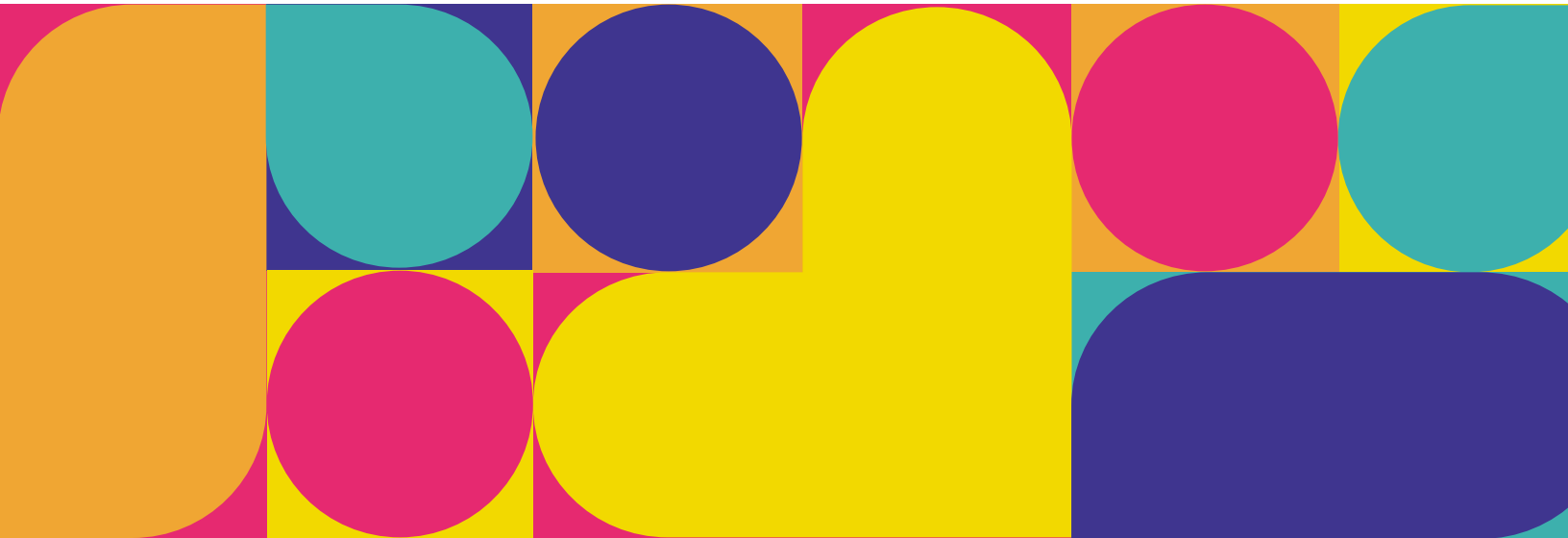
Healthcare Excellence Canada

Rethinking Patient Safety

Navigating the Measurement and Monitoring Safety Clouds: A Leaders' Self-reflection and Discussion Activity

PARTICIPANT WORKBOOK



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A holistic approach to safer, more inclusive care

Whether you deliver or receive care, everyone contributes to patient safety. For more than 20 years, Canada has recognized that strengthening patient safety is fundamental to excellent healthcare. Historically, our focus has been on preventing, measuring and responding to physical harm. Yet as we have learned over the past two decades, safety is about much more than the absence of harm.

Healthcare Excellence Canada (HEC) is at the forefront of redefining the way patient safety is defined, understood, and actioned. In our Rethinking Patient Safety initiative, we are supporting a transformative shift – from viewing safety as the absence of harm to a more holistic approach that fosters safe, inclusive care. This vision builds on insights from the Measurement and Monitoring of Safety Framework, the foundation of our reimagined approach.

Rethinking Patient Safety: Navigating the Measurement and Monitoring Safety Clouds is a self-reflection and discussion activity designed for senior leaders and board members. Accompanied by this workbook, the activity guides you through key learnings and discussions, empowering you to lead meaningful change and deepen your organization's understanding of patient safety.

By participating in this activity and completing this workbook, you will:

- **foster ongoing learning and dialogue** to rethink patient safety
- **document key insights and reflections** while identifying actionable commitments for yourself and your leadership team
- **support your accreditation processes** or discussions with regulators as a demonstration of your commitment to safer care
- **advance your professional development** as you rethink safety and lead change within your organization

As you embark on this journey, Healthcare Excellence Canada thanks you for your dedication to advancing safe, inclusive healthcare for all.

A closer look at our approach

HEC's vision for patient safety

Rethinking Patient Safety was released in 2023 by Healthcare Excellence Canada. It was developed because, despite 20 years of efforts to improve patient safety, we have not achieved the success we had hoped for. Healthcare Excellence Canada is encouraging everyone to rethink how they define and approach their work to improve patient safety.

The core statement within Rethinking Patient Safety reads, "Everyone contributes to patient safety. Together we must learn and act to create safer care and reduce all forms of healthcare harm." The document includes a table for reflection and a list of questions for discussion.

For more information about Rethinking Patient Safety and HEC's efforts to lead this transformative shift please visit our website at Rethinking Patient Safety.

The Measurement and Monitoring of Safety Framework

The Measurement and Monitoring of Safety Framework (Figure 1) serves as a conceptual model to guide healthcare organizations in their efforts to improve safety. While the nature of safety is widely discussed in the literature, there is little consensus – particularly in healthcare – about its core dimensions or what should be measured and monitored.

The framework addresses this gap by integrating five critical dimensions of safety into a single framework and offering practical examples of how these concepts can be applied across various health sectors. Synthesizing theory, literature and practice from healthcare and other industries, the framework is designed to be accessible and useful to all healthcare organizations.

The framework consists of five dimensions of safety:

Past harm

Reliability

Sensitivity to operations

Anticipation & preparedness

Integration & learning

The MMSF introduces significant advantages in understanding and improving safety, many of which are reflected in the Rethinking Patient Safety discussion guide. Specifically, the framework:

- creates a more holistic view of safety
- changes our safety focus – moving away from primarily focusing on past harm
- establishes a shared and consistent understanding of safety
- changes the way we think about safety
- encourages a shift from managing risks to managing safety
- moves beyond assurance and accountability reporting to a culture of inquiry
- empowers everyone to take a proactive role in safety
- fosters a collective responsibility for safety
- emphasizes the connection between staff and patient safety
- values soft intelligence, such as listening, observing and perceiving
- recognizes the critical contributions of patients and caregivers in creating safety

For more information about the Measurement and Monitoring of Safety Framework, please visit the Health Foundation's website.

