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Psychological Safety Implementation Guide

"The single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes."
Lucian Leape, 1994

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Purpose of This Guide

This document is intended for use by facility leaders and trained psychological safety implementation champions.

This guide supports implementation of the principles and decision support tools for psychological safety facilities and will result in:

- Reduction of harm to patients, staff and visitors.
- Increased reporting of incidents and risks in facility reporting systems.
- Processes that ensure consistent and fair responses to events.
- Structures for accountability for choices and actions.

What is Psychological Safety?

Psychological safety in health care is the shared belief that team members can make mistakes without fear of negative consequences, fostering an environment where open communication and collaboration thrive. It is a foundational component of an organization's overall culture of safety. Psychological safety is crucial in health care settings where the stakes are high and effective communication can significantly impact patient outcomes.

Psychological safety supports effective teamwork, enhances patient safety and promotes a culture of continuous learning and improvement. It is vital for creating an environment where health care professionals can thrive and provide the best possible care for their patients.

How Does it Work?

An organization is held accountable for the systems they design. Employees are held accountable for the choices they make.

Organizational Accountability:
In health care, an organization works to improve quality and safety of care delivery systems for patients and improve the environment for those who work in that system. A system is the environment in which organizational processes are performed. It is the combination of and relationship between tasks, processes, people, organizational culture, environmental factors, technology, equipment and resources. Organizations should promote a safe environment by managing systems in consistent and transparent ways.

Employee Accountability:
Leaders and team members recognize that, despite the best of intentions and training, humans are not perfect and people make mistakes. When a mistake is made, it will be reviewed, and the response will be based on choices and behaviors that occurred. This process promotes psychological safety so all staff can speak up with concerns, report errors and risks, ensure they are addressed and prevent them in the future. For leaders, this means understanding how a mistake was made and adapting the system, incentives, trainings and other processes to ensure the mistake does not happen again.

How are Behaviors Categorized and How Will Leaders Respond?

Human error: Inadvertently doing something other than what should have been done; a slip, lapse, mistake. It is a product of the current system design and/or human fallibility.

> → **Response:** Console the employee and share the lessons learned. Leaders manage through changes in processes, procedures, training, design and environment.

Unrecognized risky behavior: Behavioral choice that increases risk, but the risk is not recognized or is mistakenly believed to be justified.

> → **Response:** Coach the employee to recognize the risks in real time, make safer choices and to share lessons learned with the team. Remove incentives for risky behaviors, create incentives for healthy and safe behaviors and increase situational awareness.

Dangerous decision-making: Behavioral choice to consciously disregard a substantial and unjustifiable risk.

> → **Response:** Correct the employee. Leaders manage through individual performance improvement plans or disciplinary action that may include suspension or termination.

Purposefully causing harm: Behavioral choice to intentionally cause harm or damage to another person, place, or thing.

> → **Response:** Disciplinary action. This is rare and very serious behavior. Leaders manage through disciplinary action that may include suspension or termination.

Watch our psychological safety on-demand training videos:

- What is psychological safety?
- How do we respond fairly?

Review the "What is Psychological Safety" one-page overview handout.

Why is Psychological Safety Important?

Experts across many high-consequence, high-risk industries, including health care and emergency response, identified the need to improve the way we manage risk and prevent adverse events. Often, our human nature, biases and societal pressures cause us to act based on assumption and emotion which may lead to unfair action or inaction.

By understanding how systems create conditions that allow errors to occur, redesigning those systems and managing human behavior, we can reduce risks and improve patient safety. High-performing organizations recognize that most errors are due to flawed systems, not individual inattention. Blaming and shaming individuals does not make our systems safer. Rather, blame and shame cover up system weaknesses and errors and allow events to reoccur.

Psychological safety is foundational to safe, high-quality care and ensures people feel able to speak up, ask questions, admit mistakes, and challenge concerns without fear of punishment. Psychological safety encourages reporting while still holding people accountable for their choices and behavior.

Psychological safety:

1) **Protects patients** – When clinicians feel safe to speak up, they are more likely to question unclear orders, flag near-misses and escalate concerns early. That prevents errors from reaching patients and helps teams catch problems before they cause harm.

2) **Enables learning and improvement** – Health care is complex, and mistakes or near-misses are inevitable. Psychological safety allows staff to report incidents honestly and participate in debriefs without fear, which leads to better root-cause analyses and stronger system fixes rather than blame and silence.

3) **Strengthens teamwork** – Care is delivered by interdependent teams. Psychological safety supports clear communication, closed-loop feedback, and respectful challenge across roles and hierarchies (e.g., a nurse questioning a physician when something seems off). That kind of collaboration is critical in high-stakes situations.

4) **Reduces burnout and turnover** – Environments where people feel heard and respected are associated with lower stress and higher engagement. In contrast, fear-based cultures drive moral distress, disengagement and staff leaving, directly affecting continuity and quality of care.

5) **Supports inclusion** – Team members in different roles and from different backgrounds are more likely to contribute ideas and concerns when they feel safe. That diversity of perspective improves clinical decision-making and helps reduce disparities in care.

6) **Aligns with safety and regulatory expectations** – Accrediting bodies and safety frameworks emphasize an organizational culture where individuals are treated fairly and systems are improved.

How to Use this Guide

The steps below support implementation of psychological safety at your organization. For the purposes of this guide, “incident” means any harm event, error, mistake, near miss or “good catch” that has occurred or any identified potential risk that could cause harm to a person, property or equipment within the health care organization.

Steps for Psychological Safety Implementation

1. Ensure Executive and Leadership Commitment

Executive commitment means leadership understands and actively supports the creation of a psychologically safe environment. A safety culture is:

- Built on organizational mission, vision and values.
- Demonstrated by leaders who set the expectations, mindsets and tone.
- Shaped by staff through the workplace environment, social patterns and behaviors.
- Dependent on trust.

An organizational leader:

- Ensures safety is a core value of the organization.
- Allocates resources to support trainings that build staff capacity and empowerment.
- Manages staff, processes and resources in consistent and transparent ways.
- Identifies and mitigates potential risks in an environment.
- Proactively addresses hazards and designs safe systems so staff can make safe choices and report errors or potential risks.
- Evaluates the readiness of the organization and determines the timing and team to support the implementation of policies and processes that support Psychological Safety. (See Appendix A: Psychological Safety Implementation Readiness Checklist)

This may require some introductory training and coaching [see the AIAN QIO facility training materials].

