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PATIENT SAFETY CULTURE UNDERSTANDING IN TÜRKİYE AND THE WORLD

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ABSTRACT

For the development of patient safety culture, which has a very important place in the success of health institutions, patient-focussed, safe, effective, technological equipment brought by the modern age and equal distribution of information bring along a number of norms. Today, patient safety is recognized as a priority issue in the field of health services worldwide. The aim of this study is to emphasize the importance of patient safety in the establishment of patient safety culture and practices in health service delivery in Türkiye and in the world, to examine the quality improvement strategies in this regard in detail and to emphasize the importance of patient safety in health institutions.

Keywords: Patient Safety, Patient Safety Culture, Health Services

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1. INTRODUCTION

Patient safety culture is becoming a priority in healthcare organizations as a specific aspect of an organization's overall culture and is receiving increasing attention (Sorra and Dyer, 2010). Preventing medical errors and ensuring patient safety at every stage of health service delivery are among the main goals of the health system (Guven, 2007).As health services grow, the principle of quality in health service delivery comes to the fore. One of the most important principles in this regard is patient safety. The importance given to the concept of patient safety was first included in Hippocrates' principle of "Primum non nocere (First do no harm)". However, every medical use and intervention in healthcare services brings along some risks. Patient safety is defined as the prevention of errors occurring in health services and the reduction or complete elimination of patient harms resulting from these errors. This issue, which has been of great importance for societies since ancient times, has been supported by various practices and measures in every period, and preventing medical errors and ensuring patient safety at every stage of health service delivery has been among the priorities of the health system. In recent years in Türkiye, the concept of patient safety culture has been an issue that quality standards management units have been meticulously emphasizing, and the increase in medical errors due to the high level of risk factors in healthcare institutions has made patient safety gain importance. Health managers and employees have primary duties and responsibilities in order to anticipate errors that may occur due to risks, to prevent errors due to these situations in advance, and to provide health services in a more qualified and safe manner. The aim of this study is to emphasize the importance of patient safety in the establishment of patient safety culture and practices in health service delivery in Türkiye and in the world, to examine quality improvement strategies in this regard in detail and to emphasize the importance of patient safety in health institutions.

2. HISTORY OF PATIENT SAFETY

Although patient safety has been discussed in the last fifty years, it has actually been an important issue in the earliest periods of history. In the 1760s, in the Hammurabi Code, one of the oldest laws in history, the 9th article clearly explains the harm that a doctor can cause to a patient during an operation and the penalties that they will receive in return (Karadag, 2022). In addition, Article 218 of the same code stipulates that if a doctor injures a patient or

causes his death, his hands will be cut off as a punishment for the harm they have caused (Karadag, 2022).

Article 18 of the Regulation on the Execution of the Art of Municipal Pharmacology dated 1861 states that "When the prescribed drugs are prepared in the apothecary's shop together with the prescription and delivered to the person, the mouth of the drugs shall be sealed and the label of the drugs used shall be written as "It shall be used for this person in this way" and the "label of the drugs used shall be in orange", thus containing regulations regarding safe drug practices in today's understanding (Dilmen, 2016).

In 1883, by drawing attention to the principle that hospitals should not cause germs, which was included in Florence Nightingale's laws, attention was drawn to both patient safety and the infectious damage caused by hospitals (Topçu, and Tokaç, 2013).

The Institute of Medicine (IoM), known as the most influential organization guiding medical practices in The United States (USA), has defined patient safety as "Preventing harm that may develop in patients" (Aspeden, et al, 2004). The National Patient Safety Foundation (NPSF) has defined it as "reducing or eliminating patient confusion caused by errors in healthcare services" (The National Patient Safety, 2017). The World Health Organization (WHO) has defined patient safety as the ability to prevent or minimize preventable errors and hazards in healthcare services (The World Health Organization, 2017). According to the International Atomic Energy Agency (IAEA), it is defined as the joint effect of values, competence, attitudes and behaviors of top management, which guide the quality and institutional attitude of health and safety plans by institutions and the continuity of their application (Karadağ, 2022).

