

The Safety Alert System: A Catalyst for Change

Petrina McGrath RN PhD

VP People, Practice & Quality

Saskatoon Health Region

Safety - Provincial Strategic Priority

By March 31, 2020, no harm to patients or staff

SAFER EVERY DAY



**GOOD
CATCH or
NEAR MISS**



**LITTLE TO NO
HARM DONE**



**HARM
HAPPENS**



**SERIOUS
EVENT**



A Safety Alert System that enables our people to reliably deliver safe care and service to patients, clients and residents and protects the safety of all who enter our care and service environments



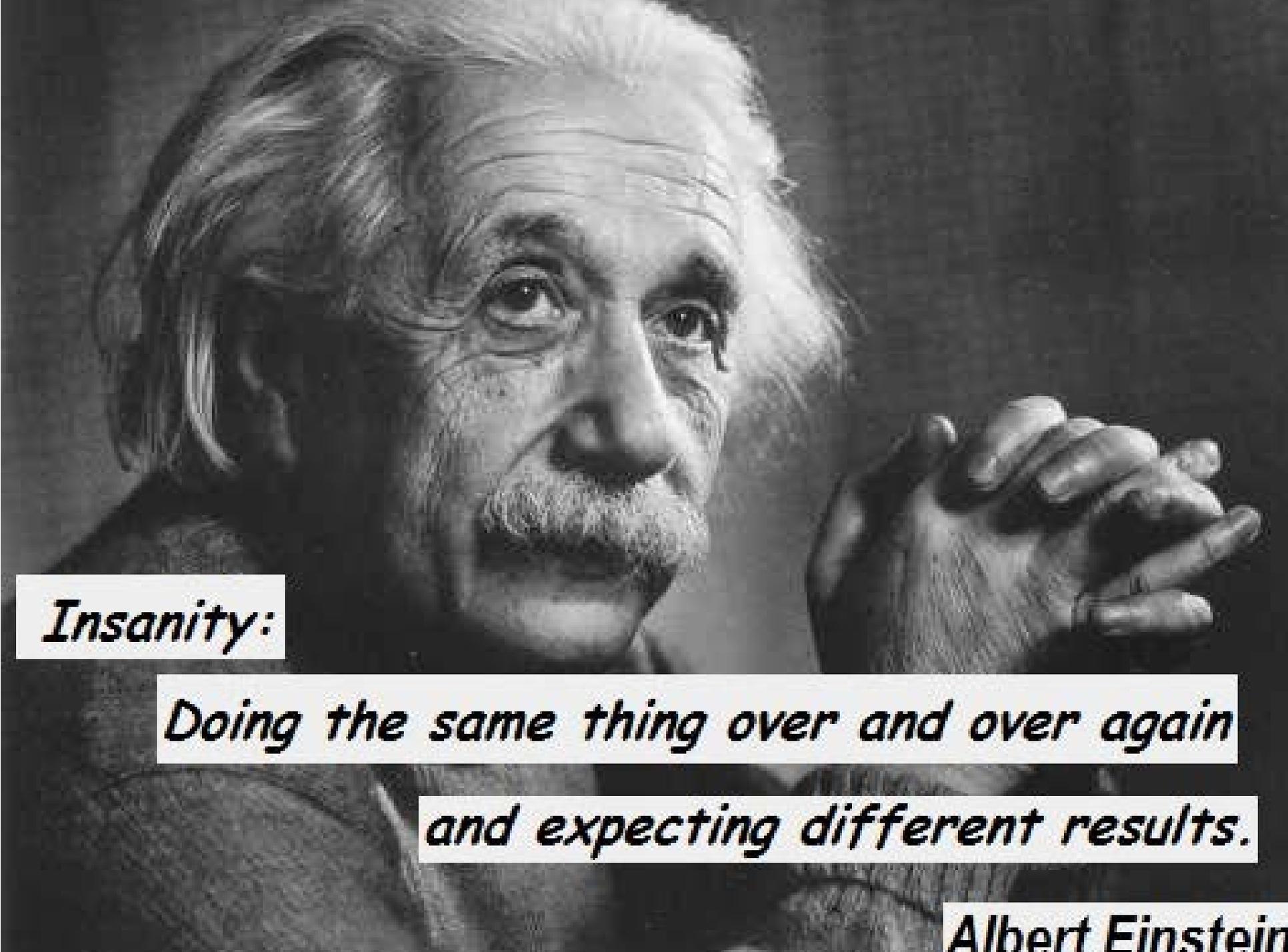
Current State



unique
cognitive
employee
task
result
meaning
symbols
type
high
values
behavior
leadership
belief
society
external
collective
success
satisfaction
cultural
problems
company
growth
expertise
social
result
management
deepest
feedback
knowledge
organizational
outlasting
important
interpersonal

