QuickSafety
An advisory on safety & quality issues

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Patient Safety Systems chapter: A must-read

Note: *The Joint Commission reminds health care providers about the valuable information in the Patient Safety Systems (PS) chapter of the accreditation manual. The chapter was included for the first time in the 2015 hospital accreditation manual; now, there is a PS chapter in all Joint Commission accreditation manuals. This Quick Safety highlights sections of the chapter, as well as helpful resources.*

Issue:

The quality of care and the safety of patients are core values of The Joint Commission accreditation process. This is a commitment The Joint Commission has made to patients, families, health care practitioners, staff and health care organization leaders. The intent of the Patient Safety Systems (PS) chapter is to provide health care organizations with a proactive approach to designing 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. There are no new requirements in the PS chapter; the standards are culled from existing chapters. The PS chapter is available online for everyone.

Highlights of the PS chapter

Becoming a Learning Organization: A learning organization is one in which people learn continuously, thereby enhancing their capabilities to create and innovate. Learning organizations uphold five principles: team learning, shared visions and goals, a shared mental model (that is, similar ways of thinking), individual commitment to lifelong learning, and systems thinking.

The Role of Organization Leaders in Patient Safety: Organization leaders and staff provide the foundation for an effective patient safety system by:

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

Safety Culture: 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.
- Safety as everyone's first priority.
- Behaviors that undermine a culture of safety are not acceptable, and thus should be reported to organizational leadership by staff, patients and families for the purpose of fostering risk reduction.
- Collective mindfulness is present, wherein staff realize that systems always have the potential to fail, and staff are focused on finding hazardous conditions or close calls at early stages before a patient may be harmed. Staff do not view close calls as evidence that the system prevented an error but rather as evidence that the system needs to be further improved to prevent any defects.
- Staff who do not deny or cover up errors but rather want to report errors to learn from mistakes and improve the system flaws that contribute to or enable patient safety events. Staff know that their leaders will focus not on blaming providers involved in errors but on the systems issues that contributed to or enabled the patient safety event.

(Cont.)

- By reporting and learning from patient safety events, staff create a learning organization.

A Fair and Just Safety Culture: A fair and just safety culture is needed for staff to trust that they can report patient safety events without being treated punitively. A fair and just culture takes into account that individuals are human, fallible, and capable of mistakes, and that they work in systems that are often flawed. In the most basic terms, a fair and just culture holds individuals accountable for their actions but does not punish individuals for issues attributed to flawed systems or processes. 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. However, staff should never be punished or ostracized for **reporting** the event, close call, hazardous condition, or concern. See the sidebar in the PS chapter on "Assessing Staff Accountability."

Data Use and Reporting Systems: An effective culture of safety is evidenced by a robust reporting system and use of measurement to improve. When there is continuous reporting for adverse events, close calls, and hazardous conditions, the organization can analyze the patient safety events, change the process or system to improve safety, and disseminate the changes or lessons learned to the rest of the organization. Organizations can engage frontline staff in internal reporting in a number of ways, including:

- Create a nonpunitive approach to patient safety event reporting.
- Educate staff on identifying patient safety events that should be reported.
- Provide timely feedback regarding actions taken on patient safety events.

Effective Use of Data: The effective use of data enables organizations to identify problems, prioritize issues, develop solutions, and track to determine success. Objective data can be used to support decisions, influence people to change their behaviors and to comply with evidence-based care guidelines. 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 organization to monitor the performance of a system, detect variation, and identify opportunities to improve. This can help the organization understand the current performance of its systems and help predict its performance going forward. Analyzing data with tools such as run charts, statistical process control (SPC) charts, and capability charts helps an organization determine what has occurred in a system and provides clues as to why the system responded as it did. After data has been turned into information, leadership should ensure the following:

- Information is presented in a clear manner. (Standard LD.03.04.01)
- Information is shared with the appropriate groups throughout the organization (from the frontline staff to the board). (Standards LD.03.04.01, LD.03.09.01)
- Opportunities for improvement and actions to be taken are clearly communicated. (Standards LD.03.05.01, LD.03.07.01)
- Improvements are celebrated or recognized.

See Table 1 in the PS chapter on "Defining and Comparing Analytical Tools."

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 in order to reduce the likelihood of experiencing adverse events. 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. A proactive approach to hazardous conditions should include an analysis of the related systems and processes, including preconditions, supervisory influences and organizational influences. This section of the PS chapter includes examples of preconditions, supervisory influences and organizational influences and a sidebar, "Strategies for an Effective Risk Assessment." There is also a section about "Tools for Conducting a Proactive Risk Assessment."

Encouraging Patient Activation: Patient activation is inextricably intertwined with patient safety. Activated patients are less likely to experience harm and unnecessary hospital readmissions. Patients who are less activated suffer poorer health outcomes and are less likely to follow their provider's advice. A patient-centered approach to care can help 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 organization. This includes adopting the following principles:

- 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 licensed independent practitioner responsible for the patient's care, or his or her designee, discloses to the patient and family any unanticipated outcomes of care, treatment and services.
- Though 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.
- Staffing levels are sufficient, and care teams have the necessary tools and skills.
- The organization has a focus on measurement, learning and improvement.
- Staff and licensed independent practitioners must be fully engaged in patient- and family-centered care, as demonstrated by their skills, knowledge and competence in compassionate communication.

Beyond Accreditation: The Joint Commission is Your Patient Safety Partner: To assist hospitals on their journey toward creating highly reliable patient safety systems, this section of the PS chapter provides a comprehensive list of resources.

Safety Actions to Consider:

- Read the PS chapter of the accreditation manual.
- Apply the principles and follow the standards in the PS chapter in your daily work, as applicable.
- Organizations should distribute the PS chapter to its care teams and leaders and facilitate discussions about how to implement the concepts and principles.
- When designing or redesigning patient-centered systems, follow the guidance provided in the PS chapter.

Resources:

See the PS chapter of the accreditation manual for a full list of references and resources.