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# Certified Professional in Patient Safety (CPPS)<sup>™</sup> Certification Prep Course

JANUARY 14, 2026



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## Introductions / Welcome/What to Expect

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LIVE WEBINARS



PRACTICE TEST



COACHING



TESTING

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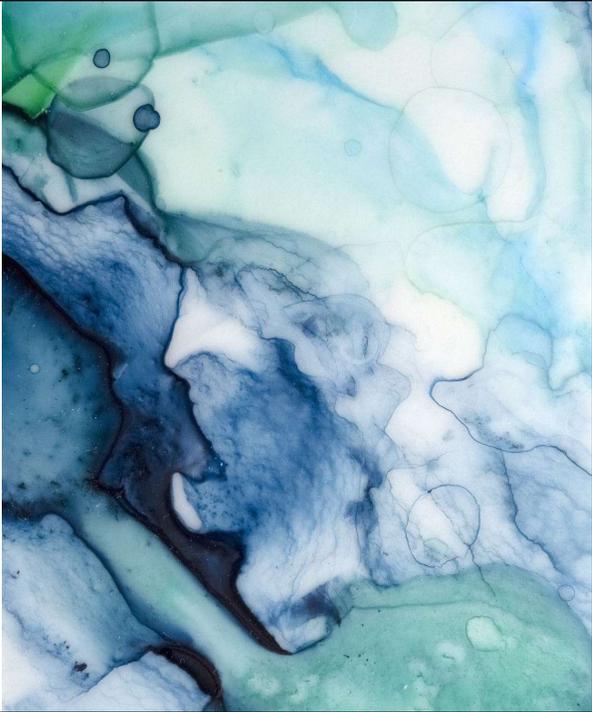
 Exam Content Areas



January 14	Culture
January 21	Leadership
January 28	Patient Safety Risks & Solutions
February 4	Measuring & Improving Performance
February 11	Systems Thinking & Design

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 Culture



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## Culture Core Elements

-  Defining safety culture as the foundation for patient safety.
-  Psychological safety as essential for reporting and learning.
-  Just Culture principles to balance accountability and system improvement.
-  Leadership's role in shaping and sustaining a culture of safety.

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## House of Safety



The diagram illustrates the 'House of Safety' model. It features a dark blue base labeled 'Culture of Safety'. Above this base are two vertical pillars, 'Safety I' on the left and 'Safety II' on the right. The roof of the house is split into two sections: 'Patient Safety' on the left and 'Zero Harm' on the right. The interior of the house is divided into two horizontal layers: 'HRO Principles' (top) and 'Just Culture' (bottom).

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## What is a Culture of Safety?

A culture of safety is an atmosphere of mutual trust where all staff can speak openly about safety issues without fear of blame or punishment.

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## Features of a Culture of Safety



