



NATIONAL ACTION ALLIANCE FOR PATIENT AND WORKFORCE SAFETY

Best Practices to Strengthen Safety
Culture, Leadership, and Governance
Change Package

Prepared for the Agency for Healthcare Research and Quality
Center for Quality Improvement and Patient Safety (CQuIPS)

by

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Introduction

Background

The National Action Alliance for Patient and Workforce Safety (National Action Alliance) is a collective effort of federal agencies and private partners, including patients and families, to improve the safety of patients and the healthcare workforce. Working together, the National Action Alliance catalyzes change by applying known harm reduction strategies, leveraging evidence-based tools and resources, and sharing best practices and lessons learned. The National Action Alliance’s vision is **safe care everywhere and zero preventable harm for all**.

The National Action Alliance builds on the work of the [National Steering Committee](#) for Patient Safety (NSC), which in 2020 released the report, *Safer Together: A National Action Plan to Advance Patient Safety*.^{1,2} The report is the result of the contributions and insights of 27 leading organizations that joined together as the NSC to develop a framework for improving patient safety and reducing harm to patients and healthcare workers. The National Action Plan (NAP) presents 17 recommendations that are organized into four foundational areas: (1) Culture, Leadership, and Governance; (2) Patient and Family Engagement; (3) Workforce Safety; and (4) Learning Health Systems.

Safety Culture, Leadership, and Governance serve as the foundation for safer healthcare. This change package builds upon the foundational work completed by the NSC. It identifies a menu of strategies, change concepts, and actions culled from high-performing healthcare systems for the purpose of sharing broadly with other healthcare systems in pursuit of zero harm.



Three high-performing healthcare systems were identified from publicly available safety and experience data: Houston Methodist (Houston, TX, and Baytown, TX), Mayo Clinic (Rochester, MN, and Eau Claire, WI), and St. Luke’s University Health Network (Bethlehem, PA, and Coaldale, PA). On-site learning visits offered an opportunity to engage with leaders and staff and observe processes that demonstrate the operationalization of each system’s safety culture, leadership, and governance. An appreciative inquiry approach was used to engage leaders and staff. This approach focused on system-driven interactions to glean insights into what contributes to the system’s safety outcomes.

Acknowledgements

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AHRQ would like to express its sincere gratitude to the healthcare systems, their leaders, and many individuals who generously contributed their time, expertise, and experiences in developing this change package. In particular, AHRQ acknowledges the significant contributions of the three high-performing healthcare systems and their individual hospitals that shared experiences and best practices so that others could learn from their quality improvement journey:

- [Houston Methodist](#): Houston Methodist Hospital (Houston, TX) and Houston Methodist Baytown (Baytown, TX)
- [Mayo Clinic](#): Rochester (Rochester, MN) and Eau Claire Hospital (Eau Claire, WI)
- [St. Luke's University Health Network](#): Bethlehem Campus (Bethlehem, PA) and Miners Campus (Coaldale, PA)

In addition, we would like to thank all the attendees of the July 2025 Technical Expert Panel (TEP). Participants included TEP members from the high-performing healthcare systems, as well as many thought leaders from the national patient safety community.

How To Use This Change Package

This change package summarizes the high-level strategies, change concepts, and actionable practices observed during learning visits to the three high-performing healthcare systems, which serve a clinically complex patient mix from urban, suburban, and rural areas. This change package serves as a menu of strategies, change concepts, and actions related to safety culture, leadership, and governance. The information provided is intended to support other healthcare systems on their zero-harm journey or those who are seeking to address specific gaps.

This change package does not represent a comprehensive review of all evidence-based safety practices related to safety culture, leadership, and governance; rather, it describes those gleaned from the high-performing healthcare systems. It is intended for use as a complementary resource with other national patient safety initiatives and improvement tools that address safety culture, leadership, and governance, such as the [NAP Self-Assessment Tool](#), the [CMS Patient Safety Structural Measure](#), and the [Leapfrog Hospital Survey](#), among others. These tools may help healthcare systems identify opportunities for improvement for which the change package can offer suggested practices to implement and test using the system's preferred quality improvement methodologies.

