

Appendix 8.1 References

1. Institute of Medicine. 2000. *To Err Is Human: Building a Safer Health System*. Washington, DC: The National Academies Press. [cited 2024 Aug 09]. p. 9728, Available from: <http://www.nap.edu/catalog/9728>. Washington, D.C.: National Academies Press; 2000.
2. de Bienassis K, Klazinga NS. Developing international benchmarks of patient safety culture in hospital care: Findings of the OECD patient safety culture pilot data collection and considerations for future work [Internet]. 2022 Jan [zitiert 24. Mai 2024]. (OECD Health Working Papers; Bd. 134). Report No.: 134. Verfügbar unter: https://www.oecd-ilibrary.org/social-issues-migration-health/developing-international-benchmarks-of-patient-safety-culture-in-hospital-care_95ae65a3-en
3. Sammer CE, Lykens K, Singh KP, Mains DA, Lackan NA. What is Patient Safety Culture? A Review of the Literature. *J Nurs Scholarsh*. Juni 2010;42(2):156–65.
4. Halligan M, Zecevic A. Safety culture in healthcare: a review of concepts, dimensions, measures and progress. *BMJ Qual Saf*. 1. April 2011;20(4):338–43.
5. Alshyyab MA, FitzGerald G, Dingle K, Ting J, Bowman P, Kinnear FB, u. a. Developing a conceptual framework for patient safety culture in emergency department: A review of the literature. *Int J Health Plann Manage*. Januar 2019;34(1):42–55.
6. Armstrong, G. (2024). Culture of Safety: What Is It and What It Is Not. In: Oster, C.A., Braaten, J.S. (eds) *The Nexus between Nursing and Patient Safety*. Springer, Cham. https://doi.org/10.1007/978-3-031-53158-3_2. In.
7. Culture of Safety. PSNet [internet]. Rockville (MD): Agency for Healthcare Research and Quality, US Department of Health and Human Services. 2019.
8. Bisbey TM, Kilcullen MP, Thomas EJ, Ottosen MJ, Tsao K, Salas E. Safety Culture: An Integration of Existing Models and a Framework for Understanding Its Development. *Hum Factors J Hum Factors Ergon Soc*. Februar 2021;63(1):88–110.
9. Kilcullen MP, Bisbey TM, Ottosen MJ, Tsao K, Salas E, Thomas EJ. The Safer Culture Framework: An Application to Healthcare Based on a Multi-Industry Review of Safety Culture Literature. *Hum Factors J Hum Factors Ergon Soc*. Februar 2022;64(1):207–27.
10. Sorra, J.S. and Nieva, V.F. (2004) Hospital Survey on Patient Safety Culture (Prepared by Westat, under Contract No.290-96-0004).
11. Health and Safety Commission. (1993).Third Report: Organizing for Safety. ACSNI Study Group on Human Factors. London: HMSO, 1993, p.10.
12. Guldenmund FW. The use of questionnaires in safety culture research – an evaluation. *Saf Sci*. Juli 2007;45(6):723–43.
13. Sexton JB, Helmreich RL, Neilands TB, Rowan K, Vella K, Boyden J, u. a. The Safety Attitudes Questionnaire: psychometric properties, benchmarking data, and emerging research. *BMC Health Serv Res*. Dezember 2006;6(1):44.
14. Feng X, Bobay K, Weiss M. Patient safety culture in nursing: a dimensional concept analysis. *J Adv Nurs*. August 2008;63(3):310–9.
15. Pfaff H, Hammer A, Ernstmann N, Kowalski C, Ommen O. Sicherheitskultur: Definition, Modelle und Gestaltung. *Z Für Evidenz Fortbild Qual Im Gesundheitswesen*. Januar 2009;103(8):493–7.
16. Churrua K, Ellis LA, Pomare C, Hogden A, Bierbaum M, Long JC, u. a. Dimensions of safety culture: a systematic review of quantitative, qualitative and mixed methods for assessing safety culture in hospitals. *BMJ Open*. Juli 2021;11(7):e043982.
17. Carvalho REFLD, Bates DW, Syrowatka A, Almeida I, Sousa L, Goncalves J, u. a. Factors determining safety culture in hospitals: a scoping review. *BMJ Open Qual*. Oktober 2023;12(4):e002310.
18. Vincent C, Staines A. ENHANCING THE QUALITY AND SAFETY OF SWISS HEALTHCARE. 2019 [zitiert 2. Juli 2024]; Verfügbar unter: <http://rgdoi.net/10.13140/RG.2.2.22966.04160>

Appendix 8.1 References

19. Lee SE, Scott LD, Dahinten VS, Vincent C, Lopez KD, Park CG. Safety Culture, Patient Safety, and Quality of Care Outcomes: A Literature Review. *West J Nurs Res.* Februar 2019;41(2):279–304.
20. National Steering Committee for Patient Safety. *Safer Together: A National Action Plan to Advance Patient Safety.* Boston, Massachusetts: Institute for Healthcare Improvement; 2020. (Available at www.ihl.org/SafetyActionPlan).
21. Carvalho REFLD, Bates DW, Syrowatka A, Almeida I, Sousa L, Goncalves J, u. a. Factors determining safety culture in hospitals: a scoping review. *BMJ Open Qual.* Oktober 2023;12(4):e002310.
22. Tawfik DS, Adair KC, Palassof S, Sexton JB, Levoy E, Frankel A, u. a. Leadership Behavior Associations with Domains of Safety Culture, Engagement, and Health Care Worker Well-Being. *Jt Comm J Qual Patient Saf.* März 2023;49(3):156–65.
23. Murray J, Sorra J, Gale B, Mossburg S. Ensuring Patient and Workforce Safety Culture in Healthcare John Murray, Joann Sorra, Bryan Gale, Sarah Mossburg | March 27, 2024 (<https://psnet.ahrq.gov/perspective/ensuring-patient-and-workforce-safety-culture-healthcare>) [Internet]. Verfügbar unter: <https://psnet.ahrq.gov/perspective/ensuring-patient-and-workforce-safety-culture-healthcare#>
24. Lee SE, Scott LD, Dahinten VS, Vincent C, Lopez KD, Park CG. Safety Culture, Patient Safety, and Quality of Care Outcomes: A Literature Review. *West J Nurs Res.* Februar 2019;41(2):279–304.
25. Frankel A, Haraden C, Federico F, Lenoci-Edwards J. *A Framework for Safe, Reliable, and Effective Care.* White Paper. Cambridge, MA: Institute for Healthcare Improvement and Safe & Reliable Healthcare; 2017.
26. WHO. *Global patient safety action plan 2021–2030: towards eliminating avoidable harm in health care.* Geneva: World Health Organization; 2021. Licence: CC BY-NC-SA 3.0 IGO.
27. Sexton JB, Adair KC, Profit J, Bae J, Rehder KJ, Gosselin T, u. a. Safety Culture and Workforce Well-Being Associations with Positive Leadership WalkRounds. *Jt Comm J Qual Patient Saf.* Juli 2021;47(7):403–11.
28. Finn M, Walsh A, Rafter N, Mellon L, Chong HY, Naji A, u. a. Effect of interventions to improve safety culture on healthcare workers in hospital settings: a systematic review of the international literature. *BMJ Open Qual.* Mai 2024;13(2):e002506.
29. Al-Surimi K, Najjar S, Al Quidaihi A, Masuadi E. The Impact of a National Accreditation Program on Patient Safety Culture in a Tertiary Hospital: Pre- and Post-Evaluation Study. *Glob J Qual Saf Heal.* 2021;4(1):18–26.
30. Pfadenhauer LM, Gerhardus A, Mozygemba K, Lysdahl KB, Booth A, Hofmann B, u. a. Making sense of complexity in context and implementation: the Context and Implementation of Complex Interventions (CICI) framework. *Implement Sci.* Dezember 2017;12(1):21.
31. Nævestad TO, Storesund Hesjevoll I, Elvik R. How can regulatory authorities improve safety in organizations by influencing safety culture? A conceptual model of the relationships and a discussion of implications. *Accid Anal Prev.* September 2021;159:106228.
32. SGAIM, SSMG, SSGIM. (2005). *Kontinuierliche Qualitätsentwicklung in der Hausarztpraxis. Empfehlungen für medizinische Qualitätszirkel: Eine Neuorientierung der Empfehlungen für die medizinische Qualitätsarbeit in der Schweiz.* Abgerufen am 04.09.2024 von https://www.hausaerzteschweiz.ch/fileadmin/user_upload/hausarzt_schweiz/Kommissionen/Qualitaet/7c_2005-12-28_Empf_med_QZ_V41.pdf.
33. SGAIM, SSMG, SSGIM. *Qualitätszirkel.* Abgerufen am 16.09.2024 von <https://www.sgaim.ch/de/qz>.
34. Conen D. [Measures to enhance patient safety. Importance of efficiency evaluation]. *Bundesgesundheitsblatt Gesundheitsforschung Gesundheitsschutz.* 2011;54(2):171–5.
35. Gehring K, Schwappach DL, Battaglia M, Buff R, Huber F, Sauter P, u. a. Safety climate and its association with office type and team involvement in primary care. *Int J Qual Health Care.* 2013;25(4):394–402.
36. Zúñiga F, Schwappach D, De Geest S, Schwendimann R. Psychometric properties of the Swiss version of the Nursing Home Survey on Patient Safety Culture. *Saf Sci.* 2013;55((Zúñiga F., franziska.zuniga@unibas.ch; De Geest S., sabina.degeest@unibas.ch; Schwendimann R.,

