Time Out for Safety: Utilizing Checklists and a Culture of Safety

Author: Kathryn Carman, MSc, LVT, VTS (Clinical Practice – canine/feline)

Abstract

The veterinary environment is defined by high-stakes cases and an intense cognitive load that, when coupled with decision fatigue, creates fertile ground for medical and operational errors. This paper proposes that clinical excellence is unsustainable without robust system buffers and a foundational "Culture of Safety." We outline a dual-strategy approach to error mitigation: the implementation of tactical cognitive aids and the fostering of psychological safety.

First, we examine the mechanics of human failure—categorized by ignorance and ineptitude—and demonstrate how checklists serve as essential "cognitive offsets" for experienced practitioners. By transferring routine critical steps to a verifiable format, checklists minimize the impact of cognitive overload and allow for advanced clinical judgment during complications. Second, we address the cultural requirement for these tools to succeed. By contrasting a "culture of blame" with a systems-based approach, this paper provides actionable steps for modeling vulnerability, "sanitizing" communication, and reinforcing non-retaliation.

Attendees will gain practical insights into root-cause analysis—shifting the focus from *who* made a mistake to *how* the system allowed it—using real-world veterinary examples such as medication labeling and administration protocols. Ultimately, this session reinforces a dual mandate for the modern veterinary team: Checklists Save Lives; Culture Saves Careers.

Introduction: The Imperative for Safety Culture

Safety in veterinary medicine requires proactive strategies that acknowledge the inherent pressures of the profession. High patient acuity, time-based care demands, drug commonalities, and multi-tasking contribute to a continuous state of high cognitive load. This environment is unsustainable without robust system buffers. Building a "Culture of Safety" is not merely about compliance; it is a foundational necessity to ensure patient well-being, reduce staff burnout and turnover, and promote a healthy, innovative workplace. This paper addresses two core learning objectives: developing practical tools for physical safety and defining the principles and action plan for psychological safety.

Physical Safety: The Power of Checklists

Categories of Errors

Errors can be categorized in many different ways. The six categories considered here are Preventable Failures, which result from bypassing the safety system in place that would prevent that failure. Complex failures are the result of multiple errors, that happen concurrently or subsequently. An example of a complex failure is the sinking of the Titanic which resulted from the ship being sailed at high speed in order to set records, misplace binoculars for the lookouts, slowing the ship when collision was imminent which resulted in a slower turn, and insufficient lifeboats for the number of passengers on board. These culminated in the loss of the ship and significant loss of life. Intelligent failures are necessary for progress, and they are failed attempts which allow for learning. Examples of intelligent failures include prototypes of an invention. Human failures are either unintentional – accidentally deleting a needed file, or intentional – not using the provided safety gear. Failure of effort results when someone does not put in the work needed to be successful, for example not studying for an exam. And failure of character is exemplified in multiple Ponzi schemes, or the Enron failure. Humans chose to do the wrong thing.

Errors often stem from two types of failure, as categorized by Gawande in his book “The Checklist Manifesto”: ignorance (we don't know the right thing to do) or ineptitude (we don’t know how to do the right thing). Germ theory is used to highlight these two categories of failure. Historically, humans did not understand germs and how diseases were transmitted. This is the example of ignorance. Now that germ theory is well understood, a nurse forgetting to wash his or her hands prior to treating a patient would be considered ineptitude. In a high-stakes, high-stress environment, ineptitude is often the dominant factor, compounded by cognitive overload.

Why Checklists Work

Checklists serve as cognitive aids, transferring critical steps from memory (where they are vulnerable to distraction and stress) to an external, verifiable format. They are designed not for training novices, but for helping experienced practitioners manage complexity and ensure consistency. By minimizing cognitive load on routine steps, the practitioner is freed to focus advanced judgment on unexpected complications.

