PLUS Cycle — Blueprint and Toolbox

Strengthening safety culture in Swiss healthcare organisations

Overview of roles, process and instruments

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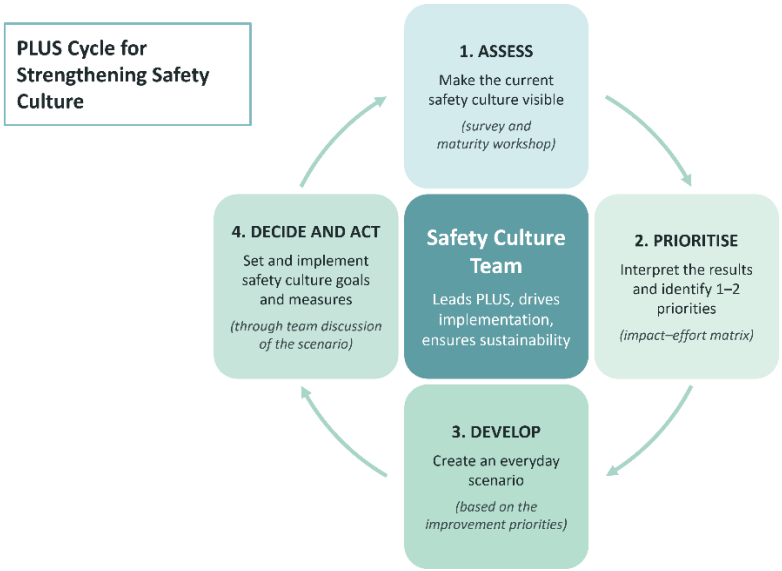
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PLUS Study Research Team
Improving Safety Culture in Swiss Healthcare Organisations

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The PLUS cycle: what is it about?

The PLUS cycle is being tested in Swiss healthcare organisations as part of the PLUS study, a national feasibility study. It is a collaborative approach that enables units or teams to better understand their safety culture, make sense of the findings together and translate them into practical, locally relevant measures. To do so, it combines a staff survey with a maturity workshop and uses an everyday scenario to arrive at measures the team supports. The local safety culture team leads the cycle, and experience gained during implementation feeds into the next cycle.



Roles

Local safety culture team: A team formed at unit level that actively implements and steers the PLUS cycle in day-to-day work. It brings together staff from the different professional groups represented in the unit (e.g. nursing, medicine, midwifery, medical-technical and therapeutic professions, and other specialist functions) and from different hierarchical levels, not only managers, so that all perspectives from practice are represented. Where possible, patients, family members or peers take part. A local coordinator ensures the link to the institutional level and the flow of information.

Institutional representatives: Representatives of the higher organisational level (hospital, clinic or institution, or hospital group where applicable). They hold strategic responsibility, provide resources and make formal decisions. They include, for example, members of the executive board, medical directorate or nursing directorate, heads of departments or divisions and, depending on the institution, other leadership functions. Each institution decides how they are involved and which workshops they attend. In all cases, the institutional representatives are informed of the SOPS and MaPSaF results, the prioritisation decision, the chosen scenario and the implementation plan. An institutional coordinator ensures the flow of information between the local and institutional levels and is the main contact person for the PLUS team. Depending on the organisation, this may be, for example, quality management, risk management, patient safety or another function that takes on this role.

Other specialist or cross-functional roles: Depending on needs and the chosen priority, they are involved at local or institutional level (e.g. infection prevention and control, pharmacy, education, human resources).

Unit/team staff: All staff of the unit or team, whose day-to-day experience forms the foundation of the PLUS cycle. By taking part in the survey (Step 1), they make visible where the unit or team currently stands. In Step 4, and where appropriate already in Step 3, they actively help shape goals and measures, either in a joint workshop or through representatives of the different professional groups.

Patients, family members and peers: People with lived experience as patients or family members. They bring a perspective that healthcare professionals alone cannot provide: how safety, communication and collaboration are experienced by those directly affected. Where possible, they take part in the local safety culture team and in the workshops, in particular the maturity workshop (Step 1) as well as the prioritisation and development of measures. The nature and extent of their involvement are agreed jointly; those involved are prepared and supported so that they can contribute their perspective on an equal footing.

PLUS team: External study team that accompanies the entire cycle. It provides instruments and materials, facilitates the workshops, supports the local safety culture team and the organisation, and carries out the final evaluation.