Appendix 8.1 References

- rene.schwendimann@unibas.ch) Institute of Nursing Science, University of Basel, Bernoullistr. 28, 4056 Basel, Switzerland):88–118.
37. Klimmeck S, Sexton JB, Schwendimann R. Changes in Safety and Teamwork Climate After Adding Structured Observations to Patient Safety WalkRounds. *Jt Comm J Qual Patient Saf.* Dezember 2021;47(12):783–92.
 38. Schwappach D, Richard A. Speak up-related climate and its association with healthcare workers' speaking up and withholding voice behaviours: a cross-sectional survey in Switzerland. *BMJ Qual Saf.* 2018;27(10):827–35.
 39. Ausserhofer D, Schubert M, Desmedt M, Blegen MA, De Geest S, Schwendimann R. The association of patient safety climate and nurse-related organizational factors with selected patient outcomes: a cross-sectional survey. *Int J Nurs Stud.* Februar 2013;50(2):240–52.
 40. Auer C, Schwendimann R, Koch R, De Geest S, Ausserhofer D. How hospital leaders contribute to patient safety through the development of trust. *J Nurs Adm.* 2014;44(1):23–9.
 41. Patientensicherheit Schweiz (2024). Machbarkeitsstudie Just Culture. Available from: <https://patientensicherheit.ch/forschung-entwicklung/just-culture/>.
 42. Patientensicherheit Schweiz. Patientensicherheit Schweiz. (2024). Just Culture [Internet]. Patientensicherheit. [cited 2024 Jun 15]. Available from: <https://patientensicherheit.ch/forschung-entwicklung/just-culture/>.
 43. Esmaeilzadeh S, Lane CM, Gerberi DJ, Wakeam E, Pickering BW, Herasevich V, u. a. Improving In-Hospital Patient Rescue: What Are Studies on Early Warning Scores Missing? A Scoping Review. *Crit Care Explor.* 21. Februar 2022;4(2):e0644.
 44. University of Washing. What is Implementation Science? [Internet]. [zitiert 3. April 2024]. Verfügbar unter: <https://impsciuw.org/implementation-science/learn/implementation-science-overview/>
 45. Rabin BA, Brownson RC, Haire-Joshu D, Kreuter MW, Weaver NL. A Glossary for Dissemination and Implementation Research in Health. *J Public Health Manag Pract.* März 2008;14(2):117–23.
 46. Wolfenden L, Foy R, Presseau J, Grimshaw JM, Ivers NM, Powell BJ, u. a. Designing and undertaking randomised implementation trials: guide for researchers. *BMJ.* 18. Januar 2021;m3721.
 47. Sacks GD, Shannon EM, Dawes AJ, Rollo JC, Nguyen DK, Russell MM, u. a. Teamwork, communication and safety climate: a systematic review of interventions to improve surgical culture. *BMJ Qual Saf.* Juli 2015;24(7):458–67.
 48. Neyens JC, Van Haastregt JC, Dijcks BP, Martens M, Van Den Heuvel WJ, De Witte LP, u. a. Effectiveness and Implementation Aspects of Interventions for Preventing Falls in Elderly People in Long-Term Care Facilities: A Systematic Review of RCTs. *J Am Med Dir Assoc.* Juli 2011;12(6):410–25.
 49. Koller, A., Cullati, S., Huber, C. G., Schwappach, D., Schwendimann, R., Staines, A., Gehri, B., Simon, M., & Haller, G. (2024). Safety culture in Switzerland: A protocol for a scoping review. Zenodo. <https://doi.org/10.5281/zenodo.11670005>.
 50. Gehri B, Koller A, Cullati S, Huber CG, Schwendimann R, Staines A, u. a. Safety culture interventions and implementation strategies used in health care settings: A scoping review protocol.
 51. Gambashidze N, Hammer A, Wagner A, Rieger MA, Brösterhaus M, Van Vegten A, u. a. Influence of Gender, Profession, and Managerial Function on Clinicians' Perceptions of Patient Safety Culture: A Cross-National Cross-Sectional Study. *J Patient Saf.* Juni 2021;17(4):e280–7.
 52. Fridrich A, Pfeiffer Y, Niederhauser A, Schwappach DL. Patient safety interventions and their implementation: Current status and directions for the future. 2021 [zitiert 20. August 2024]; Verfügbar unter: <https://rgdoi.net/10.13140/RG.2.2.16291.37926>
 53. Seppey R, Oesch A, Viehl CT. Compliance to the Surgical Safety Checklist over time in late and early adopters. *J Perioper Pr.* 2020;30(3):57–62.

Appendix 8.1 References

54. Gehring K., & Schwappach D., (2016) Wenn Schweigen gefährlich ist Speak Up für mehr Sicherheit in der Patientenversorgung. (cited on 15.09.2024). https://patientensicherheit.ch/wp/wp-content/uploads/2023/03/Schriftenreihe_08_DE_Speak_Up.pdf.
55. Allianz Peer Review CH. Interprofessionelle (Peer) Reviews: Empfehlung der Allianz Peer Review CH https://www.hplus.ch/fileadmin/hplus.ch/public/Qualitaet/Peer_Review/Peer_Review_neu/Interprofessionelle_Peer_Reviews_Empfehlung_Allianz_V2.0_20230101_D.pdf.
56. Allianz Peer Review CH. Interprofessionelle Reviews in der Psychiatrie: Factsheet mit den Erkenntnissen aus dem Pilotprojekt https://www.hplus.ch/fileadmin/hplus.ch/public/Qualitaet/Peer_Review/Peer_Review_neu/Interprofessionelle_Reviews_Psychiatrie_Factsheet_Pilotprojekt_Allianz_V1.0_20230101_D.pdf.
57. Hplus. (2022). Neue H+ Branchenlösung Interprofessionelle Reviews Psychiatrie. <https://www.hplus.ch/de/publikationen/eflash/ausgaben/07/2022/neue-h-branchenloesung-interprofessionelle-reviews-psychiatrie>.
58. GDK.CDS. (2020). Qualität im Gesundheitswesen: Sicht der Kantone Positionspapier der GDK. (cited on 11.06.2024) https://www.gdk-cds.ch/fileadmin/docs/public/gdk/themen/qualitaet/BT_Positionspapier_Qualitaet_GDK_def_d.pdf.
59. Hplus, FMH, Swiss Nurse Leaders (2020). Positionspapier: Qualitätsentwicklung braucht geeignete gesetzliche Rahmenbedingungen und bundeseinheitliche Vorgaben. (cited on 08.Jul.2024) https://www.hplus.ch/fileadmin/hplus.ch/public/Politik/Position/20200630_Positionierung_Qualitaetsentwicklung_Gesetzlicher_Rahmen_V1.0_D.pdf.
60. Haus- und Kinderärzte Schweiz (2020). Positionspapier Qualität in der Praxis. Abgerufen am 10. Juni 2024 von <https://www.hausaerzteschweiz.ch/gesundheitspolitik/positionspapiere/detail/positionspapier-qualitaet>.
61. Regener H. (1.2024). Just Culture: zentrales Element einer (Patienten-) Sicherheitskultur. star of life. https://www.paraplegie.ch/sites/default/files/2024-03/regener_h._2024._just_culture_-_zentrales_element_einer_patientensicherheitskultur_0.pdf.
62. Goetschi M. (17.09.2023). Interview. Patientensicherheit bedeutet konstante Maintenance. Blogbeitrag Careum, Abgerufen am 15. Juli 2024 von <https://careum.ch/aktuell/interview-schwendimann-patientensicherheit>.
63. Zentralvorstand FMH. CIRS-systemorientierte Verbesserung der Patientensicherheit. SAEZ. (105 (26)):28–9.
64. Gerber M, Kraft E, Bosshard C. Schweizerische Ärztezeitung. 2024;105(26):30–37 |Michelle Gerbera; Esther Kraftb; Christoph Bosshardc.
65. Guillod O. Medical error disclosure and patient safety: legal aspects. J Public Health Res. 2013;2(3):e31.
66. Pfeiffer and Schwappach (2022). Sicherheitsklima und Surgical Site Infections in Schweizer Spitälern. Referat Swissnoso Symposium 4.Mai 2022. https://swissnoso.ch/fileadmin/module/ssi_surveillance/Dokumente_D/7_Praesentationen/Referat_Pfeiffer_Schwappach_handout.pdf.
67. Fridrich DA, Fridrich A. (2024). «Wie können wir die Sicherheitskultur verbessern?» https://www.healthinsurancedays.ch/vortraege_24_pdfs/Fridrich_Health_Insurance_Days_24.pdf.
68. Paula H. Paula H. (2018). Stolpersteine und Erfolgsfaktoren beim klinischen Sicherheitsmanagement - Referat an der Jahrestagung Netzwerk Risikomanagement. Abgerufen am 16. Juli 2024 von https://www.netzwerk-risikomanagement.ch/wp-content/uploads/2018/04/b-Netzwerktreffen_Risikomanagement_Vortrag_Paula_2018-03-28.pdf.
69. Berther L, Gschwind L, Hascic A, Sahin H. Berther et al. (2021). Naming – Blaming – Shaming: Wie schafft die Medizin die Transition von der Fehler-zur Sicherheitskultur. Schriftenreihe der School of Medicine, Universität St. Gallen, «Gesundheitswesen, quo vadis? – Aktuelle Herausforderungen und Entwicklungen». https://med.unisg.ch/fileadmin/user_upload/HSG_ROOT/Institut_MED/Veranstaltungen/SGGF_HS21_Gruppe_5_Patientensicherheitsmanagement.pdf.

