Patient safety: a culture of openness and supporting staff

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Abstract

The safety of patients and staff are inextricably linked. When healthcare staff are supported by their organization, they are more confident and able to deliver high quality, safe and compassionate care for their patients. Rather than simply 'firefighting' problems they have time for reflection, and the energy and resources to prevent problems from recurring. Confident supported staff are more likely to learn from error. Promoting a culture of openness and learning from mistakes within an organization, rather than a culture of blame and punishment, is of vital importance in allowing this. Such cultures have been slow to develop in the NHS. Poor communication, failure to disseminate information, scapegoating and an unwillingness to learn leads to harm to patients. This article will review how patient safety became a matter of public interest and discuss the effect that adverse events can have on healthcare staff. It describes strategies to support and empower staff to provide the high quality, safe care that they strive for.

Keywords Confidential reporting; error; patient safety; resilience; safe systems; Schwartz round; second victim; supporting staff; WHO checklist

Introduction

It is widely accepted that most healthcare systems are not as safe as they could be. The safety of patients was thrust firmly into the public spotlight following the publication of the report *To Err is Human* by the US Institute of Medicine in 1999.[1] *To Err is Human* highlighted the tens of thousands of avoidable deaths in American hospitals every year as a result of medical errors. The first high profile concerns raised in the English National Health Service (NHS) over patient safety were also in the 1990s. An investigation into excess deaths following paediatric cardiac surgery at the **Bristol Royal Infirmary** revealed that one-third of children received '*less than adequate care*'. This was calculated to have led to between 30 and 35 excess deaths of children less than 12 months of age over a 5-year period. More recent high-profile NHS investigations into failing is care (two on-going) are:

- **Mid-Staffordshire Hospital Trust** – high number of deaths
- **Mental Health Care Trusts** – 271 deaths in vulnerable patients over 6 years
- **Gosport Hospital** – 71 patients given opioids without medical justification.

Patient safety must be prioritized within healthcare. This is of particular importance in surgery, where adverse events can have devastating consequences, both physically and psychologically, for patients. An independent enquiry is currently being held to investigate the medical malpractice of breast surgeon Mr Ian Paterson in the private healthcare sector. There have also been recent high-profile cases of medical device failure (i.e. metal-on-metal hips and PIP breast implants) which have had far reaching implications for orthopaedic surgery and cosmetic surgery respectively.

To Err is Human

The report *To Err is Human* emphasized that more often errors are caused by '*faulty systems, processes, and conditions that lead people to make mistakes or fail to prevent them*' rather than by reckless or malicious behaviour from a single individual. Behaviour like that of Ian Paterson is rare. The publication of *To Err is Human* galvanized public and political interest, and the modern patient safety agenda began in earnest. James Reason, organizational theorist and proponent of the 'Swiss cheese' model of error, describes safety as a '*dynamic non-event*'. This definition suggests that in order for nothing bad to happen, many good things must be done right.[2] The Institute of Healthcare Improvement whitepaper, 'A Framework for Safe, Reliable and Effective Care',[3] describes an approach for organizations to understand the components of safe systems of care. This framework focuses on two ways in which patients can be protected from harm (Figure 1).

- **Organizational culture**, a safe organization is the product of individual and group values, competencies and behaviours related to safety.
- **Learning systems**, a safe organization measures its performance and help teams make improvements.

The Bristol Inquiry into children's heart surgery in Bristol highlighted that both organizational culture ('*too much power in too few hands*') and failure to learn from outcome data ('*clinicians were actively collecting and discussing data but were quick to deny any adverse inferences drawn from the data*') had contributed to the number of excess deaths.

Organizational culture

In 1989, as a newly appointed consultant anaesthetist, Dr Stephen Bolsin, identified that too many babies were dying after surgery at the Bristol Royal Infirmary. He tried to remedy this but was unsupported and eventually took his concerns to the media (this is termed 'whistle-blowing'; disclosures regarding health and safety concerns are now protected in law, provided the disclosure is made to a prescribed person or body). Sixty-four people complained to the Department of Health about the Mid-Staffordshire Hospital Trust between August 2005 and March 2009 before any formal investigation. Two senior doctors raised concerns about

