Supplementary File 3: Definitions of Safety Culture	
Author	**Definition of Safety Culture**
Abstoss et al,. 2011	Safety culture can be defined as 'the product of individual and group values, attitudes, perceptions, competencies, and patterns of behaviour that determine the commitment to, and the style and proficiency of, an organisation's health and safety management'.9 (Sexton JB, Helmreich RL, Neilands TB, et al. The safety attitudes questionnaire: psychometric properties, benchmarking data, and emerging research. BMC Health Serv Res 2006;6:44.
AbuAlRub et al., 2014	Feng et al. (2008) defined patient safety culture as "the product of nurses shared values, and beliefs about patient safety" (p. 315).
Amiri et al., 2018	Patient safety culture is defined as a culture whereby nurses are aware of errors and are encouraged to discuss them. This, in turn, improves their ability to learn from past mistakes and take corrective measures (Sammer, 2010)
Ansari et al., 2020	Safety culture is defined as "the product of individual and group values, attitudes, perceptions, competencies, and patterns of behavior that determine the commitment to, and the style and proficiency of, an organization's health and safety management."
Basson., 2021	A culture of safety in the health care system acknowledges that health care is a complex, high-risk endeavor. It discourages blaming individuals when harm occurs and instead seeks systematic causes leading to errors and harm. It encourages workers to report errors and harms and uses these reports to make systematic changes to prevent their occurrence in the future. It encourages people at all levels of an organization to work collaboratively to improve safety. A culture of safety accepts that all people make mistakes and rather than blame individuals, and it seeks to create safer systems to prevent future adverse events. Safety culture can be assessed and measured in healthcare organizations. Many healthcare organizations have used the Safety Attitude Questionnaire (SAQ) to assess teamwork and safety culture.
Benn., 2012	Safety climate may be defined as those aspects of organisational culture that impact upon safety, including managerial and organisational behaviour, local workplace norms, communication, safety management, reporting systems and shared employee attitudes and values.
Berry et al., 2020	No definition of safety culture but serious safety events are defined as variations from best or expected practice that are followed by serious harm.
Blegen et al., 2009	Safety culture is thought to be the shared values, attitudes and behaviour of all staff in health facilities in regard to giving safety priority over efficiency, improving care. rovider communication and collaboration, and creating a system that learns about and learns from errors and problems.
Chera et al., 2014	Does not define safety culture, but defines safety: Safety often refers to the avoidance of catastrophic failures (eg,deathor serious injury from a medication misadministration), and quality is often used more broadly (eg, patient satisfaction scores, wait times in clinics). However, there is clearly a continuum, and the distinction between safety and quality (particularly in medicine) is often indistinct. Most medical errors do not cause fatality or serious injury, but the factors that determine whether a fatality or serious injury occurs can be unpredictable. The distinction between safety and quality is particularly blurry in interactively complex systems where seemingly minor quality issues can interact in unforeseen ways resulting in safety issues. We submit that this is the case in much of medicine (particularly in oncology),and thus safety and quality initiatives are inherently linked.
DeKorne et al., 2014	Safety culture is commonly defined as "the product of the individual and group values, attitudes, perceptions, competencies and patterns of behavior that determine the commitment to, and the style and proficiency of an organization's health and safety management" (Nieva and Sorra, 2003, p. ii18).

