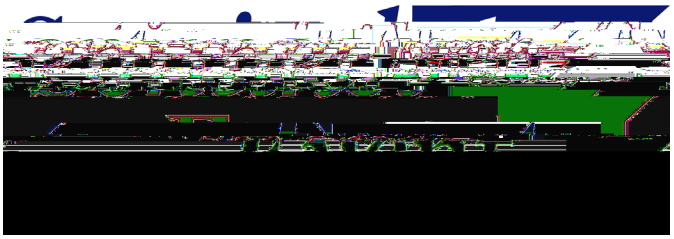

Published for Joint Commission-accredited organizations and interested health care professionals, identifies specific types of sentinel and adverse events and high risk conditions,

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The Joint Commission introduced safety culture concepts in 2008 with the publication of a *Sentinel Event Alert* on behaviors that undermine a culture of safety.[14] Further emphasis was made the following year with a *Sentinel Event Alert* on leadership committed to safety (this Alert replaces and updates that one), and the establishment of a Leadership Standard requiring leaders to create and maintain a culture of safety. The Patient Safety Systems (PS) chapter of The Joint Commission's accreditation manuals emphasizes the importance of safety culture.

Safety culture foundation

Safety culture is the sum of what an organization and in the pursuit of safety.[15] The PS chapter defines safety culture as the product of

able to be meaningfully engaged in their work, to be more satisfied, less likely to experience burnout, and to deliver more effective and safer care.[11,21] Leaders who encourage transparency in response to reports of adverse events, close calls and unsafe conditions, and who have established processes that ensure follow-up to ensure reports are not lost or ignored (or perceived to be lost or ignored), help mitigate intimidating behaviors because transparency of action itself discourages such behavior. On the opposite end of the spectrum, intimidating and unsettling behaviors causing emotional harm, including the use of inappropriate words and actions or inactions, has a detrimental impact on patient safety[10] and should not occur in a safety culture. This includes terminating, punishing, or failing to support a health care team member who makes an error (the "second victim").

Unfortunately, as attention to the need for a culture of safety in hospitals has increased, "so have concomitant reports of retaliation and intimidation targeting care team members who voice concern about safety and quality deficiencies," according to a National Association for Healthcare Quality report.[9] Intimidation has included overtly hostile actions, as well as subtle or passive-aggressive behaviors, such as failing to return phone calls or excluding individuals from team activities. Survey results released by the Institute for Safe Medication Practices (ISMP) show that disrespectful behavior remains a problem in the health care workplace. Most respondents reported experiences with negative comments about colleagues, reluctance or refusal to answer questions or return calls, condescending language or demeaning comments, impatience with questions or hanging up the phone, and a reluctance to follow safety practices or work collaboratively.[23]

Actions suggested by The Joint Commission
The Joint Commission recommends that leaders take actions to establish and continuously improve the five components of a safety culture defined by Chassin and Loeb:

[18] These actions are not intended to be implemented in a sequential manner. Leaders will need to address and apply various components to the workforce simultaneously, using tactics such as board engagement, leadership education, goalsetting, staff support, and dashboards and reports that routinely review safety data.[12]

,[16,24] states the PS chapter of The Joint Commission's accreditation manuals. Develop _____ through an organizational-wide and easy-to-use reporting system. This reporting system should be accessible to everyone within the organization. Having this system is essential for developing a culture in which unsafe conditions are identified and reported without fear of punishment or reprisal for unintentional mistakes, leading to proactive prevention of patient harm.[14,18,25,26] Leaders can augment voluntary reporting by using other methods, such as trigger tools and observational techniques, to proactively address risk and identify potential errors.[27]

Leaders can recognize “good catches” – in which adverse events are avoided – and share these “free

Health care organizations in which care team members have positive perceptions of safety culture tend to have positive assessments of care from patients as well.[57]

[33,39-40,49]

[17,18,30] Team training derived from evidence-based frameworks can be used to enhance the performance of teams in high-stress, high-risk areas of the organization – such as operating rooms, ICUs and emergency departments – and has been implemented at many health care facilities across the country.[17,30]

Safety Culture Key to High Reliability

The Joint Commission established a theoretical framework that emphasizes safety culture, leadership and robust process improvement as three domains that are critical to high reliability within a health care organization.[18] By promoting the core attributes of trust, report and improve,[15] high-reliability organizations create safety cultures in which team members trust peers and leadership; report vulnerabilities and hazards that require risk-based consideration; and communicate the benefits of these improvements back to involved staff. Leaders can self-assess performance and improvements relating to high reliability by using the Oro™ 2.0 High Reliability Organizational Assessment and Resources Tool. See this alert's Resources section for more information.

professionals' individual accountability but encourages key decision makers to consider systems and organizational issues in the management of error.[28]

Institute for Healthcare Improvement's Joy in Work initiative – Addresses clinician burnout.

Joint Commission Resources Oro™ 2.0 High Reliability Organizational Assessment and Resources application – High reliability organizations routinely self-assess. This self-assessment tool is intended for hospital leadership teams. It can be used in combination with tools (such as HSOPS and SAQ) that measure the perceptions of staff at all levels of the organization. The tool evaluates:

- Leadership commitment
- Safety culture
- Performance improvement

Patient Safety Systems (PS) chapter of The Joint Commission's accreditation manuals

Safety Attitudes Questionnaire (SAQ) – Measures six culture domains:

- Teamwork climate
- Safety climate
- Perceptions of management
- Job satisfaction
- Working conditions
- Stress recognition

Strategies for Creating, Sustaining, and Improving a Culture of Safety in Health Care – Published by Joint Commission Resources, this second edition book expands the idea of "building" a culture of safety by spotlighting the best articles related to this topic from *The Joint Commission Journal on Quality and Patient Safety*. These articles provide unique perspectives of challenges inherent when establishing and maintaining a culture of safety.

Sentinel Event Alert,