Safer Care Victoria

Victorian Safety Culture Guide

Designed for Boards, CEOs, and Executives

To receive this publication in an accessible format, email Safer Care Victoria info@safercare.vic.gov.au

Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.

© State of Victoria, Australia, Safer Care Victoria, July 2024.

ISBN 978-1-76131-636-4

Available at Safer Care Victoria www.safercare.vic.gov.au (1709046)

VICTORIA State Government

Foreword

As the Chief Executive Officer of Safer Care Victoria, it is my distinct pleasure to introduce the Victorian Safety Culture Guide. This comprehensive guide is a testament to our unwavering commitment to ensuring the highest standards of safety across the Victorian healthcare system.

Safety is not just a priority, it is a core value that shapes every decision we make and every action we take. In our rapidly evolving world, maintaining a robust safety culture is paramount. It requires continuous measurement and monitoring of our systems, behaviours and practices to proactively safeguard the wellbeing and safety of our patients, healthcare workforce and the broader community.

The Victorian Safety Culture Guide has been crafted to provide actionable insights, practical tools, and best practices in measuring and monitoring safety culture, which can be integrated into the daily operations of healthcare organisations. It is designed to support Victorian health services of all sizes and specialities in their journey towards cultivating a culture where safety is ingrained in every aspect of clinical governance and patient care.

This guide emphasises the importance of leadership in driving safety culture. As senior leaders within the health system, it is our responsibility to model safe behaviours, to encourage open communication, and to foster an environment where every individual feels empowered to speak up about safety concerns without fear of retribution. A thriving safety culture is built on trust, respect, and a shared commitment to protecting one another and the communities we serve.

Moreover, the guide highlights the significance of continuous learning and improvement. Healthcare is a dynamic field that demands constant vigilance and adaptability. By staying informed about the latest safety practices, evidence-based approaches, and regulatory requirements, we can proactively mitigate risks and prevent harm.

I extend my heartfelt gratitude to all the contributors who have shared their expertise and experiences to make this guide a valuable resource. Without the participation of clinical leaders, experts, and consumers this guide could not have been developed. Your dedication to promoting safety culture across the sector is truly commendable.

We will continue to work with you to support the implementation of this guide in a purposeful and meaningful way.

Together, we can build a safer, healthier, and more resilient healthcare system for all Victorians.

Sincerely,

Louise McKinlay
Chief Executive Officer
Safer Care Victoria
Chief Quality and Safety Officer Victoria

Contents

Acknowledgement of Country

Our office is based on the land of the Traditional Owners, the Wurundjeri people of the Kulin Nation. We acknowledge and pay respect to their history, culture, and Elders past and present. We acknowledge Aboriginal people as Australia's first peoples and as the Traditional Owners and custodians of the land and water on which we rely. We recognise and value the ongoing contribution of Aboriginal people and communities to Victorian life and how this enriches us. We embrace the spirit of reconciliation, working towards the equality of outcomes and ensuring an equal voice. For this land always was, and always will be, Aboriginal Land.

Acknowledgements

Safer Care Victoria would like to acknowledge and thank the contribution of the advisory group of Subject Matter Experts, Clinical Leaders (Boards and Executives) and Consumers who provided input in developing The Victorian Safety Culture Guide:

- Miranda Cornelissen, *Yooralla*
- Keren Day, *Barwon Health*
- Catherine Jones, *Royal Women's Hospital*
- Cathy Jones, *Goulburn Valley Health, EACH, TAC*
- Varnia Muys, *Royal Melbourne Hospital*
- Stephanie Newell, *Consumer, Patients for Patient Safety Australia*
- Katharina Redford, *Moyne Health Services*
- Matthew Sabin, *Cabrini Health*
- Raphaela Schnittker, *Safer Care Victoria*
- Valerie Villinger, *Consumer, Monash Health*

Overview

Safer Care Victoria (SCV) is committed to co-creating a consistently safe and continuously improving healthcare system. Clinical governance is the central element of a system that supports the delivery of high-quality care, with safety culture underpinning this safe system. Good governance is vital to safety culture, it drives best practice and ensures the creation of safe environments for healthcare workers and consumers.

Victoria is home to some of the best health facilities and treatments in the world. However human error, system failures and avoidable harm are realities that every healthcare system must continually strive to prevent.

The Victorian Managed Insurance Authority (VMIA) states that up to 1 in 10 of the 2 million hospital stays may be affected by an adverse clinical event.[1] While most preventable clinical incidents do not result in injury, it has been estimated that around 12 per cent of avoidable adverse events will result in serious physical or psychological harm, permanent disability or most tragically, death.[1,12]

Embedded positive safety cultures that promote continually improving quality and safety systems, and practices can result in the minimisation of harm.

Senior leaders play a critical role in implementing and sustaining positive safety culture.

Maintaining a positive safety culture involves robust measurement and monitoring of identified risks to detect early warning signs of safety concerns and predictors of harm, with safety culture as a key metric in this endeavour.[4]

In healthcare, ensuring high-quality care is paramount. The elements of high-quality care are safe, timely, effective, efficient, equitable and person-centred. This Victorian Safety Culture Guide provides healthcare Boards, Chief Executive Officers (CEO), and Executives with practical methods to measure, monitor, and enhance safety culture within their organisations.

With safety culture being a reliable predictor of clinical behaviours and outcomes[4], this guide provides comprehensive approaches to assess, understand and evaluate safety culture using a variety of methods readily available in most Victorian health services.

Glossary

Term	Definition
Adverse Patient Safety Event (APSE)	An incident that results, or could have resulted, in harm to a patient or consumer. A near miss is a type of adverse event. (SAPSE and sentinel event are a subset of APSE.)
Burnout	Burnout is defined as a syndrome of depersonalisation, emotional exhaustion and a sense of low personal accomplishment leading to decreased effectiveness at work.[14]
Consumer	The term 'consumers' is inclusive and refers to patients, residents, clients, families, supporters, carers, those with lived and living experience (LLE) carers, advocates, representatives, and communities who may be past, current, or potential users of healthcare services.
Employee feedback	Structured mechanisms and processes designed to capture insights, opinions, and experiences of employees regarding aspects of their work environment.
Employee wellbeing	Relates to all aspects of work life. It includes your workers' physical and psychological safety, workload, how their work is designed and organised, support from leaders and peers, and more. When you get it right, you create an environment that fosters meaning, purpose and belonging where workers are safe, healthy, satisfied and engaged.[14]
Organisational culture	The shared values, customs, and behaviours that shape how an organisation operates, treats its employees, serves its customers, evaluates its leaders, and measures performance. Culture is the expression of the organisation's values, norms, and behaviours. A co mmon interpretation of culture is 'the way things are done around here'.[1,11]
Safety culture (construct measure)	The product of individual and group values, attitudes, and behaviours that determine the commitment to and practice of organisational safety.[2,11]
Sentinel event	Is defined in the *Health Services (Quality and Safety) Regulations 2020* as an unexpected and adverse event that occurs infrequently in a health service and results in the death of, or serious physical or psychological injury to, a patient as a result of system and process deficiencies at the health service entity.
Serious Adverse Patient Safety Event (SAPSE)	A serious adverse patient safety event is defined, in section 3(1) of the *Health Services Act 1988*, as an event of a prescribed class or category that results in harm to one or more individuals. A prescribed class or category is an event that: • occurred while the patient was receiving health services from a health service entity; and • in the reasonable opinion of a registered health practitioner, has resulted in, or is likely to result in, unintended or unexpected harm (which includes moderate harm, severe harm or prolonged psychological harm) being suffered by the patient. To avoid doubt, this includes an event that is identified following discharge from the health service entity.[5]
Statutory Duty of Candour (SDC)	A legal obligation for Victorian health service entities to apologise to and communicate openly and honestly with patients, their families or carers when a SAPSE has occurred. It builds on the Australian Open Disclosure Framework currently used for all cases of harm and near miss. Statutory duty of candour is set out in section 128ZC of the *Health Services Act 1988*, section 22I of the *Ambulance Services Act 1986* and section 637 of the *Mental Health and Wellbeing Act 2022*.
Triangulate / triangulation	Is the practice of collecting data from multiple sources or employing various methods to confirm findings or validate conclusions. It enhances reliability and provides a comprehensive understanding of the subject.

What is safety culture?

Safety culture is an aspect of organisational culture that describes the shared beliefs, values, attitudes, and practices as they relate to safety. A powerful predictor of patient harm, an organisation's safety culture plays a pivotal role in shaping the quality of care in healthcare systems.[1,4]

Boards, CEOs, and Executives are key to building, maintaining, and leading safety culture across their organisation. It is a deliberate process involving strategic decision-making, adept risk management, effective communication, and consistent efforts to prioritise safety across all levels of the organisation.

Organisations will vary in terms of their safety culture maturity based on a variety of factors such as environmental influences and leadership.[16] Moving up and down the maturity spectrum is common and may be variable within one organisation. Consistent focus on safety improvement is required for higher maturity. For information on safety culture maturity levels refer to Appendix 4.

