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REVIEW ARTICLE

Essential actions for patient safety

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ABSTRACT

Introduction: patient safety is a key axis of healthcare quality and represents a growing challenge for health systems, given the complexity of clinical processes and the economic and social impact of adverse events.
Objective: to identify the essential actions to strengthen patient safety in the hospital setting.
Methods: a systematic literature review was conducted between 2010 and 2024, following PRISMA guidelines. The search was carried out in biomedical and multidisciplinary databases (PubMed, SciELO, LILACS, ScienceDirect, BVSALUD, and Google Scholar), complemented with official documents and gray literature. Rigorous inclusion and exclusion criteria were applied, and 21 studies were selected for comparative qualitative analysis.
Development: the findings show that the main risks to patient safety include medication errors, surgical failures, healthcare-associated infections, diagnostic errors, patient falls, unsafe transfusion and identification practices, as well as risky injections. In response, eight essential actions were identified: accurate patient identification, effective communication, medication safety, procedural safety, infection reduction through hand hygiene, fall prevention, recording and analysis of adverse events, and promotion of an institutional safety culture.
Conclusions: the implementation of clear institutional policies, managerial leadership, continuous training, and reliable data recording systems is indispensable to reduce preventable harm. The adoption of essential actions fosters the construction of a sustainable safety culture, with a positive impact on healthcare quality and patient clinical outcomes.

Keywords: Intersectoral Collaboration; Patient Safety.

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INTRODUCTION

The global landscape of healthcare has been shifting in recent years, as health systems must operate under increasingly complex circumstances. While new treatment prototypes, technologies, and care approaches can offer extensive diagnostic and therapeutic possibilities, they can also pose new threats to patient safety.

It is estimated that around 1 in 10 patients is harmed while receiving healthcare, and each year, more than 3 million people die as a result. It is estimated that more than half of these harms are preventable, that 80 % of those originating in outpatient care are preventable, and that half are due to medications.[1,2]

Patient safety is defined as the absence of preventable harm to patients and the reduction to an acceptable minimum of the risk of causing them unnecessary harm during care. In the broader healthcare context, it consists of a set of organized activities that establish processes, value systems, procedures, behaviors, technologies, and care environments to consistently and sustainably reduce risks, prevent the occurrence of avoidable harm, reduce the likelihood of causing it, and lessen its effects when it occurs.[3]

Patient safety is a fundamental principle of healthcare and is now recognized as a broad and growing challenge to international public health. It is estimated that harm to patients reduces global economic growth by up to 0.7 percent each year.[1] Investments in harm reduction can lead to significant financial savings and, more importantly, improved patient outcomes.[4]

In Europe, a large percentage of countries have a Patient Safety Strategy and periodic evaluations of their results are carried out.[5] Some countries in the region such as Mexico have implemented actions since the 2000s in the different components of their health system.[6]

The experience gained by the authors in medical collaboration was the incentive for the creation of this article, with the objective of conducting a literature review on essential actions for patient safety, in such a way that they can contribute to preventing adverse events arising from medical care in hospitals in Cuba.

METHODS

A systematic literature review was conducted following the PRISMA guidelines, with the aim of identifying and synthesizing essential actions for patient safety in the hospital setting. The search period was defined as between January 2010 and December 2024, considering the most recent and relevant scientific output in the field.

Search strategy

A structured search algorithm using keywords and Boolean operators was designed and adapted to each database. The terms used included: "patient safety" AND "essential actions" OR "patient safety" AND "essential actions" OR "segurança do paciente" AND "ações essenciais". Synonyms and DeCS/MeSH descriptors related to quality of care, adverse events, and risk prevention were considered. Articles in Spanish, English, and Portuguese were included, without geographical restriction.

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Information sources and selection process
The search was conducted in broad-coverage biomedical and multidisciplinary databases: PubMed/MEDLINE, SciELO, ScienceDirect, LILACS, BVSALUD, and Google Scholar. In addition, official documents from international organizations such as the World Health Organization (WHO) and ministries of health from various countries were consulted. Grey literature (technical reports, clinical guidelines, and regulatory documents) was included to complement the evidence published in scientific journals.

Original studies, systematic reviews, clinical guidelines, and institutional reports published within the defined time frame that directly addressed patient safety in hospital settings were included. Duplicates, articles without full-text access, publications irrelevant to the review's objective, and those outside the search period were excluded.

