The Culture of Safety in Palliative Oncological Care during the COVID-19 Pandemic

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A Cultura de Segurança no Cuidado Paliativo Oncológico durante a Pandemia de Covid-19

La Cultura de la Seguridad en la Atención Oncológica Paliativa durante la Pandemia Covid-19

Nair Caroline Cavalcanti de Mendonça Bittencourt[1]; Maria das Graças Gazel de Souza[2]; Regina Bokehi Nigri[3]; Vanessa Gomes da Silva[4]

INTRODUCTION

Currently, the world lives a scenario of pandemic caused by the severe acute respiratory syndrome coronavirus 2 – Sars-CoV-2 impacting the economy, public and mental health of the entire society[1], whose health professionals work to cope with the coronavirus disease – COVID-19, risking their lives and experiencing situations that generate physical and psychological wearing[2].

And when dealing with oncologic palliative care, whose goal is to minimize the human suffering, its principles need to be applied both individually in face of a life-threatening disease as, for example, advanced cancer and to a population suffering the risk of massive loss of lives[3].

In times of crisis, Balsanelli e Cunha[4] show that overload from long work-shifts of health professionals and physical and psychological burden end up undermining the bases for safety. The staff who works in "mode of crisis" is wearing down. This burden leads to fatigue and stress, factors that compromise the performance and may provoke errors, poor communication and failing mutual help, inter-personal problems, loss of respect and understanding.

In the area of health, there is a world movement about safety after the disclosure of the study "To err is Human: building a safer health system" in 1999[5,6].

In Brazil, the patient safety was incorporated into the political agenda since the mobilization of the Brazilian National Health Regulatory Agency (ANVISA) of the Ministry of Health with the World Health Organization – WHO to reach the objectives[6].

Safety is the first step to improve the quality of the care provided; for such, however, it is necessary the intrinsic motivation of the professionals, reminding that "Err is human, but errors can be avoided"[5].

The health systems must pull away from the culture of "guilt and shame" which impedes the recognition of the error, blocking the possibility of learning with it[7]. Resources must be invested to disclose the experiences, which can be beneficial for patients and professionals further to bringing economy to the health system[5].

According to Nieva and Sorra[7], the biggest challenge to move forward towards a safer health system lies in the change of the institutional culture of blaming the individual by the errors individually, they should not be treated as personal errors but as opportunities to improve the system and avoid damages.

DEVELOPMENT

In order to improve the coordination, cooperation and global solidarity to mitigate the virus spread, the WHO declared that the outbreak of the novel coronavirus is a public health international concern[8] and was responsible for the significant increase of the number of cases demanding hospitalization, creating preoccupations about the collapse of the health system[9].

Health professionals reported fear of contracting the disease, transmit to their family, suffering for being pulled away from their households, stress, feeling of loss of control, worthlessness and preoccupation with timing and duration of the pandemic[10].

The fear of contamination by a potentially fatal virus of origin, nature and course little known eventually affects the psychological well-being of these professionals working to cope with the disease[11]. The stress and the pressure to deal with the job, added to the risk of getting ill, provoke

[1]Nurse. Master student, Nursing School Anna Nery of the Federal University of Rio de Janeiro (EEAN/UFRJ). Palliative Care Unit of Cancer Hospital (HC IV). National Cancer Institute José Alencar Gomes da Silva (INCA). Rio de Janeiro (RJ), Brazil. Orcid iD: https://orcid.org/0000-0002-4451-6258
[2]Nurse. PhD, Nursing College of State University of Rio de Janeiro (UERJ). Palliative Care Unit of HC IV/INCA. Rio de Janeiro (RJ), Brazil. Orcid iD: https://orcid.org/0000-0002-6247-9331
[3]Physician. Master Student of the Center of Biological Sciences of Health of the Federal University of the State of Rio de Janeiro (UNIRIO). Palliative Care Unit of HC IV/INCA. Rio de Janeiro (RJ), Brazil. Orcid iD: https://orcid.org/0000-0002-2387-243X
[4]Nurse. Doctoral Student of the Post-Graduation Program Stricto Sensu of Oswaldo Cruz Institute, Biosciences in Health. Palliative Care Unit of HC IV/INCA. Rio de Janeiro (RJ), Brazil. Orcid iD: https://orcid.org/0000-0003-3438-3401
Address for correspondence: Nair Caroline Cavalcanti de Mendonça Bittencourt. Rua Visconde de Santa Isabel, 274 - Vila Isabel. Rio de Janeiro (RJ), Brazil. CEP 20560-121. Email: ncarolinne@yahoo.com.br