Recommended Actions

1) Pursue commitment and support from the full leadership team. Consider using a signed leadership pledge/covenant (see Appendix B: Sample organizational Psychological Safety Pledges).
2) Develop an implementation plan and timeline and create accountability leaders at all levels for reporting and progress updates.
3) Identify additional team members to be trained as implementation champions (see Step 2. Develop Psychological Safety Implementation Champions).
4) Ensure implementation champions have appropriate resources to lead trainings and implementation efforts.
5) Integrate psychological safety implementation and operational activities into the formal safety program, including allocating budgetary resources as necessary.
6) Communicate and demonstrate psychological safety as a core value. Share personal experiences about psychological safety.
7) Create spaces and opportunities for staff to discuss situations or conditions that could cause harm. Listen actively, document, follow up and recognize and reward staff for speaking up.
8) Use and share data to understand and demonstrate the need for psychological safety and to measure progress, such as incident and risk reporting and staff and customer survey findings on perceptions of safety.
9) Report how psychological safety has been applied and the impact of implementation to the governing body, staff and other partners.

2. Develop Implementation Champions

Designating implementation champions demonstrates commitment to psychological safety and helps staff identify internal experts that can assist. Champions have deep subject matter expertise and have a key role in ensuring progress through the organization's phases of initiation, development, implementation and sustainability.

Recommended Actions

1) Ensure the number of implementation champions within your facility is appropriate for the size of your organization. A minimum of two champions is suggested. Periodically reassess your needs for additional implementation champions.
2) Define the implementation champions' role and responsibilities, including activities such as:
   - Participating in review and revision of facility policies and procedures (see Step 3. Update Policies and Procedures).
   - Leading the development of training plans and materials.
   - Providing ongoing training for leaders, managers and staff.
   - Ensuring psychological safety training is included in new employee orientation.
   - Coaching supervisors and managers in use of decision support aids.
   - Collecting, analyzing and reporting monitoring data (see Steps 5. Operationalize and Document Psychological Safety, 7. Refine Learning System and 8. Measure Progress).

- Communicate and promote implementation progress by sharing stories and data with staff and other partners (see Step 9. Sustained Success).

3) Explore opportunities for continued education, training and networking opportunities to stay current in skills, knowledge and expertise.

Reach out to your AIAN QIO quality improvement advisor about training opportunities for new implementation champions.

3. Update Policies and Procedures

Policies and procedures related to psychological safety support all staff by providing guidance for decision-making, streamlining internal processes and supporting consistency in practice.

Review and revise policies, procedures and plans to incorporate psychological safety principles, expectations and practices (see Appendix C: Recommendations for Policy Changes). Policies and plans to review and revise include:

- Safety, risk and event management policies, procedures and plans (see Appendix D: Sample Incident Reporting Policy and Appendix E: Sample Investigation Tool).
- Human resources (HR) and staff management policies and procedures.
- Quality Assurance and Performance Improvement (QAPI) plan and procedures.
- Incident reporting procedures (including education and promotion of reporting among employees).

4. Train All Managers in Psychological Safety Principles and Appropriate Responses

Training all managers and direct supervisors is imperative to successful psychological safety implementation, as they are most often responsible for applying psychological safety's recommended response to console, coach, correct or discipline staff as appropriate. Managers and supervisors need to have in-depth understanding of psychological safety and well-developed skills to appropriately apply psychological safety principles and tools to specific incidents.

Formal facility leaders have psychological safety accountabilities, including:

- Designing systems and processes that decrease the risk for error.
- Encouraging and supporting employees to make the right choices.
- Responding to incidents, including behavior of employees in a fair, just and timely manner in all cases.

Recommended Actions

1) Provide initial training to all managers, supervisors and facility leaders on psychological safety concepts. Training includes use of a psychological safety decision support tool and review of facility incident reporting systems and response policies and processes. The facility leader-level training should include:
   - Use of example case scenarios to practice psychological safety concepts, promote discussion for application within the organization and demonstrate understanding and competency in appropriate use of the psychological safety decision support tool.

- Peer-to-peer practice, reflection, discussion and coaching for key leadership skills to respond to incidents including consoling, coaching, facilitating difficult conversations and more.
- Consider using a quiz or some method of proof of understanding and competency.

2) Provide annual or biennial training and ongoing coaching for facility leaders.
   - Create an implementation monitoring plan to evaluate and coach facility leaders' application of psychological safety (see Steps 7. Refine Learning System and 8. Measure Progress).
   - Consider embedding psychological safety discussion and debriefs into leadership meetings (see Step 7. Refine Learning System).

5. Operationalize and Document the Use of a Psychological Safety Decision Support Tool

An important component to implementing any new system is making sure a standardized process is in place so all team members can understand their responsibilities and have access to needed tools for success. For psychological safety, this means making resources readily and easily accessible when they are needed and having a designated process and place to record outcomes from incident investigation, when a psychological safety decision support tool was used, how behavioral causes were categorized, what response was recommended and any system and process improvements implemented.

Recommended Actions

1) Ensure all managers/supervisors and facility leaders have access to a psychological safety decision support tool.

2) Define where and how use of a psychological safety decision support tool will be documented when used in the incident review and response process.

   Include checkbox(es), field(s) or standard statement in free-text sections of the incident reporting system. For example: "Utilized the psychological safety decision support tool and found that [human error, unrecognized risky behavior, dangerous decision-making and/or purposefully causing harm] contributed to this error."

Consider these additional publicly accessible decision support tools:

- **Veterans Health Administration Version**
- **National Health Service (Press Ganey Version)**
- **Appendix F: Decision Support Tool**

6. Train All Employees

All employees, including leadership, should know a culture of safety and psychological safety are a core value and expectation, understand the basic concepts and language of psychological safety and how it will be implemented and monitored in the facility and recognize facility leaders are committed to psychological safety. All staff-level training can be provided by implementation champions or by managers, supervisors and other facility leaders.

Recommended Actions

1) Educate all employees on psychological safety basic principles and processes upon implementation and plan for ongoing annual refresher training.

   - All employees understand psychological safety is based on a foundation of shared accountability. The same rules and expectations apply to all employees, including leaders. There is no favoritism or differences in response based on position or role.

