


Patient Safety Culture Bundle for CEOs and Senior Leaders

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Appendix 2: Formatted Patient Safety Culture Bundle

Patient Safety Culture “Bundle” for CEO’s/Senior Leaders

PATIENT SAFETY
FORWARD WITH



1. Enabling

Organizational priority setting, leadership practices that motivate the pursuit of safety

2. Enacting

Frontline actions that improve patient safety

3. Learning

Learning practices that reinforce safe behaviours

Organizational priority

- Board educated, engaged, accountable, prioritizes patient safety?
- Safety/quality vision, strategy, plan, goals (with input from patients, families, staff, physicians)?
- Safety/quality resources/infrastructure?

CEO/senior leadership behaviours

- Relentless communication about safety/quality vision, stories, results?
- Regular/daily interaction with care settings/units, staff, physicians, patients and families?
- Model key values (e.g. honesty, fairness, transparency, openness, learning, respect, humanity, inclusiveness, person-centredness)?

Human resources

- Leaders/staff/physicians engaged, clear expectations/incentives for safety/quality?
- “Just culture” program/protocol?
- Disruptive behaviour protocol?
- Staff and physician safety (physical/psychological/burnout); safe environment program?

Health information/technology/devices

- E-health records support safety (e.g. decision support, alerts, monitoring)?
- Technology/devices support safety (e.g. human factors, traceability)?

Healthcare system alignment

- Community/industry-wide collaborations?
- Align with national/international standards (e.g. accreditation, regulatory, professional, industry)?

Care settings and managers

- Integrated, unit/setting-based safety practices (e.g. daily briefings, visual management, local problem solving)?
- Managers/physician leaders foster psychological safety (speaking up)?

Care processes

- Standardized work/care processes where appropriate?
- Communication/patient hand-off protocols (e.g. between shifts/units, across care continuum)?

Patient and family engagement/co-production of care

- Patients/families partners in all aspects of care (e.g. planning, decision-making, family presence policy, rounds, access to health record/test results)?
- Patients/families involved in local safety/quality initiatives?
- Disclosure and apology protocols?

Situational awareness/resilience

- Processes for real-time/early detection of safety risks and patient deterioration (by staff/patients families/physicians)?
- Protocols for escalation of care concerns (by staff/patients/families/physicians)?

Education/capability building

- Leaders/staff/physicians trained in safety and improvement science, teamwork, communication?
- Team-based training, drills?

Incident reporting/management/analysis






- Effective risk/incident reporting system for events related to patients/families and staff/physicians (e.g. near misses, never events, mortality/morbidity reviews)?
- Structured processes for responding to and learning from safety events/critical incidents (e.g. systems analysis, patient/family/staff/physician involvement and support)?

Safety/quality measurement/reporting

- Regular measurement of safety culture; patient/family complaints; and staff/physician engagement (by unit/setting and organization)?
- Retrospective/prospective safety and quality process and outcome measures?
- Regular, transparent reporting of safety/quality plan results?

Operational improvements

- Structured methods, infrastructure to improve reliability, streamline operations (e.g. PDSA, lean, human factors engineering, prospective risk analysis)?

Adapted from: Singer & Vogus (2013). Reducing hospital errors: Interventions that build safety culture. *ARPH* 34:373-96 JANUARY 2018