

SAFETY BEGINS WITH EMPOWERMENT: A LITERATURE REVIEW OF THE ROLE OF PATIENTS AND FAMILIES IN IMPROVING SAFETY IN HOSPITAL INPATIENT CARE

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Abstract Patient safety is a critical component of healthcare services, and family empowerment is increasingly recognized as a key strategy to enhance patient safety outcomes. Active involvement of patients and their families in the care process can reduce the risk of medical errors and improve the overall quality of care. Consequently, it is essential to explore effective strategies for implementing such empowerment in hospital settings. This study aims to identify and synthesize current evidence on patient and family empowerment through the use of safety checklists within hospital-based patient safety programs. This study employed a descriptive literature review approach followed the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) guidelines, drawing on data from peer-reviewed scientific journals published between 2014 and 2024. Analysis of 12 relevant articles revealed that patient and family empowerment significantly contribute to improving patient safety by enhancing their engagement in care processes and decision-making. The use of safety checklists was found to be an effective tool in fostering a culture of safety within hospitals, reducing medical errors, and improving the quality of care. Several factors were identified as influencing the success of patient and family empowerment initiatives, including support from healthcare providers, adequate education, and the presence of systems that facilitate effective communication. These findings highlight the need for collaborative efforts among healthcare professionals, hospital management, and patients to establish a supportive environment for empowerment, alongside continuous training for healthcare providers on the importance of safety culture. This study underscores the critical role of patient and family empowerment in enhancing the safety of hospitalized patients. Empowerment strategies, particularly those involving safety checklists, are essential in fostering a culture of safety and minimizing preventable harm in healthcare settings.

Keywords: empowerment, patient, family, checklist, safety

1. INTRODUCTION

Patient safety is a significant public health concern. Globally, it is estimated that approximately one in every twenty patients experiences harm while receiving medical care in primary, secondary, and tertiary healthcare facilities. Notably, nearly half of these incidents are preventable. Traditionally, strategies aimed at improving patient safety have primarily focused on professional-based interventions, such as developing incident reporting systems, restructuring healthcare delivery processes, and modifying professional behavior [1]. In recent years, however, there has been a growing international emphasis on patient involvement in safety initiatives. Since 2004, the World Health Organization has identified patient, family, and community engagement as one of the six foundational priorities of patient safety, maintaining its status as a core focus ever since [2].

Every year, an estimated 134 million adverse events contribute to 2.6 million deaths in low- and middle-income countries, with safety failures accounting for approximately 15% of total hospital expenditure [3]. According to Indonesia's Ministry of Health Regulation No. 11 of 2017 on patient safety, adverse events in healthcare facilities include Potential Injury Conditions, Near Miss Events, Non-Injury Events, Adverse Events, and Sentinel Events. These incidents often result from unsafe care practices, such as diagnostic errors and medication errors, and are classified under Adverse Events [4].

Patient safety in pediatric units is particularly vulnerable compared to adult populations, due to several child-specific characteristics, including physiological and developmental differences, medication dosing complexities, intricate procedures, and the critical roles of parents and caregivers. Additionally, children are more susceptible to stress and psychological trauma. Adverse events frequently occur in healthcare settings and are recognized as leading causes of patient morbidity and mortality, with 0.6% to 2% of these events resulting in death. In pediatric populations, mortality

rates due to adverse events range between 2% and 6% [5]. Approximately 2% of pediatric inpatients experience falls, with about one in four of these incidents resulting in injury—10% of which are serious. Falls account for 24% of child safety incidents, and an estimated 684,000 deaths occur annually due to falls, with over 80% of these deaths occurring in low- and middle-income countries [2].

Previous studies have identified several factors that influence patient safety culture, including staff education and training, interprofessional communication, patient involvement, organizational culture, leadership commitment to safety, and incident reporting and learning mechanisms. Additional factors such as workload and resource availability also significantly affect the development of a strong safety culture [6].