   - All employees are accountable for their own choices and behavior, including:
     - Employees know what behavior is expected of them.
     - Employees are responsible for reporting errors and potential errors.
     - Employees are responsible for following policies and procedures or suggesting revisions for policies and procedures as needed.

2) Ensure psychological safety training is included in new employee orientation.

3) Consider providing psychological safety training to non-permanent employees, including contracted and locum staff, temporary staff, students, volunteers and any others that work in your facility on a regular basis.

4) Empower all medical staff and personnel to immediately intervene whenever they feel the need to protect the patient from harm and prevent a medical accident without fear of retribution.

Adopt or adapt the AIAN QIO All Staff Training slide deck.

7. Refine Learning System

As with any change, lessons learned from going through the process of implementation are valuable. Successful implementation of psychological safety requires continuous learning and improvement. No one can expect to leave a training session feeling completely confident and comfortable with the concepts or tools of psychological safety. It will take time and energy to reach the long-term goal of psychological safety and a strong culture of safety.

Refining the learning system starts with emphasizing the fact that ALL incidents are an opportunity to learn something new. It is imperative that leaders normalize speaking openly and honestly about incidents and risks and encourage reflection about why it happened, what the impact was (or could have been) and what could be changed to prevent it from happening again. The learning system starts with reporting all incidents and risks, thoroughly reviewing those reports and following through on recommended improvement actions.

There are many ways to reinforce learning, including:

1) Continuous support and encouragement and modeling of psychological safety by leadership.

2) Manager/supervisor-to-employee coaching and modeling of psychological safety.

3) Team collaboration and peer-to-peer coaching and modeling of psychological safety.

4) Empower patients and families to immediately intervene whenever they feel the need to protect the patient from harm and prevent a medical accident without fear of retribution.
   - Posters and handouts (e.g. Joint Commission's Speak Up program).
   - Websites, QR codes or paper forms for reporting incidents.

Recommended Actions

1) Discuss scenarios and conduct simulation of working through a psychological safety decision support tool.
2) Share stories to bring psychological safety concepts to life.
3) Use measurement and case review to track and show progress.
4) Celebrate success! This is an important piece that is often overlooked, make the experience of learning fun.

8. Measure Progress

The implementation of psychological safety should be measured and monitored and built into the facility's Quality Assurance and Performance Improvement (QAPI) program (refer to the AIAN QIO QAPI Basics on-demand training series, which include several short, concept-specific videos). Patient safety and psychological safety implementation data should be reviewed, analyzed and discussed regularly to ensure continuous improvement towards successful culture change.

Recommended Actions

1) Determine what data sources and metrics will be used to measure the implementation and impact of psychological safety. Determine a baseline. Consider the following:

   - Number of incidents reported through your incident reporting system. Upon implementation, the number of incidents reported should increase. Consider stratifying your incident reporting data in several ways such as by department, reporter, by day of the week, time of day, etc., to identify strengths and improvement opportunities in reporting patterns.
   - Number of reported incidents that have documented evidence of the use of a psychological safety decision support tool (see section 5 above).
   - Percent of accuracy as assessed through retrospective case review of incidents to evaluate appropriate application of a psychological safety decision support tool and the status of follow-through on the recommended response actions.
   - Employee culture of safety survey to evaluate progress over time, such as:
     - Agency of Healthcare Research and Quality (AHRQ) Surveys on Patient Safety Culture (SOPS)
     - The Psychological Safety Company Organizational Benchmark Survey (note: there is a significant cost associated with this proprietary survey.)
     - Improvement of employee satisfaction/experience survey results (e.g., federal employee viewpoint survey [FEVS])
   - Consider a behavior-based measure of effectiveness of coaching, such as the ratio or percentage of events reported that are related to at-risk behaviors versus human error. The goal is to see a decrease in at-risk behaviors.

- Consider an employee self-reported participation in safety efforts measurement. To gather data, ask employees through survey or interview if, in the past six to 12 months, they shared information about safety risks or a mistake, identified a close call or near miss, shared ideas for improvement or participated in teams to plan and implement process improvements.
- Employee retention rates evaluated over time. Consider including exit interview or survey data to identify themes.

2) Collect and analyze data and identify opportunities for continued improvement.
3) Prioritize and implement specific improvement projects in response to this data.
4) Share results with staff, patients and community partners.
5) Celebrate progress!

9. Sustained Success

AHRQ provides these recommendations for developing and sustaining psychological safety and a strong culture of safety.

- Conduct regularly scheduled walk-arounds (leadership rounding) to learn about staff concerns regarding patient safety; include all shifts.
- Conduct monthly staff meetings and include a focus on patient safety.
- Implement transparent and biweekly/daily safety-focused “huddles.”
- Educate hospital leaders about making error reporting anonymous, easy, convenient and non-punitive.
- Set up a hotline for reporting errors and develop anonymous reporting forms.
- Involve staff directly in the problem-solving process.

Summary

Psychological safety means health care professionals feel safe and empowered to speak up and are held accountable for their choices and actions, not punished for human mistakes or for reporting errors and system vulnerabilities. Errors are identified and mitigated before harm occurs, and systems are in place to enable staff to learn from errors and near misses and prevent recurrence. Leaders are held accountable for the systems they have designed and for responding to the behaviors of staff members in a fair and just manner.

For more information, please contact your AIAN QIO quality improvement advisor or contact the AIAN QIO team at ContactUs@aianqio.org.

Appendices

Appendix A: Psychological Safety Implementation Readiness Checklist

For sections A through D, check the box if the corresponding statement is true for your organization. Each checked box earns one point. Tally the number of points in each section and indicate the section's total.

DATE:

COMPLETED BY:

A. Leadership Signals and Environment

☐ Leaders consistently encourage questions and input from staff.
☐ Leaders respond to concerns without blame or defensiveness.
☐ There is visible support for learning from mistakes.
☐ Leaders model openness (e.g., admitting uncertainty, asking for feedback).

Total: _____

B. Staff Comfort and Engagement

☐ Staff feel comfortable speaking up about concerns or errors.
☐ Staff are willing to ask questions during training.
☐ Staff believe their input will be taken seriously.
☐ There is no known fear of punishment tied to participation or mistakes.

Total: _____

C. Training Design and Facilitation

☐ Training includes opportunities for discussion and questions.
☐ Facilitators are prepared to respond neutrally and constructively.
☐ Scenarios/examples avoid blame-focused framing.
☐ Language used reinforces learning and improvement (not fault-finding).

