# Article of the week

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## Moving Toward Safer Care

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Medical errors and patient harm have become major global public health concerns. Unsafe care ranks among the top ten leading causes of mortality and morbidity worldwide. One of every ten hospitalized patients is harmed due to unsafe care. In the low to middle-income countries, 134 million patients experience harm during hospitalization, resulting in nearly 2.6 million annual death. Moreover, almost 15 % of the hospitals' budget is spent on the sequelae of medical errors. ( WHO, 2019 )

The landmark report and the "wake up" call by the Institute of Medicine (IOM) in 1999, "To Err is Human," stated that as high as 98.000 people die in the United States each year due to errors, and urgently called to establish safe healthcare. Subsequently, health care systems, professionals, government agencies, and others worldwide have pushed the agenda of safer care. Yet, little has changed, and adverse events and harm statistics continue to be alarmingly high. The gap between what we intend to do and what is happening in the real world persists despite the fund of patient safety knowledge over the last two decades. Part of this gap is that patient safety is not just a single- or one-time intervention that we pay for. Instead, it requires an organizational culture that considers patient safety in every step, by every employee, and in every moment during care delivery. Such patient safety culture (PSC) is the aggregate of individuals, teams, and units' norms, beliefs, attitudes, behaviours, perceptions, competencies, processes and reactions toward patient safety. More straightforwardly, PSC dictates the way individuals and teams "do things" in their day to day business. PSC has been linked to the occurrence of errors, patient outcomes and harms. Developing a PSC is an integral part of the patient safety strategy for any organization

Studies have shown a wide range of PSC attributes. This has been reflected in the design of PSC measurement tools. Nevertheless, PSC's significant attributes include leadership engagement, support and promotion of safety culture, teamwork and teams' structure, effective communication between individuals and groups, capturing and reporting errors, adverse events, harms, and near misses. Furthermore, PSC requires openness and mutual trust to analyze reported events, communicate learned lessons back to the frontline staff while focusing on a system rather than individuals, plan and implement corrective actions in a non-punitive, no blame or shame atmosphere. Many health organizations in Saudi Arabia have embarked on ambitious strategies to implement PSC with variable outcomes. Many others are starting this journey, particularly after the accreditation and regulatory bodies' scrutiny. In addition to that, the national healthcare transformation program, the recently established Saudi Patient Safety Center (SPSC) and the new royal decree, which mandates the implementation of patient safety strategies across all healthcare sectors in the country, will put patient safety as a national priority .

Creating PSC is one of those that is easier said than done. Nevertheless, as a starting point for any organization, assessing PSC's current status is an essential step in building a full PSC. More than dozens of tools that measure PSC are available with variable validity, adaptability, cost, and logistics needed for their use. The commonly used are the Hospital Survey on Patient Safety Culture (HSOPSC), Safety Attitudes Questionnaire (SAQ), Patient Safety Climate in Healthcare Organizations (PSCHO), Canadian Patient Safety Climate Scale (Can-PSC), Safety Organizing Scale (SOS) and many others. HSOPSC by Agency for Healthcare Research and Quality (AHRQ) is widely used outside the united states, including Saudi Arabia. SPCS has adopted this tool and encourages its use by all healthcare organizations across the country for future national and international benchmarking (a guide is available at ahrq.gov ).

The approach to implement PSC varies based on many internal and external factors. However, PSC starts in the c-suites. It is almost impossible to create and sustain PSC without genuine commitment and full engagement of its top leadership. Chief executives, boards of directors, managers and supervisors must have patient safety as the "first item of their agenda." They must promote and explicitly communicate patient safety throughout the entire system. This "tone-setting step" is crucial to create an organizational and employee's "mindset" of preoccupation with patient safety and patient harm. Embedding patient safety in every process across the system, injecting resources, commitment to capacity building and training, and periodic review of patient safety progress by all leadership levels is essential to create PSC .

Further, leaders have a pivotal role in creating a just culture and fair non-punitive system where employees feel comfortable enough to report errors, speak up for patient safety, being transparent to admit mistakes without fear of punishment or blame. Installing a reporting system to capture safety issues is another cornerstone of PSC. The safety reporting system has to be simple, user-friendly, and accessible without significantly burdening busy practitioners. Reporting safety incidents is traditionally viewed by frontline staff as a "complaint" against colleagues, which is not culturally acceptable. This conception should be carefully addressed and supported by a no shame, no blame culture. Systematic analysis of safety incidents focusing on a system rather than finger-pointing to individuals and finding the opportunities to improve and implement future preventative measures are so significant. Implementations of corrective actions require at least basic knowledge and skills of improvement. This requires the organization's commitment to inject appropriate resources like risk management and improvement science expertise, technology and adequate staffing. Such attributes enable the organization to switch on to the "learning mode" where certain behaviours generate knowledge, knowledge renders corrective actions, new norms and ultimately, sustained and growing patient safety culture .

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