Appendix 8.1 References

70. Gehring K. & Schwappach D. (2021). Patientensicherheit in der ambulanten Praxis Modul 1: Grundlagen. Patientensicherheit Schweiz. (cited 26.06.2024)- https://patientensicherheit.ch/wp/wp-content/uploads/2023/03/D_Patientensicherheit_in_der_ambulanten_Praxis.pdf.
71. Public Health Weiterbildung, abgerufen am 27. Juni 2024 von <https://www.public-health-edu.ch/mph> (<https://www.public-health-edu.ch/pdf/2270.23-de.pdf>).
72. Regener H, Kranz K, Pannek-Rademacher S. Gesamte Belegschaft in Patientensicherheit schulen. Competence. 2023 (6). Abgerufen am 28. Juni 2024 von <https://competence.ch/?s=belegschaft&x=0&y=0>.
73. FHNW. (2021). Modulbeschreibung Master of Science Angewandte Psychologie-Sicherheitskultur (03020402.EN/11). (cited on 24.6.2024). <https://www.fhnw.ch/de/studium/psychologie/master-arbeitspsychologie/module-aop/media/sicherheitskultur-hs21-fhnw.pdf>.
74. Wacker J, Staender S, Kolbe M. Ausbildung im Thema Patientensicherheit - Fachkräfte früh für eine Sicherheitskultur sensibilisieren; In book Patientensicherheitsmanagement; Edition: 1; Chapter: 6.12; Publisher: de Gruyter Verlag; Editors: Peter Gaussmann; Michael Henninger; Joachim Koppenberg; Oktober 2015. In: Patientensicherheitsmanagement. (Edition 1).
75. SMIFK. Michaud PA, Jucker-Kupper P, and members of the Profiles working group. PROFILES; Principal Objectives and Framework for Integrated Learning and Education in Switzerland. Bern: Joint Commission of the Swiss Medical Schools; 2017.
76. Eisold C, Heller AR. [Risk management in anesthesia and critical care medicine]. Anaesthesist. Juni 2016;65(6):473–88.
77. Patientensicherheit Schweiz (2023). Strategie 2023-207. Abgerufen am 24. Juli 2024 von https://patientensicherheit.ch/wp/wp-content/uploads/2023/05/Strategie_2023_2027.pdf.
78. Spitex Schweiz. (2022). Qualitätsmanual Spitex Schweiz: Handbuch für die Betriebsführung. [Unpublished manuscript]. Spitex Schweiz, Bern.
79. Schweizerischer Hebammenverband. Lern- und Fehlermeldesystem für neu zugelassene Hebammen obligatorisch. Abgerufen am 22. Mai 2024 von <https://www.hebamme.ch/qualitaet/faelle-fuer-alle/>.
80. Heime & Spitäler (17. Mai 2022). KSB wird für seine Sicherheitskultur ausgezeichnet. Abgerufen am 25. Juli 2024 von <https://www.heimeundspitaeler.ch/management/ksb-wird-fuer-seine-sicherheitskultur-ausgezeichnet>.
81. Universitäre Medizin Schweiz (unimedsuisse). Qualität. Abgerufen am 24.06.2024 von <https://www.unimedsuisse.ch/de/projekte/qualitaet>.
82. de Bienassis K, Klazinga N. Comparative assessment of patient safety culture performance in OECD countries: Findings based on the Hospital Survey on Patient Safety Culture versions 1 and 2 [Internet]. 2024 Juli [zitiert 18. Juli 2024]. (OECD Health Working Papers; Bd. 168). Report No.: 168. Verfügbar unter: https://www.oecd-ilibrary.org/social-issues-migration-health/comparative-assessment-of-patient-safety-culture-performance-in-oecd-countries_d0552328-en
83. Martins, T., Möckli, N., Zúñiga, F. et al. (2023). SPOTnat – Spitex Koordination und Qualität – eine nationale Studie. Nationaler Bericht. Universität Basel. <https://doi.org/10.5281/zenodo.7843008>.
84. Asana Spital Menzikon. Patientensicherheitskultur im Rettungsdienst. Abgerufen am 15. Juni 2024 von https://www.spitalmenziken.ch/fileadmin/user_upload/Dokumente/Menziken/Aktuell/Patientensicherheit_Artikel.pdf.
85. Arnold DM, Posch DA, Selhofer L. Einblick in die Arbeitswelt der Pflegefachpersonen in Schweizer Spitälern nach der Covid-Krise (2023). Abgerufen am 28. Juni 2024 von https://www.iuc.unibe.ch/forschung/spitalpflegereport_schweiz/index_ger.html.
86. Zúñiga F., Ausserhofer D, Serdaly C. et al. (2013). SHURP 2013 – Rapport final de l'enquête relative au personnel de soins et d'accompagnement dans les établissements-médico-sociaux en Suisse. [Unpublished manuscript]. Universität Basel. Medizinische Fakultät. Departement Public Health. Nursing Science.

Appendix 8.1 References

87. Zúñiga F., Favez L., Baumann S., et al. (2018). SHURP 2018 – Schlussbericht Personal und Pflegequalität in Pflegeinstitutionen in der Deutschschweiz und Romandie. [Unpublished manuscript]. Universität Basel. Medizinische Fakultät. Departement Public Health. Nursing Science.
88. La Fédération des hôpitaux vaudois (FHV) (2019). Enquête culture sécurité [Unpublished manuscript].
89. ASPMAD (2024). Première enquête interne sur la culture sécurité. [Unpublished manuscript]. Aide et soins à domicile.
90. Martins T, Bellagamba D, Simon M, Bucher Andary J, Zúñiga F. Martins, T., Bellagamba, D., Simon, M., Bucher Andary, J., & Zúñiga, F. (2024). Patient safety culture in home care, its antecedents, and outcomes : A scoping review protocol. Zenodo. <https://doi.org/10.5281/zenodo.10779093>. 18. März 2024 [zitiert 9. September 2024]; Verfügbar unter: <https://zenodo.org/doi/10.5281/zenodo.10779093>
91. Auer C, Schwendimann R, Koch R, De Geest S, Ausserhofer D. How hospital leaders contribute to patient safety through the development of trust. *J Nurs Adm.* 2014;44(1):23–9.
92. Zaugg B, Wangler M. A model framework for patient safety training in chiropractic: a literature synthesis. *J Manip Physiol Ther.* 2009;32(6):493–9.
93. Schwendimann R, Dhaini S, Ausserhofer D, Engberg S, Zúñiga F. Factors associated with high job satisfaction among care workers in Swiss nursing homes - a cross sectional survey study. *BMC Nurs.* 2016;15:37.
94. Pfeiffer Y, Briner M, Wehner T, Manser T. Motivational antecedents of incident reporting: evidence from a survey of nurses and physicians. *Swiss Med Wkly.* 2013;143:w13881.
95. Zúñiga F, Ausserhofer D, Hamers JPH, Engberg S, Simon M, Schwendimann R. Are Staffing, Work Environment, Work Stressors, and Rationing of Care Related to Care Workers' Perception of Quality of Care? A Cross-Sectional Study. *J Am Med Dir Assoc.* 2015;16(10):860–6.
96. Schwappach DLB. Wenn Schweigen gefährlich ist: „Speaking-up“ bei Sicherheitsbedenken. *Z Für Evidenz Fortbild Qual Im Gesundheitswesen.* 2016;114:5–12.
97. Stocker M, Szavay P, Wernz B, Neuhaus TJ, Lehnick D, Zundel S. What are the participants' perspective and the system-based impact of a standardized, inter-professional morbidity/mortality-conferences in a children's hospital? *Transl Gastroenterol Hepatol.* 2021;6:48.
98. Niederhauser A, Schwappach DLB. Speaking up or remaining silent about patient safety concerns in rehabilitation: A cross-sectional survey to assess staff experiences and perceptions. *Health Sci Rep.* 2022;5(3):e631.
99. Schwappach DL, Gehring K. Trade-offs between voice and silence: a qualitative exploration of oncology staff's decisions to speak up about safety concerns. *BMC Health Serv Res.* 2014;14:303.
100. Schwappach DLB, Niederhauser A. Speaking up about patient safety in psychiatric hospitals - a cross-sectional survey study among healthcare staff. *Int J Ment Health Nurs.* Dezember 2019;28(6):1363–73.
101. Richard A, Pfeiffer Y, Schwappach DDL. Development and Psychometric Evaluation of the Speaking Up About Patient Safety Questionnaire. *J Patient Saf.* 2021;17(7):e599–606.
102. Ausserhofer D, Schubert M, Engberg S, Blegen M, De G, Schwendimann R. Nurse-reported patient safety climate in Swiss hospitals: a descriptive-explorative substudy of the Swiss RN4CAST study. *Swiss Med Wkly.* 2012;142:w13501.
103. Ricklin ME, Hess F, Hautz WE. Patient safety culture in a university hospital emergency department in Switzerland - a survey study. *GMS J Med Educ.* 2019;36(2):Doc14.
104. Ederer C, König-Bachmann M, Romano I, Knobloch R, Zenzmaier C. Midwives' perception of patient safety culture-A qualitative study. *Midwifery.* 2019;71:33–41.
105. Wangler M, Peterson C, Zaugg B, Thiel H, Finch R. How do chiropractors manage clinical risk? A questionnaire study. *Chiropr Man Ther.* 8. Juni 2013;21(1):18.

