Resident Safety Systems (RSS)

Quality and Safety in Assisted Living Communities

The quality of care and the safety of residents are core values of The Joint Commission accreditation process. This is a commitment The Joint Commission has made to residents, families, health care practitioners, staff, and health care organization leaders.

The ultimate purpose of The Joint Commission's accreditation process is to enhance quality of care and safety for residents. Each accreditation requirement, the survey process, the Sentinel Event Policy, and other Joint Commission policies and initiatives are designed to help organizations reduce variation, reduce risk, and improve quality. Assisted living communities should have an integrated approach to safety so that safe care can be provided for every resident throughout the community.

Assisted living communities have become increasingly complex environments that depend on strong leadership to support an integrated resident safety system that includes the following:

- Safety culture
- Validated methods to improve processes and systems
- Standardized ways for interdisciplinary teams to communicate and collaborate
- Safely integrated technologies

In an integrated resident safety system, staff and leaders work together to eliminate complacency, promote collective mindfulness, treat each other with respect and compassion, and learn from safety events, including close calls and other system failures that have not yet led to resident harm. Sidebar 1 defines these and other key terms.

Sidebar 1. Key Terms

patient safety event[*] An event, incident, or condition that could have resulted or did result in harm to a patient.

adverse event A patient safety event that resulted in harm to a patient. Adverse events should prompt notification of organization leaders, investigation, and corrective actions. An adverse event may or may not result from an error.

sentinel event[†]

[*] In the term *patient safety event,* the word "patient" corresponds to "resident" in the assisted living community setting.

[†] For a list of specific patient safety events that are also considered sentinel events, *see* the "Sentinel Event Policy" (SE) chapter in E-dition® or the *Comprehensive Accreditation Manual.*

assisted living community leaders is to establish and maintain a strong safety

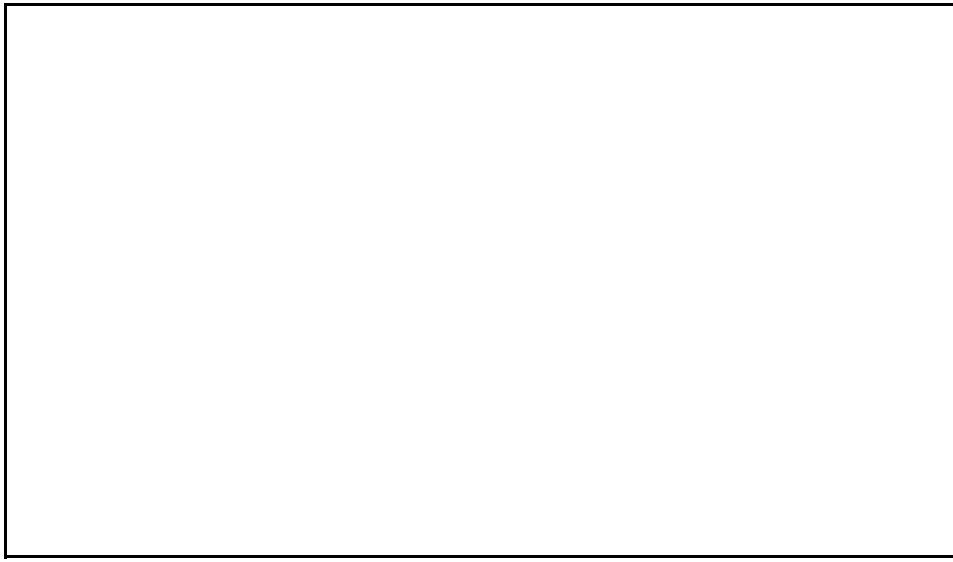

Figure 1. *The Trust-Report-Improve Cycle. In the trust-report-improve*

- Not working collaboratively or cooperatively with other members of the interdisciplinary team
- Creating rigid or inflexible barriers to requests for assistance or cooperation
- Not returning pages or calls promptly

These issues are still occurring in organizations across the continuum of health care nationwide. Of 4,884 respondents to a 2013 survey by the Institute for Safe Medication Practices (ISMP), 73% reported encountering negative comments about colleagues or leaders during the previous year. In addition, 68% reported condescending language or demeaning comments or insults, while 77% of respondents said they had encountered reluctance or refusal to answer questions or return calls.[19] Further, 6960Td(ion)TjETece

does not punish individuals for issues attributed to flawed systems or processes.[15,19,20] Standard LD.04.01.05, EP 4, requires that staff are held accountable for their responsibilities.