Figure 1. Safety culture conceptual framework (SCV)

Safety culture conceptual framework

James Reason (1997) describes five interrelated subcultures (Informed, Reporting, Just, Learning and Flexible) which contribute to the overall safety culture of an organisation.[10] Through an extensive literature review, SCV identified key elements to enhance Reason's safety culture model.

These are employee engagement, employee wellbeing, psychological safety, and leadership support making up the SCV safety culture conceptual framework (Figure 1). This framework encompasses fundamental elements that enable a safety culture to thrive and can be used to measure and monitor an organisations safety culture.

Ultimately, this framework and a strong safety culture positively influence care delivery and patient outcomes by fostering an environment where safety is prioritised, risks are managed, and continuous improvement is encouraged.

This guide uses this conceptual framework (see Figure 1)[4] to provide insights and practical methods to assess, evaluate and enhance safety culture, using employee surveys, workforce data metrics and other recommended approaches that are available in most Victorian health services.

The table below lists the safety culture conceptual framework's elements and their definitions in this context.

Elements	Definitions
Informed 	Relevant safety information is collected, analysed, and actively disseminated enabling individuals to make informed decisions.[11]
Reporting 	An environment where individuals have the confidence and feel safe to report safety issues without fear of blame, and where they can trust their concerns will be acted upon. Reporting mechanisms are user friendly, timely, and enable closed loop communication with affected employees.[11]
Just 	Just culture encourages balanced accountability between organisations and individuals, and the application of systems-thinking principles to allow fair and just responses to adverse events.[10,11]
Learning 	Adverse events and near misses are seen as opportunities for learning and changes are made as a result. It is an atmosphere where continuous learning and the pursuit to evolve, and grow are embraced.[10,11]
Flexible 	The ability to adapt, change and respond to evolving demands. Employees and leaders can shift from a conventional hierarchical model to a more agile, flatter professional structure as required.[11]

Elements	Definitions
Leadership support 	The support provided by local and senior leaders to employees through role modelling the expected behaviours and attitudes, helping employees perform their roles, feel capable to achieve their responsibilities and support their overall wellbeing.[4]
Psychological safety 	The belief held by individuals that it is acceptable to speak up and take interpersonal risks, through the form of expressing ideas and concerns, asking questions, and admitting mistakes; all without fear of negative consequences.[4,7]
Employee engagement 	Employee engagement is the strength of the mental and emotional connection employees feel toward the work they do, their teams, and their organisation.[4,15]
Employee wellbeing 	Relates to all aspects of work life. It includes your workers' physical and psychological safety, workload, how their work is designed and organised, support from leaders and peers, and more. When you get it right, you create an environment that fosters meaning, purpose and belonging where workers are safe, healthy, satisfied and engaged.[8]

Integrated frameworks for high-quality care

Fostering a positive safety culture is a prerequisite for enabling best practice in clinical governance. The Safety Culture Conceptual Framework, the Victorian Clinical Governance Framework, and the Partnering in HealthCare Framework are intricately aligned and interrelated, forming the foundation of our approach to delivering high-quality care.

The Safety Culture Conceptual Framework prioritises creating an environment where safety is paramount, employees feel empowered to voice concerns, and continuous improvement is encouraged. This robust safety culture underpins effective clinical governance, ensuring accountability and quality improvement through strong systems and leadership.

Furthermore, a positive safety culture is crucial for successful partnering in healthcare, building trust and fostering meaningful consumer engagement, aligning care with their needs and preferences.

Understanding and leveraging the connections between these frameworks, organisations can enhance their collective efforts to provide exceptional care. The accompanying image illustrates these frameworks as a triangle, with connecting arrows highlighting their interdependence and placing safety culture at the core of good clinical governance and effective consumer partnerships. See Appendix 6 for further information on the Victorian Clinical Governance Framework including roles and responsibilities of Boards, CEOs, and Executives and the Partnering in Healthcare Framework.

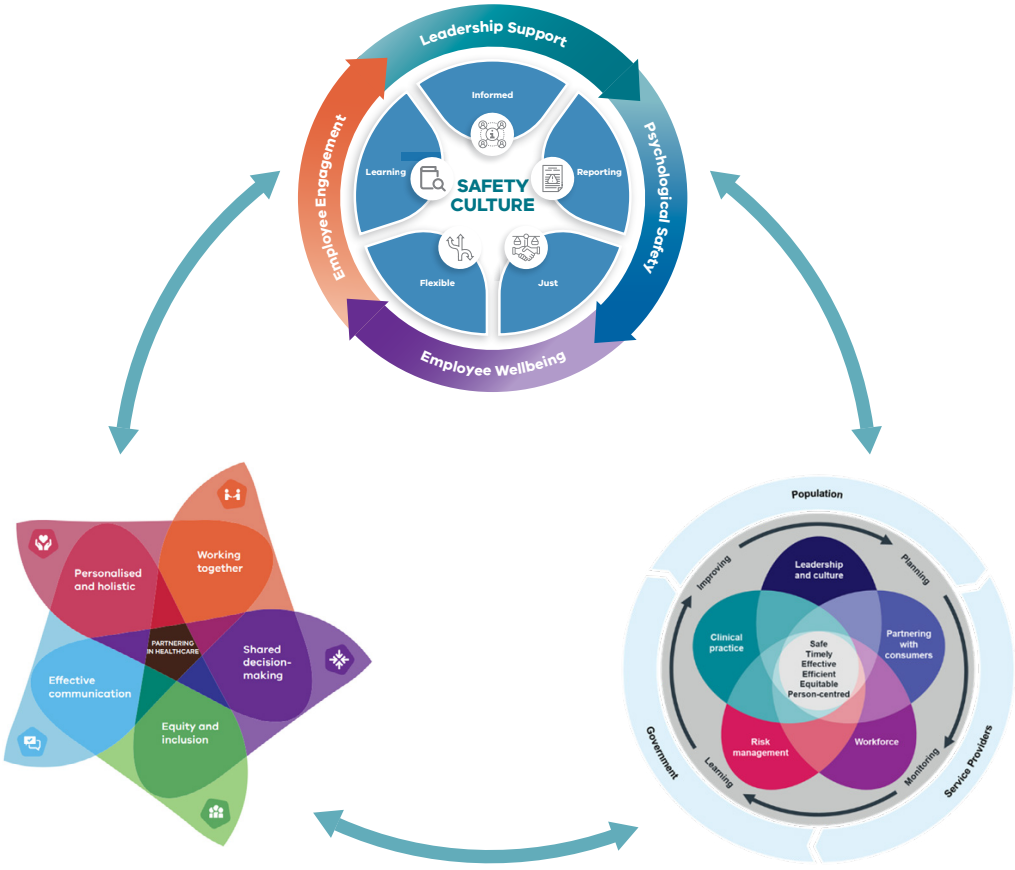

Figure 2. Connecting frameworks for high-quality care

Why is safety culture important?

Safety culture transcends compliance and procedures, it embodies the fundamental right that consumers receive safe care.

Positive safety cultures can minimise harm, enhance care quality and serve as a key metric for evaluating high quality care aligning with the National Safety and Quality Health Service (NSQHS) standards.[1]

Measuring safety culture is essential because it provides a comprehensive understanding of the attitudes, beliefs, perceptions, and practices of individuals and groups within an organisation regarding safety. This understanding is critical for creating a safe working environment to positively influence care delivery and enhance overall organisational performance. Embedding positive safety culture has many key benefits including:

Key benefits

- Strong safety cultures are essential for aligning with the proposed Victorian regulations aimed at strengthening the occupational health and safety framework, by actively managing work-related psychosocial and physical hazards.[19]
- Investigations by VMIA have shown a correlation between positive workplace safety cultures and reduced insurance claims, underlining the pivotal role of organisational culture in risk management and financial stability.[18]
- Positive safety cultures contribute to higher employee engagement, leading to improved employee retention and productivity.[2,6]
- Organisations with strong safety cultures have stronger organisational reputation and brand, which contributes to their ability to attract and retain a skilled workforce and may positively influence consumer choice.[4]
- Safety culture is enhanced by partnering with consumers. Organisations can implement Safer Care Victoria's Partnering in Healthcare Framework to partner with consumers to improve their safety culture.
- Measuring and monitoring safety culture enables organisations to identify improvement areas, engage stakeholders, and make informed, data-driven decisions to enhance safety performance.
- Assessing and evaluating safety culture gives organisations the opportunity to learn from what works and what doesn't work within their system, allowing them to take action to improve.

"A culture recognising safety is not just about physical protection, but emotional security. It is characterised by empathy, active listening, and an understanding of my needs and concerns."

– Consumer

Instilling a positive safety culture is not a one-off effort, it is a continuous process.

Employee attitudinal surveys

Surveying employees' values, attitudes, and behaviours is the most common way to assess safety culture in an organisation. SCV recommends measuring and monitoring the constructs below to align with the conceptual framework.

These constructs when evaluated, contribute to the overall measurement of safety culture.