Appendix 8.1 References

106. Ausserhofer D, Schubert M, Blegen M, De Geest S, Schwendimann R. Validity and reliability on three European language versions of the Safety Organizing Scale. *Int J Qual Health Care*. 2013;25(2):157–66.
107. Mankaka CO, Waeber G, Gachoud D. Female residents experiencing medical errors in general internal medicine: a qualitative study. *BMC Med Educ*. 2014;14:140.
108. Cullati S, Le Du S, Raë AC, Micallef M, Khabiri E, Ourahmoune A, u. a. Is the Surgical Safety Checklist successfully conducted? An observational study of social interactions in the operating rooms of a tertiary hospital. *BMJ Qual Saf*. 2013;22(8):639–46.
109. Fridrich A, Imhof A, Staender S, Brenni M, Schwappach D. A quality improvement initiative using peer audit and feedback to improve compliance. *Int J Qual Health Care*. 2022;34(3).
110. Schwendimann R, Blatter C, Lüthy M, Mohr G, Girard T, Batzer S, u. a. Adherence to the WHO surgical safety checklist: an observational study in a Swiss academic center. *Patient Saf Surg*. 2019;13:14.
111. Mascherek AC, Bezzola P, Gehring K, Schwappach DL. Effect of a two-year national quality improvement program on surgical checklist implementation. *Z Evid Fortbild Qual Gesundheitswes*. 2016;114:39–47.
112. Cullati S, Licker MJ, Francis P, Degiorgi A, Bezzola P, Courvoisier DS, u. a. Implementation of the surgical safety checklist in Switzerland and perceptions of its benefits: cross-sectional survey. *PloS One*. 2014;9(7):e101915.
113. Mascherek AC, Schwappach DLB. Patient safety climate profiles across time: Strength and level of safety climate associated with a quality improvement program in Switzerland - A cross-sectional survey study. *PLoS ONE* [Internet]. 2017;12(7). Verfügbar unter: <https://www.embase.com/search/results?subaction=viewrecord&id=L617564217&from=export>
114. Kaderli R, Seelandt J, Umer M, Tschan F, Businger A. Reasons for the persistence of adverse events in the era of safer surgery – a qualitative approach. *Swiss Med Wkly* [Internet]. 2. Oktober 2013 [zitiert 23. Juli 2024]; Verfügbar unter: <https://smw.ch/index.php/smw/article/view/1759>
115. Stocker M, Pilgrim SB, Burmester M, Allen ML, Gijssels WH. Interprofessional team management in pediatric critical care: some challenges and possible solutions. *J Multidiscip Heal*. 2016;9:47–58.
116. Klimmeck S, Sexton JB, Schwendimann R. Changes in Safety and Teamwork Climate After Adding Structured Observations to Patient Safety WalkRounds. *Jt Comm J Qual Patient Saf*. Dezember 2021;47(12):783–92.
117. Staines A, Lécureux E, Rubin P, Baralon C, Farin A. Impact of TeamSTEPPS on patient safety culture in a Swiss maternity ward. *Int J Qual Health Care*. 2020;32(9):618–24.
118. Walther F, Schick C, Schwappach D, Kornilov E, Orbach-Zinger S, Katz D, u. a. The Impact of a 22-Month Multistep Implementation Program on Speaking-Up Behavior in an Academic Anesthesia Department. *J Patient Saf*. 2022;18(7):e1036–40.
119. Valentin A, Schiffinger M, Steyrer J, Huber C, Strunk G. Safety climate reduces medication and dislodgement errors in routine intensive care practice. *Intensive Care Med*. März 2013;39(3):391–8.
120. Cullati S, Semmer NK, Tschan F, Choupay G, Chopard P, Courvoisier DS. When Illegitimate Tasks Threaten Patient Safety Culture: A Cross-Sectional Survey in a Tertiary Hospital. *Int J Public Health*. 2023;68:1606078.
121. Klingberg K, Gadelhak K, Jegerlehner SN, Brown AD, Exadaktylos AK, Srivastava DS. Bad manners in the Emergency Department: Incivility among doctors. *PLoS One*. 2018;13(3):e0194933.
122. Gehri B, Bachnick S, Schwendimann R, Simon M. Matching Registered Nurse Services With Changing Care Demands in Psychiatric Hospitals: Protocol for a Multicenter Observational Study (MatchRN Psychiatry Study). *JMIR Res Protoc*. 2021;10(8):e26700.
123. Schubert M, Ausserhofer D, Desmedt M, Schwendimann R, Lesaffre E, Li B, u. a. Levels and correlates of implicit rationing of nursing care in Swiss acute care hospitals—a cross sectional study. *Int J Nurs Stud*. 2013;50(2):230–9.

Appendix 8.1 References

124. Zúñiga F, Ausserhofer D, Hamers JPH, Engberg S, Simon M, Schwendimann R. The relationship of staffing and work environment with implicit rationing of nursing care in Swiss nursing homes – A cross-sectional study. *Int J Nurs Stud*. September 2015;52(9):1463–74.
125. Elfering A, Semmer NK, Grebner S. Work stress and patient safety: observer-rated work stressors as predictors of characteristics of safety-related events reported by young nurses. *Ergonomics*. 2006;49(5–6):457–69.
126. Stühlinger M, Schmutz JB, Grote G. I Hear You, but Do I Understand? The Relationship of a Shared Professional Language With Quality of Care and Job Satisfaction. *Front Psychol*. 2019;10:1310.
127. Heckemann B, Hahn S, Halfens RJG, Richter D, Schols JMGA. Patient and visitor aggression in healthcare: A survey exploring organisational safety culture and team efficacy. *J Nurs Manag*. 2019;27(5):1039–46.
128. Heckemann B, Siegrist-Dreier S, Thilo FJS, Hahn S. Team efficacy and leadership in managing aggressive situations in the general hospital setting: A qualitative descriptive analysis of focus groups with ward managers. *J Clin Nurs*. 2020;29(5–6):974–86.
129. Schwappach DL, Wernli M. Am I (un)safe here? Chemotherapy patients' perspectives towards engaging in their safety. *Qual Saf Health Care*. 2010;19(5):e9.
130. Schwappach DL, Frank O, Koppenberg J, Müller B, Wasserfallen JB. Patients' and healthcare workers' perceptions of a patient safety advisory. *Int J Qual Health Care*. 2011;23(6):713–20.
131. Schwappach DL, Frank O, Hochreutener MA. „New perspectives on well-known issues“: patients' experiences and perceptions of safety in Swiss hospitals. *Z Evid Fortbild Qual Gesundheitswes*. 2011;105(7):542–8.
132. Schwappach D, Pfeiffer Y. Root causes and preventability of unintentionally retained foreign objects after surgery: a national expert survey from Switzerland. *Patient Saf Surg*. 2023;17(1):15.
133. Briner M, Manser T. Clinical risk management in mental health: a qualitative study of main risks and related organizational management practices. *BMC Health Serv Res*. 2013;13:44.
134. Cullati S, Courvoisier DS, Francis P, Degiorgi A, Bezzola P, Licker MJ, u. a. Is team-based perception of safety in the operating room associated with self-reported wrong-site surgery? An exploratory cross-sectional survey among physicians. *Health Sci Rep*. 2018;1(6):e42.
135. Pfeiffer Y, Atkinson A, Maag J, Lane MA, Schwappach DLB, Marschall J. Preventing Surgical Site Infections: Are Safety Climate Level and Its Strength Associated With Self-reported Commitment To, Subjective Norms Toward, and Knowledge About Preventive Measures? *J Patient Saf*. Juni 2023;19(4):264–70.
136. Pfeiffer Y, Atkinson A, Maag J, Lane MA, Schwappach D, Marschall J. Are cross-sectional safety climate survey results in operating room staff associated with the surgical site infection rates in Swiss hospitals? *BMJ Open*. 19. April 2023;13(4):e066514.
137. Schwendimann R, Zúñiga F, Ausserhofer D, Schubert M, Engberg S, de Geest S. Swiss Nursing Homes Human Resources Project (SHURP): protocol of an observational study. *J Adv Nurs*. April 2014;70(4):915–26.
138. Bezzola P, Hochreutener MA. [Patient safety. Safer surgery in Switzerland]. *Krankenpfl Soins Infirm*. 2011;104(11):54–5.
139. Gehring K, Mascherek AC, Bezzola P, Schwappach DLB. Safety climate in Swiss hospital units: Swiss version of the Safety Climate Survey. *J Eval Clin Pract*. 2015;21(2):332–8.
140. Perneger TV, Staines A, Kundig F. Internal consistency, factor structure and construct validity of the French version of the Hospital Survey on Patient Safety Culture. *BMJ Qual Saf*. 2013;23(5):389–97.
141. Schwendimann R, Zimmermann N, Küng K, Ausserhofer D, Sexton B. Variation in safety culture dimensions within and between US and Swiss Hospital Units: an exploratory study. *BMJ Qual Saf*. 2012;22(1):32–41.
142. Gehring K, Schwappach D. [Patient safety in general practice]. *Z Evid Fortbild Qual Gesundheitswes*. 2014;108(1):25–31.