Process

Step	Who	Methods	Outcome
Step 1: Assess *"Where do we stand?"* **Aim:** *Make the current safety culture visible*	**A) Survey** *Unit/team staff* **B) Maturity workshop** **Minimum:** *Local safety culture team* **Optional:** *Institutional representatives (depending on the institution); other stakeholders from the unit/team/organisation, interdisciplinary where possible; direct involvement of patients or their family members is encouraged* **Without workshop participation:** *individual assessment* *Facilitated by the PLUS team*	**A)** *Staff survey in the participating units/teams (AHRQ Hospital Survey on Patient Safety Culture, Version 1.0[1]): Quantitative assessment of how staff perceive the safety culture in their unit/team and across the organisation.* **B)** *Maturity workshop using the Manchester Patient Safety Framework (MaPSaF)[2]: Developed at the University of Manchester, this tool describes five levels of safety culture maturity, from A "pathological" (safety is not a concern) to E "generative" (safety is an integral part of everyday practice). In the workshop, participants assess where their team and organisation stand, discuss differing perspectives, strengths and weaknesses, and develop a shared vision for a more mature safety culture.*	*Survey results report (SOPS)* *Safety culture maturity profile (MaPSaF)*
Step 2: Prioritise *"What do we focus on?"* **Aim:** *Develop a shared understanding of the SOPS and MaPSaF results and define 1 to 2 relevant and realistic improvement priorities to promote patient safety*	**Minimum:** *Local safety culture team* *Supported by the PLUS team*	*Participatory prioritisation workshop in four phases:* 1. *Presentation of the SOPS and MaPSaF results and discussion to develop a shared understanding of strengths and areas for improvement.* 2. *Each person first rates each topic or dimension individually according to impact and effort, before any group discussion; this ensures that every voice is heard, regardless of hierarchy.*	*1 to 2 jointly validated improvement priorities that take into account the results, the context, and the stakeholders concerned*

[1] *Version 1.0 of the Hospital Survey on Patient Safety Culture is used. It is established in Swiss hospitals, available in translated versions and was used in the nationally coordinated survey in 2023. This keeps the results comparable with existing Swiss data. AHRQ published a revised Version 2.0 in 2019.*

[2] University of Manchester. (2006). Manchester Patient Safety Framework (MaPSaF) Acute. https://www.ajustnhs.com/wp-content/uploads/2012/10/Manchester-Patient-Safety-Framework.pdf / Parker, D. (2009). Managing risk in healthcare: understanding your safety culture using the Manchester Patient Safety Framework (MaPSaF). https://doi.org/10.1111/j.1365-2834.2009.00993.

Step	Who	Methods	Outcome
		 3. *The ratings are combined in an impact/effort matrix:* – *Impact: To what extent would working on this topic or dimension strengthen the safety culture and contribute to patient safety?* – *Effort: How much work would be needed to make progress on this topic or dimension? (feasibility, implementation capacity, resources)* 4. *Joint discussion of the topics, taking into account the organisational context, ongoing changes and the perspectives of the various stakeholders, in order to select 1 to 2 improvement priorities.*	
Step 3: Develop *"How do we make it tangible?"* **Aim:** *Design an everyday scenario that illustrates the selected improvement priority and makes the team's own safety culture visible (e.g. as a vignette, video or role play), with reflection questions. In addition, outline initial options for tools to be further developed with the team; the final*	**Minimum:** *Local safety culture team* **Optional:** *Involvement of the unit/team staff* *Facilitated by the PLUS team*	*Co-design workshop in four phases:* • *Collect situations: The group collects real, lived situations related to the chosen priority (e.g. "When has something gone unsaid in our team?"), selects one that many people recognise and anonymises it.* • *Build the scenario: The situation is described in five elements – place and time, people and professional groups involved, trigger, critical moment, open ending – and put into a suitable format (e.g. vignette, video, mini-simulation, role play). Check questions: Do all professional groups recognise themselves in it? Is no one blamed? Is the situation an everyday one, and does it allow for different perspectives?* • *Formulate reflection questions, in three steps:* *– What is happening here? (perception)* *– Why does this happen in our team? (cultural factors)* *– What would be different with a more mature safety culture, and what would we need to get there? (shared vision, link to the MaPSaF)* • *Prepare Step 4: Identify a few potentially relevant tools from the Toolbox PLUS as a starting point, without making a final pre-selection, and prepare the facilitation materials.*	*Preparation package for Step 4, consisting of:* • *an everyday scenario illustrating the selected priority in the chosen format (e.g. vignette, video, mini-simulation, role play)* • *reflection questions* • *some initial options for tools to be considered (Toolbox PLUS), for orientation* • *a facilitation guide*