Psychological  
safety



Active  
leadership



Transparency



Fairness

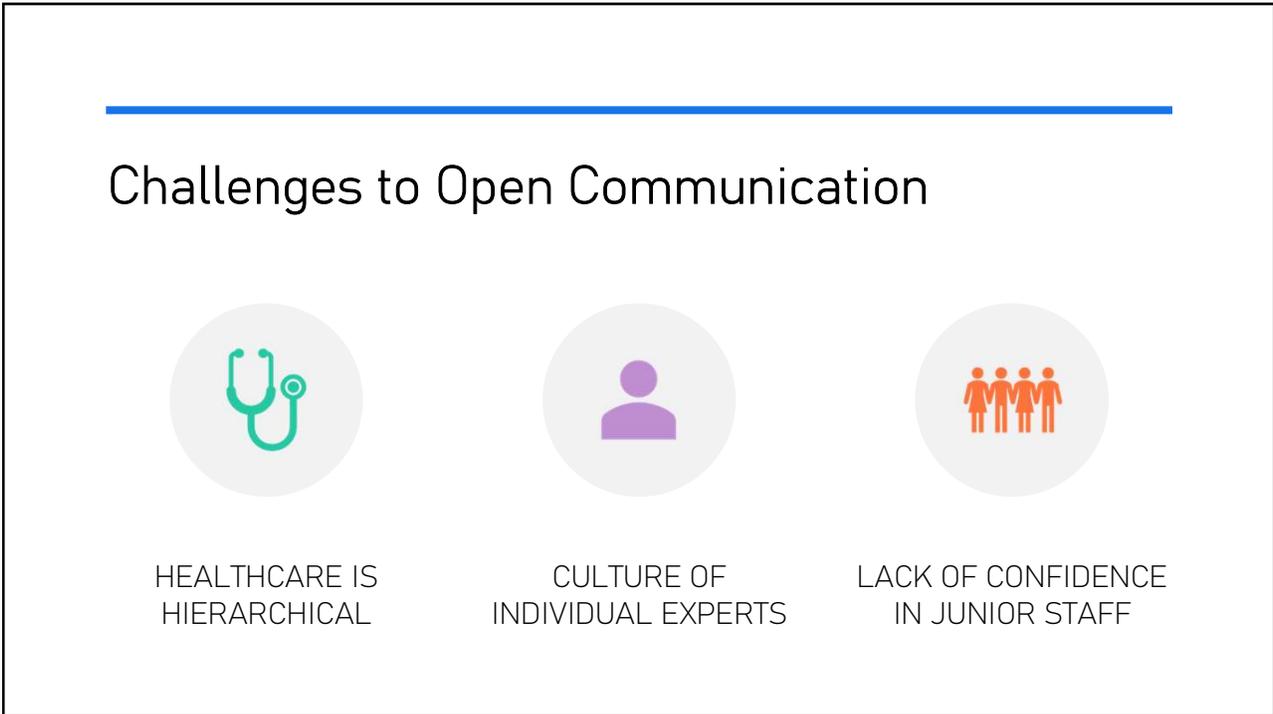


Equity and  
Inclusion

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## Leadership's Influence

- Establish a compelling vision for safety
- Build trust, respect, and inclusion
- Select, develop, and engage the Board
- Prioritize safety in leadership development
- Lead and reward a Just Culture
- Establish organizational behavior expectations



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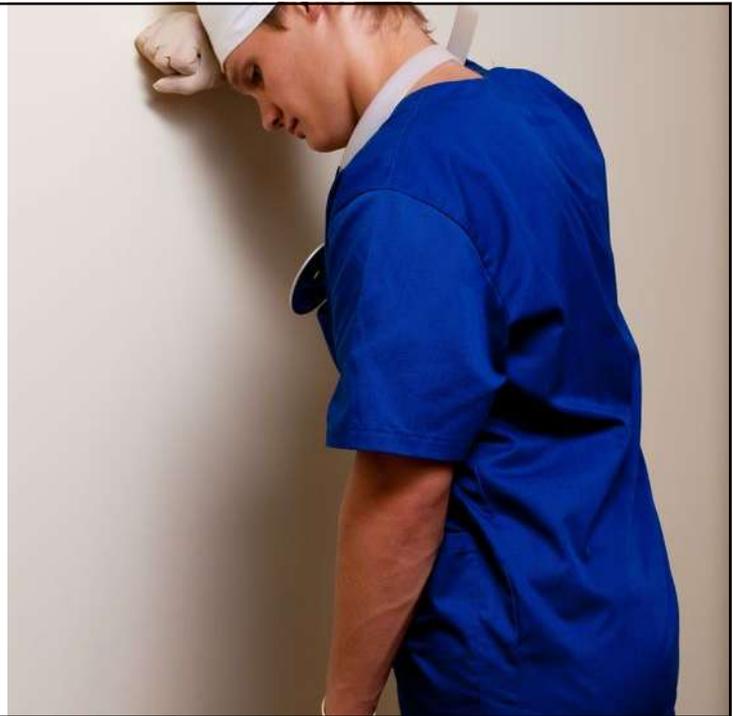
## Just Culture v. No-Blame Culture

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li>• Balances learning and accountability.</li> <li>• Encourages reporting while assessing behavior types</li> <li>• Focuses on system improvements, not punishment</li> <li>• Builds trust and transparency for continuous safety improvement.</li> <li>• Just Culture = Fair accountability + learning.</li> </ul> | <ul style="list-style-type: none"> <li>• Eliminates personal accountability entirely.</li> <li>• All errors treated as system failures.</li> <li>• Can lead to unchecked unsafe behaviors.</li> <li>• Risks weakening responsibility for critical decisions.</li> <li>• No-Blame Culture = Learning only, no accountability.</li> </ul> |
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What happens if the first question is "WHO"?