It is important to note that for some actions for which an individual is accountable, the individual should be held culpable and some disciplinary action may then be necessary. (*See* Sidebar 2 for a discussion of tools that can help leaders determine a fair and just response to a resident safety event.) However, staff should never be punished or ostracized for *reporting* the event, close call, hazardous condition, or concern.

Sidebar 2. Assessing Staff Accountability

The aim of a safety culture is not a "blame-free" culture but one that balances organization learning with individual accountability. To achieve this, it is essential that leaders assess errors and patterns of behavior in a consistent manner, with the goal of eliminating behaviors that undermine a culture of safety. There has to exist within the assisted living community a clear, equitable, and transparent process for recognizing and separating the blameless errors that fallible humans make daily from the unsafe or reckless acts that are blameworthy.[1–10]

Numerous sources (*see* references below) are available to assist an organization in creating a formal decision process to determine what events should be considered blameworthy and require individual discipline in addition to systems-level corrective actions. The use of a formal process reinforces the culture of safety and demonstrates the organization's commitment to transparency and fairness.

Reaching a determination of staff accountability requires an initial investigation into the resident safety event to identify contributing factors. The use of the Incident Decision Tree (adapted by the United Kingdom's National Patient Safety Agency from James Reason's culpability matrix) or another formal decision process can help make determinations of culpability more transparent and fair.[5]

References

1. The Joint Commission. Behaviors that undermine a culture of safety. *Sentinel Event Alert*, No. 40, Jul 9, 2008. Accessed Jan 17, 2020.https://www.jointcommission.org/resources/patient-safety-topics/sentinel-event/sentinel-event-alert-newsletters/sentinel-event-alert-issue-40-behaviors-that-undermine-a-culture-of-safety/
2. The Joint Commission. The essential role of leadership in developing a safety culture. *Sentinel Event Alert*. Mar 1, 2017. Accessed Jan 17, 2020. https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/sentinel-event/sea-57-safety-culture-and-leadership-final2.pdf

continued on next page

Sidebar 2. *(continued)*

3. Marx D. How building a 'just culture' helps an organization learn from errors. *OR Manager*. 2003 May;19(5):1, 14–15, 20.
4. Reason J, Hobbs A. *Managing Maintenance*

When there is continuous reporting for adverse events, close calls, and hazardous conditions, the assisted living community can analyze the events, change the process or system to improve safety, and disseminate the changes or lessons learned to the rest of the organization.[21–25]

A number of standards relate to the reporting of safety information, including Performance Improvement (PI) Standard PI.01.01.01, which requires organizations to collect data to monitor their performance, and Standard LD.03.02.01, which requires organizations to use data and information to guide decisions and to understand variation in the performance of processes supporting safety and quality.

Assisted living communities can engage frontline staff in internal reporting in a number of ways, including the following:

- Create a nonpunitive approach to safety event reporting
- Educate staff on and encourage them to identify safety events that should be reported
- Provide timely feedback regarding actions taken on reported safety events

When assisted living communities collect data or measure staff compliance with evidence-based care processes or resident outcomes, they can manage and improve those processes or outcomes and, ultimately, improve resident safety. The effective use of data enables organizations to identify problems, prioritize issues, develop solutions, and track performance to determine success.[10] Objective data can be used to support decisions as well as to influence people to change their behaviors and to comply with evidence-based care guidelines.[10,23]

The Joint Commission requires assisted living communities to collect and use data related to certain outcomes regarding care and harm to residents. Some key Joint Commission standards related to data collection and use require organizations to do the following:

- Collect information to monitor conditions in the environment (Standard EC.04.01.01)
- Identify risks for acquiring and transmitting infections (Standard IC.01.03.01)
- Use data and information to guide decisions and to understand variation in the performance of processes supporting safety and quality (Standard LD.03.02.01)

In a proactive risk assessment the organization evaluates a process to see how it could potentially fail, to understand the consequences of such a failure, and to identify parts of the process that need improvement. A proactive risk assessment increases understanding within the organization about the complexities of process design and management—and what could happen if the process fails.

The Joint Commission addresses proactive risk assessments in the "Environment of Care" (EC), "Infection Control and Prevention" (IC), and "Leadership" (LD) chapters. Assisted living communities are required to proactively assess the risks to resident safety and to implement processes to mitigate those risks. Organizations working to become learning organizations are encouraged to exceed this requirement by constantly working to proactively identify risk.

