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 Joint Commission has made to patients, families, health care practitioners, staff, and health care organization leaders.

The ultimate purpose of The Joint Commission's accreditation process is to effectively

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Sidebar 1. (continued)

sentinel event* A sentinel event is a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm). Sentinel events are a subcategory of adverse events.

close call A patient safety event that did not cause harm but posed a risk of harm. Also called *near miss* or *good catch*.

hazardous condition A circumstance (other than a patient's own disease process or condition) that increases the probability of an adverse event. Also called *unsafe condition*.

Quality and safety in health care are inextricably linked. Quality, as defined by the Institute of Medicine, is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.[1] It is achieved when

*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.

Describe how critical access hospitals can work to prevent patient 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 critical access hospital leaders as they work to improve patient safety in their critical access hospitals

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 critical access hospital 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 encouragement of critical access 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 critical access 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 critical access hospital.[5-9] In a learning organization, the critical access hospital provides

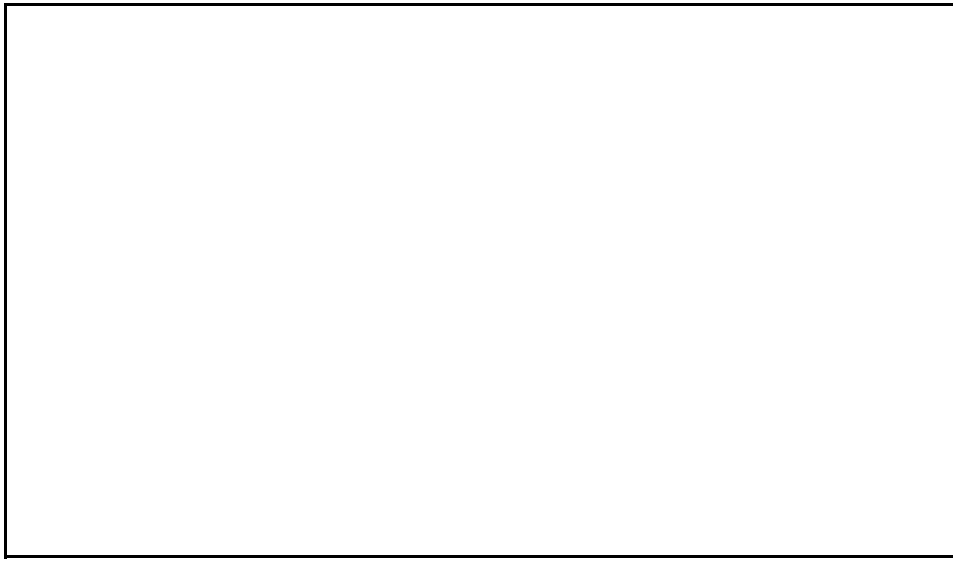

Figure 1. The Trust-Report-Improve Cycle. In the trust-report-improve cycle, trust promotes reporting, which leads to improvement, which in turn fosters trust.

Leaders and staff need to address intimidating or unprofessional behaviors within the critical access hospital, so as not to inhibit others from reporting safety concerns.[17] Leaders should both educate staff and hold them accountable for professional behavior. This includes the adoption and promotion of a code of conduct that defines acceptable behavior as well as behaviors that undermine a culture of safety. The Joint Commission's Standard LD.03.01.01, EP 4, requires that leaders develop such a code.

Intimidating and disrespectful behaviors disrupt the culture of safety and prevent collaboration, communication, and teamwork, which is required for safe and highly reliable patient care.[18] Disrespect is not limited to outbursts of anger that humiliate a member of the health care team; it can manifest in many forms, including the following:[5,13,18]

- Inappropriate words (profane, insulting, intimidating, demeaning, humiliating, or abusive language)
- Shaming others for negative outcomes
- Unjustified negative comments or complaints about another licensed practitioner's care
- Refusal to comply with known and generally accepted practice standards, which may prevent other licensed practitioners from delivering quality care

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

These issues are still occurring in critical access hospitals nationwide. Of 1,047 respondents to a 2021 survey by the Institute for Safe Medication Practices (ISMP),

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.[15,19,20]

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, below, for a discussion of tools that can help leaders determine a fair and just response to a patient 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 organizational 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 critical access hospital 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 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]

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Sidebar 2. (continued)

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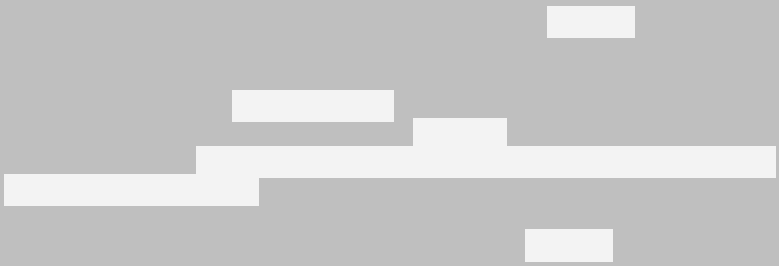

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When there is continuous reporting for adverse events, close calls, and hazardous conditions, the critical access hospital can analyze the events, change the process or system to improve safety, and disseminate the changes or lessons learned to the 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 critical access hospitals to collect data to monitor their performance, and Standard LD.03.02.01, which requires critical access hospitals to use data and information to guide decisions and to understand variation in the performance of processes supporting safety and quality.

Critical access hospitals can engage frontline staff in internal reporting in a number of ways, including the following:

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

When critical access hospitals 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 critical access hospitals 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.[9,23]

The Joint Commission and the Centers for Medicare & Medicaid Services (CMS) both require critical access hospitals to collect and use data related to certain patient care outcomes and patient harm events. Some key Joint Commission standards related to data collection and use require critical access hospitals 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)
Have an organizationwide, integrated patient safety program within their performance improvement activities (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 status purposes) 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)

Effective data analysis can enable a critical access hospital 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 critical access hospital to monitor the performance of a system, detect variation, and identify opportunities to improve. This can help the critical access hospital not only understand the current performance of critical access hospital systems but also can help it predict its performance going forward.[24]

Analyzing data with tools such as run charts, statistical process control (SPC) charts, and capability charts helps a critical access hospital determine what has occurred in a system and provides clues as to why the system responded as it did.[24] Table 1, following, describes and compares examples of these tools.

A Proactive Approach to Preventing Harm

Proactive risk reduction prevents harm before it reaches the patient. By engaging in proactive risk reduction, a critical access hospital 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 critical access hospital 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

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 patients 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 patients.

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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 causes, applicable Joint Commission requirements, and suggested actions to prevent a particular sentinel event. (For archives of previously published Sentinel Event Alerts, go to https://www.jointcommission.org/resources/sentinel-event/sentinel-event-alert-newsletters/.)

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