The change package is arranged by three primary drivers of high performance in safety that are demonstrated by Houston Methodist, Mayo Clinic, and St. Luke’s University Health Network:

1. The **safety culture** is a core value, created and sustained through purposeful actions.
2. **Leaders** embody, cultivate, and reinforce the safety culture.
3. **Governance** structures and strategic planning support safety.

While there is some overlap between actionable practices among the drivers, the focus of the overlapping practices differs under each driver. The safety culture driver describes system and workforce behaviors that result in a strong safety culture, the leadership driver describes specific leader behaviors that support high performance in safety, and the governance driver describes system structures and governing body behaviors that support safety. For example, under the safety culture driver, the actionable practice might refer to “participating” in a process, but under the leadership driver, the actionable practice might refer to “supporting and sustaining” the same process.

Exhibit 1 presents the theory of change that provides a framework for the practices presented.

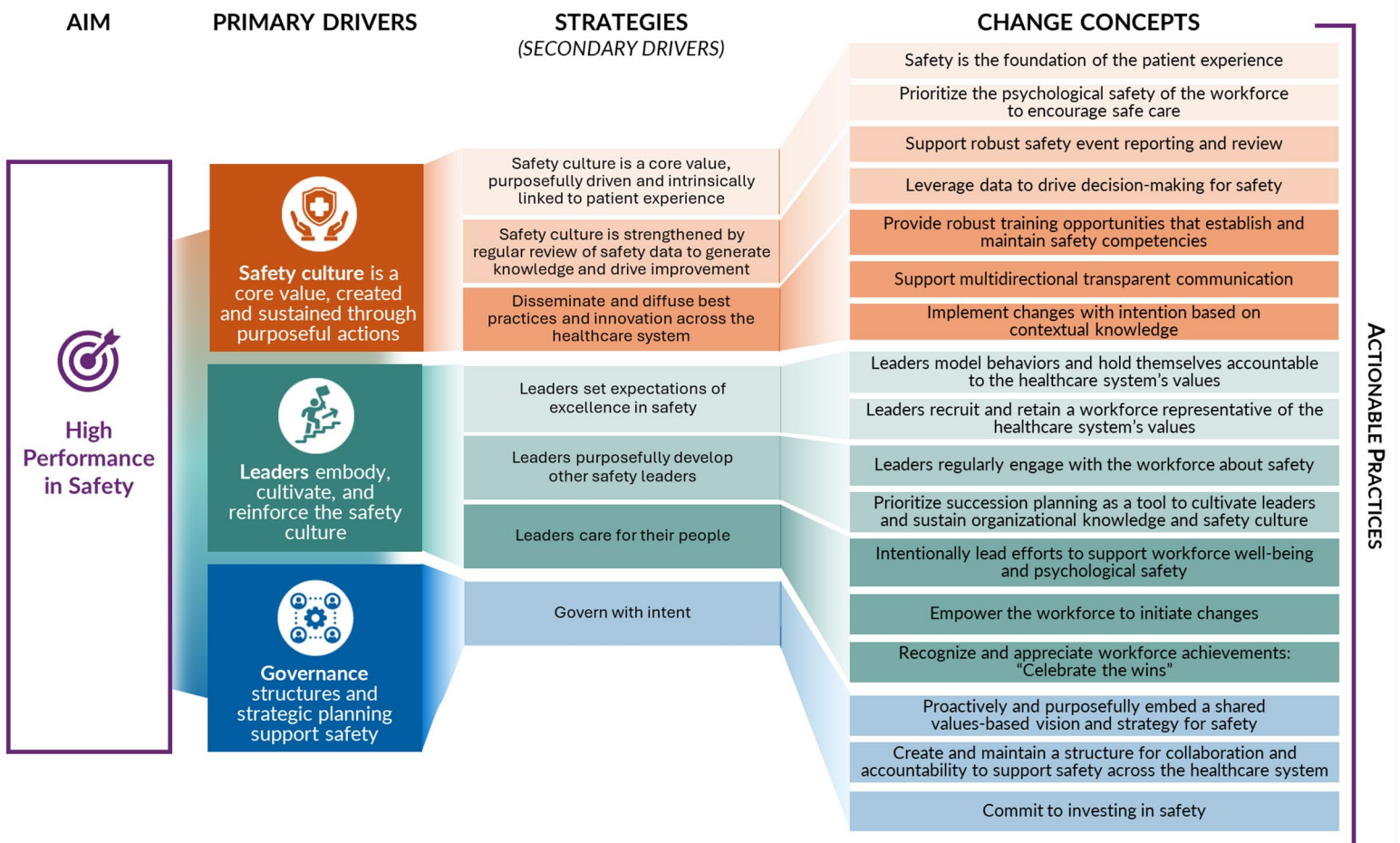


Exhibit 1. Theory of Change

As shown, the **primary drivers**—or factors that directly contribute to or primarily influence the achievement of the aim—center on the three areas of focus for this change package: healthcare system safety culture, leadership, and governance. **Strategies** enable the categorization of higher-level themes within each of the primary drivers. **Change concepts** provide broad ideas or approaches that have been demonstrated to be impactful in leading to improvements. For each change concept, specific, **actionable practices** guide healthcare systems with steps to test and implement towards safer care.

Throughout the document, selected actionable practices are presented in **bold font**. These represent actions that the high-performing healthcare systems identified as foundational to their success. Healthcare systems that are getting started on their quality improvement journey or are working to revamp their safety systems may wish to prioritize these actions in their change efforts.

