Checklist for Building a Safety Culture

The goal of this checklist is to provide tips and approaches to lead and build a culture of safety in your team.

Create knowledge and understanding of patient safety and culture within your team

- Review your Patient Safety Culture Survey results, share with your team and develop action plans. Focus on both the strengths and areas for improvement.
- Promote a “just culture” and create an understanding of what it means. You could post the one-pager on your Quality Board, discuss at staff meetings or during huddles.
- Incorporate patient safety education into all staff orientation and ongoing training.
- Share patient and provider stories. You can use your own stories or share a patient or provider story from the Canadian Patient Safety Institute.

Promote and support incident reporting and management

- Familiarize yourself with Health PEI’s risk management policies.
- Encourage your team to report incidents. Provide rewards and recognition for incident reporting (e.g. Good Catch Award for reporting near misses).
- Review your incident reporting data to identify your key incidents and share with your team.
- Complete incident investigations and follow-up in a timely way. Ensure incident investigations are multidisciplinary (including patients and families) and focus on a systems approach.
- Ensure timely feedback on incidents and lessons learned is provided to your team to prevent the incident from happening again. Also, sharing lessons learned with your team and peers demonstrates the benefits of reporting.
- Ensure you and your team understands the disclosure process and policy.

Create opportunities for your team to talk openly and share safety concerns

- Add safety as a standing agenda item for meetings; open meetings with an incident that occurred in your area.
- Ask your team to share experiences with incidents during huddles.
- Use safety crosses or calendars and other mechanisms to track measures of safety (e.g. falls, hand hygiene).
- Assign a team member to be a “safety lead or champion”. This could be rotational.
- Join or lead leadership walkabouts to discuss safety. Use a pocket guide to assist with questions. Following up and providing feedback to your team on issues discussed is critical.
- Hold “Straight Talk about Quality & Safety” sessions with your team.
- Carry out team briefings and debriefings.
- Use a Learning Board on your Quality Board to capture safety concerns.
- Lead, promote and/or support initiatives to improve safety.

Involve and communicate with patients and families

- Provide patient safety brochures and education to patients on how they can be involved in their own safety.
- Post the “Don’t just think it, ask it” poster and provide hand-outs for patients and families.
- Share the “5 Questions to Ask About Your Medications” with patients and families.
- Involve patients and families in safety discussions and solutions.
- Involve patient and families on committees to hear their safety concerns and ideas for improvement.
- Ask patients about their safety concerns during leadership walkabouts.
What is a “Just Culture”?

**Just culture** is fairly balancing an understanding of system failure with professional accountability.

Also known as **psychological safety**, it is a culture where people believe they can question existing practices, express concerns, and admit mistakes without ridicule or punishment.

Just culture is one of the key components of a safety culture.

The Canadian Medical Protective Association recognizes the following as important elements of a just culture:\(^1\):
- Main focus of safety issues analysis is identifying system failures and to the extent possible correcting them.
- Organization accepts appropriate responsibility and accountability. Individuals are not held accountable for system failures over which they have little or no control.
- Healthcare providers are able to trust that the initial responses to an adverse event, as well as any subsequent analyses and proceedings, will be conducted with **fairness, within the legislative and legal frameworks, and in accordance with established policy and/or bylaws**. The rights of all people, including patients, are protected.
- Relevant policies and procedures to support quality improvement are understood by providers and followed by leadership/management.
- Providers are confident of the organization’s response to an adverse event, which appropriately protects quality improvement information from legal, regulatory or other proceedings.
- Organization does not tolerate intentionally unsafe actions, reckless actions, disregard for the welfare of patients or staff, or other willful misconduct and misbehaviour.
- There is “a collective understanding of where the line should be drawn between blameless and blameworthy actions.”
- Disclosure of adverse events to patients is important and patients are provided factual information.
- Providers are appropriately supported, protected and educated.

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\(^1\) Learning from adverse events: Fostering a just culture of safety in Canadian hospitals and health care institutions. Ottawa, ON: Canadian Medical Protective Association; 2009.
Safety Cross² or Calendar

What is a safety cross or calendar?

✓ It is a visual data collection tool that you can use to identify areas for improvement.

✓ A safety cross is a calendar in the shape of a cross; whereas, a safety calendar looks like a traditional calendar. Both tools are used to track the number of times an incident has occurred.

Why use a safety cross or calendar?

✓ To improve patient safety and promote good practice by raising awareness within the team and others regarding the incident(s) being tracked.

✓ To provide real time incident data to let staff and patients/clients/residents know on a daily basis how many days have gone by without a new incident occurring. You can do this by displaying in a public area ‘It has been ___ days since ___ occurred in this area’.