Total: _____

D. Process and Workflow Clarity

☐ Expectations for the new process are clear and realistic.
☐ Staff understand that errors will be used as learning opportunities.
☐ There is clarity on how concerns/issues should be raised.
☐ Feedback loops are built into the implementation plan.

Total: _____

E. Risk Factors

For this section, check the box if the corresponding issue has a realistic potential to undermine your organization's psychological safety. Tally the number of boxes checked for your total for section E.

☐ Recent disciplinary actions or investigations impacting staff trust

☐ High turnover or staffing instability

☐ History of poor follow-through on staff concerns

☐ Competing priorities limiting engagement

☐ Limited leadership presence or visibility

☐ Other: _____

Total: _____

Add up the totals from sections A through D and then subtract the total from section E for the organization's final readiness score.

Overall Readiness Rating

☐ High Readiness (16-11) – Environment supports open participation and learning.

☐ Moderate Readiness (10-6) – Some gaps may impact engagement; mitigation needed.

☐ Low Readiness (5-0) – Significant barriers to psychological safety present.

Appendix B: Sample Organizational Psychological Safety Pledges

Leader Pledge: Commitment to Psychological Safety

"I commit to fostering a psychologically safe environment where every team member feels respected, heard and empowered to speak up in the interest of safety and quality.

I will:

- Invite questions, concerns and differing perspectives and then respond with openness and respect.
- Act promptly on safety concerns and close the loop with those who raise them.
- Respond fairly to choices and behaviors that contributed to incidents.
- Avoid blame and focus on learning, system improvement and prevention.
- Model transparency by acknowledging my own mistakes and encouraging others to do the same.
- Ensure all team members believe they can report concerns without fear of retaliation.
- Support teamwork, inclusion, and mutual accountability across all roles.

I understand that psychological safety is essential to safe, high-quality care, and I will hold myself accountable for creating and sustaining it every day."

Staff Pledge: Commitment to Psychological Safety

"I commit to contributing to a psychologically safe environment that prioritizes patient safety, respect and continuous learning.

I will:

- Speak up and report about concerns, risks and errors, even when it feels difficult.
- Ask questions and seek clarification to ensure safe and effective care.
- Treat colleagues with respect and listen to diverse perspectives.
- Participate in learning from errors and near-misses without blame.
- Support coworkers who raise concerns and reinforce a culture of safety.
- Take responsibility for my actions and follow established safety practices.

I understand that my voice matters, and I will use it to help protect our patients, our team and our organization."

Appendix C: Recommendations For Policy Changes

General recommendations:

1) Focus policies on the behavioral choices of managers and staff, with less emphasis on errors and their undesired outcomes. The objective is to evolve to a system that is proactive toward risk and behavioral choices rather than reactive toward errors and outcomes.
2) Ensure policies and actions implemented are all related to the risk associated with the identified choices and behavior, not the outcome of the event.
3) Remove any policy references to negligent or careless conduct as a basis for disciplinary action to reduce confusion. The term "negligent" has a social meaning that is out of place in psychological safety.
4) Ensure managers have the skills to comply with the policy language (e.g., console, coach, correct and discipline).

Sample Policy Revisions to Support Psychological Safety

1. Incorporate psychological safety into the organization's core safety policy.

Recommended Addition
Include language that explicitly states psychological safety is essential to patient safety, workforce well-being and organizational learning.

Sample Language
"Our organization is committed to maintaining a psychologically safe environment where all individuals are empowered to speak up about concerns, errors, risks, questions and ideas without fear of intimidation, humiliation, retaliation or punitive response."

2. Revise event reporting and response policies.

Key Revisions
- Emphasize learning and system improvement over blame.
- Clearly define:
  - Human error
  - Unrecognized risky behavior
  - Dangerous decision-making
  - Purposefully causing harm
- Protect individuals who report concerns.
- Require leadership follow-up and feedback after reports are submitted.

Recommended Policy Elements
- Non-retaliation protections
- Anonymous reporting options
- Timelines for leadership response
- Expectations for transparent communication during investigations

Sample Language
"Employees who report safety concerns, near-misses or errors in good faith will be protected from retaliation. Reports will be reviewed objectively and used to support organizational learning and risk reduction."

3. Strengthen workplace conduct and professional behavior policies.

Key Revisions

Expand policies beyond harassment and discrimination to address behaviors that undermine psychological safety, including:

- Intimidation
- Bullying
- Dismissive communication
- Public shaming
- Retaliation for speaking up
- Abuse of authority
- Disruptive behaviors that suppress communication

Recommended Addition
Require respectful communication across all disciplines and hierarchies.

Sample Language
"Behaviors that discourage individuals from raising concerns or participating in open communication are inconsistent with organizational expectations and may result in corrective action."

4. Add "speak up for safety" expectations.

Recommended Policy
Create formal expectations that all staff:

- Stop or question unsafe practices
- Escalate concerns when needed
- Participate in safety huddles and debriefs
- Support peers who raise concerns

Include:

- Chain of escalation
- Protection from retaliation
- Leadership accountability for response

Sample Language
"All workforce members share responsibility for patient and workplace safety and are expected to raise concerns when unsafe conditions or behaviors are observed."

5. Revise leadership accountability policies.

Recommended Additions
Leaders should be explicitly accountable for creating psychologically safe environments.

Include Expectations Such As:

- Encouraging open dialogue
- Responding respectfully to concerns
- Conducting learning-focused debriefs
- Addressing retaliation immediately
- Modeling transparency and accountability

Performance Integration
Tie psychological safety behaviors into:

- Leadership evaluations
- Annual competencies

- Employee engagement goals
- Quality and safety metrics

6. Update investigation and corrective action procedures.

Recommended Revisions
Ensure investigations:

- Focus on facts and systems
- Avoid premature blame
- Include multidisciplinary perspectives
- Categorize any contributing choices or behavior
- Maintain confidentiality when appropriate

Include Guidance On:

- Trauma-informed response after adverse events
- Supporting involved staff ("second victims")
- Communication expectations during investigations

7. Formalize debriefing and learning processes.

Recommended Policy Components
Require structured debriefs after:

- Adverse events
- Near-misses
- Sentinel events
- Workplace violence incidents
- High-risk clinical situations

8. Add anti-retaliation language across multiple policies.

Recommended Revision
Embed anti-retaliation protections into:

- HR policies
- Compliance policies
- Safety reporting procedures
- Ethics policies
- Workplace conduct standards

Sample Language
"Retaliation against individuals who raise concerns, report events, participate in investigations or question unsafe practices in good faith is strictly prohibited."

