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EDITORIAL

Quality of care and patient safety, key elements of health care

La calidad asistencial y seguridad del paciente, componentes clave en la atención

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Care quality and patient safety are essential principles and key components of health care delivery.

The approach to health care quality is more developed in adult care compared to paediatric care, yet children have a unique set of quality care demands, and while safety is an essential component of health care quality, improving the quality of the care we provide involves a lot more than merely guaranteeing safety.

When tackling safety and quality, we must take into account the following statements[1]: (1) Business as usual will not help us achieve the health care system that our children deserve; (2) Every system is perfectly designed to achieve exactly the results it gets, and (3) Knowing is not enough; we must apply. Willing is not enough; we must do.

Donadebian[2] defined quality care as ''care which is expected to maximize an inclusive measure of patient welfare, after one has taken account of the balance of expected gains and losses that attend the process of care in all its parts''. The definition of the National Health Service (NHS) of the United Kingdom[3] is more pragmatic: doing the right thing (what) to the right individual (who) at the right time (when) and in the right way from the beginning (how). The American Academy of Pediatrics (AAP) considers quality a key component of paediatric care, and issued recommendations in 2019 to guarantee a holistic approach and accelerate changes toward safer and higher-quality care.[4]

There is no health care practice that is completely free of risk, and therefore, minimising the risks associated with care delivery should always be a key objective. At present, the high complexity of care delivery and the high expectations of society as regards the outcomes of health care interventions require that we determine which are the most effective, efficient and safe procedures acceptable for patients and society, beyond habit, intuition and custom. All of it in a context in which patients must be actively involved in the care delivery process.

Evaluating care quality in paediatric care services is of the essence. This entails comparing what should be done with what is actually done, identifying discrepancies, analysing their causes, proposing and introducing the necessary changes and, last of all, assess the efficacy of these changes.[5]

To this end, we can use quality management systems, which consist simply of tools that help improve performance

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and provide a solid foundation for sustainable development initiatives. A global vision of risk management is part of the health care quality culture and requires all professionals to be involved in care safety.

Institutions committed to health care quality, such as the World Health Organization (WHO) and the Joint Commission on Accreditation of Healthcare Organizations (JACHO) recommend the implementation of health care risk management programmes. All health care systems should be designed to prevent errors. The first step is to design systems to identify and provide feedback on errors or adverse events to reduce or prevent their occurrence. And paediatrics is precisely one of the fields in which the knowledge of adverse events (AEs) is weakest and with the fewest strategies to prevent them.

One of the key pillars of safety that must be prioritised is working on risk management to increase patient safety, understood as the reduction of unnecessary health care-related risk to an acceptable minimum. The measurement of the risk associated with hospital-level procedures is important for the health care system at the health level and also the economic, legal, social and mass communication levels.

The first step in risk management is the prevention of adverse events at three levels: reducing the risk of AEs happening (*primary prevention*), early intervention to minimise the damage caused by AEs (*secondary prevention*) and prevention of recurrence to reduce their impact (*tertiary prevention*).

Risk management entails a combination of learning from things that have turned out poorly (reactive approach) preventing potential risks to avoid their consequences and impact on the interventions we perform (proactive approach). Combining the reactive and proactive approaches, we will consider the phases, techniques and tools usually employed in risk management.

Risk management is a cycle of phases that resembles the iterative cycles for improvement in the plan-do-check-act (PDCA) approach, adapted to patient management and safety.

It is essential that strategies are implemented to adopt and integrate evidence-based health care interventions and make changes to clinical practice patterns.

Risk maps, like the one published by Mora-Capín et al.,[6] are proactive tools that allow the detection of critical points for patient safety during the care delivery process (using the failure mode effects analysis approach, known as FMEA) in order to anticipate them, implementing improvement actions to minimise the probability of an AE. As these authors highlighted, periodic implementation of these techniques allows an overall reduction in the risk involved in the different processes and subprocesses that constitute care delivery in any health care setting (in this case, a hospital emergency department), especially in relation to the most severe failure modes whose correction should be prioritised. In addition, the root causes of these failures are usually shared with other, less severe failure modes, so that the effect of improvements is generalised. Needless to say, this requires considerable effort from the entire health care team and a strong and coordinated leadership, with effective communication between professionals that is not currently found across all units and departments. The success of these initiatives is not based on chance or an isolated effort at a given time, but rather reflects a culture built through years of recurrent implementation of improvement techniques through PDCA cycles, with an inherent commitment to quality and safety and the pursuit of excellence in centres, departments and units. At any rate, the scarcity of this type of study, in which the patient is the setting in which we work, with its procedures and processes, and the treatment is our ability to improve them, is as relevant as it is inspiring.

Health care quality and patient safety must be a priority and a requirement in our clinical practice as paediatricians. As professionals, we have to lead the change in our institutions and promote strategies, programmes and projects to improve quality and safety within them in pursuit of a paediatric care setting offering the quality that all children deserve.

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