Glossary

Terms Adapted from the National Action Plan:

- **Governance body:** The board of directors, or in healthcare systems without a board, the governing body that convenes to make strategic and operational decisions for the system.
- **Leader:** Any individual in a leadership position within a system, regardless of job title. Leaders can include hospital and healthcare system executives, administrative leaders, clinical leaders, division or department leaders, etc.
- **Leadership:** The action of leading a group of people or a healthcare system.
- **Senior leader:** An individual within a system who has decision-making responsibility for strategy and operations at the system level, often with the highest levels of authority (e.g., C-level executives; board of directors members).

Terms Defined by the Technical Expert Panel:

- **Best practice:** A safety culture, leadership, or governance practice gleaned from the high-performing healthcare systems that has demonstrated a positive impact on safety outcomes.
- **Dyad leadership model:** A collaborative co-leadership model where two leaders, typically a clinician and an administrator, share leadership and oversight.
- **Good catch:** A safety event that could have resulted in harm but did not reach an individual because it was identified and intervened upon by a healthcare worker. A good catch is a type of near miss.
- **Mission:** The healthcare system's purpose; what drives the healthcare system.
- **Near miss:** A safety event that could have resulted in harm but did not reach an individual because of chance or human intervention (i.e., a good catch).
- **Purposeful leader rounding:** Distinct from multidisciplinary rounding, purposeful leader rounding involves leaders engaging with the workforce, patients, and visitors on hospital units and other settings where the workforce and patients are present for the purpose of multidirectional information sharing,

problem solving, and fostering the safety culture. Leader rounds can be structured (i.e., involving the use of a framework or tool) or unstructured.