When conducting a proactive risk assessment, organizations should prioritize high-risk, high-frequency areas. Areas of risk are identified from internal sources such as ongoing monitoring of the environment, results of previous proactive risk assessments, and results of data collection activities. Risk assessment tools should be accessed from credible external sources such as nationally recognized risk assessment tools and peer review literature.

Hazardous (or unsafe) conditions also provide an opportunity for an assisted living community to take a proactive approach to reduce harm. Assisted living communities benefit from identifying hazardous conditions while designing any new process that could impact resident safety. A *hazardous condition* is defined as any circumstance that increases the probability of a safety event. A hazardous condition may be the result of a human error or violation, may be a design flaw in a system or process, or may arise in a system or process in changing circumstances.[‡] A proactive approach to such conditions should include an analysis of the systems and processes in which the hazardous condition is found, with a focus on the climate that preceded the hazardous condition.

A proactive approach to hazardous conditions should include an analysis of the related systems and processes, including the following aspects:[29]

[‡] Human errors are typically skills based, decision based, or knowledge based, whereas violations could be either routine or exceptional (intentional or negligent). *Routine violations* tend to include habitual "bending of the rules," often enabled by management. A routine violation may break established rules or policies, and yet be a common practice within an organization. An *exceptional violation* is a willful behavior outside the norm that is not condoned by management, engaged in by others, nor part of the individual's usual behavior. Source: Diller T, et al. The human factors analysis classification system (HFACS) applied to health care. *Am J Med Qual.* 2014 May–Jun;29(3)181–190.

Preconditions. Examples include hazardous (or unsafe) conditions in the environment of care (such as noise, clutter, wet floors, and so forth), inadequate staffing levels (inability to effectively monitor, observe, and provide care/treatment to residents).

Supervisory influences. Examples include inadequate supervision, unsafe operations, failure to address a known problem, authorization of activities that are known to be hazardous.

Organization influences. Examples include inadequate staffing, organization culture, lack of strategic risk assessment.

A number of tools are available to help organizations conduct a proactive risk assessment. One of the best known of these tools is the Failure Modes and Effects Analysis (FMEA). An FMEA is used to prospectively examine how failures could occur during high-risk processes and, ultimately, how to prevent them. The FMEA asks "What if?" to explore what could happen if a failure occurs at particular steps in a process.[30]

Other tools to consider using for a proactive risk assessment include the following:

Institute for Safe Medication Practices Medication Safety Self Assessment®. Available for various health care settings, these tools are designed to help reduce medication errors. Visit https://www.ismp.org/selfassessments/default.asp for more information.

Contingency diagram: The contingency diagram uses brainstorming to generate a list of problems that could arise from a process. Visit https://digital.ahrq.gov/health-it-tools-and-resources/evaluation-resources/workflow-assessment-health-it-toolkit/all-workflow-tools/contingency-diagram for more information.

Potential problem analysis (PPA) is a systematic method for determining what could go wrong in a plan under development, rating problem causes according to their likelihood of occurrence and the severity of their consequences. Visit https://digital.ahrq.gov/health-it-tools-and-resources/evaluation-resources/workflow-assessment-health-it-toolkit/all-workflow-tools/potential-problem-analysis for more information.

Process decision program chart (PDPC) provides a systematic means of finding errors with a plan while it is being created. After potential issues are found, preventive measures are developed, allowing the problems to either be avoided or a

contingency plan to be in place should the error occur. Visit https://digital.ahrq.gov/health-it-tools-and-resources/evaluation-resources/workflow-assessment-health-it-toolkit/all-workflow-tools/process-decision-program-chart for more information.

Sidebar 3 lists strategies for conducting an effective proactive risk assessment, no matter the strategy chosen.

Sidebar 3. Strategies for an Effective Risk Assessment

Regardless of the method chosen for conducting a proactive risk assessment, it should address the following points:

- Promote a blame-free reporting culture and provide a reporting system to support it.
- Describe the chosen process (for example, through the use of a flowchart).
- Identify ways in which the process could break down or fail to perform its desired function, which are often referred to as "failure modes."
- Identify the possible effects that a breakdown or failure of the process could have on residents and the seriousness of the possible effects.
- Prioritize the potential process breakdowns or failures.
- Determine why the prioritized breakdowns or failures could occur, which may involve performing a hypothetical root cause analysis.
- Design or redesign the process and/or underlying systems to minimize the risk of the effects on residents.
- Test and implement the newly designed or redesigned process.
- Monitor the effectiveness of the newly designed or redesigned process.

