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

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)?

2. Enacting

Frontline actions that improve patient safety

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)?

3. Learning

Learning practices that reinforce safe behaviours

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)?

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