MARS
Veterinary Health

Quality &
Patient Safety

Culture of Safety Toolkit

v. 1.0 | 27 January 2023 | Final

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Culture of Safety Toolkit

This toolkit can be used as resource to help establish and build a Culture of Safety within your workplace.

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v. 1.0 | 27 January 2023 | Final

Introduction

Culture can be defined as the set of collective customs, values, and characteristics shared by individuals within an organization. A “culture of safety” recognizes the complex nature of veterinary care and the challenge of achieving consistently safe care delivery. In a culture of safety, all people are treated fairly and not blamed or punished when mistakes occur, and the reporting of patient safety events is encouraged. There is a commitment across the organization to learn from these events, and to seek systematic solutions to patient safety problems.

— MVH Global Patient Safety team

In this toolkit, there are several resources that provide educational content, as well as both print and digital assets that you can use within your workplace to encourage and support building a Culture of Safety together.

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Patient Safety Event Doctrine

Philosophy

Mars Veterinary Health supports a culture of safety in our hospitals and clinics. We recognize that veterinary health professionals are human and that they work in complex environments, which means that errors will happen. As most patient safety events are the result of environmental and systems issues, we will work continually to make our systems and processes safer to benefit our patients, clients and Associates.

Commitment

- Patient safety events should be reported by all Associates as a way to continually improve the care and safety of our patients.
- Associates must be free to work, speak up and report patient safety events without fear of punishment. It is critically important that we provide support and resources to Associates who experience patient safety events. However, willful misconduct that jeopardizes patient safety will not be tolerated.
- Consistent with our patient safety event philosophy, a systems-improvement focus will be used in event analysis. The goal is to learn from these events to continually improve safety.
- As part of our responsibility to our clients, we will give prompt, clear and accurate information about patient safety events that impact their pets.

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Patient Safety Overview

What is it?

Patient safety is a scientific field that looks at harm to patients during the provision of healthcare. Healthcare is considered a 'high risk' industry, similar to the aviation and the automobile industries. We can learn a lot from these other safety fields as they are experts in looking at things that go wrong within their systems to increase safety and prevent future problems. These two industries are called 'high reliability' organizations due to their safety records and the fact that they continually work to make their systems safer.

Patient safety focuses on looking at the 'root causes' of patient safety events and making systems changes in order to prevent future events.

Data

- One in 10 human patients are injured or harmed while receiving care
- Patient safety events (PSEs) are thought to be the third leading cause of human death in the U.S., behind cancer and cardiovascular disease
- It is very likely that only about 40% of patient safety events are actually reported in human healthcare
- A strong culture of safety leads to increased staff engagement and retention

To access Patient Safety Introduction slides, click **here**.

What do we know?

- PSEs can happen (and will happen) to everyone regardless of experience or credentials. We are human and this means that mistakes will occur.
- A strong culture of safety in hospitals is critical. People need to feel safe and supported to report PSEs.
- Blaming individuals for events will not prevent these events from reoccurring and it will lead to underreporting of events.
- An expected normal rate of occurrence of patient safety events in human healthcare environments is 1-2 events/Associate/year.
- Top categories for patient safety events in both human and veterinary medicine include medication-related, anesthesia/surgery and treatment.
- A key focus of patient safety is looking at the systems in which our teams work in order to create solutions to prevent future events.
- Focus on patient safety practices and integration of patient safety tools can lead to better patient outcomes.
- There is an important impact on our team members that are associated with patient safety events. This is termed 'the second victim' concept where the patient/family are considered the first victims. It is critical to provide support for our Associates going through these events.

Key Terminology

Patient Safety Event + Learning System (PSEL)
System where patient safety events are reported, analysis is performed to determine the underlying causes, and opportunities for improvement and learnings are used to implement safety actions.

Patient Safety Event (PSE)
An incident or event that could have, or did, result in harm to a patient. This includes both medical errors and adverse events.

Systems thinking or systems-based approach
A paradigm that acknowledges the human condition (meaning that humans err) and concludes that safety depends on creating systems that anticipate errors and either prevent or catch them before they lead to harm.

Culture of Safety
A "culture of safety" recognizes the complex nature of veterinary care and the challenge of achieving consistently safe care delivery. In a culture of safety, all people are treated fairly and not blamed or punished when mistakes occur, and the reporting of patient safety events is encouraged.

Root Cause Analysis (RCA)
A process that dissects a patient safety event with the purpose of learning from that event in order to prevent similar future events. There are many ways to do a root cause analysis and this process can be quick and efficient. Two key tools that are often used for this are the Swiss cheese model and the fishbone model.