Step	Who	Methods	Outcome
selection takes place in Step 4.			
Step 4: Decide and act *"Where do we want to go, and what will we do in concrete terms?"* **Aim:** *Define safety culture goals as well as concrete measures and how they will be implemented.*	*Local safety culture team (lead)* *Involvement of the unit/team staff:* *Two options are possible:* *(a) joint workshop with the entire team or* *(b) cascade approach via delegates from the professional groups*	*"Decide and act" workshop in four phases:* • **Introduction:** *Brief introduction to safety culture, presentation of the SOPS and MaPSaF results, and rationale for the chosen improvement priority.* • **Reflect on the scenario together:** *The everyday scenario is presented and then discussed in small mixed groups (different professional groups and hierarchical levels) using the reflection questions. Each person first notes down their own view before the group discussion. This makes the different perspectives visible, identifies the underlying cultural factors and describes the desired culture.* *– In the cascade approach, the delegates carry out the same reflection with the same questions in their own teams (e.g. 20–30 minutes during a team meeting) and record the results on a shared feedback form; the local safety culture team then brings them together.* • **Select measures:** *Based on the factors identified and the starting points outlined in Step 3, suitable strategies and tools from the Toolbox PLUS are discussed. The selection is guided by three questions: Does the measure address one of the factors identified? Is it feasible in everyday practice? Does the team support it? Each person allocates points, and then a maximum of three measures are agreed on together.* • **Action plan:** *Development of an action plan and planning of implementation.*	• *A shared understanding of the underlying factors that influence the safety culture* • *Concrete goals and improvement measures for the selected priority* • *A joint implementation plan until the next PLUS cycle*
Implementation between cycles	*Local safety culture team (lead), involving institutional representatives as well as unit managers and staff*	*Implementation of the selected measures in daily practice, regular exchange and reflection on experiences*	*Documented learnings that inform the next PLUS cycle (back to Step 1)*

Toolbox PLUS | Part 1: Tools for the dimensions of safety culture

The Toolbox PLUS assigns each dimension of safety culture a goal as well as evidence-based strategies and tools; many tools address several dimensions. Most of the tools are drawn from the underlying scoping review on safety culture (Haller et al., 2024)[3]; further tools proven in practice have been added. Details, evidence and implementation resources can be found in Part 2.

The Toolbox dimensions are a synthesis of the literature and do not correspond one-to-one to the dimensions of the SOPS or the MaPSaF. The mapping tables in the appendix show which Toolbox dimensions relate to which SOPS and MaPSaF dimensions. They are based on a content assessment by the PLUS team, not on an official mapping by the instrument developers, and are intended as guidance for joint discussion. Some dimensions are only captured indirectly: in the SOPS, for example, psychological safety is reflected in communication openness and nonpunitive response to errors; involvement of patients and family members is not a separate SOPS dimension but is addressed in the MaPSaF maturity level descriptions.

Several dimension models are used in the PLUS cycle, each serving a different purpose: the PLUS safety culture model describes, in nine dimensions, what characterises safety culture and serves as a shared frame of reference. The SOPS (12 dimensions) measures how staff perceive the safety culture; the MaPSaF (10 dimensions) supports joint reflection on the level of maturity. The 11 Toolbox dimensions are action-oriented: they group the areas in which tools can be applied in practice. The mapping tables in the appendix show how the models relate to each other.

The Toolbox does not prescribe any intervention. Teams select the approaches that suit them, adapt them and combine them according to their priorities, context, resources and level of maturity, since safety culture is fostered more effectively by a bundle of coordinated measures than by single interventions.

Safety culture dimension	Aim	Strategies / tools
Engaged leadership	*Strengthen leadership in safety*	*Safety WalkRounds, leadership training and coaching, CUSP*
Open communication / Speak Up	*Raise safety concerns clearly and effectively*	*Speak Up: awareness and measurement (SUPS-Q), SBAR, CUS and Two-Challenge Rule, check-back and call-out, brief/huddle/debrief, TeamSTEPPS, CRM training, team charter, simulation training, CUSP, communication rules*
Psychological safety	*Create a climate in which everyone can ask questions, raise mistakes and voice disagreement without fear of negative consequences*	*Leadership training (incl. role modelling and feedback), team charter, Learning from Excellence, simulation training with debriefing, workshops on psychological safety and Speak Up, check-in/check-out*
Teamwork	*Strengthen collaboration*	*TeamSTEPPS, brief/huddle/debrief, SBAR, CRM training, check-back and call-out, interprofessional simulation training, CUSP*
Just culture	*Promote a fair culture*	*Just culture guide, M&M, reflective event analysis, blame-free conversations*
Organisational learning	*Promote continuous learning*	*M&M, Learning from Excellence, debrief and After Action Review, CIRS feedback, interprofessional peer review, CUSP, case reviews*

