BLAME CULTURE: HOW TO MAKE A CHANGE IN YOUR WORKPLACE

A punitive response to errors is bad for patient safety and staff morale – but there is another way

By Jennifer Trueland

When something goes wrong, a simple shift in language can make all the difference. Instead of asking ‘who’s to blame?’ or ‘what did you do?’, try asking ‘what happened?’ and ‘what were the circumstances?’. This can be the key to improving patient care as well as the lives of healthcare staff.

That’s the message in new guidance from NHS Resolution, the body that manages claims for compensation against the NHS in England. Published in July, Being Fair: supporting a just and learning culture for staff and patients following incidents in the NHS makes a powerful case for shifting away from the blame culture that still too often pervades health services.

Culture of learning from mistakes
Organisations that have a culture of learning from mistakes – and supporting those who make them – are already seeing the benefits in improved patient safety and staff productivity, as well as happiness.
‘This isn’t looking at things from the perspective of failure, it’s looking at what we do well and building on that with cultures of kindness and compassion’

Suzette Woodward, co-author of Being Fair and senior adviser to NHS Resolution

It sounds compelling, but nurses working in the stretched health service might find it hard to swallow. There have been successive attempts to induce the NHS to shift from a blame culture to one of learning, yet there are still organisations where staff feel unable to confess to errors or to flag up areas of poor practice. Why should it be different now?

The difference, say two of the authors of Being Fair, is that the idea of a just and learning culture is gaining momentum, winning support from national organisations and regulators.

‘Yes, the blame culture is still there, says Suzette Woodward, senior adviser to NHS Resolution and one of the report’s authors. ‘And yes we have been talking about it for 20 years, but what is different, or feels different, is that there’s a much greater focus from a greater group of people. It used to be isolated people saying “we’ve got a blame culture, what should we do about it?”.’

Dr Woodward says organisations including NHS Improvement and the Care Quality Commission are now putting more emphasis on the importance of a just and learning culture. ‘It feels like all of this coming together is such an amazing opportunity to do something different this time round.’

Co-author Denise Chaffer, director of safety and learning at NHS Resolution, shares this view. ‘We have support from a lot of national organisations and regulators that this is the right thing to do, and I think that’s a very powerful message,’ she says. ‘This guidance has pulled together ideas about what good looks like, and it’s not about just staff, or just patients, it’s about both.

‘What’s important to know is that staff being valued is good for patients. We need patients to be supported and looked after by staff who feel valued. This isn’t a charter for staff, it’s a charter for everyone. It’s about learning from what’s gone wrong rather than being blamed.’

Making the switch

So what can organisations do to make the shift, and what does it mean for nurses? The guidance includes case studies showing what a just and learning culture looks like in practice. One showcases a triage system implemented at Barts Health NHS Trust in London to determine whether disciplinary action is necessary or appropriate.

Another outlines the approach adopted by Mersey Care NHS Foundation Trust. This is based on the work of Sidney Dekker, a professor known for his work on human factors and safety, who says three questions should be asked when something goes wrong: who is hurt?, what do they need?, and whose obligation is it to meet this need?

The guidance also includes a suggested ‘Just and Learning Culture’
When an excellent nurse makes a mistake, they are a victim too

When Amanda Cooney got a call from one of the district nurses in her team confessing to a potentially catastrophic medication error, she didn’t hesitate in her response. The nurse, who was visiting a care home to give insulin to two patients, had given the wrong insulin to one.

‘This was a nurse with an exemplary record, an excellent, compassionate nurse, and she made a mistake,’ says Ms Cooney, district nurse team leader at Mersey Care NHS Foundation Trust. ‘No one was with her and the patient had dementia, so she didn’t have to say anything but she rang me straight away.’

Patient safety first

The priority was obviously making sure the patient was safe and the correct steps were taken, including informing the care home staff, the patient’s GP, the diabetes team, and the patient’s daughter.

But the patient wasn’t the only person who needed care. ‘She was the first victim, but the nurse was the second victim. She was so upset. She is a fabulous nurse. I needed to talk it through with her and see what she needed from me,’ says Ms Cooney.

