Becoming a Learning Organization

The need for sustainable improvement in patient safety and the quality of care has never been greater. One of the fundamental steps to achieving and sustaining this improvement is to become a learning organization. A *learning organization* is one in which people learn continuously, thereby enhancing their capabilities to create and innovate.[4] Learning organizations uphold five principles:

1. Team learning
2. Shared visions and goals
3. A shared mental model (that is, similar ways of thinking)
4. Individual commitment to lifelong learning
5. Systems thinking

In a learning organization, patient safety events are seen as opportunities for learning and improvement.[5] Therefore, leaders in learning organizations should adopt a transparent, nonpunitive approach to reporting so that the organization can *report to learn* and can collectively learn from patient safety events. In order to become a learning organization, a hospital must have a fair and just safety culture, a strong reporting system, and a commitment to put those data to work by driving improvement. Each of these requires the support and encouragement of hospital leaders.

Leaders, staff, and patients in a learning organization realize that *every* patient safety event (from close calls to events that cause major harm to patients) must be reported and investigated.[5–9] It is impossible to determine if there are practical prevention or mitigation countermeasures available for a patient safety event without first doing an event analysis. An event analysis will identify systems-level vulnerabilities and weaknesses and the possible remedial or corrective actions that can be implemented.

When patient safety events are continuously reported, experts within the hospital can define the problem, complete a comprehensive systematic analysis, identify solutions, achieve sustainable results, and disseminate the changes or lessons learned to the rest of the hospital.[5–9] In a learning organization, the hospital provides staff with information regarding improvements based on reported concerns. This helps foster trust that encourages further reporting. (*See* the "Sentinel Event Policy" [SE] chapter for more about comprehensive systematic analyses)

The Role of Leaders in Patient Safety

Hospital leaders provide the foundation for an effective patient safety system by doing the following[10]:

- Promoting learning
- Motivating staff to uphold a fair and just safety culture
- Providing a transparent environment in which quality measures and learnings about patient harm events are freely shared with staff
- Modeling professional behavior
- Addressing intimidating behavior that might undermine the safety culture
- Providing the support, resources, and training necessary to take on and complete improvement initiatives

For these reasons, many of the standards that are focused on the hospital's patient safety system appear in the Joint Commission International **Governance, Leadership, and Direction (GLD) standards**, including Standards **GLD.04.00** and **GLD.07.01** (which focuses on creating a culture of safety), and the **Quality and Patient Safety (QPS) standards**.

Without the support of hospital leaders, hospitalwide changes and improvement initiatives are difficult to achieve. Leadership engagement in patient safety and quality initiatives is imperative because 75% to 80% of all initiatives that require people to change their behaviors fail in the absence of leaders managing the change.[5] Thus, leaders should take on a long-term commitment to transform the hospital.[11]