more effective than earlier it has also become more complex, with greater use of new technologies, new generation medicines and modes treatments. With inclusion of all this healthcare has as become costlier and pose financial challenges it has also become more

complicated and poses comparatively more safety challenges to healthcare receivers as well

as providers.

Patient safety is a crucial rather vital component of health care quality. The hospitals and other health care organizations, they continually strive and struggle to improve it. Patient Safety is a basic and fundamental element of Health Care. It is a prerequisite to good quality health care and better patient outcomes. It depicts an important dimension of quality of care. It includes both medical /clinical and non-medical/non-clinical aspects of care.

The current picture of Health Care is with the evolving complexity in health care structures, processes and systems and the thus resulting in the increased risk of patient harm in health care facilities. In hospitals and healthcare organizations, harm can be caused by a wide range of reasons at different levels like infrastructure, equipment, processes, records and human factor. Patient Safety has emerged as a discipline which defines the guidelines and provides support structure pattern to prevent the harm caused by the health care service itself.

Patient Safety aims at the prevention and reduction of risks, errors and harm that is affecting to patients during provision of health care services. It acts as a cornerstone of the Health service Quality and directs and nurtures the continuous improvement based on learning from errors, incidents and adverse events. This paper tend to understand the basics of patient safety , areas of preventable and potential patient harm, how patient safety helps avoiding or reducing the patient harm and how it can be effectively implemented

Quality and Patient Safety :

Though in the industry, Quality and Patient Safety both the terms are used as synonyms and of course they go hand in hand, they are not same. Patient Safety is the absence of preventable harm and the reduction of unnecessary harm to a patient in the process of healthcare. (26)

Quality management has its focus on improving effectiveness of treatments and increasing the levels of patient satisfaction with the provided health service. On the other hand, Patient safety has its focus on safety of patients and healthcare providers from the potential harms wasted with health services. Patient safety is an essential and important aspect of an effective, efficient health care system where quality prevails.(26)The

differences between them are like - Safety has to do with no or lesser of possible harm, while Quality deals with efficient, effective, purposeful care that gets the right job done at the right time in right manner. Also, Safety keeps eyes on avoiding errors and Quality focuses on doing things better.

Safety ensures that less likely mistakes happen and Quality raises the ceiling so the overall care experience is a better one with considerable levels of Patient satisfaction.

Quality management seeks to improve effectiveness of treatments and increase patient satisfaction with the service. (26) With an increase in the elderly, aging population and rising health care costs multiples, quality management in health care has become a challenge for healthcare providers and has attracted their attention. A health care system comprises a range of health care settings from a small clinic, diagnostic centre, Pathology Lab to Nursing homes and different types of hospitals and large entities, such as pharmacies, medical clinics and hospitals, or healthcare organizations and all these components of health care system need to provide quality service for the system to work properly, effectively and efficiently.

History:

The concept of PS fids its evidence the first time in Hippocratic oath itself - *Primum non nocere*- in *Latin which means* - First do no harm. The phrase *primum non nocere* is believed to date from the 17th century. (2)

The equivalent phrase is found in Epidemics, Book I, of the Hippocratic school: "Practice two things in your dealings with disease: either help or do not harm the patient".(2) The exact phrase is believed to have originated with the 19th-century.(2)Another evidence is Nonmaleficence. It is one of the four basic ethical principles that apply to medical activities. The principle of nonmaleficence entails that that there is an obligation to health service provider not to inflict harm on patient and others. It is closely associated with the maxim *primum non nocere* (first do no harm).(27)

Since second half of 20^{th} century The Agency for Healthcare Research and Quality (AHRQ) is pioneer institution for Patient Safety concept for the first time and along with AHRQ, JCAHO, JCI, ISQua and WHO are the leader organizations working for Patient Safety. (28)

Current Scenario:

15% of total hospital activity and expenditure is seen as a direct result of adverse events in the Organization for Economic Co-operation and Development [OECD] countries, (5). In case of high-income countries, it is observed that tentatively one in every 10 patients is harmed while receiving hospital care (5). The harm caused in these cases is by a range of errors and adverse

events, out of which about half of them can be very well prevented (6). The occurrence of adverse events due to unsafe care is likely one of the top leading causes of death and disability in the world (4). Around 134 million adverse events occur in hospitals in low- and middle- income countries (LMICs), due to unsafe care, resulting in 2.6 million deaths every year (7). The study on errors and adverse events has given the estimated rate of around two-thirds of all adverse events resulting from unsafe care, and the years lost to disability and death (known as disability adjusted life years, or DALYs) occur in LMICs (8). Globally, as many as 4 to 5 out of 10 patients are harmed while receiving the health care services in primary and outpatient health care. Up to 80% of harm is preventable. The most detrimental errors are related to diagnosis, prescription and the use of medicines (9).

What Patient Safety Includes ?

Patient Safety broadly aims at absence of preventable harm and the reduction of unnecessary harm to a patient in the process of healthcare. Here the preventable and potential harm includes-

Physical harm through Patient falls, or harm due to infrastructural causes ,faulty equipments pes catheters or tubings etc , wrongly done medical or therapeutic interventions like burn due to cautery , Harm due to unnecessary or extra exposure to radiation ,etc

The next category of preventable harm is harm due to errors in errors are related to physician judgment, diagnosis, prescription and the use of medicines.

Third category is harm during preparation, processing, and administration of medicines

The fourth and important category is lac of execution of stringent Infection Control policy, SOPs and practices at all required areas of direct and indirect patient care areas including right from wards, ICUs OT, Patho Labs, diagnostics, blood storage unit to Pantry, Pharmacy, Kitchen and Laundry etc

The fifth category is due to lac documented policies and SOPs for all direct and indirect patient care procedures and records management

The sixth category of potential patient harm due to lack of proper records management

The seventh category of potential patient harm due to lack of proper system and records management for storage handling and management of high risk medications; blood ,blood products and body fluids; Look alike sound alike medicines

The next very important category is harm due to lack of effective communication – This is because of various reasons in single or in combination of causes like communication errors, communication gaps, barriers in communication, lac of effective communication, lack of clarity in communications, telephonic orders, illegible handwriting, short cuts and short forms used in communication etc

Last and important category is lac of correct identification – Lack of identification of Right patient, right medicine or surgical procedure/ intervention, right side and site, right dose, right route of administration, right frequency etc

Taking care of all these above-mentioned areas of potential but preventable harm and over and above all these proper documentation and records keeping is vital and essential for effective implementation of Patient Safety.

Why Patient Safety?

The aim of Patient Safety is an appropriate application of medical knowledge with due regard to the balance between the hazard inherent in every medical intervention and the benefits expected from it (10)

Millions of patients are injured or die because of unsafe and poor-quality health care every year. Many of the medical practices and other processes associated with health care have in built risks. They contribute significantly to the burden of harm due to unsafe

care are emerging as major challenges for patient safety. This associated risk and potential harm has become a major concern and need to be monitored and addressed continually. This is focus or scope of Patient safety. It includes a variety of reasons and range of types from risk associated with diagnosis, prescription, medication use, drug administration, diagnostic and therapeutic procedures, surgeries which are proven to be the most detrimental to risk associated with preventive care, Hospital Acquired Infection. Sepsis, inadequate monitoring and follow up, equipment failure, to errors of communication, poor coordination, patient transporting and other systems failure etc.

We have seen various categories of areas of potential and preventable harms. They can be divided into categories like - medical/clinical, Non-Medical/non clinical, or Human error, Technical error, Administrative error. According to the severity of potential harm the errors

are categorised as No harm, Close call /near miss, hazardous or unsafe condition, adverse event sentinel event and never event

