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REPORT

PLUS – Safety Culture in the Swiss Healthcare System

Final Report of the Concept Study on the Further Development of Safety Culture in Healthcare Organisations

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Lay Summary

The Swiss Federal Quality Commission (FQC) commissioned a project to strengthen safety culture in the Swiss healthcare system—that is, the way healthcare organisations promote safety in everyday practice, prevent errors, and learn from them. Strengthening safety culture ultimately improves patient safety.

To achieve this, the Geneva University Hospitals and the University of Basel developed the PLUS programme, a new approach based on a continuous improvement cycle.

Although Switzerland has many initiatives to improve patient safety, these are often poorly coordinated. In addition, there is currently no common approach that can be adapted to different healthcare settings.

The PLUS cycle addresses this gap by providing a structured yet flexible framework consisting of four recurring steps:

1. Assess the current state: Evaluate the existing safety culture.
2. Set priorities: Identify and prioritise improvement goals.
3. Develop learning cases: Create practice-based learning cases that illustrate the priority areas and encourage reflection and learning.
4. Implement training and improvement measures: Use the learning cases to support team discussions, define the desired safety culture, and implement concrete improvement measures.

What makes the PLUS programme unique?

- A Safety Culture Team connects organisational leadership with frontline teams and promotes safety culture throughout the organisation.
- Patients are actively involved in the programme.
- The programme is flexible and can be adapted to local needs and different healthcare settings.

What happens next?

The PLUS programme will now be piloted in several healthcare organisations. The evaluation will examine whether the programme is feasible in routine practice, accepted by healthcare teams, and effective in improving safety culture.

The long-term goal is to establish a coordinated national approach that strengthens safety culture across the Swiss healthcare system in a sustainable way.

Executive Summary

The project “Safety Culture: Concept and Feasibility Study”, mandated by the Federal Quality Commission (EQK), aims to develop and test an approach to strengthening safety culture in the Swiss healthcare system. Conducted between 2024 and 2027 by Geneva University Hospitals and the University of Basel, Institute of Nursing Science, the project comprises a concept study and a feasibility study.

The concept study resulted in the development of the PLUS programme (ImProving Safety CuLtUre in Swiss Healthcare Organisations), which includes the PLUS intervention with the PLUS Safety Culture Development Cycle, and a structured implementation concept. The feasibility of these components will be assessed through the PLUS study. The programme is grounded in systematic scoping reviews, stakeholder engagement, and established implementation science approaches.

The evidence indicates a fragmented landscape of safety culture activities in Switzerland, characterised by strong local initiatives but limited system-wide coordination. Despite the identification of key elements of effective safety culture development, no tested, cross-setting intervention currently exists.

The PLUS intervention addresses this gap through a structured yet adaptable approach. It combines clearly defined core elements with the flexibility to set local priorities and develop context-specific learning cases. The four-step cycle is implemented through multidisciplinary Safety Culture Teams, which bring together key professional groups and organisational levels and support the organisation-wide embedding of safety culture.

The implementation concept provides a structured yet flexible framework for implementation, complemented by ongoing consultation, train-the-trainer approaches, and a cross-organisational learning network. A multi-methods evaluation enables the assessment of implementation processes, contextual factors, and preliminary outcomes.

The feasibility study, running until April 2027 across different healthcare sectors and language regions, will assess feasibility, acceptability, and appropriateness of the intervention and generate insights into implementation and context. Participating organisations will also contribute to recommendations for potential national scale-up.

Overall, the PLUS programme offers an evidence-informed and scalable approach to strengthening safety culture and provides a foundation for its long-term integration within the Swiss healthcare system.

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1 Background and Mandate

The Federal Quality Commission (EQK) of the Federal Department of Home Affairs (FDHA) mandated the Geneva University Hospitals and the University of Basel, Institute of Nursing Science, to conduct the three-year project “Safety Culture: Concept and Feasibility Study” from April 2024 to April 2027. The aim of the project is to develop a conceptual framework and assess the feasibility of an intervention to support safety culture development across the Swiss healthcare system.