The selection process was carried out in two phases: first, titles and abstracts were reviewed to discard irrelevant records; second, the full text of potentially eligible articles was analyzed. Initially, 1,245 records were identified; after removing duplicates and applying inclusion/exclusion criteria, 78 articles were selected for full-text review. Finally, 21 studies met the criteria and were included in the synthesis. The process was documented using the PRISMA flow diagram, which illustrates the stages of identification, selection, eligibility, and inclusion.

Data extraction and analysis
Key variables were collected from each article: author, year of publication, methodological design, population or sample, main results, and conclusions related to patient safety. The information was organized into extraction matrices, and a qualitative synthesis of the findings was performed, grouping essential actions into thematic categories. A meta-analysis was not conducted due to the heterogeneity of the designs and results, but a comparative narrative approach was applied, allowing for the identification of common patterns and recommendations applicable in different hospital settings.

DEVELOPMENT

Patient safety is a fundamental component of quality care; the literature review identified several causes that threaten this process, which are listed below.

Most common causes of harm to patients:
a) Medication errors. One in 30 patients suffers harm from the medications they take, and more than a quarter of these harms are serious or even fatal. Half of all preventable healthcare-associated harms are closely related to the medications they take.[7]

b) Errors associated with surgical interventions. 10 % of preventable harm to patients occurs in this context, before and after surgical interventions.[8]

c) Healthcare-associated infections (HAIs). These prolong hospital stays and are a major cause of antimicrobial resistance, preventable deaths, and costs for patients, families, and health systems.[8] According to statistical reports, 23,6 % of patients with sepsis treated in hospitals have a direct link to the healthcare itself, and 24,4 % of cases result in death.[9]

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d). Diagnostic errors. Diagnostic errors occur in between 5 and 20 % of interactions between doctors and patients.[10,11]

e). Patient falls. Although not as frequent in pediatrics, this event does occur and in more than a third of cases causes trauma that affects clinical outcomes and generates costs for health systems.[12]

f). Risky blood transfusion practices. Unnecessary blood transfusions and incorrect transfusion practices expose patients to serious adverse reactions and infections. Based on data on adverse transfusion reactions from a group of 62 countries, the average incidence of serious reactions was 8,7 per 100,000 units of blood or blood products transfused.[13]

g). Errors related to identification. Failure to correctly identify a patient can cause many problems and seriously affect the healthcare they receive. For example, performing surgery in the wrong location could have catastrophic consequences. 12,3 % of a series of 409 very serious events affecting patients in Europe were related to patient identification errors.[14]

h). Risky injection practices. Unsafe injection practices expose patients and health workers to the risk of adverse events of an infectious and other nature.[15]

Essential patient safety actions (EPSAs) have been identified that can be applied in both secondary care (hospitals) and primary health care settings. These are safety barriers that reduce the consequences of unsafe acts; ensure clean, error-free care; simplify processes; and improve communication among health professionals.[16,17]

The eight actions and their general objectives are:

I. Patient identification: The aim is to improve the accuracy of patient identification by using at least two pieces of personal identification data to prevent errors involving the wrong patient. It is suggested that this information be included in all documents generated during the care process in all settings, including inpatient wards and in the patient's medical record.

Patients should be identified by their full first and last names. In the case of newborns, until they have been legally registered, they should be identified by their mother's last name and date of birth, which is recorded on a card at the head of the hospital bed, as well as on the newborn's wristband.

II. Effective communication: Its objective is to promote communication between health professionals, patients, and family members, in order to obtain correct, accurate, and complete information during the care process and thus further reduce errors related to the issuance of verbal or telephone orders.

In emergency situations, it is essential to listen carefully to the other professionals involved in the patient's care. We recommend clearly repeating the information and confirming that it is received and understood, transcribing it into the patient's medical record. Another high-risk moment is during internal or external patient transfers and at each shift handover. For these situations, we suggest implementing the SAER technique, which includes: the situation, the patient's history, the assessment, and recommendations.

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It is suggested that a logbook (notebook or ledger) be implemented to record verbal and/or emergency instructions. This logbook should detail the exact conditions under which work was performed, and any errors should be recorded and noted. Similarly, it is suggested that all hospitals implement a logbook for recording results and/or critical values in clinical laboratory tests, imaging studies, and histopathological examinations.

III. Safety in the medication process: This is primarily aimed at strengthening actions related to the storage, prescription, transcription, dispensing, and administration of medications to prevent errors that could harm patients. From the production laboratories to their administration by nursing staff, high-risk medications (cytotoxic drugs, radiopharmaceuticals, insulins, anticoagulants, and concentrated electrolytes), as well as medications with similar appearance and names, must be clearly labeled and separated.