There is a growing consensus on the need to reform policies and practices to better identify, address, and support harmed patients. Empowering patients and families has become a global priority [6, 7]. In the Global Patient Safety Action Plan 2021–2030, the WHO highlights patient and family engagement as one of the seven strategic objectives to support organizational learning and quality improvement. These seven objectives include: (1) policy to prevent harm, (2) high-reliability systems, (3) clinical process safety, (4) patient and family engagement, (5) workforce education and safety, (6) information, research, and risk management, and (7) synergy, partnerships, and solidarity [3].

The concept of empowerment views patients and families as integral members of the care team [8]. Effective involvement requires patients and families to possess health literacy, self-care capacity, and adherence to medical instructions especially in medication compliance [9]. Strategies to enhance patient literacy are embedded within national patient safety standards, which include: (1) patient rights, (2) patient and family education, (3) continuity and safety of care, (4) use of performance improvement methods for patient safety evaluation, (5) leadership roles in promoting safety, (6) staff training on patient safety, and (7) effective communication among staff [7]. Education empowers patients to understand their diagnoses and treatments, fosters proactive self-care behaviors, and mitigates feelings of helplessness associated with illness.

Medical errors such as medication mistakes, incomplete procedures, or poor communication can often be prevented by implementing safety checklists. Systematic checks help reduce errors by ensuring that all necessary steps are reviewed before clinical actions are taken. Checklists serve as consistent reminders to healthcare staff about the importance of patient safety, reinforcing a safety-first culture within hospital environments. Additionally, they help reduce variation in patient care practices, which is crucial since inconsistent procedures can result in unsafe outcomes. By standardizing care processes across healthcare teams, checklists enhance consistency and quality. Moreover, they enable ongoing performance monitoring and evaluation, allowing hospitals to identify areas for improvement and make necessary adjustments to promote safer care.

Accordingly, this study aims to identify and synthesize current evidence on patient and family empowerment through the use of safety checklists within pediatric patient safety programs in hospital settings.

2. MATERIAL AND METHODS

2.1. Study Design

This literature review followed the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) guidelines to ensure transparency and rigor. The eligibility criteria included full-text, peer-reviewed articles published in English between 2014 and 2024 that focused on patient and/or family empowerment in relation to patient safety within hospital settings. Studies were excluded if they did not specifically address empowerment strategies or if they focused on non-hospital environments. To enrich the contextual background, additional sources such as national health reports, textbooks, and dissertations were also considered when thematically relevant.

2.2. Information sources

The literature search was conducted across four major electronic databases: PubMed, ProQuest, ScienceDirect, and Google Scholar. The search strategy combined Medical Subject Headings (MeSH) and free-text terms such as "patient empowerment," "family engagement," "patient safety," "hospital," and "checklist." Boolean operators (AND, OR) were used to refine the search results. The final search was performed in June 2024, and no restrictions were placed on the study design to allow for comprehensive inclusion of both qualitative and quantitative studies.

2.3. Quality Assessment and statistical analysis

VT and YT independently evaluated the methodological quality of the included studies using instruments developed by the Joanna Briggs Institute (JBI) [10]. Any discrepancies in their assessments were resolved through discussion. The JBI tools comprise specific checklists designed for various study designs, including those tailored for cross-sectional studies, which were anticipated to be the predominant design among the included literature. Each checklist contains up to ten items, depending on the methodological design, and assesses key components of methodological rigor using response options of 'Yes', 'No', 'Unclear', and 'Not applicable'.

Data analysis was performed using SPSS version 25.0 (IBM Corp., Armonk, NY). To assess the level of agreement between the two reviewers regarding study selection and quality appraisal, both Kappa statistics and percentage agreement were calculated [11]. A Kappa value of 0.8 or above was interpreted as indicating a high level of agreement.

