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Guest editorial

A positive approach to patient safety

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Patient safety is a major priority for primary care. Attempts to improve patient safety have resulted in a plethora of policies and numerous approaches have been suggested. However, despite all of these valiant efforts, threats to patient safety still remain a concern to all healthcare providers and users.

Our understanding of any phenomenon is guided by the perspective with which we approach the chosen field of study. Cognitive psychologists have offered explanations as to why errors occur that are based on the infallibility of the human brain to correctly process information, especially when there are competing tasks to be performed. Undoubtedly, this has led to improved safety, such as the introduction of different shaped vials for injections so that they cannot be mistaken when picked up in a hurry. However, it has become increasingly recognised that each individual is working within a larger system and that problems within this system will lead to errors, such as the imposition of inappropriate time pressures on healthcare workers so that they are made to perform in a hurry. Researchers who try to understand these so called 'systems failures' as a cause of error, identify problems with the 'way that things are done'; processes are flawed and procedures are not followed. This has led to further research that tries to make sense of the organisational culture – 'the way that things are done around here'. Although this notion is contested and not clearly defined, it does recognise the importance of patient safety being dependent on a wider social system of which each individual is an integral part.

One aspect of understanding how complex social systems work does not appear to have been widely considered and implemented in relation to patient safety, yet it has been appreciated in other areas for many years. This is the social construction of patient safety. Patient safety is not a given entity but is actively created in the minds of individuals by a process of constant exchange and negotiation of meanings between individuals. The crucial implication is that patient safety can be regarded by the individual as something that is positive, or conversely as something that is negative. This socially constructed attitude will determine the individual's behaviour and actions.

The importance of a positive construct to patient safety has been clearly demonstrated in so-called high reliability organisations in which there are high levels of risk yet errors rarely occur. Examples include nuclear power stations, petrochemical works and flight decks of aircraft carriers. In all of these organisations there is both an individual, and collective, responsibility for safety in which all actions are governed by a mind set that constantly 'keeps an eye on the situation'. Whenever an action is performed, there is an automatic awareness of the potential errors that can occur and steps are instituted to mitigate any influences. There is also an appreciation of the notion of 'normal accidents' within the organisation, in which error is an inevitable part of the work of the organisation and can only be avoided by no actions being performed. This acceptance requires increased vigilance since if it fails the consequences can be disastrous.

A negative construct to patient safety regards an error as something that is not inevitable and that can be prevented by identifying and rectifying its underlying cause. However, it may be that such an approach can actually worsen patient safety. Current approaches to incident reporting and root cause analysis have been founded on the view that errors are produced by the system in which the individual works. Rooting out and eliminating the causes in this system should produce improved safety. The role of the individual as an active contributor to the error is ignored in an attempt to create a culture of 'no blame' so that there is increased reporting and free discussion. The underlying belief is that all healthcare providers are trying to do their best and that the system in which they are working has let them down. However, the majority of errors are due to human factors and not technical, such as unexpected equipment failure. Errors due to human factors are inevitable, 'to err is human', but the likelihood of human factors can be anticipated. For example, the chance of error is increased by a wide variety of factors, such as stress, tiredness or complexity of tasks, but an individual can be aware that they are in such circumstances and either avoid performing the task or be more vigilant to ensure that the task is performed safely. This requires a positive construct to patient safety.

The development of a positive construct to patient safety requires an approach that recognises that it is socially constructed. Social construction of attitudes requires a communication process between individuals to allow the exchange of meaning. Active communication occurs when individuals form cohesive groups. It is essential within such a model to have meetings where instead of debriefing after adverse events there is a briefing on how to recognise and deal with situations in which patient safety can be compromised. This social construction is both individual and collective since neither can be separated. This approach has been the mainstay of safety initiatives in high reliability organisations and was introduced into civil aviation as part of crew resource management. New insights into the causes of aircraft accidents were obtained from cockpit voice recorders and an important aspect was found to be lack of situational awareness and inadequate communication between crew members. Situational awareness involves a conscious recognition of all the factors and conditions that affect the safe functioning of the aircraft, including operational, technical and human factors. Training can increase this awareness to allow appropriate actions to be taken and also training can improve the important aspects of communicating this information to colleagues and the willingness to accept this feedback. An essential aspect of the training courses is that they involve groups usually based on a team who regularly work together. In such circumstances it is possible to develop both an individual and collective construct of safety.

A positive construct to patient safety requires a locus of responsibility in which the individual is the main agent to increase vigilance and take avoiding action. There is also an essential collective responsibility – but ultimately it is a personal action. An important aspect of increasing awareness is to sensitise the individual to previous events and this can occur by highlighting errors and organisational learning. In organisational learning there is both an individual and collective response to learning from experience. This process is also dependent on good communication between individuals within the organisation.

The above description of the constructs, and associated aspects, of patient safety has been clearly separated but the reality is that both are an integral part of the overall approach to improving patient safety. There is no approach that will be effective alone but the notion of a positive construct appears to have been neglected. This approach cannot be ignored if patient safety in primary care is to be improved. The challenges are tremendous. Communication between healthcare providers needs to be increased and changed in content. This will require substantial commitment by the organisations within which individuals work, resources will need to be allocated to provide trainers and group work opportunities, and above all, individuals need to appreciate the importance of this approach. What is the alternative?

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