- Safety culture
- Employee engagement
- Employee psychological safety
- Employee wellbeing
- Leadership support

In Victoria, the People Matter Survey (PMS) includes these specific constructs and is the preferred tool for measurement. These measurement constructs, taken from the PMS are outlined in Table 1. The questions for each subscale of these constructs are listed in Appendix 5.

SCV strongly encourages eligible health services to use the PMS. For those ineligible or seeking additional surveys, alternative psychometrically validated surveys are available to measure SCV's safety culture conceptual framework constructs.

As the PMS is limited to public entities, non-public health services can use alternative surveys to measure the constructs.

1. Safety Attitude Questionnaire (SAQ)

The internationally recognised SAQ short-form version is widely used to measure patient safety culture and has been validated in South Australia and Victoria. The SAQ comprises of six domains that measure all of SCV's safety culture framework constructs. The table below highlights the similarities between the SAQ and the SCV safety culture framework construct measurements.

SAQ Domain	Similar to SCV Safety Culture Framework Constructs
Teamwork climate	Safety culture (health sector only)
Safety climate	Psychological safety and safety culture
Job satisfaction	Employee engagement
Perceptions of management	Leadership support
Working conditions	Employee wellbeing
Stress recognition	Employee wellbeing

NB: The A-HSOPS 2.0 domains are not equivalent psychometric measures to the SCV Safety Culture Framework. This table only highlights the areas of alignment.

2. Australian Hospital Survey on Patient Safety Culture Version 2 (A-HSOPS 2.0)

The A-HSOPS 2.0 survey measures employee's opinions about patient safety issues and has been validated and tested for use in Australian public and private hospitals. The A-HSOPS 2.0 survey covers nine composites with 6 main domains focused on safety culture. The table below highlights the similarities between the A-HSOPS 2.0 and the SCV safety culture conceptual framework construct measures.

A-HSOPS 2.0 Survey Main Domains	Similar to SCV Safety Culture Framework Construct
Supervisor/Manager/Hospital Management	Leadership support
Your unit/work area	Psychological safety/employee wellbeing
Communication	Psychological safety
Reporting patient safety	Psychological safety
Your hospital	Leadership support
Recommendation	Employee engagement **Note:** contains only [1] question in this domain pertaining to employee engagement

NB: The A-HSOPS 2.0 domains are not equivalent psychometric measures to the SCV Safety Culture Framework. This table only highlights the areas of alignment.

Further information about the SAQ and the A-HSOPS 2.0 survey including data analysis can be found at the Australian Commission on Safety and Quality in Healthcare (ACSQH) and in Appendix 6.

For organisations that have established survey tools, SCV can provide support to review those tools to ensure the four constructs are being measured. Please contact culture.capability@safercare.vic.gov.au for support.

CONSIDERATIONS WHEN USING EMPLOYEE ATTITUDINAL SURVEYS

When implementing the PMS or alternative survey tools, it is important to consider the following points to ensure accurate and meaningful data collection and interpretation.

Considerations specific to the People Matter Survey

- The PMS, utilised throughout the public sector, is an employee attitudinal survey that uses a 5-point Likert scale to rate agreement with statements. Attitudinal survey data is typically reported using this scale as a percentage of favourable responses.
  - Percentage (%) favourable is the sum of the ratings 'strongly agree' and 'agree'. For assessing employee perceptions of safety culture and its components, an ideal favourable rating ranges between 80% and 100%. See table below for survey score ratings and their range interpretations.

Survey Score Interpretation	
80% - 100%	Optimal
70% - 79%	High average
60% - 69%	Medium average
50% - 59%	Low average
49% or below	Poor

- Positive trends in aggregated agreement scores on safety culture and its components, towards the target of 80-100%, signals ongoing improvement. This can be just as critical as achieving the target itself, as employee experiences and attitudes are highly vulnerable to external influences, employee turnover, and leader turnover.
- Health services using the PMS with fewer than 10 responses from a specific demographic group will not receive results from the Victorian Public Sector Commission (VPSC).[17]
- If an organisation receives fewer than 30 responses in total, VPSC is unable to provide details on specific demographic groups.[17] Therefore, encouraging participation in the PMS from all demographic groups within an organisation will increase response rates. Health services may need to plan ahead to accommodate this if this a known limitation.
- Contracted employees who work across multiple health services such as, Visiting Medical Officers (VMOs), may not be adequately represented in standard employee attitudinal surveys. Health services are encouraged to adopt methods that ensure the inclusion of such individuals to provide a comprehensive and accurate representation of safety culture.

General considerations for analysing and interpreting safety culture survey data

- Carefully consider survey responses that are incomplete (less than 20%) or completely blank.
- Be wary of responses that make up a substantial majority (80% to all) of the same answers. This could suggest bias and affect data accuracy therefore, exercise caution before using such data.
- Be wary of survey data that has a response rate of 30% or less, whether at the organisational level or disaggregated at the unit level.
  - At a minimum, the response rate target of 30% is appropriate to be representative of the aggregated organisational response.[15] Anything less than 30% should be treated as indicative, which should be interpreted with caution alongside alternate indicators. This is because a small percentage of respondents cannot be generalised and considered representative of the broader workforce.
  - Larger organisations should aim for 30% completion rate by ward, service, or professional craft group (depending on how the data is segmented). This allows organisations to extract more meaningful information and insights from the data which is more representative of the organisation more broadly.[15]
- Pulse surveys are highly recommended when trying to understand variabilities in the system. The psychometrically validated surveys such as the SAQ and A-HSOPS 2.0 can be used as additional pulse surveys.
- Consider intersectionality and the experiences of diverse cultural groups within the organisation or accessing health services, recognising that a simple analysis of aggregate data may obscure disparities in safety perceptions across different demographics and roles, thereby necessitating a more detailed examination of survey results.

Key messages

- Table 1 located in Appendix 1 within this guide provides detail on the measurement of these constructs specific to the PMS.
- Safety culture can be variable across an organisation, therefore segregating data helps to determine and examine vulnerabilities in the system.
- Positive trends in safety culture and its components, towards the target of 80-100%, signals ongoing improvement. This can be just as critical as achieving the target itself.
- Building and maintaining a positive safety culture is a continuous process. Consistently monitoring trends in scores over time, and responding to this information constructively, is key to improving safety culture maturity of an organisation.

Using this information to understand the employee experience, implement meaningful improvement initiatives, evaluate their effectiveness, and learn from the process is the ideal leadership behaviour expected at all levels of organisational leadership.

Triangulating safety culture measurement

Employee survey data is one component of measuring and monitoring safety culture. SCV recommends they not be measured and monitored in isolation to inform decision-making. Multiple data points should be used, such as workforce metrics and other methods (outlined in this guide) within an organisation to triangulate safety culture measurement.

Workforce metrics

Measuring and monitoring workforce metrics can provide insights into the wellbeing of employees. Workforce wellbeing is a strong predictor of employee engagement and safety culture.[9,13] These measures include above or below-average sick leave balances, excessive annual leave balances, above-average spend on agency staff, above-average overtime expenditure, and above-average employee turnover. Table 2 provides further detail on measuring and monitoring these metrics.

Use workforce data to gain continuous insights into workforce dynamics and help to identify patterns and trends that reflect the state of safety. Boards and Executives should regularly report, review, and analyse this data and incorporate this into safety metrics. These insights support proactive interventions to enhance safety practices, improve employee wellbeing and foster a positive safety culture, leading to better care delivery.

Other approaches and best practice

In addition to survey data and workforce metrics, a range of established methods in most Victorian health services are available for evaluating an organisation's safety culture. These approaches are integral in triangulating information and observing how safety culture is exhibited in practice.

Table 3 presents a range of methods for triangulating safety culture measurement including guidance for implementing and monitoring these approaches. It also provides examples of positive indicators and best practice of safety culture, demonstrating the association with the elements and constructs of the SCV's Safety Culture Conceptual Framework.

Whilst not exhaustive, the methods and approaches outlined in Table 3 are crucial for understanding how safety culture is demonstrated in practice. They align with the implementation of the NSQHS standards and effective clinical governance. Recognising that safety culture measurement requires a mixed methods approach, the recommendations offered in this guide aim to assist health service leaders to triangulate safety culture data. This information helps in understanding the impact on care delivery and patient outcomes.

This information, coupled with the measures detailed earlier in the guide will provide insights into an organisation's safety culture maturity (see Appendix 4). It will assist Boards, CEOs, and Executives in identifying systemic risks, making informed decisions to mitigate these safety risks and creating opportunities for continuous improvement promoting a robust safety culture for everyone.

Steps towards success

This guide provides a comprehensive approach for measuring and monitoring safety culture within Victorian health services. Using the methods and metrics outlined in this guide, Boards, CEOs, and Executives can gain valuable insights into the strengths and limitations of their safety environment. Remember, a strong safety culture is not just an aspiration, it's a strategic investment. By prioritising safety culture, organisations are continually learning to improve high-quality care.

