

## NQF Safe Practice #1: Culture of Safety Leadership Structures and Systems

**NQF#** Not NQF Endorsed

**Developer:** The Leapfrog Group

**Data Source:** Leapfrog Hospital Survey

**Practice Statement:** Leadership structures and systems must be established to ensure that there is organization-wide awareness of patient safety performance gaps, direct accountability of leaders for those gaps, and adequate investment in performance improvement abilities, and that actions are taken to ensure safe care of every patient served.

**Objective:** Ensure that health care organizations establish and nurture the leadership structures and systems that drive the values, behaviors, and performance necessary to create and sustain a health care culture of safety.

**Rationale:** According to The Joint Commission, leadership failure is one of the most frequent causes of sentinel events. Failure of execution of governance and administrative leadership strategies by midlevel managers is a major component of the problem.

Engagement of governance boards in quality and safety directly affects their organizations' performance. Studies of organizations from all industry sectors reveal that failure in reliability and systems performance stems from inconsistent execution more than from failure of strategy. While the severity of harm resulting from inadequate performance of leadership structures and systems that are driven by a commitment to quality control cannot be definitively quantified, chronic failure of consistent execution plagues all industries. Severe shortfalls in performance are seen across organizations throughout the entire health care industry. Preventability of harm to patients and sustainable transformation to a higher state of reliability is directly related to governance board engagement and administrative execution.

### Evidence for Rationale:

- Bossidy L, Charan R. Executivision: The Discipline of Getting Things Done. New York (NY): Crown Business; 2002.
- Denham CR. CEOs: May I have the envelope please? J Patient Saf 2008 June;4(2):119-23.
- Denham CR. Green light issues for the CFO: Investing in patient safety. J Patient Saf 2010 Mar;6(1).
- Govier I, Nash S. Examining transformational approaches to effective leadership in healthcare settings. Nurs Times 2009 May 12- 18;105(18):24-7.
- Gowen CR 3rd, Henagan SC, McFadden KL. Knowledge management as a mediator for the efficacy of transformational leadership and quality management initiatives in U.S. health care. Health Care Manage Rev 2009 Apr-June;34(3):129-40.

### Impact:

- Potential to affect large numbers, severity of harm cannot be definitively quantified

### Evidence of High Impact:

- Denham CR. Green light issues for the CFO: Investing in patient safety. J Patient Saf 2010 Mar;6(1).
- National Quality Forum (NQF). Safe practices for better healthcare—2010 update: A consensus report. Washington (DC): National Quality Forum (NQF); 2010.

### Opportunity:

- Opportunity for improvement exists, as demonstrated by the coefficient of variation for the measure.

### Evidence:

- Supported by suggestive clinical evidence and theoretical rationale.

### Citations for Evidence:

- Govier I, Nash S. Examining transformational approaches to effective leadership in healthcare settings. Nurs Times 2009 May 12- 18;105(18):24-7.
- Gowen CR 3rd, Henagan SC, McFadden KL. Knowledge management as a mediator for the efficacy of transformational leadership and quality management initiatives in U.S. health care. Health Care Manage Rev 2009 Apr-June;34(3):129-40.
- National Quality Forum (NQF). Safe practices for better healthcare—2010 update: A consensus report. Washington (DC): National Quality Forum (NQF); 2010.