Appendix 8.1 References

143. Gehring K, Schwappach D. Patient safety in outpatient care - study of Swiss primary care offices. *Ther Umsch.* 2012;69(6):353–7.
144. Jossen M, Valeri F, Heilmaier C, Schwappach D. Assessment of the safety climate in outpatient diagnostic services: Development and psychometric evaluation of a questionnaire. *Eur Radiol.* März 2019;29(3):1538–45.
145. Cullati S. et al. (2013). La culture de sécurité aux Hôpitaux Universitaires de Genève. Enquête par questionnaire menée auprès du personnel de soins, Mai-Juillet 2013 [Unpublished manuscript]. Service qualité des soins, Hôpitaux Universitaires de Genève.
146. Cullati S. et al. (2016). La culture de sécurité aux HUG. Enquête 2016 [Unpublished manuscript]. Service qualité des soins, Hôpitaux Universitaires de Genève.
147. Cullati S., et al. (2018). La culture de sécurité aux HUG. Résultats de l'enquête 2018 [Unpublished manuscript]. Service qualité des soins, Hôpitaux Universitaires de Genève.
148. Cullati S. et al. (2020). La culture de sécurité aux HUG. Résultats de l'enquête 2020 [Unpublished manuscript]. Service qualité des soins, Hôpitaux Universitaires de Genève.
149. Friedel J. (2016). The association of professional care worker characteristics and work environment factors in nursing homes: A cross-sectional study in the Swiss Nursing Homes Human Resources Project. [Unpublished manuscript]. Nursing Science. Department Public Health. Faculty of medicine. University Basel.
150. Briner M, Kessler O, Pfeiffer Y, Wehner T, Manser T. Assessing hospitals' clinical risk management: Development of a monitoring instrument. *BMC Health Serv Res.* 13. Dezember 2010;10:337.
151. Zimmermann N, Küng K, Sereika SM, Engberg S, Sexton B, Schwendimann R. Assessing the safety attitudes questionnaire (SAQ), German language version in Swiss university hospitals - a validation study. *BMC Health Serv Res.* Dezember 2013;13(1):347.
152. Ausserhofer D. Providing evidence based on content through the use of the content validity index on a safety culture in hospital measures. *Pflegewissenschaft.* 2012;14(3):151–8.
153. Cullati S. et al. (2023). La culture de sécurité aux HUG. Résultats de l'enquête 2023 [Unpublished manuscript]. Service qualité des soins, Hôpitaux Universitaires de Genève.
154. Van Vegten A, Pfeiffer Y, Giuliani F, Manser T. Patientensicherheitsklima im Spital: Erfahrungen mit der Planung, Organisation und Durchführung einer Mitarbeitervollbefragung. *Z Für Evidenz Fortbild Qual Im Gesundheitswesen.* Januar 2011;105(10):734–42.
155. Verbakel NJ, Langelaan M, Verheij TJ, Wagner C, Zwart DL, Verheij TJM, u. a. Effects of patient safety culture interventions on incident reporting in general practice: a cluster randomised trial. *Br J Gen Pract.* 2015;65(634):e319-29.
156. Verbakel NJ, de Bont AA, Verheij TJM, Wagner C, Zwart DLM, Verheij TJ, u. a. Improving patient safety culture in general practice: an interview study. *Br J Gen Pract.* 2015;65(641):e822–8.
157. Cavalcanti AB, Bozza FA, Machado FR, Salluh JIF, Campagnucci VP, Vendramim P, u. a. Effect of a Quality Improvement Intervention With Daily Round Checklists, Goal Setting, and Clinician Prompting on Mortality of Critically Ill Patients: A Randomized Clinical Trial. *JAMA J Am Med Assoc.* 2016;315(14):1480–90.
158. Colon-Emeric CS, McConnell E, Pinheiro SO, Corazzini K, Porter K, Earp KM, u. a. CONNECT for Better Fall Prevention in Nursing Homes: Results from a Pilot Intervention Study. *J Am Geriatr Soc.* 2013;61(12):2150–9.
159. González-Formoso C, Clavería A, Fernández-Domínguez MJ, Lago-Deibe FL, Hermida-Rial L, Rial A, u. a. Effectiveness of an educational intervention to improve the safety culture in primary care: a randomized trial. *BMC Fam Pr.* 2019;20(1):15.
160. Hoffmann B, Müller V, Rochon J, Gondan M, Müller B, Albay Z, u. a. Effects of a team-based assessment and intervention on patient safety culture in general practice: an open randomised controlled trial. *BMJ Qual Saf.* 2014;23(1):35–46.

Appendix 8.1 References

161. Occelli P, Quenon JL, Kret M, Domecq S, Denis A, Delaperche F, u. a. Improving the safety climate in hospitals by a vignette-based analysis of adverse events: a cluster randomised study. *Int J Qual Health Care*. 2019;31(3):212–8.
162. Riley W, Davis S, Miller K, Hansen H, Sainfort F, Sweet R. Didactic and simulation nontechnical skills team training to improve perinatal patient outcomes in a community hospital. *Jt Comm J Qual Patient Saf*. 2011;37(8):357–63.
163. Teigné D, Mabileau G, Lucas M, Moret L, Terrien N. Safety culture in French nursing homes: A randomised controlled study to evaluate the effectiveness of a risk management intervention associated with care. *PLoS ONE* [Internet]. 2022;17(12 December). Verfügbar unter: <https://www.embase.com/search/results?subaction=viewrecord&id=L2021633909&from=export>
164. Zohar D, Werber YT, Marom R, Curlau B, Blondheim O. Modifying head nurse messages during daily conversations as leverage for safety climate improvement: a randomised field experiment. *BMJ Qual Saf*. 2017;26(8):653–62.
165. Colón-Emeric CS, Corazzini K, McConnell ES, Pan W, Toles M, Hall R, u. a. Effect of promoting high-quality staff interactions on fall prevention in nursing homes: A cluster-randomized trial. *JAMA Intern Med*. 2017;177(11):1634–41.
166. Pannick S, Athanasiou T, Long SJ, Beveridge I, Sevdalis N. Translating staff experience into organisational improvement: The HEADS-UP stepped wedge, cluster controlled, non-randomised trial. *BMJ Open* [Internet]. 2017;7(7). Verfügbar unter: <https://www.embase.com/search/results?subaction=viewrecord&id=L617374278&from=export>
167. Etheridge JC, Moyal-Smith R, Yong TT, Lim SR, Sonnay Y, Lim C, u. a. Transforming Team Performance Through Reimplementation of the Surgical Safety Checklist. *JAMA Surg*. 2024;159(1):78–86.
168. Khan A, Patel SJ, Anderson M, Baird JD, Johnson TM, Liss I, u. a. Implementing a Family-Centered Rounds Intervention Using Novel Mentor-Trios. *Pediatrics*. 2024;153(2):1–16.
169. Andreoli A, Fancott C, Velji K, Baker GR, Solway S, Aimone E, u. a. Using SBAR to communicate fall risk and management in inter-professional rehabilitation teams...Situation-Background-Assessment-Recommendation. *Healthc Q*. 2010;13:94–101.
170. Caris MG, Kamphuis PGA, Dekker M, de Bruijne MC, van Agtmael MA, Vandenbroucke-Grauls CMJE. Patient Safety Culture and the Ability to Improve: A Proof of Concept Study on Hand Hygiene. *Infect Control Hosp Epidemiol*. 2017;38(11):1277–83.
171. Damery S, Flanagan S, Jones J, Jolly K. The effect of providing staff training and enhanced support to care homes on care processes, safety climate and avoidable harms: Evaluation of a care home quality improvement programme in England. *Int J Env Res Public Health* [Internet]. 2021;18(14). Verfügbar unter: <https://www.embase.com/search/results?subaction=viewrecord&id=L2007816909&from=export>
172. Dodge LE, Nippita S, Hacker MR, Intondi EM, Ozcelik G, Paul ME. Impact of teamwork improvement training on communication and teamwork climate in ambulatory reproductive health care. *J Heal Risk Manag*. 2019;38(4):44–54.
173. Gaston T, Short N, Ralyea C, Casterline G. Promoting Patient Safety: Results of a TeamSTEPPS® Initiative. *J Nurs Adm*. 2016;46(4):201–7.
174. Gillespie B, Steel C, Kang E, Harbeck E, Nikolic K, Fairweather N, u. a. Evaluation of a Brief Team Training Intervention in Surgery: A Mixed-Methods Study. *AORN J*. 2017;106(6):513–22.
175. Kemper PF, De Bruijne M, Van Dyck C, So RL, Tangkau P, Wagner C. Crew resource management training in the intensive care unit. A multisite controlled before-after study. *BMJ Qual Saf*. 2016;25(8):577–87.
176. Mayer CM, Cluff L, Lin WT, Willis TS, Stafford RE, Williams C, u. a. Evaluating efforts to optimize TeamSTEPPS implementation in surgical and pediatric intensive care units. *Jt Comm J Qual Patient Saf*. 2011;37(8):365–74.
177. Müller BS, Lüttel D, Schütze D, Blazejewski T, Pommée M, Müller H, u. a. Supporting Error Management and Safety Climate in Ambulatory Care Practices: The CIRSforte Study. *J Patient Saf*. 2024;

