Culture of Safety Top Ten Checklist

APPENDIX I: CULTURE OF SAFETY TOP TEN CHECKLIST

Associated Hospital/Organization: HRET HIIN

Purpose of Tool: A checklist to review current interventions or initiate new ones to ensure a culture of safety in your facility.

Reference: www.hret-hiin.org

1. Include patient and workforce safety data and improvement activities in presentations to the board, as well as in unit level and organization quality and safety meetings.
2. Implement daily leadership safety briefings to create shared understanding of patient and workforce safety vulnerabilities, foster mutual support and disseminate information about safety events.
3. Institute Leadership WalkRoundsTM, integrating both patient safety and workforce safety issues. Effective rounds give leaders the opportunity to observe processes and actively listen to the front lines, patients and families about their barriers and concerns, and to gather ideas for improvement.
4. Encourage reporting of patient safety events, near misses and work conditions that present physical hazards or psychological safety risks. Make reporting easy and ensure that processes exist for confidential and anonymous reporting, if needed. Reward reporting and celebrate "good catches."
5. Establish reporting, peer intervention and escalation processes to quickly extinguish disruptive, unprofessional and disrespectful behaviors.
6. Appreciate and acknowledge small wins and positive behaviors. Schedule team celebrations and integrate storytelling to prioritize joy and meaning in work and foster well-being.
7. Implement a safe patient handling and movement program. Involve front-line teams in choosing equipment and developing and implementing training programs.
8. Conduct a hazard assessment for conditions that contribute to unsafe work conditions, including risks for needle stick injuries, infection transmission, musculoskeletal injuries, disrespectful behavior, bullying and workplace violence.
9. Utilize simulation training with interprofessional teams to promote effective team behaviors, situational awareness, mutual support and anticipatory critical thinking. Use handoff communication training and process design as an opportunity to develop improved team communications.
10. Use a standard approach to balance individual accountability with leadership accountability for systems issues when addressing adverse events. Integrate support for care team members involved in an adverse patient event or workplace violence event as part of the response.