# Safe care: an additional challenge for healthcare organizations

Adverse events resulting from patient care are a serious safety and quality problem. Widespread attention to the issue stemmed from publication of the report *To Err is Human: Building a Safer Helath System* [1] in 1999, mobilizing physicians, researchers, and society in the United States. Estimates indicated a high rate of errors in healthcare, and although controversial, mortality due adverse events was considered comparable to such diseases as breast cancer. More than 15 years later, patient safety is a priority in various countries and healthcare organizations. Despite efforts and investments, the problem's magnitude and consequences persist in all settings of care, from primary care to home care [2].

The methodological challenges begin with measurement of adverse events and their avoidability. Most studies are based on retrospective patient record reviews applying screening instruments to assess the occurrence of adverse events associated with patient care rather than the course of the disease itself. This judgment focuses on the severity of the case and appropriateness of the process of care. To distinguish between the effects of each of these elements is crucial, but not trivial. Synergistic action is expected, since patients in more serious condition tend to require complex care and use resources more intensely, exposing them to higher odds of minor or serious adverse events due to human and organizational errors. In the hospital setting, intensive care units (ICUs) deal on a daily basis with the intersection between severity of cases and intensity and complexity of care. The ICU plays an essential role in the patient's prognosis and survival, but to guarantee safety in intensive care requires acting on questions related to clinical decisions, adherence to protocols, proper functioning of equipment, multidisciplinary teamwork and communication, shift handover, and even staff burnout.

Notwithstanding international recommendations that studies attempt to understand the underlying causes of harms, identification of solutions, impact, and incorporation of evidence into the organization of care [2], measuring harm is essential for understanding the problem in the Brazilian context. The article by Roque et al., in this issue of CSP can make an important contribution to patient safety in Brazil. The study has the methodological merit of its prospective design (probably pioneering), aimed at tackling the triple challenges of case severity, complexity of care, and adverse events. Conducted in a teaching hospital, the study meets an important requirement for changes in health professionals' training and promotion of a culture of organizational learning in the face of errors and problems. The fact about BRL 112.6 million (USD 34 million) was spent on intensive care in Rio de Janeiro, Brazil, in 2015 reflects the impact of these events on the Brazilian health system. In addition, some results (to a certain extent surprising), like the high pressure ulcer rate in an ICU in a teaching hospital, call attention to both the low quality of care and gaps in healthcare personnel training. Meanwhile, the types of adverse events observed in the study highlight the timeliness of the Brazilian Ministry of Health's Patient Safety Program, consistent with World Health Organization guidelines, noting that the main risks in healthcare organizations – healthcare-associated infections, pressure ulcers, falls, medication errors, and patient identification – need to be mitigated through specific protocols [3].

Thus to intervene, especially in the ICU, with the implementation of a patient safety culture and protocols. We could learn from successful experiences elsewhere in the world, e.g., as reported by Provonost et al. [4]. Finally, the article's results can contribute to specific interventions and help maintain the focus on patient safety and quality of care as priorities on Brazil's national health agenda.

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