An Adverse Event is a serious, undesirable and usually unanticipated patient safety event that resulted in harm to the patient but does not rise to the level of being sentinel.(25) A No Harm event is an error that reaches the patient but does not cause harm.(25) A Close Call or Near Miss is an error that had no impact on a patient but could have had an impact if it was not aborted, discovered or if intervention occurred prior to it reaching the patient.(25) A Hazardous or Unsafe Condition is a circumstance (other than the patient's own disease process, or condition) that escalates the chances of occurrence of an Adverse or Sentinel Event.(25) A Never Event: These are the adverse events that are unambiguous (clearly identifiable and measurable), serious (resulting in death or significant disability, and largely preventable) .(25)

Around one in 20 patients are exposed to preventable harm in medical care.(24)The studies shows that diagnostic, therapeutic prescriptive ,surgical care and medication errors are most dangerous and become a leading cause of injury and avoidable harm in health care systems *(13).*

The studies showed that the errors in surgical care procedures cause complications in up to 25% of patients. Around 7.4 million surgical patients suffer significant complications

every year, and around 1.1 million of whom die during or immediately following surgery *(18).* Sepsis is another error which may prove to be fatal as frequently not diagnosed early enough to save a patient's life. Also, these infections are often resistant to antibiotics, they can rapidly lead to deteriorating clinical conditions. The data shows about 31 million people affecting worldwide and causing over 5 million deaths per year due to sepsis *(18).* The recent studies indicate that the diagnostic or judgemental errors are found in around 5% of adults in clinics and OPDs, and more than half of which have the potential to cause severe harm. *(16).*Hospital acquired and Health care-associated infections are found in 7 to 10 per cent of hospitalized patients *(14).*Unsafe injections practices in clinics, hospitals and other health care organizations has potential hazard of transmitting infections, including HIV and hepatitis B and C, and pose direct danger to patients and health care workers; they account for a burden of harm estimated at 9.2 million years of life lost to disability and death worldwide (known as Disability Adjusted Life Years (DALYs)) *(8).*The studies on adverse transfusion reactions show that the unsafe transfusion practices expose patients to the risk of adverse transfusion reactions and the transmission of infections *(17).* Data on adverse transfusion reactions from a

group of 21 countries show an average incidence of 8.7 serious reactions per 100 000 distributed blood components *(18).* Radiation errors include overexposure to radiation and cases of wrong-patient and wrong-site identification *(19).* A review of 30 years of published data on safety in radiotherapy estimates that the overall incidence of errors is around 15 per 10 000 treatment courses *(20).*Venous thromboembolism (blood clots) is one of the most common and preventable causes of patient harm, contributing to one third of the complications attributed to hospitalization.[3] Annually, there are an estimated 3.9 million cases in high-income countries and 6 million cases in low- and middle-income countries *(22).*

How Why Patient Harm occurs and How Patient Safety helps?

The healthcare delivery system today takes into account the growing complexity in health care organizations that make humans more prone to mistakes.(3)

Avoiding Physical harm through Patient falls, or harm due to infrastructural causes like slippery floor or broken railings, HVAC settings ,faulty equipments- general or

therapeutic like trolly wheel chair or cauteries, scopes catheters or tubings etc , wrongly done medical or therapeutic interventions like burn due to cautery , Harm due to unnecessary or extra exposure to radiation ,etc Here having in built good quality infrastructure and proper upkeeping and maintenance , training of staff for handling and upkeeping, help to prevent such harms .

Errors of Judgement and diagnostic errors- Here the gaps or mistakes and errors in history taking and physical examination , preconceived notions of physicians, shadowing errors in advising diagnostics tests, errors in diagnostics at equipment , reagents and processing level even in rightly advised tests which again includes technical, skill based, and human factor which leads to errors in diagnosis and in turn the whole further treatment goes in a different and many times wrong way. Also lac of attention, physical or mental well being of physician, stress and burnouts or even lac of required skills are contributing factors here. This error also goes away long in the prescription errors. Well documented and implemented Patient safety policies put the multiple requisite check points at different steps and helps avoid the potential patient harm. Corelation of Patient history and physical examination and reding the the either or both in case of contradiction or differing opinions, Computer Operateted Physician Prescription which poses queries in case of such dichotomies, or second opinion in HIS, verbal discussion and verification with diagnostics department, SOPs for certain specific groups of

symptoms, continued medical education and training, and even curtailing the extra workloads

, some relaxing and refreshing breaks and activities, short vacations and holidays for physicians etc are few examples of such patient safety checks.