[3] Haller, G., Simon, M., Koller, A., Morandini, N., Heltsche, L., Cullati, S., & Gehri, B. (2024). *Sicherheitskultur: Konzept und Machbarkeitsstudie. Systematische Auswertung der Literatur zur Sicherheitskultur: Massnahmen und Initiativen zur Verbesserung der Sicherheitskultur in der Schweiz und international.* University of Basel & Geneva University Hospitals, commissioned by the Federal Quality Commission. https://doi.org/10.5281/zenodo.13833587

Safety culture dimension	Aim	Strategies / tools
Handling of adverse events	*Improve reporting and feedback*	*CIRS (reporting, systematic feedback, learning bulletin), M&M, interprofessional peer review*
Staffing and workload	*Reduce workload-related risks*	*Safety huddle, escalation rules incl. staff shortages, visual management, joint prioritisation*
Supervisor support	*Strengthen the role of managers*	*Coaching of managers, Safety WalkRounds, leadership conversations, structured feedback*
Handovers and interfaces	*Prevent loss of information during handovers and strengthen collaboration across units*	*SBAR, I-PASS, check-back, bedside handover, standardised transfer and handover checklists, interprofessional peer review, joint case discussions with neighbouring units*
Involvement of patients and family members (PPI)	*Involve patients in improving safety*	*Capturing the patient experience (Swiss PREMs), bedside handover (including with SBAR), information materials, participation in M&M and analyses*

Toolbox PLUS | Part 2: Tools in detail

Part 2 describes the tools and approaches from Part 1 in detail. For each tool, there is a short description, the safety culture dimensions it helps to strengthen, and references. These include studies and reviews on effectiveness and, where available, practical implementation aids such as guides, toolkits or templates.

Tool / approach	Description	Dimension	Practical resources / Further information
Safety WalkRounds	*Structured conversations between leaders and staff on site in the care areas, using predefined safety questions. "Positive WalkRounds" variant: leaders also ask what is going well.*	*Engaged leadership; Supervisor support*	*Practical resources* • *HSE Ireland – "Quality and Safety Walk-rounds Toolkit": https://assets.hse.ie/media/documents/Quality-and-Safety-Walk-rounds-Toolkit-Resources-2016.pdf* *Further information* • *Frankel et al. (2003) – Patient Safety Leadership WalkRounds (Jt Comm J Qual Saf)* • *Positive Leadership WalkRounds and safety culture (PubMed)*
Leadership training and coaching of managers	*Development of leadership competencies in safety (training, coaching, mentoring). This also includes leaders acting as role models (leadership modelling), for example by openly acknowledging their own uncertainties and mistakes, as well as skills for giving appreciative and constructive feedback. The Co-Lead programme is an open-source intervention co-designed with multidisciplinary teams to foster collective leadership behaviours.*	*Engaged leadership; Supervisor support; Psychological safety*	*Practical resources* • *Co-Lead programme (Collective Leadership for Safety Culture)* *Further information* • *Effects of leadership on safety culture – systematic review (BMC Nursing)* • *Coaching of managers in healthcare – systematic review (BMC Med Educ)*
TeamSTEPPS® (Team Strategies & Tools to Enhance Performance & Patient Safety)	*AHRQ programme developed in the mid-2000s; it comprises four modules: communication, team leadership, situation monitoring and mutual support, with the following tools and questionnaires: SBAR, check-back, brief/huddle/debrief, CUS, Two-Challenge Rule, cross-monitoring, TeamSTEPPS Teamwork Perceptions Questionnaire*	*Teamwork; Open communication / Speak Up*	*Practical resources* • *AHRQ – TeamSTEPPS tools by module* • *TeamSTEPPS Supplemental Guide (2022), synthesis for those responsible for implementation* • *Team Performance Observation Tool (observation grid)*

