

# What Does a Culture of Safety Look Like?

## Leaders create a safety culture:

- Make patient safety an urgent organizational priority
- Communicate a vision for safety excellence
- Allocate resources for safety initiatives
- Maintain a visible presence (e.g., walk rounds)
- Take action when concerns are raised
- Focus on systems analysis rather than blaming individuals
- Recognize patient safety successes

How are things going—are there any concerns you want to share with me?

Thanks for asking. Actually, I am worried about something—do you have some time this afternoon?

## Risk managers champion a safety culture:

- Encourage reporting of safety events without fear of reprisal or blame
- Investigate and follow up on reported concerns
- Identify and track safety gaps proactively
- Partner with staff to develop realistic safety goals and regularly share challenges and progress
- Implement standardized safety processes (e.g., time-outs, huddles, drills)
- Protect time for staff to complete necessary training
- Facilitate collaborative patient care

It's ok to C.U.S.\* for patient safety!  
C: I'm **Concerned**  
U: I'm **Uncomfortable**  
S: Patient **Safety** is at risk

## Staff embody a safety culture:

- Speak up about safety concerns
- Report adverse outcomes, near misses, and good catches
- Set personal goals for achieving safety excellence
- Use safety-oriented communication tools (e.g., SBAR, checklists)
- Demonstrate accountability
- Seek out necessary training
- Advocate for patient safety—every time

Dr. Jones, I'm **concerned** about Mrs. Smith.  
I'm **uncomfortable** about the way she looks—she is very pale, and seems weak.  
I'm worried **it isn't safe** to send her home right now. Could you please go and see her again?

Thank you for letting me know, Sam. I'm really busy, and she seemed fine when I saw her, but I can tell you're worried. I'll go and talk to her now. Could you please let my next patient know there will be a delay?

\*More info on C.U.S. appears in Module 2: communicating changes in a resident's condition (see full reference on the back).

## ECRI Institute Resources

A Culture of Safety: An Overview: <https://www.ecri.org/components/PPRM/Pages/PSRM11.aspx>

## Recommended Resources

### ***Lead your safety culture by referring to these resources:***

Leading a culture of safety: a blueprint for success (American College of Health Executives 2017) [https://www.osha.gov/shpguidelines/docs/Leading\\_a\\_Culture\\_of\\_Safety-A\\_Blueprint\\_for\\_Success.pdf](https://www.osha.gov/shpguidelines/docs/Leading_a_Culture_of_Safety-A_Blueprint_for_Success.pdf)

Leading for safety (American College of Health Executives) <http://safety.ache.org/>

The essential role of leadership in developing a safety culture (The Joint Commission 2017) <https://www.jointcommission.org/resources/patient-safety-topics/sentinel-event/sentinel-event-alert-newsletters/sentinel-event-alert-57-the-essential-role-of-leadership-in-developing-a-safety-culture/>

### ***Assess your safety culture by using these tools:***

Culture of safety organizational self-assessment (American College of Health Executives) <http://safety.ache.org/quiz/culture-of-safety-organizational-self-assessment/>

Leading a culture of safety: a blueprint for success (see self-assessment starting on page 33) (American College of Health Executives 2017) [https://www.osha.gov/shpguidelines/docs/Leading\\_a\\_Culture\\_of\\_Safety-A\\_Blueprint\\_for\\_Success.pdf](https://www.osha.gov/shpguidelines/docs/Leading_a_Culture_of_Safety-A_Blueprint_for_Success.pdf)

Medical office survey on patient safety culture (Agency for Healthcare Research and Quality 2019) <https://www.ahrq.gov/sops/surveys/medical-office/index.html>

### ***Improve your safety culture by referring to these resources:***

A just culture guide (National Health Service [UK] 2018) <https://improvement.nhs.uk/resources/just-culture-guide/>

Actionable patient safety solution (APPS) #1: culture of safety (Patient Safety Movement Foundation) <https://patientsafetymovement.org/actionable-solutions/challenge-solutions/culture-of-safety/>

Appreciative inquiry principles: ask “what went well” to foster positive organizational culture (American Medical Association Steps Forward 2016) <https://edhub.ama-assn.org/steps-forward/module/2702691>

Culture of safety change package: 2018 update (Health Research & Educational Trust) [http://www.hret-hiin.org/Resources/culture\\_safety/18/culture-of-safety-change-package.pdf](http://www.hret-hiin.org/Resources/culture_safety/18/culture-of-safety-change-package.pdf)

Culture of safety resources (Medical University of South Carolina) <http://ip.musc.edu/TeamWorks/index.php>

Developing a reporting culture: learning from close calls and hazardous conditions (Joint Commission 2018) <https://www.jointcommission.org/resources/patient-safety-topics/sentinel-event/sentinel-event-alert-newsletters/sentinel-event-alert-60-developing-a-reporting-culture-learning-from-close-calls-and-hazardous-conditions/>

Module 2: communicating changes in a resident's condition. Appendix: example of the SBAR and CUS tools (Agency for Healthcare Research and Quality 2014) <https://www.ahrq.gov/patient-safety/settings/long-term-care/resource/facilities/ltc/mod2ap.html>

Patient safety topics: good catches (Patient Safety Authority) [http://patientsafety.pa.gov/pst/Pages/Good\\_Catches/hm.aspx](http://patientsafety.pa.gov/pst/Pages/Good_Catches/hm.aspx)

Surveys on patient safety additional resources (Agency for Healthcare Research and Quality 2019) <https://www.ahrq.gov/sops/resources/index.html>