Prescription and Medication Errors- A patient in hospital might receive a wrong medication because of a mix-up that occurs due to wrong medicine because of similar name, similar packaging , illegible prescription writing, errors in telephonic orders, or wrong patient ,similar patient names or due to wrong dose, wrong or improper method of preparation or wrong route of administration or wrong method of administration or errors in documentation . In these cases, the prescriptions pass through different levels of care starting with the doctor in the ward, then to the pharmacy for dispensing and finally to the nurse who administers the medication to the patient and completes the recording of the

same in-patient medical records. Had there been safe guarding processes in place at the different levels, these errors could have been quickly identified and corrected. In these situation, a lack of skilled staff or lack of standard procedures for storage of medications that look alike ,prescription writing, patient identification, drug preparation and labelling, drug administration ,medical record keeping , poor communication between the different providers, lack of verification before medication administration and lack of involvement of patients in their own care might all be underlying factors contributing or leading to the occurrence of errors and its further effects. The incidences of swab or small instrument left in patients belly during surgery, surgical site infection, patient fall, burn due to cautery or power cut off or electrocution in ICU due to overloads, baby changed abducted are other few examples. The again lack of documented and implemented guidelines or lack of skilled staff or scarcity of resources are the probable reasons for gap in Patient safety. The availability of skilled staff, documented and implemented policies, procedures and SOPs, checklists, skilled and sufficient number of staff or availability of optimum resources are the remedies suggested by Patient Safety or rather prerequisites to better patient outcome. Also periodic medical/nursing/clinical/technical education and training, for Residential Medical Officers, nurses and even curtailing the extra workloads , some relaxing and refreshing breaks and activities, short vacations and holidays for physicians etc can boost the effective implementation of Patient Safety .

Good quality infrastructure, equipment and materials, and proper upkeeping, servicing, maintenance of infrastructure and equipment, positive identification and verification of patient and his therapeutic plan, improving effective communication among health care providers;

policies and procedures for the same along with the skilled and experienced staff, and continued staff education, staff welfare policies, is another guiding Patient Safety principle.

To err is human, and expecting perfect and flawless performance from human beings working in complex, high-stress environments like hospitals and health care settings is unrealistic. Managing medical errors is more complex and hence difficult. It has been based on the “personal approach”, the individual involved in the care at the time of incident are held responsible, which is referred to as blaming. Systematic improvements cannot be made as

long as we focus on blaming individuals. Also, Humans are prevented from making mistakes when they are placed in an error-proof environment where the systems, structure, processes, SOPs and tasks they work in are well designed. *(14)* Presuming that individual perfection is possible will not improve safety. The hospitals and healthcare organization have to nurture the blame free Patient Safety fostering culture. Patient Safety culture is a culture where a high level of importance is placed on safety beliefs, values and attitudes and shared by most people within the workplace *(*15*)*.

One more tool for prevention of errors is engaging patients in their own plan of care. If done well, it can reduce the burden of harm by up to 15% (9).

At hospital or any health care organization Patient Safety consists of four domains, i.e. (i) health care providers, (ii) health care infrastructure (iii) reporting and feedback on performance and (iv) recipients of health care. If these areas are well taken care of, the health service providers can expect to have a wide scope for Patient safety, good quality services, cost effectiveness and better patient outcomes. Investments in Patient Safety contributes to reducing patient harm which can lead to significant financial savings, and more importantly better patient outcomes

Organizational Culture for Patient Safety

All the above specified interventions they support and establish effective implementation of patient safety. However, one should definitely make a point that to cover all these Patient safety initiatives an umbrella of Organizational culture which is favourable for nurturing patient safety is must. Building and nurturing an organizational culture for patient safety at the root of all these activities.