Tool / approach	Description	Dimension	Practical resources / Further information
	(T-TPQ) and TeamSTEPPS Teamwork and Safety Climate Questionnaire (T-SCQ).		
SBAR	*Standardised framework for communicating about a patient's condition: Situation, Background, Assessment, Recommendation. Also used during bedside handover together with patients.*	*Open communication / Speak Up; Teamwork; Involvement of patients and family members (PPI); Handovers and interfaces*	*Practical resources* • *AHRQ – TeamSTEPPS tools (SBAR, module 1)* • *CUSP module: morning briefing, CUS, SBAR* *Further information* • *Fostering Psychological Safety: Building Team-Based Care Communication Skills (NC Med J)*
CUS and Two-Challenge Rule	*Tools from TeamSTEPPS module 4 (mutual support). They are used in interprofessional Speak Up training modules (scenarios, videos, quizzes).* *CUS: three assertive statements – "I am Concerned", "I am Uncomfortable", "This is a Safety issue" – that allow colleagues to halt the process ("Stop the Line").* *Two-Challenge Rule: if a safety concern is not addressed, it is voiced a second time and escalated if necessary.*	*Open communication / Speak Up; Psychological safety*	*Practical resources* • *AHRQ – TeamSTEPPS tools (module 4: Two-Challenge Rule, CUS)* • *Learning to Speak Up for Patient Safety – training scenarios (PMC)*
CUSP – Comprehensive Unit-based Safety Program	*Programme developed at Johns Hopkins with AHRQ support that combines improvements in safety culture, teamwork and communication with a checklist of evidence-based practices for a specific type of harm. Various toolkits are available, including setting-specific ones and ones focusing on patient outcomes or adverse events.* *Staff describe safety risks in their unit and develop their own measures as a team; the programme is structured, yet flexible enough for units to focus on the risks they themselves consider important.*	*Engaged leadership; Teamwork; Open communication / Speak Up; Organisational learning*	*Practical resources* • *AHRQ – Comprehensive Unit-based Safety Program: overview* • *AHRQ – CUSP as a culture change model (implementation guide)* • *CUSP module "Teamwork and Communication" (AHRQ)* *Further information* • *Impact of CUSP on safety culture in a surgical inpatient unit (PSNet)* • *Influence of CUSP in ICUs: Keystone ICU project (PSNet)*
Check-back and call-out	*Check-back: closed-loop communication. The receiver repeats in their own words what they have understood; the sender confirms or corrects, and the cycle is repeated until both share the same understanding.* *Call-out: stating critical information aloud in emergency situations.* *TeamSTEPPS tools, also listed in AHRQ guides (e.g. perinatal care).*	*Open communication / Speak Up; Teamwork; Handovers and interfaces*	*Practical resources* • *AHRQ – Teamwork Tools and Strategies (check-back, call-out, SBAR)* • *AHRQ – TeamSTEPPS tools by module*
Brief, huddle and safety huddle	*Brief (sharing the care plan), huddle (monitoring and adjusting the plan) and debrief (reviewing team performance) form TeamSTEPPS module 2. The safety huddle is a short interdisciplinary meeting, usually daily, to proactively identify and mitigate risks.*	*Open communication / Speak Up; Teamwork; Staffing and workload*	*Further information* • *Impact of multidisciplinary team huddles on patient safety – systematic review (BMJ Qual Saf, 2020)* • *HUSH project: implementation fidelity and effects of huddles (92 wards, 3 NHS trusts)* • *Safety huddle: concept analysis (BMC Health Serv Res, 2025)* • *Huddle intervention on surgical wards (mixed-methods study)*
Debrief and After Action Review (AAR)	*Short, structured team debrief after an event or intervention: What was planned, what happened, why, and what can we learn from it?*	*Organisational learning; Teamwork; Psychological safety*	*Practical resources* • *AHRQ – Reviewing the Team's Performance: Debrief* *Further information*

