

# World Patient Safety Day - health worker safety: a priority for patient safety

The theme for this year's World Patient Safety Day is "Health Worker Safety: A priority for Patient Safety" and whilst there are many different aspects to this in terms of both physical and psychological safety is vital to promote learning and improve patient safety.

17 September 2020

The theme for this year's World Patient Safety Day is "Health Worker Safety: A priority for Patient Safety" and whilst there are many different aspects to this in terms of both physical and psychological safety, the provision of emotional support to staff following an incident, and through whatever investigation processes follow, is vital to promote learning and improve patient safety.

Culture, specifically a just and learning culture, is a key part of this. Healthcare staff who are supported within a compassionate and inclusive environment, knowing that they will be treated fairly if things go wrong, are more likely to speak up following an incident or to prevent an incident occurring in the first place.

Alongside this, the way in which healthcare staff are supported through an investigation (be that an incident or complaint investigation or a claim or inquest) is also important. There is rarely a single root cause of an incident and an investigation which focuses solely on the actions or omissions of an individual member of staff and seeks to establish 'blame' will inevitably fail to identify the wider system issues at play which, if addressed, could also help prevent future harm to patients.

It is important to note, as highlighted in '[Being Fair](#)' published by NHS Resolution in July 2019, that a 'just culture' does not mean 'no blame' but is "the balance of fairness, justice and learning and taking responsibility for actions". In this respect, the NHS Improvement '[Just culture](#)' guide is a helpful tool to help Trusts clarify whether there is something specific about an individual member of staff that needs support or management, as opposed to a wider systems-based issue which needs to be addressed, in which case any individual remedial action is often unfair and counterproductive.

This approach aligns with the systems-based approach to investigations as set out in the [Patient Safety Incident Response Framework](#) 2000. This is currently being piloted by a number of Trusts and is planned to be fully implemented across the NHS in England by Autumn 2021, aiming to promote and facilitate the conditions for a just and learning culture, improve the quality of patient safety investigations and enhance the way in which Trusts learn from incidents to prevent future harm.

A just and learning culture is a critical ingredient for patient safety, but it is often seen as difficult to embed and measure. However, NHS Trusts which implement processes and systems to appropriately support staff following an incident or when treatment does not go as planned or expected will, over time, be able to demonstrate improvements in patient safety and the ways in which staff are supported will be valuable indicators of the extent to which a just and learning culture has been successfully embedded.

We ran a Shared Insights meeting (remotely) for NHS Trusts on 8 September 2020 in which we discussed 'The second victim and supporting clinicians through investigations, complaints, claims and inquests'. We explored various practical resources to help Trusts support healthcare workers through these processes. If you are interested in finding out more about our Shared Insights calls, please contact [Amelia Newbold](#).



**Amelia Newbold**  
Risk Management Lead

Amelia.Newbold@brownejacobson.com  
+44 (0)115 908 4856

---

## Related expertise

### Sectors

Health and care regulatory

Health and life sciences