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Moving from 'No Blame' to 'Just Culture' in Incident Reporting, Ksa Experience

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Editorial

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Every employee has a role to play in ensuring quality and safety in a healthcare set-up^[1]. Incident reporting system in the healthcare setting is intended to make the staff responsive and report the incidents, near miss or sentinel events, so that these could be explored to know the root causes and steps are adopted to reduce their likelihood^[1]. The overall purpose of the incident reporting system is risk reduction in the hospital and making the system less prone to human errors. The usual barriers to incident reporting in the health care setting are; potential lawsuit, fear of violation of privacy and fear of humiliation, unease that not anything may transform even if the incident was reported, lack of acquaintance with the procedure and impact of culpability culture^[1-3].

In King Fahad Hospital Hofuf (KFHH), although the practice of no blame in terms of incident reporting was there in the hospital policies for quite a while and was practiced in that spirit as well, however KFHH started to campaign 'Stop the blame culture,' for incident reporting in the hospital in the month 06/2012 (KAIZEN point). The new strategy aimed to handle each incident, efficiently, aiming for better and secure systems and keep away from personal culpability, conventional manner of exploration and punitive action. The new strategy was verbalized in the general orientation of the new staff, in writing to all the departments and displayed on quality boards all over the hospital. Gradually the number of incidents that were reported started to increase and within three months there was doubling in the number reported incidents. No blame culture of incident reporting is supported by relevant literature^[4,5]. In the area of IPSGs (International Patient Safety Goals) the hospital leadership decided to raise the patient safety bar in the hospital and move to the phase of 'Just culture.' This step must be looked in the context of the historical development towards just culture in this hospital. It included more than three years of build up with formulation of policies and procedures for the IPSGs, intensive staff trainings on the policies and procedures for IPSGs (by all the concerned departments) and monthly audit of IPSGs by the clinical audit program which included observation of staff practices in terms of IPSGs. With this evolution background, 'Just culture' for IPSGs was introduced in the hospital. This move was unanimously accepted by all the members of the Quality & patient safety committee of the hospital. This move was then communicated to the hospital staff verbally, in writing and displayed on all patient safety information boards throughout the hospital.

Just culture has been defined as a culture in which healthcare personnel are not punished for actions, omissions or decisions taken by them that are fitting with their experience and training, but carelessness, violations of code of clinical conduct and medical ethics and negative acts towards the patients are not tolerated^[4]. Just culture appreciates that healthcare personnel should not be apprehended for system failings over which they do not have any control. A just culture also recognizes quite a few errors are expected as a result of contact between healthcare personnel and the systems in which they do perform. However, distinctively a culture that professes "no blame" as its overriding standard, a just culture does not accept mindful disrespect of obvious risks to patients or wrong-doing (e.g., falsifying a record, performing professional duties while under the influence)^[5]. A just culture has zero acceptance for irresponsible actions^[6,7]. Moving to just culture for IPSGs in the hospital would go a long way in terms of self-accountability, accountability towards the patients, promoting professionalism and the culture of patient safety in the hospital.

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