Looking at the history of Turkish medicine, it is seen that various rules have been applied from past to present regarding the professional responsibilities of physicians. During the Shamanism period, there are documents indicating that physicians who practiced wrong medical practices were punished. During the Seljuk period, it is known that people who did not have sufficient experience were prohibited from practicing medicine and physicians who were found to be at fault were subjected to various sanctions. Written in 1041 by Hekim

Ibn-i Şerif, "Yâdigâr-ı İbn-i Şerif" emphasizes the importance of knowledge and experience, discusses the issues to be considered in drug treatment and describes the qualities that a good physician should have. In the archives of Turkish medical history, there are many consent documents regarding patient safety. In these documents, especially before surgical procedures, the patient's condition and the operation process are explained in detail, the fee to be received by the physician is specified, and commitments are taken that the patient or his relatives will not make any claims against possible risks (Tokaç, 2008).

In the Ottoman Period, medical and pharmaceutical practices were regulated within the framework of certain rules, and those who did not comply with these rules were punished by sultan and physician chief edicts (Özgönül, 2010). The earliest court decisions on physician liability were recorded in Jerusalem court records in the 12th and 13th centuries. In Europe, the first example of such a decision is found in 1390. It is known that a physician working in Marseille was held responsible and penalized as a result of a mistake he made due to lack of knowledge. The concept that is now called "malpractice" was defined by William Blackstone in England in 1768. Afterwards, the rules regarding medical errors started to be included in written sources more clearly and the awareness of the issue increased (Özgönül, L. 2010).

Archive documents from the Ottoman Empire to the present also provide information about the understanding of patient safety in healthcare services. The most frequently encountered information regarding patient safety among archive documents is the consent document. It has been observed that the Ottoman state required doctors, especially surgeons, to have a declaration of consent for the operations they would perform, and therefore prevented the patient or their relatives from turning this situation into a blood feud or demanding an inheritance in the event of any negative developments (Tokaç, M. 2009).

3. PATIENT SAFETY

Patient safety culture is a part of the institutional culture and consists of the behaviors, ideas, perceptions and values of the individuals in the institution (Kaya, 2009). In order to create a patient safety culture in hospitals, it is necessary to raise awareness of not only hospital employees and managers but also patients about patient safety (Akalın, 2004). These are services aimed at preventing errors in healthcare services and eliminating the damage and deaths caused by these errors (Akalın, 2010).

According to the National Patient Safety Agency (NPSA), patient safety is the risk assessment in hospitals, the management and disclosure of patient-related risks, the reporting and analysis of repeated risks to minimize them, and the implementation of the solutions created, thus providing a safer care process for the patient (Gözlü and Kaya, 2012).

In recent years, it has been observed that studies on patient safety in developed countries, especially in England, Australia and Canada, have accelerated and progressed more compared to recent years (Topçu and Tokaç, 2013).The leading country in studies on patient safety culture is the USA. The most influential organization established in the USA and guiding medical studies, the "National Institute of Medicine (IoM)" published a report called "To err is human" in 1999. The report drew attention to patient safety and stated that 98,000 people die each year in the USA due to medical errors alone. The report stated that the cause of death is the 5th leading cause of death after heart disease, cancer, cerebrovascular diseases and COPD. As stated in the report, the issue of patient safety has a significant impact on patients and their relatives, then on the public and state finances. For this reason, in studies to be carried out on patient safety, it is very important to first ensure that health professionals successfully ensure the patient safety reporting process, and to report medical errors to the hospital management without anyone worrying about them, thus preventing preventable medical errors and preventing the harm caused to patients as a result of these errors. The main purpose of the patient safety culture is to prevent possible medical errors that may occur at each stage of healthcare delivery and to prevent them from harming the patient (Karadağ, 2022). In the 2003 report of the Institute of Medicine, three of the twenty areas named as priority in terms of quality in healthcare are related

to patient safety. These areas are generally smart medication management, hospital infections, and patient safety in hospital services are among the issues that need to be improved (Institute of Medicine, 2003).

