Ready, Set, Go: Know Your Risks

Leadership Tool for a Learning Organization

Culture of Safety: An Overview

WHY IS A CULTURE OF SAFETY IMPORTANT?

- ❑ Numerous studies show a link between a positive safety culture (where safety is a shared priority) and improved patient safety within a healthcare organization.[1]
- ❑ Leadership support for a safety culture is cited as the most compelling strategy for achieving patient safety.[2]
- ❑ A culture of safety is necessary before other patient safety practices can be successfully introduced to a healthcare organization.
- ❑ The Joint Commission's leadership standards from its accreditation manual list specific provisions for creating and maintaining a culture of safety.[3]

DID YOU ASK?

- ❑ Is safety everyone's first priority in our organization?
- ❑ Has our organization adopted a consistent approach to fairly assess accountability for patient safety incidents by differentiating problematic individuals from the good, skilled people who were set up to fail from system errors they could not foresee?
- ❑ Has our organization created an environment that is conducive for staff to report errors and unsafe conditions because they know the information will be used to address system flaws that contribute to patient safety events?
- ❑ Is our organization continually learning from patient safety events so it can function as a high-reliability organization?

Need More Information?

As a member of ECRI Institute's risk and patient safety program, you and your staff can access guidance outlining strategies for creating a culture of safety:

- ▶ Guidance: Culture of Safety: An Overview
- ▶ Guidance: Event Reporting and Response
- ▶ Guidance: Disruptive Practitioner Behavior

ECRI Institute can help you with all of your patient safety, quality, and risk management projects. Email us at hrc@ecri.org.

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1 Berry JC, Davis JT, Bartman T, Hafer CC, Lieb LM, Khan N, Brilli RJ. Improved safety culture and teamwork climate are associated with decreases in patient harm and hospital mortality across a hospital system. J Patient Saf 2016 Jan 7. PubMed: http://www.ncbi.nlm.nih.gov/pubmed/26741790 doi: 10.1097/PTS.0000000000000251

2 National Patient Safety Foundation (NPSF). Free from harm: accelerating patient safety improvement fifteen years after To Err is Human. 2015 [cited 2019 Mar 7]. http://www.ihi.org/resources/Pages/Publications/Free-from-Harm-Accelerating-Patient-Safety-Improvement.aspx

3 Joint Commission. Comprehensive accreditation manual for hospitals (CAMH). Oakbrook Terrace (IL): Joint Commission Resources; 2019.

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