Blame does not keep patients safe

A focus on systems and culture, rather than individuals, is ideal.

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Many organisations and health systems – even the legal system, to some extent – seek to blame individual health care workers if a patient suffers harm. The truth is that human error is inevitable: people make mistakes.[1]

The health care environment is highly complex. Many systems and processes, e.g., procurement, stock room management, record-keeping, staff rosters and clinical processes, and the people involved in them, must function effectively and in step with one another in order to ensure safe care and good outcomes.

Unless those involved in a medical error deliberately sought to cause harm, blaming and punishing them does not help. Instead, focus on the systems and processes that guide and support heath care workers. Are they adequate? Do they reduce the risk of errors? If not, how can they be improved? If the system doesn't change, the next person in the job will simply repeat the error. The World Health Organization Safe Surgery approach[2] is an excellent example of minimising error by improving the system and framework.

The ideal: a culture of safety and learning

Ideally, health care providers should establish a no blame culture, or 'just culture', in their organisation.

A just culture "considers wider systemic issues where things go wrong, enabling professionals and those operating the system to learn without fear of retribution."[3] This absence of retribution is crucial. If health workers sense that making an error will have a negative impact on their career, they will not report it. However, the absence of retribution may not be enough: health workers should be treated with respect and encouraged to speak up if something is wrong, as exemplified in the WHO Safe Surgery approach.[2]

For a health care culture to be 'just', it has to be one in which people "want to share what they know, because they can see how it will help to identify real, systemic causes of patient safety lapses."[3] Team members have to be confident that managers will work with them to deal with the underlying causes or contributing factors to an error,[4] else they may lack the motivation to report errors and keep accurate records.

Creating a just culture requires leadership, joined-up thinking, collaboration with policy makers and professional bodies, good record-keeping, and human resources and administrative processes that reward quality, courage and honesty. A challenging, but worthwhile, task.

Share your thoughts

If you have transformed your organisational culture, we want to hear from you. Write to **editor@cehjournal.org**.

Useful resources

- Patient Safety Learning (**www.patientsafetylearning.org**) develop initiatives and resources (e.g. the Blueprint for Action[4]) to address systemic and cultural factors affecting patient safety and the handling of medical errors. Health workers can join in discussions and download or share resources with others, free of charge, at the Patient Safety Learning Hub: **www.pslhub.org**
- The Communication and Optimal Resolution (CANDOR) process is based on 'just culture' principles. The entire toolkit, including teaching resources, is available free of charge. **https://www.ahrq.gov/patient-safety/capacity/candor/modules.html**.

References

1 Welch DL. Human error and human factors engineering in health care. Biomed Instrum Technol 1997;31(6):627-31.

2 WHO Safe Surgery **www.who.int/patientsafety/safesurgery/en**

3 **https://www.gov.uk/government/groups/professor-sir-norman-williams-review**

4 **www.patientsafetylearning.org/resources/blueprint**

Take part in the Grand Challenges in Global Eye Health study

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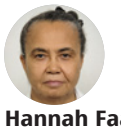

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As readers of the *Community Eye Health Journal*, you are warmly invited to take part in the Grand Challenges in Global Eye Health study, which is part of the ongoing Lancet Commission on Global Eye Health, and aims to identify the "grand challenges" in global eye health.

We hope that our results will help to guide future research, and we need your insights and ideas to make this work – whatever your role.

What is involved?

We want you to answer one question: *What are the grand challenges in global eye health?*

A grand challenge is a "specific barrier that, if removed, would help to solve an important health problem. If successfully implemented, the intervention(s) to address this grand challenge would have a high likelihood of feasibility for scaling up and impact." Grand challenges may be at a global or national level, or at the level of your clinic or community. Please think about the challenges you see in your daily work and tell us about them.

What next?

To take part, visit **http://bit.ly/eyechallenge**. Read more about the study in the Participant Information Sheet and scroll down to select whether you do, or do not, consent to take part. The responses you provide will not be presented in a way that could identify you. The deadline is **30 September 2019**.

The study has ethical approval from the London School of Hygiene and Tropical Medicine Research Ethics Committee (Ref 17487). We hope that you will participate in this exciting study and look forward to hearing about your grand challenges. Email: **Jacqueline.Ramke@lshtm.ac.uk** if you would like more information.