Journal of Positive Psychology & Wellbeing
2022, Vol. 6, No. 4, 212 – 216
http://journalppw.com
ISSN 2587-0130

An Overview Healthcare Management Roles with the Physicians, Nurses, Medical Laboratory and Pharmacist to Promote Patient Saftey and Care

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Abstract

Through interactions with healthcare administration in community settings, nurse-pharmacists, clinical laboratories, and physicians were able to enhance disease management, prevent adverse medication events, and minimize the number of patients who required hospitalization. In the end, they led to the early detection and rectification of medication safety-related difficulties, a reduction in wait times to see general practitioners, and an improvement in the ability of individuals living in the community to manage chronic diseases on their own. For the purpose of maintaining such cooperation, particularly in community settings, it is necessary to do research in order to enhance the existing policies and organizational structures. Through interaction with both the patient and the physician, the clinical pharmacist becomes an essential member of the healthcare team and contributes to the improvement of patient care.

Keywords*: nurse-pharmacists, disease management, Patient Saftey.*

Introduction

All around the world, there is a significant worry over patient safety. This is due to the fact that preventable adverse events, errors, and dangers linked with health care continue to be a significant obstacle [1]. According to the World Health Organization (WHO), the term "patient safety" refers to the prevention of errors and bad effects that are connected with receiving medical care [2]. It has been demonstrated via empirical research that the establishment of a patient safety culture inside a healthcare organization is one of the most important factors that contribute to the safety of patients [3]. A culture of patient safety can be defined

as the values, habits, and beliefs that are held inside healthcare organizations regarding the functioning of the organization, which ultimately results in behavioral norms that support safety. In essence, those who are considered to be experts in the subject of patient safety culture have reached a consensus on particular criteria that should be evaluated in healthcare facilities. Measurements are another name that is occasionally used to refer to these qualities [4]. In this study, we referred to these qualities as the dimensions of patient safety culture. These dimensions were adapted from the ten patient safety culture composite measures that were developed by the Agency for Healthcare Research and Quality (AHRQ). According to the findings of one study, the terms dimensions and composite measures can be effectively interchanged with one another. In this context, "communication about errors," "communication openness," "handoffs and information exchange," "hospital management support for patient safety," "organizational learning," "reporting patient safety events," "response to error," "staffing and work pace," "supervisor, manager, or clinical leader support for patient safety," and "teamwork" also fall under this category [5].

Additionally, there is a growing understanding of the significant role that hospital leaders or managers play in the process of instilling a culture of patient safety in healthcare organizations [6]. In this study, the managers (which consisted of departmental or unit heads) and refer to all of the middle and front-line level managers who took roles as unit or departmental heads or in an acting position in the selected hospitals of the three regions in Ghana. This is despite the fact that there is a thin line that separates leaders and managers. The participants' perspectives on the degree to which their hospitals adhere to the various components of patient safety culture were of relevance to this study. Because they are frontline supervisors and managers, their appraisal of the culture of patient safety provides insight into the context of relevant recommendations and acts as a vital step in outlining essential future initiatives targeted at enhancing quality and patient safety [6]. This is the reason why this is the case. As a result of the fact that the patient safety culture dimensions of the Agency for Healthcare Research and Quality evaluate both management and supervisor support for patient safety culture, the term "management support" was used in our research to refer to the support of the highest level, which includes the chief executive and directors of the hospitals. It was decided that these individuals would not be included in the study as participants. When we talked about supervisor support, we were referring to the assistance that was provided to the participants by their direct supervisors [6].

Review:

From a global perspective, the concept of patient safety culture continues to be a topic of discussion among patient safety scientists. However, despite the fact that patient safety culture is typically a phenomenon that is distinct to a given environment, there are many commonalities in the challenges and successes that are experienced across different countries. The existence of such commonalities affords the opportunity to gain knowledge from the achievements and difficulties of other nations. Teamwork, punitive responses to errors, and management support for patient safety have all been scored highly by participants in studies on patient safety culture [7]. These findings have been reached by the majority of the participants. Additionally, patient safety studies have incorporated comments from other categories of health professionals, including managers, physicians, registered nurses, and enrolled nurses [7]. This is due to the fact that in a hospital setting, the safety of patients ought to be everyone's concern overall.

It is important to note that research on patient safety culture have utilized a variety of methodology, such as systematic reviews, qualitative methods, and quantitative methods [8]. The quantitative approaches are the most prevalent, and they frequently make use of self-administered quantitative surveys, according to the findings of a scoping review that lasted for twenty years and included 107 papers on the subjects of patient safety culture methodologies and their prevalence [8]. A similar finding was made by a systematic analysis conducted in 2021 on the approaches that were utilized to explore patient safety culture dimensions. The review included 694 studies, but only 31 of those studies were qualitative. On the other hand, the authors of both research [9] expressed their worry regarding the scarcity of qualitative

studies that investigate patient safety culture. They also urged for the necessity of employing qualitative methods in order to gain an understanding of the specific factors that contribute to delays in developing a positive patient safety culture.

