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Fact Finders for Patient Safety: Use of Sterile Gloves for Interventional Pain Procedures

Haewon Lee*

Department of Orthopedic Surgery, University of California, USA

DESCRIPTION

Many see quality healthcare as an overarching umbrella that supports patient safety. For example, the Institute of Medicine (IOM) believes that patient safety is "indistinguishable from the delivery of quality care". Ancient philosophers such as Aristotle and Plato focused on quality and its properties. In fact, quality is his one of the great ideas of the Western world. Harleton considered several conceptualizations of quality and concluded with a very abstract definition: Quality is the optimal balance between realized potential and a framework of norms and values. This conceptual definition reflects the fact that quality is an abstraction and has no distinct entity. Rather, it is based on interactions between parties agreeing on standards and components. Recent IOM work to identify the components of quality care for the 21st century focuses on conceptual components of quality rather than on measured indicators. Quality care is safe, effective, patient-centred, timely, and efficient. As such, safety is the foundation on which all other aspects of quality care are built. A similarly abstract definition of patient safety has emerged from the movement to improve the quality of healthcare. There are different approaches to more specific required elements. Patient safety is defined by IOM as "prevention of patient harm". The AHRQ Patient Safety Network website glossary extends the definition of loss prevention. "Freedom from accidental or preventable medical malpractice". Patient safety practices are defined as "those that reduce the risk of adverse events associated with medical exposure with various diagnoses or conditions." Although this definition is specific, it is rather imperfect because there are so many practices that have not been well-studied for their effectiveness in preventing or reducing harm. In the United States, in April 1982, the public and the medical field of anesthesia were shocked by the ABC television program 20/20, "Deep Sleep." Producers presented reports of anesthesia accidents and explained that 6,000 Americans each year die or suffer brain injuries related to these accidents. Together, we agreed to sponsor a symposium on anesthesia induced injury to share statistics and conduct research. Attention was drawn to medical errors in 1999 when the Institute of Medicine reported that approximately 98,000 medical error deaths occur in hospitals each year. By 1984, the American Society of Anesthesiologists (ASA) established the Anesthesia Patient Safety Foundation (APSF). APSF marks the first use of the term "patient safety" on behalf of professional laboratories. Also in Australia, the Australian Patient Safety Foundation was established in 1989 to monitor anesthesia errors. Both organizations quickly expanded as the scale of the medical malpractice crisis became known. Patient safety is the cornerstone of quality healthcare. Much of the work defining patient safety and harm prevention practices focuses on adverse outcomes such as mortality and morbidity. Much work is still needed to assess the impact of care on positive quality indicators such as adequate self-care and other health-improving measures. This systematic review shows that the most important first step is to assess safety culture in primary care, which provides a basic understanding of health-care providers' safety-related perceptions. The most commonly used safety culture assessment tool is HSOPSC, which helps identify areas for improvement at individual, departmental and organizational levels. This review recognized the need for regular assessments of safety culture in primary care to assess safety effectiveness in healthcare settings. In addition, the results of this review were used to inform an empirical study of safety culture in primary care in Oman, using the Hospital Survey on Patient Safety Culture (HSOPSC) tool, and in context in primary care. Develop a template for

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Corresponding author Haewon Lee, Department of Orthopedic Surgery, University of California, USA, E-mail: HAL_026@health.ucsd.edu

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developing a safety culture of rapid economic growth.

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CONFLICTS OF INTEREST

The authors declare no conflict of interest.