Institutions providing health services are organizations that use many separate professional departments such as institutional infrastructure, physical conditions, human resources, technology, and have limited norms and are in matrix structures with continuous social purposes. Health institutions are among the high-risk businesses because they are based on human life. In our daily lives, almost everyone's births and deaths occur in hospitals. It is of vital importance for health institutions, which have an important place in our lives, to implement the patient safety process and necessary procedures while improving the service quality. According to NPSA, it is explained as the practices carried out in order to prevent or minimize the losses that may occur due to an unexpected or undesirable situation during the provision of health services. For this purpose, it continues the supported activities to minimize the events that endanger patient safety during the provision of health services and to improve safety and quality. The point emphasized here is that patients can receive treatment in a safe environment and be protected from preventable medical errors (The National Patient Safety Agency, 2021). Despite the fact that it has been the subject of many researches and initiatives aimed at developing applications for approximately twenty years, undesirable situations related to patient safety still continue (The National Patient Safety Agency, 2021). In the world, 80% of the damages that occur in patients receiving primary and outpatient healthcare services are preventable. It has been observed that 4 out of every 10 patients in developed and developing countries are harmed due to preventable medical errors. Some of the most harmful errors occur with diagnosis, prescription and medication use (Slawomirski, et al., 2018).

According to the WHO data, it was stated that more than 750 thousand people died due to preventable medical errors in Europe in 2019 (The World Health Organization, 2019). According to the "Patient Safety Economics Acute Care Technical" report conducted in Canada, the financial burden of preventable situations was recorded as approximately 397 million dollars in 2009-2010. This table includes the care after the patient is discharged from the hospital, as well as general financial processes such as functional losses and professional

productivity (Etchells, et al., 2012). A study conducted in the USA showed that preventable healthcare-based finances in 2010 were between 6.8 billion dollars and 27 billion dollars. As a result of the data obtained, the economic and social financial and public health services and other social institutions do not lose confidence. Economic and social finances include physical and psychological fatigue, pain and sadness, and reduced economic productivity. Financial losses due to harm to patients cause trillions of dollars in damage every year (Slawomirski, et al., 2018).

The Agency for Healthcare Research and Quality (AHRQ) has proposed 10 topics to prevent undesirable situations in hospitals (The Agency for Healthcare Research and Quality, 2018):

1. Preventing central catheter-related bloodstream infections.
2. Reorganizing hospital discharge processes.
3. Preventing preventable hospital deaths and the common cause of hospital-acquired venous thromboembolism (VTE).
4. Providing complete information to patients using blood thinners to use their medications correctly and safely.
5. Limiting shift times for health professionals and other hospital personnel.
6. Collaborating with organizations that work on patient safety.
7. Choosing good hospital design principles.
8. Providing training on effective communication among hospital personnel.
9. Measuring patient safety culture for evaluation.
10. Ensuring that chest tubes are placed safely and sterile.

4. PATIENT SAFETY CULTURE AND DEVELOPMENT IN THE WORLD

In 1955, American Doctor Ernest Cedman conducted research on patient outcomes. Later, in 1984, the Anesthesia Safety Foundation established the "Harvard Medical Practice" study in New York, USA. In 1922, the "Medical Practice Studies" were initiated in Colorado and Utah. In 1995, the 1st Annenberg Patient Safety Conference was held. In 1996, studies on patient safety gained momentum and politicians began to participate in regulations on the subject. Between 1997 and 1998, reports prepared with research results on the subject guided studies on patient safety and these reports were presented to the public. According to a series of reports published by the "Institute of Medicine (IoM)" under the "Quality Chasm" series since 1999, 98,000 people lose their lives each year in the United States due to medical errors. The majority of medical errors are due to errors in the system rather than personal errors. (Akalın, 2004). In 2000, norms related to quality and patient safety began to be established to increase the quality of patient service care. The National Patient Safety Task Force (FDA, AHRQ, CDC, CMS) was established in 2001. In 2002, health insurance companies also conducted studies showing that they care about patient safety. In 2003, the "Vision for Public Health Improvement Strategies" was announced in the new research process by the "Joint International Commission", the International Health Organization (IOM) published the Priority Areas for National Action report, the FDA determined the criteria for drug coding, and the Health Development Institute developed interactive quality resources (Korkmaz, 2018). The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) first accepted national patient safety goals in the USA in 2003. These goals are determined for all departments providing healthcare services and the topics are reviewed annually. Patient safety goals are explained in detail below (Joint Commission on Accreditation of Healthcare Organizations, 2010):