Appendix 8.1 References

178. Picard J, Evain JN, Douron C, Maussion É, Stihle X, Manhes P, u. a. Impact of a large interprofessional simulation-based training course on communication, teamwork, and safety culture in the operating theatre: A mixed-methods interventional study. *Anaesth Crit Care Pain Med* [Internet]. 2022;41(1). Verfügbar unter: <https://www.embase.com/search/results?subaction=viewrecord&id=L2016372066&from=export>
179. Reszel J, Weiss D, Sprague AE, Fell DB, Dunn S, Walker MC, u. a. A mixed-methods evaluation of the MOREOB program in Ontario hospitals: participant knowledge, organizational culture, and experiences. *BMC Health Serv Res*. 2019;19(1):N.PAG-N.PAG.
180. Schepper SD, Geuens N, Roes L, Fransen E, Hilderson D, Franck E. Generic Crew Resource Management training to improve non-technical skills in acute care - Phase 2: A pre-post multicentric intervention study. *Clin Simul Nurs*. 2021;61:65–78.
181. Slater BL, Lawton R, Armitage G, Bibby J, Wright J. Training and action for patient safety: Embedding interprofessional education for patient safety within an improvement methodology. *J Contin Educ Health Prof*. 2012;32(2):80–9.
182. Stead K, Kumar S, Schultz TJ, Tiver S, Pirone CJ, Adams RJ, u. a. Teams communicating through STEPPS. *Med J Aust*. 2009;S128-32.
183. Aaberg OR, Ballangrud R, Husebø SIE, Hall-Lord ML. An interprofessional team training intervention with an implementation phase in a surgical ward: A controlled quasi-experimental study. *J Interprof Care*. 2019;1–10.
184. AbuAlRub RF, Abu Alhijaa EH. The Impact of Educational Interventions on Enhancing Perceptions of Patient Safety Culture Among Jordanian Senior Nurses. *Nurs Forum (Auckl)*. 2014;49(2):139–50.
185. Ahsan A, Setiowati L, Noviyanti LW, Rahmawati IN, Ningrum EH, Putra KR. Nurses' team communication in hospitals: A quasi-experimental study using a modified teamstepps. *J Public Health Res* [Internet]. 2021;10(2). Verfügbar unter: <https://www.embase.com/search/results?subaction=viewrecord&id=L2007035803&from=export>
186. Alcântara de Moraes MV, Sales de Almeida ÍL, Fontenele Lima de Carvalho RE. Patient safety culture assessment before and after safety huddle implementation. *Rev Esc Enferm USP*. 2023;57:1–8.
187. Ansari S, Rayfield M, Wallis V, Jardine J, Morris E, Prosser-Snelling E. A Safety Evaluation of the Impact of Maternity-Orientated Human Factors Training on Safety Culture in a Tertiary Maternity Unit. *J PATIENT Saf*. 2020;16(4):E359–66.
188. Benn J, Burnett S, Parand A, Pinto A, Vincent C. Factors predicting change in hospital safety climate and capability in a multi-site patient safety collaborative: a longitudinal survey study. *BMJ Qual Saf*. 2012;21(7):559–68.
189. Berkowitz R, Schreiber R, Paasche-Orlow M. Team Improvement and Patient Safety Conferences Culture Change and Slowing the Revolving Door Between Skilled Nursing Facility and the Hospital. *J Nurs CARE Qual*. 2012;27(3):258–65.
190. Bhayat S, Birch J, Ganado CC. Development of better teamwork on a NICU using the TeamSTEPPS concept. *Infant*. 2020;16(4):166–70.
191. Blegen MA, Sehgal NL, Alldredge BK, Gearhart S, Auerbach AA, Wachter RM. Republished paper: Improving safety culture on adult medical units through multidisciplinary teamwork and communication interventions: The TOPS project. *Postgrad Med J*. 2010;86(1022):729–33.
192. Brilli RJ, McClelland Jr. RE, Crandall WV, Stoverock L, Berry JC, Wheeler TA, u. a. A comprehensive patient safety program can significantly reduce preventable harm, associated costs, and hospital mortality. *J Pediatr*. 2013;163(6):1638–45.
193. Bronkhorst B, Tummers L, Steijn B. Improving safety climate and behavior through a multifaceted intervention: Results from a field experiment. *Saf Sci*. 2018;103((Bronkhorst B., bronkhorst@essb.eur.nl; Steijn B., steijn@essb.eur.nl) Erasmus University Rotterdam, Erasmus School of Social and Behavioural Sciences, Department of Public Administration&Sociology, Burgemeester Oudlaan 50, Rotterdam, DR, Netherlands):293–304.
194. Bryan Sexton J, Berenholtz SM, Goeschel CA, Watson SR, Holzmüller CG, Thompson DA, u. a. Assessing and improving safety climate in a large cohort of intensive care units. *Crit Care Med*. 2011;39(5):934–9.

Appendix 8.1 References

195. Burström L, Letterstål A, Engström ML, Berglund A, Enlund M. The patient safety culture as perceived by staff at two different emergency departments before and after introducing a flow-oriented working model with team triage and lean principles: a repeated cross-sectional study. *BMC Health Serv Res*. 2014;14(1):296–296.
196. Campbell D, Dontje K. Implementing Bedside Handoff in the Emergency Department: A Practice Improvement Project. *J Emerg Nurs*. 2019;45(2):149–54.
197. Chang BH, Hsu YJ, Rosen MA, Gurses AP, Huang S, Xie A, u. a. Reducing Three Infections Across Cardiac Surgery Programs: A Multisite Cross-Unit Collaboration. *Am J Med Qual*. 2020;35(1):37–45.
198. Chang OH, Levy B, Lytle H, Pope R, Phiri H, Gellhaus T, u. a. Implementation of the Alliance for Innovation on Maternal Health Program to Reduce Maternal Mortality in Malawi. *Obstet Gynecol*. 2019;133(3):507–14.
199. Chu-Weininger MYL, Wueste L, Lucke JF, Weavind L, Mazabob J, Thomas EJ. The impact of a tele-ICU on provider attitudes about teamwork and safety climate. *Qual Saf Health Care*. 2010;19(6):e39.
200. Cooke M. TeamSTEPPS for health care risk managers: Improving teamwork and communication. *J Healthc Risk Manag*. 2016;36(1):35–45.
201. Deraniyagala R, Liu C, Mittauer K, Greenwalt J, Morris CG, Yeung AR. Implementing an Electronic Event-Reporting System in a Radiation Oncology Department: The Effect on Safety Culture and Near-Miss Prevention. *J Am Coll Radiol*. 2015;12(11):1191–5.
202. Desai S, Fiumara K, Kachalia A. Building an Ambulatory Safety Program at an Academic Health System. *J PATIENT Saf*. 2021;17(2):E84–90.
203. Dirik HF, Intepeler SS. An authentic leadership training programme to increase nurse empowerment and patient safety: A quasi-experimental study. *J Adv Nurs John Wiley Sons Inc*. 2024;80(4):1417–28.
204. Donnelly LF, Dickerson JM, Goodfriend MA, Muething SE. Improving patient safety: Effects of a safety program on performance and culture in a department of radiology. *Am J Roentgenol*. 2009;193(1):165–71.
205. Dubois H, Schmidt PT, Creutzfeldt J, Bergenmar M. Person-centered endoscopy safety checklist: development, implementation, and evaluation. *World J Gastroenterol*. 2017;23(48):8605–14.
206. Dunn AS, Reyna M, Radbill B, Parides M, Colgan C, Osio T, u. a. The Impact of Bedside Interdisciplinary Rounds on Length of Stay and Complications. *J Hosp Med*. 2017;12(3):137–42.
207. Edwards PJ, Scott T, Richardson P, Espinoza S, Sainfort F, Rask K, u. a. Using staff perceptions on patient safety as a tool for improving safety culture in a pediatric hospital system. *J Patient Saf*. 2008;4(2):113–8.
208. Frankel A, Grillo SP, Pittman M, Thomas EJ, Horowitz L, Page M, u. a. Revealing and resolving patient safety defects: the impact of leadership WalkRounds on frontline caregiver assessments of patient safety. *Health Serv Res*. 2008;43(6):2050–66.
209. Ginsburg L, Norton PG, Casebeer A, Lewis S, Ginsburg L, Norton PG, u. a. An educational intervention to enhance nurse leaders' perceptions of patient safety culture. *Health Serv Res*. 2005;40(4):997–1020.
210. Gu Y, Liang L, Ge L, Jiang L, Hu X, Xu J, u. a. Application of comprehensive unit-based safety program model in the inter-hospital transfer of patients with critical diseases: a retrospective controlled study. *BMC Health Serv Res*. 2021;21(1):1–9.
211. Haerckens MHTM, Kox M, Noe PM, Van Der Hoeven JG, Pickkers P. Crew Resource Management in the trauma room: A prospective 3-year cohort study. *Eur J Emerg Med*. 2018;25(4):281–7.
212. Haller G, Garnerin P, Morales MA, Pfister R, Berner M, Irion O, u. a. Effect of crew resource management training in a multidisciplinary obstetrical setting. *Int J Qual Health Care*. 2008;20(4):254–63.
213. Hanskamp-Sebregts M, Zegers M, Westert GP, Boeijen W, Teerenstra S, Gulp PJ van, u. a. Effects of patient safety auditing in hospital care: results of a mixed-method evaluation (part 1). *Int J Qual Health Care*. 2019;31(7):8–15.

