1. Do they have a program to encourage staff or patients/residents/families to engage their healthcare team when risk/safety issues arise? Something like a “speak-up” campaign.
	1. *Probe to contrast post-event reporting/surveys vs. real time engagement & speaking up*
2. Who does the program target? Staff or patients/residents/families? Both? (We’re trying to discover if they have some kind of non-staff program.)
3. How does it work? What tools (for patients/residents/families and staff) are they using?

*Examples: Patients’ rights materials, Incident reporting system, staff rounding, etc.*

1. Will they be willing to share the program/materials with us?
2. How do they know the program is working?
	1. Do they collect any data to measure the program’s success?
	2. Does the program make a difference?
	3. How is the organization acting on the what they hear?
	4. Is the pt./resident/fam input incorporated in the organization’s quality improvement process/strategy?
3. How was the program developed? Internally/home grown? From an outside source? Where/who?
	1. Can they point us to any good sources of info?
	2. Do you know anyone else we should talk to (in-house or externally)?
4. Is the patient/resident/family speak up campaign included in your patient safety/quality plan?