Walk the Walk

What does it take to truly establish a culture of safety in your hospital? According to Mark P. Jarrett, MD, senior vice president and chief quality officer at Northwell Health in New York, the secret to success is none other than leadership. And, he claims, good leadership is ensuring that the culture will sustain itself beyond your tenure. “Simply budgeting dollars will not fix the issue,” he says; “a thoughtful patient safety strategy requires leaders to engage on a personal level.” Jarrett points out that, in commercial aviation and nuclear—two industries widely hailed as highly reliable—analysis following accidents nearly always reveals the problem to stem from failure of leadership to promote a safety culture.

In an article written for the Journal of Healthcare Management, Dr Jarrett encourages leaders to “walk the walk” in their efforts to establish a lasting culture of safety. By “walk the walk,” Jarrett is talking both figuratively and literally: he encourages healthcare executives to do weekly patient safety rounds in which they engage with and listen to staff and drive home the importance of and commitment to safety. Jarrett also recommends a brief, daily telephone discussion to “engage all leaders in a rapid situational safety review of the organization.”

According to Jarrett, there are several factors that are essential to a safety culture—and these can only be fostered by effective leadership. These are:
Commitment
Nonpunitive response to errors and “near misses”
Shared belief in the importance of safety
Teamwork
Widespread trust

Measurement

How do leaders achieve these foundational elements? To begin with, says Jarrett, measure. The only way to gauge success in performance improvement efforts is through measurement. At Northwell—a metropolitan system with 21 acute-care and 450 ambulatory locations—Jarrett’s team employs the Agency for Healthcare Research and Quality (AHRQ) Hospital Survey on Patient Safety Culture, administered every 18 months.

Human Error

The results of the survey must be analyzed with a keen understanding of human psychology, cautions Jarrett. He reminds healthcare leaders to question the outcomes and never assume the causes behind the data. Rather than celebrate results indicating 100% compliance, first determine if the numbers stem from complacency in reporting rather than conformity.

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safety culture as a foundation to build on—and only then will we know that every patient, including our own family members, can receive the best possible care.”

**Teamwork**

A “team approach is necessary to drive lasting cultural change throughout the organization,” Jarrett maintains. At Northwell, they have adopted TeamSTEPPS, developed by the Department of Defense to heighten patient outcomes through multidisciplinary team training and common terminology to improve communication.

**Just Culture**

Finally, a successful safety culture must be founded on a “model of shared accountability” that is based in nonpunitive reporting of errors, staff accountability and willingness by care providers to speak up.

Jarrett concludes, “Improvement will only occur if leadership establishes a safety culture as a foundation to build on—and only then will we know that every patient, including our own family members, can receive the best possible care.”

Be sure to read “Patient Safety and Leadership: Do You Walk
the Walk?” to see Jarrett’s checklist of elements required for the promotion of patient safety. **ACHE Members:** Visit [ache.org/Journals](http://ache.org/Journals) and select *Journal of Healthcare Management* to log-in and access for free.