Pogreške u zdravstvenoj njezi, kako s njima postupiti i priopćiti ih

Errors in nursing care, how should we deal with them and communicate them

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Medicinske pogreške javljaju se tijekom svakodnevnog rada. O njima se nerado komunicira, kako u timu, tako s pacijentom i članovima obitelji. Loša komunikacija nerijetko je pogreška koja omogućava druge pogreške za koje je odgovoran ljudski i/ili tehnički faktor. Postupci koje provodimo u dijagnostici, liječenju i zdravstvenoj njezi pacijenata su usmjereni na očuvanje i poboljšanje njihovog zdravlja. Međutim, medicina krije i opasnosti koje mogu dovesti do štetnih posljedica. Nikome nije namjera nekoga ozlijediti ili učiniti pogrešku, ali složenost procesa, tehnologije i međuljudskih odnosa te njihov međusobni odnos u modernoj medicini i zdravstvenoj njezi, nesumnjivo nosi rizik nastajanja pogrešaka u odlučivanju i djelovanju. One mogu biti neznatne i prolazne, ali mogu uzrokovati trajno oštećenje zdravlja, pa i smrt.

U organizacijama s razvijenom kulturom učenja iz pogrešaka otkrivanje propusta i uklanjanje uzroka koji su omogućili njihovo nastajanje, važnije je od optuživanja pojedinca. Proces prilagodbe takvom načinu razmišljanja u medicini je spor i težak. Iako se već nekoliko desetljeća u zdravstvene ustanove uvode sustavi upravljanja pogreškama, medicina i dalje na ovom području zaostaje za industrijskim granama. Za napredak potrebno je promijeniti način razmišljanja ljudi koji rade u sustavu zdravstva ili donose odluke o zdravstvenoj politici, prilagoditi zakonske propise i razviti metode upravljanja i analize rizika. Priznavanje pogrešaka, izvještavanje i razvoj kulture učenja na greškama imaju esencijalnu vrijednost za vrsnoću sestrinske prakse.

Medical errors occur during daily work. Health professionals are reluctant to communicate them both in the team and so to a patient and his family members as well. Poor communication is often a mistake that allows for other mistakes that a human and/or technical factor is accountable for. The procedures conducted in the diagnosis, treatment and nursing care of patients are focused on maintaining and improving their health. However, medicine hides the danger that can lead to adverse consequences. No one intends to hurt someone or make a mistake, but the complexity of the processes, technology and human relationships and their interrelationship in modern medicine and health care undoubtedly carries a risk of making mistakes in decision-making process and actions. They may be minor and transient, but can also lead to permanent health impairment, even death.

In the organizations with a developed culture of learning from mistakes, the discovery of failures and elimination of the cause that enabled their occurrence is more important than to blame individuals. The process of adapting to this way of thinking in medicine is slow and cumbersome. Although the systems of managing errors have been introduced in medical institutions for several decades, medicine continues to lag behind the industry in this field. In order to achieve progress, we need to change the mindset of people who work in the health care system or make decisions on the health policy, adapt legislation and develop the methods of managing and analyzing risks. Admitting errors, reporting and developing a culture of learning from errors are of a paramount importance for the excellence of nursing practice.

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