Levels of harm in MVH's PSE system, 'Halo'

- **Death** – incident in which death of the patient may have been caused or brought forward in the short term by the incident
- **Serious** – incident in which patient was harmed and required a significant change to the initial treatment plan for that patient
- **Minor** – incident in which patient was harmed, with mild and short-term impact
- **Good catch** (near miss, no harm) – incident which had potential to cause harm to a patient, but resulted in no harm

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Find Your Starting Point on Your Culture of Safety Journey

Answer the questions below to find your starting point. Follow the guidance provided on the following page on how to use and implement the resources provided in this toolkit to support a Culture of Safety within your team and workplace.

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Which Level Is Your Team Starting At?

Level 1

Your team and organization may be at the very start of your Culture of Safety journey, which means that Associates will need educational materials and guided support at initiation. There may not be any awareness of a safety culture among Associates, and so it will be crucial to reinforce what it is, why it is important and how it makes the system and team provide better patient outcomes.

These resources within the toolkit will provide foundational information as well as help engage Associates as we build a Culture of Safety together:

- Patient Safety Doctrine
- Email
- Fact Sheet
- Screensavers/Yammer Posts
- Culture Conversations Guide
- Discussion Prompt Cards

Level 2

Your team and organization values patient safety, and you react and respond appropriately when there is an incident. The safety culture in place currently is reactive, and there is an opportunity to shift to a more proactive approach to predict and prevent patient safety events before they happen.

These resources within the toolkit will provide opportunities to build on the culture already in place as we build a Culture of Safety together:

- Patient Safety Doctrine
- Email
- Fact Sheet
- Flyer
- Screensavers
- Culture Conversations Guide
- Discussion Prompt Cards

Level 3

Your team and organization have systems in place to manage hazards and prioritize patient safety, and would benefit from some resources to continue to grow as healthcare providers.

These resources within the toolkit will help you proactively build on the culture of safety that has begun to take shape as we build a Culture of Safety together:

- Patient Safety Doctrine
- Email
- Poster
- Screensavers
- Culture Conversations Guide
- Discussion Prompt Cards

Level 4

Your team and organization is playing offense: thinking ahead, anticipating risks and solving problems. Your leadership helps drive continuous improvement, and your culture of safety shows strength.

These resources within the toolkit will provide reminders and continuing education as we build a Culture of Safety together:

- Patient Safety Doctrine
- Email
- Screensavers
- Culture Conversations Guide
- Discussion Prompt Cards

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A Systems-Based Approach

Focus on the problem, not the person

Systems thinking or a systems-based approach is a paradigm that acknowledges the human condition (meaning that humans err) and concludes that safety depends on creating systems that anticipate errors and either prevent or catch them before they lead to harm.

This approach looks at the environment within which people work, including the systems and processes set up within the hospital to ask, “where are the weaknesses — or vulnerable areas — that could lead to error or harm to a patient?” There are several areas (often called factors or contributory factors) within a system that can lead to system weaknesses or patient safety events. Common “factor” areas include people factors, patient factors, task factors, equipment/resources, communication or organizational. After a patient safety event occurs, examining these areas is important to help determine where the weaknesses are that could have led to that event. The goal is to strengthen the areas of weakness to continually make the system stronger — and in turn increase safety for patients.

A Workplace Example

A very basic example of how to implement systems-based thinking after a patient safety event can be seen in addressing a mix-up of two drugs with like-sounding names.

In veterinary medicine, two drugs that commonly get mixed up are “Cerenia” and “Convenia.” These are both injectable drugs with like-sounding names and the colors on the packaging are very similar. These drugs are also stored in the fridge, often right next to each other.

If a nurse accidently reaches for the wrong bottle and gives the wrong medication, it does not make sense to blame the individual because the system (drug name, colors, location in the fridge) sets the stage for a mistake to happen. Unless a change is made to the label on the bottles or the locations of these drugs within the fridge, Associates will continue to make this same mistake.