Tool / approach	Description	Dimension	Practical resources / Further information
	According to AHRQ, a debrief can take about 3 minutes or less and is most useful when linked to concrete team goals.		• *QIC-WD – synthesis of reviews on After Action Reviews* • *Tannenbaum & Cerasoli (2013) – meta-analysis on debriefs* • *Debriefing after simulation training – systematic review (PubMed)*
CIRS – reporting, feedback and learning	*Anonymous reporting system for critical incidents and near misses. In Swiss hospitals and clinics, operating a CIRS is a mandatory quality improvement measure under the quality contract pursuant to Art. 58a of the Swiss Health Insurance Act (KVG); reporting itself is voluntary. For safety culture, what matters is therefore less the existence of the system than whether incidents are actually reported and whether the feedback loop is closed: reporters receive feedback, and the improvements implemented are made visible. Possible formats include individual feedback to reporters, a learning bulletin or newsletter with anonymised cases and actions taken, and discussion in team meetings or huddles.* *Since 2006, Patient Safety Switzerland has operated CIRRNET, a supra-regional network of local reporting systems, and uses it to publish Quick-Alerts with practical recommendations.*	*Handling of adverse events; Organisational learning*	*Practical resources* • *Patient Safety Switzerland – CIRRNET and Quick-Alerts* • *Patient Safety Switzerland – Recommendations for introducing and operating a CIRS* *Further information* • *Benn et al. (2009) – Feedback from incident reporting: information and action to improve patient safety (Qual Saf Health Care)* • *SAFE Loop – intervention to strengthen reporting systems through feedback (PMC, 2025) (not yet peer-reviewed)*
Just culture – recommendations, guide	*Fair and consistent treatment of staff after an event: system and organisational factors are considered first; individual measures are only indicated in justified cases. Decision aids structure the conversation among leaders and reduce the influence of unconscious bias.*	*Just culture; Handling of adverse events; Psychological safety*	*Practical resources* • *Patient Safety Switzerland – Just culture recommendations* • *NHS England – Being fair tool: https://www.england.nhs.uk/patient-safety/patient-safety-culture/being-fair-tool/*
Team charter (team norms)	*Document developed jointly by the team that describes values, behaviours, expectations and shared goals. It should remain a living document, reviewed at regular intervals (e.g. quarterly). Visible team norms that are regularly recalled reduce uncertainty about expectations.*	*Open communication / Speak Up; Psychological safety*	*Further information* *Fostering Psychological Safety: Building Team-Based Care Communication Skills (NC Med J)* • *Article in Organizational Dynamics (2025)*
Learning from Excellence (LfE)	*Approach developed in the United Kingdom: staff report examples of excellent work by colleagues in order to learn from them and make appreciation visible.* *The official website offers a quick guide and a freely available quality improvement toolkit.*	*Organisational learning; Psychological safety*	*Practical resources* • *Learning from Excellence – implementation resources* • *LfE quick guide (PDF)* *Further information* • *LfE in the recovery room: qualitative study (BMC Health Serv Res, 2025)* • *LfE in a maternal and child care pathway (Int J Environ Res Public Health, 2021)*
Structured handovers: I-PASS and standardised transfer and handover checklists	*I-PASS is a standardised handover framework for shift changes and transfers: Illness severity, Patient summary, Action list, Situation awareness and contingency planning, Synthesis by receiver. In addition to the framework, the programme includes training, a written handover*	*Handovers and interfaces; Open communication / Speak Up; Teamwork; Involvement of patients and family members (PPI)*	*Practical resources* • *Patient Safety Switzerland – Safe medication at interfaces (progress! programme)* • *I-PASS Institute – training and implementation support*

