

Personal View

Can we have a culture of patient safety without one of staff safety?

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Michael Sinnott, *senior staff specialist and senior lecturer, Princess Alexandra Hospital and University of Queensland, Brisbane, Australia*, Ramon Z Shaban, *senior research fellow, Griffith Health Institute, Griffith University and Princess Alexandra Hospital, Brisbane*

Correspondence to: michael_sinnott@health.qld.gov.au

The history of patient safety

The patient safety movement reached its tipping point in 2000 after the publication, in the 1999 US Institute of Medicine Report, *To Err is Human*, of the extraordinary finding that there were up to 100 000 preventable deaths in US hospitals every year.¹ The patient safety movement used James Reason's paradigm of accident causation, the so called "Swiss Cheese Model", to explain why systems failures cause most adverse events among patients, and identified the "no blame" culture as a way to improve outcomes among patients.² Removing the fear of reporting errors means that systems failures can be identified and remedied before bad patient outcomes occur.

Despite the development of the no blame approach to patient safety, we have observed the opposite culture in relation to staff safety.

Observing a paradox: the scalpel versus the ampoule

While demonstrating two safety products to operating room nurses in the United States and Australia, one of the authors (MS) observed reactions that initially caused him concern. The first safety product was a new, sterile version of the popular single handed scalpel blade remover, which, when used with a hands free passing technique, can prevent up to 50% of all scalpel injuries.³ Scalpel injuries—the second most common cause of sharps injuries in the operating room—can cause infection with HIV, hepatitis B, C, and D, and other serious illnesses. They can also damage digital nerves, arteries, or tendons, requiring microsurgery and up to three months off work to undergo extensive rehabilitation. Psychosocial distress, inability to have unprotected sexual intercourse for three months, post traumatic stress syndrome, and economic and psychological costs associated with seroconversion of a healthcare worker after exposure have also been reported. The second safety product is designed to safely open glass ampoules. Although ampoule cuts are the most common cause of sharps injury, they rarely lead to occupational infection, suture, or the need for rehabilitation.

The operating room nurses tried the new scalpel blade remover and all acknowledged that the invention was clever and safe. However, when they were asked if they would change practice and use it, their responses varied markedly. Most reported using their fingers or artery forceps (haemostats) to remove used blades, practices that are proscribed by Australian Standards and the US Occupational Safety and Health Administration guidelines on bloodborne

pathogens and needlestick prevention. Interestingly, when they then used the glass ampoule opener, their response was markedly different: their demeanour changed and they wanted to own one immediately.

Interpretation: self blame versus no blame

My (MS) initial reaction to this observation was disbelief—the nurses' reaction seemed to defy common sense and the statistics of injury risk. In their responses they seemed to be saying that they were more fearful of cutting themselves with a clean glass ampoule than with a dangerous and potentially infectious used scalpel blade.

In attempting to reconcile this incongruity it occurred to us that this behaviour might be an example of what is referred to as “blameworthiness”, a term that we loosely define as the assignment of a level of self blame by the injured party on the basis of a cultural perception of risk. Because ampoule cuts are so common, they are not deemed to be the fault of the clinician. The responsibility for ampoule cuts can be easily relegated to the fault of the ampoule.

However, in the case of a scalpel injury, the opposite occurs. The staff member is often immediately embarrassed, believing the injury to be a result of their inability or failure to safely complete a simple part of their daily work routine. A culture of blame (and self blame) seems to surround these events. As an emergency physician, MS has often seen embarrassment, apology, and self admonishment among hospital staff members presenting to the emergency department after a sharps injury.

This presents a paradox: staff work in a so called blameworthy culture with respect to their own safety that is contrary to the no blame culture they are expected to adhere to in order to optimise patient safety. This paradox can be seen at individual and institutional levels. We see health administrators

espousing the virtues of the no blame culture as a means to improve patient safety, but they fail to lead by example and pay attention to staff safety. This perpetuates the blameworthy culture, where staff fail to report personal injuries and don't ask the administration to supply them with safety equipment to prevent such injuries.

It would be difficult to argue that the absence of a culture of personal safety is entirely the responsibility of the employer. Research shows that employees—particularly health employees—have a poor understanding of occupational and workplace health and safety.⁵ In fact we would argue from personal experience that to put patient safety above everything else, including health employees' own safety, is professionally acceptable, and even esteemed.

Perhaps nowhere is this more evident than in emergency medicine and healthcare, and, more broadly, in the work of emergency service workers.

Physician, take care of thyself

To put this into perspective, a moment of personal reflection might help.

Have you or any of your colleagues ever driven back to the hospital for an emergency when you were tired or speeding? In doing so did you put patient safety ahead of your own safety? If you crashed would you blame your own foolishness for the crash? (An example of blameworthiness.)

Can you recall the mid-1980s and the introduction of universal precautions? Did you ever say you couldn't possibly wear gloves for your own protection because they would make cannulation too difficult, so much so that the inevitable multiple attempts would cause the patient unnecessary pain? When a needlestick injury occurred was it just inevitable, and moreover was it your fault for losing concentration? (Another example of

blameworthiness.)

Doctors and healthcare workers actually do understand the importance of personal staff safety—at least for their patients, if not themselves. For example, when slit lamp examination of a patient with bilateral eye pain reveals salt and pepper lesions, a diagnosis of flash burn is made. Treatment includes education about the importance of the patient wearing a welding mask at work to prevent future flash burns.

Unfortunately, in practice, the approach is one of “do as I say, not as I do.”

Doctors and healthcare workers understand the importance of patient safety—and of staff safety when this applies to a third party. However, to date, practitioners have not been able to reconcile this with the importance of their own personal workplace safety.

Accordingly, we argue that it is impossible to develop a congruent culture of patient safety in the environment where a war between the blameworthy culture and the no blame culture rages daily at the individual and institutional level. We ask if a culture of staff safety is in fact a prerequisite to a culture of patient safety?

Notes

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Footnotes

We thank Ellen Burkett for her help in shaping the ideas presented here.

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www.icmje.org/coi_disclosure.pdf (available on request from the corresponding author) and declare: no support from any

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