Inside Accreditation & Quality

When patient safety and quality operate apart—and how leaders can bring them back together

by Dom Nicastro

For hospital accreditation and quality leaders, patient safety and quality improvement are often described as inseparable. In reality, they frequently operate as parallel functions—adjacent on paper but disconnected in execution.

Safety work is commonly reactive, driven by incident reporting and investigations after harm occurs. Quality improvement tends to be retrospective, anchored in performance indicators reviewed weeks or months after care delivery. That lag slows learning, weakens accountability, and limits the organization's ability to translate frontline risk into enterprise-level change.

Albert Ogannisyan, founder and clinical researcher at HealthBridge Global Institute and vice president of clinical operations at HealthBridge US, says the problem is not structural alignment alone. Even when safety and quality are formally integrated, safety data often fails to shape leadership behavior.

Why safety and quality still function in silos

According to Ogannisyan, the issue is rarely a lack of data or formal governance structures. Most hospitals already collect safety reports, track quality metrics, and maintain QAPI frameworks. The breakdown occurs when safety intelligence fails to influence leadership behavior.

Safety data often remains isolated in reporting systems, while quality dashboards focus on lagging indicators. When those streams do not converge at the governance level, organizations lose the opportunity to act on early warning signs.

"Integration breaks down when leaders are not held accountable for the safety tradeoffs they're given," Ogannisyan says. The information exists. What's missing is attention and consequence, he adds.

This dynamic allows risk to accumulate quietly. By the time adverse outcomes appear in quality metrics or survey findings, the organization has already missed multiple opportunities to intervene upstream.

Paying attention to early warning signals

Ogannisyan encourages quality leaders to look beyond conventional quality measures and place greater emphasis on leading safety indicators.

"Quality leaders are highly advised to pay close attention to near misses, informal safety issues, pattern-related minor events, and deviations of workflow because these are likely to be the prelude to severe damage," he says. "The early indicators often give a more practical idea than lagging indicators like readmission or infection rates."

The challenge is that near misses and minor events can generate large amounts of data, which organizations sometimes dismiss as noise.

"The trick is designed triage, but not quantity reduction," he says.

Ogannisyan cautions against pushing the burden of filtering data onto frontline managers. Without centralized review, recurring vulnerabilities can be dismissed as unit-level noise rather than recognized as system-level risk.

"A central quality and safety analytics functionality should filter near-miss data. Filtering must emphasize system vulnerability, recurrence, and severity potential instead of the number of incidences."

He advocates for a centralized, multidisciplinary safety and quality analytics function with the authority to escalate systemic patterns to executive leadership for action.

Where the loop fails between events and improvement

Many hospitals describe their safety processes as “closed loop,” but Ogannisyan consistently sees a failure point between identifying patterns and redesigning systems. Root cause analyses are completed. PDSA cycles are documented. Recommendations are written. Yet meaningful operational change often stalls.

“Learning takes place, redesign does not,” Ogannisyan says.

The reason is usually structural. Patterns are identified without assigning a clear operational owner responsible for changing workflows, staffing models, or technology.

“Root cause analyses usually end with recommendations and no budget, time frames, and executive sponsors,” he adds.

Governance that goes beyond dashboards

Governance plays a defining role in whether safety and quality function as a system or remain fragmented. Ogannisyan argues that safety cannot be delegated solely to operational teams or treated as a periodic agenda item.

Boards and quality committees often rely on stable dashboards as reassurance that risk is under control. But stable metrics can mask rising frontline hazards.

Ogannisyan urges governing bodies to ask different questions, such as:

- What risks are not improving despite steady numbers?
- Where are staff working around systems to stay safe?
- Which hazards are knowingly being accepted operationally?
- What close calls would have caused harm under slightly different circumstances?

Effective governance, in his view, involves regular review of safety trends, explicit accountability for corrective action, and alignment of resources with high-risk areas.

Accreditation as a floor, not the goal

Accreditation standards often imply integration between patient safety and quality, but Ogannisyan notes that they can inadvertently reinforce a compliance-driven mindset if organizations focus narrowly on survey readiness.