2.4. Data Collection process

The selection process involved two independent reviewers who first screened the titles and abstracts to assess relevance, followed by full-text assessments for final inclusion based on the eligibility criteria. Discrepancies between

reviewers were resolved through discussion until consensus was reached. Data were then extracted using a standardized form that captured essential study information, including publication year, country, setting, study design, target population, type of intervention, and key outcomes related to empowerment and patient safety.

A thematic synthesis approach was applied to the extracted data. The data were coded and organized into thematic categories, with particular focus on empowerment strategies, implementation of safety checklists, barriers and facilitators to safety culture, and reported outcomes on patient safety. These themes were refined through iterative review, and the synthesis was presented in a narrative format to highlight how patient and family empowerment particularly through the use of safety checklists contributes to improving patient safety outcomes in hospital settings.

2.5. Characteristics of the Included Studies

A total of twelve articles were included in this review. Of these, five were observational cross-sectional studies, four employed qualitative methodologies, two were descriptive quantitative studies, one was a randomized controlled trial (RCT), and one utilized a mixed methods design. The studies originated from various countries, with four conducted in Iran, two in Taiwan, two in Turkey, and one each from Syria, China, Bangladesh, Saudi Arabia, and South Korea. The detailed characteristics and key findings of each included study are presented in **Table 1**.

A clear overview of the procedure in literature management can be seen in the figure below::

