Editorial:

Safety of health care

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Patient safety has been high on the national and international agenda in health care. In our country probably more than 50 %of patients experience an adverse event while in hospital a figure which is higher than those around the word.

Considerable efforts have been made to improve safety and it is natural to ask whether these efforts have been well directed.

We believe that the lack of reliable information on safety and quality of care is hindering improvement in safety.

The principle approach to patient's safety has been to establish local and national reporting systems.

These systems invite voluntary reporting of safety incidents with the aim of feeding back the finding in to the system. Reporting systems are valuable component of a safety system

In order to do that we have to choose indicators which are important to patients?

These indicators include hospital mortality by which report the hospital standarised mortality ratios then the mortality after surgery and the surgical subspecialties.

Health care acquired infection is very important the introduction of mandatory reporting and accompanying infection control intiatives are now reducing infection nationally.

The other indicator is drug errors and adverse events which has many causes some of them are undoubtedly preventable and the overall level of adverse drug events would be an important indicator of the safety of any healthcare system.

The lack of reliable data on safety and quality over time hinders improrement efforts at every level of the national health services.

Finally the absence of solid measurement of safety and indeed quality is a worldwide problem.The development of electronic medical records provides considerable potential for obtaining safety data ,but much remains to be done to develop valid approaches for routine monitoring and detection of error and harm.

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