- **Safety event:** An incident or circumstance that could have resulted in harm (i.e., near miss or good catch) or did result in harm to a patient.
- **Shared accountability:** A collaborative approach to healthcare involving patients, the healthcare workforce, and healthcare leaders to mutually participate in and take responsibility for achieving patient-centered health outcomes.
- **Shared governance:** A collaborative management approach that allows employees to actively participate in the decision-making processes of their system. This model aims to enhance employee engagement and accountability, fostering a sense of ownership that can lead to improved work performance and ethical standards within the system.³
- **Tiered huddles:** Structured daily meetings that occur across multiple levels of leaders within a healthcare system to facilitate communication from the unit level to senior system leaders
- **Triad leadership model:** A collaborative leadership model where three leaders, typically a physician, a nurse, and an administrator, share leadership and oversight.
- **Values:** Core cultural tenets that stand the test of time. They are enduring and steadfast and set the stage for the vision—the “North Star.”
- **Vision:** The future state that describes where the healthcare system wants to go.
- **Workforce:** All members of the care team, not just clinical staff.

Primary Drivers

Primary Driver: The Safety Culture is a Core Value, Created and Sustained Through Purposeful Actions



Strategy (Secondary Driver)	Change Concept	Change Concept Description	Actionable Practices
Safety culture is a core value, purposefully driven and intrinsically linked to patient experience.	Safety is the foundation of the patient experience.	High performers view safety as a key part of the patient experience. Patients and their loved ones are an essential part of the care team, and their feedback is incorporated into the design of safety processes and interventions.	<ul style="list-style-type: none"> • Conduct multidisciplinary rounds and bedside shift reports to coordinate care team messaging to the patient and family. • Engage in shared decision-making with patients and families. • Use purposeful leader rounding to engage patients and families and encourage collaboration, visibility, trust building, and problem-solving. • Narrate care processes to explain the purpose and rationale to patients and families. • Showcase patient stories and celebrate successes through multiple modalities and types of media, e.g., websites and social media. • Emphasize compassionate and responsive care through family advisory councils and patient stories. • Bring the voice of the patient into each quality, safety, and leadership meeting.
Safety culture is a core value, purposefully driven and intrinsically linked to patient experience.	Prioritize the psychological safety of the workforce to encourage safe care.	High performers prioritize the psychological safety of the workforce to ensure they feel safe to speak up and voice safety concerns. They focus on processes, and balance system and personal accountability when a safety event occurs. They recognize that workforce psychological safety allows a system to create and sustain a speak-up culture. When the workforce feels safe, they are empowered to deliver safe patient care.	<ul style="list-style-type: none"> • Encourage transparent safety reporting processes, while also establishing avenues for anonymous reporting of safety events. • Provide access to trained professionals for the workforce to have open conversations about their well-being. • Utilize peer support programs that can be proactively deployed to support the workforce in response to harm events. • Provide the workforce with opportunities and tools that make it easy to speak up. • Normalize a positive response to individuals speaking up. • Celebrate the workforce for speaking up at the system level. • Use a systematic event review framework that focuses on process optimization over personal fault and balances personal and system accountability.

Strategy (Secondary Driver)	Change Concept	Change Concept Description	Actionable Practices
Safety culture is strengthened by regular review of safety data to generate knowledge and drive improvement.	Support robust safety event reporting and review.	High performers expect the workforce to report safety events/concerns and use structured methods to analyze events and drive improvement.	<ul style="list-style-type: none"> • Establish a user-friendly system for reporting all safety events. Use positive reinforcement to encourage reporting, such as system-level recognition, and establish a structure to close the loop on actions that occurred as a result of reporting. • Conduct a structured review and analysis process on good catches to prevent future safety events. • Obtain input from the workforce involved in safety events as part of the structured process to review each safety event (e.g., Root Cause Analysis). • Develop an action plan from every safety event review and disseminate it across the system. • Include event reporting as a standing item in meeting agendas to facilitate communication and collaboration. • Maintain a hotline for patient-reported safety events/concerns. • Leverage electronic health record surveillance capabilities to alert potential safety events for clinical review and follow-up (real-time and retrospective). • Capture and share learnings from both failures and successes.
Safety culture is strengthened by regular review of safety data to generate knowledge and drive improvement.	Leverage data to drive decision-making for safety.	High performers use objective data to make safety decisions. They monitor data in close-to-real-time and present it in ways that can be operationalized through quality improvement activities.	<ul style="list-style-type: none"> • Develop and use data dashboards to transparently track baseline data and progress. • Benchmark data internally and externally and establish standard metrics, definitions, and data sources that are shared across the healthcare system. • Maximize the use of real-time data and share data transparently to support clinical decision making. • Use all available data to support structured quality improvement efforts.

