What's New in the Patient Safety World

April 2017

Joint Commission Sentinel Event Alert on

Safety Culture

The Joint Commission has just published a Sentinel Event Alert on the role of leadership in establishing a culture of safety (TJC 2017). It emphasizes that leaders promote a culture of safety not by words but rather by their actions.

It stresses 3 of James Reason's essential elements of a safety culture: (1) Just Culture (2) Reporting Culture (3) Learning Culture. It emphasizes the critical importance of a transparent, non-punitive approach to reporting and learning from adverse events, close calls, and unsafe conditions.

The alert identifies 11 tenets of a safety culture:

1. Apply a transparent, nonpunitive approach to reporting and learning from adverse events, close calls and unsafe conditions.
2. Use clear, just, and transparent risk-based processes for recognizing and distinguishing human errors and system errors from unsafe, blameworthy actions.
3. CEOs and all leaders adopt and model appropriate behaviors and champion efforts to eradicate intimidating behaviors.
4. Policies support safety culture and the reporting of adverse events, close calls and unsafe conditions. These policies are enforced and communicated to all team members.
5. Recognize care team members who report adverse events and close calls, who identify unsafe conditions, or who have good suggestions for safety improvements. Share these "free lessons" with all team members (i.e., feedback loop).
6. Determine an organizational baseline measure on safety culture performance using a validated tool.
7. Analyze safety culture survey results from across the organization to find opportunities for quality and safety improvement.
8. Use information from safety assessments and/or surveys to develop and implement unit-based quality and safety improvement initiatives designed to improve the culture of safety.

9. Embed safety culture team training into quality improvement projects and organizational processes to strengthen safety systems.
10. Proactively assess system strengths and vulnerabilities, and prioritize them for enhancement or improvement.
11. Repeat organizational assessment of safety culture every 18 to 24 months to review progress and sustain improvement.

The Alert provides examples of what some hospitals have done under each of the "tenets" described above. It also has excellent references and links to a variety of useful resources for leadership and safety culture.

We've never been fans of the variety of "culture" surveys that are widely used. When applied to assess the "culture" of an organization as a whole they can be terribly misleading. Culture at the unit level is much more important. All the surveys out there tend to show the same thing: physicians and administrators generally paint a more positive view of the "organizational culture" than do nurses and other frontline personnel. And the culture often varies dramatically from unit to unit. And people often respond to such surveys with the answers they think you want to hear rather than what they actually think, even when the surveys are "anonymous".

We've always found that you get a much better feel for the "culture" of a unit on your Patient Safety Walk Rounds than you get from any formal survey. When you have direct interaction with frontline staff in an informal and non-punitive fashion, they are more likely to be forthcoming and point out potential vulnerabilities that they might not when responding to a formal survey or questionnaire. Our October 7, 2014 Patient Safety Tip of the Week "Our Take on Patient Safety Walk Rounds" discusses in detail how you can make such rounds valuable and help improve your culture of safety (and also warns how you can misuse such rounds to be detrimental in promoting a culture of safety!).

We are disappointed The Joint Commission barely mentioned the role of Patient Safety Walk Rounds. We would have given them a place as a formal "tenet" for the role of leadership in fostering a culture of safety.

Some of our prior columns related to the "culture of safety":

April 2009	"New Patient Safety Culture Assessments"
June 2, 2009	"Why Hospitals Should Fly...John Nance Nails It!"
January 2011	"No Improvement in Patient Safety: Why Not?"
March 2011	"Michigan ICU Collaborative Wins Big").
March 29, 2011	"The Silent Treatment: A Dose of Reality"
May 24, 2011	"Hand Hygiene Resources"
March 2012	"Human Factors and Operating Room Safety"
July 2012	"A Culture of Disrespect"
July 2013	""Bad Apples" Back In?"
July 22, 2014	"More on Operating Room Briefings and Debriefings"

October 7, 2014 "Our Take on Patient Safety Walk Rounds"
July 7, 2015 "Medical Staff Risk Issues"
September 22, 2015 "The Cost of Being Rude"
May 2016 "ECRI Institute's Top Ten Patient Safety Concerns for 2016"
June 28, 2016 "Culture of Safety and Catheter-Associated Infections"

References:

TJC (The Joint Commission). Sentinel Event Alert 57: The essential role of leadership in developing a safety culture. TJC 2017; March 1, 2017
https://www.jointcommission.org/sea_issue_57/