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## Patient Safety: A Deep Concern to Caregivers

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### Abstract

*Patient safety is a global concern and is the most important domains of health-care quality. Medical error is a major patient safety concern, causing increase in health-care cost due to mortality, morbidity, or prolonged hospital stay. A definition for patient safety has emerged from the health care quality movement that is equally abstract, with various approaches to the more concrete essential components. Patient safety was defined by the IOM as “the prevention of harm to patients.” Emphasis is placed on the system of care delivery that prevents errors; learns from the errors that do occur; and is built on a culture of safety that involves health care professionals, organizations, and patients. Patient safety culture is a complex phenomenon. Patient safety culture assessments, required by international accreditation organizations, allow healthcare organizations to obtain a clear view of the patient safety aspects requiring urgent attention, identify the strengths and weaknesses of their safety culture, help care giving units identify their existing patient safety problems, and benchmark their scores with other hospitals.*

**Keywords:** Commercialism; Medication Error; Prescription; Nurse; Patient; Healthcare

**Abbreviations:** Institute for HealthCare Consumerism's (IHC); Institute of Medicine (IOM); Incident Reporting Systems (IRS); Third Next available Appointment (TNA); Wait Time to Consultation (WTC); Sound-Alike/Look-Alike Drugs (SALAD); Swiss Emergency Triage Scale (SETS); Hepatitis C virus (HCV); Hospital-acquired pneumonia (HAP); Human Development Index HDI); Global Antimicrobial Surveillance System (GLASS); Antimicrobial Resistance (AMR); Multidrug-Resistant (MDR); Emergency Department (ED); Fabry disease (FD); Attention deficit hyperactivity disorder (ADHD); Alzheimer's disease (AD); Vaccine-Preventable Diseases (VPDs); Health literacy (HL); American College of Clinical Pharmacists (ACCP); American Society of Health System Pharmacists (ASHP); Clinical Pathways (CPs); Medication Non-Adherence (MNA)

### Introduction

Since patient safety was first brought to light in the 1990s, studies have shown a staggering number of patients harmed by preventable medical errors. These errors include systems failures, human factors, complicated technologies, powerful drugs, prolonged hospital stays, and cost-cutting measures, to name a few. Medical errors can cause serious injury or death and result in billions of dollars in excess health care costs nationwide each year. WHO estimates that one out of every 10 patients worldwide are injured by these errors. Death may not quite be the final cure for life's ills that Socrates imagined. Recent safety issues imposed by healthcare providers are merely medication safety, provider patient ratio, length of physician consultation, medical supply shortages, quality reporting, antibiotic resistance, sepsis, unnecessary emergency hospitalizations, poor diagnosis, wrong prescribing and treatment etc. A good health system aims to deliver the best possible care to the individual patient while at the same

time being responsive to the health needs of the entire population it serves. For many health systems worldwide, resources are an important limitation. Commercialism and profit orientation in medicine are an important cost driver. Similar controversies exist with regard to improvements in quality and fairness of healthcare delivery. It is increasingly hard to find areas of life into which commercialism has not encroached. The corrosive effects of advertising and commercialization are more damaging because of the ways modern societies have come to rely on physicians, and are often made less healthy in the process. Here it is important to remember that commercial forces not only respond to markets, but work diligently to create markets. A prime example is pharmaceutical advertising to the public. Drug advertisements influence patients to ask their physicians about drugs that have been promoted.

