Progress on Patient Safety

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The field of patient safety is growing rapidly; students are being trained, clinicians and researchers are creating new interventions, hospitals are implementing programs, managers are evaluating practices and governments are launching national agencies. With the huge attention given to patient safety nowadays, it is easy to forget how difficult it was in previous years to find clear accounts of patient injury, describe and analyze them. Medico-legal records, oriented to blame and compensation rather than safety, were the primary source of information. On the contrary, narrative case histories and supplementary analyses and remarks are now widely available. Analyses of incidents are now routinely done, although often in a structure of accountability rather than in the spirit of reflection and learning. Main progress has been made in evaluating the nature and scale of harm in different countries in the world. Globally, even in the developing areas of the world, World Health Organization (WHO) itself is implementing safety projects with its international partners. Jointly, this demonstrates a significant amount of effort. Yet, some believe that outcomes of care have improved quickly all over the world; people now survive illnesses, such as myocardial infarctions and strokes, which were previously deadly. As the effectiveness of healthcare improves, increasing numbers of patients are ageing with their illness under control. Current developments suggest that by 2030 as many as 25% of the population in different countries may be surviving into their 90s. In a lot of cases, a disease which was once deadly has become a chronic condition with all the related implications for the individual, society and the healthcare system. The need for healthcare to develop and change is to a large degree the consequence of the achievements of modern medicine. The focus of care should move quickly from high quality care in hospitals to a focus on the whole patient journey over years or even over a lifetime. These changes are long overdue but becoming more and more crucial.

To improve safety, healthcare will require recognizing and applying multi-component interventions, based on theoretical models about how to improve safety in hospitals. These interventions comprise strategies for healthcare leaders, clinicians and patients and these include: safety as best practice, improving healthcare processes, risk control, improving capacity for monitoring and mitigation. Indeed, when we are associated by ordinary goals and/or measures, we are supposed to employ as many interventions and incentives as possible to improve safety. These strategies are appropriate for all levels of the healthcare system from the frontline to regulation and governance of the system. Some of the aforementioned strategies aim to optimize the care provided to the patient while others are focused on the management of risk and the avoidance of harm in healthcare.

Safety as Best Practice: Complying with proven evidence and norms will create a better quality and safety. Numerous patients are harmed because established, scientifically-based standards of practice were not consistently followed. Safety interventions of this kind first organize the scientific evidence, then identify the core practices and endeavor to reliably bring these practices to patient care. We should identify a standard set of safety critical procedures and encourage the staff to follow them. However, in practice these are always difficult, complex interventions encompassing techniques, organization and leadership. Such interventions are certainly complex and only succeed because of a sophisticated approach to clinical engagement and implementation. For example, the reduction of healthcare associated infections requires changes to the organization of care, the equipment used, simplification of scientific guidelines, involving multidisciplinary teams, educational program, technical support and a major program of implementation.

Improvement of Work Processes and Systems: Incident and event analysis shows a great deal about the vulnerabilities in our systems and show us the range of factors which need to be addressed if we wish to design a safer, high quality healthcare system. During serious incident analysis, a variety of contributing factors relating to the patient, task, staff, working environment and environmental factors are always appearing. This is the common territory of the organizational accident in which immediate errors and failures are identified which are strongly affected by wider contributing factors. These factors also pinpoint the ways of intervention and optimizing the healthcare system.

Risk Control: It is very well known that safety is achieved by avoiding taking unnecessary risks in the processes. Healthcare rarely forces limits on either productivity or professional autonomy even when safety is being compromised. Preventing risk sometimes means losing out on the possible gain that taking the risk may have allowed. Increasing risk rules in hospitals can lead to avoidance of treating higher risk conditions, supportive of patients presenting with lower risk. Healthcare contains examples of risk control but these are seldom discussed in the context of patient safety. Risk control can be attained by strictly limiting the circumstances in which a unit can operate. Risk control can include withdrawing services or activities when they have become unsafe to the patient and/or staff. It is believed that much more consideration should be given to the control of risk to protect both patients and staff from engaging in unnecessarily risky activities.

Monitoring, Adaptation and Response: Safety is achieved by the continuous trials to reduce errors and by actively managing the problems/incidents that occur. It is believed that errors and failures may occur frequently in any system, thus we should develop methods of monitoring, adapting and responding and recovering from any failure. Adapting and responding to problems happens frequently in healthcare and is as relevant to man-agers as to frontline staff. Managers tend to resolve problems, but this is mainly done on individual basis. Preferably, senior clinicians and managers should maintain safety at a good level by relying on practiced organizational and cultural adjustments. It is believed that in order to avoid potential confusion in healthcare, one should use the more everyday terms of monitoring, adaptation and recovery (active management) to indicate occasions where hazards or failures have been detected.

Mitigation: Mitigation is the action of reducing the severity, significance, or distress of some events. This strategy accepts that patients and healthcare providers will sometimes be seriously harmed during their healthcare and, critically, that the concerned healthcare organization then has a responsibility to mitigate that harm. In particular it is believed that hospitals should have effective systems in place to support patients, caregivers and staff in the outcome of serious failures and harm. A full approach to safety must include the mitigation of harm, even if managing complaints and litigation should not control attempts to improve safety.

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