Xournals

Academic Journal of Nursing and Midwifery Studies

ISSN UA | Volume 01 | Issue 01 | June-2018

Role of Nurse in Patient Safety

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Available online at: www.xournals.com

Received 2nd January 2018 | Revised 12th March 2018 | Accepted 6th May 2018

Abstract:

In current scenario, a portion of hospitalized patients die during or after hospitalization which is ultimately increasing the demands to participate in quality improvement activities and role of nurses in these efforts. In year 2004, the Institute of Medicine (IOM) reported in Keeping Patients Safe: Transforming the Work Environment of Nurses that nurses play a very significant role in patient safety, therefore, nurses are always considered at the "sharp end" of error. Therefore, patient safety is one of the essential and significant component of nursing care and calls for global solutions. Improving the patient safety has been therefore primary concern for health services globally as today's its one most challenging issue. Here in this paper an effort has been put to understand the role of nurse in patient safety. This paper has reviewed about the different researchers work and tried to put highlights on what nurses have already incorporated to enhance the safe care and positive outcomes from patients.

Keywords: *Patient Safety, Role of Nurses*

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Introduction

World Health Organization defined patient safety as: *"the reduction of risk of unnecessary harm associated with healthcare to an acceptable minimum. An acceptable minimum refers to the collective notions of given current knowledge, resources available and the context in which care was delivered weighed against the risk of non-treatment or other treatment"* (https://www.sidiief.org). The Institute of Medicine defined patient safety as *"the prevention of harm to patients"* and this definition has been emerged from the health care quality movement. The AHRQ Patient Safety Network Web site elaborated the prevention of harm as the "freedom from accidental or preventable injuries produced by medical care." Further, the National Quality Forum defined patient safety in its report *Standardizing a Patient Safety Taxonomy* as impact and severity of a process of care failure: "temporary or permanent impairment of physical or psychological body functions or structure" but this classification refers to negative outcomes of lack of patient safety; it is not a positive classification. Origins of the patient safety problem are classified into type (error), communication, patient management, and clinical performance. Further this type of errors and harm are classified into latent failure, active failure, organizational system failure, technical failure (https://www.ncbi.nlm.nih.gov).

Council of European Union and World Health Organization in 2009 and 2010 respectively has broadly abstracted the prevention of unnecessary patient harm or potential harm and further defined patient safety as the pursuit of the reduction and mitigation of unsafe acts within the healthcare system (Vaismoradi, *et al.* 2011).

In current health care environment, determining the factors related with the provision of patient safety is critical. Majority of medical errors can be reduced if an efforts has been put to determine the factors related to patient safety (Al-Awa, *et al.*, 2011). In today's healthcare environment patient care is most challenging inspite of numerous alertness and healthcare provided, therefore patient safety is one of the important component of healthcare quality. It always requires feedback with the intention of its implementation for better improvement on the identification of specific problem. Patient safety culture must be analyzed at different levels of healthcare system, in which it examines how the perceptions, behaviors, and capabilities of an individuals and groups determine an organization's promise, style, and ability in health and safety management. It is also used by organizations in determining the targets for interferences to improve patient's safety (Al-Doweri, *et al.* 2015).

Hofoss in 2008 come up with an ideas for patient safety improvement, in that he said that one can investigate on basis of particular cases of adverse events, the design of healthcare delivery systems, or the culture of the care-giving institutions. After the study, it was concluded that the chronological study suggests a developmental trend and the three approaches discussed should not be necessarily taken as a steps up the ladder of evolution as each approach does have its merits.

In January 2003, the Patient Safety Council of Malaysia was established to ensure that the "rakyat" receive safe health care. Dr. Lucian Leape wrote in Journal of the American Medical Association issue that, *"The transforming insight for medicine from human factors research is that errors are rarely due to person failing, inadequacies and carelessness. Rather, they result from defects in the design and conditions of medical work that lead careful, competent, caring physicians and nurses to make mistakes that are often no different from the simple mistakes people make every day, but which have devastating consequences for patients. Errors result from faculty systems and not from faulty people. So, it is the system that must be fixed. Errors are excusable; ignoring them is not"* (http://patientsafety.moh.gov.my)

According to the American Nurse Today, advocacy is very important as patient safety completely depend on nurse advocacy. The Institute of Medicine (IOM) reported in *To Err is Human: Building a Safer Health System* that every year 100,000 deaths attributable due to medical errors. Further in year 2004, the Institute of Medicine reported in *Keeping Patients Safe: Transforming the Work Environment of Nurses* that nurses play a very crucial role in patient safety. In hospitals nurses are at the "sharp end" of errors because of their closeness and continuity with patients. They only have the opportunity to prevent any kind of error happens (https://www.americannursetoday.com).