Strategy (Secondary Driver)	Change Concept	Change Concept Description	Actionable Practices
Disseminate and diffuse best practices and innovation across the healthcare system.	Provide robust training opportunities that establish and maintain safety competencies.	High performers offer multiple opportunities for competency-based training that is grounded in their values, including safety, quality, and patient experience. These competencies are consistently reinforced with the workforce, beginning with orientation.	<ul style="list-style-type: none"> • Embed the healthcare system’s values, including safety, in new employee orientation and reinforce through values-based training. • Require annual safety competencies and training for the entire workforce. • Use simulation-based and hands-on training to develop and reinforce safety competencies. • Provide targeted training in response to identified failures to prevent recurrence. • Partner with local organizations and facilities that have training resources that can be shared to expand access to learning opportunities.
Disseminate and diffuse best practices and innovation across the healthcare system.	Support multidirectional transparent communication.	High performers create channels for open and transparent communication across all levels of the healthcare system, ensuring workforce and patient voices are heard and addressed. They use multiple modalities for real-time communication, both informal and formal, and consistently close the loop with timely feedback.	<ul style="list-style-type: none"> • Establish open communication with patients and families at admission and encourage engagement in care. • Embed patients and families in safety councils and advisory committees. • Leverage virtual meeting platforms, such as Microsoft Teams, to enable real-time, transparent communication related to safety across units/clinics, departments, and leadership teams. • Use daily management boards at the unit/clinic level for leaders to communicate safety priorities with the workforce and encourage staff input. • Create communication channels to collect workforce ideas, such as "Voice of Staff" tickets that are reviewed and responded to by leaders. • Participate in structured daily meetings that occur across multiple levels of leaders within the healthcare system to facilitate communication from the unit to senior system leaders (i.e., tiered huddles).

Strategy (Secondary Driver)	Change Concept	Change Concept Description	Actionable Practices
Disseminate and diffuse best practices and innovation across the healthcare system.	Implement changes with intention based on contextual knowledge.	High performers leverage change management and implementation science principles to maintain an appropriate balance between standardization and planned adaptation to local needs. They approach the rollout of safety plans with clear intention, while actively seeking feedback from all interested parties and monitoring the results of changes.	<ul style="list-style-type: none"> • Start with small pilot tests and plan for broad dissemination once changes have been refined. • Recognize the need for standardized key processes across the system but incorporate phased implementation and planned adaptation based on local needs when appropriate. • Communicate the benefit of changes to stakeholders to gain buy-in. • Make tests of change and results visible. • Listen to late adopters and resisters to understand and resolve barriers to implementation. • Ensure physician champions are supported by quality and safety professionals.