It is vital to perform and document double verification before the preparation and administration of at least high-risk medications and to corroborate the presence of allergies reported in the history or clinical record or expressed as a response from the companions of hospitalized patients.

IV. Safety in procedures: It represents a fundamental link, since it is nothing more than strictly complying with the safety practices already established and accepted internationally and reducing adverse events to avoid the presence of sentinel events derived from surgical practice and high-risk procedures outside the operating room.

A crucial aspect of critical care services is the procedural safety checklist, including the establishment of policies for marking procedures. A time format must be established for all invasive, critical, and/or high-risk procedures performed.

Each surgical unit must implement a surgical safety checklist considering its phases and timing: before induction of anesthesia, before the surgical incision, and before the patient leaves the recovery room in the operating room.

V. Reduction of the risk of healthcare-associated infections (HAIs): Its objective is to contribute to their reduction, through the implementation of a comprehensive hand hygiene program during the care process.

In each institution, the hospital Hygiene-Epidemiology department and its professionals must have a Comprehensive Hand Hygiene Program, which must include: the schedule for continuous training of all professionals, the timely management of supplies and equipment for hand hygiene in conjunction with the administrative and general services area, and ensuring the control of water quality.

We must teach handwashing from undergraduate studies, systematically and unexpectedly evaluate healthcare personnel, and visualize at each sink the steps and times of correct handwashing, considered a very effective measure in the prevention of healthcare-associated infections.

Preventing healthcare-associated infections (HAIs) is in the hands of professionals, who must wash their hands properly with soap and water, a procedure that should last 40 to 60 seconds, or disinfect with alcohol-based gel, a process that should last 20 to 30 seconds.

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Hand hygiene should be performed at five moments:[18]
1. before touching the patient.
2. before performing an aseptic procedure or technique.
3. after having been at risk of exposure to body fluids.
4. after touching the patient.
5. after contact with the patient's environment.

Handwashing has a technique that has been shown to be safe,[18] but is not always well known or known but not followed, and which we describe below:
- Rub the palms of your hands together.
- Rub the palm of your right hand against the back of your left hand, interlacing your fingers and vice versa.
- Rub the palms of your hands together with your fingers interlaced.
- Rub the back of your fingers with the palm of your other hand, holding your fingers together.
- Rub your left thumb in a rotating motion, trapping it with the palm of your right hand, and vice versa.
- Rub the fingertips of your right hand against the palm of your left hand in a rotating motion and vice versa.
- Rinse your hands with water, use a towel or disposable paper to touch it and then turn off the tap.
- Let your hands dry without shaking.

Each action described must be repeated five times and the hands will be safe only once they are dry.

We suggest implementing a continuous training schedule for all professionals with the aim of achieving their adherence and conscious compliance.

VI. Reduction of the risk of harm to the patient due to falls: Its objective is to prevent harm to the patient through proper continuous assessment and reduction of the risk of falls.

Risk factors for a patient to suffer falls in the hospital environment will be considered:[3]
a) Intrinsic factors: These are factors related to the patient and are determined by innate changes in their physiology. Examples include age, acute or chronic illnesses, and medication use.
b) Age: children under 6 years of age, due to multifactorial risks, may experience a fall.
c) Extrinsic factors: these correspond to factors determined by the environment or environmental factors, which can be architectural in the hospital unit such as so-called barriers; equipment or furniture; or related to care processes.

We suggest that each hospital service develop a tool to assess the risk of falls in patients, which includes the following aspects:
1. Physical limitations of the patient: children with musculoskeletal and neurological disorders; cerebrovascular disease, spinal cord injuries, head trauma, prolonged bed rest, previous history of falls, malnutrition, obesity, prolonged fasting, any physical disability that affects mobility, use of orthopedic devices, prostheses, orthoses and postoperative period.
2. Mental state of the patient: as may occur in children with disorientation, confusion, seizures, altered state of consciousness, spinal cord injuries, paralysis, proprioceptive deficit due to anesthesia or sedation, agitation, depression, suicidal risk, biochemical dysfunctions;

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hypoglycemia, hyponatremia, hyperkalemia, neuromuscular impairment; head trauma, sequelae of poliomyelitis or disability resulting from cerebral palsy.

3. Communication problems: These include anatomical hearing impairments, sensory perception disorders (visual and auditory), central nervous system disorders, effects of medications, physical barriers (orotracheal intubation), and psychological barriers (psychosis). If Cuban professionals are working in countries with indigenous or Afro-Cuban populations, they must consider the limitations in understanding dialects.