The Institute of Medicine in *The Future of Nursing: Leading Change, Advancing Health* report released in October 2010 respond to the need to assess and transform the nursing profession with following four key messages:

- Nurses must complete their education and training.
- Nurses must attain higher levels of education and training through an improved education system.
- Nurses must work cooperatively with physicians and other healthcare specialists, in reforming healthcare in the United States.
- Workforce planning and policy making require better data collection and information (Schmidt, *et al.* 2013).

Nursing is basically a knowledge and practical-based profession. Nurses must be a critical thinker and must use their knowledge in care of the patient. Earlier, Florence Nightingale encouraged for safe care and proposed that nurses had to put the patient in safe condition. According to ANA, essential feature of nursing is the provision of a caring relationship that facilitates health and healing. Nurses are abide the laws, rules, and ethics of the profession and standards procedure of the issuing authority (Ballard, 2003).

Kieft, et al. in the article *"How Nurses and their Work Environment affect Patient Experiences of the Quality of Care: a Qualitative Study"* discussed perspective of nurses. In which following eight points are essentials elements in a work environment for delivery high quality nursing care:

- Adequate Staffing
- Autonomous Nursing Practice
- Clinically Competent Nurses
- Control over Nursing Practice
- Culture that Values Concern for Patients
- Nurse–Physician Relationships
- Support of Nurse Manager
- Support for Nursing Education

Table 1: According to Nurses following are the factors influencing patient safety

Category	**Description of the category**
Patient Factors	Relate to patients' influence on patient
Individual Staff Factors	It basically refers to different personal characteristics of the nurses and other health care providers.
Team Factors	It refers to different aspects of the interaction between nurses and other health care providers.
Task and Technology Factors	Concern mainly workplace technologies and the processes involved in storing and sharing of information.
Work Environment Factors	Related to workplace conditions
Organizational And Management Factors	Concern to the conditions of the health care organization.
Institutional Context Factors	Refer to the conditions of the outer context of the health care organization.

(Source: Ridelberg, *et al.*, 2014)

Since early 1990, United States have been continuously trying to understand and improve the patients safety in health care instead of this also harm from healthcare remains high to around 400,000 deaths and over $1 trillion in costs annually. It was found that the errors in healthcare are mainly due to the defective systems, processes, and conditions that ultimately lead individuals to make mistakes or fail to prevent them. For improving the safety in healthcare a proper framework require which includes governance, teamwork and communication, effective error-prevention strategies embedded, and patient/family engagement in care, etc. Yet, we don't had any effective strategies to address the patient safety (Federico and Billett, 2017).

Patient satisfaction with nursing care has become an outcome indicator of quality and efficiency of the health care system. Many studies have been conducted regarding patient satisfaction in different countries concluding that nursing services have not fully satisfied the patient needs for example, a study in university hospitals in Iran showed that only 39.7% were satisfied with nursing services. Effective and continuous interaction and communication are different factors related to patient satisfaction Negarandeh, *et al.* 2014).

International Agencies

Different international agencies working to improve the patient safety level are as follows:

- **World Health Organization**

Patient safety is the primary and global priority of the world health organization. World Health Organization estimated that one in ten patients is effected by

preventable errors that ultimately effect the health of an individual. Supporters of WHO had effectively working in controlling the cost of non-quality and at the same time also enhancing the capabilities of professional to fulfill the healthcare needs. World Health Organization in collaboration with other countries governments took the initiative to ensure the access to high-quality, safe, efficient healthcare services. World Health Organization in 2004 launched the Patient Safety Programme also.

- **World Alliance for Patient Safety**

It recommended the system-wide interferences and changes in organizational culture juts to enhance and improve the patient safety. Different research and action priorities were published in 2008 by the World Alliance for Patient Safety for developed and developing countries to mitigate all risk related with unsafe care.

- **Organization for Economic Co-operation and Development**

Unwarranted intervention, failure to administer appropriate care and medical error are the three types of problem encountered by the Organization for Economic Co-operation and Development.

- **International Council of Nurses**

It mainly focusses on the shortage of qualified nursing staff due to which quality of care and patient safety is at risk therefore, International Council of Nurses focus on the initial training that fulfill the requirements of nursing practice as well as the education programs. International Classification for Nursing Practice Programme was launched by International Council of Nurses for developing a classification that could be used by experts to describe nursing practice globally.

- **West African Health Organization**

West African Health Organization recommended to improve the quality of health care systems and focused on the improved education system for health professionals.

- **Alliance francophone pour la qualité et la sécurité des soins**

Alliance francophone pour la qualité et la sécurité des soins main objective is to indorse culture and health improvement initiatives to French-language health care institutions and health care professionals (https://www.sidiief.org).

