UC DAVIS HEALTH

Implementing Safety Culture at the Frontline of Healthcare

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Presentation format

Agency for Healthcare Research and Quality (AHRQ)

SBAR

- Situation
- Background
- Assessment
- Recommendation/ Request

- Literature review
- Methods
- Conclusion

Situation

Healthcare safety

- Interacting systems
- Intricate networks
- Safe designs
- Understanding human factors
- Prevent, recover, mitigate

Background

The Impact of Errors

- Up to 98,000 deaths due to medical error each year
- Errors considered a sign of an individual's incompetence or recklessness
- Medical errors, adverse events and near misses go unreported

Assessment

The Impact of Errors

- Unreported events are missed opportunities to learn and improve
- Providers may experience adverse consequences

Recommendation

Building a Culture of Safety

- Create an environment in which safety is a top priority
- Foster a culture that encourages learning from errors
- Five components:
  - Trust
  - Accountability
  - Identifying unsafe conditions
  - Strengthening systems
  - Assessment

Safety Culture and Patient Outcomes

Safety Culture and the Second Victim

Methods

Implementing Evidence into Practice

Frontline Safety Culture: Implementation Guide

- Bridge the gap between policy and practice
- Errors are treated not as personal failures, but as opportunities to improve the system and prevent harm

Methods

Implementing Evidence into Practice

Frontline Safety Culture: Implementation Guide

Adverse event management

Just Culture

- Psychological safety
- Active leadership
- Transparency
- Fairness

Conclusion

- *Reporting Culture and Learning Culture*
- Support second victims

Thank you, questions?

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