Tool / approach	Description	Dimension	Practical resources / Further information
	template and observation with feedback. One variant involves patients and family members in ward rounds. *Standardised transfer and handover checklists define the minimum information to be passed on when patients are transferred between units or institutions (e.g. diagnoses, medication, allergies, pending tests, risks, contact persons). They should be developed together with the units involved and adapted to the local context.*		• *PSNet – Patient Safety Primer: Handoffs (overview of I-PASS, SBAR and other handover tools)* *Further information* • *Starmer et al. (2014) – Changes in medical errors after implementation of a handoff program (N Engl J Med)* • *Khan et al. (2018) – Patient safety after implementation of a coproduced family centered communication programme (BMJ)*
Morbidity and mortality reviews and conferences (M&M / MMR)	*Structured discussions or reviews of complications and deaths in order to identify system improvements. They address a wider group of learners and are distinct from sentinel event analyses conducted by a small team. A literature review recommends a multidisciplinary team, a structured presentation format and an analysis of the error process with follow-up actions, and notes that a standardised review can be introduced hospital-wide.* *Good practices mentioned: integrate M&M into patient safety governance and track results; use a short, standardised procedure that can be adapted to each specialty; involve patients (a Dutch experience in gynaecological oncology introduced patient participation in M&M); create a safe climate for discussion.*	*Organisational learning; Handling of adverse events; Just culture*	*Practical resources* • *Patient Safety Switzerland – Guide to morbidity and mortality conferences (PDF, German)* • *Patient Safety Switzerland – M&M pocket card for facilitators (PDF, German)* • *M&M curriculum guide focusing on patient safety (MedEdPORTAL)* *Further information* • *Informing best practice for conducting M&M reviews – literature review (Aust Health Rev, 2018)* • *Standardisation of M&M – systematic review (PSNet, J Patient Saf 2024)* • *Learning From M&M Conferences: Focus and Sustainability (PubMed)* • *Mortality and morbidity meetings and patient safety governance (PMC)* • *Mortality review process: organisational factors (PMC; mentions the AHRQ 6-step toolkit)* • *Cyclical workflow for implementing M&M findings (BMC Health Serv Res, 2022)* • *Introducing an M&M conference in a regional hospital (PMC)* •
Interprofessional (peer) review	*A voluntary procedure based on peer exchange: interprofessional teams from other institutions analyse processes and interfaces using patient records, often prompted by unusual values in quality indicators derived from routine data, and develop improvement proposals together with the care team. The procedure is confidential and free of blame and sanctions. In Switzerland, the Peer Review CH alliance (H+, FMH, Swiss Nurse Leaders) promotes the IQM procedure in acute somatic care and, since 2023, an analogous procedure in psychiatry.*	*Organisational learning; Handling of adverse events; Handovers and interfaces*	*Practical resources* • *Interprofessional peer review procedures: recommendation of the "Peer Review CH" alliance* • *Interprofessional reviews in psychiatry*
Speak Up – raising safety concerns / Psychological safety	*Patient Safety Switzerland offers the SUPS-Q questionnaire, a tool to measure and monitor the Speak Up culture within one's own organisation, as well as a practice recommendation with concrete guidance for leaders and staff, and awareness-raising materials (including explanatory videos) to promote Speak Up.*	*Open communication / Speak Up; Psychological safety*	*Practical resources* • *Patient Safety Switzerland – Speak Up resources* • *SUPS-Q questionnaire* • *Practice recommendation no. 8* *Further information* • *O'Donovan & McAuliffe (2020) – systematic review of interventions*

Tool / approach	Description	Dimension	Practical resources / Further information
			• *Changing minds, saving lives: how training psychological safety transforms healthcare* • *A concept analysis of psychological safety: Further understanding for application to health care*
Simulation-based interprofessional team training (incl. CRM- and TeamSTEPPS-based training)	*Practice-oriented training in which teams rehearse critical situations realistically, ideally interprofessionally and directly in their own work environment (in situ simulation). The main learning effect occurs in the structured debriefing, in which the team itself reflects on what happened instead of being lectured. To ensure that the content is taken on board, scenarios are developed together with staff, for example based on their own CIRS reports or near misses in the unit. Staff can also be trained as peer instructors (train-the-trainer), which increases acceptance and lowers the threshold for openly discussing errors and uncertainties. Afterwards, supervisors support the transfer into everyday practice, e.g. by taking up identified system problems and reporting back on improvements.* *CRM (Crew Resource Management): Training concept originating from aviation that focuses on teamwork, communication and decision-making in critical situations.*	*Teamwork; Open communication / Speak Up; Psychological safety*	*Further information* • *Impact of Teamwork and Communication Training Interventions on Safety Culture and Patient Safety in Emergency Departments – systematic review* • *Does classroom-based Crew Resource Management training improve patient safety culture? – systematic review* • *Promoting a Culture of Safety as a Patient Safety Strategy – systematic review (Ann Intern Med, 2013)*
Involvement of patients and family members (PPI)	*Proactive involvement of patients and family members at two levels: (1)* **Capturing their perspective:** *feedback on the patient experience, e.g. using the Swiss PREMs (ANQ), which can also be used outside the national measurement and complements the staff survey (SOPS) with the patient perspective. (2)* **Involving them actively:** *bedside handover (including with SBAR), encouraging patients to ask questions (e.g. Ask Me 3), escalation systems that can be activated by patients and family members, and participation in M&M, event analyses and the local safety culture team.*	*Involvement of patients and family members (PPI)*	*Practical resources* • *ANQ – Patient and parent experience* • *Swiss PPIE Network* • *AHRQ – Guide to Patient and Family Engagement in Hospital Quality and Safety* • *AHRQ – Strategy 3: Nurse Bedside Shift Report (brochure, checklist, training)* • *IHI – Ask Me 3 (posters and brochures in English, French and Spanish)* • *AHRQ – Questions Are the Answer and communication tools for patients* *Further information* • *PSNet – Patient Engagement and Safety (overview)* • *Patient- and family-activated escalation systems – systematic review* • *Involvement of those affected, relatives and the public: assessment of the need for action to promote quality in healthcare from the perspective of patient organisations*

