Survey on Perceptions of a Nonpunitive Culture Produces Surprising Results: Part 1

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Despite a growing awareness of the system-based causes of errors, many health care professionals are still struggling to come to terms with the role of individual accountability in a nonpunitive culture. A survey conducted by the Institute for Safe Medication Practices (ISMP) presented a series of statements about a nonpunitive culture and asked respondents to tell us about their personal beliefs on this topic. We emphasized that there were no right or wrong answers; we were interested only in the respondents’ perceptions.

More than 1,200 participants suggested that work is needed on all fronts to fully adopt a nonpunitive culture. The survey data showed that frontline staff members might have received less education about the basics of this type of culture.

About 15% of respondents believed that a nonpunitive culture excuses poor performance and absolves staff members of personal responsibility for patient safety. Another 21% noted that such a culture might increase carelessness, because individuals learn that they will not be punished for their mistakes.

Significant differences, however, existed between respondents of different backgrounds. Not a single risk manager felt that a nonpunitive culture excuses poor performance, and only 8% agreed that such an approach might absolve the staff of responsibility or exacerbate carelessness. Yet 21% to 26% of pharmacy technicians indicated that a nonpunitive culture excuses poor performance, absolves staff of responsibility, and increases carelessness. Similarly, 26% of staff nurses worried about increased carelessness if punishment was not an option when someone made a mistake.

Actually, a nonpunitive, system-based approach to error reduction does not diminish accountability; instead, it redefines and directs it in a more productive manner so that the managers and leaders are equally accountable for patient safety, not a complete absence of errors. Further, there is no evidence to support the premise that a nonpunitive culture increases carelessness. In fact, experience has shown that it increases staff awareness of safety and sparks enthusiasm for changing systems and practices associated with errors.

Frontline staff members (22%) were more likely than administrators (16%) or managers (9%) to believe that a nonpunitive culture would be detrimental to an organization. Similarly, nurses (19%), pharmacists (16%), pharmacy technicians (15%), and physicians (13%) agreed more readily than risk managers (5%) and executives (10%) that a nonpunitive culture inhibits their ability to weed out “bad apples.”

Technically, weeding out undesirable employees should occur during the recruitment process or in the initial probationary period, when a more accurate measure, other than the presence or absence of errors, can be used to carefully evaluate competency. A nonpunitive culture does not inhibit this process; it strengthens it by eliminating the use of errors as a performance measure and by forcing more accurate means of evaluating basic competency.

Most respondents (64%), especially physicians (78%), nurses (70%), and executives (70%), suggested that remedial education was an effective nonpunitive remedy for staff members who have made errors. However, remedial education is punitive in nature, because it inappropriately targets individuals who made the mistake. A more effective, nonpunitive approach assumes that others are likely to make the same mistake, given similar circumstances. Thus, if a knowledge deficit contributed to an error, educational efforts would be directed more appropriately to all who might make a similar error.

Quality improvement staff and pharmacists often assume a leadership role in carrying out “root cause” analyses of adverse drug events. For this process to be used effectively, all attention should shift away from individuals and should be placed on the system-based causes of errors. Thus, it is reasonable that staff members working on quality improvement (16%) and pharmacists (13%) were more likely than nurses (5%), physicians (5%), and pharmacy technicians (7%) to believe that only system errors exist. Yet even in a nonpunitive culture, we must not forget that human error does occur. We must clearly acknowledge this fact, and we must look beyond it to identify and correct the system-based causes that allow human error to affect patients.

Approximately 11% of managers, 14% of administrators, and 18% of staff employees felt that a nonpunitive culture tolerates failure. Yet, in reality, it is a punitive culture that tolerates failure; a nonpunitive culture can remove the fear of failure as a barrier to patient safety. A punitive culture stifles creativity, innovation, and a willingness to change, because the possibility of failure is widely feared and is perceived to be totally unacceptable. Punitive cultures tend to “remember” failures for a long time, making it even more difficult for people to speak up about problems or to suggest new ideas for improvement.
this viewpoint, a nonpunitive culture offers just the opposite—a nurturing environment that is open to innovation, creativity, and change, because fear of failing is not a limiting factor.

Overall, the respondents were able to offer definitive opinions about many of the statements on the survey. But the jury is still out on the more controversial issues, such as the monitoring of errors as a performance or competency measure; the role of sanctions to improve performance; amnesty reporting policies; “error-prone” individuals; dealing with policy violations; and the public’s view of a nonpunitive culture. More than 25% of all respondents remained undecided or could neither agree nor disagree with survey statements on these more difficult issues that often undermine our best efforts to embrace a nonpunitive culture.

Look for a further discussion of our survey results in Part 2 of this article in the March issue of *P&T*.

The reports described in this column were received through the USP–ISMP Medication Errors Reporting Program (MERP). Errors, close calls, or hazardous conditions may be reported on the ISMP (www.ismp.org) or the USP (www.usp.org) Web site or communicated directly to ISMP by calling 1-800-FAIL SAFE or via e-mail at ismpinfo@ismp.org.