

Patient Safety Concept and Implementation in Traditional/Complementary Alternative Medicine (TM/CAM)

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ABSTRACT

Safety in patient in-service health is essential for increasing the quality of service health. The development of TM/CAM services in Indonesia started with the passing of Law No. 17 of 2023. However, in practice is not yet lots done because it still does not have a receptacle or service. Besides that, there is still limited availability of TM/CAM staff with formal education, Done with studies literature about concept safety patients and implementation in the TM/CAM services. A literature review is a series of related research with library data collection methods or object research. His research dug through a diverse information article in a journal/bibliography. Analysis of the data used in the study using an analysis of which one is a concept and which the other is an implementation in the TM/CAM, Thereby important implementation of the patient safety concept in a way general under ICPS developed and how its implementation in TM/CAM. The point similarity description detection, incident, and harmful incident is first known with Adverse vent, mitigation, and contributing factors/hazards in TM/CAM. Report risks, incidents, harmful incidents, and their importance to climate and culture safety patients in TM/CAM. Some incidents mainly originate from the biological (herbal), and acupuncture is relatively small. With the increasing interest of the public in safety healthcare, TM/CAM professions in parts of the world and practitioners are responsible for improving safety products and practices. This is by the perception public that TM/CAM is natural and considered safe. Therefore, there exists a need for reporting and research across the country to get sufficient data for analysis. Various types of incidents related to TM/CAM are potentially harmful, as well as various activities described as TM/CAM practices and organizations involved in the training or supervision of practitioners. The evaluation strategies need to consider these issues to reduce future risks.

Keywords: TM/CAM, Concept Safety Patent, ICPS, incident, risk

INTRODUCTION

The safety of patients become a global issue in various countries (WHO, 2019); it is estimated that 10-25% of patients who take care of experienced hospitalization incident safety patients (Green, 2021). Safety patient is a system that creates care for patients, covers assessment of risk, identification and management of risk patients, reporting and analysis of incidents, ability to study incidents and actions continued, as well as implementation solutions To minimize emergency risks and prevent injuries caused by mistakes _ consequence carry out something action or no take proper action taken. (Permenkes no. 11 of 2017)

The objective of the patient's safety is to avoid and reduce risks, errors, and losses that occur in patients during service health, including TM/CAM services. Apart from that, the main goal of safety patients is to prevent detrimental things related to service health and overcome no impact avoided from the effects side with increased service health quality (Wake et al., 2021)

Safety-related health can originate from individual factors or systems. However, energy health, specifically nurses, is a potential contributor to increasing the safety of patients in general and preventing frequent falls, pressure sore / decubitus, infections, error treatment, error documentation, and injuries Because equipment. Failure to maintain the safety of patients in a significant way can increase the cost of care, morbidity, and mortality (Lee et al., 2022),

Almost every medical action keeps potency risk. Lots of types of medicine, types of examinations and procedures, as well as patients and the number of staff, are sufficient potential factors Lots for medical (medical errors). Error medical is interpreted as a failure action medical that has planned for resolution not as desired (error action) or wrong planning to reach something goal (error planning).

Treatment health traditional/complementary and alternative (TM/CAM) as group systems, practices, and products medical and care general diverse health not considered part of conventional treatment. However, debates about the effects of clinical surveys from TM/CAM interventions from various parts of the world consistently document that part big residents using TM/CAM.

Thus, TM / CAM is a component general in choice service health globally and must fulfill patient effectiveness and safety demands. On the year 2009, a workshop consisting of a researcher academic And clinical with an interest special in TM/ CAM security was held in Tromso, Norway, in the lower shade of NAFKAM (National Research Center in Complementary and Alternative Medicine). The workshop discusses method priority and constraints in research TM/CAM security.

Benefits Which can from the workshop This group research and academic collaboration covers a series of experiences in the field, understanding of theory, consistency terminology, definition And method study, And identification methodology And constraint study. In discussions about internal safety TM/CAM services severa,l terms.

Safety: the reduction of risk of unnecessary harm to an acceptable minimum (note: some forms of harm are necessary, such as an incision in operation)

Event: something that happens to or involves a patient.

Incident (completely, incident safety patient): an event circumstance which could have resulted, or did result, in unnecessary harm to a patient.

Harmful incident (formerly adverse event): an incident that resulted in harm to a patient.

Side effect: a known effect, other than that primarily intended, related to the pharmacological properties of a medication.

Adverse reaction: unexpected harm resulting from a justified action where the correct process was followed for the context in which the event occurred.

Incident type: a descriptive term for a category made up of incidents of a common nature, groups because of shared, agreed features. Something incident or circumstances

Which consists of incident - incident, whose nature is general, group because of similarity, and characteristic features that agree.