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What happens if the first question is "HOW"?

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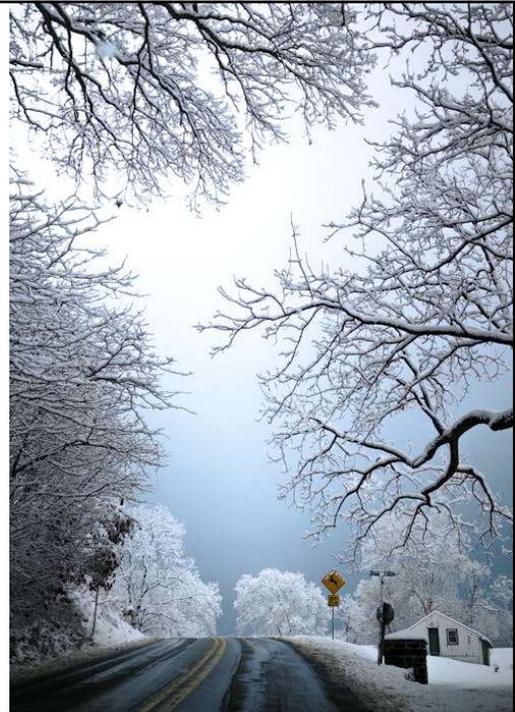
Human Error	At-Risk Behavior	Reckless Behavior
<p><i>Product of Our Current System Design and Behavioral Choices</i></p> <p>Manage through changes in:</p> <ul style="list-style-type: none"> <li>• Choices</li> <li>• Processes</li> <li>• Procedures</li> <li>• Training</li> <li>• Design</li> <li>• Environment</li> </ul>	<p><i>A Choice: Risk Believed Insignificant or Justified</i></p> <p>Manage through:</p> <ul style="list-style-type: none"> <li>• Removing incentives for at-risk behaviors</li> <li>• Creating incentives for healthy behaviors</li> <li>• Increasing situational awareness</li> </ul>	<p><i>Conscious Disregard of Substantial and Unjustifiable Risk</i></p> <p>Manage through:</p> <ul style="list-style-type: none"> <li>• Remedial action</li> <li>• Punitive action</li> </ul>
Console	Coach	Punish

Source: American College of Cardiology

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## Human Error, At Risk Behavior, or Reckless Behavior?

On a snowy winter night, John had to run to the store to buy a new formula for his colicky newborn. His wife had not slept in 24 hrs. so tension in the home was high. He got into the car and backed out of the driveway looking at his upset wife in the doorway, but not looking in his rear-view mirror. In his haste, he hit his neighbor's mailbox and destroyed it.

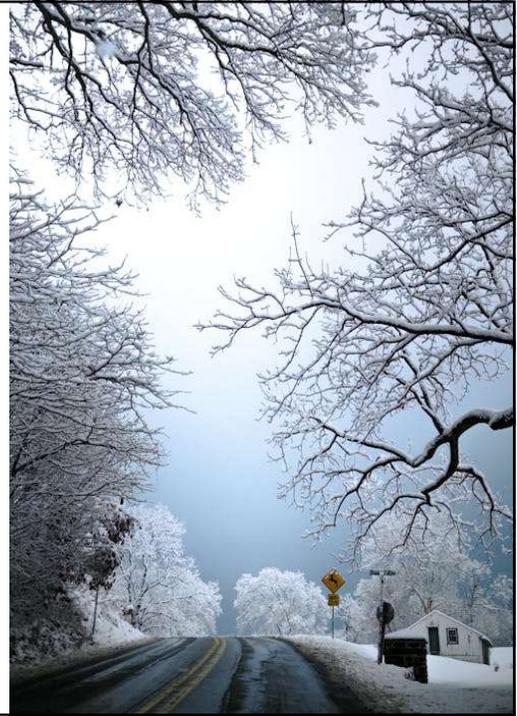


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## Human Error, At Risk Behavior, or Reckless Behavior?