Appendix D: Sample Incident Reporting Policy

Note: RED TEXT indicates facility decisions and customization.

Policy/Procedure Number	
Policy/Procedure Name	**Incident Reporting**
Type of Policy/Procedure	**Facility Wide**
Date Approved	
Date Due for Review	
Policy/Procedure Description	

Purpose:

The purpose of this policy and procedures is to define incidents, when and how to report them using ["THE INCIDENT REPORTING SYSTEM" OR NAME OF SYSTEM] and to describe how to document the investigation and corrective action(s) taken to mitigate and prevent harm, reduce the risk errors and improve safety.

Definitions:

1) **Incident:** An event or situation that has caused or could cause harm to individual(s), property, facility or grounds.

2) **Near Miss:** An event or situation that would have resulted in an accident, injury or harm but did not, either by chance or through timely intervention; a close call.

Policy:

1) All incidents, which include adverse events, near misses and areas of risk, will be reported by staff using ["THE INCIDENT REPORTING SYSTEM" OR NAME OF SYSTEM] upon occurrence or identification (recommended within 24 hours).

2) Incidents that occur within the facility or grounds that must be reported include but are not limited to:
   - Physical or psychological harm to patients, visitors or staff
   - Occupational illnesses or staff injuries
   - Errors or near misses that have caused or could cause injury or harm to individual(s), property, facility or grounds, including but not limited to:
     - Medical errors
     - Medication errors
     - Adverse drug reactions
   - Processes, systems or equipment that have caused or could cause injury or harm to individual(s), property, facility or grounds
   - Staff behavior that has or could cause injury or harm to individual(s), property, facility or grounds
   - Hazardous conditions that have caused or could cause injury or harm to individual(s), property, facility or grounds
   - Security or safety threats or risks to individual(s), property, facility or grounds
   - Property damage to any equipment, supplies, facility, grounds or vehicles

3) All staff have the responsibility to report and/or ensure reporting of incidents in which he/she is involved, that he/she has witnessed or observed or that has been verbally reported to

him/her. **NOTE: If an individual is unable to enter the incident into** ["THE INCIDENT REPORTING SYSTEM" OR NAME OF SYSTEM] **before the end of shift, he/she must alert the manager or supervisor on duty and request assistance.**

- If it is found that individual(s) intentionally refused to report an incident or hindered an incident investigation, the individual(s) will be coached or disciplined by his/her supervisor(s) as appropriate.

4) Incident reports may be filed individually or collaboratively. Duplicate reports of the same incident will be reviewed and closed together.

5) All review, investigation and corrective action information will be documented electronically with the incident in ["THE INCIDENT REPORTING SYSTEM" OR NAME OF SYSTEM].

6) Each incident will be opened and reviewed as soon as possible and no later than two business days of the initial report.

7) Incidents will be closed within 30 days of the initial report unless incident requires additional and/or external review and follow-up (e.g., exposures, worker's comp).

8) Incident data will also be reviewed in aggregate to determine if there are patterns in type, location, time of day, cause, etc. System and process improvements will be made as appropriate.

9) If an incident involves harm to a patient, the facts of the incident related to the patient's condition and care will be documented in the patient's medical record. However, the incident report, investigation and/or corrective actions will not be referred to in the patient's medical record.

Procedures:

Reporting an Incident:

1) Ensure all individual(s) involved are safe, and emergent or urgent care is provided.
   - If the incident involves harm to a patient, staff will notify the patient's provider as soon as possible.

2) Staff member(s) aware of the incident will submit an online ["THE INCIDENT REPORTING SYSTEM" OR NAME OF SYSTEM] report upon occurrence or identification of an incident or before the end of shift. **NOTE: If an individual is unable to enter the incident into** ["THE INCIDENT REPORTING SYSTEM" OR NAME OF SYSTEM] **before the end of shift, he/she must alert the manager or supervisor on duty and request assistance.**
   - If an individual needs assistance using ["THE INCIDENT REPORTING SYSTEM" OR NAME OF SYSTEM], he/she can contact his/her supervisor, the safety officer, quality manager/coordinator or another staff member.
   - If ["THE INCIDENT REPORTING SYSTEM" OR NAME OF SYSTEM] is unavailable due to computer, intranet or software problems, incidents will be reported using the ["THE INCIDENT REPORTING SYSTEM" OR NAME OF SYSTEM] downtime form (add as appendix). The completed paper form will be submitted directly to the safety officer or designee.
   - Steps to report via ["THE INCIDENT REPORTING SYSTEM" OR NAME OF SYSTEM]: See application and training supports housed on the IHS intranet at http://home.ihs.gov/the incident reporting system/

3) Staff member(s) aware of the incident will also report the incident to their direct manager and/or supervisor, including confirmation they have submitted the incident electronically or they have asked another staff member for submission assistance.

4) Externally reportable events (include links and instructions for any required externally reportable events):

   - State
   - Federal
   - The Joint Commission (TJC)
   - Other

Reviewing and Investigating an Incident:

1) Upon receipt of an incident report, the safety officer or designated ["THE INCIDENT REPORTING SYSTEM" OR NAME OF SYSTEM] administrative user will:
   - Change the incident's pending status to open status.
   - Send the submitter confirmation that the report was received (via email or ["THE INCIDENT REPORTING SYSTEM" OR NAME OF SYSTEM] message/notification).
   - Determine which department(s) are involved with the occurrence of the incident.
   - Notify each involved department's manager and/or supervisor of the incident.
   - If incident caused harm to one or more individuals, categorize the incident using the defined harm categories (see ["THE INCIDENT REPORTING SYSTEM" OR NAME OF SYSTEM] training materials for more details and definitions).
   - Designate an investigation lead.
     - The investigation lead should be a representative of the department or role primarily involved in the incident.
     - The investigation lead may be a department leader or frontline staff member.