### Commercialism in Healthcare Service

Healthcare Commercialism is defined by the IHC Forum as, “transforming an employer's health benefit plan into one that puts economic purchasing power—and decision-making—in the hands of participants. This is best achieved by supplying employees with the decision-making information and support tools they need, along with financial incentives, rewards, and other benefits that encourage personal involvement in altering

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health and health care purchasing behaviors. Commercialism in health care is an application of operating and managing principles typically found in business and commerce (financial incentivizing, profit-making, competition, marketing/advertising, and focus on the bottom line) to health care delivery. The US health care system ranks the highest on commercialism among Western industrialized democracies. Commercialism poses a threat to medical professionalism, patient care, and even the integrity of science, which is a foundation of our trust in medicine and medical professionalism. This is a timely topic that is getting some attention in the bioethics and medical literature. The idea of the profit motive in healthcare and the impact that it has on the professional practice of nurses and physicians should be thoroughly judged. The public healthcare systems have always had various weaknesses, which the capitalist media have relentlessly exploited. A private healthcare sector is nearly always active alongside the public system, providing parallel provision for those who can pay cherry-picking profitable services, offering 'hotel' style hospital accommodation, short waiting times for treatment – i.e. in general offering a model of a commodified service that looks attractive precisely because it is expensive. However, the most important common factor in the success of capital's drive to convert state-funded health care into a profit-making commodity has undoubtedly been the wider hegemony of neoliberalism, both as a system of social practices and as a system of ideas. In Germany for example, private hospitals treat patients who are older on average and who have more serious health conditions than those in public hospitals. The data also show that private for-profit hospitals are better equipped to treat difficult cases and more complex pathologies. Moreover, a larger proportion of beds in these hospitals are reserved for emergency room and intensive care patients [1-3].

### Medication Safety

Close to 6,800 prescription medications and countless over-the-counter drugs are available in the United States. It is estimated that in 2019, 25 billion retail prescriptions will be filled throughout the United States [4]. To further complicate a practitioner's responsibility during patient care, there are thousands of health supplements, herbs, potions, and lotions used by the public regularly to treat their health problems [7]. Each year, in the United States alone, 7,000 to 9,000 people die as a result of a medication error. The total cost of looking after patients with medication-associated errors exceeds \$40 billion each year [8]. The underlined causes are many – distractions, distortion, illegible writing, over/under dosing, SALAD, wrong metric measures, error induced kidney/liver dysfunction, wrong duration, use of abbreviations, supplement overload, wrong indication or direction, negligence, prescribing high risk medications etc. [9-13]. The cost of medication errors worldwide has been estimated as US\$42 billion/year [14, 15]. Doctors in US incorrectly prescribe antibiotics in nearly a third of cases. Study finds more than half of US population receives prescription annually and estimates

'inappropriate' prescriptions in doctor's office setting at up to 30% [16]. NHS medication errors raise fears thousands could be dying because of 237 million mistakes every Year, some 237 million errors are made annually [17]. In India, studies done in Uttarakhand and Karnataka have documented ME rate to be as high as 25.7% and 15.34%, respectively, in hospitalized patients.

### Nurse/Patient Ratio

Despite progress in the healthcare industry toward achieving goals, nurse managers and administrators working on hospital units continue to struggle with knowing what constitutes the right number and quality of nurses matched to patients' needs to achieve clinical outcome targets. Consider that in 2016, 62.2% of the country's 2.7 million nurses worked in hospitals with a median pay of \$68,450 per year [18]. With salaries making up nearly half of U.S. hospitals' expenses and nursing comprising about 30% of salaries, effective management of nursing resources, including staffing, is imperative for meeting financial outcomes. Higher nurse staffing and richer skill mix are associated with improved patient outcomes [19]. In addition, nurses provide up to 80% of primary healthcare. The dissatisfaction with the nursing care may indicate poor healthcare quality and decreases the achievement of standards [20].

### Length of Physician Consultation

Primary care-driven health systems are effective at reducing disease, mortality and promoting a more equitable distribution of health worldwide. As the global population increases, the demand for primary care is also growing in both economically developed, low-income, middle-income countries. This is leading to an array of different consultation lengths, with concerns among primary care physicians worldwide about the impact of shorter consultations [21, 22]. Average consultation length is also used in the primary care monitoring tool as an outcome indicator [23]. Consultation length is affected by the number of topics discussed with the patient; Consultation length often varies from one country to another and is determined by both patient's and doctor's characteristics; can be attributed to GP, patient and practice characteristics. While Deveugele et al. found that a longer consultation length was linked to females and older age. Howie et al. further discuss the issue of less attention being given to psychosocial issues in consultations [24, 25]. In USA the average consultation length has increased steadily to over 20 min [26], more than 15 min in Canada [27] and less than 15 minutes in Australia [28]. Comparing this, terrible found in Hongkong and Afghanistan (around 3 min), in China and India (2 min) and less than 1 min in Bangladesh [29- 33].