It is evident that with increased knowledge and technology the healthcare become more complex as well as complicated and poses significant risks to patients. Also this is been

> accepted that system failures contribute to a larger extent to patient safety incidents than the human factors, the authorities and managers of health care organizations they still often blame their employees and individuals for the

incidents and sentinel events or bad things happened. This results in fear in the mind of the blamed employee as well as other co- workers and which leads to breeding a culture of fear and mistrust among the scared health care staff. Such health care professionals and workers are deliberately not likely or very less likely to report incidents and near misses when they occur and health care organizations are unable to learn from mistakes. We also need to throw some light on the routes of this scenario. The health care organizations have to have develop an organizational culture of trust, support and fairness. They must encourage the reporting of incidents, objective screening of it, systematic analysis for finding the route cause, prompt planning and implementing curative actions and preventive actions (30,31,33,35)

Benefits of Patient Safety

The effective implementation Patient Safety practices in hospital settings and health care organizations intensively improve the quality delivery of patient services and the quality of patient care. But Patient Safety initiatives can also provide important business advantages for healthcare institutions, including the following benefits (11)

- Improved quality of health services & patient outcomes — Effective implementation of Patient Safety practices intensify the value for patients by providing safe and better healthcare services that more effectively treat medical conditions and reduce rates of errors re-do's , increased length of stay for the same ailments due to the errors and mistakes ,in turn elongated recovery . Such results also prevent unnecessary readmissions and the associated added costs or reduced reimbursement rates.
- • Increased patient satisfaction — The provision of safe and good quality health care services lead to better patient outcomes, better recovery of patients, reduced length of stay and early return to normal or expected daily routine of the patients as well as care takers. This also prevents extra cost of patient care and patient sufferings. This directly turns into increase in the levels of patient satisfaction with safe and better healthcare services.

- Increased patient database — Patients are becoming more knowledgeable consumers of healthcare services. Satisfied patients are more likely to remain with healthcare providers for their future health services needs as they provided good quality services with better or expected patient outcomes in a timely manner. Hence, they are less likely to change healthcare providers. Also satisfied patients act as catalysts or referees for more new patients from their family, friends, relatives and acquaintances
- Reduced operating costs — Patient Safety implementation initiatives typically result in greater operating efficiencies due to improved skill sets and safety practices and reduced errors and re do's and it also to leads effective utilization of resources that in turn contributes reduced operating costs.
- Stronger financial performance — By increasing productivity, good quality health services, better patient outcomes and reducing costs, healthcare institutions can achieve increased patient base and stronger financial results, thereby building a more solid financial base and providing financial resources for further investment.
- Reduced employee stress and burnouts- With implementation of patient safety initiatives, a better system in terms of good quality infrastructure, materials, equipment and instruments, skilled and experiences staffs and well documented and implemented policies, processes and standard operating procedures are in place for all the patient care activities. Also periodic refreshing and upgrading of skills and knowledge is done by trainings, Records management and maintenance is done properly. Check points are kept in risk prone areas which are more prone to potential patient harm, like positive patient identification, records management, surgical safety checklists etc. These initiatives definitely reduce the employee work related stress and burnout and in turn improved physical and mental wellbeing of the health care providers.
- Greater employee motivation and engagement — Patient Safety implementation initiatives depend on empowering employees to increase patient value. Empowered employees are motivated and more engaged, and are likely to exhibit higher levels of job skills and performances. In healthcare the patients prefer the same staff for providing said services against the newer ones. Also motivated employees can be deployed to perform more value-added functions and facilities can be redesigned to offer new or expanded services.
- Organizational Development of the healthcare organization - The better systems and processes, better and improved outcomes, better organizational performance, reduced cost, better financial performance and profitability, satisfied, engaged and motivated

staff, better reputation and branding can be summarized in one term as organizational development. Patient safety initiatives catalyses the Organizational Development of the healthcare organization.

- Better image and Branding – Image of healthcare organization is definitely built and raised in the minds of satisfied patient due to good quality healthcare services and better patient outcomes with reasonable time and cost. This contributes to marketing as well as branding of the healthcare organization without allocation of cost or expenditure

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