# Road Map to a Safety Culture

*For Patients, Residents, and Clients*

## Learning

| Specific Action(s) | Audit Questions |
|---|---|
| *Effective Process Improvement (EPI) Work Plan* | 1. The steps for identifying a specific action plan and measure of success for Learning are completed.<br>2. The work group has devised a structured implementation plan for Learning.<br>3. Structured roll-out strategies for Learning are in place.<br>4. A plan is in place to sustain implementation progress and spread of Learning. |
| 1. Develop a robust system of data-gathering that can improve patient safety and quality. | 1a. The facility has a system in place for reporting safety events that do reach the patient/resident.<br>1b. The facility has a system in place for reporting near misses and other patient safety concerns.<br>1c. Processes are in place to encourage and reward staff/physicians for reporting (e.g. include mention in performance evaluations, acknowledgement from senior leadership).<br>1d. Processes are in place to assess barriers to safety event data-gathering (e.g. system difficult to access, reporting format too time consuming to complete).<br>1e. A process is in place to capture and utilize patient safety data from sources beyond reports (e.g. global trigger tool, claims, mortality reviews).<br>1f. CEOs gather data by conducting rounds that involve seeking input from staff and physicians.<br>1g. Physicians are an integral part of rounding (e.g. leading rounds, contributing safety concerns).<br>1h. Leaders frequently round within their departments.<br>1i. A process is in place to ensure patients/residents/clients/families members contribute input during rounding.<br>1j. A process is in place to ensure multidisciplinary staff members contribute input during rounding.<br>1k. A process is in place to prioritize and act upon input gathered during rounding. |
| 2. Use evidence-based *prospective* analysis methods to identify potential failures in care. | 2a. Evidence-based, standard analysis methods are in place (e.g. failure mode and effects analysis — FMEA) to proactively analyze at least one potentially high-risk area/topic annually.<br>2b. Team members conducting proactive analyses have received training.<br>2c. The facility has set clear expectations that staff and physicians are required to participate in analysis sessions when needed.<br>2d. The facility has a process in place to communicate to staff that an analysis session is:<br>• A safe, confidential process<br>• Designed to identify process breakdown; not assign blame.<br>2e. A process is in place to prioritize and act upon issues identified during the analysis. |

*Continued*

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## Learning

| Specific Action(s) | Audit Questions |
|---|---|
| 3. Use evidence-based *retrospective* methods of analysis to identify root causes of problems or events. | 3a. Evidence-based, standard analysis methods are in place (e.g. root cause analysis) to retrospectively analyze problems.<br>3b. The facility has established criteria for when an analysis needs to be conducted.<br>3c. At a minimum, an analysis is conducted for adverse events that result in death or serious injury to a patient/resident and for any other event where an analysis is required by law.<br>3d. The analysis requires explanation for each human error and at-risk behavior.<br>3e. Team members facilitating analyses have received training.<br>3f. The facility has set clear expectations that staff and physicians are required to attend analysis sessions when needed.<br>3g. The facility has a process in place to communicate to staff that an analysis is:<br>• A safe, confidential process<br>• Designed to identify process breakdown; not assign blame.<br>3h. A process is in place to prioritize and act upon issues identified during the analysis. |
| 4. Develop solutions/action plans and monitor progress. | 4a. A designated person (role) has the authority and resources to require and support the implementation of action plans.<br>4b. The facility has a standard process in place for tracking progress on action plans put in place. |
| 5. Share what is learned. | 5a. A process is in place to provide feedback to staff on actions taken in response to their reports.<br>5b. A process is in place to regularly share patient safety success stories throughout the organization.<br>5c. A process is in place to share lessons learned from events and alerts about potential patient safety threats with appropriate entities inside and outside of the organization (e.g. within units, across units, with similar departments outside the facility). |
| 6. Spread solutions/action plans. | 6a. A process is in place to identify other units and departments that may benefit from implementing action plans/solutions.<br>6b. Department staff members/physicians have access to de-identified data, analyses, and action plans/solutions in order to customize action plans/solutions to their own environments |