Practical Application in Veterinary Practice

Checklists and standardized protocols can be deployed across numerous areas to prevent common errors:

- The 5 Rights: Standardizing medication administration (Right Patient, Drug, Dose, Route, Time).
- Anesthesia and Surgical Preparation: Ensuring all equipment is checked and patient preparation is complete prior to induction.

- Hospital Transfers: Standardizing handoffs between shifts or departments.
- Protocols as Checklists: Standard operating procedures, such as proper PPE use, maintenance checks, prescription verification, and handling high Fear/Anxiety/Stress (FAS) patients, are all forms of prescriptive checklists.

Implementation Success Factors

To be successful, checklists must be implemented strategically:

1. Start Small and Simple: Introduce one or two checklists for high-risk or high-frequency tasks first.
2. Keep it Concise: Sub-lists should adhere to the cognitive limit of 5 to 9 items.
3. Checklists are for Masters: Leadership must model the consistent use of checklists to demonstrate that they are a tool for quality assurance, not merely a training device. Don't forget to inspect what you are expecting – follow up on the checklists to make sure they are being utilized correctly.

Psychological Safety: The Culture of Trust

Physical safety protocols, however well-designed, cannot function without the bedrock of psychological safety. This concept is defined as the shared belief that the team is safe for interpersonal risk-taking; team members feel secure to speak up, offer feedback, or admit a mistake without fear of shame or punishment.

Blame vs. Safety

The opposite of a culture of safety is a culture of blame. In a blame culture, mistakes are attributed to individual moral or professional failings. This leads to a detrimental cascade of effects, including inhibited error reporting, increased burnout and turnover, toxic workplace dynamics, and a stifled environment for innovation. When team members are afraid to report near-misses or errors, the system loses valuable data points required for improvement.

The Systems-Based Approach

We must adopt a systems-based approach, recognizing that humans will always make errors, regardless of their competence or motivation. The goal is to move the blame away from the person and onto the system design. This requires:

- Non-Retaliation Culture: Ensuring zero punitive action for reporting an error (unless malicious intent is proven).

- Feedback as a Gift: Encouraging open, non-judgmental communication about processes.
- Root Cause Analysis: When an error occurs (e.g., administering the wrong dose of bupivacaine), the focus shifts from *who* made the mistake to *how* the system allowed it. Changes must be implemented system-wide (e.g., changing the placement of local anesthetic labels to differentiate them visually from other injections).

Steps to Creating a Culture of Safety

Each person in the hospital is responsible for creating a culture of safety. The hospital leadership team will have the most significant impact on team culture, but everyone on the team can model a culture of safety. Creating this culture often includes the following steps:

1. Model vulnerability: openly admit to your own mistakes, asking "dumb" questions knowing that others may also have the same question, state your "intent" to focus on the best patient outcome and not to critique colleagues' skills.

2. Create a safe space for others: Use appreciative inquiry, practice active listening, and inviting the opinions of those who wouldn't normally speak up to reinforce that their opinion is valid and valuable.

3. Sanitize the blame game: shift the tone of the responses by always assuming good intentions. Instead of accusatory statements, chose statements that invite dialogue and reinforce the systems-based approach to correcting problems. If one person made the mistake, another person could again in the future. Work together to prevent future mistakes.

4. Reinforce the Safety: Utilize the positive shout-out and publicly thank colleagues when they catch mistakes. This goes back to modelling vulnerability. Defend the absent when others are speaking negatively about staff who aren't present. Remind everyone to assume good intent and work towards correcting the system that allowed the mistake.

Conclusion and Call to Action

Creating a safe workplace requires commitment to both the tangible and intangible. Checklists provide crucial mitigation for acute failure; a culture of psychological safety provides the long-term, structural resilience needed for sustained excellence. Change begins with identifying one single, preventable error or near-miss in the hospital and asking: How can we change the system to prevent this from happening again?

The ultimate takeaway is encapsulated in the dual mantra: Checklists Save Lives; Culture Saves Careers.

Resources

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