Chapter 10
Evaluation of the Broken Windows Theory in Terms of Patient Safety

Erkan Turan Demirel
https://orcid.org/0000-0001-7754-774X
Firat University, Turkey

Eda Emul
https://orcid.org/0000-0002-9649-9971
Firat University, Turkey

ABSTRACT

The broken windows theory introduces an approach applicable to different fields of discipline insofar as it explains how disorder (crime, etc.) occurs in a community and provides a basis from which solutions can be developed to prevent it. Considering the complexity of healthcare systems, irregularities, and rule violations that commonly mark them and put human health at risk, it is important to produce more effective solutions by taking advantage of different perspectives. This study evaluates the applicability of the broken windows theory to patient safety. As this theory can be an effective solution to the medical errors, neglect and rule violations that commonly occur in the delivery of health services, it is important that further research on this subject be performed.

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INTRODUCTION

Based on current conditions, the following developments seem to be leading the health sector: Types of service and diversity in provision are increasing. Health informatics and technology are developing. In society, the rate of health literacy is increasing. Patients and their relatives have access to a broad level of knowledge about their rights and are more conscious about their rights. With the impact of these developments, interest in the quality of healthcare is increasing.

The concept of patient safety is one of the first concepts among the primary factors in the quality of healthcare. In general terms, it is expressed as the precautions taken by the healthcare institution and its personnel to prevent harm to the patient. Healthcare personnel cannot usually agree on how to evaluate various factors of benefit and harm because of a lack of concrete evidence about the benefits and harms (Ersoy and Aydın, 1994). It is possible to eliminate this conflict by using the ethical values that have been adopted and implemented by institutions and healthcare personnel.

Practices aimed at ensuring and maintaining patient safety are the most important indicators of healthcare quality. Patient safety refers to all kinds of measures taken by health institutions and their employees to prevent potentially negative effects of health services on individuals (Güven, 2007). At a conference in Geneva in 2007, the World Health Organization (WHO) noted that each year around ten million people worldwide are injured or killed by preventable medical errors, a fact which points to the need for further studies on patient safety (WHO, 2007: cited in Aydemir, 2015).

A healthcare system built on quality and reliability is one defined by patient safety and the prevention of medical errors at every step of the health services delivery process. Therefore, patient safety has been the focus of recent studies and clinical care practices. The idea of patient safety can be described as the development of practices aimed at eliminating the damages to patients and healthcare workers derived from procedural medical errors and the measures taken for ensuring that the errors are identified, reported, and corrected before they cause damages. In effect, patient safety aims to eliminate preventable medical errors and to take precautions against unexpected events at every stage of the healthcare delivery system (Emül, 2017).

While health workers used to be at the center of health service delivery, the focus has now switched to patient satisfaction and patient rights in line with the effects of modernization and social development on the healthcare sector. Factors such as the increased interest in diversity and quality of health service delivery, which emerged as a result of technological and pharmacological developments, the decrease in trust and confidence in health institutions due to errors made by health professionals operating in this complex system, the increased amount of pressure on health professional and health institutions, and the deterioration in the peaceful
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