- Verify patient identity information.
- Maintain and improve communication between those providing patient care.
- Ensure the safety of smart and important medicines.

- Eliminate or reduce wrong site, wrong patient, wrong surgical operations.
- Improve the safety of infusion pump use.
- Improve the adequacy of clinical alarm systems.
- Preventing infectious.

At the World Health Assembly in 2004, the "World Alliance for Patient Safety" was launched with the support of the WHO President and the Health Ministers of many countries. Subsequently, in 2005, the "World Alliance for Patient Safety 10 Actions", "Global Patient Safety Challenges" and "Patient Safety Solutions" were announced by the WHO. With this movement pioneered by the WHO, this issue has become increasingly talked about in European countries and our country, and various legislative studies and regulations regarding patient safety have been put forward. Research and efforts conducted to date show that safety problems are much more complex and widespread than initially anticipated. (NPSF, 2015). Since 2004, three "Global Patient Safety Challenges" have been launched in collaboration with the World Alliance for Patient Safety (WHO):

1. "Clean Care is Safer Care" (2005) to prevent healthcare-associated infections.
2. "Safe Surgery Saves Lives" (2008) to reduce the risks associated with surgery.
3. "Medication Without Harm" (2017) to ensure medication safety.

The data obtained from the challenges are encouraging. For example, the "Clean Care Safe Care" movement has been secured by Ministerial commitments covering 85% of the world's population. This campaign has taken on many of the characteristics of a social movement (Poulter, et al., 2017). The World Medical Association's "Patient Rights Declaration" was published in Santiago in 2005. Although the basis of this declaration is rights based on the principle of autonomy, the right to health education was also defined for the first time. In its most current form, patient rights include the following headings (Patient Rights Guide, 2013).

1. Patients' right to access quality health services.
2. Patients' right to choose health services.
3. Patients' right to determine their own roadmap.
4. The right to approach an unconscious patient.
5. The right to approach a patient who lacks legal capacity.
6. The right to intervention against the patient's wishes.
7. The patient's right to be informed.
8. The patient's right to privacy.
9. The patient's right to health education.
10. The patient's right to fulfill their religious obligations.
11. The patient's right to protect their dignity.
12. The patient's right to know, choose and change hospital personnel.
13. The right to determine priority.
14. Prohibition of euthanasia.

Joint Commission International (JCI) has taken an active role in some operational practices related to WHO Patient Safety Solutions. The International Patient Safety Goals have been published by JCI as follows (JCI, 2006):

- Goal 1: Identify patients correctly
- Goal 2: Improve effective communication
- Goal 3: Increase the safety of high-risk drugs
- Goal 4: Ensure safety in surgery
- Goal 5: Reduce the risk of healthcare-associated infections
- Goal 6: Reduce the risk of patient injuries from falls

In the international conference held in Geneva in 2007, the World Health Organization (WHO) stated that approximately 10 million people in the world are injured or die each year due to preventable medical errors, and therefore called on countries to conduct more research on patient safety (Tuncel, 2013). Patient Safety Solutions, published in 2007, aims to transform knowledge into practical solutions and disseminate these solutions internationally. Solutions are standardized tools for healthcare professionals to prevent risks from reaching the patient. In this context, 9 patient safety solutions have been published (WHO):

1. Communication in Healthcare.
2. Right Party Right Procedure.
3. Control of Concentrated Electrolytes.
4. Verification of Patient Identity.
5. Drug Safety.
6. Safety of Invasive Catheters and Tubes.
7. Use of Single-Use Syringes.
8. Safety of Medicines That Spell and Read Similar.
9. Hand Hygiene.