serious mental health problems increasing the turnover and the Burnout syndrome, further to creating serious problems as anxiety and depression[12].

The early adoption of oncologic palliative care helps professionals to provide care to COVID-19 patients, regardless of being in life ending conditions, reminding that these professionals also need to provide care to the family who, in this context, can be called upon to take tough decisions. Therefore, take good care of the workers is paramount since physical and mental health is the requirement to approach the other, making them feel welcome and safe[3].

This scenario can increase episodes of errors, harming the users and affecting the institutions in quality and quantity, for the professionals they are often associated to feelings of shame, guilt and fear of punishments, losing the opportunity of knowing and handling these flaws correctly[13].

Scott et al.[14] reported in their article that professionals involved in patient safety-related events described a six-stages trajectory for post-trauma recovery: chaos and accident response; intrusive reflections; restoring personal integrity; enduring the inquisition; obtaining emotional first aid and moving on: quit, survive or thrive. The conclusion of this article suggested that the institutions have the duty of providing trainings continuously that promote emotional support to deal with this critical moment and are clear in defining what second victim is and its prevalence[14].

Scott et al.[14] defined the concept of second victim as healthcare professionals involved in unforeseen adverse event, medical error and/or injury related to the patient, becoming victims resulting from the trauma caused by the event. Often, there is the feeling of responsibility for the outcome of the patient and for the error, underestimating their clinical skills and base of knowledge.

Understand the occurrence of the error can stimulate notifications and contribute to change the current scenario of sub-notifications. It is relevant to invest in the culture of the organizational safety based in the dissemination of the concept of patient safety and non-punitive discussions about human error[15]. Several publications report experiences of cases of second victims and traumas in emotional, social, cultural, spiritual and physical contexts[16] (Figure 1).

It was also described a domino effect phenomenon in four groups: patient and family (first victim), healthcare professionals (second victim), hospital institution (third victim) and patients who will suffer subsequent damages (fourth victim)[17] (Figure 1).

According to Duarte et al.[17], the notifications need to be stimulated in the health institutions, facilitating the knowledge of the occurrences (Figure 2). It is fundamental that the manager offers understanding and correct treatment without blaming the professional, emphasizing the necessity of a complete analysis of the entire organizational system[13]. In oncologic palliative care, this evaluation is paramount because these are more vulnerable patients and susceptible to complications.

The second victim can react in different ways, the most common are: guilt, anxiety, fatigue, frustration and less common: relive the event by traumatic post-stress, avoid caring for patients, symptoms of severe anxiety to resume work, depression and suicidal ideation[18] (Figure 1).

Denham[19] proposed that the second victim should have rights, called "TRUST": treatment that is just; respect; understanding and compassion; supportive care; transparency and opportunity to improve (Figure 2).

It is considered that the systematic notification of incident and adverse events can promote interdisciplinary discussions to pursue solutions anchored in basic safety actions to avoid recurrence and identify gaps in the patient safety[20] (Figure 2).

Therefore, reduce elements hampering the effective communication of the team, further to promoting the notification of incidents and adverse events are ways to improve and managerial tools to stimulate safe and effective care[16] (Figure 2).