TM/CAM services in Indonesia are more known with health Traditional in Law no . 17, the year 2023. In article 22 sub, article 1 point w mentions service health traditional based on the method the treatment consists above: a) Service Health traditional use Skills; and/ or b). Service Health's traditional use of herbs. Human Resources of Health article 199 a. Clinical psychology; b. Nursing; c. midwifery ; d. pharmacy; e. Public health c; f. health environment; g. power nutrition ; h. Physical Therapy; i . medical technology; j. biomedicine technology; k traditional health; and l. Other Health Workers determined by the Minister Traditional health consists of herbal medicine, traditional healer, and traditional healer intercontinental. (Traditional China Medicine) which has had formal education.

Several Type Category Man Power Traditional health (TM/CAM) a lot done developed with training within a short period which follows TM/CAM developments in TM/CAM in the world. According to WHO, there are several growing TM/CAM groups with formal education or short-term training, including 1) Group Body Mind Therapist combining mental and respiratory as well as movement body with for example, meditation, biofeedback, hypnosis, yoga, tai chi, guided imagery, therapy art and so on 2) group Practice based biological among others, with vitamins, supplements, plants or herbal 3) group manipulative includes massage, chiropractic, reflexology 4) Use energy like such as reiki, touch healing, 5) Holistic approaches include and Traditional Chinese medicine including There is acupuncture, naturopathic medicine, homeopathy, and Alexander technique.

According to WHO, there is Therapy included _ in the TM/CAM category, namely acupuncture used simultaneously with conventional medicine treatment. General TM/ CAM has already been evaluated and proven safe and useful. However, there are some who still do Not yet have clear security and Already feel the benefits by society in a way subjective. Several product supplements or nutrition herbs circulating in the community have not received approval from the Food and Drug Administration (FDA) <https://www.nhs.uk/conditions/complementary-and-alternative-medicine> This matter still lacks information on safety patients in the TM/CAM that way need a description of the concept and implementation of safety patents in the TM/CAM.

METHOD

Done with studies literature about concept safety patients and implementation in the TM/CAM services. A literature review is a series of related research with library data collection methods or object research. His research dug through a diverse information article journal/bibliography. Data used in the study is secondary data through several related articles with TM/CAM. Analysis of the data used in the study using an analysis of which one is a concept and which the other is an implementation in the TM/CAM

RESULTS AND DISCUSSION

Several studies have shown that there are challenges, especially in TM/CAM safety, to harmful incidents with TM/CAM. Studying in the TM/CAM does not always need to approach different research from conventional health services; of course important to apply existing knowledge and expertise obtained. However, the team researcher must include people who know special about TM/CAM. Taxonomy for gathering report errors must be based on theoretical concepts of error and must cover information about the factor system (Taib IA et al.; 2011). However, there are factors specifically possible for a project study in key concepts like how to classify incidents badly. For example, definitions that have been produced in Australia, Canada, and Europe are not consistent. World Alliance for Safety Patients, as part of the WHO initiative on Safety Patients, reached a consensus about the International Classification of Patient Safety (ICPS) patients. Classification This covers set definition safety standards that are intended to be clear and firm as well as reflect use terms every day and consistent with Family Classification WHO International.

The advantage of such a universal system should be obvious in collecting, classifying and analyzing safety data. One important change is the renaming of 'adverse event' to 'harmful incident,' which is intended to avoid the common confusion between the terms 'adverse event' and 'adverse reaction.' The WHO has identified different forms of classification of risk for different purposes, and the ICPS presented a classification of 13 incident types], such as 'clinical administration,' 'clinical process,' and 'behavior,' that aims to be universally applicable. All incident types except one ('oxygen/gas/vapor') seem potentially relevant to

WHO has identified various forms of classification risk For different purposes, and ICPS presents a classification of 13 types of incidents (WHO; 2009), such as ' administration clinical, ' clinical process, 'and ' clinical process. ' behavior,' which aims to be able to apply universally. All types of incidents except one (oxygen/gas/ vapor) can be relevant in a way potentially enters TM/CAM.

Patient Safety Concept in Tm/Cam Services

Principles of patient safety in a way general can be used in TM/CAM services with the use of The International Classification for Patient Safety (ICPS) as a reference WHO The International Classification for Patient Safety (ICPS) has formulated gathering organized concepts and terms _ to in framework conceptual For possible consistent organization from events related important _ with safety patient. The development of ICPS was first identified as an initiative by the Organization World Health (WHO) World Alliance For Safety Patients in 2005 conceptual framework and accompanying taxonomy provide a method for organizing safety data for patients. For objective aggregation, analysis, and translation become information available used as well guide study safety patient ICPS was created To can applied in a way wide in context research and improvement quality and safety patient. Has applied in various skills or specializations in various worlds; however, still not yet lots reported for TM/CAM services

WHO has also applied the practice framework ICPS concept; one development is a Minimal Information Model for Reporting Incident Safety Patients (MIM-PS), which is functional as a template for a minimum set of common data categories. To facilitate guide reporting, all at once possible. For comparison.MIM-PS combines ICPS and International Classification Diseases (ICD), Classification International Functional (ICF), Disability and Health. (De Feijter et al., 2012).

