

## Safety in the emergency health services

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Although it is seemingly obvious, it is important to remember that health care is a complex activity with many risks, in which errors are common. Many professionals are aware of this, but perhaps have not yet incorporated risk reduction into daily clinical practice and organization as a consistent and routine strategy. The inclusion of concern for patient safety and operational safety management in the agenda of professionals is a current activity in which many organizations are increasingly becoming involved.

Numerous studies serve to remind us of the magnitude of the problem<sup>1-5</sup> and provide estimates of mortality and morbidity that may be due to safety problems have been widely discussed in the last decade<sup>6,7</sup>. Especially important is the fact that most studies agree in identifying about 50% of adverse events (AE) resulting from health action are potentially preventable to a high or very high degree. This fact is what must lead to a positive and necessarily active approach, to avoid all such harm.

Preventable AE can often be attributed to factors related with the system, which is not sufficiently robust. This idea is one of the pillars of the current focus on patient safety. In most instances, AE are produced by system failures and should not be simplistically attributed to ineptitude on the part of the individual. The traditional approach assumes that an aware, well trained professional does not make mistakes. This traditional point of view equates error with incompetence and provides for punishment as the most effective way to motivate professionals to be more careful. Using this blame-laying approach has toxic effects. The working professional is hardly likely to communicate or comment on the error, making it almost impossible to learn from them.

If patient safety in general is a matter of great importance, in the field of emergency medicine it

becomes particularly so. The study entitled Harvard Medical Practice<sup>1</sup>, noted that adverse events appearing in the ED were more easily preventable than in other areas of the hospital, with over 70% of those detected being preventable.

Emergency medicine often involves simultaneous assessment and treatment of numerous patients with a wide range of conditions and forms of presentation that must be managed with limited clinical information and resources. In the emergency department we also encounter circumstances that increase the risks, which has led some to ask: Emergency medicine: A practice prone to error?<sup>8</sup>

There are certain intrinsic factors and others that are structural which make us think that the answer to the question is affirmative. On many occasions the emergency department is characterized by a level of complexity and intensity of activities that may be aggravated by circumstances such as the following: the multitasking nature of the work, frequent distractions, work-shift changes and multiple transitions in healthcare, rapid decision-making, poorly differentiated health problems of varying severity, onset of fatigue and lack of feedback that often does not allow error identification, among other elements that are intrinsic to the nature of the work in the ED.

From a structural point of view, problems include overcrowding, understaffing or excessive staff turnover, insufficient supervision and inexperience in some professionals.

In our view, all this means that the probability of error in the ED is even higher than in other departments. Many hospitals are now working on proper management of the risks described, aiming to reduce these problems related to patient safety. Precisely in this issue of EMERGENCIAS there is an interesting study by Thomas et al.<sup>9</sup> on a pharmaceutical intervention program to improve

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patient safety. Studying the appearance of AE, the authors observe that the use of medication occupies the most prominent place in terms of the cause of the problem. It is a transverse process par excellence, involving many professionals, affects most patients in the hospital setting, and is often a high risk situation.

It is well known that there is a significant problem in our current healthcare practice related to so-called regular medication taken by patients. Those who visit the ED and those admitted to hospital may receive inappropriate medication or stop taking necessary medication: there is a need for adequate reconciliation between regular and newly prescribed medication. The above-cited work<sup>9</sup> proposes the intervention of a pharmacist who would review and reconcile such medication in conjunction with the attending physician.

Many hospitals have taken steps to incorporate a clinical pharmacist into the chain of professionals attending patients, thus increasing patient safety. An important example is validation by the pharmacist of prescriptions for drugs issued in hospitalization areas. There is probably still some way to go for night shift or weekends, when the possibility of pharmacist validation is limited in many centres. Together with electronic prescription, whose effectiveness in reducing errors is widely recognized, pharmacist validation is an important step towards safer medication.

Reconciliation of medication is another far-reaching step aimed at avoiding drug-related problems (DRP). Intervention by the hospital pharmacist is one more step in our endeavour to achieve patient safety, and as previously mentioned, a more robust system. The proposal by Tomás et al<sup>9</sup> is one of those that will definitely be taken into account in the future. As the authors mention, the limitations of the program proposed include the impossibility of providing such a service for all patients 24 hours a day. And it is too soon to know whether its implementation is generalizable to other services and with the same organizational form. However, the program presents an encouraging capability to detect and resolve many DRPs.

Fifteen years ago, when we started to evaluate

hospitals, it was very uncommon to find systematic validation by the pharmacist of all prescriptions. Even when we inquired about this, it sounded a little odd. In the case of reconciliation of medication in the ED and in hospitalization, we hope that such solutions can be progressively introduced and if possible, the sooner the better.

The potential benefit of pharmacist intervention in the ED has been underestimated<sup>10</sup> and sometimes not even considered as another member of the ED team<sup>11</sup>. However, there are EDs with such programs and cost savings have been observed<sup>12</sup>; in addition there is a perception among physicians and pharmacists that the quality and safety of medication improve with these measures. We hope these data and the cited work act as a stimulus to reconsider those views.

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