Heartbeat
Connecting health and care communities

Blame Free Culture Policy

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PURPOSE

This document sets out the basis of a blame-free culture (BFC) and the principles under which it will operate in the practice. Also refer to the Being Open Policy.

The purpose of a BFC is to generate an open and fair environment where errors and near misses are reported and examined, and where lessons are learned and established into new day to day practices, without the fear from staff that their mistakes will "count against them" in some way. This does not preclude formal reporting or actions in relation to incidents, however it does seek to establish the principle of openly reviewing routine errors, omissions, and incidents to learn from them without fear.

The establishment of a BFC will not however override the need for proper professional or regulatory control or clinical accountability, which may be implemented over and above BFC procedures as the need may arise. Practice staff and clinical professionals will be made aware of the nature of the BFC culture and the limits under which this will operate in normal circumstances. It is expected that as part of their professional status they will be aware of the professional and regulatory / contractual issues under which they must operate, and the nature of items which must be referred to regulatory bodies.

Patient and staff safety hinges on the safe design, operation and maintenance of equipment, systems and procedures, together with awareness of the human factors from which errors may arise.

POLICY

- Staff are encouraged to report incidents using the Significant Event Toolkit [*] reporting procedure.
- Reported events will be documented by each person directly involved with the event, and reported to the practice manager, who will carry out an initial review.
- Where the Practice Manager considers that there may be regulatory or other significant reporting issues involved, he / she may terminate the normal review process (below) and seek advice from external sources or GP partners as appropriate. At this point the matter will become confidential and controlled, subject to management discretion.
- Where the event reported is regarded as a "normal" event involving genuine error or learning issues, the matter will be discussed at an appropriate meeting of clinicians with the following key objectives:

    - Encourage any staff members directly involved to present the item.
    - Encourage an open and honest discussion without a consideration of fault.
    - Identify the nature and cause of the incident.
    - Identify any actions required immediately to rectify the situation and to prevent a similar recurrence.
    - Discuss and document the nature of the incident, and how processes and procedures may be changed to improve safety or efficiency.
    - Discuss how and when changes may be implemented.
    - Agree implementation and a suitable review period to ensure that any changes have been firmly embedded within normal practice.