# Systems Transformation – Safety Culture

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## BACKGROUND

### Safety Culture

- “an integrated pattern of individual and organizational behaviour, based upon shared beliefs and values that continuously seeks to minimize patient harm, which may result from the processes of care delivery” (Kristensen 2016)
- Concerted efforts have been made to improve patient safety over the past decade BUT
  - We are not where we want to be
  - We need to do better
  - To make the next leap in safety, a culture of safety is considered key

## OBJECTIVES

- To demonstrate how one can contribute to a culture that promotes patient safety
- To outline the importance of the leader in setting the culture, including leaders at every level
- To enable one to use many techniques to teach leadership in setting a culture of patient safety

## INTENDED LEARNING OUTCOMES

<table>
<thead>
<tr>
<th>Knowledge</th>
<th>Describe system factors that can affect patient safety, including resource availability and physical and environmental factors; Describe the features of a “just culture” approach to patient safety</th>
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<tbody>
<tr>
<td>Skills</td>
<td>Use cognitive aids such as procedural checklists, structured communication tools or care paths to enhance patient safety</td>
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<tr>
<td>Attitudes and Behaviours</td>
<td>Demonstrate ability to recognize the role of patient safety in safe healthcare delivery</td>
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<tr>
<td>Integration</td>
<td>Speak up in situations where patient safety may be at risk</td>
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## CASE

A junior resident assesses a patient who has presented to the Plastic Surgery clinic for removal of a basal cell carcinoma. During this assessment, the resident recognizes that the patient has dementia and will not be able to consent to the procedure. When the junior resident informs the senior resident of his findings, the senior resident indicates there is no need to go through a full consent discussion with the patient as the patient has dementia and will not understand. The junior resident states that since this is not an emergency procedure, he will wait to start the procedure until the patient’s substitute decision maker returns so that consent may be obtained.

### Questions for discussion

- How can the junior resident handle this situation?
- What is the perspective of the substitute decision maker or patient?
- What are the challenges and opportunities to teach patient safety in this setting?

## ASSESSMENT METHODS

- Case based discussion participation
- Situational judgment testing scenarios
- 360/Multisource feedback
- OSCE station
- Presentation at M and M rounds
- Simulation
- Safety culture surveys
- Portfolio

## TEACHER’S GUIDE

Organization members should feel comfortable reporting errors when they occur. Analyze errors with a sense of curiosity instead of shame. It is hoped that providing a safe environment where staff can openly examine errors without fear of punishment will improve reporting of errors so that they can be avoided in the future.

A just culture is not a blame-free culture though. For truly egregious behaviour, there is a role for punitive action. But the norms, policies, and disciplinary process need to be fair, clear, and graded.

How do you know when you have a safe culture? People speak up because they feel safe. Video from The Joint Commission (4:16) [https://www.youtube.com/watch?v=DBVuu4Qj-Fs](https://www.youtube.com/watch?v=DBVuu4Qj-Fs)

## INSTRUCTIONAL METHODS

- Case-based teaching
  - Small group facilitated discussion
  - Large group – patient/family speaker
  - Modelling intended behaviour in the moment
  - Embed in other existing teaching sessions
  - Online modules
  - Review patient feedback
  - Portfolio

## OTHER RESOURCES

A TED Talk by Atul Gwande on the importance of checklists (19:19) [https://www.youtube.com/watch?v=L3QkaS249Bc](https://www.youtube.com/watch?v=L3QkaS249Bc)

WHO Online Patient Safety Quiz

SAFETY CULTURE REFERENCES

13. IHI. Develop a culture of safety. 2016.

This leadership module on Conflict Management can be accessed at [www.sanokondu.ca](http://www.sanokondu.ca)

More information about TISLEP is available at [http://tislep.pgme.utoronto.ca](http://tislep.pgme.utoronto.ca)