The mandate comprises two phases: the concept study and the feasibility study. As part of the concept study, the programme “PLUS” (Improving Safety Culture in Swiss Healthcare Organisations) was developed. The name “PLUS” reflects both the focus on improvement and the intended added value for advancing safety culture.

During the concept phase, a structured intervention approach and an implementation strategy were developed which were then included in the study protocol.

This process was based on the synthesis of scientific evidence, in particular the findings presented in the published scoping review report (Haller et al., 2024), as well as on consultations with key stakeholders. These form the foundation for the feasibility study.

This report summarises the work and findings of the concept phase. The feasibility, acceptability, and appropriateness of the approach will be assessed in the feasibility study through implementation in selected healthcare organisations.

2 Abbreviations

AHRQ	Agency for Healthcare Research and Quality
CFIR	Consolidated Framework for Implementation Research
CICI	Context and Implementation of Complex Interventions
ERIC	Expert Recommendations for Implementing Change
JBI	Joanna Briggs Institute
MaPSaF	Manchester Patient Safety Framework
PLUS	Improving Safety Culture in Swiss Healthcare Organisations (programme name)
SOPS®	Survey on Patient Safety Culture
TeamSTEPPS®	Team Strategies and Tools to Enhance Performance and Patient Safety

3 A Safety Culture Framework for the Swiss Healthcare System

Safety culture has been defined as the product of individual and group values, attitudes, perceptions, competencies, and behavioural patterns that shape an organisation’s commitment to and approach to

safety (ACSNII, 1993; European Patient Safety Foundation, 2026; Vincent & Staines, 2019; Weaver et al., 2013). Organisations with a positive safety culture are characterised by communication based on mutual trust, a shared understanding of the importance of safety, and confidence in the effectiveness of preventive measures.

Building on this definition and the Context and Implementation of Complex Interventions (CICI) framework (Pfadenhauer et al., 2017), a framework tailored to the Swiss context was developed (see Figure 1). It aims to capture patient safety culture as a complex and context-dependent phenomenon and to embed it appropriately within the Swiss healthcare system.

Therefore, key actors, structures and influencing factors were identified at the macro, meso and micro levels. These include health policy and regulatory conditions, as well as governance structures, at the macro level and inter-organisational collaboration, networks, and institutional arrangements, at the meso level. At micro level. nine key dimensions were identified that shape safety culture in everyday clinical practice. These dimensions are dynamically interconnected and interact reciprocally, reflecting the complex, relational, and can be purposefully strengthened.

Within the PLUS programme, safety culture is understood as “how we do safety here”, the everyday practices, behaviours, and interactions that shape patient safety in routine clinical work. It is grounded in shared values, attitudes, and patterns of teamwork across all organisational levels and forms the foundation for safe, high-quality care.

It is not understood as a static state, but as an ongoing, collective process that requires continuous reflection, learning, and active development. This understanding forms the basis for the development of the PLUS intervention.

