Patient Safety Systems (PS)

Quality and Safety in Health Care

The quality of care and the safety of patients are core values of The Joint Commission accreditation process. This is a commitment The /F51 65 Tf Commission

continued on next page

Shading indicates a change effective January 1, 2024, unless otherwise noted in the What's New.

The Joint commitment 65 Tf 22.880TSr

Sidebar 1. *(continued)*

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

[*] 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.*

patients). Joint Commission–accredited organizations should be continually focused on eliminating system failures and human errors that may cause harm to patients, families, and staff.

Goals of This Chapter

This "Patient Safety Systems" (PS) chapter provides home care organizations with a proactive approach to maintaining or redesigning a patient-centered system that aims to improve quality of care and patient safety, an approach that aligns with the Joint Commission's mission and its standards.

The Joint Commission partners with accredited home care organizations to improve their ability to protect patients. The first obligation of health care is to "do no harm." Therefore, this chapter focuses on the following three guiding principles:

1. Aligning existing Joint Commission standards with daily work to engage patients and staff throughout the health care system, at all times, on reducing harm.
2. Assisting home care organizations to become learning organizations by advancing knowledge, skills, and competence of staff and patients by recommending methods that will improve quality and safety processes.
3. Encouraging and recommending proactive quality and patient safety methods that will increase accountability, trust, and knowledge while reducing the impact of fear and blame.

It informs and educates home care organizations about the importance and structure of an integrated patient safety system and helps staff understand the relationship between Joint Commission accreditation and patient safety. It offers approaches and methods that may be adapted by any health care organization that aims to increase the reliability and transparency of its complex systems while removing the risk of patient harm.

The PS chapter refers to specific Joint Commission standards, describing how existing requirements can be applied to achieve improved patient safety. It does not contain any new requirements. Standards cited in this chapter are formatted with the standard number in boldface type (for example, "Standard RI.01.01.01") and are accompanied by language that summarizes the standard. For the full text of a standard and its element(s) of performance (EP), please reference E-dition or the *Comprehensive Accreditation Manual*.

Throughout this chapter, we will do the following:

Discuss how home care organizations can develop into learning organizations

Identify the role leaders have to establish a safety culture and ensure staff accountability
Explain how home care organizations can continually evaluate the status and progress of their patient safety systems
Describe how home care organizations can work to prevent patient/client safety events with proactive risk assessments
Highlight the critical component of patient activation and engagement in a patient safety system
Provide a framework to guide home care organization leaders as they work to improve patient safety in their organizations

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[4]

In a learning organization, patient safety events are seen as opportunities for learning and improvement.[5] Therefore, leaders in learning organizations 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 home care organization must have a fair and just safety culture, a strong reporting system, and a commitment to put that data to work by driving improvement. Each of these require the support and active engagement of home care organization leadership to support and nurture the just and safe culture.

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

possible remedial or corrective actions that can be implemented. When patient safety events are continuously reported, experts within the home care organization 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 home care organization.[5-9] In a learning organization, the home care organization 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

Organization 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 home care organization's patient safety system appear in the Joint Commission's Leadership (LD) standards, including Standard LD.03.01.01 (which focuses on having a culture of safety).

Without the support of home care organization leaders, sustainable organizationwide 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 leadership managing the change.[5] Thus, leadership should take on a long-term commitment to transform the home care organization.[11]

