Culture of Patient Safety acknowledges that “to err is human”; supports speaking up, raising concerns and active listening; ensures transparency by identifying human and system factors contributing to error; and engages in interprofessional teamwork to deliver highly reliable excellent care.

A Just Culture has clear, collective organizational understanding of human error, including a clear line between blameless and blame-worthy actions. A just culture recognizes that even competent professionals will make unintentional errors.

Four types of behavior can be involved in error: 1. Human error, 2. At-risk behavior, 3. Reckless behavior, and 4. Intentional/Mal-intent. Because each type of behavior has a different cause, a different response is required.

Active Failures encompass all those factors that can influence people and their behavior in the workplace (human factors).

Latent Conditions permit errors to occur and stem from the workplace culture (contributing factors).

Root Cause Analysis (RCA) is a systematic review process to identify factors that contribute to adverse events or near misses. RCA focuses on systems and processes improvement to reduce or eliminate the risk of recurrence.

Reason’s “Swiss Cheese” Model: Both human & system factors cause errors.

An Error is an act of commission (doing something wrong) or omission (failing to do the right thing) that leads to an undesirable outcome or significant potential for such an outcome.

IPI Patient Safety Competencies for Health Professions Students

- Describe the differences between unintentional error, at-risk behavior, and reckless behavior.
- Use appropriate interprofessional communication and mutual support techniques to escalate the conversation around safety concerns.
- Identify the relationship between human factors, healthcare system complexity, and patient safety.
- Perform analyses of adverse events and apply strategies to reduce errors.
- Describe the rationale for error reporting and disclosure, apology and support.
**Definitions related to Patient Safety:**

- **Event:** An error, mistake, incident, accident, or deviation, regardless of whether or not it results in patient harm.
- **Adverse event:** Bodily or psychological injury caused by medical management rather than the underlying condition of the patient. Adverse events may or may not result from errors.
- **Preventable adverse event:** An adverse event attributable to errors.
- **Near miss:** Error that did not reach the patient, either by chance or through timely intervention.
- **Sentinel event:** An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof.
- **Event report:** Information provided regarding an unsafe condition, near miss and events that reached the patient whether or not harm occurred.

**Communication Tools used in a Culture of Patient Safety:**

- **SBARQ:** Situation-Background-Assessment-Recommendation-Question. To ensure patient safety, every member of the healthcare team must have all essential information readily available. SBARQ standardizes communication amongst team members, builds consensus around a course of action and actionable recommendation, and triggers appropriate questions.
- **CUS:** I'm Concerned; I'm Uncomfortable; We have a Safety issue!
- **ARCC:** Ask a question; Request a change; Voice a Concern; Invoke the Chain of Resolution.
- **Read back:** A healthcare provider receiving a verbal order must write it down and read it back to the prescriber to verify the accuracy of what was heard, and receive verbal confirmation of accuracy with yes or no, and never uh-huh.
- **IM SAFE:** Individual factors affecting human performance: Illness, Medication, Stress, Alcohol, Fatigue, and Emotion.
- **5 Whys:** A “drill down” question-asking technique used to understand the cause-and-effect relationships underlying a particular problem. The primary goal of the technique is to determine the root cause of a defect or error. (The "5" in the name derives from an empirical observation on the number of iterations typically required to resolve the prob-

**OHSU’s patient safety policy:** "As part of a culture of patient safety, OHSU is committed to fostering institutional transparency regarding safety concerns, near misses and adverse events, shedding light on these, learning from them, and improving our systems and processes to ultimately help OHSU reduce harm and risk of harm. OHSU is committed to respectfully managing events in a timely way, being sensitive, just and responsive to those harmed, involved and affected by the event, meeting regulatory requirements, and reporting serious adverse events to select organizational leadership with oversight responsibility for quality and safety."

Knowing how fatigue, stress, poor communication, disruption and inadequate knowledge and skill affect health professionals is important because it helps us to understand predisposing characteristics that may be associated with adverse events and errors. Working together, we can ensure a culture of patient safety and quality improvement.