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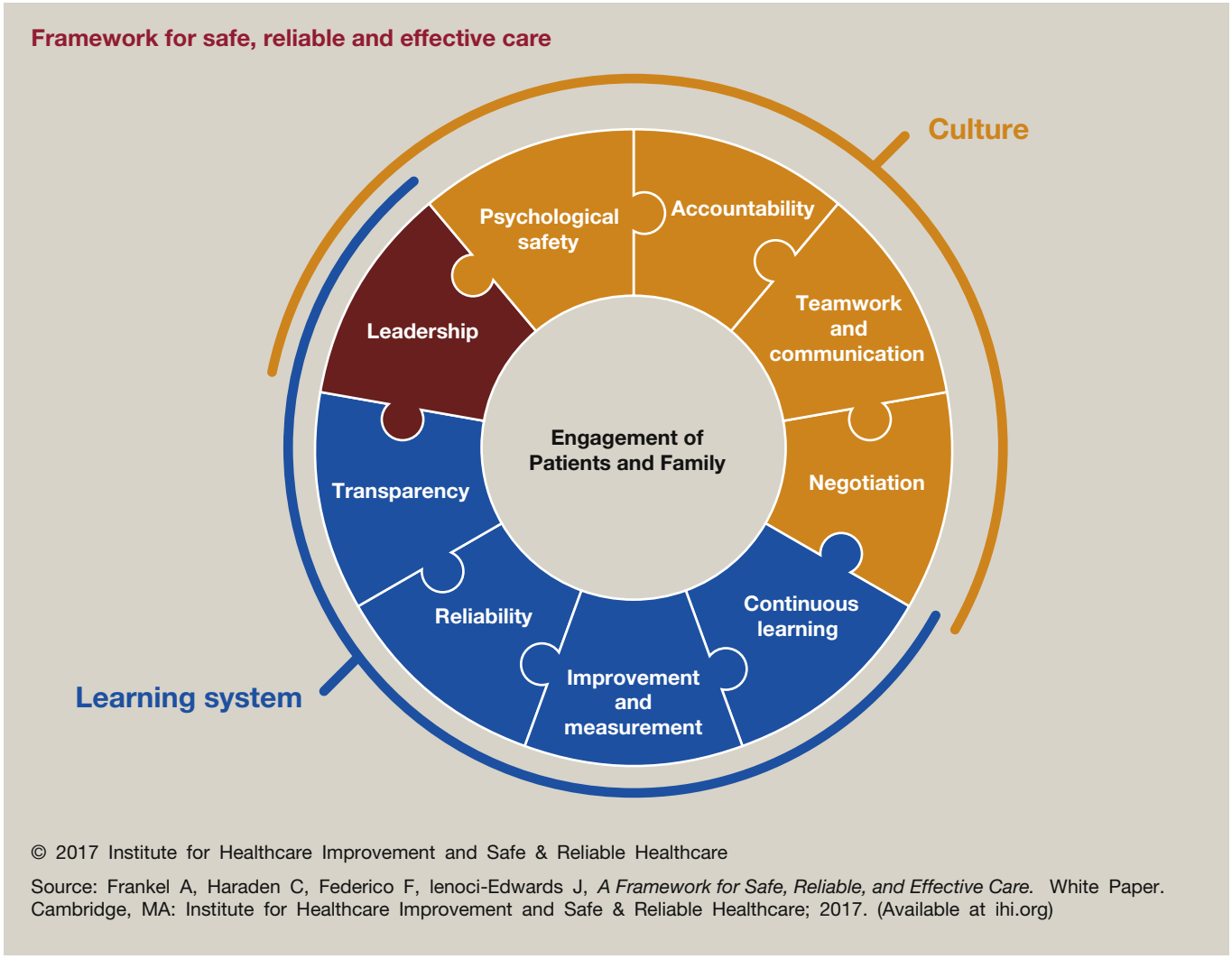

Figure 1

Ian Paterson as early as 2003 within the private hospital in which he worked. One claimed that Mr Paterson was 'untouchable' because of the money he made for the hospital. Organizational culture is key to ensuring that cover ups do not happen. In each of the above cases the organization did not have a culture or learning system in place to detect and reflect that they had a problem and that as a consequence mistakes were being made.

More concerningly, healthcare culture can actively cover up mistakes. Dr Albert Wu (John Hopkins University, Baltimore, USA) writing in the *British Medical Journal* described how patients want to believe that doctors do not make mistakes, and that the medical profession has colluded in propagating that belief. This fallacy has resulted in a culture of blame and individual doctors being held responsible for their mistakes. From the patients' perspective, with each medical error treated as an anomaly, with organizations saying, 'It will never happen again'. This means opportunities for learning are lost, and the same error is as likely to happen again.[4]

Duty of candour

Openness with patients and relatives when there is a medical error causing harm above a certain harm threshold has now been enshrined in law. Healthcare providers registered with the Care Quality Commission (CQC) have a statutory duty of candour, the CQC is able to act if this duty is breached. Doctors have an ethical duty of candour to be open and honest when things go wrong. The duty of candour promotes a culture of openness. It may or may not prevent the most serious breaches of care. However, it does nothing to help an organization learn from everyday smaller problems, mistakes and near misses. The open reporting of these by staff is perhaps of even greater value than an enquiry commenced only once a serious safety breach has been identified.

Learning from errors

In 1955, the Ministry of Health advised '*a brief report should be prepared as soon as possible after any occurrence of the kind in*

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