Comparisons of Cultures

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	Characteristics of a Culture of Safety	Characteristics of a Culture of Blame
Leadership and Support	• Leaders promote a culture of safety [1,2] • Leadership provides the resources needed to promote patient safety [3]	• Leadership not visible in supporting safety • Leadership does not provide resources needed to promote patient safety
Event Analysis	• Root Cause Analysis approach: "what happened, why did it happen, what to do to prevent from happening again" [4]	• Punitive approach to "near misses' and errors [5]
Reporting	• Learn from reported medical errors to prevent reoccurrence [6] • More reports being generated is perceived positively by the organization as opportunities to make improvements in the system are identified [7]	• There is a reluctance to report errors because of fear of punitive response and suppression of open discussion related to medical errors[8]
Communication	• Effective open communication[9] • Recognition of importance of communication and collaboration among all team players	• Lack of effective communication • Hierarchical communication[9]
Emphasis	• Emphasis on prevention, not punishment	• Emphasis on punishment, not prevention

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[4]VA National Center for Patient Safety. (2005). *Veterans Health Administration: Root cause analysis (RCA).* http://www.patientsafety.gov/rca.html

[5]Hughes, R. (2004). First, do no harm. Avoiding the near misses: taking into account one ever-present factor: human fallibility. *American Journal of Nursing*, 104(5), 81-84.

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[7]Dotan, D. (November, 2003). *Parallels in aviation and medicine*. Unpublished manuscript.

[8]Simpson, K. R. & Berry, M. C. (2001). Second opinion. Should there be mandatory reporting of medical errors? Writing for the pro positions… writing for the con position*. MCN: American Journal of Maternal Child Nursing*, 26(3), 120-121.

[9]Page, a. (Ed.). (2004*). Keeping patients safe: transforming the work environment of nurses*. Washington, D. C.: The National Academies Press.

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