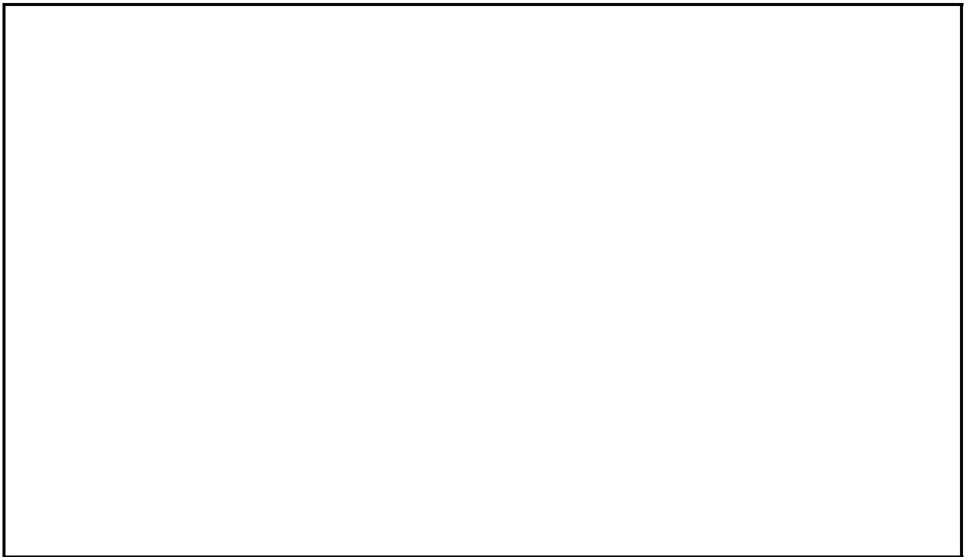

A strong safety culture is an essential component of a successful patient safety system and is a crucial starting point for home care organizations striving to become learning organizations. In a strong safety culture, the home care organization has an unrelenting commitment to safety and to do no harm. Among the most critical responsibilities of home care organization leaders is to establish and maintain a strong safety culture within their organization. The Joint Commission's standards address safety culture in Standard LD.03.01.01, which requires leaders to create and maintain a culture of safety and quality throughout the home care organization.

The *safety culture* of a home care organization is the product of individual and group beliefs, values, attitudes, perceptions, competencies, and patterns of behavior that determine the organization's commitment to quality and patient safety. Home care organizations that have a robust safety culture are characterized by communications founded on mutual trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of preventive measures.[12] Organizations will have varying levels of safety culture, but all should be working toward a safety culture that has the following qualities:

- Staff and leaders that value transparency, accountability, and mutual respect.[5]
- Safety as everyone's first priority.[5]
- Behaviors that undermine a culture of safety are not acceptable, and thus are reported to organization leadership by staff, patients, and families for the purpose of fostering risk reduction.[5,11,13]
- Collective mindfulness is present, wherein staff realize that systems always have the potential to fail and staff are focused Td(culture)Tj31.3Tf100Tz000rg23.80Td4rways have

A safety likely culture operates effectively when the home care organization fosters a cycle of trust, reporting, and improvement.[11,16] In home care organizations that have a strong safety culture, health care staff trust their coworkers and leaders to support them when they identify and report a patient safety event.[11] When trust is established, staff are more likely to report patient safety events, and home care organizations can use these reports to inf7.750T00rg48of.6Td7Tj6.890Td(st.pi00Tz00(them(home)Tj25.470Td(care)Tj18.670Td



patibe.89io7.

events, theirseT BT /F5Tf reporti 20.99 0 Td (a)Tj 6j00 Tz 0 0 (them (homand)Tj 17.26 0Td 5 0 Td (contribuvely)Tj 0 Td (reporti 34.53 0 Td (theactual0 Td (2.94 0 T

that this problem is worsening.[19] While these data are specific to medication safety, their lessons are broadly applicable: Behaviors that undermine a culture of safety have an adverse effect on

continued on next page

Sidebar 2. Assessing Staff Accountability *(continued)*

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 patient 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

continued on next page

t v s t

t t

When home care organizations collect data or measure staff compliance with evidence-based care processes or patient outcomes, they can manage and improve those processes or outcomes and, ultimately, improve patient safety.[25] The effective use of data enables home care 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 and the Centers for Medicare & Medicaid Services (CMS) both require home care organizations to collect and use data related to adverse patient events, incidents, or outcomes and patient harm events. Some key Joint Commission standards related to data collection and use require home care organizations to do the following:

- Identify risks for acquiring and transmitting infection (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)
- Have an organizationwide, integrated patient safety program (Standard LD.03.09.01)
- Evaluate the effectiveness of their medication management system (Standard MM.08.01.01)
- Report (if using Joint Commission accreditation for deemed inpatient hospices) deaths associated with the use of restraint and seclusion (Standard PC.03.05.19)
- Collect data to monitor their performance (Standard PI.01.01.01)
- Improve performance on an ongoing basis (Standard PI.03.01.01)

yz t

Effective data analysis can enable a home care organization to “diagnose” problems within its system similar to the way one would diagnose a patient’s illness based on symptoms, health history, and other factors. Turning data into information is a critical competency of a learning organization and of effective management of change. When the right data are collected and appropriate analytic techniques are applied, it enables the home care organization to monitor the performance of a system, detect variation, and identify opportunities to improve. This can help the home care organization not only understand the current performance of organizational systems but also can help it predict its performance going forward.[24]

- Information is shared with the appropriate groups throughout the organization (from the front line to the board) (Standards LD.03.04.01, LD.03.09.01)
- Opportunities for improvement and actions to be taken are communicated (Standards LD.03.05.01, LD.03.07.01)
- Improvements are celebrated or recognized

A Proactive Approach to Preventing Harm

Proactive risk reduction prevents harm before it reaches the patient. By engaging in proactive risk reduction, an organization can correct process problems to reduce the likelihood of experiencing adverse events. Additional benefits of a proactive approach to patient safety include increased likelihood of the following:

- Identification of actionable common causes
- Avoidance of unintended consequences
- Identification of commonalities across departments/services/units
- Identification of system solutions

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.

Sidebar 3. ***(continued)***

Test and implement the newly designed or redesigned process.
Monitor the effectiveness of the newly designed or redesigned process.

Encouraging Patient Activation

To achieve the best outcomes, patients and families must be more actively engaged in decisions about their health care and must have broader access to information and support. Patient activation is inextricably intertwined with patient safety. Activated patients are less likely to experience harm and unnecessary hospital admissions. Patients who are less activated suffer poorer health outcomes and are less likely to follow their physician's or other licensed practitioner's advice.[31,32]

A patient-centered approach to care can help home care organizations assess and enhance patient activation. Achieving this requires leadership engagement in the effort to establish patient-centered care as a top priority throughout the home care organization. This includes adopting the following principles:[33]

- Patient safety guides all decision making.
- Patients and families are partners at every level of care.
- Patient- and family-centered care is verifiable, rewarded, and celebrated.
- The physician or other licensed practitioner responsible for the patient's care, or the physician's or other licensed practitioner's designee, discloses to the patient and family any unanticipated outcomes of care, treatment, and services.
- Transparent communication when harm occurs. Although Joint Commission standards do not require apology, evidence suggests that patients benefit—and are less likely to pursue litigation—when physicians disclose harm, express sympathy, and apologize.[34]
- Staffing levels are sufficient, and staff has the necessary tools and skills.
- The home care organization has a focus on measurement, learning, and improvement.
- Staff must be fully engaged in patient- and family-centered care as demonstrated by their skills, knowledge, and competence in compassionate communication.