Figure 1: The Measurement and Monitoring of Safety Framework

Understanding the safety cloud activity

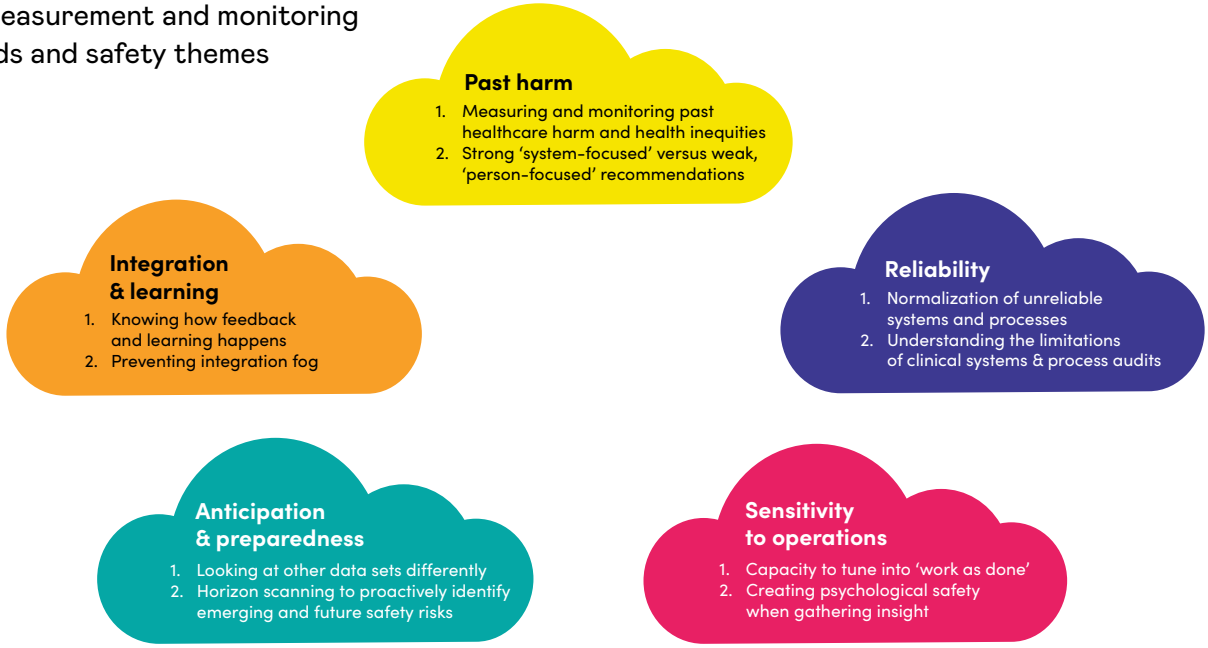
Senior leaders and board members play a vital role in championing Rethinking Patient Safety. This activity fosters self-reflection and dialogue among leaders across all sectors of healthcare, focusing on the five domains of the Measurement and Monitoring of Safety Framework – the foundation of the approach. While progress has been made in reporting and learning from harm, it is now time to harness insights from broader sources of safety information.

What are safety cloud themes?

The exercise delves into the five domains of the Measurement and Monitoring Safety Framework – past harm, reliability, sensitivity to operations, anticipation & preparedness, and integration & learning – through the use of safety clouds. Each safety cloud contains two themes, encouraging leaders to first engage in self-reflection and then participate in reflective conversations (Figure 2).

The themes within each safety cloud highlight common challenges healthcare organizations may face as they shift toward Rethinking Patient Safety and refine their approach to measuring and monitoring safety. Detailed explanations of these themes can be found beginning on page 10 of this workbook.

Figure 2: Measurement and monitoring safety clouds and safety themes



Why participate in a leader's self-reflection and discussion?

Rethinking Patient Safety emphasizes that everyone contributes to patient safety. As senior leaders and board members, it is important to understand your role in fostering environments where safety thrives. This includes supporting improvement efforts that extend beyond learning from and preventing harm, incorporating broader safety intelligence and ensuring that everyone has the opportunity to contribute to safer care.

Self-reflecting on your leadership role and the questions you can ask yourself and others is an important first step toward creating safer care. While we have learned a lot about safety in the past 20 years, we have not progressed as much as we had hoped. Now is the time to rethink patient safety and lead meaningful change toward safer care for all.

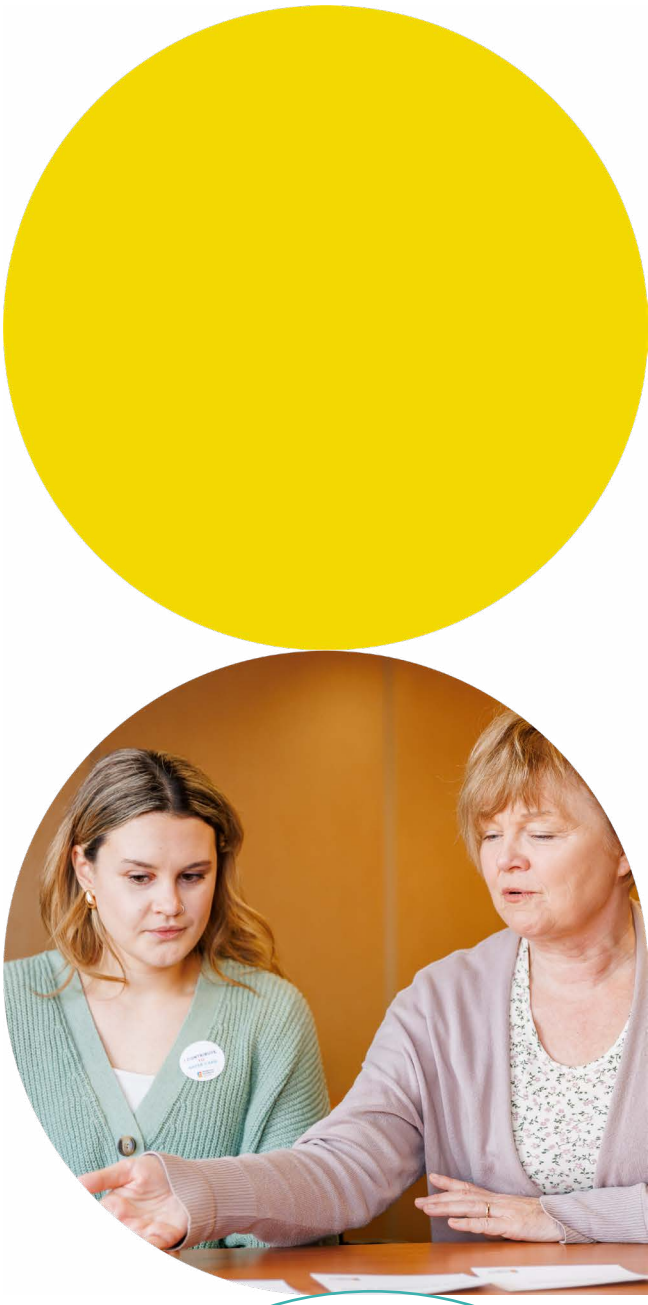
Participating in this activity also supports your continuing professional development. You can use this workbook in accreditation and interviews with regulators to demonstrate how you, as a leader, are learning.

