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

#### 1. Enabling
Organizational priority setting, leadership practices that motivate the pursuit of safety

- 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

- 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

- 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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