On a snowy winter night, John had to run to the store to buy milk. His car was parked in the driveway. John got into the car and turned his head to back out of the driveway. Although he carefully looked at the path behind the car, his vision was limited. He inadvertently hit his neighbor's mailbox and destroyed it.

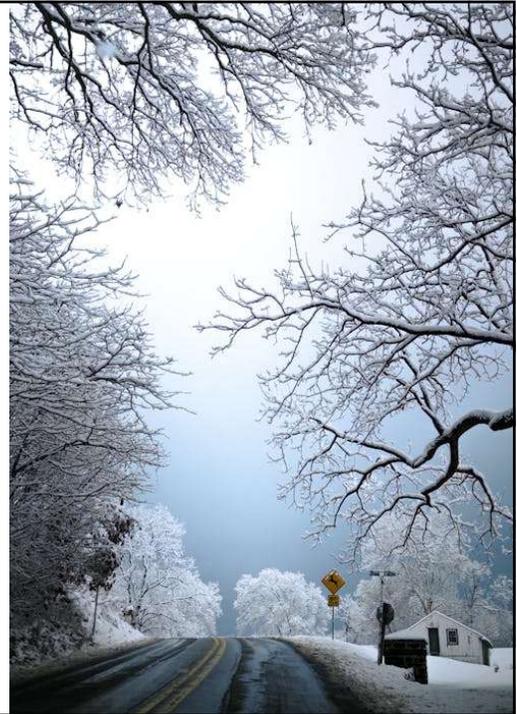


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## Human Error, At Risk Behavior, or Reckless Behavior?

On a snowy winter night... John yelled "yee haa," closed his eyes and hit the throttle. He never saw his neighbor's mailbox.



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## Which One is At Risk Behavior?

- A. Misreading a critical accounting value.
- B. Driving a company truck while intoxicated.
- C. Purposefully ramming a forklift into a train.
- D. Performing a critical procedure by memory.

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## Perspectives of Safety

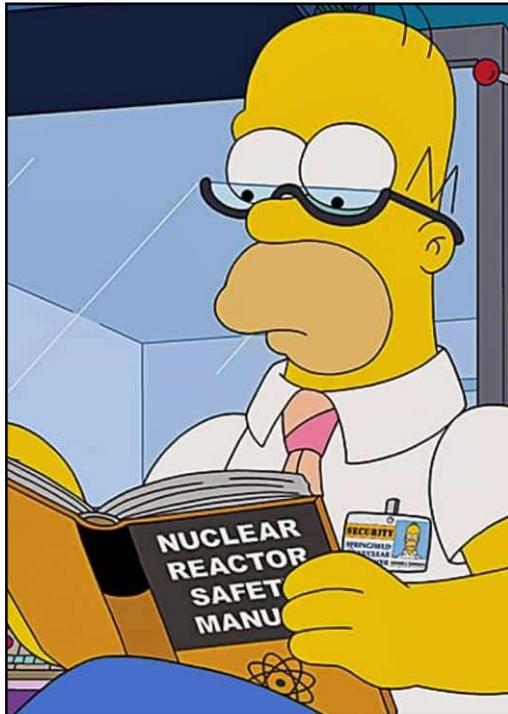


	Safety I	Safety II
<b>Focus</b>	Prevent things from going wrong	Ensure that things go right.
<b>View of Safety</b>	Absence of <b>failure</b> , harm or adverse events	Presence of <b>successful</b> outcomes
<b>Approach</b>	<b>Reactive:</b> Analyze and eliminate failures	<b>Proactive:</b> Understand and enhance everyday work
<b>Assumption</b>	Systems are basically safe; accidents are anomalies	Systems are complex; variability is normal
<b>Methods</b>	<b>Retrospective</b> , Root cause analysis, compliance, error reduction	<b>Resilience</b> engineering, adaptability, flexibility
<b>Goal</b>	Minimize risk and errors	Maximize system capacity to succeed under varying conditions

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## What can we learn about safety culture from other industries?