2) Upon receipt of an incident report, the investigation lead will:
   - Determine if incident requires an investigation.
     - If yes, proceed to 2b and the investigation procedure.
     - If no, the investigation lead will submit a statement and rationale to safety officer that the incident does not require investigation. Procedure ends here.
   - Coordinate with the involved department(s) to form an investigation team.
     - Each department involved should have at least one representative member of the investigation team.
     - Team members may be department leaders or frontline staff.
   - Facilitate an initial meeting to assign roles, tasks and deadlines to each team member.

3) The investigation team will:
   - Initiate an investigation by:
     - Interviewing the staff member(s) involved in the incident to obtain the subjective standard perspective by asking:
       - What happened?
       - What normally happens?
       - What does the policy/procedure require (if applicable)?
     - Interviewing other staff not involved in the incident to obtain the objective standard perspective by asking:
       - What normally happens in this type of situation?
     - Reviewing all pertinent policies and procedures related to the incident.

- Determine the cause(s) of the incident, including any human behaviors (human error, at-risk behavior and/or reckless behavior) that contributed to the incident.
- Plan corrective actions to address the cause(s), address human behaviors and to mitigate harm caused by the occurrence of the incident.
- Provide documentation of the investigation and corrective action plan to the safety officer or designee within 14 business days of the incident report.
- Implement and monitor the corrective action plan.
- Report corrective action plan progress and data to the safety officer or safety committee and/or executive leadership team on a regular basis until the corrective action plan is complete.

Closing an Incident:

1) The safety officer or designated ["THE INCIDENT REPORTING SYSTEM" OR NAME OF SYSTEM] administrative user will:
   - Ensure all investigation and corrective action plan documentation is entered into ["THE INCIDENT REPORTING SYSTEM" OR NAME OF SYSTEM]
     - Include the statement, "Utilized the psychological safety decision support tool and found that [human error, at-risk behavior and/or reckless behavior – OR – no staff behavior] contributed to this error."
   - Close the incident in ["THE INCIDENT REPORTING SYSTEM" OR NAME OF SYSTEM] when (NOTE: The incident may be re-opened at any time if new information needs to be included in the incident documentation):
     - Incident investigation is complete and documented.
     - Incident corrective action plans have been submitted.

Managing ["THE INCIDENT REPORTING SYSTEM" OR NAME OF SYSTEM]:

1) The safety officer or designated ["THE INCIDENT REPORTING SYSTEM" OR NAME OF SYSTEM] administrative user will:
   - At least monthly, review and aggregate data to identify trends.
   - Create data reports.
     - Weekly/monthly ELT report
     - Data/info report to all-staff
     - Quarterly report to governing board
   - At least quarterly, review and update ["THE INCIDENT REPORTING SYSTEM" OR NAME OF SYSTEM] user access information.
   - Regularly communicate incident data, follow-up, improvements made and accomplishments to all-staff.

Related Documents (list and link any related plans, policies, procedures or other documents that support this document):

- Safety Plan
- Quality Plan
- IHS Headquarters or Area Office Policy
- THE INCIDENT REPORTING SYSTEM Downtime Form
- Root Cause Analysis (RCA) Form
- Other

References (list and link any sources referred to within or in creation of this document):

- Regulations
- Accreditation Standards
- Other

Approved By:	Date(s):

Appendix E: Sample Investigation Tool

Incident Investigation Tool

What happened?

According to person(s) that reported the incident:	According to others who were present (if applicable):

What normally happens?

According to person(s) involved:	According to others in the department and/or similar role:

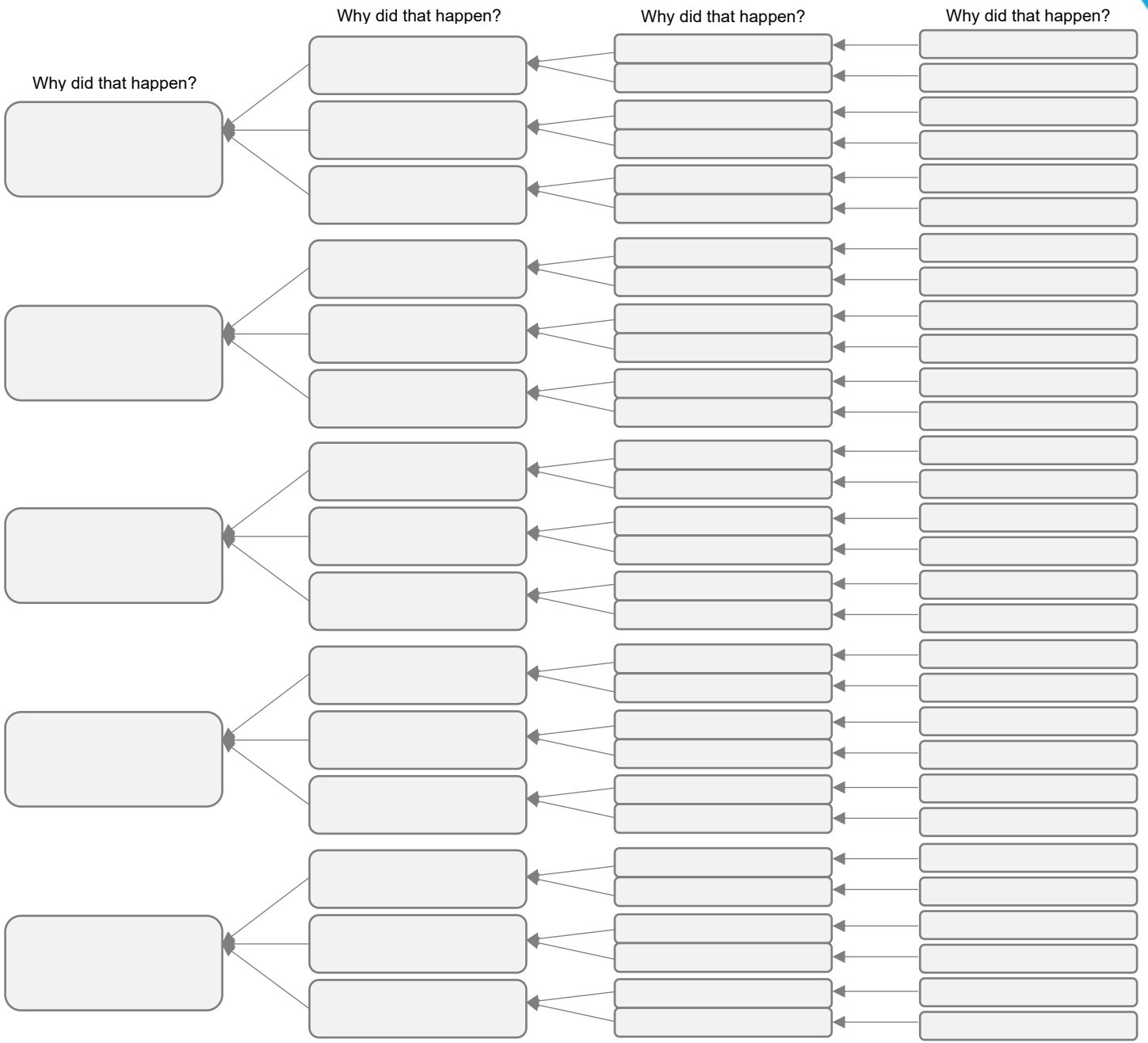
What does the procedure require?