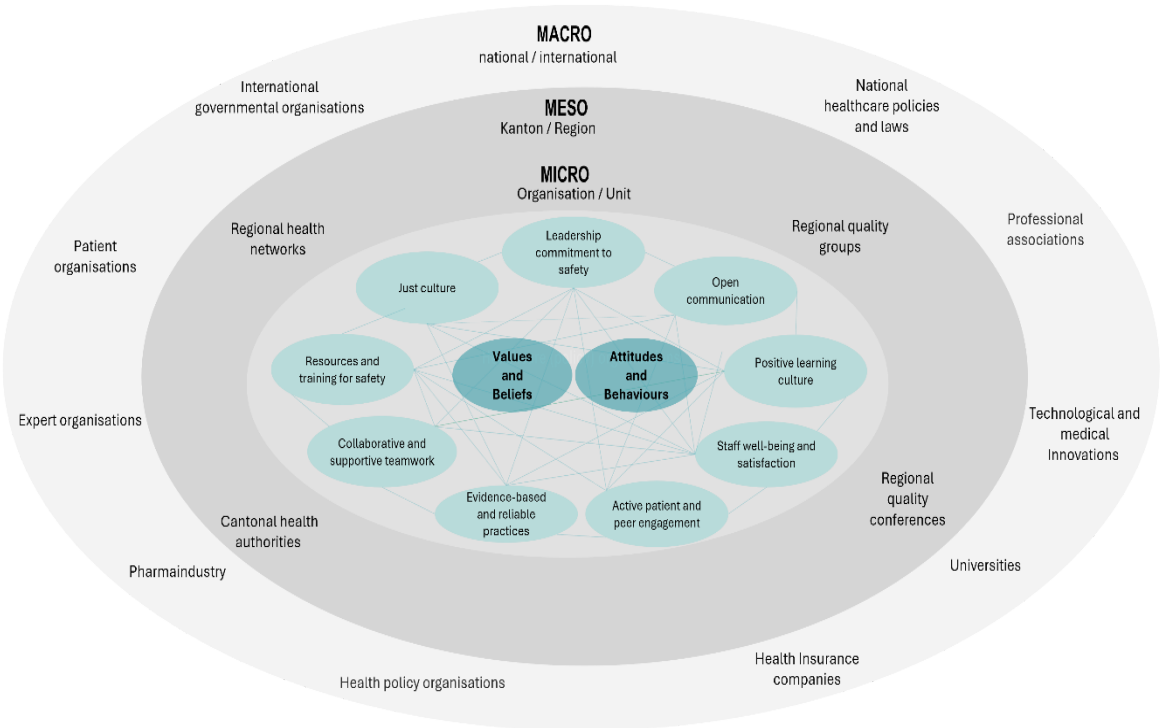

Figure 1: Swiss Safety Culture Framework for Healthcare

4 Systematic Literature Review

4.1 Purpose and Methodological Approach

As part of the conceptual study, a systematic evaluation of the literature on safety culture and approaches to improve it was conducted. The objectives were (1) to assess the current state of safety culture in Swiss healthcare and (2) to identify interventions and implementation strategies used to improve safety culture both in Switzerland and worldwide.

To this end, two scoping reviews were carried out following the Joanna Briggs Institute (JBI) methodology (de Bienassis & Klazinga, 2024). Both reviews were based on systematic searches in major electronic databases and reference lists and included literature published since 2000. The first review additionally incorporated relevant grey literature. Study selection and data extraction were conducted by two independent reviewers using predefined inclusion and exclusion criteria. In the event of disagreement over the selection, a third independent expert was called upon.

The reviews mapped definitions, measurement methods, interventions, and implementation strategies, as well as facilitators and barriers to improving safety culture across different healthcare settings. In addition, findings from safety culture surveys in Swiss healthcare institutions were synthesised descriptively.

Further methodological details are presented in the published scoping review report (Haller et al., 2024).

4.2 Overview of the Scoping Reviews

The following sections summarise the key findings of the two scoping reviews (Haller et al., 2024), which form the evidence-based foundation for the development of the PLUS programme.

4.2.1 Safety Culture in Switzerland (Scoping Review 1)

The first scoping review provided an overview of safety culture in Switzerland across healthcare settings and system levels. Guided by the project's safety culture framework, the analysis mapped policy initiatives, national programmes (e.g. speak-up initiatives and morbidity and mortality reviews), and institutional survey activities.

The literature indicates strong local engagement in safety culture but limited coordination and system-wide learning. Most published studies focused on the micro level of healthcare organisations, particularly hospitals.

Approximately one quarter of the identified reports described institutional safety culture surveys, most commonly using the AHRQ Surveys on Patient Safety Culture. Findings revealed variation in perceptions across professional groups and institutions. Recurrent challenges included management support, teamwork, handoffs and transitions, and incident reporting.

Several reports emphasised the importance of appropriate legal frameworks and confidentiality protections to enable learning from errors without fear of punitive consequences.

National initiatives led by Swiss Patient Safety Foundation have played a key role in raising awareness and developing practical tools.

Overall, the Swiss literature depicts a fragmented landscape characterised by active local initiatives but limited integration across organisational and system levels.