Over the years, many advances have been made in practices that support patient safety and in raising awareness of patient rights. For example, in 2009, the European Union published the report "Patient safety, including infection prevention and control" on healthcare, and in 2012, it launched the "European Union Network for Patient Safety and Quality of Care (PASQ)", a network that aims to improve the safety of care by sharing knowledge, experience and implementing good practices. With the establishment of national plans, networks and organizations in many countries, the way has been paved for patient safety practices (Dhingra, et al., 2021). The importance of patient safety, which has been better understood in epidemics, was recognized as an important milestone in this regard by the 194 countries participating in the 72nd World Health Assembly held in Geneva in 2019 with a joint resolution titled "Global action on patient safety". For the first time in history, "World

Patient Safety Day" was adopted on 17 September 2019 (World Health Organization, 2023).

In the "WHO Global Patient Safety Action Plan 2021-2030 Information Meeting" organized by WHO on 27.11.2020, the strategic goals and objectives expected to be achieved between 2021-2030 were defined under the following headings (WHO)

- Strategic Goal 1: Policies to eliminate preventable harms in health services
- Strategic Goal 2: High reliability systems
- Strategic Goal 3: Safety of clinical processes
- Strategic Goal 4: Patient and family participation
- Strategic Goal 5: Education, skills and safety of healthcare professionals
- Strategic Goal 6: Knowledge, research, risk management and improvement
- Strategic Goal 7: Synergy, partnerships and solidarity

The activities expected from countries by 2030 in line with the global patient safety goals by WHO are listed below. (WHO):

- All countries will establish and implement a national patient safety policy.
- All countries will designate a national patient safety coordinator.
- All countries will conduct regular patient safety surveys in healthcare settings.
- Healthcare-associated infection (HAI) reduction.
- Serious preventable harm related to medication reduced by 50% (compared to baseline).
- Venous thrombo-embolism deaths reduced.
- Fall deaths reduced.
- Safer healthcare policies and guidelines will be developed with the participation of patient and family representatives.

- Patient safety curriculum will be implemented in all healthcare undergraduates.
- All countries will participate in annual Global Ministerial Summits on patient safety.
- All countries will have established a national patient safety network.

5. PATIENT SAFETY CULTURE AND DEVELOPMENT IN TÜRKİYE

The efforts of private hospitals to gain international certification and be accredited by "Joint Commission International (JCI)", which they started in the 2000s in order to differentiate themselves by increasing their service variety in terms of quality and scale, have paid off and started a new era. Accreditation is not only for hospitals, but also with the addition of some laboratories and private ambulance companies, patient safety studies have spread to different areas. The public sector has also started to accompany the studies of the private sector (Sur and Say, 2013).

In Türkiye, studies on patient safety have been addressed within the scope of the Turkish Healthcare Quality System since 2005. The criteria determined to ensure patient safety in healthcare are included in the quality standards published by the Ministry and healthcare organizations are obliged to apply these standards compulsorily. In Türkiye, quality studies including patient and employee safety came to the agenda with the Health Transformation Program in 2003 and in this context, quality studies in health were initiated in 2005. In order to ensure patient and employee safety and satisfaction, quality criteria were first developed in 2005. With the revision made at the beginning of 2007, it became a set consisting of 150 questions. In 2009, the "Private Hospital Service Quality Standards" and the SKS Hospital (Version 5) Set published in 2015 were published. In the SKS Hospital (Version 6) set published in 2020 with the revision made later, patient and employee safety, patient and employee satisfaction, risk management, learning from mistakes and continuous quality improvement perspective were taken to the center of the set.