### High WTC

Waiting is a common phenomenon in the doctor's waiting room. High number of patients, shortage of staff and aging equipment are among the factors contributing to a lengthy waiting time. At the emergency department (ED), prolonged

wait times have been found to be associated with increased morbidity and mortality, and decreased patient satisfaction [34]. Although delays in care delivery are common—and unpleasant—occurrences in both public and private health care systems, there are few reliable data with which to determine the prevalence, degree, or nature of the problem. Patient waiting time in hospital emergency to receive the first treatment step was 66 min in Australia [35], 45 min in USA [36], 50 min Iran [37] and 64 min Turkey [38]. According to SETS, care to be initiated in life-threatening emergencies (receiving immediate care), urgent conditions (to be seen within 20 minutes) [39].

### Shortage of Physicians

The world health organization predicts that the world needs an additional 10 million health care workers by 2030 [40]. Between 2000 and 2030, the number of people in the United States over the age of 65 was expected to double. This elderly population makes twice as many physician visits as those under 65 [41]. More hospital staff along with physicians will be required with population growth. Interestingly, South Asian countries are lack of hospitals comparing to that. Nearly 86% of all the medical visit in India are made by rurales with majority still travelling more than 100 km to avail health care facility of which 70-80% is born out of pocket landing them in poverty. Government succeeded in generating infrastructures in urban area but fail to do so in rural, sustaining 70% of India population [42]. However, The Times of India claims healthy doctor-patient ratio, 1:921 [43, 44], which is much lower reported in Nepal (2.28 doctors, nurses, and midwives per 1000 population) [45], worst in rural Bangladesh (1 for 1000 people) [46].

### Shortage of Hospital Supply

Drug shortages have become all too common and affect all aspects of the health care delivery system. The increased number of drug shortages has had a negative impact on patient care as well as cost/financial implications. Shortages of critical drugs such as chemotherapy agents, analgesics, injectable nutritional supplements, anesthetics, anti-infectives, and cardiovascular agents are common [47-50]. The impact of drug shortages is multifaceted, with over 50% of health care practitioners believing that shortages have influenced practice and resulted in inferior patient care [51]. A Canadian study relayed anesthesiologists' opinion that drug shortages were responsible for prolonged recovery times, delayed surgical procedure scheduling, and increased recovery cost. Nearly half of them (49%) felt shortages were the impetus for the administration of inferior anesthetics. Drug shortages often impact vulnerable populations including cancer patients or neonates, for whom few, if any, equivalent alternatives exist; shortages may result in clinical complications, as exemplified by selenium shortages. Drug shortages may also force practitioners to prescribe infrequently used medications and concentrations, which can lead to medication errors as demonstrated with prior fentanyl shortages. Drug shortages

have also impacted life outside of patient care; for example, a planned execution in Oklahoma was delayed due to a drug shortage [52].

### Quality Reporting by Hospital Staffs

IRs are and will continue to be an important influence on improving patient safety. However, they are not the panacea that many believe them to be. They have several limitations that should be considered. Most of these limitations stem from inherent biases of voluntary reporting systems. These limitations include: i) IRs can't be used to measure safety (error rates); ii) IRs can't be used to compare organizations; iii) IRs can't be used to measure changes over time; iv) IRs generate too many reports; v) IRs often don't generate in-depth analyses or result in strong interventions to reduce risk; vi) IRs are associated with costs. IRs do offer significant value; their value is found in the following: i) IRs can be used to identify local system hazards; ii) IRs can be used to aggregate experiences for uncommon conditions; iii) IRs can be used to share lessons within and across organizations; iv) IRs can be used to increase patient safety culture. Moving forward, several strategies are suggested to maximize their value: i) make reporting easier; ii) make reporting meaningful to the reporter; iii) make the measure of success system changes, rather than events reported; iv) prioritize which events to report and investigate, report and investigate them well; v) collaborate with diverse stakeholders to enhance the value of IRs [53-57].