Primary Driver: Leaders Embody, Cultivate, and Reinforce the Safety Culture



Strategy (Secondary Driver)	Change Concept	Change Concept Description	Actionable Practices
Leaders set expectations of excellence in safety.	Leaders model behaviors and hold themselves accountable to the healthcare system's values.	High performers expect leaders to model safety behaviors and create pathways to ensure leaders are approachable and accountable for a culture of safety.	<ul style="list-style-type: none"> • Make it acceptable for the workforce to fail and learn from failures—fail forward.* • Develop and model humility, emotional intelligence, and critical self-analysis.* • Take accountability for specific safety achievements of the healthcare system.* • Set and communicate expectations related to physical and psychological safety across the healthcare system for patients and the workforce.* <p><i>*Indicates a leader-driven practice, rather than a system-driven practice</i></p>
Leaders set expectations of excellence in safety.	Leaders recruit and retain a workforce representative of the healthcare system's values.	High performers prioritize recruiting a workforce based on cultural fit. Job descriptions emphasize safety, and the workforce is held accountable for providing safe, high-quality care.	<ul style="list-style-type: none"> • Establish an extensive vetting process for new leaders with multidisciplinary and multi-level interviews to ensure alignment with the safety culture. • Provide resources to support workforce career advancement. • Ensure leaders fit into the culture of the healthcare system and manage out leaders that do not fit into the culture after giving them the resources and support to succeed.
Leaders purposefully develop other safety leaders.	Leaders regularly engage with the workforce about safety.	High performers actively support leaders to model the culture of safety through rounding and regular engagement with the workforce and patients.	<ul style="list-style-type: none"> • Require and support regularly scheduled leader rounding with the workforce and patients focused on problem-solving, patient safety concerns, real-time reporting, and accountability. • Support and sustain structured daily meetings that occur across multiple levels of leaders to facilitate communication from the unit to senior system leaders (i.e., tiered huddles). • Establish an escalating safety event review, analysis, and response process that quickly gets information to those who need it and hold leaders accountable for responding to events.

Strategy (Secondary Driver)	Change Concept	Change Concept Description	Actionable Practices
Leaders purposefully develop other safety leaders.	Prioritize succession planning as a tool to cultivate leaders and sustain organizational knowledge and safety culture.	High performers intentionally assess leaders for cultural fit and develop leaders through mentorship and succession planning.	<ul style="list-style-type: none"> • Evaluate individual alignment with values, strengths, and interests during regular workforce interactions to identify emerging leaders. • Intentionally develop current and future leaders through mentorship, coaching, and training with succession planning in mind.
Leaders care for their people.	Intentionally lead efforts to support workforce well-being and psychological safety.	High performers recognize that well-being and psychological safety are fundamental to safe patient care. They also consider workforce well-being and safety key drivers to reduce burnout and turnover.	<ul style="list-style-type: none"> • Provide meaningful peer support for difficult situations encountered during clinical practice. • Proactively take leadership accountability to identify and alleviate causes of workforce burnout at the local level (e.g., respect for time, staffing, and administrative burden). • Train the workforce to facilitate sensitive topic discussions. • Check on workforce well-being if performance issues are identified.
Leaders care for their people.	Empower the workforce to initiate changes.	High performers empower the workforce to identify opportunities and solutions for improvement across the healthcare system.	<ul style="list-style-type: none"> • Maintain a system for transparent team communication at all levels. • Empower the workforce with the autonomy and resources to resolve safety concerns for patients and staff. • Provide mechanisms, such as employee engagement surveys, patient safety culture surveys, or 360-degree reviews, for the workforce to provide feedback about direct supervisors related to safety culture.
Leaders care for their people.	Recognize and appreciate workforce achievements: “Celebrate the wins.”	High performers have well-developed programs tied to their values that recognize workforce achievements and engagement in intentional and endurable ways.	<ul style="list-style-type: none"> • Recognize and appreciate the workforce for their achievements, including those related to the healthcare system’s values, like safety.* • Establish various levels of recognition based on the types of recognition valued by the workforce. • Develop a clear peer nomination process for recognizing excellence in safety. • Decrease barriers and burdens for the workforce to complete their work.* • Encourage the workforce to submit safety projects for awards.* <p><i>*Indicates a leader-driven practice, rather than a system-driven practice</i></p>