Why did it happen?

NOTE: Not all boxes must be filled in but try to fill in as many as possible. If more space is needed, please include additional diagrams/notes as an attachment

Contributing factors may include but are not limited to human factors, situational factors, technology, equipment, supplies, physical environment, information, communication or policies and procedures.

What happened?



What did/do we have in place to prevent this from happening?

Action Plan:

What we will change:	By when:	How we will measure/monitor this change:	Who is responsible for this change:	Date completed:

Appendix F: Decision Support Tool

Categorizing Choices and Behavior

	Did they choose the behavior?	Did they recognize the risk?	Did they know someone would be harmed?	Appropriate Response
Human Error	No	NA	NA	Console
Unrecognized Risky Behavior	Yes	No	No	Coach
Dangerous Decision-Making	Yes	Yes	No	Correct
Purposefully Causing Harm	Yes	Yes	Yes	Disciplinary Action

Appendix G: Psychological Safety Case Scenario Answer Guide

Case Study	Did they choose they behavior?	Did they recognize the risk?	Did they know someone would be harmed?	Behavior	Appropriate Response
#1 – Chris, LPN, and vaccine storage temperature out of range	Yes – Chris noted the temp error and decided to continue using the vaccine.	Yes – Chris was aware of the policy due to recent review.	No – Chris thought they were "probably still fine."	Dangerous decision-making	Correct – Consider system-level solutions such as automated alerts for temps out of range.
#2 – Riley, RN, and critical lab result in wrong patient chart	No – Riley made an error because they were trying to multitask with several patient charts open at once.	NA	NA	Human error	Console – Revise policies and procedures to prevent the same mistake in the future.
#3 - Marcus and bleach-based cleaner on equipment screen	Yes - Marcus made a good choice in taking responsibility for helping clean the equipment.	Yes – Marcus said he remembered that there ARE different rules but didn't remember what they are or look them up before acting.	No – Marcus did not recognize that the incorrect cleaning solution would damage or destroy the equipment.	Dangerous decision-making	Correct – Consider system-level solutions such as color-coding bottles and labeling or adding visual cues to equipment with the approved cleaning products that can be used.

#4 – Nurse Yellow and Mr. Grey's inpatient fall with major injury	Yes – Nurse Yellow admitted that they didn't do the one-hour safety check as is common for late-night transfers.	No – Nurse Yellow assumed the bed alarm and fall safety measures carried over to the new room.	No – Nurse Yellow wasn't aware that his fall risk was so high due to missing information on the handoff form and incomplete messaging during the handoff process.	Unrecognized risky behavior	Coach – Implement process improvements identified in the review process such as updating the handoff form to include critical safety information.
#5 – Dr. Thompson and high potassium lab result	Yes – Dr. Thompson assumed this was a lab error and instructed the nurse not to intervene.	No - Dr. Thompson assumed this was a lab error and did not validate the initial result.	No – Dr. Thompson assumed the patient would be okay until morning rounds.	Unrecognized risky behavior	Coach – Consider escalating this case to clinical leaders for FPPE review; suggest further investigation around the finding that staff report a previous pattern of ignoring critical labs when it is busy to determine if this is repetitive behavior.

Appendix H: Case Scenarios

Scenario 1

Chris, a licensed practical nurse (LPN), is responsible for preparing and administering vaccines during afternoon clinic hours. The clinic follows strict protocols for vaccine storage and temperature monitoring to ensure vaccine effectiveness.

One afternoon, Chris notices that the vaccine refrigerator temperature log shows the temperature briefly exceeded the safe range earlier that morning. Clinic policy requires that any potentially compromised vaccines be quarantined and not administered until reviewed by the clinic manager or pharmacy department.

Chris is aware of this policy because the clinic reviewed it during a staff meeting two months earlier after a similar incident occurred.

However, the clinic is running behind schedule and several children are waiting for immunizations required for school enrollment. Chris decides to continue using the vaccines from the refrigerator without reporting the temperature excursion, assuming the vaccines are “probably still fine” and wanting to avoid delaying the clinic.

Later that week, the clinic manager reviews the temperature logs during a routine audit and notices the out-of-range reading. When questioned, Chris confirms they were aware of the temperature excursion but chose not to report it and to continue administering the vaccines.

During the investigation, the following details emerge:

- Vaccines administered during the several days following the out-of-range temperature recording may have been compromised.
- Several affected families were identified and must be contacted to potentially repeat the immunizations.

	Did they choose the behavior?	Did they recognize the risk?	Did they know someone would be harmed?	Appropriate Response
Human Error	No	NA	NA	Console
Unrecognized Risky Behavior	Yes	No	No	Coach
Dangerous Decision-Making	Yes	Yes	No	Correct
Purposefully Causing Harm	Yes	Yes	Yes	Disciplinary Action

Scenario 2

Riley, a registered nurse, is responsible for reviewing morning lab results and preparing them for the attending physician's review. One patient, Ms. Orange, had a CT scan scheduled to rule out appendicitis the night before.

Riley receives a lab report showing elevated white blood cell count, which is significant for the patient's current abdominal pain. The lab result is critical and needs to be highlighted for the physician.

Riley intends to attach the result to the patient's chart for the morning physician review. However, while updating multiple patient charts at once, Riley accidentally attaches Ms. Orange's lab results to another patient's chart. The physician reviews the other patient's chart and does not see the critical lab value.

By the next shift, the error is caught when another nurse notices the misplaced report. Ms. Orange experiences increased pain overnight, but no permanent harm occurs because she is promptly evaluated the following morning.