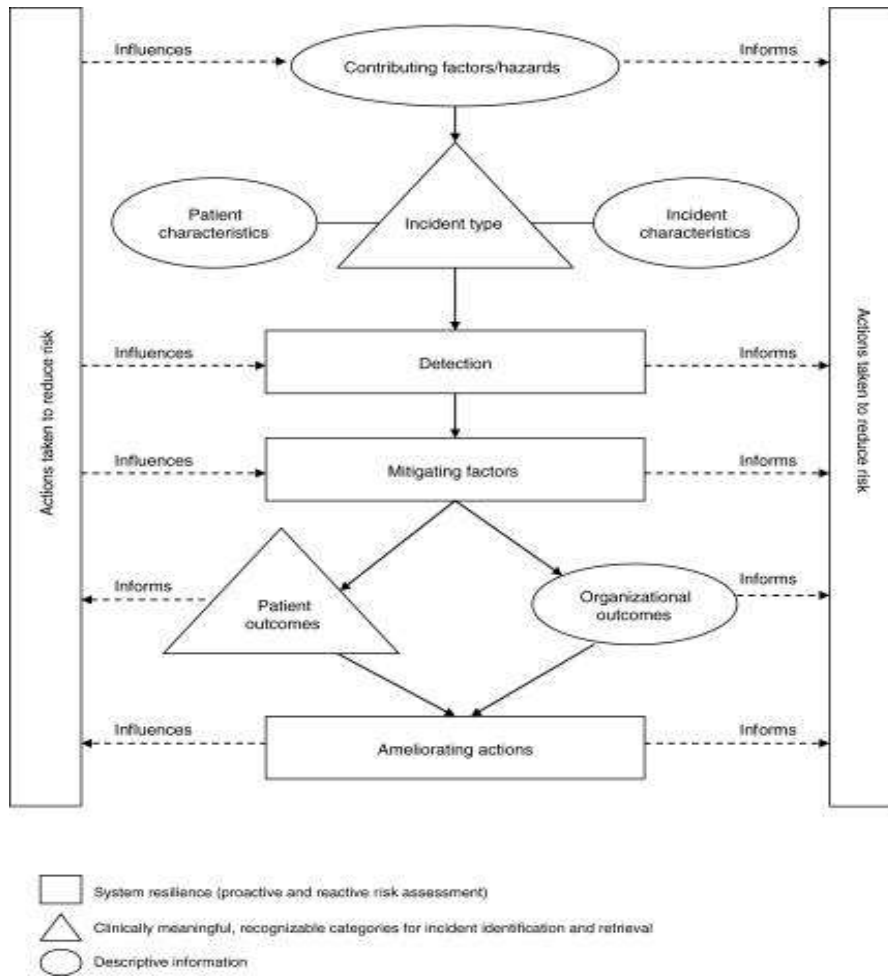


Figure 1 Conceptual framework for the ICPS.

Framework conceptual ICPS provides incoming understanding _ sense about the world of safety patients and contains draft safety patients who can linked with existing regional and national classifications. This consists of 10 classes level high and around 600 concepts that group together incident to in meaningful categories _ in a way clinical, giving information descriptive, representing resilience system, and inform learning and analytical processes. (fig 1) Incident safety is when an incident or possible circumstances result in, or of course result in, no loss necessary for patients. Incident safety patients can form possible events reported, incidents almost what a shame, what didn't happen harm, or adverse events. Class, type incident, is a term descriptive for categories consisting of incidents of that nature generally grouped _ based on agreed features together, like incident 'process/ procedure clinical ' or ' treatment / IV fluids '. Although each draft is defined clearly and distinct from draft other, incidents safety patients can classified more from One type of incident. Patient outcomes are impacts to patients, all of them or part caused by something incident. Results obtained from patients can classified according to type of harm, level of harm, and impact on social and/ or economy. Together, class-type incidents and outcomes are intended to group incident safety patients into meaningful categories clinically.

Information is descriptive and relevant, providing context for the incident captured by four classes: characteristic patient, characteristics incidents , contributing factors/hazards,

and outcomes organization. Characteristics of patients categorize demographics, the reason for beginning to look for treatment and primary diagnosis. Characteristics incidents classify information about circumstances around incidents like where and when, in the journey of the patient through system service health, incidents that happened, who was involved, and who reported them. Contributing factors/hazards are circumstances, actions, or perceived influence role in the origin, start or development of something incident or that improves the risk of something incident. For example are factors man as behavior, performance or communication; factors system like environment work; and factors external outside control organization, like environment natural or policy legislative. More than one factor cause and/ or danger is usually involved in One incident safety patient. Organizational results refer to the impact on the entire organization or part caused by something incident like enhancement use source for nurse patients, media attention, or consequence law.