✓ To link the data to an improvement goal/initiative.

How to use the safety cross or calendar?

✓ Each safety cross or calendar represents one calendar month and one box should be coloured daily (green=no incident, red=incident). Only count an incident once. (Note: if you are using the safety calendar, you will need to add the days of the month to the template).

✓ If more than one occurrence happened in a day, you can record the exact number in the corner of the box.

✓ Ensure that all staff are aware of the cross or calendar and know how to complete it. Assign responsibility to fill it in daily.

✓ Place it on your Quality Board so everyone will see it on a regular basis.

✓ Be honest with your data; it is for improvement not judgment.

✓ Link the data you collect to an improvement.

“Simplicity is key to the effectiveness of the safety cross”

# Safety Calendar

<table>
<thead>
<tr>
<th>Measure</th>
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Days Without Incident
Safety Questions for Leadership Walkabouts

Being visible and discussing safety issues with staff is critical to building a culture of safety.

- What safety initiatives are happening here?
- What safety issues are you concerned about?
- Have there been any incidents lately where a patient was harmed?
- Have there been any near misses?
- Where can we make some safety improvements?
- What can I do to help?
- Ask a patient about their experience.

Follow-up and feedback on issues discussed is critical.
Learning Board

- A learning board is a simple and easy to use tool that can be added to your Quality Board.
- It is a visible way to share and discuss quality and safety concerns.
- All you need is a sheet divided into three sections: “opportunities”, “actions”, and “outcomes”.
- Any team member, patient/client/resident or family member can write on opportunity for change on the learning board. Actions refer to what is done in response to the opportunities, and outcomes refer to the end results of the actions taken.
- Please see the following page for a template you can print and post on your Quality Board.

Sample learning board:

<table>
<thead>
<tr>
<th>Opportunities</th>
<th>Actions</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>We should use each others’ first names</td>
<td>We will introduce each other during our morning huddle</td>
<td>The use of first names is included in our huddle standard. Jane will champion this practice.</td>
</tr>
<tr>
<td>Our supply cupboard needs to be organized</td>
<td>John will organize the supply cupboard next Thursday</td>
<td>The supply cupboard is now organized</td>
</tr>
<tr>
<td>We should be using clippers instead of razors to shave the incision site.</td>
<td>The team working with Dr. Smith will test the use of clippers on Wednesday morning</td>
<td>We are now using clippers for about half of our surgeries</td>
</tr>
</tbody>
</table>

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**Learning Board**

Please submit opportunities for change below. We will identify the actions taken and the outcomes of those actions. All team members, patients/clients/residents and families are encouraged to submit ideas.

<table>
<thead>
<tr>
<th>Opportunities</th>
<th>Actions</th>
<th>Outcomes</th>
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<tbody>
<tr>
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Don’t just think it, ask it!

ASK questions about your care
Ask your health care provider questions until you have all the information you need. Write down any questions so you do not forget. If you do not understand, ask for it to be repeated.

LISTEN to the answers
Listen to everything your health care provider tells you. Write down notes to help you remember. Ask a family member or friend to listen with you.

TALK openly about concerns
Talk with your health care provider about your concerns. Tell them about your medical history and any medications that you are taking.

Interpretation services are available to help you. Ask your health care provider for more information.

You might ask:
• Can you explain that to me again?
• Can I talk to another health care provider?
• What are the risks to this treatment? How will it help me?
• Why am I taking this medication? Are there side effects? How often do I need to take it?
• What are the risks in not taking this treatment or medication?
• Have you washed your hands?

You are the most important member of your health care team.
Remember to Ask, Listen and Talk to ensure you receive the safest care possible.


Health PEI
One Island Health System
5 QUESTIONS TO ASK ABOUT YOUR MEDICATIONS when you see your doctor, nurse, or pharmacist.

1. CHANGES?
   Have any medications been added, stopped or changed, and why?

2. CONTINUE?
   What medications do I need to keep taking, and why?

3. PROPER USE?
   How do I take my medications, and for how long?

4. MONITOR?
   How will I know if my medication is working, and what side effects do I watch for?

5. FOLLOW-UP?
   Do I need any tests and when do I book my next visit?

Keep your medication record up to date.

Remember to include:
- [ ] drug allergies
- [ ] vitamins and minerals
- [ ] herbal/natural products
- [ ] all medications including non-prescription products

Ask your doctor, nurse or pharmacist to review all your medications to see if any can be stopped or reduced.

Visit safemedicationuse.ca for more information.