Make the most of your safety discussions

There is no expectation of perfection – in fact, your safety conversations are expected to identify gaps. The important thing is for you, as a leader, to take time to self-reflect on how you lead for safety, and engage with other leaders to gain diverse perspectives on the challenges identified in the safety clouds.

What matters is that you have an honest, open and inclusive conversation about the challenges related to each safety theme and its associated question.

Do NOT try to cover all 10 themes in one session. Instead, break the exercise into manageable parts. A series of deeper, more meaningful conversations over time will enable you to thoroughly explore each safety theme. Consider focusing on one safety theme discussion per meeting when your leadership team gathers. And be sure to allocate **20 to 30 minutes** for each safety theme discussion.



Choose your path

We have presented five safety clouds (each associated with two unique safety themes) connected to Rethinking Patient Safety and the Measurement and Monitoring of Safety Framework. Some themes may resonate with you more strongly than others, and your organization might face greater challenges – denser clouds – in one or two areas.

Use the table below to pinpoint which area of patient safety is most relevant to your current leadership challenges. Reflect on the questions on the left, then review the corresponding discussion themes on the right. This guide is designed to help you choose a starting point for deeper, focused conversations that drive meaningful change in your organization.

Past harm

If you are wondering…	Consider focusing on…
How your organization can focus on addressing social and systemic inequities that lead to harm	Theme 1: Measuring and monitoring past healthcare harm and health inequities
Do the recommendations from your incident reviews primarily focus on reminding staff to comply with policies and procedures, providing more training or conducting more audits on safety procedures	Theme 2: Strong 'system-focused' versus weak 'person-focused' recommendations

Reliability

If you are wondering…	Consider focusing on…
How you can gain deeper insights into unreliable systems and processes and how these connect with unsafe care	Theme 1: Normalization of unreliable clinical systems and processes
How to move beyond audit data to better understand levels of reliability within your organization and the limitations of audits	Theme 2: Understanding the limitations of clinical systems and process audits

Sensitivity to operations

If you are wondering…	Consider focusing on…
How to better understand the data in committee reports and dashboards, but you're also curious to tune into how care is delivered and how patients and caregivers experience safety	Theme 1: Capacity to tune into 'work as done'
How you can support the creation of psychological safety, so staff, patients, and caregivers can surface their concerns	Theme 2: Creating psychological safety when gathering insight

Anticipation & preparedness

If you are wondering…	Consider focusing on…
How you can consider other forms of safety data that can give you the heads-up on future safety	Theme 1: Looking at other data sets differently
How you can adopt a more proactive approach to anticipate future harms instead of learning only from past incidents and complaints	Theme 2: Horizon scanning to proactively identify emerging and future safety risks

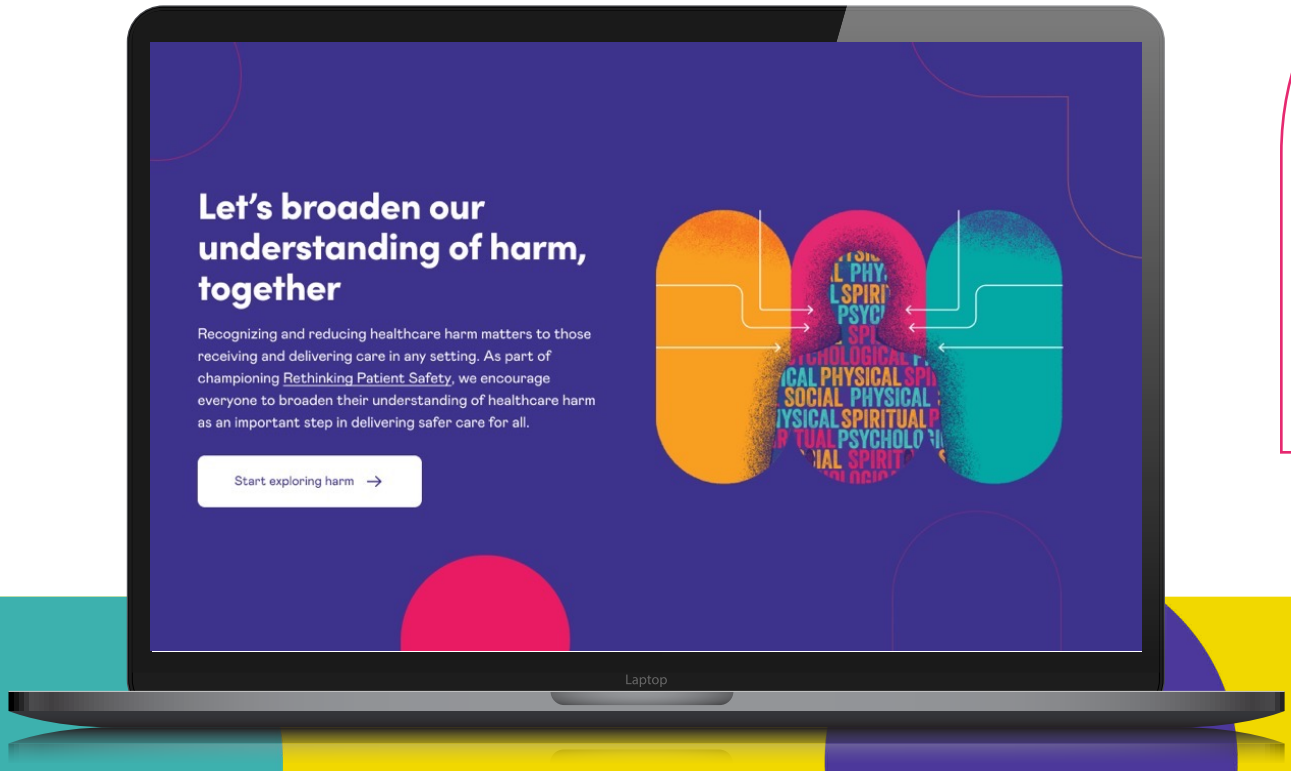
Integration & learning

If you are wondering…	Consider focusing on…
How staff learn and identify areas of improvement from past patient safety incidents, concerns, audits and patient culture surveys	Theme 1: Knowing feedback and learning happens
How to digest large amounts data and understand what this really means for safety in your organization	Theme 2: Preventing integration fog

Measuring and monitoring the safety clouds and safety themes

The following pages guide you through the five dimensions of the Measurement and Monitoring Safety Framework, along with associated safety clouds and themes. You'll find background information, reflective questions, and space to document your insights and observations.

