EPA 10 – Contribute to a Culture of Safety and Improvement

1. Short description	The graduate recognizes safety and quality issues for patients, and more broadly, for systems of care. They collaborate with other members of the health care team to participate in the quality improvement cycle on a day-to-day basis. This includes routine demonstration of patient safety habits as well as possible opportunities for: recognition of near misses, identifying system barriers to optimal patient safety or quality of care, participation in developing quality improvement plans, among others.	
2. Most relevant CanMEDS roles	Health advocate Professional Collaborator Medical Expert	
3. Entrustable behaviors	**Pre-entrustable** The learner • Requires prompting to demonstrate common safety habits • Requires prompting to reflect on and develop plans around patient safety • Attributes a single cause to events caused by a deficient system	The learner • Regularly demonstrates and engages is expected safety habits (e.g., universal precautions, hand washing, team time-outs, medication reconciliation, surgical checklists) • Identifies situations that may jeopardize patient safety • Recognizes how the system contributes threats to patient safety • Seeks help appropriately when a patient is identified as being at risk • Recognizes system barriers/errors, reflects on one's contribution, and develops own learning plan
5. Assessment suggestions (note items in italics are optional)	• Demonstration of patient safety habits (i.e., handwashing, speaking up and identifying issues, actively participating in team time-outs or debriefing sessions, medication reconciliation, surgical checklists) in the clinical setting. • Participation in reflection exercise on quality and/or patient safety (i.e., Reflection on systemic threats to patient safety observed in clinical work or talks through possible system solutions to address patient safety concerns.) • Participation in system improvement activities such as: morbidity and mortality rounds, documentation of adverse event/error or near miss situation, or participation in root-cause analysis (including in simulation or OSCE setting). • Direct observation of an adverse event disclosure with standardized patient (simulation or OSCE setting). • Participation in the development of a quality improvement plan.	