There is a complex relationship between type incidents and contributing factors. Depending on the context, circumstances, and results, an incident can become a contributing factor to other incidents, and/ or several contributing factors can become possible circumstances reported.

Detection class factor mitigation, action improvements and actions taken to reduce risk catch relevant information with the prevention, recovery errors, and resilience system. Draft recovery error, which originates from knowledge industry and theory error, is really important. If one wants to happen to learn from incident safety patients. Draft resilience in the ICPS context is defined as 'the extent of a system in a way continuously prevents, detect, mitigates or ameliorates hazards or incidents' so that an organization can 'bounce back' to its original ability to provide core function.

Detection is interpreted as something action or resulting circumstances found in something incident. For example, an incident can detected through a change in patient status or via a monitor, alarm, audit, review, or evaluation risk (Figure 2). Mechanism detection can enter the system as a barrier official or developed informally. Factor mitigation is action or preventing circumstances or moderate development something detrimental incident patient. Factor mitigation is designed To minimize harm to patients after errors occur and trigger mechanism control damage (Figure 3). Simultaneous detection and mitigation can hinder development incidents until they are achieved and/ or endanger the patient. If an incident the results in loss, action repair can done. Action repair is actions taken _ or circumstances changed For repair or compensation loss after something incident. Action repair applied to patients (management clinical on injury, request sorry) and at home sick (provision staff, changes culture, and management claim). Actions taken _ For reduce risk concentrate on the steps taken For prevent repeat incident safety in the same patient or similar and on the rise resilience system. Actions taken _ To reduce risk is actions taken _ To reduce, manage or control future losses, or _ possibility of loss, which is related to something incident. Action This can addressed to patient (provision adequate service, support _ taking decision), against staff (training, availability policy / protocol), against organization (improvement leadership / guidance, assessment risk proactive), and against agents and equipment therapeutic. (routine audit) Detection, factors mitigation and action repair influence and inform actions taken to reduce risk.

Using standardized concepts _ in an international way with agreed definitions and preferred terms possibly creates comparison and thereby more analysis and interpretation towards data and information safety patients. Organize concepts This uniform classification will make it easier to describe, measure, and monitor To increase the maintenance of

patients, study epidemiology , and inform planning policy health . But ICPS hasn't fully developed. Framework concept gives runway, there is several challenges related implementation in countries with different cultures and conditions socio its economy different Because the foundation from developed countries, however, addressed For use in developing countries and in transition, then guide its use required For ensure that ICPS is appropriate For used in various location. (Castro et la; 2009)

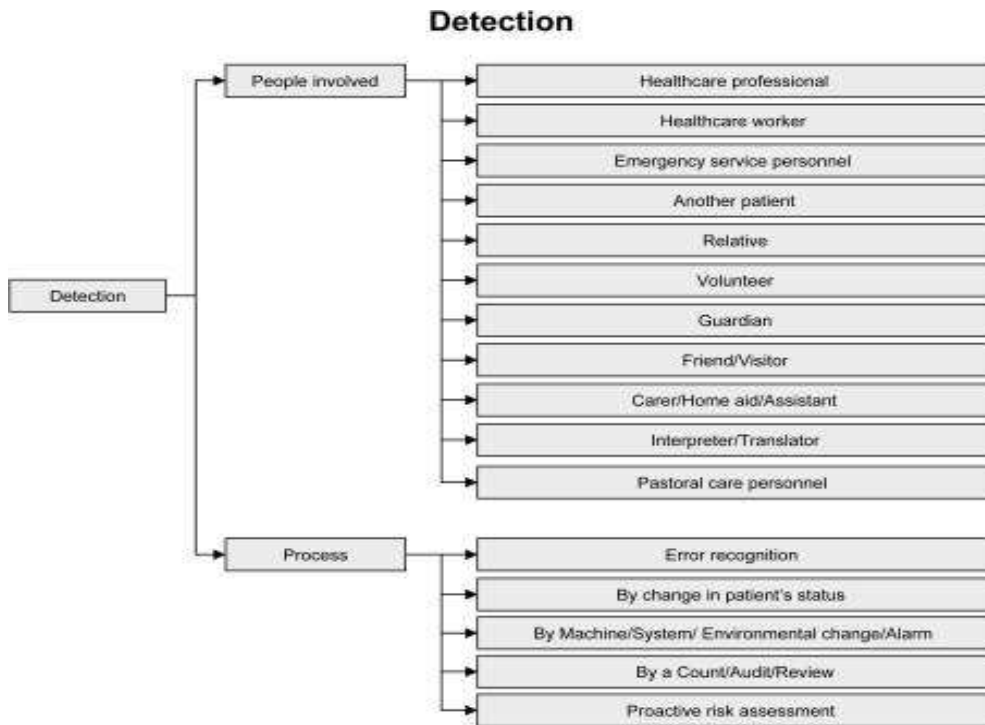
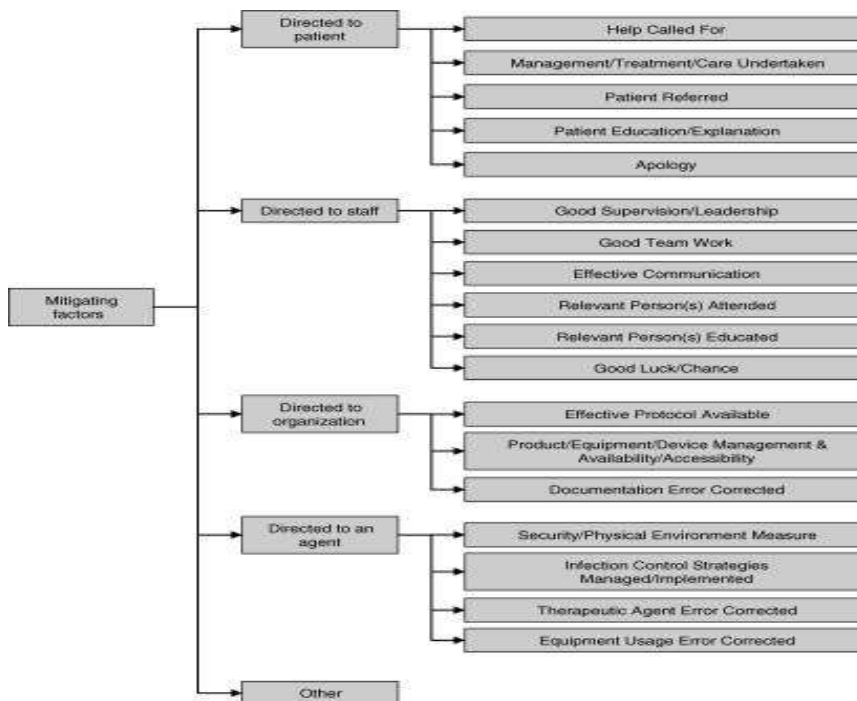