From the perspective of the World Health Organization (WHO), patient safety (PS) refers to the prevention of medical errors and the bad impact that these errors have on patients while they are receiving healthcare [10]. As a result of unsafe medical practices, patients may get injuries, pass away, or become disabled. There has been an increase in the number of instances of this kind, which has led to the realization that the patient safety culture (PSC) in the healthcare business all over the world needs to be improved. In addition to this, the safety of patients has been regarded as one of the key components of healthcare management [5]. One piece of research suggested that safety is an essential and fundamental component of research pertaining to patient care. In a work that is considered to be a landmark in the field of PS, Kohn et al. [6] advocate for the use of a systematic approach to PS management in order to prevent and mitigate errors. Because of this, it is crucial to have an understanding of the beliefs, attitudes, norms, and values of PS as well as its thresholds [11]. This is necessary in order to guarantee the greatest possible level of safety culture in the whole healthcare industry.

Non-punitive responses to errors and the frequency of event reporting were two of the variables that obtained low positive scores [11]. Both of these dimensions were evaluated. This is due to the fact that a significant proportion of respondents stated that they do not report occurrences to their managers or supervisors. It is possible that this is due to the fact that employees are afraid of being chastised for making a mistake and the lack of understanding regarding safety hazards. As a result of such a culture, the staff might be more likely to conceal problems that could subsequently have an effect on the efficiency of PS. It's possible that managers, supervisors, and coworkers could all contribute to the development of a culture that includes non-punitive responses to errors. It is possible that the dangers of patients complaining are another factor that contributed to this outcome. Additionally, it is possible that patient requests for compensation contributed to a reduction in the frequency of event reporting [12].

In certain regions, managers demonstrated effective handover and information exchange practices, however in the majority of health institutions located in other regions, these practices were entirely absent. Despite the fact that they are consistent with the findings of McElroy et al. [13], the causes for sub-standard handover are a cause for concern. Not accompanying patients out of the outpatient department (OPD) and arriving late to work are two examples of symptoms that indicate a decline in the quality of care provided, a lack of enthusiasm, and a loss of professional and ethical standards. Despite the fact that participants reported that there is a scarcity of workers, as revealed by another study [13], the authors are of the opinion that task-sharing and better dedication to work among health professionals could potentially enhance the sub-standard handing over processes that are now in place. In addition, a few of the participants indicated that certain shortages were fabricated and were primarily caused by employees who pursued additional education without taking additional time off for study. Others, on the other hand, were on leave for approved reasons, such as study leave, maternity leave, or annual leave. It is therefore dependent on the season that we are in. If everyone is working, there will be no scarcity of resources. As a result, the Ministry of Health is unable to hire additional staff members while those employees are on leave, and they will be terminated once everyone returns to work. These findings are consistent with those of Akologo et al. [14], who discovered a low positive rating on staffing as a patient safety culture dimension in three selected hospitals located in the Upper East region of Ghana. The finding that there is an exceptional lack of staff is corroborating these findings. In light of the fact that Akologo et al. [14] conducted a quantitative analysis, they were unable to provide an explanation for the observed deficiency; hence, this current work fulfils this gap. Investigations carried out in other locations, such as Tanjung As a matter of urgency, we recommend that the management reassess the elements that are under their control, such as the right planning of leave and capacity building. This is because such measures can lead to quick achievements in the

direction of patient safety culture interventions. The provision of human resources is the most fundamental instantaneous and wise activity that can be taken to increase patient safety, according to one article that was presented with the number 14.

It was indicated by nurses in a study conducted in Iran that managers should be concerned about the psychological and emotional care of their workers. This is because managers' supporting behavior motivates nurses to enhance their abilities and implement safety culture measures [15]. A reactive management strategy and the failure to promote general safety in hospitals both have a detrimental impact on the culture of patient safety in that particular institutional environment. Some of the factors that contribute to this are a lack of human and medical resources. It is imperative that the management of healthcare facilities be worried about absenteeism and presenteeism because, in the end, these factors put the lives of patients in jeopardy. due to the fact that the backing of management is essential in developing a culture of patient safety. Improvisation has been necessary as a result of the lack of assistance and resources, which has resulted in a reduction in patient safety. The results of this investigation indicate that management has not placed a high priority on patient safety and, in fact, demonstrates a lack of commitment to the same. Despite the fact that the findings on the absence of managerial support with resources are frequent [16], they are also in agreement with the findings of Mawuena, who explored the effects of resource limits and excessive workload in Ghanaian hospitals. In addition, the research conducted by Mawuena discovered that health professionals are more likely to remain silent when they do not receive any positive benefits from verbalizing their displeasure with the absence of provided resources. Increasing the amount of financial, human, and logistical resources that are invested in health facilities is something that management should emphasize in order to ensure the safety of patients. When anything like this is put into action, it will transfer rhetoric into practice [17].

Conclusion:

For the purpose of monitoring and disciplining worker absenteeism as well as reporting late for duty, strong leadership, management, and governance are essential. The establishment of uniform policies is required in order to guarantee that the turnover of responsibility is not delegated to student nurses. It is imperative that education concerning the connection between handover and patient safety be incorporated into human resource management strategies. Not only should the executive management of health facilities be helpful when accreditation is needed, but they might also be more consistent in their operations. It is also the responsibility of management to make sure that health professionals have access to the resources they need in order to avoid taking shortcuts and the practice of regular improvisation. Due to the fact that every manager now responds in accordance with his own manner, there is also a need to standardize such techniques in order to prevent managers from exploiting their subordinates. In order to establish a culture that is supportive of patient safety, it is imperative that management provide assistance in the form of resources, the motivation of workers, and training on patient safety.

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