- Responsibility for many lives
- High-risk environments with severe consequences
- Highly complex systems requiring coordination
- Multiple steps must align perfectly for success
- Limited individual control over outcomes

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## High-Risk Industries: What Sets Healthcare Apart?

### Aviation



- Multiple redundant systems
- Safe means to report error
- Not expected to be perfect
- Very few fatalities

### Healthcare

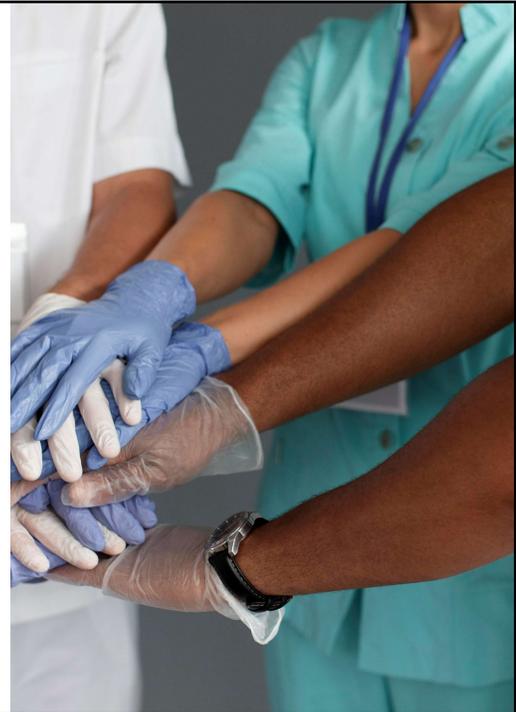


- Occasional redundant systems
- Fear of reporting error
- Error as a cost of doing business
- Expected to be perfect
- Unexpected deaths occur daily

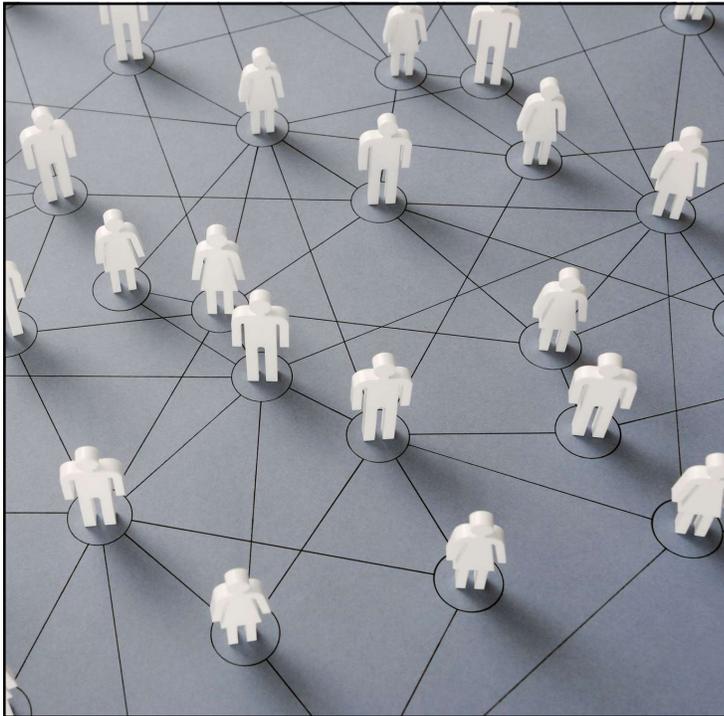
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## Practical Strategies for Building Culture

- Leadership walk-arounds
- Safety huddles
- Storytelling for learning
- Confidential reporting systems
- Continuous learning loops.
- Blame-free reporting environment
- Open discussion of human factors



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## Role of Communication in Culture

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### How can YOU foster a culture of safety?



