The Role for Leaders of Health Care Organizations in Patient Safety

Abstrak:

We review what leaders of health care systems, including chief executive officers and board members, need to know to have “patient safety literacy” and do to make their systems safe. High reliability organizations produce reliable results that are not dependent on providers being perfect. Their characteristics include the commitment of leadership to safety as a system responsibility, with a culture of safety that decreases variability with standardized care and does not condone “at-risk behavior.” A business case can be made for investing resources into systems that produce good outcomes reliably. Leaders must see patient safety problems as problems with their system, not with their employees. Leaders need to give providers information to make and monitor system progress. All medical errors, including near misses, and processes associated with all adverse events may provide information for system improvement. Improving systems should produce better long-term results than educating workers to be more careful. (Am J Med Qual 2007;22:311-318).

Keyword:

adverse event; at-risk behavior; benchmark; clinical pathway; culture of safety; disclosure of medical error; error reporting; failure mode and effect analysis; health care leadership; high reliability organization; medical error; near miss; patient safety; proactive hazard analysis; recovery rate