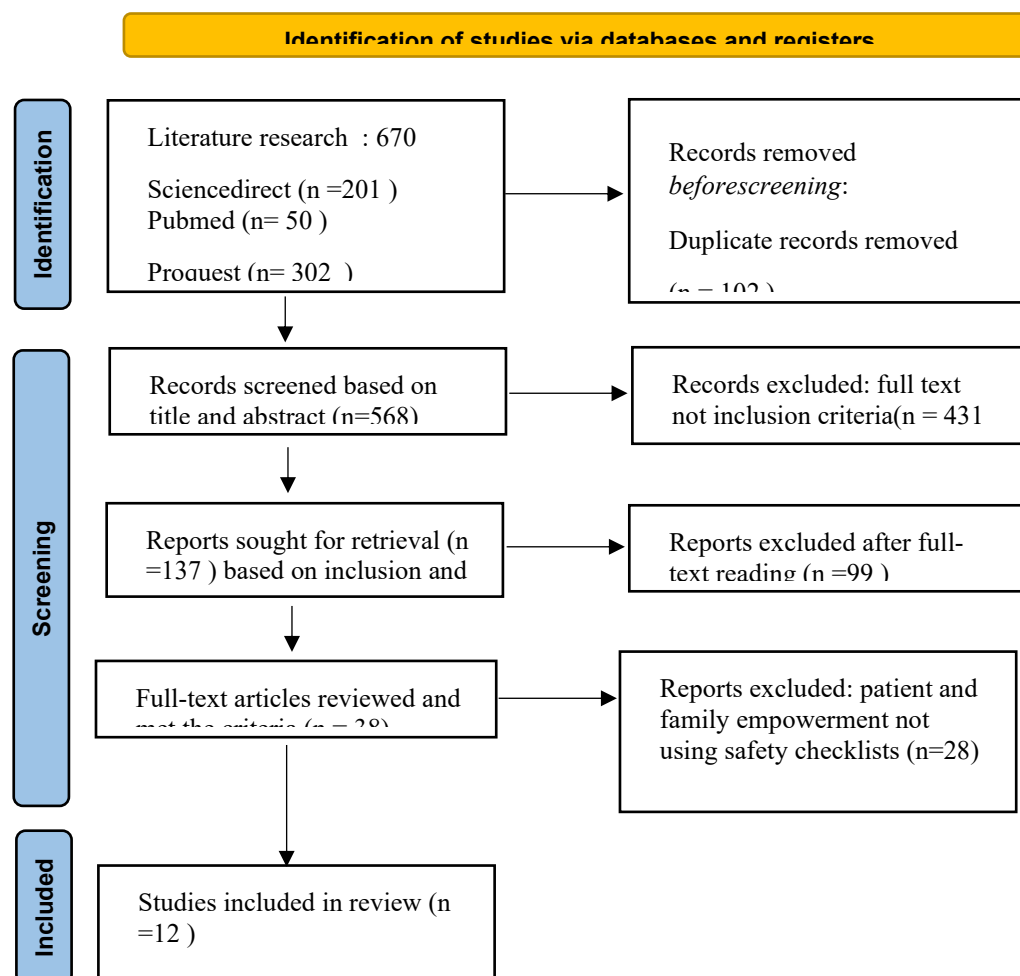


Figure .1 PRISMA flowchart for article selection on patient and family empowerment using safety checklists in implementing a safety culture for patients in hospital

Tabel 1. The baseline characteristics of the included studies

No	Author	Title	Objective	Method	Finding
1.	Harris K, Søfteland E, Moi AL, Harthug S, Storesund A, Jesuthasan S, Sevdalis N, Haugen AS. BMC Health Serv Res. 2020	Patients' and healthcare workers' recommendations for a surgical patient safety checklist – a qualitative study	To investigate perceived risk elements identified by patients and healthcare providers that should be included in a surgical safety checklist implemented by patients themselves	1. Exploratory qualitative design 2. Focus group interviews with postoperative patients and healthcare professionals from various surgical specialties in Norway 3. Participants identified safety risk factors categorized into preoperative information, preparation, postoperative information, and follow-up plans.	1. Four main categories emerged: preoperative information, preoperative preparation, postoperative information, and postoperative plans and follow-up. 2. Both patients and healthcare providers expressed the need for a checklist to assist with information retention and communication. 3. Findings indicate that a patient-initiated checklist can enhance patient engagement, reduce errors, and mitigate risks of complications. 4. The study supports the development of a patient- driven checklist to complement existing safety programs and improve communication. 5. It highlights the importance of patient involvement in safety initiatives and the potential benefits of surgical safety checklists.

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2.	Garfield S, Furniss D, Husson F, Etkind M, Williams M, Norton J, Ogunleye D, Jubraj B, Lakhdari H, Franklin BD. BMJ QualSaf. 2020	How can patient-held lists of medication enhance patientsafety? A mixed-methods studywith a focus on user experience	To identify mechanisms that support patient safety, including key features, as well as enabling and inhibiting factors related to the use of medication checklists.	Mixed-methods design involving semi-structured interviews and questionnaires administered to 60 patients and their family members.	1. The study found that patient-held medication checklists were useful in enhancing medication safety, improving the accuracy of medication administration, identifying potential drug interactions, facilitating communication, enabling patients to review their own medications, and serving as reminders for appointments, medication intake, and refills. 2. Patients, families, and healthcare professionals recognized multiple benefits of patient-held medication lists. The findings suggest that targeted interventions are needed to raise awareness about the critical role of these checklists in improving patient safety. Moreover, empowering patients and families to select the method that best fits their needs is essential, as a one-size-fits-all approach may not be effective.
3.	Kim YS, KimHS, Kim HA, Chun J, KwakMJ, Kim MS, Hwang JI, Kim H. BMC Health Serv Res. 2020	Can patient and family education prevent medical errors? A descriptive study	To investigate the impact of patient and family education on the prevention of medical errors, with the aim of providing baseline data for developing educational content.	1. Descriptive design 2. Sample: 242 participants 3. Data collection involved face-to-face surveys to ensure informed consent and clarity regarding the purpose of the study	1. Patient safety officers placed greater emphasis on cultivating a culture of safety compared to patients and families. 2. Patient and family involvement was identified as the most critical element in preventing medical errors, with significant differences observed between groups. 3. The importance of patient and family participation in safety initiatives was highlighted, with a strong emphasis on communication and education. 4. All groups acknowledged the potential of educational content to reduce medical errors, indicating a shared understanding of its importance..
4	Sarkhosh S, Abdi Z, Ravaghi H. BMC Nurs.2022	Engaging patients in patient safety: a qualitative study examining healthcare managers and providers' perspectives	To explore the perceptions of healthcare providers (HCPs) and managers regarding patient participation in the patient safety process.	1. Qualitative study conducted in three teaching hospitals in Tehran, Iran. 2. Data were collected through semi-structured interviews with 31 HCPs and managers working in educational hospitals.	1. Participants believed that patients and families could play an effective role in maintaining and enhancing patient safety through various forms of involvement. However, several barriers were identified at the patient, provider, and system levels that hindered patient participation in delivering safe care. 2. Participants identified both enablers and barriers to patient engagement in safety-related activities across

