



Just Culture and Patient Safety Reporting for Healthcare Managers Training Course

13 – 17 June 2027
Kuwait

Just Culture and Patient Safety Reporting for Healthcare Managers Training Course

Ref: 1356_200244 **Date:** 13 – 17 June 2027 **Location:** Kuwait **Fees:** 5500 Euro

Overview

Just Culture and Patient Safety Reporting for Healthcare Managers Training Course is a one-week intermediate course for healthcare managers, safety, quality, risk, HR, governance, and operations personnel who leave with a Patient Safety Reporting Improvement Plan. Participants connect psychological safety, fair accountability, reporting pathways, event review, system factors, feedback, and action tracking. The course addresses under-reporting and inconsistent responses through practical decision tools and learning routines. Agile Leaders Training Center presents just culture and patient safety reporting through managerial controls.

Who Should Attend

- Functions responsible for patient safety governance and reporting systems
- Teams responsible for clinical quality, risk, compliance, and assurance
- Personnel responsible for workforce policy, employee relations, and psychological safety
- Functions responsible for incident review, learning, and improvement actions
- Operational leaders responsible for care delivery and staff communication

The course assumes participants oversee healthcare teams or safety processes and leaves out legal adjudication, professional discipline, and specialist clinical investigation.

Departments and Industries

The course supports departments and industries that manage care delivery, safety events, workforce response, and organizational learning.

- Hospitals, clinics, ambulatory care, and diagnostic services
- Patient safety, clinical governance, quality, and risk functions
- Nursing, medical, pharmacy, and allied health operations
- Human resources, compliance, legal liaison, and internal audit teams
- Healthcare education, rehabilitation, and long-term care services

Learning Objectives

By the end of this course, participants will be able to:



- Analyze barriers to patient safety reporting and psychological safety
- Apply fair response criteria to human error, at-risk behavior, and reckless behavior
- Build a patient safety incident reporting pathway and feedback loop
- Use systems thinking to review events and contributory factors
- Evaluate learning communications, safety actions, and action effectiveness
- Build a Patient Safety Reporting Improvement Plan

Course Agenda

Day 1: Just Culture and Reporting Foundations

- Patient Safety Culture Diagnostic Map
- Psychological Safety Barrier Assessment
- Just Culture Principles and Fairness Test
- Reporting Trust and Openness Pulse Check
- Leadership Behaviors and Governance RACI

Day 2: Fair Accountability Decisions

- Human Error Response Decision Guide
- At-Risk Behavior Coaching Matrix
- Reckless Behavior Escalation Criteria
- System Conditions and Individual Actions Map
- Consistent Manager Response Checklist

Day 3: Reporting Pathways and Event Review

- Patient Safety Incident Reporting Workflow
- Report Intake and Triage Criteria
- Event Timeline and Contributory Factors Map
- System-Based Review Question Set
- Patient Family and Staff Engagement Plan

Day 4: Learning Feedback and Improvement

- Reporting Feedback Loop Design
- Learning Communication Brief Template
- Safety Action Strength Assessment
- Action Ownership and Tracking Register
- Reporting and Learning Dashboard



Day 5: Just Culture Management Practice

- Exercise: Diagnose Reporting Culture Barriers
- Exercise: Apply Fair Response Decision Criteria
- Exercise: Review an Event Through Systems Thinking
- Exercise: Design Feedback and Action Tracking
- Capstone Exercise: Patient Safety Reporting Improvement Plan

Practical Exercises

The course uses suggested activities from hospital, ambulatory, diagnostic, rehabilitation, and long-term care settings.

- Suggested activity: assess reporting barriers and leadership behaviors affecting psychological safety.
- Suggested activity: classify response options for human error, at-risk behavior, and reckless behavior.
- Suggested activity: map an incident reporting pathway and conduct a system-based event review.
- Suggested activity: build a Patient Safety Reporting Improvement Plan with feedback, actions, owners, and measures.

FAQs

What is just culture in patient safety reporting?

Just culture in patient safety reporting combines fairness, transparency, learning, and proportionate accountability while examining system conditions that shape individual actions.

Who suits just culture and patient safety reporting training, and what does it assume?

Just culture and patient safety reporting training suits healthcare managers and safety, quality, risk, HR, governance, and operations personnel and assumes responsibility for teams, reporting, reviews, or learning actions.

How does just culture training differ from incident investigation training?

Just culture training concentrates on reporting climate and fair managerial response; incident investigation training concentrates on evidence collection, analysis methods, and formal investigation outputs.

How does just culture distinguish human error and risky behavior?

Just culture distinguishes behavior by examining the action, context, system conditions, choices, and organizational response rather than treating every adverse outcome as equivalent misconduct.



How can patient safety reporting produce learning?

Patient safety reporting produces learning when reports are reviewed for system factors, communicated through feedback, converted into safety actions, assigned to owners, and monitored for effectiveness.

Conclusion

The course connects just culture, psychological safety, fair accountability, reporting pathways, event review, feedback, and improvement. Participants take back a Patient Safety Reporting Improvement Plan that assigns responsibilities, decision tools, learning routines, actions, and measures. The plan changes how managers receive reports, respond to staff, share learning, and monitor safety actions.