Figure 2 Detection.



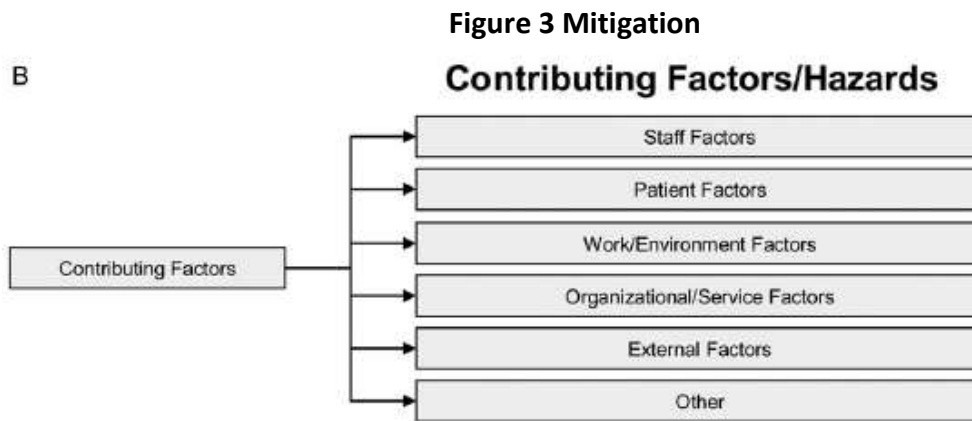


Figure 4 Contributing factors / Hazards

Human Factors & Ergonomics Society of Australia (HFESA) on Good Work Design (GWD). This matter based on principles base that GWD is a human - centered approach that ensures that Good job available for workers Explanation of the GWD iterative process with refers to three phase Discovery, Design , and Realization. In context, first it is explained necessity involved since early individuals and teams who direct and constitute GWD receiver, highlighting the necessity to learn and understand context, task, and job .. Phase lastly, Realization, refers to results and results reality that leads to optimal levels and balance between productivity, health , welfare, and safety employee. (Karanikas et al., 2021) This GWD factor is one factor that can influence the safety of patients, together with staff conditions, patients yourself as well as situation condition organization, as well as known policy factors as Contributing factors/hazards (figure 4). By principle,used incident types include

1. Clinical administration
 2. Clinical process/procedure
 3. Documentation
 4. Healthcare-associated infection
 5. Medication/IV fluids
 6. Blood/blood products
 7. Nutrition
 8. Oxygen/gas/ vapor
 9. Medical devices/equipment
 10. Behavior
 11. Patient accidents
 12. Infrastructure/building/fixtures
 13. Resources/organizational management
- (Runciman et al; 2009)

A number of descriptions are as follows: clinical administration; Actions associated with processing patient information through the healthcare system. Examples of this involve factors associated with appointments, allocation of tasks, patient admission and discharge. Medication/IV fluids : Any processes and actions involved regarding the administration of patient medication(s) or fluids. This information is only to be classified if the incident involved medication or IV fluid being given to the wrong patient, the wrong medication was used,

wrong dose, formulation, route, quantity, dispensing etc. Type of medication(s) involved in the incident eg Antidepressant or could state the brand name of the drug.