While the clouds are presented sequentially, they work together as an integrated system. As you explore each cloud, consider how it connects to and builds upon the others to create a comprehensive approach to safety.



Past harm

Past harm asks the question, "Has patient care been safe in the past?"

- This involves assessing various types and aspects of harm to determine whether care has been safe in the past and is becoming safer. For example, it considers how long ago the harm occurred and the amount of harm over time.
- It is often described as, "looking in the rear-view mirror."
- It involves revisiting past events so we can learn and improve.
- While measuring and understanding past harm is critically important, it alone cannot significantly improve safety and should not be mistaken for measuring safety.

For additional material and learnings about healthcare harm please visit understandharm.ca

How do we currently answer the question, **“Has care been safe in the past?”**

Past harm safety cloud themes

Past harm

1. Measuring and monitoring past healthcare harm and health inequities
2. Strong ‘system-focused’ versus weak, ‘person-focused’ recommendations

Safety cloud theme 1: Measuring and monitoring past healthcare harm and health inequities

Reflective question

How might we improve our understanding of past healthcare harm so that we know whether patients and communities with social and systemic inequities are more likely to experience healthcare harm related to patient safety incidents?

Background

We know, based on evidence and the lived experiences of people and communities, that social and systemic inequities have created barriers to receiving safe and high-quality healthcare. These inequities can contribute to unsafe care such as:

- maternity and obstetric safety incidents
- overuse of restraints
- over-sedation and tranquilization
- seclusion in mental health settings

Such incidents can result in **safety incidents,** which can potentially cause **physical, psychological, social and spiritual harm.**

Evidence to support examples related to maternity incidents, overuse of restraints, over sedation and seclusion in mental health settings:

Longwoods Videos. (n.d.). The impacts of racism on healthcare quality and safety in Canada: A case study and practical advice from Ontario Midwifery

Boakye, P. N., Prendergast, N., Bandari, B., Brown, E. A., Odutayo, A., & Salami, S. (2023). Obstetric racism and perceived quality of maternity care in Canada: Voices of Black women. *Women's Health, 19*(1), 1–13. https://doi.org/10.1177/17455057231199651

First Nations Health Authority. (n.d.). Remembering Keegan: A BC First Nations Case Study Reflection "*Survivors have testified to abuses – including use of restraints – in these schools and hospitals. This is not abstract in the context of health services that are delivered in BC in close proximity to the 21 former residential schools and three former Indian hospitals (Coqualeetza Indian Hospital in Chilliwack, Miller Bay Indian Hospital in Prince Rupert and Nanaimo Indian Hospital in Nanaimo)*" (pg. 21). (see also this CBC report)

Centre for Addiction and Mental Health (CAMH). (n.d.). Dismantling Anti-Black Racism: A strategy of fair & Just CAMH. *"In a recent analysis of CAMH data, rates of restraint use were 44 per cent higher among Black patients than among white patients."* pg. 5

Black Health Alliance, Health Inequities. (n.d.). *"Black Ontarians experience higher rates of restraint and confinement under the care of the mental health and addictions system."*

This safety cloud theme is asking you to consider:

What does your organization's past harm data look like, and does it give you insights into health inequities?

Can you identify specific incidents that make the issues of inequities and patient safety incidents easier to see?

How might you strengthen your organizational knowledge to gain insights into the impact health inequities have on patient safety?

Safety cloud theme 2: Strong 'System-focused' versus weak 'person-focused' recommendations

Reflective question

How many recommendations from our incident investigation reports focus on improving the design of the healthcare system (i.e. system focused) and how many focus on asking point-of-care healthcare staff to comply, try harder or do additional tasks (i.e. person-focused)?

Background

- Incident investigations in healthcare often result in what human factors experts call "weak, person-focused" recommendations. Weak recommendations include reminding staff to comply with safety policies and procedures, introducing more safety policies and procedures or adding additional safety checks. Refer to Figure 3 for examples of strong, moderate and weak recommendations.
- Human factors research shows that when we rely solely on person-focused recommendations, the same types of incidents are likely to recur.
- Our focus needs to be on designing healthcare systems that enable staff to deliver safe patient care.
- Healthcare leaders need to understand that person-focused solutions and recommendations are generally weaker than those that involve redesigning healthcare systems and reengineering cultures, which are the strongest (Figure 3).
- Designing healthcare systems to enable staff to deliver safe patient care will achieve greater improvements in safety than simply telling staff to comply, do better or do more.

Figure 3: Strong, moderate and weak recommendations[1]

Recommendation strength	Types
Strong	Redesign a healthcare pathway, process or other part of the work environment.
	Engineering controls like designing in a 'forcing function.'
	Effect cultural improvement to develop a psychologically safe culture.
	Redesign equipment, IT systems to improve their usability, accessibility and functionality.
	Simplify or standardize processes, pathways or equipment.
	Carry out usability testing (formative and summative) when implementing new equipment, workplaces or IT systems.
Moderate	Resolve equipment availability problems.
	Resolve staffing problems.
	Reorganize workload to address high workload or task overload.
	Develop and deliver simulation-based training.
	Enhance documentation or communication.
	Eliminate or reduce distractions and interruptions.
	Introduce a safety checklist.
	Review rostering or the appropriateness of the staff mix.
Weak	Add in additional safety checks for staff to carry out.
	Raise staff awareness of a policy or process.
	Carry out an audit or review.
	Increase staff supervision.
	Informing, notifying, issuing warnings.
	Discipline or suspend staff who make errors.
	Rewrite safety policies and procedures.
	Introduce more safety policies and procedures.
	Check staff understanding of safety processes (without considering how work is actually done).
	Share the investigation findings.
	Carry out didactic training which involves reminding staff about safety policies and procedures, or 'counselling' staff about the way to deliver safe patient care.
	Other recommendations which do not take account of the workflow and task demands in a clinical area.

[1] Figure 3 is based on the following research papers:
- Hibbert, Thomas, Deakin et al. Are recommendations from root cause analysis effective and sustainable? An observational study. International Journal of Quality in Health Care, 30; 124-131; 2018.
- Cafazzo and St Cyr. From discovery to design: the evolution of human factors in healthcare. Healthcare Quality, 2012:15 Spec No:24-9. doi: 10.12927/hcq.2012.22845.