Actively set a positive tone.



Set a common goal, invite everyone in.



Use structured communication tools.



Fairness & Accountability



Be respectful to colleagues and patients.



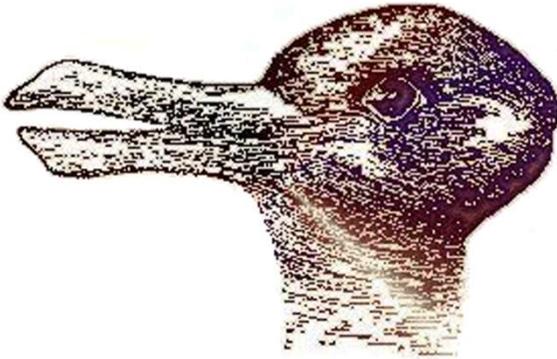
Agree on critical language.



Discuss errors openly.

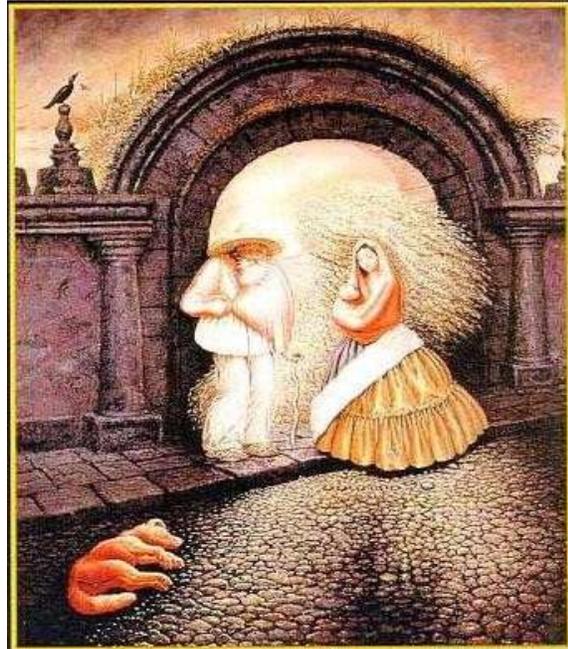
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What do you see?



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—  
What do you see?



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## Communication During Flight 1539

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- Clear Role Assertion
- Use of Critical Language
- Structured Information Sharing (example: SBAR)
- Closed-Loop Communication
- Prioritization Under Pressure
- Calm Tone Despite Stress
- Coordination Across Multiple Stakeholders
- Transparency About Uncertainty

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## Team Communication as a Safety Tool

Why it matters:

- Improves team collaboration, communication and coordination
- Reduces slips, lapses and mistakes
- Addresses human factors (stress, fatigue, cognitive overload)



-Brene' Brown

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## Communication Tools & Frameworks

Examples:

- Crew Resource Management
- TeamSTEPPS®
- SBAR



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# TeamSTEPPS®

Team Strategies & Tools to Enhance Performance & Patient Safety

## TeamSTEPPS®

Team Strategies & Tools to Enhance Performance & Patient Safety

Agency for Healthcare Research and Quality (AHRQ)

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## SBAR

- **S = Situation** (a concise statement of the problem)
- **B = Background** (pertinent and brief information related to the situation)
- **A = Assessment** (analysis and considerations of options – what you found/think)
- **R = Recommendation** (action requested/recommended – what you want)

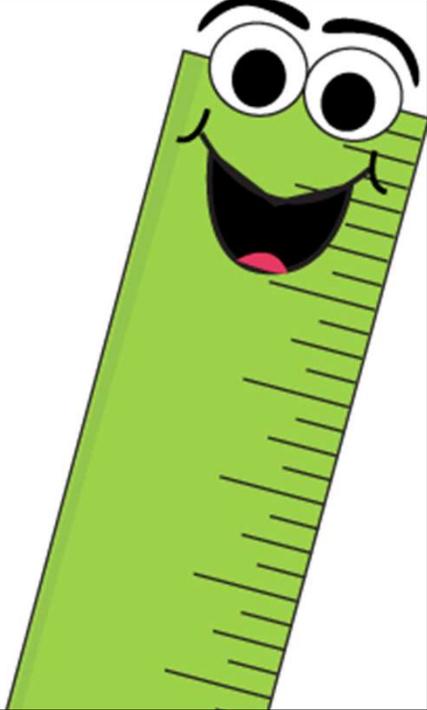
NURSE REPORT SHEET UNIT: \_\_\_\_\_ DATE: \_\_\_\_\_