The model (Figure 3) summarises the steps towards a comprehensive method to measuring and monitoring safety culture using a five-level approach. This approach captures the methods and measures detailed in this guide, supporting the SCVs safety culture conceptual framework. The visual representation serves as a reminder of the essential components necessary to assess and understand safety culture, how it is applied in practice, and observing the impact and benefits of a strong safety culture within an organisation.

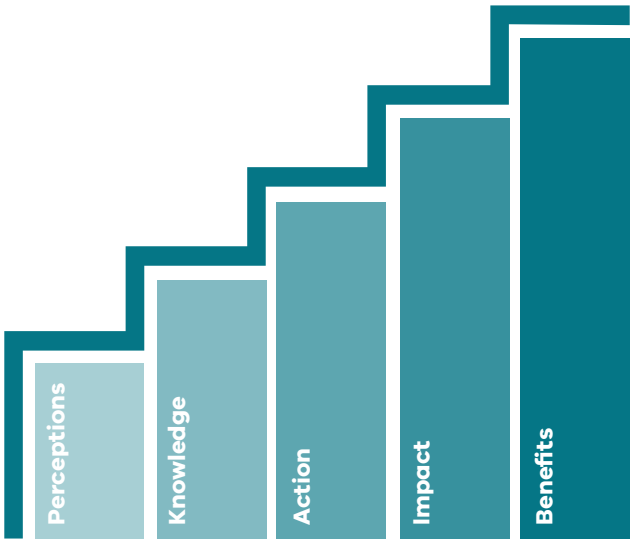

Figure 3.
Measuring and monitoring safety culture – Steps toward success

Benefits
The benefits of a good safety culture can be seen through reduced costs from minimised patient and employee harm, an enhanced organisational reputation where consumers feel safe seeking care and an environment which attracts and retains a skilled and stable workforce (e.g., positive reflections in workforce metrics, employee and consumer feedback, clinical reported outcomes).

Impact
What are the impacts? How safe is the workplace? These can be quantified by number of reported adverse events or the types of adverse events reported. Are there unintended consequences from prioritising safety? How can these be managed without compromising safety?

Action
The behaviours observed in the organisation that demonstrate safety culture. How is safety culture practised in the organisation? (e.g., using methods and approaches outlined in Table 3 can help triangulate data and information on safety culture practices) What is the data telling you? What are consumers telling you?

Knowledge
How much people know about safety culture relative to what leaders think they know (e.g., employee attitudinal survey results are segregated to understand safety culture across multiple craft groups). Are there gaps in perceptions of safety culture between leaders and the workforce? What are the other measures telling you? (e.g., workforce metrics).

Perception
Measuring individuals, attitudes, and perception of safety culture within the organisation (e.g., employee attitudinal survey data). What is the survey data telling you about employee's values, beliefs, and perceptions?

Safety culture in action

Below are examples of safety culture in action, tailored to the responsibilities of Boards, CEOs, and Executive leaders. Use these practices and habits to drive and sustain a positive safety culture. These examples provide a starting point for organisations to adapt and expand to meet their specific needs and contexts.

For Boards

- Clearly define values, embed safety culture in strategy and hold the CEO accountable for leading the strategy.
- Actively role model safety values clearly within the organisation through active ways (including values as part of meetings and language used in emails).
- Actively participate in walkarounds. These visits offer an opportunity to meet and gather feedback directly from staff, patients and carers about their experience and safety. Board members are encouraged to share their feedback with relevant executive leaders.
- Review and monitor safety culture metrics regularly, ensuring results from staff surveys are reported back to the Board.
- Ensure safety culture discussions are integrated into standing agenda items at Board committee meetings.
- Oversee the implementation of open communication and psychological safety, such as regular team check-ins, anonymous feedback channels, training on psychological safety, active listening and empathy.
- Celebrate staff who exemplify success in the desired culture and safety parameters.
- Integrate consumer and employee feedback data relating to patient safety into standing agenda items and Board committee meetings.
- Ensure consumer and staff voices are included through fair representation at committee meetings.

For CEOs

- Communicate the safety culture vision, role model the expected behaviours, and hold leadership accountable.
- Integrate safety culture training for all staff, including Boards, and ensure access to safety expertise.
- Ensure safety culture metrics are integrated into safety and quality performance metrics and regular reporting.
- Actively participate in walkarounds, leading the expected behaviours whilst observing safety culture in practice (like Board members above).
- Ensure systems and processes enable open communication and reporting of risk or harm to promote psychological safety.
- Empower leaders and staff to dedicate time to safety culture improvement work.
- Regularly review safety culture metrics and dedicate Board time to discussion on safety culture.
- Listen to and actively respond to safety concerns raised by staff and consumers.
- Promote diverse and inclusive consumer and staff representation in committees.
- Implement and monitor diversity training programs and inclusive policies to evaluate their impact on safety and wellbeing throughout the organisation.
- Include an individual with safety and culture expertise on appropriate committees, or ensure an advisor with these skills is available to the CEO and the Board.
- Enable improvements in workforce expertise and capability in safety culture across all levels of the organisation.
- Liaise with other government departments, external agencies, and media in line with safety culture principles and practices as required.
- Ensure Executives understand their responsibilities related to fostering a safety culture.

For Executives

- Develop detailed plans to operationalise the organisation's safety culture vision and integrate metrics into performance evaluations.
- Role model the expected and desired behaviours of a positive safety culture.
- Demonstrate that decision-making prioritises safety.
- Implement robust processes for the investigation and reporting of adverse patient safety events.
- Report safety culture performance metrics, identify areas for improvement, and implement corrective actions.
- Listen, and actively respond, to safety concerns raised by staff and consumers.
- Regularly lead and perform walkarounds, demonstrating the expected behaviours for all staff, whilst observing safety culture in practice. This is most effective when done unannounced. Ensure any feedback gathered from staff, patients and or carers is shared.
- Provide adequate resources and training for staff to perform their jobs effectively and safely.
- Enable psychological safety by offering various feedback channels that encourage open communication and ensuring all feedback is acknowledged and addressed regardless of the outcome.
- Actively engage staff and consumers to include diverse perspectives on safety issues and decision making whilst promoting cultural sensitivity and respect for all individuals and backgrounds.
- Regularly review safety policies, practices, and incidents to refine strategies and enhance overall safety.
- Recognise and incentivise adherence to safety protocols and contributions to enhancing safety culture.
- Enable and support staff to do improvement work based on learnings from culture metrics, feedback, and safety reviews.

Key messages

- It is in the Board, CEO and Executives' best interest to be aware of and invested in their organisation's safety culture. Investing in a strong safety culture isn't just about doing what's right for patients and staff—it's also a strategic imperative.
- A robust safety culture improves organisational resilience, mitigates risks, fosters trust among stakeholders and enhances overall performance, thereby reducing the likelihood of errors, adverse events and the consequent financial burden associated with patient and employee harm.
- A strong safety culture minimises the risk of adverse events and improves patient experience and outcomes.
- Prioritising and improving employee safety and experience will lead to improved care delivery and a sustainable workforce.
- Investment and commitment in culture and safety systems reduces risk, improves care delivery and enhances patient outcomes.
- Demonstrating a commitment to safety enhances your organisation's reputation and builds trust with patients, staff, and stakeholders.
- Positive safety cultures can minimise the financial costs associated with harm and compensations, ensuring long-term sustainability and growth.
- Remember, investing in safety culture isn't just a moral imperative—it's a strategic decision that can safeguard your organisation's future.

Appendix 1

VICTORIAN PUBLIC SECTOR SAFETY CULTURE FRAMEWORK MEASURES

The table below is relevant for health services using the People Matter Survey to measure employees' attitudes toward safety culture. It provides an overview of the measurement constructs relating to the safety culture conceptual framework and how to interpret them. For details on other survey tools, and how to measure and interpret data, please see section Employee attitudinal surveys.

Table 1. Victorian public sector safety culture framework measures

Construct measure	Location within the PMS subscale(s)	Optimal score	Below optimal scoring
Safety Culture	The Patient Safety (health sector only) subscale measures several components of James Reason's Safety Culture model, but it is not exhaustive. This subscale can be used in combination with the other subscales listed below to determine the strength of an organisation's safety culture. • **Patient Safety** subscale contains 8 questions.	• The reported % favourable score (Strongly Agree and Agree) of the eight questions of the Patient Safety (health sector only) subscale should range from 80-100%.	• Below optimal scoring may indicate a suboptimal Safety Culture. • Measuring trends provides critical insights into areas needing improvement and helps track the effectiveness of interventions. • Further information and triangulation with other data is needed.
Employee Psychological Safety	The Safe to speak up subscale within the PMS measures psychological safety. This is located under the Workgroup Climate section. • **Safe to speak up** subscale has 2 questions.	• The reported % favourable score (Strongly Agree and Agree) of the Safe to speak up subscale should range from 80-100%.	• Below optimal scoring tmay indicate employees do not feel safe to speak up. • Further investigation and triangulation with other data is needed.
Employee Engagement	Use the below subscales within the PMS to measure Employee Engagement: • **Employee Engagement** subscale contains 5 questions.	• The reported % favourable score (Strongly Agree and Agree) should be from 80-100% in all Employee engagement subscale questions.	• Below or outside optimal scoring ranges may indicate suboptimal Employee Engagement. • Further triangulation with other data and information is needed.