Blood/blood products : Components found within blood and procedures involved in the handling of blood or blood products. This includes transfusions, storage and preparation. List of blood/blood products involved.

Nutrition : Processes involved in nutritional care, such as general or specialized dietary requirements. This also includes any procedures involved in the handling, transport and storage of food and drink

Oxygen/gas/ vapor : Incidents associated in the administration, prescription of any oxygen or specific gas or vapors . Other logistical errors, including delivery, supply and storage, are also included. Specify in text the type of oxygen/gas/ vapor that was involved in the incident

Medical device/equipment : Any problems relating to medical devices or equipment in patient care or medical procedures. Examples are equipment malfunction, appropriateness for task and unsanitary equipment. These include events that involved equipment or device failures, breakages, malfunctions at the time of the incident. This also includes a lack of medical equipment and medical supplies

Patient incidents : Injuries sustained from physical trauma, falls, the environment or adverse effects while in the health care system. These classifications are consistent with the National Coronial Information System Data Dictionary

Infrastructure/building/fixtures : Incidents involving healthcare infrastructure

Implementation in TM/CAM services

In safety, patients on CAM use approach classification and terms used in the ICPS developed by WHO, which has been used in various fields and specializations and d various parts of the world.

Referring to the use of ICPS requires expertise in the TM/CAM field that can be referred to from competence Competent TCM doctor is found in the Entry-Level Occupational Competencies, Performance Indicators, and Assessment Blueprint for the Doctor of Traditional Chinese Medicine developed by the College of Traditional Chinese Medicine

Practitioners and Acupuncturists of British Columbia consisting of from

The competencies and indicators for Dr.TCM are displayed in a grid on the following pages, grouped into Practice Areas as shown below:

1. Interpersonal Skills
2. Professionalism
3. Practice Management
4. Traditional Chinese Medicine Foundations
5. Fundamentals of Biomedicine
6. Diagnostics and Treatment
7. Acupuncture Techniques
8. Herbal Dispensary Management
9. Safety
10. TCM Classics
11. Advanced TCM Practice
12. Scholarship and Research

Where special for safety there are consist

1. Evaluation patients risk profile.

- a Determine profile risk relative to treatment acupuncture .
- b Determine the level of risk relative to TCM herbal treatment .

2. Provide environment safe work .

- a. Maintain knowledge latest about disease infectious and technical control infection .
- b. Apply universal precautions to control infection.
- c. Ensure effective supervision of staff and/ or students.
- d. Check the facility for the danger of electricity, risk of fire, and danger of physically causing an accident, and take action to minimize it
- e. Set procedures and routes for facility evacuation emergencies.
- f. Set the procedure for maximizing the protection of self, staff, and patients If happen behavior rough or violence

3. Manage risk to the patient.

- a Include action prevention security in the herbal medicine plan.
- b Manage reaction harm and accident consequence treatment.
- c Respond with appropriate to circumstances emergency medical.
- d Manage contact blood to blood and give instructions For following carry-on post-exposure.
- e Cleaning spill blood and fluids body other.
- f Control and small extinguish fire.

4. Make sure the equipment is safe and functional.

- a Select upgrading equipment safety patient.
- b Maintain equipment in circumstances Good.
- c Clean equipment in a way regular, and disinfection is necessary (Moir, 2020)

Challenge special in study TM/CAM safety Study about incident-related harm with TM/CAM does not always need different research health conventional ; of course, it is important to apply existing knowledge and skills obtained. However, team researchers must include people who know special about TM/CAM. Taxonomy for gathering report error must based on concepts error and necessary covers information about factor system However So, there are factors specifically possibly project research safety in TM/CAM. Challenges this, though presented here, especially in connection with project supervision, also raise questions study secondary.

Risk in TM/CAM

Risk, in a way, can und understood as a possibility. Possible results can be detrimental. Differentiated there is between direct and indirect risk . Direct risk refers to harm consequence action clinically, “ caused by medical treatment, procedures and products pharmacological ”, and perhaps including: which unexpected “adverse reaction[s]” from a “justified treatment”; known “side effect[s]...related to a medicine's pharmacological properties”; and medical errors . Indirect risk, by contrast, refers to “a threat to patient safety that is, in the broader sense, associated with the whole treatment setting and clinical practice.”