Home care organizations can adopt a number of strategies to support and improve patient activation, including promoting culture change, adopting transitional care models, and leveraging health information technology capabilities.[33]

A number of Joint Commission standards address patient rights and provide an excellent starting point for home care organizations seeking to improve patient activation. These standards require that organizations do the following:

- Respect, protect, and promote patient rights (Standard RI.01.01.01)
- Respect the patient's right to receive information in a manner the patient understands (Standard RI.01.01.03)
- Respect the patient's right to participate in decisions about their care, treatment, and services (Standard RI.01.02.01)
- Honor the patient's right to give or withhold informed consent (Standard RI.01.03.01)
- Address patient decisions about care, treatment, and services received at the end of life (Standard RI.01.05.01)
- Inform the patient about their responsibilities related to their care, treatment, and services (Standard RI.02.01.01)

Beyond Accreditation: The Joint Commission Is Your Patient Safety Partner

To assist home care organizations on their journey toward creating highly reliable patient safety systems, The Joint Commission provides many resources, including the following:

- *Office of Quality and Patient Safety*: An internal Joint Commission department that offers home care organizations guidance and support when an organization experiences a sentinel event or when a safety event is reported that may require analysis or improvement work. The Office of Quality and Patient Safety assesses the thoroughness and credibility of a home care organization's comprehensive systematic analysis as as

If an answer cannot be found in the FAQs, organizations can submit questions about standards to the Standards Interpretation Group by clicking on a link to complete an online submission form.

National Patient Safety Goals: The Joint Commission gathers information about emerging patient safety issues from widely recognized experts and stakeholders to create the National Patient Safety Goals® (NPSG), which are tailored for each accreditation program. These goals focus on significant problems in health care safety and specific actions to prevent them. For a list of the current NPSG, go to the NPSG chapter in E-dition or the *Comprehensive Accreditation Manual* or http://www.jointcommission.org/standards_information/npsgs.

Sentinel Event Alert: The Joint Commission's periodic alerts with timely information about similar, frequently reported sentinel events, including root ca

informa8ion abo0Td(and)Ti17.650Td(specific)Ti32125.510Resources.52945/9i5.20off11.30.255.720Tde

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 Jul;87(7):853–858.
6. Wu A, ed. *The Value of Close Calls in Improving Patient Safety: Learning How to Avoid and Mitigate Patient Harm*. Oak Brook, IL: Joint Commission Resources, 2011.
7. Agency for Healthcare Research and Quality. *Becoming a High Reliability Organization: Operational Advice for Hospital Leaders*. Rockville, MD: AHRQ, 2008.
8. Fei K, Vlasses FR. Creating a safety culture through the application of reliability science. *J Healthc Qual*. 2008 Nov–Dec;30(6):37–43.
9. Massachusetts Coalition of the Prevention of Medical Errors: When Things Go Wrong: Responding to Adverse Events. Mar 2006. Accessed Jan 17, 2020. http://www.macoalition.org/documents/respondingToAdverseEvents.pdf
10. The Joint Commission. *The Joint Commission Leadership Standards*. Oak Brook, IL: Joint Commission Resources, 2009.
11. Chassin MR, Loeb JM. High-reliability healthcare: Getting there from here. *Milbank Q*. 2013 Sep;91(3):459–490.
12. Advisory Committee on the Safety of Nuclear Installations. Study Group on Human Factors. *Third Report of the ACSNI Health and Safety Commission*. Sudbury, UK: HSE Books, 1993.
13. Leape L, et al. A culture of respect, part 1: The nature and causes of disrepectful behavior by physicians. *Academic Medicine*. 2012 Jul;87(7):1–8.

14. Weick KE, Sutcliffe KM. *Managing the*

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. Mar 2009. Accessed Jan 17, 2020. http://www.aarp.org/health/medicare-insurance/info-03-2009/beyond_50_hcr.html
32. Towle A, Godolphin W. Framework for teaching and learning informed shared decision making. *BMJ.* 1999 Sep 18;319(7212):766–771.
33. Hibbard JH, et al. Development of the patient activation measure (PAM): Conceptualizing and measuring activation in patients and consumers. *Health Serv Res.* 2004 Aug;39(4 Pt 1):1005–1026.
34. Kachalia A, et al. Effects of a communication-and-resolution program on hospitals' malpractice claims and costs. *Health Affairs.* 2018 Nov; 37(11). Accessed Jul 31, 2021. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.0720.