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Predictive risk for patient safety culture

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Medical errors impact up to 440,000 people's lives, per year in the US, with more people dying from medical errors each year than highway accidents, breast cancer, or AIDS combined. This makes medical errors the third leading cause of death in the US alone, after cancer and heart disease and are responsible for 11% of all deaths in Australia. In other words, medical errors in Western healthcare has been implicated in more than 5 million deaths, contributed to the disability-adjusted life years of more than 20 million people and had cost healthcare approximately $1 trillion over the past decade. Health care services are yet to recognise and appreciate such measurable approaches, and continue to rely on post mortem or misadventure examinations. This has contributed to a restricted, deficient or non-existent database that can provide predictive measurements of healthcare incidents, or calculate quality intervention relationships between organisational determinants and clinical outcomes. A systematic review of the patient safety culture within health care settings was undertaken to examine and provide a deeper understanding of the significance of predictive measurement of organisational factors to enhance the culture of patient safety. In so doing solutions are provided that may address organizational culture challenges. These include actions that organizations can undertake to identify, measure and adopt innovative safety and quality improvement strategies. Further, it is highlighted how to initiate, maintain and sustain a culture of organizational safety through a predictive measure of the risks that closes the gap between patient safety and health care delivery.