EDITORIAL

Prioritizing Safety and Quality: The Cornerstones of Effective Healthcare

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Patient safety is the foundation of high-quality healthcare. It is largely understood now that safety is more than the absence of harm, and thus, creating safer healthcare services is a high priority across the globe. [1] Although there are undoubtedly long-standing historical roots to healthcare quality and safety, the last few decades have seen significant advancements in safe and quality oriented research, practice, and legislation. [2]

Defining Safety in Healthcare : Beyond error avoidance

The Institute of Medicine defines quality of care as the "degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge". Quality improvement is the framework used to systematically improve care through the standardization of processes to reduce variation, achieve predictable results, and improve outcomes for patients and health care organizations.

The Focus on Safety in healthcare goes beyond merely avoiding errors; it embodies a culture of transparency, justice, vigilance, and continuous improvement in all its aspects. The report titled "To Err is Human: Building a Safer Health System", by the Institute of Medicine also highlighted the fact that its not the bad people but the bad systems of care which largely were responsible for the devastating medical errors. [2]

Quality in healthcare has to be value driven and patient centred as value is dependent on the outcome which is the sole criterion for measuring healthcare.[3] Thus, the concept of Quality in healthcare is multifaceted, which is not just about the delivery of advanced treatments but focusing that the healthcare services are safe, patient-centered, timely available, efficient, equitable, and evidence-based. [2-4]

Therefore quality improvement in any healthcare institution should involve assessing process and outcome measures of safety, to see that how effective is the system, whether the care is patient-centred or not and to ensure that the care is provided timely, efficiently and equitably. The highest quality of care involves the System-based practice, practice-based learning, evidence-based medicine, evidence-based practice, quality assurance, and a rigorous process for performance improvement. [3]

Safety and quality are closely related concepts. Better healthcare systems are by their very nature safer, and safer systems produce better health outcomes. Healthcare policy, institutional governance, and daily clinical practice should prioritise this synergy.

Modern Approaches to Quality Improvement

Research on achieving the best possible healthcare outcomes for individuals and population of research to achieve optimal healthcare outcomes is known by many similar names as the improvement science(IS), dissemination and implementation research, and knowledge transfer or knowledge translation (KT) [5]

Historically, efforts to improve patient safety and quality

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Published Online First: 10 Oct 2024

Open Access at: https://journal.jkscience.org

Cite this article as: Gupta S, Kotwal U. Prioritizing Safety and Quality: The Cornerstones of Effective Healthcare. JK Science 2024;26(4):201-2

have concentrated on improvement science, which emphasises measurement, feedback to decision-makers, and organisational change. These efforts aim to address specific clinical problems or quality gaps, such as error detection and management, improving a particular aspect of care quality, etc.; however, they may not be widely disseminated or adhere to the Standards for Quality Improvement Reporting Excellence (SQUIRE) guidelines.[6]

However, Implementation Science focusses more broadly, encouraging the integration of evidence-based practices into standard healthcare delivery procedures through the methodical application of research findings, enhancing the effectiveness, safety, and quality of healthcare environments.[7]

Another important aspect of the quality and safety in healthcare is the Knowledge translation which in itself is the key component of Implementation science. As delivery of safe and quality healthcare is a multiple stakeholder process with involvement of many people like administrators, policy makers, healthcare workers and the patients, thus generation of Knowledge to build awareness and its dissemination so as to strategically change the practitioner behaviour plays an important role.[8]

Current Challenges and focus areas

Recent studies have shown that medical errors remain a leading cause of preventable deaths worldwide. Negative outcomes of care, such as mortality and morbidity, have dominated most of the work defining patient safety and harm prevention approaches.[3] Shift of the current focus of healthcare on quality and safety has improved the organization and delivery of patient care .[2] The focus has shifted away from individual error to highlight the common latent factors faced by all the healthcare stakeholders thus affecting the overall delivery of safe and quality services. It is imperative to put strong safety procedures into place, promote an environment of non-punitive reporting, and encourage open dialogue regarding mistakes and near-misses. Errors should be seen as chances for systemic learning and progress rather than as something to be blamed for, according to healthcare organisations.

Implementing Safety And Quality Measures

It is important to ensure that efforts and measures like putting in place strict safety and quality procedures, promoting open communication about mistakes and near-misses, and cultivating a culture of non-punitive reporting are in place. Healthcare institutions must move away from a blame-oriented approach and towards one that views errors as opportunities for system-wide learning and improvement.

Conclusion

The path to optimum healthcare quality and safety continues, despite the tremendous progress that has been made; new problems and persistent obstacles are always changing the healthcare landscape.

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