It is proposed that each health institution have assessment tools, using fall risk scales for all patients from the moment they request medical attention, at each change of shift or service, as well as informing patients and family members about the risk of falls and the safety measures that the unit takes to reduce the risk and documenting the evidence.

VII. Recording and analysis of sentinel events, adverse events and near misses: Its objective is to seek information on near misses, adverse events and sentinels, through a registration application that allows analysis and promotes decision-making so that their occurrence can be prevented at the local level.[19]

It is suggested that department heads and nursing supervisors, with guidance from members of the quality circles and the hospital committee, should establish a standardized adverse event reporting format. Quality circle meetings within each department and the hospital committee should foster a fair, non-punitive culture and implement a program to support secondary victims, including healthcare professionals.

VIII. Patient safety culture: Measuring patient safety knowledge is very important because it promotes behavioral change and allows for continuous improvement actions in the area of safety.[20] Professionals and other workers in the hospital institution must have a clear understanding of the following concepts or definitions:
An "incident" is defined as any type of mistake, error, accident or deviation, event, lack of consideration, regardless of whether the result harms the patient or not.[20]

An "adverse event" is harm suffered by a patient as a result of errors, incidents, accidents or deviations during medical care.[20]

"Patient safety" is care free from accidental injury, ensuring the establishment of operating systems and processes that minimize the probability of error and maximize the probability of its prevention.[20]

A "Patient Safety Culture" is the result of individual and group values, attitudes, perceptions, competencies, and behavioral patterns that determine an organization's commitment, style, and competence in managing health and safety. Organizations with a positive safety culture are characterized by communication based on mutual trust, a shared perception of the importance of safety, and confidence in the effectiveness of preventive measures.[20]

The Safety Culture should have the following dimensions:
The existence of teamwork within the service requires mutual support from the staff, respectful treatment, and above all, support among colleagues when someone is overloaded with work.

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It would be important to assess the involvement of supervisors and medical and nursing staff in addressing patient safety issues, as well as the expectations that senior managers have regarding staff participation in implementing safety procedures. Supervisors should consider suggestions from subordinate staff to improve their performance.

It is suggested that improvement work be carried out when any failure is detected during the care process, in order to prevent its recurrence and evaluate the effectiveness of the actions that were put in place to improve patient safety.

We believe that patient safety should be a priority for management, as well as fostering a positive work environment. Ideally, we would see the manager's concern and support following an adverse event.

An important dimension is the general perception of doctors and nurses regarding the safety of care processes, as well as the presence of problems of this nature.

It is important to maintain communication and feedback about errors being disclosed to staff, incidents that occur in a service, and the actions taken to prevent their occurrence.

Staff should have the freedom (openness in communication) to express negative aspects that may affect the care the patient receives, as well as the freedom to question the decisions or actions of their superiors.

Another important dimension is to keep a statistical record that allows the measurement of the frequency with which errors are reported that are believed not to harm the patient, those that are manifest and corrected before harming the patient, and those that are estimated to have harmed the patient.

Staff sufficiency and management are of high value, which would allow us to know if the staff is sufficient to handle working hours, especially during the excessive and exhausting night workloads.

The evaluation and handling of information by patients should be considered very important when they are transferred from one service to another, or during changes in work teams.

The response to errors should not be punitive. This dimension refers to the opinion of doctors and nurses regarding the attitude of their colleagues or superiors when they learn of an error, such as using it against them, seeking to assign blame, and creating fear among staff who make the mistake that it will be recorded in their personnel file.

We suggest applying a patient safety culture survey to all medical and nursing staff on an annual basis, the individual results of which should always be kept confidential.

CONCLUSIONS

In order to achieve sustainable and significant improvements in care, it is recommended to develop clear institutional policies, strengthen management leadership, implement data records that allow for the identification and assessment of risks, provide systematic training and evaluation of professionals, and actively involve patients and families in the care process.

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RVG: Conceptualization, Data curation, Formal analysis, Research, Methodology, Project management, Software, Supervision, Validation, Visualization, Original draft writing, Writing-revision and editing.
AGB: Conceptualization, Data curation, Formal analysis, Research, Methodology, Project management, Software, Supervision, Validation, Visualization, Original draft writing, Writing-revision and editing.
RAF: Conceptualization, Formal Analysis, Research, Original Draft Writing, Writing-Revision and Editing.
LLP: Data curation, Research, Methodology, Original draft writing, Writing-revision and editing.
YMP: Data curation, Research, Methodology, Original draft writing, Writing-revision and editing.

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