4.2.2 Safety Culture Interventions and Implementation Strategies (Scoping Review 2)

The second scoping review examined interventions and implementation strategies aimed at improving safety culture in Switzerland and internationally. A total of 115 studies from 26 countries were included, covering Europe, Asia, Africa, the Americas and Australia/New Zealand. All but one study focused on the micro level of healthcare delivery.

A broad range of interventions was identified, including the WHO Surgical Safety Checklist, Crew Resource Management, TeamSTEPPS, structured educational programmes on teamwork and collaboration, and multifaceted interventions such as safety huddles. Reported effects on safety culture varied considerably, with the same intervention showing different levels of effectiveness in outcomes depending on context and implementation conditions.

Across studies, teamwork and communication were the dimensions most consistently showing improvement. Leadership engagement and organisational context were identified as key determinants of implementation success. Facilitators included visible leadership support, organisational endorsement, the involvement of local champions, opportunities for shared learning, and recognition of small successes. Conversely, rigid hierarchical structures and limited management involvement were frequently reported as barriers.

4.3 Cross-cutting findings and implications for the implementation concept

Safety culture is a multifaceted concept comprising various interrelated and partly overlapping dimensions. In the Swiss healthcare system, both the level and perception of safety culture vary considerably depending on context, care setting, professional group, and role.

The findings indicate that sustainable improvement of safety culture requires, in particular, strong leadership engagement, management support, effective teamwork, involvement of relevant stakeholders at all levels, and appropriate regulatory frameworks.

However, the effectiveness of interventions aimed at improving safety culture is inconsistent, and no standardised approach has yet been identified that reliably strengthens safety culture within healthcare organisations. Across both scoping reviews, no single intervention was found to be consistently effective across different care settings.

Given the variability in perceptions of safety culture and the differing applicability of interventions across contexts and care settings, it is essential that intervention and implementation strategies are designed to be flexible and adaptable to local organisational conditions.

5 From Evidence to Implementation Principles

5.1 The PLUS Programme

The PLUS programme provides the overarching framework for strengthening safety culture and guides both the development of the intervention and its evaluation within the concept and feasibility study.

The name “PLUS” refers both to the working title “ImProving Safety CuLtUre in Swiss Healthcare Organisations” and to the added value that the intervention aims to achieve.

It comprises three main components:

1) the PLUS intervention, operationalised through the PLUS Safety Culture Development Cycle, which defines the structured approach to safety culture development,
2) the implementation concept, which specifies how the intervention is introduced and embedded in organisations, and
3) the PLUS study, which evaluates the feasibility and applicability of the intervention across different healthcare settings.

5.2 Methodological Framework

5.2.1 Implementation Mapping as Overarching Framework

Implementation mapping provided the overarching methodological framework for Phase 1 and ensured systematic alignment between evidence, theory, and practical application. The development of the PLUS intervention was guided by this approach, following Fernandez et al. (2019) and Schultes et al. (2022).

The structured, multi-step process guided (1) the identification of relevant stakeholders and analysis of barriers and facilitators to implementation, (2) the definition of intervention and implementation objectives, (3) the development of a logic model and implementation strategies, and (4) the co-design of the study protocol and evaluation framework.

5.2.2 Stakeholder Consultation

The findings of the scoping reviews were critically reflected upon and further developed through exchange with an interdisciplinary group of stakeholders. This group included clinicians, managers, patient representatives, quality specialists and experts from academia, health policy and professional organisations.

Stakeholder involvement was primarily conducted through formal project governance structures, including the Scientific Advisory Board and Steering Committee. Additional ad hoc consultations with clinical organisations supported contextual validation of specific elements of the implementation concept. The feedback obtained confirmed the relevance of the underlying evidence and informed key design decisions but did not constitute a systematic stakeholder data collection process.

Through these consultations, six key requirements for a feasible and sustainable intervention to strengthen safety culture across different healthcare settings were identified: (1) applicability across care sectors; (2) integration into existing organisational structures; (3) routine assessment with feedback loops; (4) meaningful patient involvement; (5) strong leadership engagement; and (6) sustainability beyond the project duration.

