New Sentinel Event Alert on Establishing and Improving Safety Culture in Health Care

Leadership’s Failure to Address Safety Culture a Contributing Factor to Adverse Events

(OAKBROOK TERRACE, Illinois – March 1, 2017) – In health care, leadership’s failure to create an effective safety culture is a contributing factor to many types of adverse events such as wrong-site surgery and delays in treatment, according to a new Sentinel Event Alert issued by The Joint Commission. The alert provides actions and resources to help health care organizations establish and continuously improve upon key components of safety culture during this month’s National Patient Safety Awareness Week, March 12-18, and year-round.

Safety culture is the product of individual and group beliefs, values, attitudes, perceptions, competencies and patterns of behavior that determine an organization’s commitment to quality and patient safety. Insufficient support for reporting patient safety events, intimidation of staff who report events, and refusal to consistently prioritize and implement safety recommendations are some of the factors that contribute to poor safety culture, according to the Joint Commission Center for Transforming Healthcare.

“A strong safety culture begins with leadership; their behaviors and actions set the bar,” notes Ana Pujols McKee, MD, executive vice president and chief medical officer, The Joint Commission. “I urge all health care leaders to make safety culture a top priority at their health care organization. Establishing and improving safety culture is just as critical as the time and resources devoted to revenue and financial stability, system integration and productivity—because a lack of safety culture can have serious consequences for patients, staff and other stakeholders.”

The Sentinel Event Alert outlines 11 tenets for health care leaders to address safety culture, including:

1. Transparent, non-punitive approaches to reporting and learning from adverse events, close calls and unsafe conditions.
2. Clear, risk-based processes for recognizing and separating human error and error arising from poorly designed systems from unsafe or reckless actions.

3. Adoption of appropriate behaviors and championing efforts to eradicate intimidating behaviors.

4. Establishment, enforcement and communication of all policies that support safety culture and the reporting of adverse events, close calls and unsafe conditions.

5. Recognition of care team members who report adverse events, close calls and unsafe conditions or who have suggestions for safety improvements.


7. Assessment of safety culture survey results from across the organization to find opportunities for improvement.

8. Development and implementation of unit-based quality and safety improvement initiatives in response to information gained from safety assessments and/or surveys.

9. Implementation of safety culture team training into quality improvement projects.

10. Proactive assessment of system (such as medication management and electronic health records) strengths and vulnerabilities, and prioritizing them for enhancement or improvement.

11. Organizational reassessment of safety culture every 18 to 24 months to review progress and sustain improvement.

To access the full alert and accompanying infographic, visit The Joint Commission website. 

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About Sentinel Event Alert

Sentinel Event Alert is published periodically by The Joint Commission for health care professionals. It identifies specific types of sentinel and adverse events and high-risk conditions, describes their common underlying causes, and recommends steps to reduce risk and prevent future occurrences. Sentinel Event Alert topics are determined by The Joint Commission’s Patient Safety Advisory Group, composed of external members, including nurses, physicians, pharmacists, risk managers and other professionals who have hands-on experience in addressing patient safety issues in a wide variety of health care settings. The advisory group is presided over by Ana Pujols McKee, MD, executive vice president and chief medical officer, The Joint Commission. Sentinel event statistics and previous issues of Sentinel Event Alert are available on The Joint Commission website.

The Joint Commission

Founded in 1951, The Joint Commission seeks to continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value. The Joint Commission accredits and certifies more than 21,000 health care organizations and programs in the United States. An independent, nonprofit organization. The Joint Commission is the nation’s oldest and largest standards-setting and accrediting body in health care. Learn more about The Joint Commission at www.jointcommission.org.