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The Safety Culture Series

System Errors and individual responsibility

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Let’s talk about the Manchester Patient Safety Framework...

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What is ‘System Errors and Individual Responsibility’?

What sort of reporting systems are there?

How are reports of incidents received?

How are incidents viewed- as an opportunity to blame, or improve?

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The Safety Culture Series

Levels of Culture

1. Pathological

. Incidents are seen as ‘Bad luck’
. Incidents are outside the organisation’s control
. Incidents are a result of error and staff behaviour
. Main response is disciplinary action

2. Reactive

. Organisations sees itself as a victim of circumstances
. Individuals are seen as the cause
. Actions focus on discipline and training
. No support given to those involved in incidents (staff, patients, relatives)

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Levels of Culture

3. Bureaucratic

. Recognition that systems contribute to incidents, not just individuals
. States an ‘open and fair culture’ but it isn’t perceived by staff that way
. ‘Being open’ protocols have been written and support processes exist, but are not widely known about or used.

4. Proactive

. Incidents are seen as a combination of individual and system faults.
. Has evidence of open, fair and collaborative culture
. System analysis completed in response to an incident
. Incident decision tree used to identify whether individual has responsibility
. Organisation speaks openly with staff and patients following events causing death or serious harm

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Levels of Culture

5. Generative

. Organisational and system factors are the focus. Staff aware of own accountabilities and empowered to address risks and issues
. Triangulation of data across incidents, audits, complaints and litigation
. Staff, patients and families well supported post-incident
. High level of openness about all incident types irrespective of harm

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How does your team and organisation fair?

Use these characteristics to reflect on:

. What's your team's local culture (or climate) like?
. What's the organisation's culture like?
. How is it changing over time?

As a service user:

. What evidence of these do you see in the services you use?

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Culture is critical!

Building a strong culture is critical, but can take a long time.

If you would like advice and support on improving your culture, comment below and we'll be in touch