5.2.3 Implementation Approach and Design Principles

To identify and address setting-specific determinants of implementation, established implementation science approaches are applied, in particular the Consolidated Framework for Implementation Research (CFIR) (Damschroder et al., 2022) and the ERIC taxonomy (Powell et al., 2015). Contextual factors related to resources, governance, leadership, and staffing are assessed and analysed using CFIR. Based on this analysis, context-appropriate implementation strategies are selected from the ERIC taxonomy.

To ensure feasibility and national scalability, the PLUS intervention is based on standardised tools, measurement methods, and core components. At the same time, structured local adaptation is enabled by distinguishing between mandatory core elements, which are implemented consistently across sites, and adaptable elements that can be tailored to local contexts.

Participating organisations build on existing safety culture structures and processes, thereby strengthening organisational ownership and supporting sustainable integration into routine clinical practice.

The resulting implementation concept integrates empirical evidence from the scoping reviews with national requirements and established implementation frameworks and is operationalised in the PLUS study protocol and implementation plan. This approach balances the need for comparability and scalability with the heterogeneity of organisational contexts within the Swiss healthcare system.

5.2.4 Logic Model

As part of the implementation mapping process, a logic model was developed to describe how the PLUS intervention is expected to influence safety culture (see PLUS Implementation Plan, Appendix 1).

The model integrates insights from the scoping reviews, stakeholder consultations and implementation frameworks, and provides a structured representation of how the intervention is expected to lead to change. It links key inputs and resources, the main intervention activities and their expected outputs and outcomes, while also illustrating important implementation conditions and mechanisms of change.

Within the model, safety culture development is assumed to occur through a sequence of activities, including structured assessment of safety culture, collective reflection on organisational practices, and the co-creation of context-specific learning cases. These activities are designed to foster dialogue, shared understanding, and organisational learning within teams.

Operationally, these mechanisms are implemented through the PLUS Safety Culture Development Cycle described in the following section.

5.3 The Intervention: The PLUS Safety Culture Development Cycle

The intervention, referred to as the PLUS Safety Culture Development Cycle, represents a structured, theory-informed, and scalable approach to strengthening safety culture across diverse healthcare settings. It is conceptualised as a cyclical, participatory process that promotes dialogue, shared learning and locally grounded reflection. At the same time, the intervention remains adaptable to different organisational contexts and levels of maturity through both flexible implementation arrangements and the development of locally relevant learning cases that shape the content of the intervention.

In practice, the intervention consists of a defined set of core components centred on the multidisciplinary Safety Culture Team, which serves as the central organisational structure for coordinating the safety culture activities.

These activities follow a four-step process:

1. Assess Safety Culture
2. Prioritise
3. Develop learning cases
4. Train and action planning

This structure reflects progression from assessment to prioritisation, contextualised learning, and practice-oriented capability building. It aims to strengthen collective awareness, reflective capacity, and shared responsibility for safety in everyday clinical work.

5.4 Description of the Intervention Components

5.4.1 Key Element: The Safety Culture Team

The Safety Culture Team is a multidisciplinary group composed of at least one representative from strategic leadership, operational leadership, clinical staff, and quality management. This composition ensures that strategic, operational, and frontline perspectives on patient safety are represented. At the same time, it ensures that safety culture is considered across all levels of the organisation and embedded in everyday work practices.

Where feasible, patients as well as peer experts are included to incorporate patient perspectives and experiential knowledge. This includes patients, former patients, relatives, and trained patient partners (peer experts) who contribute their experiential knowledge on care processes and patient safety.

The team functions as the central coordinating body for safety culture activities, integrates the development of safety culture into routine organisational structures, and oversees the implementation of the PLUS intervention.

5.4.2 Step 1: Assess Safety Culture

The assessment of safety culture establishes a shared reference point for staff and leadership and provides the foundation for targeted improvement efforts. A multi-method approach is applied, combining quantitative measurement using the AHRQ Survey on Patient Safety Culture (SOPS®,

Version 1) (Agency for Healthcare Research and Quality, 2024) with structured qualitative reflection based on the Manchester Patient Safety Framework (MaPSaF) (Parker, 2006).

External facilitation is provided for the MaPSaF workshop on maturity level discussions to foster open dialogue, strengthen psychological safety, mitigate hierarchical dynamics, and enable independent facilitation within the organisation in the long term.

