PATIENT SAFETY

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Medicine will never be risk-free. From the beginning of train - ing, doctors are taught that errors are unacceptable and that the philosophy of primum non nocere (first, do no harm) should - permeate all aspects of treatment. Y et, worldwide, despite all the improvements in treatment and investment in technologies, y Nudge: Improving Decisions about Health, Wealth, and Happiness with Thaler with unsafe practices, incompetent healthcare professionals, poor governance of healthcare service delivery , errors in diagnosis and treatment and non-compliance with accepted standards. When errors occur, it is important that there are systems in place to ensure that all those a ff ected are informed and cared for, and that there is a process of analysis and learning to uncover the causes and prevent recurrence of such events. It is equally important to learn more about the characteristics and facilitators of safe, high-quality care. The study of patient safety is now a healthcare discipline in its own right, encompassing patient safety methodologies, health service design, investiga tion of incidents and related research. The development of risk management strategies within the healthcare setting attempts to address these failings. Comprehensive risk management is not just an exercise in ligation avoidance but aims to develop a cultural a wareness and support for all healthcare workers in defining and delivering high-quality clinical care. A milestone report by the US Institute of Medicine of the National Academy of Sciences (now the National Academy of Medicine), To E r r i s H u m a n : B u i l d i n g a S a f e r H e a l t h S y s t e m , drew widespread attention to the impact of medical error on healthcare outcomes. The World Health Organization (WHO) estimates that, even in advanced hospital settings, one in 10 patients receiving health care will su ff er preventable harm, although measurement of the incidence of suboptimal out comes remains challenging. In addition to the potential for needless su ff ering, the financial burden of unsafe care globally is compelling, resulting as it does in prolonged hospitalisation, loss of income, disability and litigation costing many billions of dol lar s every year. In 2017 the Organisation for Economic Co-op eration and Development (OECD) published The Economics of Patient Safety , which indicates that this is a problem faced in all healthcare systems, with iatrogenic patient harm being the 15th leading cause of the global disease burden and accounting for 15% of all OECD countries' hospital expenditure. While the relationship between medical error and litiga tion is particularly complex, sophisticated healthcare systems understand that e ff ective strategies to promote patient safety and quality improvement must include a whole organisational culture change with both central senior management inv ment and active engagement by all those within the organ isation. Furthermore, clinical audit, data management and incident reporting must be carried out in a 'blame-free' culture with an emphasis on education and the avoidance of an adver sarial culture, which hinders activ e participation. PATIENT SAFETY

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