ORGANIZATIONAL CULTURE



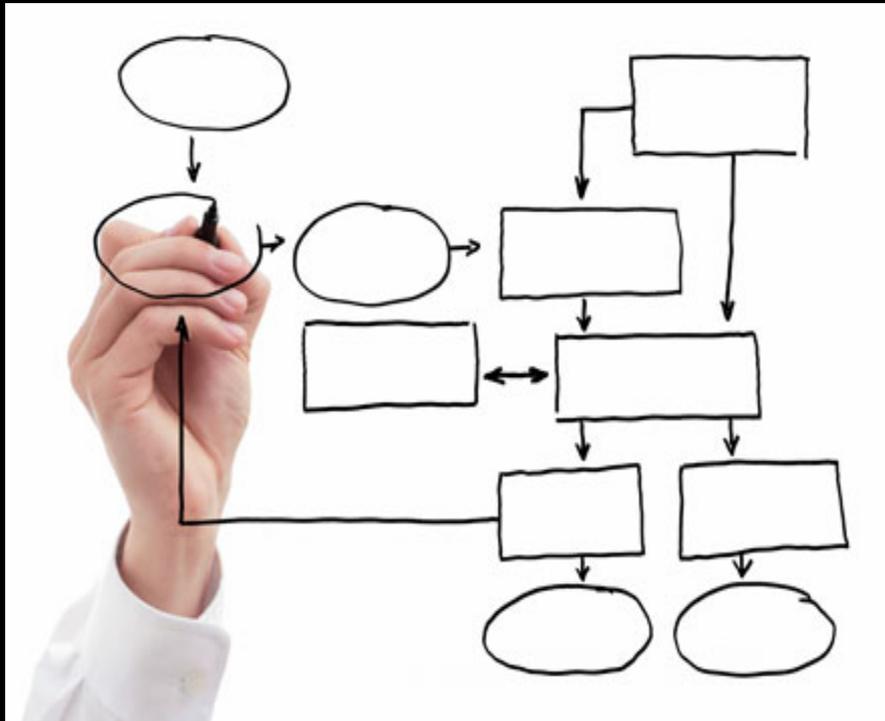


Insanity:

***Doing the same thing over and over again
and expecting different results.***

Albert Einstein

It is about Process, Behaviors & Actions



Key Elements

- Reporting (by anyone), Call 1600
- Who can call, staff, physicians, patient, families, visitors
- Classification (4 levels)
- Response
- Mitigation and mistake proofing
- Building capacity through the process
- Increased Senior Leadership involvement
- Oversight

Key Tenants

- It is safe to report mistakes
- When mistakes are reported, they will be corrected
- Those who report mistakes will be praised
- It is everyone's job to be an inspector, to stop, and fix. If they can't to escalate to the next level for support

I ALWAYS
WONDERED WHY
SOMEBODY DID'NT
DO SOMETHING ABOUT
THAT. THEN I REALIZED
I AM SOMEBODY



Learning to Date

- Personally
 - modeling, so important, asking for feedback
 - commitment to following standard work, decrease variability,
 - Keep focused on the process , the results will come
 - Challenge of learning and leading at the same time.
 - I can't manage through a data base
 - Need to set visual controls on the back end of the process in order to trigger problem solving

Learning to Date – Our Organization

- Gaps in structure becoming visible
- Need to push culture with each incident – normalization is evident
- Challenge to balance urgency to fix and bringing people along in the process; focus on learning
- Elevating respect and dignity issues
- Management system – we had many – not helpful
- Multiply priorities is a risk – Capacity
- **This is a game changer!!!**
- **But risk is high that we will fall into old ways!!**



**Courage does not
always roar
sometimes courage is
the quiet voice at the
end of the day saying
*“i will try again
tomorrow”***

Mary Anne Radmacher