One of the key form main from risks of omission is negligence associated risks with not proper delivery, referring patients to accept necessary needs, giving prolonged treatment, and not properly reflecting “ evidence of effectiveness' similarly, effectiveness can also cause impact related to professional violation behavior, incl agreement patient ; and financial , interpersonal , or “ violations. ” sexual appearance with a deviation of “ procedures operation, standard or rule. Treatment that is not safe in a way culture represents another form of loss indirect and refers to health treatment that does not own sensitivity culture or does not adhere to “ values or preference patient ”. (Ijaz, 2020).

Risk can be prevented or overcome through detection in a way systematic approach in-clinical TM/CM with significant event audit (SEA) and Failure modes and effects analysis (FMEA). SEA is a tool used for studying adverse events (AE) and detection for preventing future incidents in regional healthcare service (RHS).

This matter needs the participation active all actors and experts to validate the analysis. FMEA is tool evaluation risk engaging proactive clinical process selection, input from group expert multidisciplinary, process description, failure mode (FM) identification for every steps, approx frequency, severity and ability detection. FMs, counting risk priority risk number (RPN), and action prioritized improvements for preventing FMs. From the studies conducted, it turns out that in acupuncture, problems can arise, delayed in treatment and modality needle insertion. With combination of SEA and FMEA is possible reveal potency risk for patient and advise action for more TM/CM safer and reliable . (Rossi et al., 2017)

Analysis of incidents can divided into two major areas: First involves analysis of individual factors and fields, and the other study of how systemic organization healthcare contributes to adverse outcomes . Because the organization service health involves a large number of variables, more serious incidents with numerous individuals and contributing factors to onset incident the can happen in period longer time. In circumstances like this, analysis organization with a perspective systemic very effective for interpreting incident

The objective of the main management risk is to increase culture safety. This matter is not easy to achieve because medical culture is still based on cognitive sources and technical skills, while the collaboration process interpersonal and interdisciplinary need to be developed to identify obstacles capable of preventing or repairing errors cognitive or procedural possibilities _ happen can cause adverse events

According to the literature , the risk highest happen side effects of TM/CM, in general, related to plant medicines and herbs and especially originate from self-medication, the use of unsafe products containing numerous/various frequent herbs used with incorrect dosage and/ or are taken in the presence of specific contraindications. Another danger originates from the consumption of herbs and medicines in a way that simultaneously every plant medicine and herb with biological activity can interact with medicines and improve or reduce expected effects because of the action against P glycoprotein and system microsomal cytochrome P450. Examples generally are Echinacea angustifolia (DC), Heller (narrow-leaved coneflower), and grapefruit juice , which improves the bioavailability and toxicity of many drugs (inhibitors channel calcium , statins, and medications psychoactive). An example other is Hypericum perforatum L. (St. John's wort), which has activity inducer enzymes and can interfere with many treatments by reducing the blood level of many drugs (cyclosporine, digitalis, theophylline , anti-retroviral drugs , and oral anticoagulants)

There is an incident effect related to low acupuncture _ compared to other therapies besides no effect side in phase diagnostic . Overview systematic to published articles for 20 years show that the level effect serious side very low (0.020-0.1%) and especially related to the insertion of needles by non personnel qualified health workers / doctors, there not enough skill professional and manual skills . (Rossi et al., 2017).

Consideration of Safety in Acupuncture

Two from the assessed research report side effects (Hong & Cho, 2016); (Tsai et al., 2021). Hong and Cho (2016) note the reaction was mild (pain headlight in three case participants) and did not bother participants in the finished study. In Tsai et al . (2018), one patient experienced dizziness, and another experienced Dizzy light blood on one-point

acupuncture. Sick head, lightheaded, dizzy light, light bleeding, and bruising are effects of general acupuncture. Injury serious, like

pneumothorax or infection, yes happen with stab needle acupuncture invasive, but matters This

incident seldom happens. As (Saunders & Berry, 2019) note, acupuncture can used to nurse children from babies until teenagers are old and is considered safe. Results reported by Jindal et al. (2008) show a level side effect of 1.55 per 100 treatments and numbers the For effect side weight of 5.36 per 10,000 treatments. (Green, 2021)

Research results show that the country's prevalence of TM/CAM in patients taking care of road surgery is high enough, and the main determinants of its use are age, patient perception of security, and level of income. As outlined with Therapy biological, 72 % of herbal products are not branded, more than two-thirds Perception security from the subject study, almost a third 30.7% of patients considered CAM safe, while 41.3% were not Certain will be safe. Only 13.2% and 65.3% had take notes effect side and interaction drug . (Oluwatosin Stephen Iloria ; 2024)

harmful incidents

Serious incidents TM/CAM related rarely happen. As an example, several survey perspectives have proven it safe in Japan, England, and Germany. Data from about 2.2 million session treatments show risk maximum incident harm is 1: 76,000 patients treated. Likewise, surveys prospective against 50,276 manipulations cervix No find exists incident seriously dangerous This data show that TM/CAM risks can be classified as ' very low ', Therefore that is the necessary amount a large sample, which is possible need collaboration international, so you can interesting correct conclusion from studies surveillance. (White et al., 2014).