Apart from accreditation and quality management in Türkiye, an important development, especially in the field of patient safety, was the establishment of

the “Patient Safety Association” in 2006. The association, which achieved a first in Ankara, organized the “International Patient Safety Congress” twice in 2007 and 2008. According to the data of June 2024, there are a total of 38 healthcare institutions in Türkiye that have received JCI certificates. four of these are primary health services, three are ambulance services, one is a laboratory and 30 are hospitals (Joint Commission International, 2024). In Türkiye, practices related to patient safety are addressed in the “Quality Standards” structure published by the Ministry. In the dimensioning system, the Standards were placed on a model consisting of five dimensions, both vertical and horizontal, and designed to cover all parts of the organization. The vertical dimensions include Corporate Service Management, Health Service Management, Support Service Management, Indicator Management, while the horizontal dimension includes Patient and Employee Safety." This statement can be found in (General Directorate of Health Services Department of Quality, Accreditation and Employee Rights in Health, 2024). The “Communiqué on the Procedures and Principles Regarding the Ensuring and Protection of Patient and Employee Safety in Healthcare Institutions and Organizations” (Official Gazette, 2019) was published in the official gazette dated April 29, 2009 and numbered 27214 and put into effect.

The Ministry of Health has enacted the following legislation related to the Quality System in Health. Ministry of Health Inpatient Treatment Institutions Institutional Quality Improvement and Performance Evaluation Directive (2005).

- Directive on Quality Improvement and Performance Evaluation in Health Institutions and Organizations Affiliated to the Ministry of Health (2007)

- Directive on Performance and Quality in Health (2009)

- Regulation on Ensuring Patient and Employee Safety (2011)

- Regulation on the Improvement and Evaluation of Health Service Quality (2013)

- Regulation on the Improvement and Evaluation of Quality in Health (2015)

Among the duties of the General Directorate of Health Services under Article 355 of the Presidential Decree No. 1, the following issues are related to patient safety are as follows:

a) To plan all kinds of preventive, diagnostic, therapeutic and rehabilitative health services, to make technical arrangements, to set standards, to classify these services and providers, and to carry out related works and procedures.

b) To make arrangements for patient rights and patient and employee safety.

c) To supervise the compliance of health institutions and organizations with the policies and regulations determined by the legislation, and to impose the necessary sanctions.

d) To Establish the necessary commissions for planning and establishing standards.

e) To Determine and ensure the implementation of quality and accreditation rules in health services Quality Standards in Health (QSS) and Implementation Guidelines published within the scope of these duties are given below (Healthcare Quality, Accreditation and Employee Rights website):

- SKS Hospital
- SKS ADSH
- SKS Dialysis
- SKS 112
- SKS Medical Center
- Safe Surgery Implementation Guide
- Safe Delivery Process Implementation Guide
- Medication Management Guide
- Document Management Implementation Guide
- Survey Implementation Guide
- Indicator Management Guide

- COVID- 19 Diagnostic Laboratories in Light of SKS Clinical Microbiology Laboratories Quality Management Guidelines

- Clinical Microbiology Laboratory Quality Management Guidelines

- Clinical Quality Measurement and Evaluation Guidelines

- Clinical Quality Implementation and Data Quality Improvement Guidelines

- Guidelines for Appropriate Oxygen Therapy in Newborns

- Guidelines for the Prevention of Hospital-Associated Venous Thromboembolism

- SKS Hospital Risk Management Guidelines

The topics addressed related to patient safety within the scope of the HCS are as follows (Healthcare Quality, Accreditation and Employee Rights website:

- Control and prevention of infections

- Drug safety

- Correct identification of the patient

- Strengthening communication between patients and healthcare professionals

- Patient participation in the care process

- Prevention of falls

- Safe surgery

- Information security

- Radiation safety

- Transfusion safety

- Medical device safety

- Waste safety

- Facility safety

6. PATIENT SAFETY TOOLS

In order to increase patient safety and improve the quality of healthcare services, processes that help to predict and eliminate problems can be developed or the root cause of the problems can be investigated and prevented to prevent recurrence. The tools used in this direction are a bridge integrated with the system approach.

Retrospective Event Analysis: These methods are based on remedial activities and are detailed below.