5.4.3 Step 2: Prioritise

Based on the results of the safety culture assessment, one to two priority areas for improvement are identified through a structured process. Both quantitative findings (e.g., low SOPS scores and low maturity levels according to MaPSaF) and qualitative criteria are taken into account, such as relevance to patient safety, visibility in daily practice, and the extent to which issues can be influenced by the organisation. The aim is to define contextually relevant and feasible priorities (Agency for Healthcare Research and Quality, 2017; Baltussen & Niessen, 2006).

5.4.4 Step 3: Develop Learning Cases

One to two context-specific learning cases are developed to translate the selected improvement priorities into concise, practice-oriented reflection tools. Based on realistic clinical situations, they illustrate how organisational and structural factors shape care processes and influence patient safety.

The development follows an iterative, contextually grounded approach in line with design thinking (Altman et al., 2018; Oliveira et al., 2021; Wiedemann & Friebe, 2022). It starts from a concrete clinical situation that exemplifies the selected priority. Guiding questions structure the development, addressing involved actors, contributing factors, consequences, and key learning points for patient safety. The focus is placed on system-level factors rather than individual errors.

The learning cases integrate both staff and patient perspectives to make differing understandings, uncertainties, and coordination challenges visible. In line with clinical vignettes (Depaigne-Loth et al., 2024), they stimulate reflection and support discussion of possible courses of action.

5.4.5 Step 4: Train and Action Planning

The training begins with a brief, standardised introduction to the concept of safety culture to establish a shared conceptual foundation among participants.

This is followed by a structured discussion of the previously developed learning cases. Drawing on practice-based examples, the cases highlight gaps, opportunities for improvement, differing perspectives, and factors influencing patient safety in everyday practice. They examine situations from multiple perspectives and illustrate the priority areas identified in the safety culture assessment. In doing so, participants deepen their understanding of underlying system mechanisms, contributing factors, and patterns relevant to patient safety.

Building on these reflections, teams jointly formulate a limited number of key system-level insights, develop a shared understanding of the desired safety culture, and translate these into one to three concrete, feasible, and context-specific actions.

Figure 2: The PLUS Safety Culture Development Cycle

5.5 Implementation Strategies

To support implementation of the PLUS intervention across diverse healthcare settings, a set of implementation strategies was identified and operationalised.

Barriers and facilitators to the implementation of the PLUS intervention were identified in the scoping reviews and the consultation with stakeholders and safety culture experts (Haller et al., 2024). Based on these findings, *a* set *of* implementation strategies was selected and operationalised using the Expert Recommendations for Implementing Change (ERIC) taxonomy (Powell et al., 2015).

Key strategies include securing formal organisational commitment, providing an implementation blueprint and supporting materials, offering ongoing consultation, applying train-the-trainer approaches, enabling structured local adaptation, and establishing a cross-organisational learning collaborative.

Operationally, these strategies are implemented through a set of coordinated activities that support organisations throughout the implementation process. These include, for example, the establishment of a collaboration agreement and the involvement of external facilitators, who, within a train-the-trainer model, prepare local actors to independently carry out safety culture activities within their organisations. In addition, regular coordination meetings support implementation through consultation, joint problem-solving, and monitoring of implementation progress.

While the core elements of the intervention remain standardised across sites, the implementation approach allows for targeted adaptation to local conditions. Organisations can adapt certain aspects of the implementation process to their existing structures and processes, making use of available resources and established coordination mechanisms.

Second, contextualisation is built directly into the intervention itself: participating organisations identify their own safety culture priorities based on the assessment results and develop context-specific learning cases that reflect locally relevant clinical situations. These learning cases subsequently form the basis for the training and reflection activities, ensuring that safety culture discussions are grounded in everyday practice and organisational realities.

Participation is staggered to enable iterative learning and adaptive support. This is facilitated through a cross-organisational learning network that promotes the exchange of experiences, best practices, and lessons learned, thereby supporting continuous learning and the sustainable integration of safety culture development activities.

