



# The Role of the Patient Safety Officer in Promoting Hospital Patient Safety

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Received July 8, 2022; Accepted July 22, 2022; Online Published August 1, 2022

Patient safety as a basic principle of quality is dominant in the global health agenda and mentioned as an essential requirement to organize a qualified health care system.<sup>1</sup> In hospitals, the Director or chief executive officer (CEO) has the main responsibility for patient safety in the whole hospital, although all clinical leaders are responsible for patient safety within their ward. To clarify responsibilities and support clinical leaders in their work with patient safety, a formal structure is necessary. This formal structure may include a director of patient safety and patient safety officers (PSOs) in each large clinical unit. Moreover, a patient safety committee must be established to reviews all serious events and takes initiatives to improve clinical practice. Unfortunately, the main cause of medical errors in most cases are due to system weakness and therefore the Director and other clinical leaders have responsibility as other clinical staffs when medical errors happen.<sup>2</sup>

Based on the World Health Organization (WHO) document, PSO is a qualified senior staff member with responsibility and accountability for patient safety. PSO has to develop a schedule of audits, risk management program in order to identify, assess and reduce any adverse events, medication errors and other patient safety subjects. Also, PSO develop reports on different safety and risk activities and disseminate them internally and externally. Furthermore, PSO measures outcome of care to assess performance, with a special focus on patient safety and finally acts on results of audits, measures and feedback by implementing patient safety improvement projects.<sup>1</sup>

Two major outcomes of world patient safety movement due to Institute of Medicine's 1999 report on patient safety, *To Err Is Human*, were (1) new guidelines that focus on requirements for documenting compliance with patient safety data and (2) a new responsibility for health care organizations to establish a "safety culture" based on the "science" of safety.<sup>3,4</sup> Thus, PSO is an emerging role to fulfill these responsibilities. PSOs as managers of hospital's patient safety programs, have a broad portfolio of tasks and responsibilities. These tasks range from

reviewing patient charts in order to gather and present data that show compliance with formal regulations to the socially engaged task of planning and implementing programs so as to show improvement on safety targets. Thus, PSOs tasks lead to quality improvement due to data surveillance and reporting. Also, PSO role was defined as establishing connections within and between departments in the hospital. Usually, Most PSOs are nurses and this background help them to connect frontline staff to the hospital's patient safety goals due to greater credibility with frontline staff and their supportive role between staff.<sup>4</sup>

Although PSO's activities could lead to patient safety improvement and the quality consequently health care delivery; however, to achieve this success, there are serious challenges in this field such as high degree of mistrust and fear of reprisal on the frontline.<sup>4</sup> To manage and overcome such challenging issues, the Director (CEO), PSOs and other staffs must create and establish a safety culture together to improve medical error reporting system and implement patient safety improvement projects.

## Conflict of Interest Disclosures

The author declared that they had no conflict of interest.

## Ethical Approval

Not applicable.

## Funding/Support

None.

## References

1. World Health Organization. Patient Safety Assessment Manual for Primary Care. Cairo: WHO Regional Office for the Eastern Mediterranean; 2022.
2. Smiseth OA. Safety first. In: Smiseth OA, ed. *Managing a Hospital: How to Succeed as a Clinical Leader in the Post-Pandemic Age*. Cham: Springer; 2023. p. 1-8. doi:10.1007/978-3-031-17611-1\_1.
3. Plantz D. The patient safety and quality improvement act: a total eclipse. *UMKC Law Rev.* 2018;87:751.
4. van de Ruit C, Bosk CL. Surgical patient safety officers in the United States: negotiating contradictions between compliance and workplace transformation. *Work Occup.* 2021;48(1):3-39. doi:10.1177/0730888420930345.