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ЕВРОПЕЙСКА АСОЦИАЦИЯ НА СТАРШИТЕ БОЛНИЧНИ ЛЕКАРИ

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PROMOTING A BLAME FREE CULTURE IN ORDER TO REDUCE MEDICAL INJURIES

Meeting of the Board of Governors of HOPE

Amsterdam (NL) - April 21, 2006

During its meeting held in Amsterdam on April 21, 2006, HOPE, the European Hospital and Healthcare Federation adopted a resolution on patient safety following the various activities relating to patient and in particular the work of the Council of Europe, in which HOPE has been involved.

Patients who suffer from a medical injury want at least explanations for what happened, apologies for the patient's situation, assurance that the same mistake should not happen to anybody else. Evidence shows at the same time that an emphatic and problem solving approach from the hospital and healthcare staff when something goes wrong will reduce further complaints, claims and other actions form patients.

If patients want to complain there should be at least three different elements. First, Local Complaints Committees/Patients Advisory Boards as independent bodies should exist to help patients when they have difficulties in contacts concerning the health care, attitudes from staff, waiting times etc. Very often, they could solve the patient's problem by investigating the case and talking to the medical staff.

The second element is an economic compensation system. In Scandinavian countries, there are no-blame compensation systems where the patient could get economic compensation without going to court if the medical injury was avoidable by an experienced specialist. In other countries, it is necessary for the patient to prove that the doctor was negligent, made an error or omission, which might end up in court. Many countries now try to use more of administrative procedures rather than going to court.

The third element is a disciplinary system for medical staff. The patient should be able to file a complaint to a "Medical Responsibility Board" if he/she thinks that a medical staff member should be disciplined (admonition or warning) for neglect of professional duties. Such a board or another medical authority should also have the power to withdraw the licence of medical staff.

If the patient has the right to make complaints to a local Complaints Board, make claims to an economic compensation system (preferably using an administrative system instead of court) and file a complaint for disciplinary actions to a medical responsibility board, it is then easier to use incident-reporting systems in health care as blame free systems. Again, the value of having a blame free reporting system is that it could be used to learn how to avoid future mistakes.

Mistakes appear in every human activity, there is an opportunity to learn from mistakes and to prevent them.

A system's approach is the best way to improve patient safety, instead of blaming the individual. Effective risk management requires understanding of human behaviour, varieties of human error and conditions likely to promote them. It must be accepted that people will make mistakes, processes and equipment will fail. Individuals should be allowed to make errors. The systems approach takes into account many components recognised as contributing to an incident or to the events leading up to it. This moves the investigator away from

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focusing blame on individuals and looks at what was wrong with the system in which the individuals were working. Systems should therefore be designed and maintained to reduce as far as reasonable the likelihood of patient harm caused by mistakes. By accepting this approach, organisations can focus on change and develop defences and contingency plans to cope with these failures, can learn lessons and potentially stop the same incident recurring or harming patients and providers of care. Even if a system approach generally should be used, it would be helpful for some individuals to get training in order to improve performance, which could be facilitated by a supporting organisation.

Patient safety culture

A safety culture is essentially a culture where everyone has a constant and active awareness of the potential for things to go wrong, that is open and fair, where people are able to learn about what is going wrong and then put things right. At all levels, problems and errors should be treated open and fair in a non-punitive atmosphere. The response to a problem does not exclude individual responsibility, but focuses on improving organizational performance rather than on individual blame.

Blame free incident reporting systems

The primary objective of an incident reporting system is the enhancement of patient safety, by learning from adverse events and mistakes made. Incident reporting systems are not intended to identify and punish the individual staff members involved in patient safety incidents.

An incident reporting system should:

- preferably be voluntary in nature. In most instances it is just the professional in question who knows about a near miss or an adverse event;
- preferably be confidential. However, if the event shall lead to any analysis and learning, the names of the involved personnel have to be known locally;
- preferably be anonymous (especially at regional and national levels) - depending on trust in administration and regulatory bodies in society;
- be non-punitive with respect to those who report, but providing no immunity if the knowledge of the event is brought to supervisory bodies or legal authorities in some other way;
- be objective with findings and recommendations;
- encourage unrestricted reporting by all working in the health care system;
- provide incentives for reporting;
- receive reports of serious and fatal events caused by incidents, “near misses,” and hazardous situations that could lead to safety incidents;
- be independent of regulatory or accrediting processes;
- there should be a single format for the reporting of all incidents, preferably including discrete categories for onward reporting to public authorities or for separate analysis.

What could hospitals do without waiting for new incident reporting systems?

Data from complaints systems, economic compensation systems and current incident reporting systems should be used to learn:

- medical injuries causing death or permanent disability should be analysed with Root Cause Analysis in order to learn and change routines and systems to avoid injuries;
- risk analysis should be undertaken for medical procedures that could cause severe harm to patients in order to change routines and systems;
- the management systems quarterly reports should include the number of analyses performed compared with the number of severe reports in the reporting systems and severe claims;
- patient safety is not a cost - it is economic attractive for hospitals. A 500 bed hospital will save 500,000 Euro/year by reducing hospital infections with 10%. A medical injury will cause extra bed-days, re-operations and extra outpatient visits.

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