Appendix 1

Table 1. Victorian public sector safety culture framework measures

Construct measure	Location within the PMS subscale(s)	Optimal score	Below optimal scoring
Leadership Support	Use the below subscales within the PMS to measure Leadership Support. • **Senior Leadership** — Senior Leadership subscale contains 3 questions. • **Job and Manager Factors** — Manager Leadership subscale contains 3 questions. — Manager Support subscale contains 5 questions.	• The reported % favourable score (Strongly Agree and Agree) should range from 80-100% for each of the three subscales. — It is important to analyse this data at the direct manager level and at the senior level for a detailed look at leadership support. This is vital for understanding how safety culture is perceived, communicated, and practiced throughout the varying leadership levels across the organisation.	• Below optimal scoring may indicate suboptimal Leadership Support in any or all these three subscales. • Further triangulation with other data and information is needed.
Employee Wellbeing	Employee wellbeing supports employee engagement, and correlates strongly with psychological safety. Use the below subscales within the PMS to measure Employee Wellbeing: • **Wellbeing** subscale — 2 specific questions (see Appendix 5 for questions and responses, please note not a Likert scale). • **Violence and Aggression** subscale — 1 question (see Appendix 5 for question and responses, please note not a Likert scale).	**For Wellbeing subscale:** • The reported % favourable should be 80-100% of employees reporting nil or low/mild work-related stress. • The reported % favourable should be 80-100% of employees reporting no experiences of Burnout. Note: Burnout is referred to as fatigue in PRISM reports. **Violence and Aggression subscale:** • The reported % favourable should be 80-100% of employees reporting no experience of occupational violence and aggression.	• Below or outside optimal scoring ranges may indicate suboptimal Employee Wellbeing. • Further triangulation with other data and information is needed.

Appendix 2

WORKFORCE DATA METRICS

To understand the wellbeing of employees and its impact on engagement and safety culture, it is essential to measure and monitor various workforce metrics. The table below provides detailed information on these metrics, including their operational definitions, data collection sources, interpretation guidelines, and indicators of optimal and below-optimal signals.

Table 2. Workforce data metrics

Data Type	Operational definition	Data Collection Source	How to interpret	Optimal signals	Below optimal signals
Sick leave	The average rate of sick leave in the ward, team, or service.	Established internal workforce data reporting.	The average sick leave rate will vary by team and by time period. Ideally, sick leave metrics should be interpreted by reviewing regularly and over time to determine if there are any outliers (in time period or by team or staff member).	• Sick leave trends are at what is expected. (Expected levels are determined by organisation and or at unit level). • People are taking annual leave or other breaks as needed.	• High rates of sick leave may indicate an issue. When there is high sick leave in conjunction with excessive annual leave balances, this can be an indicator of risk of burnout. • Low sick leave rates with high excessive annual leave balances may suggest employees are not taking any form of wellbeing break. • Further triangulation with other data and information is needed.
Excess annual leave	An excessive annual leave balance is specific to the organisation's Enterprise Bargaining Agreement and/or local leave policy.	Established internal workforce data reporting.	Excessive annual leave balances can mean workforce and wellbeing challenges where employees are not taking adequate breaks.	• Low rate of excess annual leave indicates employees are taking their entitled breaks. • Continue to monitor with implementation of annual leave plans.	• High excess annual leave balances indicate employees are not taking breaks and are at risk of negatively impacting their wellbeing. • Prioritisation and implementation of leave plans required. • High excess annual leave with high sick leave signals suboptimal working conditions. • Recommended to undertake an in-depth culture survey.

Appendix 2

Table 2. Workforce data metrics

Data Type	Operational definition	Data Collection Source	How to interpret	Optimal signals	Below optimal signals
Vacancy rate	The average rate of vacant positions in the ward, team, or service.	Established internal workforce data reporting.	The average vacancy rate will vary by team and by time period. Vacancy rate metrics should be interpreted by reviewing regularly and over time to determine if there are any anomalies or exceptions (either in time period or by team).	• Low vacancy rate indicates departments are staffed to profile. However, this does not signal that capability and skill mix meets requirements to ensure delivery of safe, quality care.	• High rates of vacant positions may signal suboptimal workforce conditions, including skill mix uncertainties required for service delivery and safe, quality care impacting safety culture. • Some vacancies are budget driven adding complexity to the issue, therefore, further triangulation with other data and information is needed.
Overtime	The average spend on overtime in the ward, team, or service.	Established internal workforce data reporting.	The average overtime rate will vary by team and by time period. Ideally, overtime metrics should be interpreted by reviewing regularly and over time to determine if there are any anomalies or exceptions (either in time period or by team or staff member).	• Employees are working to contracted hours and not working overtime. • Expenditure on overtime is low while meeting operational needs. • Overtime is voluntary and occasional overtime reflects manageable workload fluctuations.	• Persistent high levels of overtime can indicate workforce issues. • Increase spend on overtime, agency, and casual workforce. • If vacancy rates are high and overtime increases, employees are then limited to take leave as no one to cover roster deficits. • Further triangulation with other data and information is needed. Recommended to undertake an in-depth culture survey.
Spend on agency staff	The average spend on agency staff in the ward, team, or service.	Established internal workforce data reporting.	The average spend on agency staff will vary by team and by time period. Ideally spend on agency staff metrics should be interpreted by reviewing regularly and over time to determine if there are any outliers (in time period or by team).	• Low spend on agency staff in combination of other optimal workforce metrics is ideal. • Lower spend on agency staff is better in combination with low vacancy rates.	• High spend on agency staff in combination with any of the workforce metrics (sick leave, excessive annual leave balances, and vacancy rate) is a signal of suboptimal workforce conditions. • Further triangulation with other data and information is needed. Recommended to undertake an in-depth culture survey.

Appendix 2

Table 2. Workforce data metrics

Data Type	Operational definition	Data Collection Source	How to interpret	Optimal signals	Below optimal signals
Employee attrition	The voluntary and involuntary departures from an organisation.	Established internal workforce data reporting. E.g., employee exit surveys (organisation wide or unit specific).	Analysing reasons for departure, identify trends and assess potential impacts on stability and satisfied workforce. Monitor departure rates over different periods.	• Low attrition suggests a stable workforce and positive work environment. • Exit surveys enable comprehensive analysis of employee feedback detailing reasons for leaving (e.g., open ended questions pertaining to safety culture can be helpful for triangulating information).	• High attrition rates suggest suboptimal working conditions for individuals, leading to higher turnover rates above expected rates. Recommended to undertake an in-depth culture survey. • Employee exit surveys relies on close-ended, biased or limited-responses to question limiting comprehensive evaluation of safety culture.

"Good patient outcomes do not rely on a super human effort plus luck but rather on well designed patient centred systems and processes which operate within an environment of trust and respect."

– Advisory group member

Appendix 3

APPROACHES TO TRIANGULATE SAFETY CULTURE DATA

To effectively triangulate safety culture, it is important to utilise various processes and methods for a more comprehensive and reliable assessment. The table below summarises recommended approaches, including their operational definitions, implementation and monitoring strategies, indicators of a positive safety culture and best practices, and alignment with safety culture elements from the conceptual framework.

Table 3. Approaches to triangulate safety culture data

Process or method	Operational definition	Implementing and monitoring	Positive safety culture indicators and best practice	Demonstrated safety culture elements
Multi-disciplinary and inter-disciplinary Morbidity and Mortality meetings	The presence of psychologically safe, structured, facilitated, and well managed meetings of healthcare professionals from various disciplines to discuss and analyse patient morbidity and mortality cases using a systems thinking approach.	Health services are expected to internally report, monitor, and evaluate the effectiveness of morbidity and mortality meetings. This may include: • Assessing the quality of processes • Identifying common themes and recommendations from the patient case reviews. • Ensuring integration into local governance structures.	• The meetings are conducted regularly with good attendance and contribution from varying professional groups. • They involve a diverse panel of professionals representing different craft groups. • The meetings foster collaboration and trusting environments. Team members feel psychology safe to share insights knowing the focus is on learning and improvement. • Communication is open and non-punitive. The information from these reviews is fed back to staff at all levels relevant to the review. • The organisation uses these reviews to identify systemic issues to implement changes and enhance patient and or staff safety. • Actively learn from presented cases, acknowledging success, and prompt recognition of adverse events, whilst fostering environments that encourages reporting of notifications of such events. • Sharing these learnings across the organisation and more broadly demonstrates transparency and continuous improvement. • A systems thinking approach is applied with the review of patient cases. • Outcomes and evaluation are ongoing and recorded at higher governing structures. • **Best practice guidance:** *SCV's System-focused framework for morbidity and mortality meetings to be published in late 2024. This framework will offer comprehensive best practices for Victorian health services to conduct morbidity and mortality meetings effectively.*	Learning culture Just culture Informed culture Psychological safety Flexible culture

"A focus on patient safety that encourages staff (and everyone) to openly communicate, trust, engage, and work on improving systems to ensure patient safety, without blame on individuals."

