Sidebar 1. Assessing Staff Accountability

The aim of a safety culture is not a "blame-free" culture but one that balances organizational learning with individual accountability. To achieve this, it is essential that leaders assess errors and patterns of behavior in a consistent manner, with the goal of eliminating behaviors that undermine a culture of safety. There has to exist within the hospital a clear, equitable, and transparent process for recognizing and separating the blameless errors that fallible humans make daily from the unsafe or reckless acts that are blameworthy.[15,18,23,35,38–43]

Numerous resources are available to assist an organization in creating a formal decision process to determine what events should be considered blameworthy and require individual disciplinary action in addition to systems-level corrective actions, such as the Incident Decision Tree (adapted by the United Kingdom's National Patient Safety Agency from James Reason's culpability matrix)[37] or the Just Culture Algorithm (Just Culture Company).[35,36] The use of a formal process reinforces the culture of safety and demonstrates the organization's commitment to transparency and fairness.

Reaching a determination of staff accountability requires an initial investigation into the patient safety event to identify contributing factors. The use of formal decision-making tools or processes can help make determinations of culpability more transparent and fair.[5]

(*See also* references 13, 16, 22, 23–29)

Data Use and Reporting Systems

An effective culture of safety is evidenced by a robust reporting system and use of data to improve. When hospitals adopt a transparent, nonpunitive approach to reports of patient safety events or other concerns, the hospital begins reporting to learn and to learn collectively from adverse events, close calls, and hazardous conditions. Although this section focuses on data from reported patient safety events, it is but one type of data among many that should be collected and used to drive improvement.

When there is continuous reporting for adverse events, close calls, and hazardous conditions, the hospital can analyze the events, change the process or system to improve safety, and disseminate the changes or lessons learned to the rest of the organization.[21–24]

A number of standards relate to the reporting of safety information, including but not limited to **Standard GLD.04.01**, the **QPS standards**, and the **Medication Management and Use (MMU) standards**, which require hospitals to collect data to monitor their performance; to use data and information to guide decisions; and to understand variation in the performance of processes supporting safety and quality. Hospitals can engage frontline staff in internal reporting in a number of ways, including the following:

- Create a nonpunitive approach to patient safety event reporting as explained in the previous paragraphs.
- Implement measures to encourage increased reporting (**Standard QPS.03.04, ME 6**).
- Educate staff on and encourage them to identify patient safety events that should be reported.
- Provide timely feedback regarding actions taken on reported patient safety events.

Effective Use of Data

The meaningful use of data is a critical component of a patient safety program. Data to be collected should be selected with care in order to ensure that they are relevant and in accordance with laws and regulations,