### Access to Healthcare

According to the National Rural Hospital Association, "Currently one in three rural hospitals is in financial risk. At the current rate of closure, 25% of all rural hospitals will close within less than a decade in USA." [58] A relatively similar situation found in China. Chinese patients often choose to directly access higher level hospitals, thus bypassing primary care facilities. As a result, higher level hospitals are overcrowded, while primary care facilities remain underutilized [59]. Conversely, poor housing condition, unsafe drinking water, lack of sanitation, use of biomass fuels, exposure to environmental odds as a part of the livelihood among the marginal population group often increase the risk of numerous health problems in India. Twelve percent of critically ill patients remain untreated in the less developed villages [60]. According to WHO, 5.9 million children under 5 years of age died in 2015, with a global under-five mortality rate of 42.5 per 1000 live births. Levels of child mortality are higher in developing countries. Moreover, leading causes of child death in the post-neonatal period were pneumonia, diarrhea, injuries and malaria [61].

### Hospital Acquired Sepsis

Astonishingly, it seems that healthcare access and HCV prevalence are related in Pakistan; it is estimated that 70% of new HCV infections in Pakistan are attributed to routine medical procedures. Particularly concerning are infections

caused by contaminated syringes, which are so prevalent in the healthcare settings. Villages are gripped by fear; no one knew whose life would be taken next by the deadly virus [62]. Nosocomial infections, otherwise known as hospital-acquired infections, are those infections acquired in hospital or healthcare service unit that first appear 48 h or more after hospital admission or within 30 days after discharge following inpatient care. HAP is the second most common nosocomial infection, and is the most common hospital infection leading to death in critically ill patients [63]. European acute care hospitals estimated the prevalence of healthcare-associated infections to be 6%; of these, UTI was the third most common infection (19%). Based on this, the annual health burden of hospitalized patients with UTI was estimated to be 81.2 disability-adjusted life years per 100 000 individuals in the general population [64]. Healthcare-associated infections occur in both adult and pediatric patients. Bloodstream infections, followed by pneumonia and urinary tract infections are the most infections in children, urinary tract infections are the most common healthcare – associated infections in adults [65]

#### Availability of Essential Drugs

Worldwide, many countries have developed a list of essential medicines for children to improve prescribing. The WHO recommends that each country evaluate and adapt the list in order to create a list of essential medicines that is appropriate for its own environment. Specialty drugs are administered to less than 1% to 2% of the US population, yet they account for 38% of US prescription drug costs. By 2018, US specialty drug costs are expected to account for 50% of all US prescription drug costs [66]. In China, access to essential medicines for children is hampered by low availability. WHO has estimated that at least one-third of the world's population does not have regular access to essential medicines [67]. Among Asia Pacific countries, Korea was a country where more medicines were available than other countries [68]. A survey of the availability and price of 32 medicines for chronic diseases in six low- and middle-income countries (Bangladesh, Brazil, Malawi, Nepal, Pakistan and Sri Lanka) concluded that improvement of governance and management efficiency, and assessing local supply options, may improve availability of essential drugs. Prices could be reduced by improving purchasing efficiency, eliminating taxes and regulating mark-ups [69]. In Canada, there is no list or central source of information related to safety, efficacy and tolerability of medication forms and formulations for children [70] and we cannot think of its existence in south Asian countries.

