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EDITORIAL

Seven steps to patient safety? … If only

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Working with fellow practice developers at an IPDC practice development school in Northern Ireland recently has made me think some more about patient safety and effective cultures. Apparently there are seven steps to patient safety (National Reporting and Learning Service, 2004). These are:

1. Building a safety culture
2. Leading and supporting staff
3. Integrating risk management activity
4. Promoting better reporting
5. Involving and communicating with patients and the public
6. Learning and sharing safety lessons
7. Implementing solutions to prevent harm

One look at these steps and the practice developer will know they are far from being steps and far from a linear process. Each forms a complex phase inter-related to the others and each has, at least, primary and secondary level complex interventions and evaluations. Building a safety culture extends far beyond anything to do with patient safety and takes years of concerted effort. It is interesting to consider the amount of resource put into addressing errors versus preventing them. Advances in patient safety, especially where human error is concerned, depend upon a collective ability to learn from mistakes, whether near misses or mistakes resulting in actual harm to a patient. To promote a culture in which people can learn from mistakes, managers will have to re-evaluate their organisational patient safety policies. It is often a default position that policies are built on a belief that human error is first, wrong and second, that it can be totally eliminated. Norman (1988, p ix) commented:

> *'People make errors, which lead to accidents… The standard solution is to blame the people involved. If we find out who made the errors and punish them, we solve the problem, right? Wrong. The problem is seldom the fault of an individual; it is the fault of the system. Change the people without changing the system and the problems will continue.'*

An unintended consequence of recent reports into patient safety maybe an enhanced focus on the punishment of individuals rather than a focus on preventing errors and enabling 'safe' reporting of mistakes. The more serious the outcome the more blame can be attributed to the individual. There are differences between human error, negligence, actions where there has been a conscious disregard of significant risk and an intentional disregard of policy and/or procedures.

If human error is a social issue then part of the response is to have built in within organisational policies socially just positions and responses. Central to this is developing a learning culture. Here, I do mean a learning culture and not the predominant training culture, which is part of the current default policy response to dealing with error, negligence and every other patient safety concern. A challenge for practice development is how it can contribute to the development of a learning culture

that enables managers to create fairer and more socially just cultures within their organisations. The benefits of this will extend beyond patient safety.

In this issue of the journal, we have several papers that acknowledge the complexity of the healthcare context including patient safety; further, the authors of these papers share with us the methods and processes they've been working with as well as some of the outcomes that have been achieved. A common theme in these papers is that they explore and/or address in collaboration with others some of the challenges in ensuring effective person-centred cultures where learning and safety are key attributes.

References

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