MEDICATION SAFETY

World Patient Safety Day 2022: Medication without Harm

Who would make such a mistake? Considerations for the second victim

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With the 2022 World Health Organisation's Patient Safety Day focusing on medication safety, it is important to highlight the need to care for all people who are impacted by mistakes and errors, especially if they result in patient harm.

Too often I have heard, 'who would make such a mistake?', or 'that doctor/nurse/pharmacist should not be working as they make mistakes', or 'this incident has been the result of someone not concentrating properly', resulting in labelling the health professional at the centre of the incident as incompetent and to blame for the error.

At the time the incident occurs, there may be no recognition of something going wrong. It is only after the patient suffers complications as a result of the medication error, that there is a realisation of failure and guilt in response to being part of the cause. The main victims of medication errors are the patients and their families. The second victim — the health care worker — may have a curtain of blame from their organisation and peers which can cause the person(s) involved psychological harm, guilt, and a significant emotional toll. After making an error an intense period of professional and personal anguish may follow, even among the 'strongest' caregivers. The impact can be devastating, and some instances result in loss of career or even loss of life.

> *"Second victims are health care providers who are involved in an unanticipated adverse patient event, in a medical error and/or a patient related injury and become victimized in the sense that the provider is traumatized by the event. Frequently, these individuals feel personally responsible for the patient outcome. Many feel as though they have failed the patient, second guessing their clinical skills and knowledge base".*[1]

Medication errors are a common cause of harm to patients in acute care settings, which can result in morbidity and mortality. The focus of clinical incident review must be on improving systems of care with a result in learning from mistakes, rather than focusing on an individual's performance. It is important to review medication errors to understand what has unfolded and why, before change can be implemented to prevent similar errors from occurring in the future.

Investigations of unanticipated clinical events often reveal experienced, well-intentioned clinicians surrounded by complex clinical conditions, poorly designed processes, and inadequate communication patterns.

When a serious event occurs, a health care system with a strong culture of safety will respond not only to support patients and family members, but also provides support to its clinicians.

It is important to raise awareness of the second victim phenomenon and ensure a proactive response in supporting health professionals involved with medication incidents. Promotion of a 'Just Culture' versus a 'Blame Culture' environment will help promote clinician healing and recovery from the second victim experience.

The promotion of healthcare workers' wellbeing improves staff morale, leads to fewer medical errors, and is critical in protecting and supporting future clinicians from emotional trauma experienced after unanticipated clinical events.

References

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