#### High Prices of Drugs and Health Services

Retail prescription drug spending in the US has been estimated at over US\$340 billion annually, with projected growth to nearly US\$600 billion by 2025, accounting for more than 10% of total healthcare spending in the US [71, 72]. High costs of new drugs and price increases for existing products have brought criticism and political interest in the drug pricing

debate over rising drug prices as well as cost effectiveness and affordability [73–76]. Drug price transparency has been argued as a potential solution to improve affordability within the US and abroad as it would improve the negotiating position for purchasers around the world [77]. According to a March 2017 Bloomberg article, “in the U.S., \$15 of every \$100 spent on brand-name drugs goes to middlemen...[and] the largest share, about \$8, goes to benefit managers” [78]. Patients are the central figures in any healthcare system, and although they are often the victim of misaligned incentives, they also bear some responsibility for rising costs. Typically, patients are motivated to spend as little as possible out of pocket. India is the world's largest democracy, with an independent media and strong civil society. However, India ranks 130 on 2018 out of 189 countries HDI [79]. Poor households spent nearly 15% of their monthly income on healthcare in India [60].

#### Justified Use of Biotech Products

Biologic agents, which are produced or derived from a living organism, are the most rapidly growing class of specialty drugs, and hold promise to revolutionize the management of a range of chronic medical conditions [80, 81]. The challenge, however, is reconciling the potential therapeutic benefit with the high cost of these agents. Specialty drugs contribute significantly to the inpatient diagnosis-related group payment system, often with unproved benefits over less-expensive therapies. These medications often may be more appropriate for initiation in the ambulatory setting, after the mechanism of payment for continued therapy has been established. As healthcare costs rise and reimbursements decrease, healthcare organization leadership and clinical providers must collaborate to provide high-value healthcare. Medications are a key driver of the increasing cost of healthcare, largely as a result of the proliferation of expensive specialty drugs, including biologic agents. Loosely defined based on their high costs, the need for special handling protocols, and close patient monitoring, specialty drugs are projected to account for 50% of the total medical expenditure by 2019 [82].

#### Antibiotic Resistance

Antibiotic treatment is one of the main approaches of modern medicine, which is used to combat infections. The “golden era” of antibiotics ranged from the 1930s to 1960s, which gave rise to many antibiotics [83]. In 2018, GLASS reveals widespread occurrence of antibiotic resistance among 500 000 people with suspected bacterial infections across 22 countries. The most commonly reported resistant bacteria were *Escherichia coli*, *Klebsiella pneumoniae*, *Staphylococcus aureus*, and *Streptococcus pneumoniae*, followed by *Salmonella spp.* “Some of the world's most common – and potentially most dangerous – infections are proving drug-resistant,” –as stated by the director of WHO's Antimicrobial Resistance Secretariat [83]. AMR poses a serious global threat of growing concern to human, animal, and environment health. This is due to the emergence, spread, and persistence of MDR bacteria or “superbugs.” MDR bacteria exist across the animal, human,

and environment triangle or niche and there is interlinked sharing of these pathogens in this triad. The plausible causes of “the global resistome” or AMR include excessive use of antibiotics in animals (food, pets, aquatic) and humans, antibiotics sold over-the-counter, increased international travel, poor sanitation/hygiene, and release of nonmetabolized antibiotics or their residues into the environment through manure/feces. These factors contribute to genetic selection pressure for the emergence of MDR bacterial infections in the community. Recently, the global consumption of antimicrobials in livestock has indicated the hotspots of antibiotics use across the continents that will have economic and public health impacts in the years to come. In food animals, antibiotics are commonly used in cattle, chicken, and pigs and it is projected that in 2030 such use will increase up to 67% in the most populated countries of the world. Furthermore, as many antibiotics are often inappropriately prescribed, a more personalized approach based on precise diagnosis tools will ensure that proper treatments can be promptly applied leading to more targeted and effective therapies. However, in more general terms, also the overall use and release of antibiotics in the environment needs to be better controlled [84-87].