Encouraging Resident Activation

To achieve the best outcomes, residents and families must be more actively engaged in decisions about their health care and must have broader access to information and support. Resident activation is inextricably intertwined with resident safety. Activated residents are less likely to experience harm and unnecessary hospitalizations. Residents who are less activated suffer poorer health outcomes and are less likely to follow their health care provider's advice.[31,32]

Joint Commission Resources: A Joint Commission affiliate that produces books and periodicals, holds conferences, provides consulting services, and develops software products for accreditation and survey readiness. (For more information, visit http://www.jcrinc.com.)

Webinars and podcasts: The Joint Commission and its affiliate, Joint Commission Resources, offer free and fee-based webinars and podcasts on various accreditation and safety topics.

Speak Up™ program: The Joint Commission's campaign to educate residents about health care processes and potential safety issues and encourage them to speak up whenever they have questions or concerns about their safety. For more information and education resources, go to http://www.jointcommission.org/speakup.

Joint Commission web portals: Through The Joint Commission website (at http://www.jointcommission.org/toc.aspx), organizations can access web portals with a repository of resources on the following topics:

- Zero Harm
- Emergency Management
- Health Care Workforce Safety and Well-Being
- Infection Prevention and Control
- Suicide Prevention
- Workplace Violence Prevention

References

1. Committee to Design a Strategy for Quality Review and Assurance in Medicare, Institute of Medicine. *Medicare: A Strategy for Quality Assurance,* vol. 1. Lohr KN, editor. Washington, DC: The National Academies Press, 1990.
2. Juran J, Godfrey A. *Quality Control Handbook*, 6th ed. New York: McGraw-Hill, 2010.
3. American Society for Quality. *Glossary and Tables for Statistical Quality Control*, 4th ed. Milwaukee: American Society for Quality Press, 2004.
4. Senge PM. *The Fifth Discipline: The Art and Practice of the Learning Organization,* 2nd ed. New York: Doubleday, 2006.
5. Leape L, et al. A culture of respect, part 2: Creating a culture of respect. *Academic Medicine*. 2012 Ij33.6804(respect)3Tj6710.5Tf32.840Td(Academic)TjETBT/F710.5Tf10

21. Heifetz R, Linsky M. A survival guide for leaders. *Harvard Business Review*. 2002 Jun;1–11.
22. Ontario Hospital Association. *A Guidebook to Patient Safety Leading Practices: 2010*. Toronto: Ontario Hospital A27ssociation, 2010.
23. The Joint Commission. The essential role of leadership in developing a safety culture. *Sentinel Event Alert*. Mar 1, 2017. Accessed Jan 17, 2020. https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/sentinel-event/sea-57-safety-culture-and-leadership-final2.pdf
24. Ogrinc GS, et al. *Fundamentals of Health Care Improvement: A Guide to Improving Your Patients' Care*, 2nd ed. Oak Brook, IL: Joint Commission Resources/Institute for Healthcare Improvement, 2012.
25. Agency for Healthcare Research and Quality. *Becoming a High Reliability Organization: Operational Advice for Hospital Leaders*. Rockville, MD: AHRQ, 2008.
26. Nelson EC, et al. Microsystems in health care: Part 2. Creating a rich information environment. *Jt Comm J Qual Patient Saf*. 2003 Jan;29(1):5–15.
27. Nelson EC, et al. Clinical microsystems, part 1. The building blocks of health systems. *Jt Comm J Qual Patient Saf*. 2008 Jul;34(7):367–378.
28. Pardini-Kiely K, et al. Improving and sustaining core measure performance through effective accountability of clinical microsystems in an academic medical center. *Jt Comm J Qual Patient Saf*. 2010 Sep;36(9):387–398.
29. Diller T, et al. The human factors analysis classification system (HFACS) applied to health care. *Am J Med Qual*. 2014 May–Jun;29(3)181–190.
30. The Joint Commission. *Root Cause Analysis in Health Care: A Joint Commission Guide to Analysis and Corrective Action of Sentinel and Adverse Events*, 7th edition. Oak Brook, IL: Joint Commission Resources, 2020.
31. AARP Public Policy Institute. Beyond 50.09 chronic care: A call to action for health reform. (Sentin)TJ33.0CTd(,)Tj4.714.71475083 Tc/bPubli_50_hcr.html22.480Td(Commi

for al.