<table>
<thead>
<tr>
<th>Barriers</th>
<th>Strategies to Overcome</th>
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| Lack of communication                        | ● Encourage use of the CUS tool – “I am concerned. I am uncomfortable. This is a safety issue.”  
  ● Two-attempt rule of voicing concerns to communicate hazardous situations that initially may be misinterpreted, as well as to escalate the concern to a higher level provider when necessary.  
  ● Utilizing the brief communication format of SBAR for urgent issues - situation, background, assessment, and recommendation. |
| Heterogenous training and practice patterns   | ● Establishing institutional guidelines to address deficits in knowledge on QI.  
  ● Provide training to educate healthcare professionals on safety errors and reporting. |
| Time consuming reporting systems              | ● Frequent messaging and reminders can be used to reiterate the importance of reporting and reinforce behaviors that may not be part of usual patient care.  
  ● Provide targeted training to address specific group concerns regarding reporting. |
| Lack of confidence in knowledge for identification of errors | ● Implement educational curricula focused on patient safety to define terminology and demonstrate how institutional processes have been changed based on event reporting.  
  ● Encourage discussion with a colleague or supervisor if there are feelings of uncertainty regarding when to report a potential safety event. |
| Feeling of lack of feedback or change after reporting | ● Review reported errors during educational sessions or staff/unit meetings to provide transparency.  
  ● Engage staff in root cause analysis and multidisciplinary discussions when problem solving safety events. |
| Concern for blame or negative repercussions  | ● Promote a just culture in the workplace rather than disciplinary action, championed by institutional leadership.  
  ● Utilize incentives to promote reporting and improve compliance. |