The Joint Commission

Sentinel Event Alert

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Leadership committed to safety

Leadership is a critical function in promoting high quality, safe health care. In health care organizations, leadership is provided by the governing body, the chief executive and senior managers, and the leaders of the clinical staff. When a sentinel event occurs in a health care organization, inadequate or ineffective leadership is often one of the contributing factors. In fact, inadequate leadership was a contributing factor in 50 percent of the sentinel events reported to The Joint Commission in 2006. (1) Research shows that leadership makes a major difference in the quality and safety of patient care. (2,3,4,5,6,7,8) "Leaders must recognize that all sentinel events involve a failure in the systems and processes which led to the event," says Jeff Selberg, CEO of Exempla Healthcare. "As leaders, we are accountable for those systems and processes which provide the framework for the clinical environment our staff works within. My first priority is to understand how we improve our clinical environment to reduce the possibility of doing harm."

Health care organizations have not developed the "zero-defect" safety interventions seen in other high-risk industries such as aviation, energy and manufacturing. (8,9) But health care is moving in that direction. Progressive health care leaders have begun to apply lessons learned in other industries to reduce risk and strengthen the defenses against preventable patient harm in health care environments. (2,3,8)

The Swiss cheese model, safety culture, and leaders

James Reason, in his Swiss cheese model of safety, describes the defenses an organization constructs to prevent human error from causing harm. (10) These defenses include the systems and processes within which fallible humans work and the teamwork that create safety. Health care leaders actively seek out and support the establishment of these defenses to help keep patients safe. In a perfect world, these defenses would be impenetrable and patients would always be safe. But that isn't the case. These defenses, like slices of Swiss cheese, have holes—latent hazards and weaknesses—that do not always prevent the human error from reaching the patient. These latent hazards or weaknesses include, for example, poor design, lack of supervision, and manufacturing or maintenance defects. When defenses fail in health care, a patient or staff member is endangered or harmed. While leaders can and should support defenses and interventions to reduce risk, this is not enough; a culture of safety (11) must also be established.

A safety culture is expressed in the beliefs, attitudes and values of an organization's employees regarding the pursuit of safety. It is present in the organization's structures, practices, controls, and policies, which are used to achieve greater safety. A safety culture is characterized by a continual drive toward the goal of maximum attainable safety. A safe culture is a wary culture, one that has a 'collective mindfulness' of the things that can go wrong. (11) Therefore, in safe organizations, safety is rooted in the culture and the system, rather than in the behavior of individuals. In organizations that are highly reliable in being safe—"high reliability organizations"—everyone is sensitive to operations and understands that a change in one area can often impact other areas and the work load. (12) A safe clinical environment is strengthened when work processes—such as daily check-ins and safety huddles—allow leaders and staff to discuss and learn about safety issues together. (8,13) Health care leaders can develop a business case that makes safety improvement financially beneficial. (3) They also can break down the barriers between clinical, operational and financial "silos" by developing and recruiting leaders who understand the importance of all three areas working closely together in order to create safety. (2) Safety design is a conscious effort that involves everyone in the organization—including the board. (3,14) Leaders who are committed to safety listen carefully, ask the difficult questions, and conduct patient-centered conversations. These leaders display a commitment to the personal growth, collaboration and openness necessary to achieve organizational transformation in regard to safety. (2,8) These leaders also consistently ask the question: Could an adverse event that occurred in another organization happen in ours?

Leaders must consistently make safety a top priority in their decision-making. Safety must be supported at all levels of the organization and by both administrative and clinical leaders. Unfortunately, patients and health care staff may perceive a considerable difference between what leaders say and what is actually occurring—for example, when leaders do not support the reporting or managing of errors for fear of litigation. It is common for staff to believe that financial considerations consistently trump quality and safety concerns. (2,3,4) Factors commonly identified as contributing to adverse events – such as poor communication, inadequate training and lack of procedural compliance – can often be traced to a breakdown in systemic solutions intended to prevent harm.

Appropriate evaluation of adverse events and discipline

A thorough and appropriate evaluation of adverse events is necessary to help prevent future occurrences. Actions taken in response to adverse events can be administrative or disciplinary as well as safety-related. These actions must not only be fair, they must be perceived to be fair; otherwise, future reporting of events may be discouraged. Such an approach is consistent with a culture of safety and is symbolic of a "just" culture. A just culture is not wholly blame-free. It is one that has a clear and transparent process for evaluating errors and separating blameworthy from blameless acts. The former are considered for disciplinary action with a set of guidelines that are applied equitably and consistently across all groups within the organization. There are tools and techniques that can help organizations examine an adverse event and determine if disciplinary action is appropriate. (15,16) Blameless acts are particularly important sources of information about system vulnerabilities. Understanding how blameless (as well as blameworthy) acts and weak defenses interact to result in an adverse event is a vital part of the learning an organization should gain following an adverse event investigation.*