Ms Cooney is one of about 50 ‘just and learning ambassadors’ at Mersey Care, where she leads a team of about 20 district nurses in Sefton. The team was formerly part of Liverpool Community Health NHS Trust, which was taken over last year after serious concerns about patient care and safety.

She firmly believes that rather than blaming people for mistakes, it is essential to learn from them.

‘I had come from a team where there was low morale, a poor culture. Staff were feeling blamed, and not being honest when things went wrong’

Amanda Cooney, district nurse team leader

The just and learning ambassador role is something I am really passionate about. It fits with my values. I’d been thinking for a long time that if we worked in this way, the outcomes would be better for patients.

‘I had come from a team where there was low morale, a poor culture, a lot of patient harm. Staff felt blamed, and were not being honest when things went wrong.’

‘They were frightened because there was a lot of blame: you were “sent to Coventry” for speaking up. So it was about promoting a culture where people felt psychologically safe to speak up.’

When Ms Cooney talked it over with the district nurse once they left the care home, the nurse ‘identified the learning herself’, she says. ‘She saw what we needed to do to make sure we didn’t make the mistake again.’

‘Meet hurt with healing’

The district nursing team also discussed the issue and came up with ideas to reduce risk. ‘It came from them,’ Ms Cooney says. Practical changes included keeping the insulin in a locked cupboard and adding a picture of each patient to their nursing file.

Ms Cooney has every praise for the trust’s senior management team, particularly Mersey Care director of workforce Amanda Oates, who has blogged about the journey to a just and learning culture. ‘Our chief executive is 120% behind this as well,’ says Ms Cooney. ‘It’s great to be able to be really proud of where you work.’

For Ms Cooney, a compassionate approach is vital whether you’re working with colleagues or patients. And that includes when things go wrong.

‘Don’t meet hurt with more hurt – meet it with healing and learning.’
you can therefore say there’s a business case for being kind.’

Of course, if everything were perfect in the health service, then there would be no need for the guidance. The document itself paints a mixed picture, and includes several challenges.

Equity and fairness
These include ensuring that organisations embed the principles of equity and fairness in their policies, practices and culture – the report highlights, for example, the disproportionate disciplinary action experienced by black, Asian and minority ethnic (BAME) staff – and tackling bullying and harassment.

‘We see some excellent practice, and areas where staff feel very supported and there’s a more open and valuing way of working,’ says Dr Chaffer. ‘The problem is that there’s variation. But it’s not up for debate; we have to do it. To make it safer, we have to have a culture where we learn.

‘There’s lots of evidence from other industries that the most important thing when something goes wrong is using simple phrases like “what’s happened?” and not “who’s to blame?”’. It’s so simple, but it’s a shift in emphasis from “Who did this, who’s responsible and tell me the timeline?” to “Who has been hurt, how are we going to understand what’s happened and how are we going to prevent it happening to someone else?”

So how can nurses be persuaded that it’s okay – even desirable – to be open? NMC director of fitness to practise Matthew McClelland has no doubt that nurses should feel this way – and accepts that the regulator has a role in spreading and encouraging a just and learning culture.

Being open about mistakes
‘The first thing is to be clear that we care about a just culture – that it’s something that we value,’ he says, pointing to last year’s announcement of the NMC’s new person-centred fitness to practise approach. A just and learning culture is embedded in the NMC’s work, he adds, from ensuring it is reflected in educational standards to working with employers.

The shift from a blame culture also has immediate relevance for fitness to practise processes – for example, regulators will give weight to the context in which an incident takes place, and also an individual’s recognition of the need to take remediation action (such as extra training or mentoring) if required.

‘We want to reassure nurses that they should be open about mistakes,’ Mr McClelland says. ‘This isn’t about punishing people for the past; it’s about ensuring someone is safe for the future.’

The RCN’s head of nursing (quality and regulation), Christine Callender, agrees that when things do go wrong it is important that nurses are able to speak openly about the errors so that they can learn from them and act to prevent recurrence.

‘No nurse goes to work with the deliberate intention to cause harm, so when something goes wrong it can be devastating,’ she adds.

‘It is important that nurses are supported through the process of what went wrong and a more systems-based approach is established to learn from and continuously improve patient safety and prevent an ongoing culture of blame.’

Jennifer Trueland is a health journalist