Cross-cutting methods

The following methods can be used across several dimensions and are established good practice:

Group	Methods	Purpose
Team rituals	*Check-in / check-out; regular short briefings (cf. safety huddle); visual management*	*Create a shared picture of the situation, raise concerns early, make workload visible*
Conversations and feedback	*Structured feedback; leadership conversations; blame-free conversations; reflective event analysis; case reviews*	*Learn from experience, leadership through dialogue, fair handling of events*
Rules and processes	*Communication rules (cf. team charter); escalation rules: agreed criteria on when, how and to whom safety concerns or bottlenecks are passed on (e.g. in case of staff shortages, high workload or when a concern is not heard, cf. Two-Challenge Rule); joint prioritisation (impact/effort matrix)*	*Clarify expectations, escalate risks in good time and without hesitation, use resources in a targeted way*
Learning and training formats	*Practice-oriented, participatory formats instead of lecture-style teaching: exercises based on the team's own cases (e.g. from CIRS), role play and simulation with debriefing (cf. simulation training), peer learning and train-the-trainer, short recurring learning units integrated into daily work*	*Build knowledge and skills close to practice, ensure transfer into everyday work*

Appendix: Mapping tables from the SOPS (Hospital Survey 1.0), the MaPSaF and the PLUS safety culture model to the Toolbox

From the SOPS dimensions to the Toolbox

SOPS dimension	Toolbox dimension (primary)	Toolbox dimension (complementary)
Teamwork Within Units	*Teamwork*	*Psychological safety*
Supervisor/Manager Expectations & Actions Promoting Patient Safety	*Supervisor support*	*Engaged leadership*
Organizational Learning – Continuous Improvement	*Organisational learning*	*Handling of adverse events*
Management Support for Patient Safety	*Engaged leadership*	–
Feedback & Communication About Error	*Handling of adverse events*	*Organisational learning*
Communication Openness	*Open communication / Speak Up*	*Psychological safety*
Frequency of Events Reported	*Handling of adverse events*	*Just culture*
Nonpunitive Response to Errors	*Just culture*	*Psychological safety*
Staffing	*Staffing and workload*	–
Teamwork Across Units	*Handovers and interfaces*	*Teamwork*
Handoffs & Transitions	*Handovers and interfaces*	*Open communication / Speak Up*
Overall Perceptions of Patient Safety	*cross-cutting**	–

From the MaPSaF dimensions to the Toolbox

MaPSaF dimension	Toolbox dimension (primary)	Toolbox dimension (complementary)
1. Commitment to overall continuous improvement	*Engaged leadership*	*Organisational learning*
2. Priority given to safety	*Engaged leadership*	*Supervisor support*
3. System errors and individual responsibility	*Just culture*	*Psychological safety*
4. Recording incidents and best practice	*Handling of adverse events*	*Just culture*
5. Evaluating incidents and best practice	*Handling of adverse events*	*Organisational learning*
6. Learning and effecting change	*Organisational learning*	–
7. Communication about safety issues	*Open communication / Speak Up*	*Psychological safety*
8. Personnel management and safety issues	*Just culture*	*Supervisor support*
9. Staff education and training	*cross-cutting***	*Teamwork*
10. Teamwork	*Teamwork*	–

** The overall perception is an outcome measure, not a lever in itself. If it is low, it is worth looking at the other dimensions to identify the causes.*

*** There is no separate Toolbox dimension for this; the cross-cutting group "Learning and training formats" and simulation-based team training are relevant.*

From the PLUS safety culture model to the Toolbox

PLUS model dimension	Toolbox dimension (primary)	Toolbox dimension (complementary)
Visible leadership commitment	*Engaged leadership*	*Supervisor support*
Open communication	*Open communication / Speak Up*	*Psychological safety*
Just culture	*Just culture*	*Psychological safety*
Positive learning culture	*Organisational learning*	*Handling of adverse events*
Supportive teamwork	*Teamwork*	*Handovers and interfaces*

PLUS model dimension	Toolbox dimension (primary)	Toolbox dimension (complementary)
Patient and peer involvement	*Involvement of patients and family members (PPI)*	–
Staff well-being	*Staffing and workload*	*Psychological safety*
Safety resources and training	*Staffing and workload*	*cross-cutting***
Evidence-based practice	*cross-cutting****	*Organisational learning*

**** There is no separate Toolbox dimension for this; evidence-based practice is mainly supported by tools such as M&M, interprofessional peer review and case reviews.*