Critical Incident/Root Cause Analysis: It is a tool that helps to examine and document the cause, causal effects or root causes of the problem that occurred. In cases that affect important or harmful patient harms, an in-depth examination is needed to determine the true root causes. Thus, in the event of an error, current improvements in the processes can be made by going from general causes in organizational processes to specific causes in clinical processes. In any emergency situation, health care organizations need to measure the results or activities of initiatives that have implemented risk reduction strategies based on root causes in the situation (Wu, et al., 2009).

Pareto Charts: After collecting the necessary data about the problem, it is used to help determine the first improvement initiatives and to focus on the activities in the areas that provide high returns (Wu, et al., 2009).

Fishbone Diagram: Also known as the cause-effect diagram, this tool is used to organize and define the causes of the problem in the structural process (Wu, et al., 2009).

Prospective Event Analysis - Proactive Methods: It is based on preventive activities rather than corrective activities.

Failure Mode and Effects (FMEA): It is a meta-system in the process to help before problems occur. The main purpose of FMEA is to prevent known or potential errors before they reach the user. (Chin, S., et al., 2009) For this reason, each error risk is thoroughly evaluated and prioritized (Fracica, et al., 2010).

7. PATIENT SAFETY THREATS

They are at the heart of health services and should be addressed as a primary issue by every health institution and health professional. Nevertheless, there are some dangers and risks during the provision of health services. Patient safety risks and dangers are detailed as follows:

- Medication Errors: These are the most common and risky patient safety problems among patients. Incorrect drugs, incorrect dosages or drugs administered in the wrong way can cause serious errors. These errors can seriously harm the health of patients and it is of great importance for professionals to be careful and receive training in drug management (Aslan, 2020).
- Infection Control Problems: They pose a very serious danger for patients. Infections can cause serious consequences, especially in cases such as surgical interventions or diseases that weaken the immune system. For this reason, health institutions should develop comprehensive policies and methods specific to infection control (Doğanyiğit, 2021).
- Surgical Errors: They are one of the most important problems encountered in the hospital area. Wrong surgical operations may occur for similar reasons such as wrong-site surgery, surgery performed on the wrong patient or lack of communication between surgical team members. These errors can seriously affect the lives of patients. In order to increase surgical safety, training and communication channels of surgical teams should be kept open (Ergen and Tank, 2023).
- Communication Problems: Inadequate and incorrect communication between healthcare professionals can make the coordination of patient care delicate and can cause errors. In addition, communication problems between patients and healthcare professionals can also affect patient safety (Arslanoğlu, 2019).
- Infrastructure and Technology Problems: Inadequacies in technological systems or infrastructure used in healthcare services can endanger patient safety. For example, defective patient record systems or failure of medical devices can cause patients to receive incorrect treatment. Investments should be made and revised to eliminate technological problems with infrastructure systems in healthcare institutions and organizations (Shaw, A., et al., 2020).

- Patient Identity Confusion: Patient identity confusion is a serious factor that causes treatment to be administered to the wrong patient. Identity verification processes may be inadequate or incomplete. For this reason, patient identity information should be fully checked and directly verified at every stage (İpek and Tonkuş, 2020).
- Device and Equipment Errors: The problem of power outages in the error-free operation of very important devices such as life support devices is an important factor that undermines patient safety. Healthcare workers should be aware of the correct and effective use of devices and ensure that their maintenance is carried out at regular intervals. Routine maintenance of devices should be carried out, and control and calibration processes should be carried out regularly and monitored (Gökkaya, 2023)
- Healthcare Worker Inadequacy and Human Factors: Human factors such as health care workers being weak, exhausted, stressed or overworked can negatively affect patient safety. Strategies should be developed to minimize the inadequacy of personnel or employees working on shifts and to coordinate the workload of employees (Kaya and Gündüz, 2022).
- Lack of Patient Companionship: Approaches to healthcare service delivery partnership aim to place people using the services at the center of care, support them in the decision-making process to understand their service experiences, and include them in the design and delivery of care. Stages such as patients not being involved in treatment processes and decisions or incomplete information being provided pose a threat to patient safety (Ocloo, et al., 2021).
- Inadequate Emergency Preparedness: Inadequate preparations by healthcare institutions and organizations, long stays of patients, medical errors due to frequency and intensity, and inappropriate interventions can pose a risk to patient safety. Establishing emergency plans for healthcare institutions, having qualified staff, suitable infrastructure, and organizing drills at certain periods are important approaches in this regard. (Mckenna, et al., 2019)
- Radiologic Imaging and Radiation-Specific Risks: Since the functions of radiology are primarily related to diagnosis, many errors performed in radiology departments disrupt diagnosis and treatment. Such errors result