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					patient, provider, and system domains, suggesting the need for complex and multifaceted initiatives to address these challenges. 3. The study calls for further research to enhance understanding of the issues and potential solutions for improving patient engagement in safety initiatives within the Iranian healthcare context.
5	Rose L, IstamboulianL, Amaral ACK, BurryL, Cox CE, Cuthbertson BH, IwashynaTJ, Dale CM, Fraser I. Co-designed and. J Crit Care. 2022	Co-designed and consensus based development of a quality improvement checklist of Patient and family-centered actionable processes of carefor adults withpersistent criticalillness	To achieve consensus among stakeholders regarding the most important care processes to be included in a checklist aimed at improving the quality of care for patients with persistent critical illness.	This study employed the Delphi method. 1. In the first round, participants rated the importance of various care processes. 2. In the second round, participants reviewed their responses along with the average scores and standard deviations to assess the stability of their ratings. 3. In the third round, participants evaluated additional items suggested by others to ensure comprehensive consideration of all actionable processes. 4 Interviews were conducted with a diverse group of stakeholders, including: 3 patients, 11 family members, 9 nurses, 6 pharmacists, 6 speech therapists, 4 physicians, 4 respiratory therapists, and one each of a	1. The study produced a quality improvement checklist comprising actionable care processes considered important by stakeholders to enhance patient- and family-centered care. 2. Further research is needed to determine optimal implementation strategies and evaluate their impact on outcomes and patient experiences.

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				physiotherapist, nutritionist, and social worker.	
6	Poveda VB, Lemos CS, Lopes SG, Pereira MCO, Carvalho R.. Rev Bras Enferm. 2021	Implementation of a surgical safety checklist in Brazil: cross-sectional study	To identify the implementation process of the Surgical Safety Checklist in hospitals in Brazil.	1. Cross-sectional study design 2. Sample: 531 participants	1. A total of 84.27% of participants reported the use of the checklist in their workplace. 2. During the “Sign-in” phase, 79.65% of professionals confirmed patient identification using two indicators. 3. During the “Time-out” phase, 51.36% of surgeries were initiated without confirming at least one checklist item. 4. In the “Sign-out” phase, 69.34% of professionals either failed to count or only counted surgical instruments and suturing needles once, and only 36.36% reviewed concerns regarding postoperative recovery. 5. The study highlights the need for improvement in checklist implementation in Brazil to ensure safer surgical procedures. aman
7	M.,Patabendige., Hemantha, Senanayake. (2015). 1. BMC Pregnancy and Childbirth,	Implementation of the WHO safechildbirth checklist program at a tertiary care setting in Sri Lanka: a developingcountry experience	To examine the institutionalization of the World Health Organization (WHO) Safe Childbirth Checklist (SCC) in a tertiary care setting in Sri Lanka.	1. Prospective observational study. 2. Healthcare workers were trained in the use of the SCC, which was to be applied to every woman admitted to the maternity ward during the study period. 3. A self-administered, qualitatively validated questionnaire was distributed to	1. The WHO Safe Childbirth Checklist (SCC) was designed to improve patient safety by addressing the leading causes of maternal and neonatal morbidity and mortality during childbirth. 2. The average compliance with the checklist was 71.3%, and healthcare workers reported a generally positive attitude toward its use. 3. The checklist promoted essential safety practices, facilitated interpersonal communication, and encouraged teamwork among healthcare providers, aiming to reduce preventable childbirth-related harm.

