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Safety culture 2018

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Safety in healthcare has received substantial attention worldwide. Rapid change in healthcare has mandated greater attention to safety, which is essential for quality patient care, employee welfare and morale. Safety is a condition or state of being resulting from the modification of human behavior and/or designing of the physical environment to reduce hazards, thereby reducing the chance of accidents. The biggest challenge to moving toward a safer health system is changing the culture from one of blaming individuals for errors to one in which errors are treated not as personal failures, but as opportunities to improve the system and prevent harm. Promoting a culture of safety has become a pillar of the patient safety movement. Patient safety is the avoidance and prevention of patient injuries or adverse events resulting from the processes of health care delivery. Patient safety also means prevention of harms to patients. Organizations with a positive safety culture are characterized by communications founded on mutual trust, by shared perceptions of the importance of safety and by confidence in the efficacy of preventive measures. Two important concepts affect the culture of safety: Error reporting and disclosure of errors. The acceptance of and means by which errors are identified, reported and communicated to those involved or affected, have much to do with how well safety is ingrained in the healthcare organization's culture. Most patient injuries are due to system failure. Most medical errors result not from the errors of individuals, but from numerous latent errors that exist within complicated systems of care delivery. This approach to medical error is well supported and consistent with historical efforts in healthcare quality improvement. The goal to develop a positive culture of safety has tremendous potential to benefit patients.

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