– Advisory group member

Appendix 3

Table 3. Approaches to triangulate safety culture data

Process or method	Operational definition	Implementing and monitoring	Positive safety culture indicators and best practice	Demonstrated safety culture elements
Implementation of SCVs Adverse Patient Safety Event (APSE) policy and guideline	This method establishes a governance system for reporting and managing APSEs, Serious APSEs (SAPSE) and Sentinel Events (SE) within a health service. It involves the process of monitoring, identifying, notifying, reporting, reviewing, and learning from APSEs to drive subsequent improvements.	Health services are encouraged to adopt a classification reporting system, such as the Victorian Health Incident Management System (VHIMS) in the public sector or equivalent incident management reporting systems for private health services to determine the severity of APSEs. Health services are expected to: • Monitor APSEs closely to ensure timely identification and response. • Manage APSEs effectively, adhering to the established guidelines and protocols. • Integrate APSE reporting into existing governance structures to facilitate comprehensive oversight and accountability.	• At a minimum have a classification system that identifies the severity of APSEs that are reported to understand the incident severity rating (ISR). • Monitoring trends of reported APSEs may identify common contributing factors, detect clinical risks, and prioritise issues requiring a quality improvement response. • Even proportion of number and severity of events reported across wards, services, and teams may reflect a shared commitment to safety where all units and craft groups recognises the importance of reporting APSEs. • High reporting rates of adverse events including near misses may be indicative that employees feel safe to report concerns. • Management of reported APSEs are consistent with a just culture with a focus on learning to prevent from recurrence e.g., SCV system-based review templates are used (see the APSE guide for details). • Demonstrate open disclosure or Statutory duty of candour occurs with patient, carer, and families as soon as practical for all APSEs causing harm and near misses. (e.g., track and monitor open disclosure frequency through existing data collection sources of APSEs such as VHIMS). • There are established clinical governance processes to implement, monitor and evaluate the effectiveness of implementation of endorsed recommendations including clinical audits and reporting to the Board. • Closing events involves open communication and sharing of learnings within the health service and across the sector supporting learning and improvement. • Please note: APSEs, SAPSEs and SEs may share similar or overlapping indicators of a positive safety culture. The examples presented provide an overview of these indicators demonstrating best practice. • Refer to Appendix 6 to access SCV's APSE guideline and policy.	Reporting culture Employee engagement Learning culture Psychological safety Just culture

One out of ten healthcare related episodes results in an adverse event. Of these more than half are preventable.[3]

Appendix 3

Table 3. Approaches to triangulate safety culture data

Process or method	Operational definition	Implementing and monitoring	Positive safety culture indicators and best practice	Demonstrated safety culture elements
Sentinel Event (SE) reporting and management	Refers to the unexpected and adverse event that occurs infrequently in a health service, resulting in the death of, or serious physical or psychological injury to, a patient due to system and process deficiencies at the health service entity. SEs are a subset of a SAPSE and align with national and Victorian reporting categories.	Health services are expected to: Establish internal reporting processes to promptly identify and respond to SEs. This may involve: • Use of incident reporting systems, at safety committees, at morbidity and mortality meetings, soliciting consumer and staff feedback and or complaints. • Manage SEs effectively, adhering to SCVs established guides and protocols. • Review and monitor outcomes and recommendations. Integrate SE reporting into existing governance structures to facilitate comprehensive oversight and accountability.	• All leaders within the organisation understand what constitutes a SE and can enact the process to escalate these within their reporting lines and relevant regulations. • Leaders, senior staff, and Consumers regularly access training relevant to adverse event reviews including methodologies and human factors training (e.g., SCV online training modules). • An organisational culture where the identification and notification of SE is seen to be an opportunity to identify risk and improve safety and quality standards. • Embedded clinical governance processes to identify SE (e.g., Morbidity and Mortalities, Incident review huddles, consumer feedback etc). • Diverse stakeholder engagement including consumer, clinicians, and external experts in panel review processes. • Family members are involved to inform the SE review, in line with SDC requirements. Review and improvement of this process is recorded and actioned. • Findings and lessons learnt from reviews focus on system issues and not human error. • Meeting SCV recommended timelines for notification, report submission and implementation of recommendations. • SEs are notified and reported externally to SCV as per obligations (3 days from identification of SE). • Recommendations are Specific, Measurable, Achievable, Relevant and Timebound (SMART) and designed to prevent from reoccurrence. • Have standing agenda items in clinical governance/quality and safety meetings to track and monitor SE recommendations and actions. • Refer to Appendix 6 for access to further information on sentinel events.	Reporting culture Just culture Learning culture Leadership support Psychological safety

"A good safety culture is comfort in reporting patient safety concerns without fear of retribution, open and transparent leadership emphasising the importance of patient safety."

– Advisory group member

Appendix 3

Table 3. Approaches to triangulate safety culture data

Process or method	Operational definition	Implementing and monitoring	Positive safety culture indicators and best practice	Demonstrated safety culture elements
Implementation of the Statutory Duty of Candour (SDC) legislation	A legal obligation for Victorian health service entities to ensure that patients and their families or carers are apologised to and communicated with openly and honestly when a SAPSE has occurred. The SDC builds on existing elements within the Australian Open Disclosure Framework.	Health services are encouraged to establish Internal reporting and monitoring of data which is measured against the legislative requirements of the SDC. These reports should be integrated in local governance structures to facilitate comprehensive oversight and accountability.	• Compliance with the Victorian Duty of Candour Guidelines, which is the legislative instrument containing key requirements and timelines. • All APSEs that meet the definition of a SAPSE are required to undertake the SDC process indicating organisations commitment to transparency and accountability. • Implementation and compliance of the SDC legislation. (Refer to the Victorian Duty of Candour Guidelines in Appendix 6 for more information). • Implementation of the Victorian Duty of Candour Framework, which is a guide to support the SDC process with regard to patient considerations. • Appropriate collection and documentation processes for timelines, meetings, and review procedures demonstrates organisations commitment to comprehensive monitoring and learning culture. • Regularly reviewing the SAPSE compliance data against SDC requirements enhances a positive safety culture by promoting continuous improvement that values learning from events. Reporting of SAPSE data to the Secretary is set out in the Statutory Duty of Candour Data Collection Reporting Guidelines. Refer to Appendix 6 for further information. Health services are encouraged to contact Safer Care Victoria for support and guidance in the implementation of these approaches. For furthvver information email sentinel.events@safercare.vic.gov.au	Reporting culture Just culture Learning culture Leadership support

"Information flows freely upwards, downwards and sideways, both good and bad news is shared, people feel heard and underestood and see action as a result of speaking up."

– Advisory group member

Appendix 3

Table 3. Approaches to triangulate safety culture data

Process or method	Operational definition	Implementing and monitoring	Positive safety culture indicators and best practice	Demonstrated safety culture elements
Accreditation preparedness and assessments	Accreditation is an important part of clinical governance where an assessment is performed by an external accrediting body following an evaluation of an organisation's adherence to the NSQHS. Safety culture enables high quality, safe care to occur and drives best practice towards good clinical governance.	Health services are encouraged to collect evidence demonstrating health service meets the NSQHS standards for accreditation readiness. Accreditation report and outcomes provided by the agency to the healthcare organisation will provide information to how the organisation meets the NSQHS standards.	• Accreditation standards met in all categories is a sign of a culture of safety. Evaluation and improvement being evident throughout the organisation in relation to the action or standard that is under review. • Demonstrate the measuring and evaluation of clinical care and processes against the NSQHS. • Accreditation can help to identify the actual practices in the organisation as they relate to safety and how protocols and policies are implemented in the health service. • Safety is not just compliance but an inherent part of the daily operations and decision-making processes of the organisation. • Completing a self-assessment and bringing together evidence demonstrating how the organisation is meeting the NSQHS. This demonstrates a culture of continuous learning and improvement. • Recommendations help to identify vulnerabilities in the system and often prioritises issues that have not been addressed.	Reporting culture Leadership support Informed culture Learning culture
Employee Feedback	The mechanisms to gather employee feedback leading to actions and continuous improvement initiatives including communication feedback loops. Employee feedback mechanisms can be used to help triangulate data and information for a more comprehensive analysis of safety culture.	Health services leaders are encouraged to adopt multiple local employee feedback channels to facilitate open communication where staff feel psychologically safe to raise concerns and or ideas trusting they are heard, and their concerns are acted on regardless of outcome. Health services should adopt internal reporting to monitor employee feedback, identify themes and response to feedback.	• Leaders promote and encourage staff feedback. E.g., purposeful leadership walkarounds that are unannounced and informal. • Employees feel psychologically safe and take interpersonal risk to raise concerns. • Timely review and actions taken based on feedback received. • Leaders reinforce the communication loop and report back actions or outcomes. Employees feel heard even when no actions are taken. • Leaders demonstrate safety as a priority and allocate resources for safety initiatives.	Employee psychological safety Leadership support Employee engagement Reporting culture

