Patient Safety Culture Bundle for CEOs and Senior Leaders

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Appendix 1: Bundle Key Concepts Summary

- *Front-line leadership/distributed leadership:* Recognized as a key driver for change in healthcare; local leaders translate senior leader priorities/values into action at the microsystem level; they have great impact in unit cultures and learning processes (Scoville et al. 2016).
- *High reliability/resilience:* Reliable/mindful organizations are: preoccupied with failure (look for small signals of failure vs. preoccupation with success); reluctant to simplify interpretations (acknowledge complexity); sensitive to operations (aware of what is happening at front lines); committed to resilience (acting quickly when things go wrong; e.g., patient deterioration); and defer to experts (vs. authority) (Weick and Sutcliffe 2015).
- *Implementation science:* Supplements patient safety science; focuses on identifying and implementing valuable practices and lessons learned and scaling up/translation across the organization and system (National Patient Safety Foundation 2015).
- *Industry-wide standardization/alignment:* A key feature in other high-risk industries is alignment across the sector related to key priorities, national/international standards and regulation of safety-critical practices and technologies (Dixon-Woods and Pronovost 2016; National Patient Safety Foundation 2015).
- *Just culture:* A culture that recognizes that individual practitioners should not be held accountable for system failings over which they have no control. A just culture recognizes many individual or "active" errors represent predictable interactions between humans and the system in which they work. A just culture also does not tolerate conscious disregard of clear risks to patients or gross misconduct (National Patient Safety Foundation 2015).
- *Patient and family engagement:* Recognized as a primary area of focus in patient safety/quality; includes engagement at three levels: direct care (diagnosis, treatment decisions, monitoring), organizational design and governance (planning, patient advisory councils, quality improvement projects) and policy making (public health, research priorities, resource allocation) (Carman et al. 2013).
- *Patient safety measurement:* Five dimensions: past harm (incidents, mortality); reliability (compliance); sensitivity to operations (walk-rounds, staffing levels, escalation); anticipation and preparedness (risk registers, safety culture scores, absenteeism); integration and learning (automated alerts, board dashboards) (Vincent et al. 2016).
- *Physician leadership:* Recognized as a key driver for change in healthcare; six strategies for engaging physicians: discover common purpose; reframe values and beliefs; segment the engagement plan; use engagement-improvement methods; show courage; adopt an engaging style (Reinertsen et al. 2007).
- *Psychological safety:* An environment where anyone can ask questions without looking stupid; anyone can ask for feedback without looking incompetent; anyone can be respectfully critical without appearing negative; anyone can suggest innovative ideas without being perceived as disruptive (Frankel et al. 2017).
- *Safety science:* focuses on contributing factors and underlying causes of risk and harm, including errors and human factors. It includes many disciplines not typically considered part of healthcare. Recognizes the fundamental importance of system design in driving workforce behaviour. In other industries, such as aviation, safety experts accept that human error must be expected and anticipated and its effects mitigated. Safety science and human factors engineering is used to design systems to prevent errors and to mitigate harm when errors occur (National Patient Safety Foundation 2015).
- *Staff engagement*: A joyful, engaged workforce will have: physical and psychological safety; meaning and purpose; choice and autonomy; recognition and awards; participative management; camaraderie and teamwork; daily improvement; wellness and resilience; real-time measurement (Perlo et al. 2017).
- *Staff safety/health*: A precursor to providing high-quality care is staff who are free from physical harm during daily work (Perlo et al. 2017).
- *Teamwork/communication:* Gaps in communication and/or poor teamwork are frequently noted as contributing factors to many patient safety events. Strong teams that train together and have established and reliable communication practices will have superior patient safety performance (Baker 2015).

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