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No	Author	Title	Objective	Method	Finding
				all nursing and midwifery staff to assess their knowledge and attitudes toward the checklist. Each SCC item was reviewed to evaluate compliance	4. Barriers to full implementation included increased workload and limited staff knowledge. 5. The average knowledge level among healthcare workers regarding the checklist was 60.1% (95% CI: 57.2–63.1), while overall compliance stood at 71.3%. 6. A total of 69.4% of respondents agreed that the checklist stimulated interpersonal communication and team collaboration. 7. Implementation was hindered by increased workload, low enthusiasm from healthcare workers toward additional routine tasks, and perceived ease-of-use limitations of the checklist
8	Jared, D., Padgett., Kenneth, Gossett., Roger, W., Mayer., Wen-Wen, Chien., Freda, Turner. (2017). The Qualitative Report	Improving Patient Safety through High Reliability Organizations	To explore the introduction of a safety culture and improvements in patient safety	Data collection included semi-structured interviews, observation of nursing and respiratory staff, and review of organizational documents regarding the implementation of High Reliability Organization (HRO) theory and its impact on improving patients' quality of life..	1. Patient and family empowerment in hospitals can be enhanced through the use of safety checklists, which serve as tools for communication and engagement. 2. Checklists help ensure that critical information is recorded and shared among care providers, fostering a collaborative environment where patients and families can actively participate in their care. 3. Involving patients and families in safety protocols can improve patient satisfaction and safety outcomes, as empowered patients are more likely to voice concerns and adhere to treatment plans—ultimately contributing to a stronger culture of safety within the organization.
9	Emmanuel Aoudi Chance, Dia Florence Innocent Sardi Abdoul International Journal of Nursing Sciences, 2024	The effectiveness of checklists and error reporting systems in enhancing patient safety and reducing medical errors in hospital settings: A narrative review	To explore the impact of checklists and error reporting systems on hospital patient safety and medical errors.	Data were collected through a literature search of academic databases covering the period from 2013 to 2023.	Checklists and error reporting systems are interrelated. Interprofessional collaboration is emphasized in the implementation of checklists to enhance patient safety.
10	James D. O'Leary MB BCh MD,	Effect of surgical safety checklists on pediatric surgical	To determine whether the implementation of a	1. etrospective cohort study using healthcare database	1. A total of 14,458 and 14,314 surgical procedures were identified in the pre- and post-checklist implementation groups, respectively.

Tabel 1. The baseline characteristics of the included studies

No	Author	Title	Objective	Method	Finding
	Duminda N. Wijesundera MD PhD, Mark W. Crawford MBBS Competing interes CMAJ,2016	complications in Ontario	surgical safety checklist is associated with a reduction in the proportion of pediatric patients experiencing perioperative complications.	records to compare the risk of perioperative complications among pediatric patients undergoing common surgical procedures before and after the mandatory implementation of a surgical safety checklist. 2. Sample: 116 acute care hospitals in Ontario.	2. The proportion of children experiencing perioperative complications was 4.08% (95% Confidence Interval [CI]: 3.76%–4.40%) before the checklist implementation and 4.12% (95% CI: 3.80%–4.45%) after implementation.
11	Hardeep Singh, MD, et al, The Joint Commission Journal on Quality and Patient Safety, 2022	Developing the Safer Dx Checklist of Ten Safety Recommendations for Health Care Organizations to Address Diagnostic Errors	To develop the Safer Dx Checklist, which includes 10 high-priority safety practices that healthcare organizations (HCOs) can use to conduct proactive risk assessments to address diagnostic errors.	1. Initially, the team identified potential practices based on a review of current literature and reports from national and international organizations. 2. Interviews were conducted with quality and safety leaders. A Delphi panel was convened, followed by an online expert panel, to prioritize 10 safety practices. 3. The prioritization process considered both the potential impact on safety and the feasibility of implementation within a 1–3 year timeframe. 4. Cognitive walkthroughs were conducted to assess face validity with end-users. 5. The team also conducted content analysis at each step to identify themes influencing prioritization and implementation of the checklist..	1. total of 71 candidate practices were identified through the Delphi panel consisting of 28 experts; 65% of participants reached consensus on 28 practices. 2. A multidisciplinary panel of 10 experts refined and finalized the top 10 practices, which were developed into a checklist accompanied by an implementation guide. 3. The selected practices addressed themes such as creating organizational accountability and leadership in diagnostic safety, involving patients in diagnostic safety efforts, and developing infrastructure to support measurement and improvement activities. 4. Qualitative analysis revealed insights into implementation challenges and facilitators. End-users from three different HCOs contributed to refining the implementation guidance for the checklist.

