Blame often attributed to others in patient safety incident reports

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When primary care staff members report patient safety incidents, they often attribute blame not to system failures but to the actions of individuals, according to a new study. Because fear of blame and retribution are known to prevent health care staff, particularly in hospital settings, from using incident reporting systems to communicate patient safety concerns, researchers in the United Kingdom explored the nature of blame from primary care incident reports themselves.

They analyzed incident reports from the England and Wales National Reporting and Learning System according to pre-specified classification systems to describe incident type, contributory factors, outcomes and severity of harm.

Healthcare professionals making incident reports attributed blame to a person in 45 percent of cases (n=975/2148; 95 percent CI, 43-47 percent). In 36 percent of cases, reporters attributed fault to another person, while 2 percent of reporters took personal responsibility. Blame directed at others was more likely in discharge planning, communication, referrals, and diagnosis and assessment incidents, and was commonly associated with incidents where a complaint was anticipated.

The high frequency of blame in primary care incident reports, the authors suggest, may reflect a health care culture that leads to blame and retribution. Improving patient safety through analysis of incident reports and identifying areas for learning will require a shift towards a culture that identifies system failures rather than blaming individuals, they

conclude.

More information: http://www.annfammed.org/content/15/5/455.full

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