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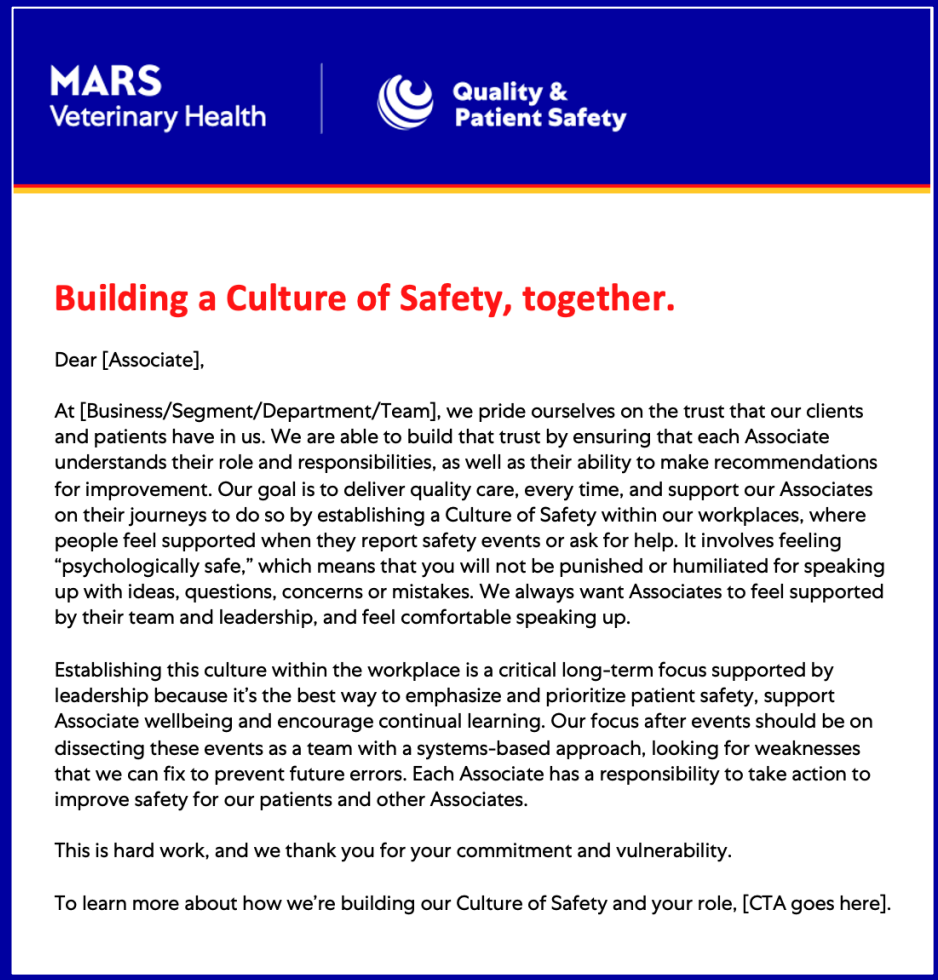
Email Content (Word)

Sample email content is available here.

If your team or organization regularly communicates important information via email, it may be beneficial to use an email to introduce and reinforce your Culture of Safety. This is also an opportunity for leadership to share a message and express their support.



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Building a Culture of Safety, together.

Dear [Associate],

At [Business/Segment/Department/Team], we pride ourselves on the trust that our clients and patients have in us. We are able to build that trust by ensuring that each Associate understands their role and responsibilities, as well as their ability to make recommendations for improvement. Our goal is to deliver quality care, every time, and support our Associates on their journeys to do so by establishing a Culture of Safety within our workplaces, where people feel supported when they report safety events or ask for help. It involves feeling "psychologically safe," which means that you will not be punished or humiliated for speaking up with ideas, questions, concerns or mistakes. We always want Associates to feel supported by their team and leadership, and feel comfortable speaking up.

Establishing this culture within the workplace is a critical long-term focus supported by leadership because it's the best way to emphasize and prioritize patient safety, support Associate wellbeing and encourage continual learning. Our focus after events should be on dissecting these events as a team with a systems-based approach, looking for weaknesses that we can fix to prevent future errors. Each Associate has a responsibility to take action to improve safety for our patients and other Associates.

This is hard work, and we thank you for your commitment and vulnerability.

To learn more about how we're building our Culture of Safety and your role, [CTA goes here].

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Newsletter Content (Word)

Sample newsletter content is available here.

Newsletters often reach beyond small teams or organizations and are a great way to share brief summaries of larger updates to a broad internal audience. Sharing the Culture of Safety information with a larger group is an opportunity to spark conversation with colleagues.

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Building a Culture of Safety, together.

Establishing a Culture of Safety is the best way to emphasize and prioritize patient safety, support Associate wellbeing and encourage continual learning within [Business/Segment/Department/Team]. It's not enough to simply reflect on safety events that have occurred in a non-judgmental manner; we also want to make sure we are playing active roles in ensuring that events happen less frequently or are less severe.

To learn more about how we're building our Culture of Safety and your role, [CTA goes here].