Appendix 8.1 References

214. Hassan AE, Mohammed FA, Zakaria AM, Ibrahim IA. Evaluating the Effect of TeamSTEPPS on Teamwork Perceptions and Patient Safety Culture among Newly Graduated Nurses. *BMC Nurs.* 2024;23(1):1–11.
215. Haugen AS, Søfteland E, Eide GE, Sevdalis N, Vincent CA, Nortvedt MW, u. a. Impact of the World Health Organization's Surgical Safety Checklist on safety culture in the operating theatre: a controlled intervention study. *BJA Br J Anaesth.* 2013;110(5):807–15.
216. Haugen AS, Søfteland E, Sevdalis N, Eide GE, Nortvedt MW, Vincent C, u. a. Impact of the Norwegian National Patient Safety Program on implementation of the WHO Surgical Safety Checklist and on perioperative safety culture. *BMJ Open Qual.* 2020;9(3).
217. Haynes AB, Weiser TG, Berry WR, Lipsitz SR, Breizat AHS, Dellinger EP, u. a. Changes in safety attitude and relationship to decreased postoperative morbidity and mortality following implementation of a checklist-based surgical safety intervention. *BMJ Qual Saf.* 2011;20(1):102–7.
218. Hefner JL, Hilligoss B, Knupp A, Bournique J, Sullivan J, Adkins E, u. a. Cultural Transformation After Implementation of Crew Resource Management: Is It Really Possible? *Am J Med Qual.* 2017;32(4):384–90.
219. Henkin S, Chon TY, Christopherson ML, Halvorsen AJ, Worden LM, Ratelle JT. Improving nurse–physician teamwork through interprofessional bedside rounding. *J MultidiscipHealthc.* 2016;9((Henkin S.; Halvorsen A.J.) Department of Medicine, Mayo Clinic, Rochester, MN, United States):201–5.
220. Hinde T, Gale T, Anderson I, Roberts M, Sice P. A study to assess the influence of interprofessional point of care simulation training on safety culture in the operating theatre environment of a university teaching hospital. *J Interprof Care.* 2016;30(2):251–3.
221. Hwang JI, Kim SW. Using an Early Warning Score for Nurse Shift Patient Handover: Before-and-after Study. *Asian Nurs Res.* 2022;16(1):18–24.
222. Isaak V, Vashdi D, Bar-Noy D, Kostisky H, Hirschmann S, Grinshpoon A. Enhancing the Safety Climate and Reducing Violence Against Staff in Closed Hospital Wards. *Workplace Health Saf.* 2017;65(9):409–16.
223. Je SM, Kim HJ, You JS, Chung SP, Cho J, Lee JH, u. a. Assessing safety attitudes among healthcare providers after a hospital-wide high-risk patient care program. *Yonsei Med J.* 2014;55(2):523–9.
224. Jing Miao, Barvin S, Mohd Yussof SRB, Joy Boon Ka Chong. Impact of medication safety initiatives on patient safety culture in a community pharmacy in Singapore. *Singapore Med J.* 2023;64(8):522–6.
225. Johnson J, Latif A, Randive B, Kadam A, Rajput U, Kinikar A, u. a. Implementation of the Comprehensive Unit-Based Safety Program to Improve Infection Prevention and Control Practices in Four Neonatal Intensive Care Units in Pune, India. *Front Pediatr [Internet].* 2021;9((Johnson J., jjohn245@jhmi.edu) Division of Neonatology, Department of Pediatrics, Johns Hopkins University School of Medicine, Baltimore, MD, United States). Verfügbar unter: <https://www.embase.com/search/results?subaction=viewrecord&id=L636961209&from=export>
226. Jones K, Skinner A, High R, Reiter-Palmon R. A theory-driven, longitudinal evaluation of the impact of team training on safety culture in 24 hospitals. *BMJ Qual Saf.* 2013;22(5):394–404.
227. Källman U, Rusner M, Schwarz A, Nordström S, Isaksson S. Evaluation of the Green Cross Method Regarding Patient Safety Culture and Incidence Reporting. *J Patient Saf.* 2022;18(1):e18–25.
228. Kuy S, Romero RAL. Improving staff perception of a safety climate with crew resource management training. *J Surg Res.* 2017;213((Kuy S., sreeram@gmail.com; Romero R.A.L.) Surgical Service, Center for Innovations in Quality, Outcomes and Patient Safety, Overton Brooks Veterans Affairs Medical Center, Shreveport, Louisiana, United States):177–83.
229. Kwon C, Duzyj C. The Impact of TeamSTEPPS Training on Obstetric Team Attitudes and Outcomes on the Labor and Delivery Unit of a Regional Perinatal Center. *Am J Perinatol.* 2024;41:e901–10.
230. Lai YH, Wu MJ, Chen HH, Lin SP, Wu CY, Chin CS, u. a. Impacts of Huddle Intervention on the Patient Safety Culture of Medical Team Members in Medical Ward: One-Group Pretest-Posttest Design. *J MultidiscipHealthc.* 2023;16((Lai Y.-H.; Chen H.-C.; Hou S.-C.; Chang C.-W., wen6081@gmail.com) Department of Nursing, Taichung Veterans General Hospital, Taichung, Taiwan):3599–607.

Appendix 8.1 References

231. Lamming L, Montague J, Crosswaite K, Faisal M, McDonach E, Mohammed MA, u. a. Fidelity and the impact of patient safety huddles on teamwork and safety culture: an evaluation of the Huddle Up for Safer Healthcare (HUSH) project. *BMC Health Serv Res*. 2021;21(1):1–11.
232. Lefebvre G, Honey L, Hines K, Keough A, Roye C, Bellemare S, u. a. Implementing Obstetrics Quality Improvement, Driven by Medico-legal Risk, is Associated With Improved Workplace Culture. *J Obstet Gynaecol Can*. 2020;42(1):38-47.e5.
233. Lemos C de S, Poveda V de B. Effect of implementing an anesthesia nurse checklist in a safety and teamwork climate: quasi-experimental study. *Rev Esc Enferm USP*. 2022;56:1–9.
234. Lin DM, Carson KA, Lubomski LH, Wick EC, Pham JC. Statewide Collaborative to Reduce Surgical Site Infections: Results of the Hawaii Surgical Unit-Based Safety Program. *J Am Coll Surg*. 2018;227(2):189-197.e1.
235. Magill ST, Wang DD, Rutledge WC, Lau D, Berger MS, Sankaran S, u. a. Changing Operating Room Culture: Implementation of a Postoperative Debrief and Improved Safety Culture. *World Neurosurg*. 2017;107((Magill S.T., stephen.magill@ucsf.edu; Wang D.D.; Rutledge W.C.; Lau D.; Berger M.S.; Sankaran S.; Lau C.Y.; Imlershein S.G.) Department of Neurological Surgery, University of California San Francisco, San Francisco, California, United States):597–603.
236. Mahoney JS, Ellis TE, Garland G, Palyo N, Greene PK. Supporting a psychiatric hospital culture of safety. *J Am Psychiatr Nurses Assoc*. 2012;18(5):299–306.
237. Mazur L, Chera B, Mosaly P, Taylor K, Tracton G, Johnson K, u. a. The association between event learning and continuous quality improvement programs and culture of patient safety. *Pr Radiat Oncol*. 2015;5(5):286–94.
238. McLean SE, Jensen LA, Schroeder DG, Gibney NRT, Skjodt NM. Improving adherence to a mechanical ventilation weaning protocol for critically ill adults: outcomes after an implementation program. *Am J Crit Care*. 2006;15(3):299–309.
239. Mohsen MM, Gab Allah AR, Amer NA, Rashed AB, Shokr EA. Team Strategies and Tools to Enhance Performance and Patient Safety at primary healthcare units: Effect on patients' outcomes. *Nurs Forum (Auckl)*. 2021;56(4):849–59.
240. Molina G, Jiang W, Edmondson L, Gibbons L, Huang LC, Kiang MV, u. a. Implementation of the Surgical Safety Checklist in South Carolina Hospitals Is Associated with Improvement in Perceived Perioperative Safety. *J Am Coll Surg*. 2016;222(5):725-736.e5.
241. Ohrn A, Rutberg H, Nilsen P. Patient safety dialogue: evaluation of an intervention aimed at achieving an improved patient safety culture. *J Patient Saf*. Dezember 2011;7(4):185–92.
242. O'Leary K, Creeden A, Slade M, Landler M, Kulkarni N, Lee J, u. a. Implementation of Unit-Based Interventions to Improve Teamwork and Patient Safety on a Medical Service. *Am J Med Qual*. 2015;30(5):409–16.
243. Pettker CM, Thung SF, Norwitz ER, Buhimschi CS, Raab CA, Copel JA, u. a. Impact of a comprehensive patient safety strategy on obstetric adverse events. *Am J Obstet Gynecol*. 2009;200(5):492.e1-8.
244. Pitts SI, Maruthur NM, Ngoc-Phuong Luu, Curreri K, Grimes R, Nigrin C, u. a. Implementing the Comprehensive Unit-Based Safety Program (CUSP) to Improve Patient Safety in an Academic Primary Care Practice. *Jt Comm J Qual Patient Saf*. 2017;43(11):591–7.
245. Pronovost PJ, Berenholtz SM, Goeschel C, Thom I, Watson SR, Holzmueller CG, u. a. Improving patient safety in intensive care units in Michigan. *J Crit Care*. 2008;23(2):207–21.
246. Ross J, Wolf D, Reece K. Highly reliable procedural teams: the journey to spread the universal protocol in diagnostic imaging. *Perm J*. 2014;18(1):33–7.
247. Savage C, Gaffney FA, Hussain-Alkhateeb L, Achheim PO, Henricson G, ANTONIADOU I, u. a. Safer paediatric surgical teams: A 5-year evaluation of crew resource management implementation and outcomes. *Int J Qual Health Care*. 2017;29(6):853–60.