At the end of the study, a final meeting with all participating organisations is held to reflect on lessons learned and to formulate recommendations for the national level.

Further details on the operationalisation of the implementation strategies are provided in the study protocol and the PLUS Implementation Plan (Appendix 1).

5.6 Implementation Phases

The implementation of the PLUS intervention will follow three phases:

1) a baseline and preparation phase (Phase 1)
2) an implementation phase (Phase 2), and
3) a network and sustainability phase (Phase 3).

These phases structure both the delivery of the intervention and the timing of data collection.

6 Evaluation

6.1 Outcomes

The evaluation of the PLUS intervention comprises four domains: implementation outcomes, process outcomes, contextual factors, and intervention outcomes. This multi-domain approach enables a comprehensive assessment of both the implementation process and preliminary intervention effects.

Implementation outcomes focus on feasibility, acceptability, and appropriateness and will be assessed using validated instruments such as the Feasibility of Intervention Measure (FIM), Acceptability of Intervention Measure (AIM), and Intervention Appropriateness Measure (IAM) (Weiner et al., 2017) via online surveys among members of the Safety Culture Team and staff of participating units.

Process outcomes focus on implementation fidelity. Fidelity will be assessed using a structured checklist applied during regular implementation check-ins. In addition, intervention-related insights will be documented throughout the implementation. These include data generated as part of the intervention process, such as baseline assessments of safety culture perceptions (e.g. using the Surveys on Patient Safety Culture, SOPS®), structured reflections on organisational safety culture (e.g. using MaPSaF), and the development of context-specific learning cases.

During the sustainability phase, qualitative data on implementation experiences, including lessons learned, best practices, and transferable insights, will be systematically collected through cross-organisational network formats, particularly network meetings and a final synthesis workshop. These data are intended to inform potential future scale-up.

Contextual factors include organisational characteristics and structures for patient involvement, which are assessed at baseline and subsequently complemented by ongoing qualitative data on barriers and facilitators to implementation.

Intervention outcomes relate to preliminary changes in safety culture perceptions following the initial rollout of the PLUS intervention. These will be assessed through a follow-up SOPS® survey in Phase 3. Analyses are exploratory and intended to inform future effectiveness evaluations.

An overview of the evaluation is presented in Table 1.

Domain	Outcome / Focus	Data source	Method	Time point
Implementation outcomes	Feasibility, Acceptability, Appropriateness	Staff & Safety Culture Team	FIM, AIM, IAM (survey)	End Phase 2
Process outcomes	Fidelity	Safety Culture Team	Monthly implementation check-ins	Phase 2
	Safety culture perceptions (baseline)	Organisations	SOPS® survey	Phase 2, step 1
	Reflection on maturity level	Safety Culture Team	MaPSaF workshop (qualitative)	Phase 2, step 1
	Learning cases	Safety Culture Team	Qualitative document analysis	Phase 2, step 3
	Good practices	All organisations	Network meetings	Bi-monthly, Phase 3
	Lessons learned & recommendations for national level	All organisations	Final meeting	End of study
Context factors	Organisational context, patient engagement structures	Organisations	Context questionnaire	Phase 1
	Barriers & facilitators to implementation	Safety Culture Team	Monthly implementation check-ins	Phase 2
Intervention outcomes	Safety culture perceptions (follow-up)	Staff & Safety Culture Team	SOPS® survey	Phase 3

Table 1: Evaluation Overview

As shown in Table 1, the evaluation integrates multiple data sources and methods across all implementation phases.

6.2 Data Collection, Management, and Analysis (condensed)

Quantitative data are analysed descriptively to explore patterns and trends, while qualitative data are analysed using thematic content analysis informed by established conceptual frameworks. Data are managed and stored in accordance with institutional research data governance standards to ensure confidentiality, security, and long-term availability.

7 Sustainability and Long-Term Integration

The PLUS intervention is designed as a recurring development and learning cycle rather than a one-time project. Driven by the Safety Culture Team, the four steps, assessment, prioritisation, development of learning cases, and training with action planning, form an iterative process that supports continuous system improvement.