During the investigation, the following details emerge:

- Riley intended to follow correct procedure and had previously completed the task correctly.
- The hospital's electronic health record system allows multiple open patient charts simultaneously, increasing the chance for selection errors.
- Staffing and workload were normal, but Riley was managing several charts and patients at once.
- Riley had recent training on charting procedures.

	Did they choose the behavior?	Did they recognize the risk?	Did they know someone would be harmed?	Appropriate Response
Human Error	No	NA	NA	Console
Unrecognized Risky Behavior	Yes	No	No	Coach
Dangerous Decision-Making	Yes	Yes	No	Correct
Purposefully Causing Harm	Yes	Yes	Yes	Disciplinary Action

Scenario 3

Marcus is a patient care technician on a busy medical floor. After helping a patient, he notices a portable vital signs machine has visible smudges and what looks like dried blood on the screen and casing. Wanting to keep the equipment clean and ready for the next patient, Marcus grabs a spray bottle from the supply cart nearby and wipes down the entire machine, including the screen.

The spray bottle contained a strong, bleach-based cleaner intended for hard surfaces like countertops and bed rails, not for sensitive electronics. Within a day, the screen stops working, and the machine has to be pulled from use. When the biomedical team inspects it, they find the internal screen coating has been destroyed by the chemical. The machine, which costs more than $8,000, cannot be repaired and has to be replaced.

No patients were harmed, but the unit is now short one vital signs machine during a busy period, requiring staff to share equipment across the floor.

During the investigation, the following details emerge:

- The hospital has a policy that lists approved cleaners for each type of equipment. The vital signs machine requires a specific, low-alcohol wipe.
- The supply cart where Marcus found the spray bottle holds several different cleaning products stored side by side. The bottles are similar in size and color. The cart does not have any labels indicating which products are safe for which surfaces.
- Marcus said he remembered different cleaners have different rules but did not remember what those rules are and did not look them up before acting. He received general cleaning training during his orientation two years ago.
- Several other staff members on the unit said they are also unsure which cleaner to use on the vital signs machines and have used different products at different times without knowing it was a concern.

	Did they choose the behavior?	Did they recognize the risk?	Did they know someone would be harmed?	Appropriate Response
Human Error	No	NA	NA	Console
Unrecognized Risky Behavior	Yes	No	No	Coach
Dangerous Decision-Making	Yes	Yes	No	Correct
Purposefully Causing Harm	Yes	Yes	Yes	Disciplinary Action

Scenario 4

Mr. Grey is a 78-year-old patient admitted to the hospital with an infection. His chart shows that he has fallen before, has trouble feeling his feet and sometimes gets confused. Because of these risks, he must always have special fall safety steps in place.

In the middle of the night, Mr. Grey is moved to a different room on a different floor. The nurse who receives him, Nurse Yellow, gets him settled but does not complete the safety check the hospital requires any time a patient is moved to a new unit. This check ensures fall prevention steps are still in place in the new room. The bed alarm that should alert staff if Mr. Grey gets up was never turned on in the new room.

A few hours later, Mr. Grey gets up on his own to use the restroom. He falls and breaks his hip.

During the investigation, the following details emerge:

- The hospital requires that a fall risk check must be done within one hour any time a patient moves to a new unit. The computer system showed a reminder for this check when Mr. Grey arrived, but Nurse Yellow closed the reminder without completing it.
- Nurse Yellow was caring for two other patients who were also being moved to their floor at the same time. They did not realize the bed alarm and fall safety items had not carried over.
- The nurse who sent Mr. Grey from the other floor did not mention his fall precautions during handoff. The handoff form staff use does not have a section for listing active safety measures like bed alarms.
- Staff on the receiving floor said that late-night transfers happen often and the one-hour safety check is frequently missed. No one flagged this issue before Mr. Grey's fall.
- Nurse Yellow has no prior safety incidents. They reported the missed check themself right after the fall.

	Did they choose the behavior?	Did they recognize the risk?	Did they know someone would be harmed?	Appropriate Response
Human Error	No	NA	NA	Console
Unrecognized Risky Behavior	Yes	No	No	Coach
Dangerous Decision-Making	Yes	Yes	No	Correct
Purposefully Causing Harm	Yes	Yes	Yes	Disciplinary Action

Scenario 5

Dr. Thompson is covering several patients overnight. One patient, Mr. Green, has a history of chronic kidney disease and is admitted for heart failure exacerbation.

During the evening, the lab system reports that Mr. Green's potassium level is 7.0 mmol/L, which is critically high and requires immediate action including cardiac monitoring and treatment to lower potassium. Dr. Thompson receives the alert via the electronic health record system and a nurse calls to report the critical value.

Dr. Thompson glances at the lab value, comments “it’s probably a lab error” and instructs the nurse to hold off on notification and treatment until morning rounds.

Over the next two hours, the patient develops ventricular arrhythmias. The rapid response team is called and Mr. Green is stabilized, but he suffers a cardiac arrest with significant hypoxic injury.

During the investigation, the following details emerge:

- Hospital policy requires that any critical lab value be addressed immediately, with interventions or escalation if necessary.
- The nurse clearly communicated the severity and required urgency.
- Dr. Thompson had full access to the patient’s chart and prior labs and was aware of the patient’s high-risk status.
- Staff report that Dr. Thompson has previously minimized abnormal lab values when the unit was busy.

	Did they choose the behavior?	Did they recognize the risk?	Did they know someone would be harmed?	Appropriate Response
Human Error	No	NA	NA	Console
Unrecognized Risky Behavior	Yes	No	No	Coach
Dangerous Decision-Making	Yes	Yes	No	Correct
Purposefully Causing Harm	Yes	Yes	Yes	Disciplinary Action

Scenario Worksheet

Instructions

- Introduce yourselves.
- Open the scenarios from the Zoom chat.
- Read the first scenario aloud and complete the questions below.
- Complete additional scenarios if time allows
- Be prepared to report to the larger group.

Scenario #: _____

What type of behavior best fits the situation?

- ☐ Human error
- ☐ Unrecognized risky behavior
- ☐ Dangerous decision-making

Why?

What is the most appropriate response?

- ☐ Console/support
- ☐ Coach
- ☐ Correct
- ☐ Disciplinary action

Were there any system or process issues that contributed?

What could improve psychological safety?