Tabel 1. The baseline characteristics of the included studies

No	Author	Title	Objective	Method	Finding
12	Jonathan Taiswa, Mary Kipmeremo, Alex Chebor International Journal of African Nursing Sciences (2023)	Effectiveness of checklists in multidisciplinary rounds for improving patient safety in the pediatric intensive care unit: a systematic review protocol	To assess the level of compliance and identify factors influencing adherence to the WHO Surgical Safety Checklist (SSC) in teaching and referral hospitals in Southwestern Kenya.	1. Cross-sectional mixed-methods design 2. Compliance with the WHO SSC was assessed through a retrospective review of 424 randomly selected surgical records. 3. Forty operating room (OR) staff were included using a census method, with 31 of them interviewed using structured interviews to gather qualitative data on staff- and institution-level factors affecting SSC compliance. 4. Quantitative data were analyzed using the Statistical Package for Social Sciences (SPSS).	1. Higher compliance was observed in elective surgeries (78%) compared to emergency surgeries (22%). 2. Compliance varied by type of surgery, with adult general surgeries showing the highest compliance (40%) and orthopedic surgeries the lowest (4%). A downward trend in compliance was observed across the three key surgical phases: 'Sign-in' (5.7%), 'Time-out' (1.8%), and 'Sign-out' (0.7%). 3. The overall average compliance rate was 2.7%. Key staff-related factors affecting compliance practices included years of experience, attitudes, and perceptions toward the checklist.

RESULT

The analysis of included studies highlights significant findings regarding the implementation and effectiveness of checklists to enhance patient safety across various healthcare contexts. Harris et al. [21] identified critical risk factors and emphasized the potential for patient-driven checklists to improve patient engagement, communication, and reduce surgical complications. Garfield et al. [16] underscored the importance of patient-held medication checklists in enhancing medication accuracy and facilitating communication, recommending tailored interventions for optimal utility. Kim et al. [17] reported that patient and family education plays a crucial role in preventing medical errors, advocating for comprehensive educational strategies to foster stronger safety cultures within healthcare settings. Sarkhosh et al. [1] recognized both enablers and barriers to patient involvement in safety initiatives, stressing the importance of adopting multifaceted approaches to overcome systemic and cultural challenges effectively. Rose et al. [20] developed a consensus-driven checklist aimed at improving critical care quality, highlighting extensive stakeholder collaboration as integral to enhancing patient- and family-centered care. Poveda et al. [14] identified significant compliance gaps with surgical checklists in Brazilian hospitals, emphasizing the urgency for targeted educational and policy interventions. Patabendige and Senanayake [15] documented moderate compliance with the WHO Safe Childbirth Checklist in Sri Lanka, citing increased workload and knowledge deficits among healthcare workers as primary barriers. Padgett et al. [22] indicated that empowering patients through checklists significantly enhances communication, patient satisfaction, and reinforces organizational safety culture. Chance et al. [12] demonstrated the synergistic role of checklists and error-reporting systems in promoting interprofessional collaboration, ultimately reducing medical errors. O'Leary et al. [18] found no statistically significant reduction in pediatric surgical complications following checklist implementation, highlighting the complexity of measuring outcomes and suggesting the need for broader evaluation criteria. Singh et al. [19] successfully developed the Safer Dx Checklist to reduce diagnostic errors, promoting structured safety practices and heightened organizational accountability. Finally, Taiswa et al. [13] observed notably low compliance rates with surgical safety checklists in Kenyan hospitals, identifying key issues such as staff attitudes and institutional support as critical areas requiring immediate attention. Collectively, these studies reinforce the crucial role of checklists in patient safety initiatives while emphasizing the necessity of context-specific implementation strategies and proactive measures to address identified barriers.