from the application of theoretical aspects of imaging, inadequacy or misperception, misinterpretation of imaging findings, and inadequate and timely communication of imaging findings to the desired person for action (Larson, et al., 2015).

- Dissatisfaction of Healthcare Workers and Inadequate Job Satisfaction: Improved job satisfaction is an important factor that positively affects the success of healthcare professionals and the care experience of patients. Job satisfaction is a factor that increases institutional and professional commitment and creates motivation. Increased job satisfaction and contentment contribute to the provision of safe and significant quality care (Facts About Speak Up, 2010).

8. CONCLUSION AND SUGGESTIONS

Healthcare institutions are risky organizations that involve many disciplines and generally involve high-risk business processes. Within such a structure, it is possible for different errors to occur that affect and harm the patient. Efforts to prevent medical errors and make healthcare institutions safer continue with error reporting processes developed by patient and employee safety centers of many countries.

In preventing or minimizing errors, the first step is to know the errors and prevent them from being repeated. Designing automations that allow hospital employees to report errors safely and without fear of punishment or humiliation and learning from the errors that occur can create a positive safety culture.

Creating awareness that safe patient care is the responsibility of all hospital personnel and ensuring that healthcare managers embrace this issue, supporting effective communication among personnel, providing training to all personnel, especially on reporting near-miss errors, and developing user-friendly reporting automations are very important.

There is a general disconnect between the communication skills of doctors and healthcare personnel and their ability to understand patients in terms of health literacy. Each healthcare professional should be able to analyze the patient's receiver characteristics in communication and change the signals as

a sender towards a different target.

The responsibility in providing healthcare services does not end with providing treatment services only. It is important to educate patients and their relatives and to know the ways to stay healthy. Health literacy is recommended to "ask the necessary questions before applying to the doctor and leave with the answers after preparing" due to any problem.

Under these conditions, the importance of the "Speak Up" study supported by the Joint Commission is seen;

- Speak up: Ask your questions to the other party out loud.
- Pay attention: Focus on the care service provided. Make sure that you are getting the right medicines from the right healthcare professional.
- Educate yourself: Improve yourself, research, learn.
- Ask: Ask your questions to the people around you that you trust.
- Know: Know which medicine you are taking and why you are having the examination done.
- Use: Use a hospital, clinic, surgery center, or other type of health care organization that has been carefully checked out
- Participate: Be sure to accompany all treatment results.

The priority order of the Speak Up study is as follows;

- Help prevent mistakes during your health care.
- Help prevent mistakes during surgery.
- Learn detailed information about organ donation.
- Know what you can do to prevent infections.
- Help prevent mistakes regarding the medications you are using.
- Organize what you need after medical care.
- Support in preventing medical care examination errors.
- Learn your rights.

- Support in preventing medical care, research, examination, learning errors.
- Learn about the doctors and other healthcare personnel who are caring for you.
- Support in preventing mistakes in medical care with your children.
- Stay healthy and support others in this regard.
- You should know what to do before consulting a doctor.

Intensive work is being carried out in Türkiye to spread patient safety awareness and develop its culture at an international level. Thanks to these studies, the preferability, continuity, continuity of health institutions and the satisfaction of service areas are also ensured. It cannot be ignored that patient safety benefits the health care worker and the institution beyond patient satisfaction.

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