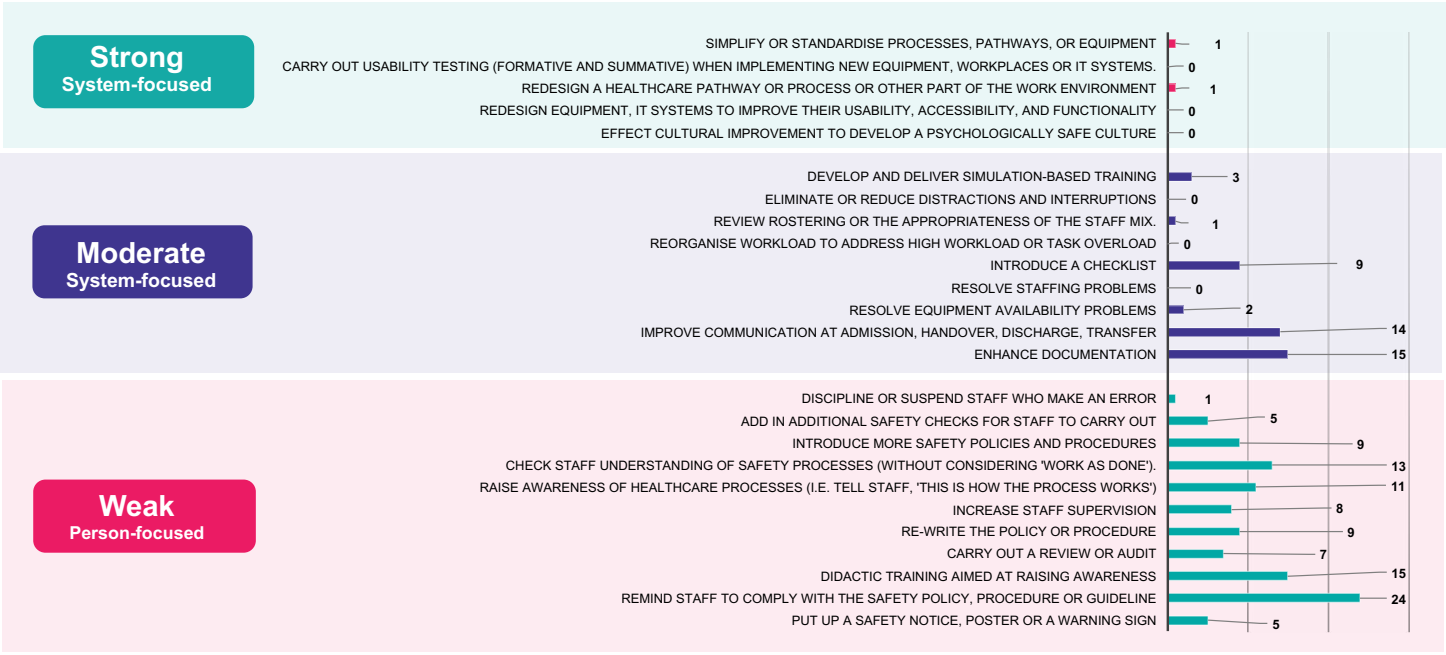
This safety theme cloud is asking you to:

- Review the mocked-up profile for Organization A (Figure 4) and the examples of weak, moderate and strong recommendations (Figure 3).
- As a leader, reflect on the recommendations made in your organization's incident investigations.

What would your organization's profile look like?

What needs to change?

Figure 4: Healthcare Organization A's* breakdown of strong, moderately strong and weak recommendations from incident investigation reports



*Organization A is a mocked-up organizational profile that typifies what we see when we carry out an analysis of recommendations in incident investigation reports.

Takeaway task

Source five recently completed incident investigation reports from your organization and review the recommendations section of the report.

Do the recommendations match your perception of your organization's focus?
Are the recommendations mainly person-focused or system-focused?

Were there any surprises?

Now that you have explored **past harm**, been introduced to a broader view of healthcare harm and completed the two past harm safety theme clouds, think and reflect on how you can better answer the question, **"Has care been safe in the past?"**

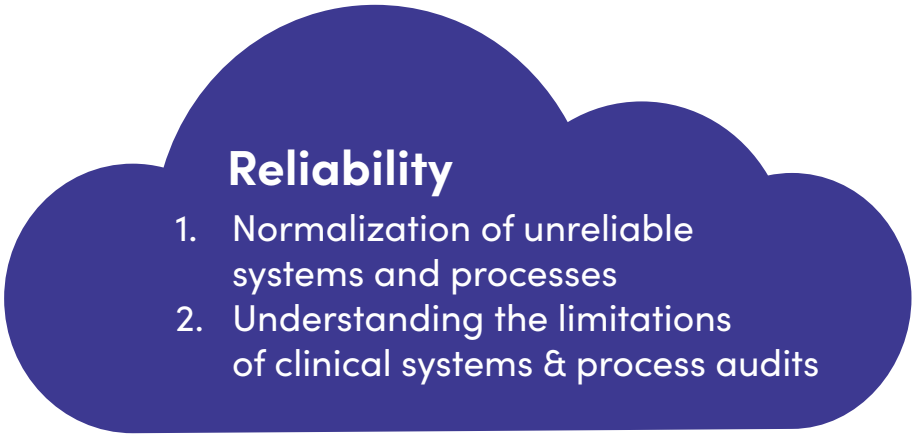
Reliability

Reliability asks the question, **"Are our clinical systems and processes reliable and, if they are not, what might that mean for the safety of the patient?"**

- Reliability gauges the probability that a task, process, intervention or pathway will be carried out or followed as specified.
- The concept of "failure-free operation over time" applies mostly to technology.
- In healthcare, we must recognize that variation is necessary due to differences in patients and care environments; for example, treatments are adapted to fit patient needs.
- Sources of poor reliability include staff skills and experience, team factors such as poor communications, and inadequate design of clinical environments and supports systems, and the belief among clinical staff that improving unreliable systems is someone else's responsibility.

How do we currently answer the question, **"Are our clinical systems and processes reliable?"**

Reliability safety cloud themes



Safety cloud theme 1:
The normalization of unreliable clinical systems and processes

Reflective question

Which clinical systems and processes in your organization are like a dripping tap that never gets fixed? Why are they not fixable?