Dickens et al., 2021	No definition
Edwards et al., 2008	Patient safety initiatives can be defined as those activities intended to prevent or ameliorate the aforementioned adverse outcomes or injuries.
Frankel et al., 2008	Safety climate is a proactive metric of safety that complements traditional retrospective metrics (e.g., number of fatalities and accidents). Draws on SAQ.
Ginsburg et al., 2005	No definition but references Battles (2003) and Battles and Lilford (2003)
Gupta et al., 2015	No definition
Habahbeh et al., 2020	Patient safety was defined by the Institute of Medicine as 'the prevention of harm to patients' (Aspden et al, 2004).
Hefner et al., 2016	Patient safety culture defined as a product of group values, attitudes, and patterns of behaviour that influence an organization's health and safety activities.
Hinde et al., 2016	"Safety culture" is described as "The product of individual and group values, attitudes, perceptions, competencies, and patterns of behaviour" (Health and Safety Commission, 1993, 23).
Jones, F. et al., 2013	No definition, but: The Agency for Healthcare Research and Quality's (AHRQ) patient safety culture survey (PSCS) was developed to measure the culture of safety.
Jones, K. et al., 2013	Safety culture can be defined as the learned, shared, enduring values and behaviours of organisation members regarding the organisation's willingness to detect and learn from errors.
Kuosmanen et al., 2019	Safety culture comprises the beliefs, attitudes, values, norms, and procedures that are jointly shared among professionals of an organisation (Nieva & Sorra, 2003; Reason, 1997) and influence the way in which work is carried out (Wakefield, McLaws, Whitby, & Patton, 2010).
Kristensen et al., 2016	A culture of safety can be defined as 'An integrated pattern of individual and organisational behaviour, based upon shared beliefs and values that continuously seeks to minimise patient harm, which may result from the processes of care delivery'.
Kuy et al., 2017	No definition
Ling et al., 2016	No definition
Lopez-Jeng et al., 2020	Not safety culture, but organisational culture. The repetition and reinforcement of individual behaviors can lead to a culture change in group values, attitudes, competencies, and behaviors (Biglan & Embry, 2013; Glenn, 2004). Additionally, the changes in individual values, attitudes, competencies, and behaviors in prompting the changes in group behavior can increase innovation and leadership. According to Mountford & Webb (2009), clinicians, or other frontline decision makers, are the ones who provide notable quality care because they have the technical and professional knowledge, are committed to improving the clinical experience, and advocate excellence by responding to patient needs, positioning them to lead long-term change. The behavior change of clinical leaders can facilitate unit group changes within the organization. When unit group values, attitudes, competencies, and behaviors change, the group culture change can promote a hospital-wide organizational culture change within health care.

Lozito et al., 2018	No definition but used HSOPS.
Mazur et al., 2015	High reliability and value creation industries, including some health care organizations, have successfully promoted a culture of safety (at least in part) by developing and fostering event reporting and analysis mechanisms and engaging in continuous quality improvement (CQI) efforts.
Milton et al., 2020	No definition but use Healthcare Quality Competency Framework
Paine et al., 2010	A common definition is the set of norms, values, perceptions and beliefs that govern behaviour and ultimately outcomes.
Patterson et al., 2012	No definition
Profit et al., 2014	No specific definition of patient safety culture, but used HSOPS and SAQ.
Pronovost et al., 2008	The Institute of Medicine (IOM) created a compelling case for patient safety in its To Err is Human report. However, consensus on patient safety goals, priorities, methods, and measures for safety initiatives is slow to emerge.
Razzani et al., 2020	Safety culture is considered a key underlying factor shaping the behaviors, perceptions, attitudes, and commitments of clinicians. It can affect the process of providing care and the effectiveness of interventions. Such a patient safety culture emphasizes the importance of accurate report writing, and the analysis of near misses and medical errors that often lead to adverse health events.Having the appropriate atmosphere in terms of patient safety culture in a unit reduces the rate of errors and their adverse effects on patients.
Reszel et al., 2019	The MOREOB program aims to create a culture of patient safety in obstetrical units by using high reliability organization (HRO) principles, including awareness of systems that influence patient care and outcomes, focusing on near-misses as opportunities to improve processes, a culture that promotes open communication and teamwork, and a commitment to ongoing training and learning.
Sexton et al., 2011	Assessing culture involves careful and time consuming observation of norms, beliefs, values, artifacts, symbols, and rituals. Social scientists and other researchers often forego the deeper culture assessment and opt for the more efficient technique of climate assessment.
Slater et al., 2012	Since the influential 1999 Institute of Medicine report To Err Is Human raised international awareness of the extent of patient harm in health care, there has been an explosion in the number of campaigns and initiatives aiming to improve patient safety.
Tetuan et al., 2017	Safety culture is characterized by a blame-free environment, interdisciplinary collaboration to seek solutions, consistent adherence to evidence-based policies, and leadership's commitment to prioritize resources for safety concerns (Agency for Healthcare Research and Quality, 2012).
Timmell et al., 2010	Safety culture covers a wide range of elements, from effective communication and teamwork to awareness of safety hazards and taking action to prevent them. Examples of programs that effectively improve safety culture are rare.
Vigorito et al., 2011	Local norms and behaviors related to patient safety in the ICU, also known as safety culture, is associated with a unit's ability to improve clinical outcomes.
Watts et al., 2010	Culture of safety within a healthcare organization is one such intermediate measure of improved safety for patients, and the components of a culture of safety, such as reporting and analyzing injuries and close calls, establishment of a just culture, and training with safety in mind have been well described. Author uses SAQ.
Yuce et al., 2020	Hospital safety culture has been defined as the individual and organizational perceptions and behaviours that determine commitment to patient safety.

Zhu et al., 2020	No definition