#### Unnecessary Emergency Hospitalizations

As concern grows in most countries over increasing health care costs, more attention is focused on reducing waste and unnecessary services. Reducing avoidable emergency department (ED) visits is an important health system goal. Around 15% of ED visits end in inpatient admission [88, 89]. A significant number of ‘avoidable’ ED visits reported by National Hospital Ambulatory Medical Care Survey from 2005 to 2011 for mental health and dental conditions, where the ED is not fully equipped to treat [90]. In the US, the Centers for Medicare & Medicaid Services has implemented the first financial penalties on hospitals for excessive readmissions. Attention likely will be increasingly directed to all hospitalizations because readmissions represent only approximately 9% of hospital admissions and to avoidable ED visits because of the expense of providing care in this setting and its tendency to lead to unscheduled hospital admissions [91]. Because some visits are preventable, they may indicate poor care management, inadequate access to care, or poor choices on the part of patients. ED visits for conditions that are preventable or treatable with appropriate primary care lower health system efficiency and raise costs. An estimated 13% to 27% of ED visits in the United States could be managed in physician offices, clinics, and urgent care centers, saving \$4.4 billion annually [92-94].

#### Poor Health Diagnosis

Both clinicians and patients rely on an accurate diagnostic process to identify the correct illness and craft a treatment plan. Achieving improved diagnostic accuracy also fulfills organizational fiscal, safety, and legal objectives. ‘Improving Diagnosis in Health Care’, report by Institute of Medicine in the

USA concluded that most people will likely experience a diagnostic error in their lifetime [95]. Every nine minutes, a patient in a U.S. hospital dies because a diagnosis was wrong or delayed -- resulting in 80,000 deaths a year [96]. Terms such as overdiagnosis, underdiagnosis and undiagnosed are now frequently used, but their relationship to diagnostic error remains undefined [97]. Some research suggests that 40% of people in the vegetative state are misdiagnosed [98]. Because the clinical features of FD overlap with those of other disorders, errors and delays in diagnosis are common [99]. Despite being an extensively studied condition, the causes of ADHD remain poorly understood and substantial in children, controversy exists regarding its correct diagnosis [100]. In a retrospective analysis of clinical trials, 63% of deceased patients who were clinically diagnosed with AD while alive were found to have AD with other pathology [101]. The rate of misdiagnosis of patients with bipolar receiving outpatient treatment was quite high and they often received a misdiagnosis of depression [102]. Laryngeal edema has been associated with a mortality rate of 12–40%, and in many undiagnosed cases, family history and recurrent skin and abdominal attacks since childhood could have informed the correct diagnosis [103].

#### Wrong Dispensing

Dispensing errors occur in clinical and community pharmacy and commonly involve supply of the wrong drug, the wrong strength and the wrong form of medication [104, 105]. They occur at an average rate of 4 in 250 prescriptions (1.6%) in pharmacies in the United States [106], and incidences up to 45% have been reported in different pharmacy settings [107]. A study in the Netherlands showed that 41% of all medication incidents in community pharmacies related to information technology, were about choosing the wrong drug. One third of incidents were associated with confusion of similar drug names and nearly half were associated with drug strength confusion [108]. Drug strength confusion can happen when two strengths of the same drug look alike, e.g. 3.75 mg and 0.375 mg pramipexole [109]. Drug name and strength confusion are serious issues as they are preventable errors with potential detrimental impact on clinical practice and patient safety [110, 111].

#### Lack of Therapeutic Guideline Implementation

Research indicates that clinical guidelines are often not applied. The success of their implementation depends on the consideration of a variety of barriers and the use of adequate strategies to overcome them. Despite the growing number of guidelines, their use in practice is frequently reported as being unpredictable, often slow and complex. It is estimated that about 30%–40% of patients receive treatment that is not based on scientific evidence, and 20%–25% receive treatments that are either not needed or potentially harmful [112,113]. Guideline adaptation has been defined as a systematic approach to modify and contextualize evidence-based guidelines to suit implementation in the local healthcare

system. The process provides an opportunity to systematically consider transferability of recommendations across different settings, including variation in needs, values, costs, and availability of resources [114]. In India, clinical guidelines, also called standard treatment guidelines (STGs), are developed at the national and state levels and by a wide range of agencies. However, the quality of these guidelines is uncertain [115].