Appendix 3

Table 3. Approaches to triangulate safety culture data

Process or method	Operational definition	Implementing and monitoring	Positive safety culture indicators and best practice	Demonstrated safety culture elements
Employee Feedback	As above.	As above.	• Varying reporting channels enhances employee engagement and speaks to the commitment from the organisation around continuous improvement. • Leaders demonstrate purposeful conversations with employees asking them "What matters to you?". Feedback can be submitted in the form of written or verbal methods. Some examples include in team or other group meetings, safety huddles, organisational reporting and escalation structures.	As above.
Consumer feedback	Methods to collect and monitor the number and type of Consumer compliments and complaints, as a marker of the quality of care provided by the healthcare service. Consumer feedback includes compliments and complaints which can be used to triangulate safety culture data and information for a more comprehensive analysis.	Health services are encouraged to establish Internal reporting and monitoring of data which is measured against the legislative requirements of the SDC. These reports should be integrated in local governance structures to facilitate comprehensive oversight and accountability. • Patient experience and feedback questionnaires and surveys (e.g., The Victorian Healthcare Experience Survey (VHES) and Patient Reported Experience Measures (PREMS). • Consumer/Community Advisory Committees (CACs) and or other representative advisory committees within the health service.	• Collecting data and information about Consumer's perceptions and experiences of patient safety culture is vital to improving services and safety for patients. • An increase in number of complaints can be a sign of improved consumer psychological safety and engagement however, an increase of complaints relating to patient safety can also be indicative of a suboptimal safety culture within the organisation. Therefore, careful analysis alongside other safety culture measures, including review of each complaint is required for theming and monitoring over time. • An increase in the number of Consumer complaints from a particular area may be seen as an early warning signal that something in the system may not be working calling for review and action. • Regular deep dives into Consumer complaints are recommended along with patient journey/workflows to help triangulate information to help identify systemic issues. • There are processes embedded to obtain feedback from organisation's Consumer representatives/groups ensuring a diverse range of feedback in addition to Consumer's/patient's individual experience.	Informed culture Reporting culture Learning culture Leadership support

"Safety is part of the DNA of the organisation and modelled every day."

– Advisory group member

Appendix 3

Table 3. Approaches to triangulate safety culture data

Process or method	Operational definition	Implementing and monitoring	Positive safety culture indicators and best practice	Demonstrated safety culture elements
Consumer feedback	As above.	• Consumer/Patient Reported Indicators (e.g., Patient Reported Outcome Measures (PROMS). • Complaints reported to the Health Complaints Commissioner.	• Processes embedded throughout the organisation where Consumers voice is included on safety committees and partnering is evident. • Involving impacted Consumers in adverse event reviews enhances understanding of contributing factors leading to more accurate and meaningful outcomes. • Incorporating Consumer insights and perspectives demonstrates a commitment to listening to and valuing consumer input which drives improvement work. • There are processes in place to collect and respond to Consumer complaints and complements. • Implementing the Health Complaints Standards (2023) align with best practice in handling complaints and underline the importance of feedback and governance in healthcare. • Learning from Consumer feedback including compliments and complaints are vital components in triangulating safety culture data and information. It provides insights directly from the recipients of care, empowering organisations to make informed improvements that prioritise patient safety and satisfaction.	As above.
Other forms of reporting unethical conduct e.g., whistle blowing activity	The reporting of concerns of wrongdoing by individuals within an organisation to raise awareness about potential safety issues, ethical violations, or policy breaches. *Employees may feel morally compelled to report serious wrongdoing despite internal reporting options.*	Recognise whistleblowing as a method for reporting concerns, enabling identification of gaps in existing reporting channels, and uncovering systemic issues. Health services are encouraged to collect information and monitor through existing governance structures.	• When corrupt conduct is reported, organisation leaders acknowledge, review and respond in ways to demonstrate their commitment to psychological safety, transparency, and accountability. They analyse and implement actions to prevent reoccurrence. • Timely investigations using a systems thinking approach and corrective actions implemented. • Communicate outcomes to whistleblowers to demonstrate responsiveness and in reinforce trust. • Establish anonymous reporting channels, ensure confidentiality is maintained and whistle-blowers are protected from retaliation. • Monitor whistleblowing activity, trends and patterns that can unveil systemic issues. • Learn from past events to prevent reoccurrence.	Reporting culture Employee psychological safety Learning culture

"I felt safe and respected I was seen as a whole person not just my presenting symptoms."

– Consumer

Appendix 4

SAFETY CULTURE MATURITY MODEL

Professor Patrick Hudson, recognised for his work on safety management systems, developed a model for safety culture maturity.[6] Hudson's model conceptualises the maturity of an organisation's safety culture in several stages.

The model can support an organisation's understanding of its own safety culture and its potential for improvement. The maturity and perception of safety culture can vary among departments, wards, and services across one organisation.

It is never fixed and remains a continuous process, therefore regular measurement and monitoring of an organisation's safety culture is paramount.

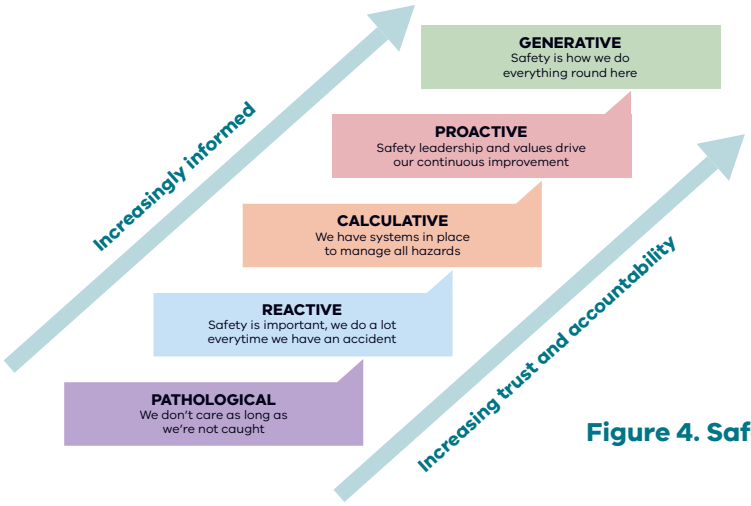

Figure 4. Safety culture maturity

This table explains the safety culture maturity stages within this model.

Safety culture stages	Description
Pathological	'Organisation's care less about safety than being caught'. Safety is seen as a problem caused by individuals. The main drivers are business performance and the desire not to get caught by the regulator.
Reactive	'We do a lot when we have an incident'. Organisations start to take safety seriously but only action after incidents or accidents (can be temporary for pathological cultures). Blaming, naming, shaming, and retraining individuals is common.
Calculative	'We have systems in place to manage hazards'. Safety is driven by management systems with a great deal of data collection (e.g., risk assessment, cost-benefit analyses). Staff and management follow the procedures but do not necessarily believe those procedures are critically important to their jobs or the operation.
Proactive	'Safety issues are starting to be anticipated before they arise'. The organisation has systems in place to manage hazards and staff and management have begun to acquire beliefs that safety is genuinely worthwhile.
Generative	'Safety is how we do business around here'. There is a participation and contribution to safety at all levels from the organisation. Safety is perceived as an inherent part of the organisation. The value system associated with safety and safe working is fully internalised as beliefs almost to the point of invisibility.

Appendix 5

PEOPLE MATTER SURVEY QUESTIONS

The following table presents the questions from the People Matter Survey categorised within their relevant constructs as they relate to the safety culture conceptual framework. It provides the subscale questions, organised by their corresponding construct measures, alongside survey responses.

People matter survey subscale questions

Construct measure	Subscale name in the PMS	Questions within the subscale	Survey responses
Safety Culture	Patient Safety (health sector only)	• Trainees in my discipline are adequately supervised. • This health service does a good job of training new and existing staff. • The culture in my work area makes it easy to learn from the errors of others. • Patient care errors are handled appropriately in my work area. • My suggestions about patient safety would be acted upon if I expressed them to my manager. • Management is driving us to be a safety-centred organisation. • I would recommend a friend or relative to be treated as a patient here. • I am encouraged by my colleagues to report any patient safety concerns I may have.	Responses collected using a Likert scale: • Strongly agree • Agree • Neither agree nor disagree • Disagree • Strongly disagree • Don't know
Psychological Safety	Workgroup Climate section - Safe to speak up subscale	• People in my workgroup are able to bring up problems and tough issues. • I feel safe to challenge inappropriate behaviour at work.	Responses collected using a Likert scale: • Strongly agree • Agree • Neither agree nor disagree • Disagree • Strongly disagree

