Patient Safety
Through the Eyes of the Patient

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Objectives

- Culture of safety
- Importance of reporting
- Jeff's story
- Vital behaviors
- Summary

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"**Shared values (what is important) and beliefs (how things work) that interact with an organization's structures and control systems to produce behavioural norms**

B Uttal "The corporate culture vultures" ***Fortune*** **1983**

Improving Patient Safety: Culture of Safety

- **“Just Culture”**
  - Prevention of errors and adverse events
  - Capture near misses
  - Learning from events when they do occur
  - Move away from “Shame and Blame”
  - Focus on system issues
  - Emphasis on teamwork and communication
  - Disclosure of harm
  - Continuous quality improvement

Improving Patient Safety: Reporting

- To promote continuous quality improvement
- Incident reporting is **NOT** intended for disciplinary measures
- May require some review of procedures/ protocols
- Trending
- Important to learn from adverse events

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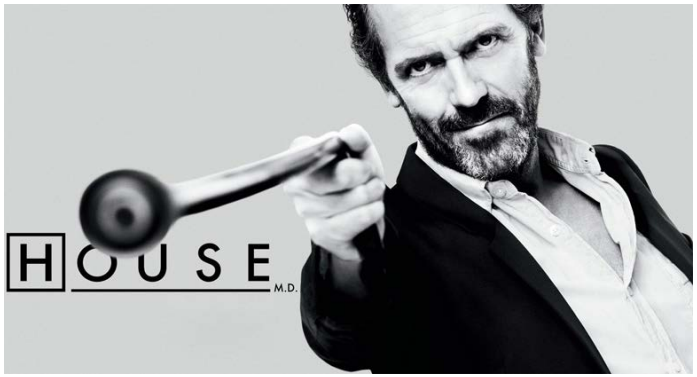
Charting Humanity

VS.



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Your Role in Patient Safety

Vital Behaviours

SPEAK UP | **HOLD EACH OTHER ACCOUNTABLE** | **ASK FOR HELP**

Whenever concerned about **SAFETY, QUALITY OF CARE** or **SERVICE** and/or **QUALITY OF WORK LIFE**

Especially when

- **BROKEN RULES**
- **MISTAKES**
- **INCOMPETENCE**
- **POOR TEAMWORK**
- **LACK OF SUPPORT**
- **DISRESPECT**
- **MICROMANAGEMENT**

crucial conversations

VitalSmarts

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Summary

- The culture determines what behaviors are acceptable and unacceptable
- **Communication is of utmost importance**
- Speak up
- Systems thinking
- Create an open, diverse and transparent culture
- Quality improvement
- Accreditation ready every day – Standards and ROPs
- Partner with patients and families and include them as part of the team

Encourage event/incident reporting and near-misses, and use them as opportunities to prevent future errors

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Questions/Discussion

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