Appendix 8.1 References

248. Schmidt J, Gambashidze N, Manser T, Güß T, Klatthaar M, Neugebauer F, u. a. Does interprofessional team-training affect nurses' and physicians' perceptions of safety culture and communication practices? Results of a pre-post survey study. *BMC Health Serv Res.* 2021;21(1):341.
249. Schwartz ME, Welsh DE, Paull DE, Knowles RS, DeLeeuw LD, Hemphill RR, u. a. The effects of crew resource management on teamwork and safety climate at Veterans Health Administration facilities. *J Healthc Risk Manag.* 2018;38(1):17–37.
250. Sculli GL, Pendley-Louis R, Neily J, Anderson TM, Isaacks DB, Knowles R, u. a. A High-Reliability Organization Framework for Health Care: A Multiyear Implementation Strategy and Associated Outcomes. *J Patient Saf.* 2022;18(1):64–70.
251. Sheth S, McCarthy E, Kipps AK, Wood M, Roth SJ, Sharek PJ, u. a. Changes in efficiency and safety culture after integration of an I-PASS-supported handoff process. *Pediatrics* [Internet]. 2016;137(2). Verfügbar unter: <https://www.embase.com/search/results?subaction=viewrecord&id=L608566087&from=export>
252. Sim MA, Ti LK, Mujumdar S, Chew STH, Penanueva DJB, Kumar BM, u. a. Sustaining the Gains: A 7-Year Follow-Through of a Hospital-Wide Patient Safety Improvement Project on Hospital-Wide Adverse Event Outcomes and Patient Safety Culture. *J Patient Saf.* 2022;18(1):e189–95.
253. St.Pierre M, Gall C, Breuer G, Schüttler J, Schüttler J. Beeinflusst jährliches Simulationstraining das Sicherheitsklima einer universitären Klinik? : Prospektive Fünfjahresuntersuchung anhand Dimensionen des „Safety Attitudes Questionnaire“. *Anaesthesist.* 2017;66(12):910–23.
254. Thomas L, Galla C. Republished: Building a culture of safety through team training and engagement. *Postgrad Med J.* 2013;89(1053):394–401.
255. Tietschert M, Higgins S, Haynes A, Sadun R, Singer SJ. Safe Surgery Checklist Implementation: Associations of Management Practice and Safety Culture Change. *Adv Health Care Manag.* 2024;22.
256. Timmel J, Kent PS, Holzmüller CG, Paine L, Schulick RD, Pronovost PJ. Impact of the Comprehensive Unit-based Safety Program (CUSP) on safety culture in a surgical inpatient unit. *Jt Comm J Qual Patient Saf.* 2010;36(6):252–60.
257. van der Nelson HA, Siassakos D, Bennett J, Godfrey M, Spray L, Draycott T, u. a. Multiprofessional team simulation training, based on an obstetric model, can improve teamwork in other areas of health care. *Am J Med Qual.* 2014;29(1):78–82.
258. Verbeek-van Noord I, Smits M, Zwijnenberg N, Spreeuwenberg P, Wagner C. A nation-wide transition in patient safety culture: a multilevel analysis on two cross-sectional surveys. *Int J Qual Health CARE.* 2019;31(8):627–32.
259. Vigorito MC, Mcnicoll L, Adams L, Sexton B. Improving Safety Culture Results in Rhode Island ICUs: Lessons Learned from the Development of Action-Oriented Plans. *Jt Comm J Qual Patient Saf.* 2011;37(11):509–14.
260. Watts BV, Percarpio K, West P, Mills PD. Use of the Safety Attitudes Questionnaire as a measure in patient safety improvement. *J Patient Saf.* 2010;6(4):206–9.
261. Weaver SJ, Rosen MA, DiazGranados D, Lazzara EH, Lyons R, Salas E, u. a. Does teamwork improve performance in the operating room? A multilevel evaluation. *Jt Comm J Qual Patient Saf.* 2010;36(3):133–42.
262. Wong SY, Fu ACL, Han J, Lin J, Lau MC. Effectiveness of customised safety intervention programmes to increase the safety culture of hospital staff. *BMJ Open Qual* [Internet]. 2021;10(4). Verfügbar unter: <https://www.embase.com/search/results?subaction=viewrecord&id=L636189359&from=export>
263. Youssef S, Nache A, Wijesekara C, Middleton RJ, Lewis D, Shurrah AE, u. a. Effect of a Quality Improvement Program to Improve Guideline Adherence and Attainment of Clinical Standards in Dialysis Care: Report of Outcomes in Year 1. *Nephron.* 2017;136(2):75–84.
264. Toolkit for Using the AHRQ Quality Indicators. Content last reviewed March 2017. Agency for Healthcare Research and Quality, Rockville, MD. <https://www.ahrq.gov/patient-safety/settings/hospital/resource/qitool/index.html>.

Appendix 8.1 References

265. Aaberg OR, Hall-Lord ML, Husebø SIE, Ballangrud R. A human factors intervention in a hospital - evaluating the outcome of a TeamSTEPPS program in a surgical ward. *BMC Health Serv Res.* 2021;21(1):1–13.
266. Etemadifar S, Sedighi Z, Sedehi M, Masoudi R. The effect of situation, background, assessment, recommendation-based safety program on patient safety culture in intensive care unit nurses. *J Educ Health Promot.* 2021;10:422.
267. The CUSP Method. Content last reviewed December 2023. Agency for Healthcare Research and Quality, Rockville, MD. <https://www.ahrq.gov/hai/cusp/index.html>.
268. Haller G, Garnerin P, Morales MA, Pfister R, Berner M, Irion O, u. a. Effect of crew resource management training in a multidisciplinary obstetrical setting. *Int J Qual Health Care.* 2008;20(4):254–63.
269. Staines A, Lécureux E, Rubin P, Baralon C, Farin A. Impact of TeamSTEPPS on patient safety culture in a Swiss maternity ward. *Int J Qual Health Care J Int Soc Qual Health Care.* 16. November 2020;32(9):618–24.
270. Storm M, Schulz J, Aase K. Patient safety in transitional care of the elderly: Effects of a quasi-experimental interorganisational educational intervention. *BMJ Open [Internet].* 2018;8(1). Verfügbar unter: <https://www.embase.com/search/results?subaction=viewrecord&id=L623794230&from=export>
271. McGuire MJ, Noronha G, Samal L, Yeh HC, Crocetti S, Kravet S, u. a. Patient safety perceptions of primary care providers after implementation of an electronic medical record system. *JGIM J Gen Intern Med.* 2013;28(2):184–92.
272. McKenzie L, Shaw L, Jordan J, Alexander M, O'Brien M, Singer S, u. a. Factors Influencing the Implementation of a Hospitalwide Intervention to Promote Professionalism and Build a Safety Culture: A Qualitative Study. *Jt Comm J Qual PATIENT Saf.* 2019;45(10):694–705.
273. Proctor E, Silmere H, Raghavan R, Hovmand P, Aarons G, Bunger A, u. a. Outcomes for Implementation Research: Conceptual Distinctions, Measurement Challenges, and Research Agenda. *Adm Policy Ment Health Ment Health Serv Res.* März 2011;38(2):65–76.
274. Chamberlain P, Brown CH, Saldana L. Observational measure of implementation progress in community based settings: The Stages of implementation completion (SIC). *Implement Sci.* Dezember 2011;6(1):116.
275. Marsteller JA, Hsu YJ, Chan KS, Lubomski LH. Assessing content validity and user perspectives on the Team Check-up Tool: expert survey and user focus groups. *BMJ Qual Saf.* April 2017;26(4):288–95.