

# New alert focuses on leadership's role

A new Joint Commission newsletter titled *Sentinel Event Alert* urges health care leaders to step up efforts to prevent errors by taking the zero-defect approach used in other high-risk industries such as aviation and nuclear energy. The newsletter suggests that a thorough and appropriate evaluation of errors is necessary to prevent future occurrences. The Joint Commission is advocating greater involvement by health care trustees, executives, and physician leaders, contending that the overall safety and effectiveness of a health care facility ultimately depends on administrative and clinical leaders who set the tone and drive improvements.

To improve patient safety, the newsletter recommends that the governing body, chief executive officer (CEO), senior managers, and medical and staff leaders at health care organizations implement a series of 12 specific steps, including the following:

- Define and establish an organization-wide safety culture that includes a code of conduct for all employees
- Institute an organization-

wide policy of transparency that sheds light on all adverse events and patient safety issues

- Make the organization's overall safety performance a key, measurable part of the evaluation of the CEO and all leadership

- Create and communicate a policy that defines behaviors that are to be referred for disciplinary action, and a timeframe for that action to take place

- Add a human element to safety improvement by having patients communicate their experiences and perceptions to leadership

Other strategies for improving safety include creating a culture of safety where adverse events are openly discussed without fear of reprisal; ensuring that caregivers involved in an event that results in unin-

tentional patient harm receive attention that is just, respectful, compassionate, supportive, and timely; and rewarding and recognizing staff whose efforts contribute to patient safety.

In addition to specific recommendations contained in the newsletter, The Joint Commission urges health care organizations to use the Leadership chapter of its accreditation standards to improve patient safety. The standards require health care organizations to create systems to support a culture of safety, and provide the human and financial resources necessary to assure safety. The standards also cover reporting systems for adverse events and near-misses, and the design of processes to support safety.

The complete *Sentinel Event Alert* is available at <http://www.jointcommission.org>.

## Correction

The name of Anton N. Sidawy, MD, FACS, was spelled incorrectly in the October 2009 *Bulletin* article, "Members in the news" (page 37). The editors regret the error.