Building a Culture of Safety, together.

At [Business/Segment/Department/Team], we pride ourselves on the trust that our clients and patients have in us. Our goal is to deliver quality care, every time, and support our Associates on their journeys to do so by establishing a Culture of Safety within our workplaces, where people feel supported when they report safety events or ask for help without fear of punishment. This is a critical long-term focus supported by leadership because we want Associates to feel a strengthened belief and pride in our Purpose: A Better World for Pets.

To learn more about how we're building our Culture of Safety, [CTA goes here].

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Fact Sheet (PowerPoint)

The fact sheet is available here.

Healthcare providers work in fast-paced environments and sharing updates about our Culture of Safety in a question-and-answer format makes it quick and easy to read and understand what is happening in the organization.

There is also a version of the fact sheet that includes a place for organizations to insert their own logos in addition to the Quality & Patient Safety logo.

What you need to know about our Culture of Safety:

What is a Culture of Safety?
A Culture of Safety is one where people feel supported when they report safety events or ask for help. They will not be punished or humiliated for speaking up with ideas, questions, concerns or mistakes. We never want Associates to feel intimidated by their teammates or by possible repercussions when reflecting upon safety events or near misses.

Why is this important?
Establishing a Culture of Safety is the best way to emphasize and prioritize patient safety, support Associate wellbeing and encourage continual learning. Our focus after events should be on dissecting these events with a systems-based approach, looking for weaknesses that we can fix to prevent future errors.

What does success look like?
A supportive team and a collaborative work environment may look different within each team. For example, you may report or discuss safety events more often and feel comfortable speaking up about safety events both before and after they occur. You may also see an increase in team collaboration on safety processes.

What is my role?
Establishing a Culture of Safety is also a personal transformation, to ensure that you are confronting your own vulnerabilities, identifying areas for growth and being the best teammate you can be. Participate in team meetings and safety discussions however feels right to you. and take advantage of the resources you have available in your leadership, your peers, and the Culture of Safety Toolkit.

To learn more about how we're building our Culture of Safety together, [CTA to go here].

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Cultivate strengths. Inspire change. Advance care.

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Flyer (PowerPoint)

The flyer is available here.

For teams or organizations that share pertinent information via bulletin board or posted signs in staff areas, sharing a flyer is a great way to keep our Culture of Safety top of mind and spark discussion among teammates.

There is also a version of the flyer that includes a place for organizations to insert their own logos in addition to the Quality & Patient Safety logo.

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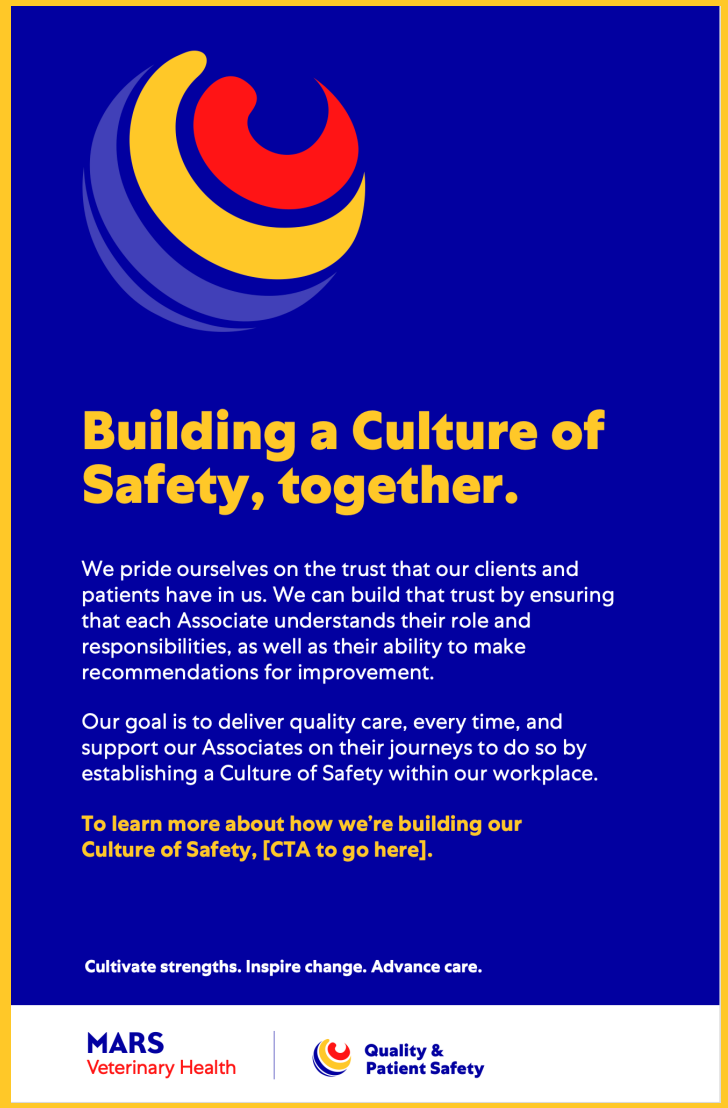
Poster (PowerPoint)

The poster is available here.

