# A call for a safety culture in our Zimbabwean health system

**Categories :** Health talks with Dr Chireka

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**By Doc Beecee**

I have experienced and have heard of unpleasant experiences with our health service delivery system in Zimbabwe. There are patients who do not know the right channels to follow- or maybe there are no right channels available- to seek redress for these. I receive a lot of emails about bad practice in our system and I am resisting the temptation to paint the whole system with the same brush. It's so easy to say that the whole health system in Zimbabwe is collapsed and nothing good can come out of it. This is far from the truth, as we in fact do have a lot of good practice in our health service delivery system, but it is not shared or celebrated. I believe in celebrating small victories and in using the negative publicity as a learning experience to do better next time.

We have a situation where if a patient complains about their experience of our health service delivery system , the service providers will quickly go into a defensive mode and refute the allegations levelled against their institution. It appears to me also that patients are sometimes exaggerating the nature of their complaints. Sometimes, it seems as if they just join the bandwagon of bashing our hard working health professionals. The status quo is untenable and this attitude of ‘us’ and ‘them’ must stop. There is urgent need for the culture to change if we are to improve the safety of patients in our health system. Safety issues are part of global health and the World Health Organisation is leading in that transformation. In 2004 , in response to World Health Assembly Resolution 55.18 , the World Health Organisation (WHO) established the World Alliance for Patient Safety (renamed Patient safety in 2009) to coordinate and accelerate global efforts to improve patient safety.

In view of this, I call for genuine engagement of patients and families who have had bad experiences with our health care delivery systems . I call these patients " wounded healers" as they can provide insight and learning concerning system failures. It is very vital that the voice of patients is heard in the global arena of health care and that patients are at the heart of decision making.

Our culture has to change. As they say, culture eats strategy for breakfast. This means that for any strategy to work it, has to address the culture hence my call for cultural change. The change in culture starts with Dr Chireka, with you reading this article and all patients, health professionals and our leaders.

**Firstly**, I call for a new culture where all workers accept responsibility for their safety, that of their coworkers, patients and visitors. There is a tendency to think that safety issues are for administrators and safety officers only, but the message should be that patient safety matters and is everyone's responsibility, including that of frontline staff. If a cleaner is mopping the floor, he or she must realise that it can be a trip hazard if no proper signs are put to alert people of the floor’s condition.

**Secondly,** I call for a new culture that prioritizes safety above financial and operational goals. There is a tendency of seeing safety as a burden or extra cost that must be done away with. No shortcuts should be allowed that will put safety of patients at risk. We know that resources are scarce and leaders are looking at ways of cutting costs. This must be done but not at the expense of patient's safety. Wards must be well staffed with the right number of nurses and doctors. We know that overworked and stressed professionals do make mistakes easily and that will put patient's safety at risk. Financial and operational goals must take into consideration the safety of patients and make sure that is not compromised. Hospitals are there to treat patients but sadly at times they become death traps and harm patients.

**Thirdly,** I call for a new culture that rewards the identification, communication and resolution of safety issues. It should not be seen as witch hunt, which it isn’t, but the identification of safety issues must be encouraged. There must be a way of communicating safety issues and also ways of resolving them. It's pointless recording safety issues without taking action to resolve them. Lessons must be learnt and measures put in action to prevent errors from happening again.

**Fourthly**, I call for a new culture that provides for organisational learning from accidents. When accidents happen, every effort should be made to find out what happened, how it happened and why it happened. Having done that there is need to look at how the accident can be prevented in future. An action plan must be drawn up and implemented immediately. This must be done in a culture of learning and not to score points at each other or trying to blame someone for the system failure. In this learning, it is vital to engage patients and families who have experienced harm in hospitals. They can provide insight and learning concerning health system failures. The organisation must use patient experience as a learning tool and must promote patient leadership and involvement in patient safety efforts at all levels. Patients’ and health-care users’ experiences

and perspectives are needed in efforts to achieve integrated and people-centred health systems and services. It is therefore essential to ensure that their voice is heard in health care.

**Fifthly**, I call for a new culture that provides appropriate resources, structure and accountability to maintain effective safety systems. Resources must be allocated to address patient safety issues and structures must be in place such as channels through which they can forward their complaints. There should be a visible complaints procedure and the time frame it will take to address the issues raised must be specified. In case patients are not happy with the initial response by the hospital or any health provider, an appeal process must be explained. Health providers must be clear that they are accountable to their patients and regulators as well.

**Lastly**, but not least, I would like to urge patients to speak up when in hospitals or when being attended to by health professionals. We know that it is intimidating when you are lying in bed and faced by doctors during ward rounds. My advice is that you must pay attention and ask questions if there is anything that you do not understand. You should never give up responsibility for your own health. Do not be afraid to remind the nurse to recheck the dose of your medication or to ask your doctor to wash his or her hands before examining you. In old days, good patients were the ones who did not make any fuss and were grateful for the treatment they were getting. Sadly it turns out these patients do not do so well. The ones who do well are the ones who play a more active role in their own treatment. I urge patients to be more involved in their health care and, in doing so, they reduce the risk of hospital errors. If you ever have questions or concerns about anything during your hospital stay, you must speak up.

This article was compiled by **Dr. Brighton Chireka** who is a GP and a Patient Engagement Advocate (PEA) in Folkestone Kent, UK. You can contact him on **info@docbeecee.co.uk**