By embedding this cycle into existing quality management structures, organisations can regularly assess their safety culture, redefine priorities, and initiate locally tailored improvement actions. In this way, safety culture development becomes part of routine organisational practice, rather than an externally driven initiative.

Following the feasibility study, participating sites are encouraged to formally institutionalise the Safety Culture Team and integrate the PLUS cycle into their established quality cycles. Repetition at defined intervals strengthens local ownership, reinforces shared understanding, and enables adaptive learning over time.

Training modules and learning cases can be refined, expanded, and shared within the safety culture community.

8 Patient and Peer Involvement

Patient and peer involvement is a central element of the PLUS programme. The terms patient and peer perspectives refer to the involvement of patients, former patients, relatives, or trained patient partners (peer experts), who contribute experiential knowledge about care processes and patient safety.

Integrating these perspectives is essential for the sustainable development of a safety culture and organisational learning. Accordingly, patient and peer involvement is embedded at all relevant stages of implementation. As organisations differ in their experience of, and readiness for, patient participation, the inclusion of patient and peer perspectives is context-sensitive; that is to say, it is implemented where appropriate and feasible within the respective organisational context.

Within the PLUS study, this involvement is operationalised through three complementary elements.

First, organisational preconditions for patient involvement are systematically assessed to inform the evaluation of safety culture and, where appropriate, to be considered in the planning of measures to improve safety culture.

Secondly, the active involvement of patient partners and peers is encouraged wherever possible. Their roles include providing advice, jointly developing activities, and contributing to training and evaluation processes. This ensures that patient perspectives are systematically integrated into organisational learning and improvement processes.

Third, patient and peer perspectives are deliberately integrated into the learning cases to enable reflection on patient safety not only from the perspective of staff, but also from that of patients and peers.

9 Feasibility Study: Setup and Purpose

A feasibility study is conducted to inform the further development and potential scale-up of the PLUS programme. Its aim is to generate practice-oriented and context-sensitive evidence on the feasibility, acceptability, and appropriateness of the intervention and its implementation across diverse healthcare settings in Switzerland.

The PLUS feasibility study is a multicentre, multi-method implementation study in which the PLUS intervention and its implementation strategy are tested. The study is planned to continue until April 2027.

Participating organisations are recruited from an existing network of interested partners as well as through communication activities (e.g. the PLUS website and newsletters from H+ and the Swiss Patient Safety Foundation). Selection aims to ensure a balanced representation of healthcare sectors and organisational types (university hospitals, non-university hospitals, psychiatric care, long-term care, and ambulatory care), as well as language regions across Switzerland, to support the transferability of findings. Within each organisation, multiple units and their healthcare teams are involved to enable organisational-level learning and reflection.

The study serves as a learning platform to assess implementation processes, contextual influences, and preliminary indications of changes in safety culture. The insights generated will inform the further development of the PLUS programme, while participating organisations formulate recommendations for potential scale-up at the national level.

Further details on implementation are provided in the study protocol (Appendix 1).

10 Conclusion and Outlook

The conceptual phase of the project “Safety Culture: Concept and Feasibility Study” led to the development of the PLUS programme, comprising the PLUS intervention with the PLUS Safety Culture Development Cycle, and a corresponding implementation concept. These were developed based on systematic literature reviews (scoping reviews), stakeholder involvement, and the application of established implementation science approaches. Together, they provide a coherent and evidence-informed foundation for assessing the feasibility of the intervention across diverse healthcare settings

The scoping reviews identified both persistent challenges and promising approaches to strengthening safety culture in Swiss healthcare organisations. Combined with stakeholder input, they highlighted key elements of effective safety culture development, including collective reflection, shared ownership,

leadership engagement, team-based learning approaches, and structured feedback mechanisms. At the same time, the findings indicate that there is currently no standardised and validated intervention that addresses safety culture comprehensively and can be applied across different healthcare settings.

The implementation concept provides a structured approach for implementation across different organisational contexts. The planned feasibility study will generate insights into implementation processes, contextual influences, and preliminary outcomes.

These findings will inform further refinement of the intervention and support decision-making regarding potential scale-up and long-term integration of safety culture development within the Swiss healthcare system.

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