Organizations should have a transparent and equitable disciplinary process that takes into account personal responsibility and accountability. To further illustrate the importance of a just culture, note the following two actions that erode leadership credibility and undermine organizational safety culture:

1. Terminating or failing to support an employee who committed a blameless act* during the course of an adverse event. (16,17) The National Quality Forum Safe Practices include "Care of the Caregiver" and address the just, respectful and compassionate support of caregivers involved in serious unintentional harm, as well as using the employee's first-hand knowledge of the event during the adverse event investigation, risk identification and mitigation activities. (18,19,20)
2. Exempting influential individuals from complying with organizational quality and safety policies, such as policies on intimidating and disruptive behaviors.

The inconsistent application of such policies are noticed by staff and are correctly interpreted as only paying lip service to safety. (21)

Existing Joint Commission requirements
The Leadership chapter in the standards manual addresses leadership and safety, specifically relating to the organization's governing body, the chief executive and senior managers, and medical and clinical staff leaders. The standards specifically require that these three leadership groups create a culture of safety (11) by creating an atmosphere of trust and fairness that encourages reporting of risks and adverse events, by allocating the resources necessary to support safety, by discussing and reporting safety issues and indicators, and by developing plans to assure and improve safety performance, especially in relation to high-risk or problem-prone processes. Other issues covered in the standards are: the implementation of important systems within the organization that support safety; the organization's safety program for reporting adverse events and near misses; and the design or modification of processes to support safety.

Joint Commission suggested actions
The following suggested actions are directed to senior leadership—the governing body, the chief executive and senior managers, and medical and clinical staff leaders:

1. Define and establish an organization-wide safety culture that includes a code of conduct for all employees, including contract workers.
2. Institute an organization-wide policy of transparency that sheds light on all adverse events and patient safety issues within the organization, thereby creating an environment where it is safe for everyone to talk about real and potential organizational vulnerabilities and to support each other in an effort to report vulnerabilities and failures without fear of reprisal. (8,9)
3. Make the organization's overall safety performance a key, measurable part of the evaluation of the CEO and all leadership. (3)
4. Ensure that caregivers involved in adverse events receive attention that is just, respectful, compassionate, supportive and timely. Also, make sure they have the opportunity to fully participate in the investigation, risk identification and mitigation activities that will prevent future adverse events.
5. Create and communicate a policy that defines behaviors that are to be referred for disciplinary action; include the timeframe that the disciplinary action should take place.
6. Regularly monitor and analyze adverse events and close calls quantitatively and communicate findings and recommendations to leadership, the board and staff. (8) Conduct root cause analyses of adverse events. Look for patterns in root causes that identify latent hazards and weaknesses in the defenses against errors—the holes in the slices of cheese—and make sure they are addressed. (2,14)
7. Regularly hold open discussions with risk management, performance improvement, physician, nursing and pharmacy leaders, and with physicians and staff caring for patients, to develop a true, unvarnished view of the safety risks and barriers to safety facing patients and staff. Patient safety rounds at the point of care could provide the ideal opportunity for these discussions, which should focus on learning and improvement, not blame or retribution.
8. Prioritize and address safety risks and barriers to safety according to a timeline, with the highest priority items getting immediate attention. Make a visible commitment of time and money to improve the systems and processes needed to defend against hazards and minimize unsafe acts. (2, 8,14) For example, some organizations create an emergency patient safety fund.
9. Establish partnerships with physicians and align their incentives to improving safety and using evidence-based medicine. (3,14)
10. Add a human element and a sense of urgency to safety improvement by having patients communicate their experiences and perceptions to board members, executive leadership, medical staff, and other key leadership groups; also solicit patient input into safety design. (14,23,24)
11. When planning and implementing safety improvements, use the expertise of front-line staff who understand the risks to patients and how processes really work. (8,14)
12. Regularly measure leadership's commitment to safety using climate surveys and upward appraisal techniques (in which staff review or appraise their managers and leaders).(14,25)
13. When leaders assess managers during the annual performance review, make sure they ask about the safety issues the manager encountered, how they were handled, and the impact their actions had on reducing unsafe conditions.
14. Communicate to staff when their work improves safety. Reward and recognize those whose efforts contribute to safety.

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* Understanding the relationship of personal responsibility for unsafe acts to the culture of safety, determining whether individual acts are blameless or blameworthy, and responding properly to this difference, are all critical elements in creating high reliability in health care. The Joint Commission will be providing further advice on these complex topics.