The adoption of measures related to the culture of organizational safety allows the professionals to feel comfortable to discuss the human error[15].

The basic assumption should be that human beings are fallible and errors are expected, even in the best organizations, must be seen as consequences and not causes, their origin lies not in the "perversity of the human nature", but in the existing systemic factors[21].

CONCLUSION

During the pandemic, the health institutions need to redouble their attention with measures that favor the reception of professionals and implement actions to strengthen the culture of safety. In this scenario where health professionals are valuable, it is indispensable to promote actions that protect their health.

The Nucleus of Quality and Safety of the Patient, anchored in the reflection proposed, suggests that the referenced orientation contributes to stimulate managerial actions in order to emphasize the development of the culture of safety.

CONTRIBUTIONS

All the authors contributed for the conception and/or planning of the study, gathering, analysis and

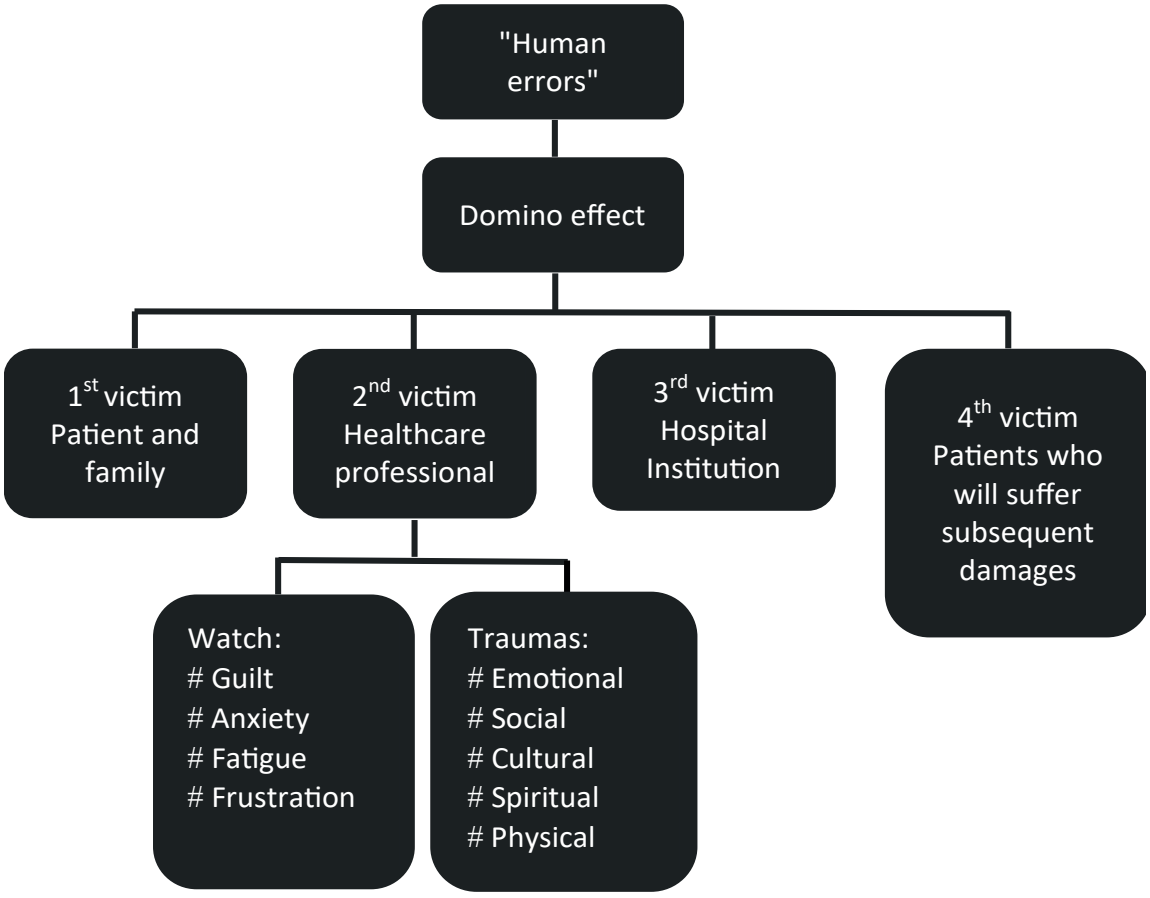

Figure 1. Effects of the human error, 2020

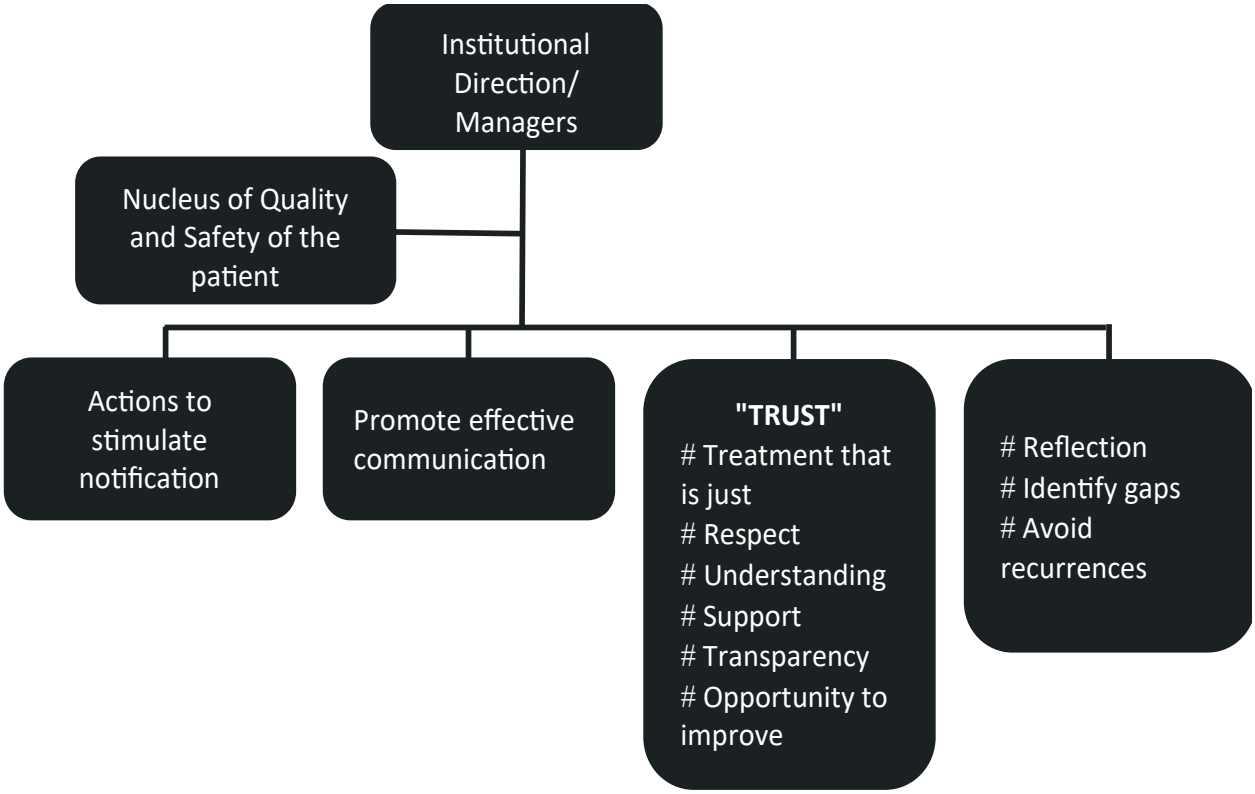

Figure 2. Proposal of institutional approach, 2020

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DECLARATION OF CONFLICT OF INTERESTS

There is no conflict of interests to declare.

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