### Poor Vaccination

Of the nearly 10 million children who die each year before reaching their fifth birthday, WHO (World Health Organization) estimates that 2.5 million die from diseases that could be prevented with currently available or new vaccines [116]. However, in the United States it is estimated that 40,000–80,000 people die annually from VPDs, while hundreds of thousands more are hospitalized. The majority of cases and 99% of the deaths from VPDs are in older adults [117]. Yet, people continue to challenge the evidence and refuse vaccinations in many parts of the world. Vaccine hesitancy is the refusal of people to take vaccines or a delay in vaccine acceptance despite vaccination offers from health authorities. This behavioral phenomenon is context- and vaccine-specific. HL is independently associated with several undesirable health outcomes, including poorer overall health status, hospitalization, mortality, and healthcare costs [118]. The Philippine dengue vaccination is the only mass dengue vaccination to date with more than 800,000 individuals vaccinated. Vaccination controversy due to perceived increased risk of serious dengue illness and death with the media associating the vaccine program to practices and corruption has caused low vaccine acceptability [119]. In India, Healthcare was found to be manufacturing Endocrine Disruptors (Estrogen receptor antagonist), a drug that is approved neither in India nor elsewhere [120]. Point is the same company supplied rancid Vitamin A capsules in Bangladesh which caused sickness (experiencing vomiting sensation and feeling unwell) in children of Chittagong, Cox's Bazaar and Lakhimpur among other places of Bangladesh, back in 2013 [121].

### Pharmacists Role

Medication errors are common in community pharmacies. Safety culture is considered a factor for medication safety but has not been measured in this setting. Both the discovery and reporting of medication errors can be improved by creating an environment where consultation about medication regimes are promoted between members of a network and with pharmacists. Understanding the safety culture of community pharmacies can help identify areas of strength and those that require improvement [122]. Standardized patient safety course should be considered in the curriculum for junior pharmacy students to improve their attitude toward patient safety. The World Health Organization (WHO) has also introduced an inclusive patient safety curriculum [123]. With the shifting role of community pharmacists towards patient education and counselling, they are well-positioned to conduct a post-discharge home visit which could prevent or solve drug-

related problems [124]. Close attention to patient safety associates with lowered incidences of adverse events in hospitals. Pharmacists are well positioned to facilitate the in-patient care and discharge process by performing medication reconciliation, identifying patients with poor health literacy or non-adherence, and providing tailored discharge counselling [125]. Both the ACCP and ASHP have identified CPs as tools for pharmacists to provide cost-effective patient care plans, integrate pharmaceutical services, institutional culture, and partake leadership position in the development and implementation of the multifaceted pharmaceutical care [126]. Pharmacists have the unique education and training to identify MNA events early, as well as developing strategies to mitigate or resolve MNA related issues [126-130]. Pharmacists are not alone in their quest for patient safety and quality care. Still their role is significant in patient-care and safety measurement.

### Conclusion

The expectation of the health care system is better care for patients care that is standards-based and outcomes-driven. This expectation is founded on the dual principle that every patient deserves to be safe and every patient deserves optimal medication therapy. Community pharmacists most frequently initiated practical issues, but explored patients' medication beliefs inadequately. Inadequate patient counselling during the transition is a contributing factor. They must adapt their communication to address the wide variety of patients' drug-related problems during these home visits and achieve patient-centered communication. It imparts increased patients' satisfaction, better recall of information and improved health outcomes and requires active participation of both the pharmacist and the patient. Patients should be encouraged to express their needs and concerns regarding their medication, which pharmacists should address to support patients in making informed decisions. It is important to discuss patient experiences, beliefs and adherence issues pro-actively, since not all patients might express these issues themselves. In pharmaceutical treatments, a unique pattern of social network in each healthcare setting can steer behaviors within organizations towards risk reduction in such environments. Gaining insight in the communication during these home visits could be valuable for optimizing these visits; and consequently, to improve patient safety at readmission to primary care.

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