Appendix 5

People matter survey subscale questions

Construct measure	Subscale name in the PMS	Questions within the subscale	Survey responses
Leadership Support	Senior Leadership	• Senior leaders provide clear strategy and direction. • Senior leaders model my organisation's values. • Senior leaders demonstrate honesty and integrity.	Responses collected using a Likert scale: • Strongly agree • Agree • Neither agree nor disagree • Disagree • Strongly disagree
	Manager Leadership	• My manager treats employees with dignity and respect. • My manager models my organisation's values. • My manager demonstrates honesty and integrity.	Responses collected using a Likert scale: • Strongly agree • Agree • Neither agree nor disagree • Disagree • Strongly disagree
	Manager Support	• My manager provides me with enough support when I need it. • My manager gives me feedback that helps me improve my performance. • My manager listens to what I have to say. • I can discuss problems or issues with my manager. • I receive meaningful recognition when I do good work.	Responses collected using a Likert scale: • Strongly agree • Agree • Neither agree nor disagree • Disagree • Strongly disagree
Employee Engagement	Engagement	• My organisation motivates me to help achieve its objectives. • My organisation inspires me to do the best in my job. • I would recommend my organisation as a good place to work. • I feel a strong personal attachment to my organisation. • I am proud to tell others I work for my organisation.	Responses collected using a Likert scale: • Strongly agree • Agree • Neither agree nor disagree • Disagree • Strongly disagree

Appendix 5

People matter survey subscale questions

Construct measure	Subscale name in the PMS	Questions within the subscale	Survey responses
Employee Wellbeing	Wellbeing subscale	• How would you rate your current level of work-related stress?	Responses collected using an ordinal scale: • Nil - not experiencing any work-related stress • Low or mild • Moderate • High • Very high • Severe
	Wellbeing subscale	• Overall, based on your definition of burnout, how would you rate your level of burnout?	Responses collected using an ordinal scale: • I enjoy my work. I have no symptoms of burnout • Occasionally I am under stress, and I don't always have as much energy as I once did, but I don't feel burned out. • I am definitely burning out and have one or more symptoms of burnout, such as physical and emotional exhaustion. • The symptoms of burnout that I am experiencing won't go away. I think about frustration at work a lot. • I feel completely burned out and often wonder if I can go on. I am at the point where I may need some changes or may need to seek some sort of help.
	Violence and aggression	• During the last 12 months in your current organisation, have you been subject to aggression or violent behaviour at work?	Responses collected using a nominal scale: • Yes • No • Not sure

Appendix 6

ADDITIONAL RESOURCES

- Adverse Patient Safety Event Policy.
  https://www.safercare.vic.gov.au/sites/default/files/2019-08/Policy%20-%20Adverse%20Patient%20Safety%20Events.pdf
- Adverse Patient Safety Event Guideline.
  https://www.safercare.vic.gov.au/sites/default/files/2023-07/Adverse%20Patient%20Safety%20Event%20guideline_Safer%20Care%20Victoria.pdf
- Morbidity and Mortality Meetings Framework and Toolkit.
  Please contact culture.capability@safercare.vic.gov.au for a copy of this resource.
- Partnering in healthcare – A framework for better care and outcomes.
  https://www.safercare.vic.gov.au/sites/default/files/2019-02/Partnering%20in%20healthcare%20framework%202019_WEB.pdf
- Safe Work Australia (2016).
  https://www.safeworkaustralia.gov.au/resources-and-publications/video-and-audio/moving-culture-ladder-professor-patrick-hudson
- Safe Work Australia (2019). Work related psychological health and safety National guidance material.
  Work related psychological health and safety - A systematic approach to meeting your duties (safeworkaustralia.gov.au)
- Safety culture: The ultimate goal (2001). *Flight safety magazine*.
  https://www.skybrary.aero/bookshelf/books/1091.pdf
- Sentinel Event Reporting.
  https://www.safercare.vic.gov.au/report-manage-issues/sentinel-events
- Staff Attitudinal Questionnaire (SAQ) and the Australian Hospital Survey on Patient Safety Culture (A-HSOPS 2.0) survey and analysis can be found at the Australian Commission on Safety and Quality in Healthcare's (ASQHC) website.
- Statutory Duty of Candour Data Collection.
  https://www.safercare.vic.gov.au/sites/default/files/2023-05/Statutory%20Duty%20of%20Candour%20Data%20Collection%20-%20Reporting%20guideline.docx
- Statutory Duty of Candour Resources and Training.
  https://www.safercare.vic.gov.au/report-manage-issues/sentinel-events/adverse-event-review-and-response/duty-of-candour
- Victorian Clinical Governance Framework.
  https://www.safercare.vic.gov.au/best-practice-improvement/publications/clinical-governance-framework
- Victorian Duty of Candour Guidelines.
  https://www.safercare.vic.gov.au/sites/default/files/2022-10/Victorian%20Duty%20of%20Candour%20Guidelines%20-%20FINAL.docx

References

1. Australian Commission on Safety and Quality in Healthcare (ACSQH). (2019). The state of patient safety and quality in Australian hospitals 2019. https://www.safetyandquality.gov.au/sites/default/files/2019-07/the-state-of-patient-safety-and-quality-in-australian-hospitals-2019.pdf
2. (ACSQH). (2023). About patient safety culture. *Australian Commission on Safety and Quality in Healthcare*. https://www.safetyandquality.gov.au/our-work/indicators-measurement-and-reporting/patient-safety-culture/about-patient-safety-culture
3. Duckett, S., & Jorn, C. (2018). All complications should count Using our data to make hospitals safer. *Grattan Institute*. https://grattan.edu.au/wp-content/uploads/2018/02/897-All-complications-should-count.pdf
4. Evans, M., Loveday, T., & Kobialka, O. (2023). Leading indicators of patient harm. *Tactix Sensor Group*. *Please contact culture.capability@safercare.vic.gov.au for a copy of this resource.*
5. Health Services (Quality and Safety. Authorised by the Chief Parliamentary Counsel. Retrieved from https://content.legislation.vic.gov.au/sites/default/files/2022-11/20-77sra002%20authorised.pdf
6. Hudson, P. (1999). Safety culture–theory and practice. *The human factor in system reliability–is human performance predictable*, 1-12. https://dvikan.no/ntnu-studentserver/reports/MP-032-$$ALL.pdf#page=85
7. National Health Service (NHS). (2022). Safety culture: Learning from best practice. *NHS England*. Retrieved from NHS England » Safety culture: learning from best practice
8. NSW Government. (2022). What workplace wellbeing is – and isn't. Retrieved from https://www.nsw.gov.au/mental-health-at-work/stories/mental-health-at-work-blogs/what-workplace-wellbeing-%E2%80%93-and-isnt
9. Rasool, S. F., Wang, M., Tang, M., Saeed, A., & Iqbal, J. (2021). How toxic workplace environment effects the employee engagement: The mediating role of organizational support and employee wellbeing. *International Journal of Environmental Research and Public Health, 18* (5), 2294. https://doi.org/10.3390/ijerph18052294
10. Reason, J. (1998). Achieving a safe culture: theory and practice. *Work & Stress, 12* (3), 293–306. Retrieved from https://www.raes-hfg.com/reports/21may09-Potential/21may09-JReason.pdf
11. Safer Care Victoria (SCV). (2022). Leadership and Safety Culture Factsheet. Retrieved from https://www.safercare.vic.gov.au/sites/default/files/2022-08/SCV-Leadership-safety-culture-factsheet.pdf
12. Safer Care Victoria (SCV). (2023). Strategic plan 2023-2026. *SCV*. https://www.safercare.vic.gov.au/sites/default/files/2023-10/SCV%20Strategic%20Plan%202023-2026.pdf
13. Saleem, F., Malik, M. I., & Qureshi, S. S. (2021). Work stress hampering employee performance during COVID-19: is safety culture needed?. *Frontiers in Psychology, 12*, 655839.

References

https://doi.org/10.3389/fpsyg.2021.655839

14. Smallwood N, Bismark M, Willis K. (2023). Burn-out in the health workforce during the COVID-19 pandemic: opportunities for workplace and leadership approaches to improve well-being. *BMJ Leader (7)*, 178-181.
Burn-out in the health workforce during the COVID-19 pandemic: opportunities for workplace and leadership approaches to improve well-being | BMJ Leader
15. The Science Behind Random Sampling. Culture Amp. Retrieved from https://support.cultureamp.com/en/articles/7048400-the-science-behind-random-sampling
16. Vaughn, V. M., Saint, S., Krein, S. L., Forman, J. H., Meddings, J., Ameling, J., Winter, S., Townsend, W., & Chopra, V. (2018). Characteristics of healthcare organisations struggling to improve quality: results from a systematic review of qualitative studies. *BMJ Quality & Safety*. https://doi.org/10.1136/bmjqs-2017-007573
17. Victorian Public Sector Commission (VPSC). (2023). Data collection statement: People Matter Survey. *VPSC*. https://vpsc.vic.gov.au/data-and-research/about-the-people-matter-survey/data-collection-statement-people-matter-survey/
18. Victorian Managed Insurance Authority (VMIA). (2022). Mapping a safety culture in the Victorian public health care sector. Government of Victoria State Services Authority. Mapping a safety culture in the Victorian public health care sector – VPSC
19. Work Safe Victoria. (2022). Proposed OHS Amendment (Psychological Health) Regulations. *Victorian Government*. https://engage.vic.gov.au/proposed-psychological-health-regulations

Safer Care
Victoria