Background

Unreliable clinical systems and processes can sometimes create safety risks. Examples include booking systems that result in unworkable schedules for staffing, clinics and operating rooms. Others include multiple patient information systems that do not talk to each other, equipment that is unavailable or not working when needed, and work environment issues like poor Wi-Fi connectivity.

This safety theme cloud is asking you:

What systems and processes in your organization are tolerated and worked around, and have become normalized?

Safety cloud theme 2: Understanding the limitations of clinical system and process audits

Reflective question

When we review audits of clinical processes and systems, do we critically examine the potential negative side effects and limitations of the audit approach?

Background

Healthcare audits that measure percentage compliance based on documented patient records may create a false sense of compliant behaviour.

Examples include:

- high compliance rates for completion of client care plans, falls risk assessments or the Surgical Safety Checklist, may not reflect the quality of their implementation
- documentation of vital signs, pressure injury prevention and other care bundles that reflects record keeping rather than the actual clinical practice
- hand hygiene audits where staff alter their behaviour because they are aware the auditor has come to observe their practice

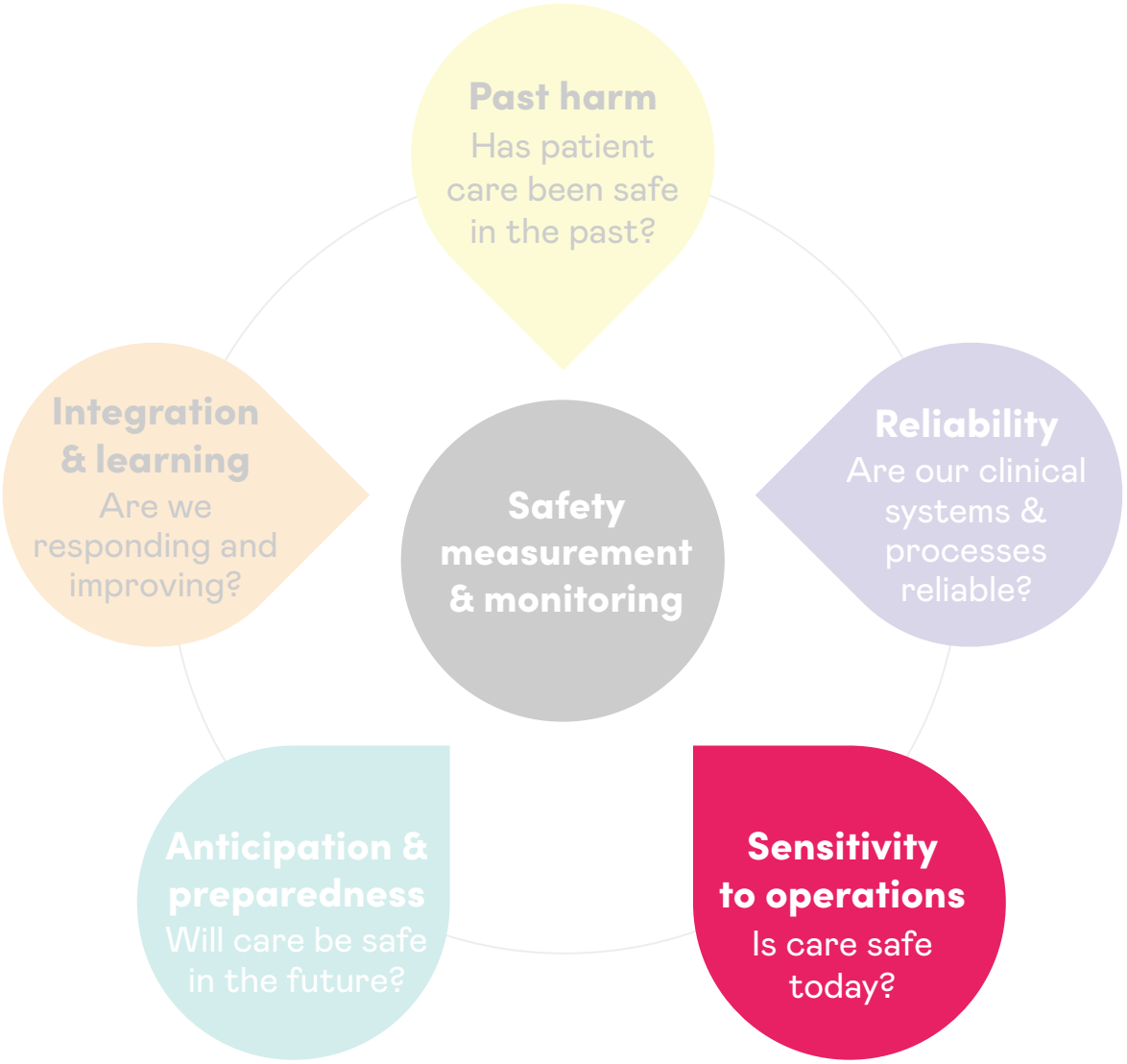
This safety theme cloud is asking:

How can you, as leaders, ensure that safety audit data accurately reflects the quality of care delivered, rather than just measuring what is documented or observing behaviour that may be altered because staff are aware they are being observed?

How can you, as leaders, use the practice of inquiry to gain deeper insights into the reliability of your clinical systems and processes?

Now that you have explored **reliability** and have completed the two reliability safety theme clouds, think and reflect on how you can better answer the question, "**Are our clinical systems and processes reliable?**"

Sensitivity to operations



Sensitivity to operations asks the question, **"Is care safe today?"**

- This domain concentrates on the day-to-day, hour-by-hour and even minute-by-minute management of safety.
- It involves capturing safety intelligence through observing, listening and perceiving the healthcare setting, then **acting** on the information you have gathered.
- This domain places value and emphasis on informal safety intelligence gathered from observations, intuition, critical thinking, experience, relationships and conversations.
- The goal is to continuously assess if care is safe today, so we can **act** upon safety in **real time**.
- The approach emphasizes creating safety proactively rather than reacting and responding after harm has occurred.

How do we currently answer the question, **"Is care safe today?"**

Sensitivity to operations safety cloud themes

Safety cloud theme 1: Capacity to tune into 'work as done'

Reflective questions

- How do we, as leaders, capture insights into 'work as done'?
- What else can we do to learn from what we see, hear and perceive (i.e. insights that may not be easily quantified)?

Background

'Work as done' refers to how healthcare is delivered on an hour-by-hour, shift-by-shift basis. The Measurement and Monitoring of Safety Framework tells us that we gather important insights into safety through conversations, observations, listening and tuning into how care is delivered. What we see, hear and perceive is as important as the metrics we count and report.

For example, a healthcare professional might share that they feel scared or reluctant to speak up and ask for help in their team. Or you may observe a staff member being denigrated when raising a safety concern with a senior colleague.