<b>S</b>	Patient Name: Room Number: Diagnosis: Isolation:	Allergies: Code Status: Fall Risk/Safety:	Physician: Attending: Consults:
<b>B</b>	PMH:		Accuchecks: Frequency: Last Results:
<b>A</b>	<b>Cardiac:</b> BP/HR/Pulses/Edema/Heart Sounds Current Rhythm: DVT Prophylaxis? <b>Pulmonary:</b> Breath Sounds/SpO2/Rate <b>GI:</b> NG/OGT/Peg: Location: Securement: Measurement: <b>Skin:</b> Wounds/Dressings/Drainage: <b>GU:</b> Urine Color/Cloudiness/Odor: <b>IV Access:</b> IV Device: Date of Insertion: Medications:	Weight: Weight Frequency: Secretions: Vent/Bipap Settings: Diet: Nausea/Vomiting: Last BM: Foley: Fluids: Gtt:	Pain/Sedation: Location: Pain Meds & Last Dose: GI Prophylaxis: Bowel Sounds: Abdominal Pain: Output: Psychosocial: Labs/Cultures/Tests:
<b>R</b>	DC Plan:	Shift Goals:	Misc:

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## Measurement of Culture

- If we value safety, we should measure it—and use results to learn and improve.
- Use validated tools (e.g., AHRQ Safety Culture Survey).
- Assess perceptions across all levels of the organization.
- Results should drive action plans and continuous improvement.
- Measurement is not about blame—it's about learning and transparency.



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## CPPS Exam – Culture Domain: Key Takeaways

Safety Culture	Psychological safety	Just Culture	Leadership's Role
High Reliability Organization (HRO) Principles	Communication Tools	Human Factors	Measurement

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## Practice Questions

A nurse reports a near miss involving a medication error. The manager responds by saying, "Thank you for speaking up. Let's review the process together."

Which principle of a Culture of Safety does this response best demonstrate?

A. Transparency

B. Punitive accountability

C. Hierarchical decision-making

D. Outcome-based discipline

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## Practice Questions

A technician skips a checklist step during a procedure because "it saves time." No harm occurs.

According to Just Culture principles, what is the most appropriate response?

A. Console the individual

B. Coach the individual

C. Punish the individual

D. Ignore the behavior

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## Practice Questions

Which of the following is a core feature of a Culture of Safety?

A. Expecting perfection from individuals

B. Psychological safety for all team members

C. Blame-free environment with no accountability

D. Relying solely on event reporting for improvement

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## Practice Questions

An organization conducts an AHRQ Safety Culture Survey and finds that staff fear reporting errors.

What is the best next step to strengthen safety culture?

A. Increase disciplinary actions for errors

B. Allow for anonymous reporting

C. Stop measuring culture until fear decreases

D. Require staff to sign a pledge to report errors

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## Resources

- Certified Professional in Patient Safety (CPPS)<sup>™</sup>: <https://www.ihi.org/learn/certifications/cpps>
- Safety I, Safety II, and the New Views of Safety: <https://psnet.ahrq.gov/primer/safety-i-safety-ii-and-new-views-safety>
- Team Stepps: <https://www.ahrq.gov/teamstepps-program/index.html>
- SBAR: <https://www.ihi.org/library/tools/sbar-tool-situation-background-assessment-recommendation>
- Learning Patient Safety Culture: Turning Fog to Concrete: <https://www.ihi.org/library/blog/learning-patient-safety-culture-turning-fog-concrete>
- Crew Resource Management:: <https://psnet.ahrq.gov/issue/conflict-resolution-applying-aviation-crew-resource-management-healthcare>