Primary Driver: Governance Structures and Strategic Planning Support Safety

Strategy (Secondary Driver)	Change Concept	Change Concept Description	Actionable Practices
Govern with intent.	Proactively and purposefully embed a shared values-based vision and strategy for safety.	High performers recognize safety as a core value critical to their patient-focused mission. The vision is clearly communicated and embodied across all levels, guiding short-term decisions and long-term strategic planning—leading to a strong, visible culture of safety.	<ul style="list-style-type: none"> • Commit to safety, quality, and patient experience as core values (i.e., Safety is a Core Value). The values drive the mission and vision across the entire healthcare system. • Establish a memorable, plain language slogan that speaks to the values inherent to the healthcare system. Develop the slogan with input from the board, workforce, leaders at all levels, and the community. • Craft short- and long-term strategic plans that explicitly center the shared values, mission, and vision as specific areas of assessment and revisit them regularly. • Align improvement projects and other initiatives with shared values and evaluate their success. • Use values to guide decision-making and prioritize resources. • Emphasize values visibly and consistently across the system in different ways, e.g., quality awards, values-based workforce recognition.

<p>Govern with intent.</p>	<p>Create and maintain a structure for collaboration and accountability to support safety across the healthcare system.</p>	<p>High performers maintain a governance structure underpinning their safety program that supports values-based decision-making, collaboration, and accountability across the system. The governance structure facilitates the patient and workforce experience from the unit level, across disciplines and specialties, up to the governing board. The governance structure also provides a mechanism to disseminate and standardize safety practices across the healthcare system, while allowing for adaptation as needed to respond to varying local conditions. Clinical and administrative leaders are held accountable for collaborating on safety decision-making.</p>	<ul style="list-style-type: none"> • Continuously monitor performance and decrease barriers to safety and quality.* • Employ a mechanism to hold the workforce accountable for safety outcomes and for maintaining the culture of safety, e.g., by incorporating expectations related to physical and psychological safety into position descriptions and rewarding good performance.* • Pair clinical and administrative leaders in all areas (e.g., using a dyad or triad model) based on complementary individual strengths and weaknesses to ensure all necessary perspectives are considered in decision-making. • Use healthcare system data to evaluate the effectiveness of safety governance and systems for their impact on safety, quality, and the patient experience. • Begin governance body meetings with the voice of the patient, serious safety events, and good catches. • Implement a shared accountability model that empowers the workforce to actively participate in decision-making related to safety and quality, e.g., shared governance. • Recruit inspirational safety champions to serve within the governing body. • Prioritize safety competencies for all members of the workforce from the board to the bedside. • Centralize system-wide safety, quality, patient experience, and data analytics experts partnered with trained hospital-based “boots on the ground” to ensure system-wide alignment of efforts. • Establish processes to conduct peer review of serious safety events. • Establish an escalating safety event review, analysis, and response process that quickly gets information to those who need it to take action and hold leaders accountable for responding to events. • Use stakeholder analysis to identify who to involve in problem-solving and effectively leverage expertise. • Share safety events, quality concerns, and best practices across the system through the formal committee structure, learning networks, and the use of common metrics. • Embed the community in the structure for safety and collaboration (e.g., invite volunteers, patient and family advisory council members, patients, and community members to serve on safety committees). <p><i>*Indicates an action taken by the governance body</i></p>
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Strategy (Secondary Driver)	Change Concept	Change Concept Description	Actionable Practices
Govern with intent.	Commit to investing in safety.	High performers dedicate substantial human and financial resources to support safety. They consider safety as an important independent factor when evaluating return on investment, and proactively invest in workforce training and development, technology, and processes that support safety.	<ul style="list-style-type: none"> • Provide funding for robust real-time patient care data reporting and analysis systems, benchmarked to similar healthcare systems. Purchase data visualization tools to ensure data is usable by the workforce and can be used to support decision-making. • Recognize that safety, quality, and patient experience are competitive business advantages. Value harm avoidance as an independent return on investment worthy of prioritization. • Budget for trained safety, quality, and analytics professionals. • Provide compensation or protected time away from patient care for quality and safety-related activities, e.g., clinical ladder, administrative hours. • Invest in patient safety event reporting systems that streamline the event reporting process and allow for faster data analysis and response.

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