Hanging a Culture of Safety poster in a high-traffic area of your workplace serves as a frequent reminder about the importance of the initiative and each person's role.

There is also a version of the poster that includes a place for organizations to insert their own logos in addition to the Quality & Patient Safety logo.



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Screensavers (PowerPoint)

Screensaver options are available here.

If your team or organization relies on computers during the workday, sharing our Culture of Safety messaging as screensavers serves as a reminder of the importance of each person's role. These can also be utilized as small posters when printed.

There are versions of the screensaver options that include a place for organizations to insert their own logos in addition to the Quality & Patient Safety logo.

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Yammer Posts (PowerPoint)

Yammer post options are available here.

These Yammer posts make it easy to share what's happening within your team or organization and inspire Associates. The files can also be repurposed as stickers, printed cards, magnets or other collateral.

There are versions of the Yammer posts that include a place for organizations to insert their own logos in addition to the Quality & Patient Safety logo.

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Culture Conversations Guide

Culture Conversations Guide is available here.

The Culture Conversations Guide is a reference tool to help leaders inspire, establish and reinforce a Culture of Safety within their teams.

The guide serves as initial leadership training material and as a road map that can be utilized repeatedly.

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Factor Discussion Prompts

10 Common Contributory Factors

A contributory factor of a problem or event is one of the things that caused it to exist or happen. These discussion prompts are designed to give you some key talking points in each of the most common 'factor' categories in patient safety. These are aids to help us talk about patient safety events.

There are 10 main factors that can be at play during a patient safety event. Print out the Factor Discussion Prompt cards to use during your next team meeting to help lead the conversation as you review each potential factor as a group.

Printable Cards

Discussion prompt cards are available here.

Using these cards to spark discussion about a patient safety event may inspire Associates to think more critically about what happened, identify opportunities to make real changes and emphasize the focus on the problem, not the person.

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TeamSTEPPS – Our voices, together, for safer care

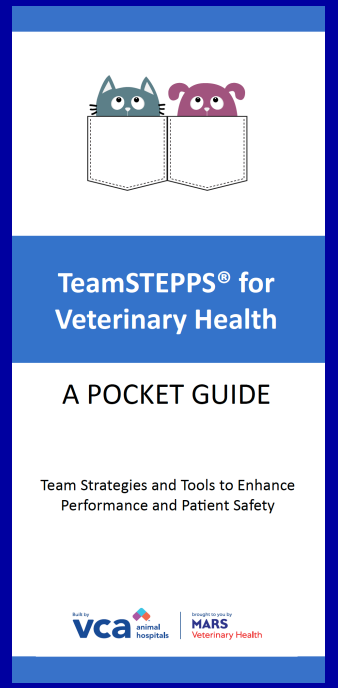
What is TeamSTEPPS?
TeamSTEPPS is a set of approaches to improve communication and teamwork, used by human healthcare teams across the globe with proven positive impacts on patient care and patient safety culture. TeamSTEPPS is about recognizing that each of us has a voice and the power to champion change. TeamSTEPPS tools for communication, leadership, situation monitoring and mutual support provide Associates with a common language to use their voice to improve patient safety and team-based care to create A Better World for Pets.

What does TeamSTEPPS stand for?
Team **S**trategies and **T**ools to **E**nhance **P**erformance and **P**atient **S**afety

What do you mean by TeamSTEPPS tools?
TeamSTEPPS tools include tools for consistent patient handoffs, 'the debrief,' 'the check-back' and also tools to help manage conflict and to help people have a voice when they have concerns for safety.

To access the TeamSTEPPS SharePoint site click **here**.

The TeamSTEPPS One Pager is available **here**.
The TeamSTEPPS Pocket Guide is available **here**.



Mars Ombudsman Program

The Mars Ombudsman Program is an independent, confidential, informal and neutral resource available to all Associates. It is a safe place for Associates to seek guidance, voice concerns or discuss options for any work-related matter.

Ombudsman Contacts:

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