From a systematic review conducted by Dana et al. of fifteen studies, about 40% of the research included side effects reported in the TM/CAM modalities studied. Between research reporting side effects, part big was considered a risk directly, as 13% reported part big bleeding and bruising after treatment acupuncture and dizziness moment yogic treatment. All effect sizes were assessed as light and natural temporary.

Identified TM/CAM modalities to overcome the impact of bad treatment cancer is system medical alternative, Therapy manipulative and based body, Therapy based biological, and therapeutic mind-body. TM /CAM modality is used To reduce anxiety, pain, and toxicity, prevent trauma, and improve the quality of related health, functional mobility, and level of activity physique. Part 58.3% of studies were included in the review. This No-report side effect from TM/CAM modality was used to overcome the side effects of treatment cancer in children and young adults. Lack of information safety This comes to attention because parents need to know if actions give rise to burden addition or endanger the child. To increase awareness about safety in the field, it is necessary to system reporting impact universal and uniform bad in/ CAM research. (Mora et al., 2022)

Perceived as safe due to being "natural"

Opinions and perceptions about TM CAM is Therapy safe Because experience does not pay enough attention to security or effect side. Listen thereby report incident danger possibility smaller reported compared to with drugs conventional, Contamination during preparation also raises other risks are necessarily identified and reported, through system supervision passive moment this applied to treatment conventional, Factors this also gives rise to question study about How public can be educated For understand that TM/CAM practices and products can be linked with incident dangerous, without giving rise to worries that don't need.

For several TM/CAM treatments, it is frequently easy to identify influential components connected to incident harm (e.g., needles acupuncture); however, some big TM/CAM interventions are complex treatments. The researchers need to determine whether they must search for dangerous components or handle safety at a systematic level. The moment this is only a little available experience connected with the problem. Product medication used in TM/CAM like extract plant tend to have complex pharmacology that owns many effects and physiological possibility represent profitable synergies _ or detrimental interactions, depending on the context specifically . Problem This is made worse by the general practice that combines many compounds in one product, so it is difficult to identify potency incidents, harm, or interaction with other products.

Special challenge: 'healing crisis'

One of the problems related to relevant risks _ with the security of a number of TM/CAM therapy is what is called crisis healing , which is also known as ' aggravation therapeutic. ' therapeutic aggravation' TM/CAM practitioners consider crisis healing as a sign positive predicting _ repair condition furthermore as seen as become sign that potency healing self body has activated. Crisis healing fulfills the general definition of an incident as dangerous. Harmful incident (formerly adverse event): an incident that resulted in harm to a patient. An example similar to treatment is fever and inflammation-related locales with immunization: This Possibly is proof that the response is immunological; it is still dangerous, and the patient must know about the risk . We need to understand related effectiveness, frequency of different therapies and different cultures , predictability, and relationships with different therapists from the so-called' crisis healing. '

Factor safety patient related with culture safety patients who effectively reduce error medical lower costs , and guarantees safety patient (Farokhzadian et al., 2018). With this own consequence for executives, hospitals, or clinics, conventional and special related to TM/CAM services must be ensured can give service health quality . Several studies emphasize the connection between doctor-patient and cultural safety patient in organizational health. Likewise, climate safety increases the safety of patients. Approach collaborative This produce more coordination, sharing of information, and work the same team, everyone that required For service safe and thriving health. According to a study, conditions and satisfaction at work in a way significantly influence the culture safety of patients, and a safe environment This matter shows that condition Work improvement and satisfaction Work for professionals' health can help create a focused culture of staffing, expenses work, leadership, and development professional is factor the key is that you can increase condition Work . (Buljac-Samardzic & van Woerkom, 2015)

CONCLUSION

With the increasing interest of the public in safety healthcare, TM/CAM professions in parts of the world and practitioners are responsible for improving safety products and practices. The patient safety concept was developed by WHO and can used with adjustments to several terminologies and descriptions. Thereby can reduce risk and incident-related harm with various TM/CAM products and practices. ICPS guidelines need to be applied to the implementation of TM/CAM services and are necessary for patient safety research on TM/CAM which must be documented moreover first, especially if the data a small amount. Reducing risk is one of them with increased culture safety among stakeholders representing the interests of various parties. products and practices. International collaboration to develop and provide resources special and avoid duplication, and provide sufficient data sets with

diverse adequate practice to be able to meaningful. Required more information about incident events This is in the environment and groups different populations Various types incident potentially harmful related with TM/CAM, as well various the activities described as TM/CAM practices as well amount organizations involved in training or supervision practitioner. Issues need to be considered in a careful for facilitate understanding more carry-on about events as well as design perspective and evaluation strategies for reducing future risks.

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