

Making Patient Safety a Priority: Moving from a culture of blame to learning via narrative

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As the complexity of both our healthcare system and our patients increases, so too does the potential for adverse events. Traditionally, there has existed a medical “culture of blame” that discourages the reporting or discussion of errors. Without a safe space in which to share these cases with others, we are left in isolation to make sense of the thoughts, emotions and fears that accompany them. In addition, the ability to learn from each other in a way that improves patient safety is also lost.

At McMaster Family Practice (part of the McMaster FHT) we have adopted the practice of meeting regularly in a safe, non-blaming, and supportive environment to share our stories of near and actual misses with the goal of improving patient safety. The purpose of this session is to demonstrate how through the use of stories we are able to explore the impact of medical error on both patient and caregivers, pass on knowledge and experience, gain insights which can lead to effective change in practice and/or policies in an environment that breaks down the medical “culture of blame” and traditional sense of hierarchy to make patient safety a priority. We hope that participants are inspired to think of ways in which their own FHT can begin to have open discussions and foster an environment that is safer for both its team members and its patients.