Review of Literature

Alfredsdottir and Bjornsdottir (2007) studied about the role of nurses in operating room. For the study, a semi structured interviews were conducted in 2004 with 8 nurses, further followed by two groups in 2005. In the study, the author concluded that securing patient safety and preventing mistakes were main elements in operating room. During interviews, the nurses found that the ongoing methods of prevention and protection that characterizes operating room nursing as crucial in enhancing safety. Conclusively they said that nurses need interference to enhance patient safety in operating room.

Vaismoradi, *et al.* (2011) studied about the 'Iranian nursing students' viewpoints regarding patient safety and to provide patient safety how efficiently nursing education play its role in development. For the study, 17 junior and senior nursing students were selected for qualitative and semi-structured interviews. Conclusively, the author found that 'safety as patient comfort', 'not being knowledgeable or experienced enough' and 'being helped to internalise the principles and values of patient safety' were three main themes. Nursing education must focuses on practical education in comparison to theoretical concepts of patient safety.

Wilson, *et al.* (2012) studied about the differences in perceptions of patient safety culture between charge and non-charge nurses and found that the non-charges nurses are more positive about patient safety in comparison to charge nurses.

Magalhães, et al. (2013) analyzed the potential association between nursing workload and patient safety in the medical and surgical inpatient units of a teaching hospital and found that the increase in the number of patients to each nursing team will ultimately results in increased rates mismanagement related to patient safety.

Blignaut, *et al.* (2013) studied about the vision of professional nurses about the patient safety and level of care in South Africa and connection between these vison and nurses professional qualification. For study purpose, 1117 professional nurses from medical and surgical units of 55 private and 7 public hospitals were selected. The author identified the problem related to nurse-perceived safety and level of care but failed to report adverse incidents in patients and professional nurses and concluded that qualification of nurses had no relation with perceptions of patient safety and level of care.

Kirwan, *et al.* (2013) explored the connection between the ward surroundings where nurses practice and patient safety outcomes on the basis of ward level variables and nurse level variables. The study was carried out within a European FP7 project: Nurse Forecasting: Human Resources Planning in Nursing (RN4CAST) project. For study purpose 108 general medical and surgical wards in 30 hospitals throughout Ireland were selected and the survey was carried out using a questionnaire. The survey results that positive practice environment improves patient safety outcomes therefore, nurse education level and the work environment must be recognized and improved.

Negarandeh, *et al.* (2014) studied about the impact of regular nursing rounds on patient satisfaction with nursing care. For the study, the authors selected 100 hospital patients in medical surgical ward and found that the regular nursing rounds had a positive impact on patient satisfaction. Therefore, it can be concluded that the regular nursing round can improve the patient-nurse connections and also indorse the quality of nursing care and patient satisfaction.

Kieft, *et al.* (2014) done a qualitative study to understand what factors of nurses and their work environment affect patient experiences of the quality of care, focusing mainly on the views of Dutch nurses. For study purpose, four focus groups were selected, one each with 6 or 7 registered nurses. In their study they observed that clinically competent nurses, autonomous nursing practice, adequate staffing, control over nursing practice, etc. are the basic elements that should be incorporated in daily nursing practice which would definitely result in positive response at patient ends.

Jarrar, *et al.* (2015) aims to forecast the impact of patient to nurse ratio on level of care and patient safety in Malaysian private hospitals. For study, the author collected data from questionnaire from 652 nurses and found that nurses with higher ratio of patients have greater negative association on quality of care and patient safety. Nurses delivering care for 11-15 patients and nurses delivering care for more than 15 patients comparatively had significant negative impact on both quality of care and patient safety.

Choi (2015) examines about the role of nurses in patient advocacy and its associated goals. In this article the author put the highlights on how nurses practice patient advocacy in healthcare settings and even how they develop this role further through prescribed education, workplace learning, and promoting an organizational culture in favour of patient advocacy.

Kowalski and Anthony (2017) conducted a content analysis of AJN articles to explore the nurse's role in promoting patient safety. After going through the different articles published AJN, the author concluded that patient safety must be given more importance as getting more complex day by day. Infection prevention, medication safety, and response to new technology were the three major themes related to patient safety repeated throughout the 115 years. In 1999, the IOM put a highlight on patient safety and marked it as serious problem. Efforts made by nurses in promoting patient safety inspire the nurses to take required action that improves safety in today scenario.

Sonğur, *et al.* (2017) identified the effects of nurses' patient safety perceptions and their evidence-based nursing attitudes in the hospital on the patient safety level and worker performance. For the study, nurses working in a state hospital in Burdur, Turkey were selected and found that the evidence-based practice and service quality must be enhanced to achieve positive outcomes from patients.

Conclusion

After studying the different opinions of different researches, it can be concluded that to achieve positive outcomes from safety, nurses play a very significant role. This article has reviewed what nurses have already incorporated to enhance the safe care and also suggested few additional activities for future. For improving the patient safety, different initiative must be taken in the form of short training or courses so that people dealing with patient can improve their interaction and communication level.

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