These moments offer powerful opportunities to understand the true dynamics of care delivery and address safety issues as they arise. By tuning into the realities of 'work as done,' leaders can gain a deeper understanding of how safety is experienced, not just measured.

This safety theme cloud is asking:

How do you, as a leader, get insights into 'work as done'?

What else can you do to tune in by listening, observing and perceiving care as it is delivered in the real world?

Safety cloud theme 2: Creating psychological safety

Reflective question

How do we, as leaders, create a psychologically safe space that allows us to see, hear and perceive safety intelligence from patients, families, caregivers and staff who genuinely represent those who receive and deliver care in our organizations?

Background

In his book, the Four Stages of Psychological Safety, Tim Clark highlights how creating "inclusion safety" – where everyone is treated respectfully, knows their experiences matter and can openly contribute regardless of seniority or professional background – is the first step to building psychological safety.

A lack of inclusion safety sometimes means leaders only hear the safety concerns and experiences of a limited demographic of patients, families, carers and staff. As leaders, we need to tune into broader forms of safety intelligence in a way that ensures everyone's voices – including patients, communities and staff who are seldom heard – can contribute to safer care.

This safety theme cloud is asking you to:

Consider how you may broaden your approach to better hear and understand diverse safety concerns and experiences that reflect those who deliver and receive care.

Now that you have explored **sensitivity to operations** and have completed the two sensitivity to operations safety theme clouds, think and reflect on how you can better answer the question, "**Is care safe today?**"

Anticipation & preparedness

Anticipation & preparedness asks the question, "**Will care be safe in the future**?" This domain focuses on identifying and addressing potential safety risks before they occur. Key aspects include:

- anticipating and preparing for problems rather than waiting for things to go wrong before addressing them
- developing strategies to prevent potential future harm, by drawing insights from past harm, reliability and sensitivity operations
- exploring opportunities to develop systematic ways to anticipate future risks
- using a variety of tools and techniques to build an understanding of the factors that give rise to safety issues
- strengthening staff resilience and critical thinking skills so they can detect and anticipate potential problems
- creating an army of safety detectives and problem solvers by fostering curiosity and inquisitiveness

How do we currently answer the question, **"Will care be safe in the future?"**

Anticipation & preparedness safety cloud themes

Anticipation & preparedness

1. Looking at other data sets differently
2. Horizon scanning to proactively identify emerging and future safety risks

Safety cloud theme 1: Looking at other data sets differently

Reflective question

What other data sets might shine a light on the emerging patient and staff safety threats that our team or organization is facing

Background

Anticipation and preparedness can be enhanced when leaders look beyond what is traditionally presented as patient safety data in board and senior leadership reports. All too often, the patient safety data that leaders are presented with focuses on patient harm – but safety is far broader than physical harm.

By looking at data sets not traditionally labeled as patient safety data, senior leaders can proactively identify potential issues before incidents occur. Since these data sets are already routinely reviewed by senior leaders, developing the habit of asking yourself, "What could be the impact on safety?" enables you to build the skill of scanning for and anticipating future safety risks.

This safety theme cloud is asking you to:

Consider how other types of data that you collect in your settings might inform your understanding of future safety risks.

Safety cloud theme 2: Horizon scanning to proactively identify emerging and future safety

Reflective question

How do we, as leaders, ensure that we spend time horizon scanning for emerging and future safety risks to gain insight into whether care will be safe in the future?

Background

Standards, guidelines and regulations for safety are important and necessary. The Measurement and Monitoring of Safety Framework (Health Foundation, 2013) identified that, at times, healthcare organizations have become so focused on meeting standards, guidelines and regulations that they have little bandwidth to think critically, foster the desired safety culture or engage in horizon scanning to proactively identify emerging or future risks to safety.

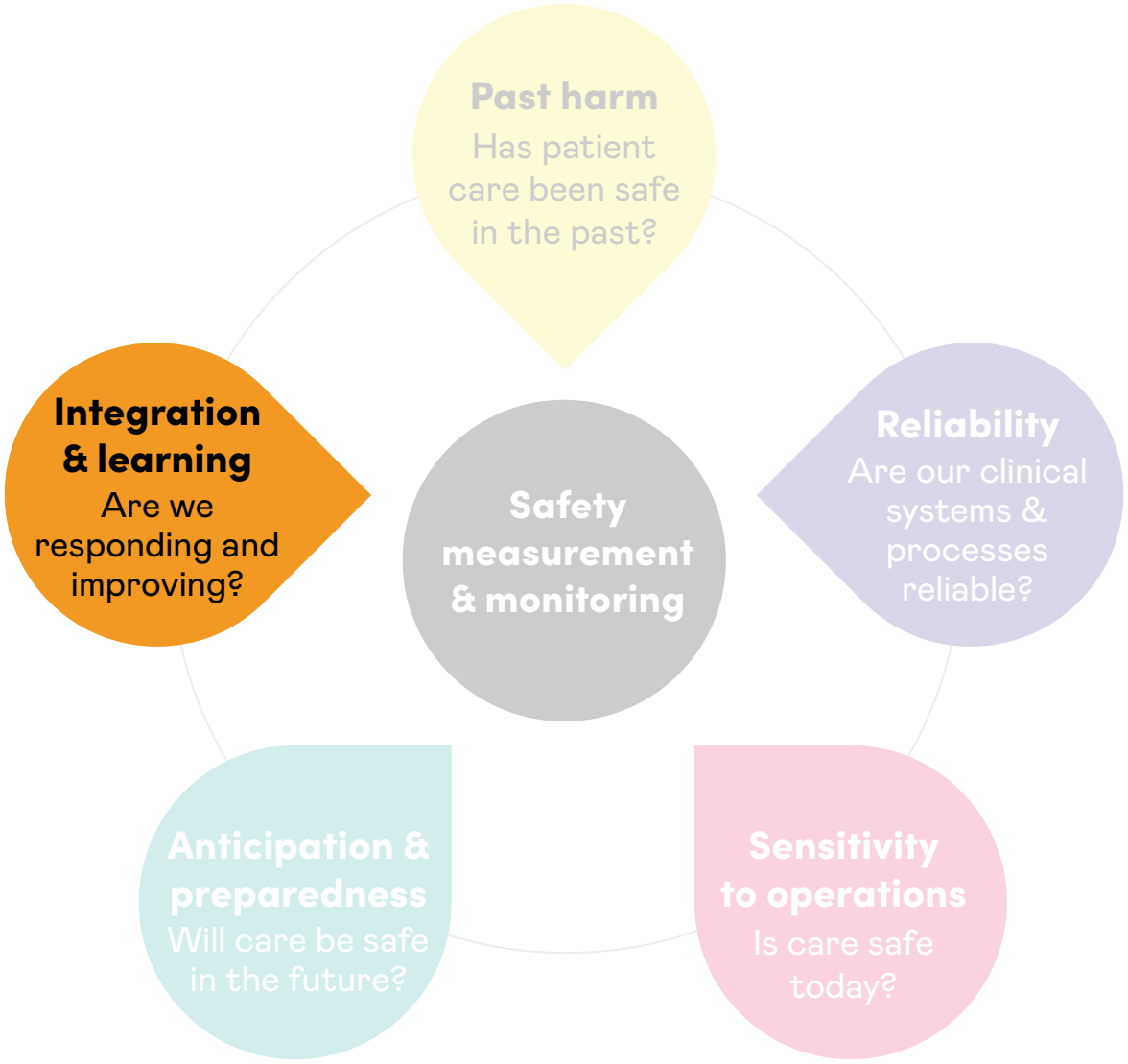
This safety theme cloud is asking you to reflect on what happens in your organization:

How does your organization think critically about patient safety issues, make efforts to create the desired patient safety culture or proactively identify emerging or future risks to safety?

Share how you do or might create capacity to answer the question, **"Will care be safe in the future?"**

Now that you have explored **anticipation & preparedness** and have completed the two anticipation & preparedness safety theme clouds, think and reflect on how you can better answer the question, **"Will care be safe in the future?"**

Integration & learning



Integration & learning asks the question, "**Are we responding and improving**?"

- This domain focuses on developing systems to promote a continuous cycle of learning and sharing – not just from safety incidents, but from multiple sources of safety intelligence across all other domains.
- Integration and learning should serve as the scaffolding that connects and supports the other domains.
- While progress has been made in reporting, responding and learning from harm, true integration and learning requires us to move beyond past harm and proactively improve safety.
- Safe organizations not only report and learn from patient safety incidents, but also actively seek insights from the other domains and respond with inquiry, listening, learning and sharing.
- Organizations need to determine how to gather, integrate and apply patient safety information from multiple sources – and then determine how to use the information to drive meaningful improvement.
- Integration & learning is like weaving together five strands into a strong rope. When all five domains of safety are interwoven, a more resilient and safer system emerges (Figure 5).

Figure 5: The measurement and monitoring of safety framework displayed as a braided rope

How do we currently answer the question, **"Are we responding and improving?"**

Integration & Learning safety cloud themes

Safety cloud theme 1: Knowing how feedback and learning happens

Reflective question

How do we, as leaders, get assurance that what is learned from safety investigations and audits is fed back to point-of-care healthcare teams in a way that supports learning and improvement?

Background

Healthcare organizations often struggle with how to effectively share learning from incident investigations, safety audits, walking rounds and safety culture surveys. The challenges lie in ensuring that feedback reaches the right teams in a meaningful way and that it is shared more broadly across the organization.

Common challenges include:

- simply informing staff of the outcome of an audit or investigation and expecting improvement to occur
- failing to reach hard-to-access groups such as staff who do not access emails or the intranet, staff who work night shifts and staff without a local office)
- sharing findings without context or engagements strategies, such as storytelling or case vignettes, to make the learning more impactful
- limiting feedback to the team involved in an incident without sharing it more broadly across the organization, particularly in areas where similar risks may exist

This safety theme cloud is asking:

What approaches does your organization use to feedback learning to teams?

Reflecting on how learning is fed back, can you identify any gaps in feedback loops or ways to check in with teams to determine if the learning has been understood and if they are supported to implement changes?

Safety cloud theme 2: Preventing integration fog

Reflective question

How might we triangulate and integrate patient safety data in a way that does not make it difficult for senior leaders to understand what the data is telling them?

Background

Healthcare leaders sometimes face an avalanche of patient safety metrics and information – from dashboards and scorecards to board and senior leadership reports and papers. This overload of information – or integration fog – can obscure meaningful insights, making it hard for leaders to interpret and act on safety data in a meaningful way.

Meanwhile, healthcare organizations in many cases continue using outdated safety metrics and approaches when more relevant safety data is available. And when color-coded data (e.g. red, amber, green) draw attention only to high-risk (red) areas, leaders may overlook broader safety trends. Cutting through this fog requires a thoughtful approach to selecting, presenting, discussing and integrating safety data.

This safety theme cloud is asking you to:

Reflect on how your organization's patient safety data is integrated and presented. Have a reflective conversation about how you, as leaders, navigate your safety dashboards and safety reports. Is there integration fog?

If yes, how could the data or reports be presented more clearly?

Now that you have explored **integration & learning**, and have completed the two integration & learning safety theme clouds, think and reflect on how you can better answer the question, "**Are we responding and improving?**"

Your safety journey continues

You've now explored each safety cloud and reflected on the key question it asks:

Past harm – Has care been safe in the past?

Reliability – Are our clinical systems and processes reliable?

Sensitivity to operations – Is care safe today?

Anticipation & preparedness – Will care be safe in the future?

Integration & learning – Are we responding and improving?

Like the braided rope illustrated on page 36, these domains work together to create safer care. Each strand strengthens the others. Your reflections and insights can now become catalysts for meaningful change in your organization.

We encourage you to:

- schedule regular safety discussions with your leadership team
- revisit specific safety clouds or create new safety clouds as challenges and opportunities emerge
- use this workbook to welcome and guide new leaders in your organization's safety journey
- share insights from your safety cloud discussions broadly within your organization
- explore additional safety activities available to support your organization's journey toward Rethinking Patient Safety.

The path to safer care is ongoing. Thank you for your commitment to creating environments where safe, inclusive care can thrive.

Additional Resources

- Rethinking Patient Safety
- The measurement and monitoring of safety
- Measurement and monitoring of safety through the eyes of patients and their care partners
- Effective Governance for Quality and Patient Safety: An eight module, self-directed learning program
- Patient Safety Essentials: A six module, self-directed learning program
- EXTRA™: Executive Training Program

Notes

Notes

Healthcare Excellence Canada (HEC) works with partners to spread innovation, build capability, and catalyze policy change so that everyone in Canada has safe and high-quality healthcare. Through collaboration with patients, caregivers and people working in healthcare, we turn proven innovations into lasting improvements in all dimensions of healthcare excellence. Launched in 2021, HEC brings together the Canadian Patient Safety Institute and Canadian Foundation for Healthcare Improvement. HEC is an independent, not-for-profit charity funded primarily by Health Canada. The views expressed herein do not necessarily represent the views of Health Canada.