Editorial

Without engaged healthcare professionals there is no future for patient safety

Although all people make errors, they do not all have the same meaning or transcendence. Clinical errors have a very different importance because the health (and sometimes the life) of patients is at stake.

The idea that only "bad" professionals make errors, precisely because of their ineptitude, is false. It would be fantastic if it were true, because it would imply that, with a simple solution, separating these "bad professionals", we would solve the problem of patient safety. But the reality is much more complex and all professionals, even those with an excellent track record, can make an error with serious or fatal consequences.

The organizational culture that shares the idea that errors are occasional and the result of the inexperience of a few professionals, only leads to hide or disguise reality and, ultimately, to subject patients to a greater risk. Healthcare organizations that act in this way lose the opportunity to prevent future safety incidents and also put at risk the legal certainty, clinical judgement capacity and working wellbeing of their professionals.

Just because we accept that errors can happen does not mean that we allow them to happen without trying to avoid them. Precisely because we know that they occur, we have an obligation to detect the potential errors inherent in care activity in order to act accordingly. Not to do so is irresponsible and inadmissible.

The management of the risks inherent in the healthcare activity is key to the patient safety and for professionals' effectiveness. When an adverse event occurs, we observe a domino effect and after the patient suffers damage of a different entity, are the professionals, most directly involved, who also experience anxiety symptoms, feelings of guilt and doubts about their clinical capacity that diminish their competence and can put other patients at risk. These professionals are known since Albert Wu[1] coined this term, as the second victims, since they become traumatized by the incident. The number of professionals involved in these circumstances varies according to the studies, oscillating around 70%.[2] It is estimated that approximately 24% of these healthcare providers need time off work and 25% need to change their center or activity. This is a common experience and requires a specific intervention, such as that proposed by Susan Scott (ForYoU)[3], Albert Wu (RISE^3) or our primary prevention program (MISE).[4]

The use of the term "victim", which refers to professionals, has recently been called into question by of patients' relatives,[4] who ask that it be abandoned because it seems that professionals avoid responsibilities,

contributes to paying more attention to the suffering of professionals than to that of patients or their families and, above all, because their suffering cannot be compared with others, especially after the pain of the loss of a loved one.

Today we consider that this trauma affects both when the patient suffers some damage in the course of the health care he is receiving (adverse event), when a near miss occurs (that does not reach the patient) or even when there is no safety incident, but the professionals feel that the evolution of their patients are not what they expected. In all these cases, we observe this response which varies in severity according to the personality characteristics of the professionals, their ability to cope with stress and, depending on the incident, the type of damage that the patient has suffered, or could have suffered.

We must also be aware that not all system or organizational failures, nor all human errors, are the same. It is necessary to differentiate between situations in which an unforeseen adverse event occurs in an organization committed to the patient safety, and those in which adverse events are the result of known situations for which appropriate decisions were not taken. The first case is part of the uncertainty in which decisions are made and clinical procedures executed. The second is reckless behavior.

Clinical errors are usually the end of a chain that has, in origin, a system or organizational failure that favors (and sometimes determines) that a frontline professional in the care of a patient commits a mistake that sometimes causes harm (adverse event).

Adverse events associated with an unwanted and avoidable outcome, such as those occurring in the case of chronic course processes,[5] are clearly the most difficult to identify and prevent. Organizations that share an organizational culture that includes recognizing and talking about their failures and mistakes are the ones that manage to avoid them in the future. And this means creating an appropriate framework for doing so.

Well-being at work and a non-punitive safety culture determine the achievement of optimum quality of care. Denying the importance of 'caring for those who care' is undermining possibilities for patient safety.[6] Organizations that implement interventions to help professionals deal with safety incidents stand out for their ability to reduce the number of adverse events. Those organizations make their professionals gain confidence in their ability to cope with the growing complexity and uncertainty of clinical practice and thus achieve optimal quality of care.

Enhancing patient safety goes through empowering and engaging healthcare professionals.

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