Standards define the pattern of integration, but they don’t enforce it.

Organizations that perform well include safety expectations within everyday quality management—not just during survey cycles. These organizations maintain ongoing executive safety walkarounds, real-time escalation pathways, and system redesign tracking that continues regardless of accreditation timing.

“Regressive organizations make the safety work a survey and an intermittent activity,” Ogannisyan says. High-performing ones treat it as continuous, he adds.

Translating frontline insight into enterprise action

Frontline reporting often surfaces risks that leaders already “know about,” yet change still fails to occur. Ogannisyan sees this as a failure of escalation design rather than reporting culture.

The issue isn’t how much risk is reported, he says. It’s whether unresolved risk automatically reaches decision-makers with the authority to act.

Effective organizations establish formal escalation pathways with defined response timelines. When risks are not resolved at one level, they are automatically elevated for executive review.

Measuring integration without vanity metrics

Traditional metrics such as harm rates and reporting volume offer limited insight into whether safety is truly embedded within quality systems. Ogannisyan recommends additional leading indicators, including:

- The time from risk identification to system change
- The proportion of safety actions completed on schedule
- Workaround rates in high-risk workflows
- Safety performance during periods of operational stress

These measures focus on system responsiveness rather than retrospective outcomes.

System redesign over individual correction

Following serious events, organizations often default to retraining or disciplinary action. Ogannisyan argues that this response undermines long-term improvement.

“Corrective action should be clearly forbidden by the leaders on the basis of default response unless the factors of the system are excluded,” he says. “Leaders who redesign systems should be rewarded through performance reviews.” That focus on redesign should be what gets recognized, he argues, “not those who retrain their staff or coerce them into complying.

“Sustained change requires governance structures that reward system redesign rather than individual compliance enforcement,” says Ogannisyan.

Sustaining alignment under operational strain

Staffing shortages, throughput pressure, and financial constraints place safety-quality integration under strain. Ogannisyan says organizations that maintain alignment do so by making safety tradeoffs explicit rather than implicit.

That includes protected safety budgets, predefined escalation triggers during crises, and executive directives clarifying when safety margins are narrowing. Safety decisions need to be overt.

Operational stress exposes whether safety and quality are truly integrated or merely aligned during stable conditions. When staffing shortages intensify, census spikes, or financial pressure mounts, safety often becomes negotiable while throughput remains nonnegotiable.

Ogannisyan notes that this is where integration most predictably collapses. Safety controls are quietly relaxed, workarounds become normalized, and frontline teams are left to absorb risk without visibility or support. These decisions are rarely framed explicitly as safety tradeoffs, which makes them difficult to govern.

“The problem isn’t that leaders make tradeoffs,” according to Ogannisyan. It’s that the tradeoffs are implicit and undocumented.

Organizations that maintain alignment during stress do so by predefining thresholds that trigger executive review. When staffing ratios slip, equipment availability narrows, or care pathways are compressed, safety implications are escalated deliberately rather than absorbed silently. This prevents erosion from becoming the new baseline and reinforces that safety remains a quality obligation even when operations are strained.

Culture that survives leadership turnover

Finally, Ogannisyan cautions against safety cultures that depend on individual leaders. Durability comes from structural embedding, not personalities.

That structure includes board-level accountability, standardized escalation pathways, safety measures tied to executive compensation, and governance processes that persist beyond leadership transitions.

For accreditation and quality leaders, the takeaway is clear: Patient safety and quality cannot function as parallel efforts. When they operate as a single system—reinforced by governance, accountability, and redesign—organizations are better positioned to improve outcomes, withstand surveys, and reduce long-term risk.

When asked to identify one decision quality leaders most often mistakenly defer, Ogannisyan points to accountability for system redesign.

Too many organizations delay assigning clear ownership when safety issues span departments or challenge existing power structures. Instead, they rely on committees, extended analysis, or additional monitoring while risk persists.

Stopping that deferral requires leaders to name owners, fund change, and accept disruption. Without that step, he adds, safety intelligence remains descriptive rather than transformative, and quality programs remain reactive despite sophisticated tools and frameworks.