Healthcare organization

Topic: Healthcare organization Most healthcare organizations in the U. S. have such policies in practice that promote non punitive culture and environment. Work processes are designed in such ways that help in cultivating a non punitive culture and encourage error-reporting.

What is non punitive culture? It is “ safety culture that practices a set of values, beliefs, and norms about what’s important, how to behave, and what attitudes are appropriate when it comes to patient safety in a work group. Organizations with effective safety cultures have a constant commitment to safety as a top-level priority, and these actions and attitudes are evident throughout the organization.”

According to ISMP survey on non punitive culture, results of the prevailing environment are stunning. Awareness on system-based reasons of error is increasing. Organizations still need to tackle accountability of related staff in a non punitive culture. The survey points out the need to whole-heartily adopt the culture on all platforms, particularly front-line staff who may not be as conscious as doctors, nurses, and other Para-medical staff about the main principles of non-punitive culture.

Deming’s Total Quality Management (TQM) principles hold the key to follow the processes that adhere to the principles of TQM. Non punitive culture necessarily points towards a paradigm change from individuals to processes; processes need to be foolproof so that there is no scope for any individual to commit errors. Here, it would be logical to quote the case analysis (Lagasse 1995) of quality of preoperative care by statistical process control and its adverse results. Out of 116 anesthetics errors, 9 were human errors and 107 were system errors. It definitely shows that the major deciding factor is the system, which should be robust enough to be measured.

The big question arises – Is health care an ethical organization? Safety audits are held very often in health care organizations. Take for example the audits in neonatal unit (L Lee 2008). It is a must in clinical governance. It helps health care organizations to get high turnover and closing loopholes. Such audits help in better and efficient practice.

Audit helps in maintaining standards as in the case of NHS. Regularity in conducting safety audits ensures that they are effective. It involves making of checklists for all known error-prone activities. Any of the checklist is selected and the process is followed to any point so that relevant staff performs an instant review of the ongoing work to the end number of the checklist. All this is eye-catching, helping to create an ethical infrastructure. Audits are " real time", measuring actual practice. Checklist reviews help in locating errors and risky situations. They make the staff conscious of safety processes. Practice can be changed according to the feedback received. It helps in making a formal action plan to re-audit the standard within a time break. In the case of NHS, the process was adapted for neonatal intensive care unit (NICU) practice.

Thus, such ethical audits comply with guidelines and protocols, as in the case of NHS, infection control standards were successfully reached. There are certain limitations to standards compliance. We need to overcome the limitations so that healthcare organizations perform their functions in ethical environment. For this, we need to develop the " habit for change" and the " habit for systems thinking".

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