DISCUSSION

Incident reporting remains a major concern in the context of patient safety culture. Many incidents could potentially be prevented if safety culture were implemented effectively. The most commonly cited issue is non-compliance by healthcare personnel with standard operating procedures (79%) [12-15]. Other contributing factors include patients' neglect of early signs of complications, lack of a sense of responsibility or follow-up on errors, and insufficient support, loyalty, or learning opportunities extended to patients [1, 13, 16, 17].

Barriers to incident reporting persist and are attributed to various causes, including lack of training, fear of retaliation or consequences, high staff turnover, and inadequate follow-up by hospitals after incidents are reported [18-20]. This review highlights the importance of continuous education, effective communication, and teamwork in enhancing patient safety.

Empowering patients and their families during hospitalization is crucial in supporting patient safety [16]. The role of family members as partners in care becomes especially important when the patient is unable to care for themselves due to disability or young age [15, 17]. Their involvement is believed to prevent safety incidents. Studies reveal variability in safety culture implementation, ranging from poor to good, with incident reporting being a consistently weak area [21, 22]. Contributing factors include staff attitudes, poor documentation, insufficient training, inadequate staffing, and high workload.

Several studies suggest that ongoing efforts to strengthen patient safety culture are essential and should actively involve both patients and families [15, 17, 20]. A weak safety culture can increase healthcare costs and worsen patient outcomes. Patient involvement plays a vital role, as patients can contribute by communicating their health status, asking questions, and reporting adverse events.

Findings indicate that patient and family participation, along with engagement from healthcare professionals, is the most critical factor in preventing safety incidents. However, barriers to involvement vary across clinical settings such as emergency departments and intensive care units, often related to the duration and complexity of care. Overall, the evidence underscores the effectiveness and necessity of patient and family empowerment in preventing safety incidents.

The use of safety checklists has been implemented in various contexts, and findings consistently demonstrate substantial benefits for patient safety. These include enhanced medication safety, acting as reminders for patients and families, and reducing errors and complications. Checklists also improve interpersonal communication and teamwork.

However, several barriers to implementation remain, such as increased workload, low staff enthusiasm, and perceived complexity of checklist use.

Several studies have specifically examined surgical safety checklists in patients undergoing surgical procedures [13, 14, 18]. Collectively, these findings affirm that patient and family engagement in safety culture through checklist use is both beneficial and recommended. Ongoing refinement and integration of such tools are essential to sustain improvements in patient safety.

CONCLUSION

Family empowerment through the use of safety checklists not only enhances pediatric patient safety but also improves the overall care experience and outcomes. Active involvement, better communication, and structured learning processes enable families to contribute significantly to a safer and more effective care environment.

The active participation of patients and their families during hospitalization is a cornerstone of patient safety. The involvement of family members as care partners is particularly crucial when patients are unable to advocate for themselves due to disability or age. Evidence indicates that the most important factor in preventing safety incidents is the collaborative participation of patients, families, and healthcare providers.

Additionally, the studies reviewed highlight context-specific barriers to patient and family engagement, such as differences in clinical settings (e.g., emergency departments vs. intensive care units) and lengths of stay. Nonetheless, the overall findings strongly support the value and necessity of patient and family empowerment in preventing safety-related incidents in hospitals.

Ethics Approval: Not required.

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