
ICU Volume 6 - Issue 1 - Spring 2006 - Editorial

Safety in Care

Author

Jean-Louis Vincent

Head, Department of Intensive Care,

Erasme Hospital Free University of Brussels, Belgium

Safety must be a key priority for any service driven industry where errors have the potential to cause harm to people (Dorman 2005). All humans make errors, and doctors are no exception. Each year the media highlight cases where the wrong limb has been amputated or the wrong organ removed, where chemotherapy has been given intrathecally instead of intravenously, where excess doses of radiotherapy have been given, ... the list goes on. Medical errors are very much a fact of life; doctors, even intensivists (!), are not infallible. One recent study (Rothschild et al. 2005) reported that 223 serious medical errors occurred in one ICU over a 6-month period, equating to 149.7 errors per 1000 patient days, or 1.5 errors per day for a 10-bed ICU; 11% of these errors were potentially life-threatening (Rothschild et al. 2005). Another study focusing on medication errors found one preventable error for every five doses of medication administered (Kopp et al. 2006). These statistics will be of no great surprise to any of us, but what can and

should be done to reduce the incidence of such errors, to improve safety in our ICUs?

Over the years, healthcare services have developed a 'cover-up' culture where mistakes have been hidden, or even denied, and reporting discouraged. However, this traditional attitude is beginning to change as we learn from other industries where great harm is possible, e.g. aviation and nuclear power, which approach the concept of safety with a no-fault or limited fault approach (Pronovost et al. 2005). Systems are being designed to make it harder for people to make errors and easier for them to report errors when they do occur without fear of unwarranted personal reprisal. Medical errors are rarely the fault of one individual, but more likely the result of multiple failings in the system behind the individual. Changing the system is more likely to prevent a similar error occurring in the future than chastising one person. Those involved need to look beyond the immediate event to the assumptions and conditions that gave rise to it, and then introduce global, as well as local, reforms to prevent it happening again (Reason et al. 2001).

In this issue, Drs Gaba, Manser, Pronovost, Fliin, Al-Ansari and colleagues present some of the potential organizational and management mechanisms that can be used to improve patient safety on our ICUs. Improving safety is a key step in improving quality of care (Institute of Medicine 2000), surely a primary aim for us all.

Published on : Thu, 15 Aug 2013