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 enhance quality of care and patient safety. 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. Hospitals should have an integrated approach to patient safety so that safe patient care can be provided for every patient in every care setting and service.

Hospitals are complex environments that depend on strong leadership to support an integrated patient 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 patient safety system, staff and leaders work together to eliminate complacency, promote collective mindfulness, treat each other with respect and compassion, and learn from patient safety events, including close calls and other system failures that have not yet led to patient harm. Sidebar 1 defines these and other key terms.

Sidebar 1. Key Terms

- patient

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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 processes and results meet or exceed the needs and desires of the people it serves.[2,3] Those needs and desires include safety.

The components of a quality management system should include the following:

- » Ensuring reliable processes
- » Decreasing variation and defects (waste)
- » Focusing on achieving positive measurable outcomes
- » Using evidence to ensure that a service is satisfactory

Patient safety emerges as a central aim of quality. *Patient safety*, as defined by the World Health Organization, is the prevention of errors and adverse effects to patients that are associated with health care. Safety is what patients, families, staff, and the public expect from Joint Commission–accredited organizations. While patient safety events may not be completely eliminated, the goal is always zero harm (that is, reducing harm to 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.

*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.*

Goals of This Chapter

This "Patient Safety Systems" (PS) chapter provides health 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 organizations to improve the ability of health care systems 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 health 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 hospitals 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 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, you will see the following: 34.6 0 Ta96 0 TdExplTz 0 0 T /F1als

» Discuss how hospitals can develop into learning organizations

» Identify work organization[s]: 0 48.200 Tz 0 0 dnt

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ments 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

Hospital leaders provide the foundation for an effective patient safety system by doing the following:[10]

» Promoting learning
» Motivating staff to in

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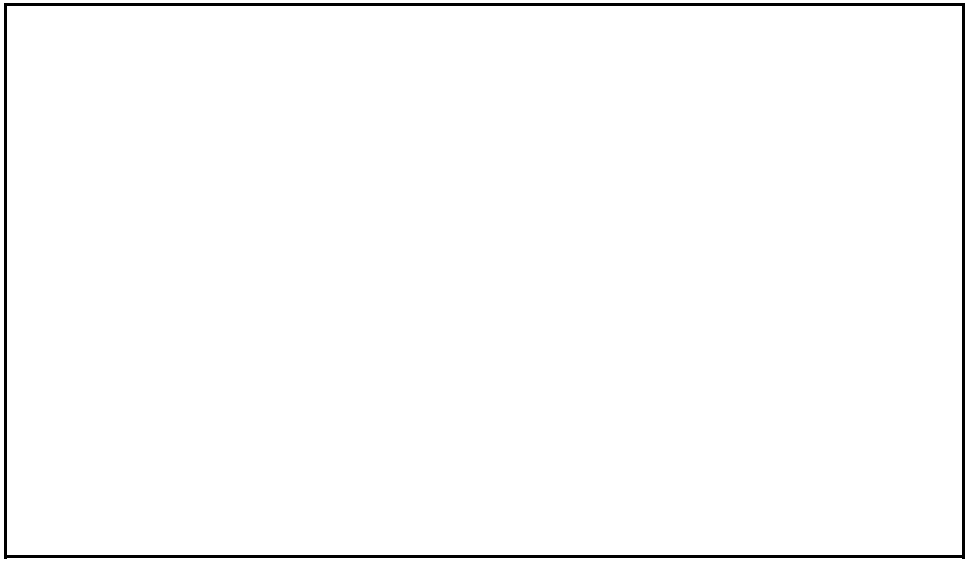

- Not working collaboratively or cooperatively with other members of the interdisciplinary team
- Creating rigid or inflexible barriers to requests for assistance or cooperation
- Not returning pages or calls promptly

These issues are still occurring in hospitals nationwide. Of 1,047 respondents to a 2021 survey by the Institute for Safe Medication Practices (ISMP), 79% reported personally experiencing disrespectful behaviors during the previous year. In addition, 60% reported witnessing disrespectful behaviors. The respondents included nurses, physicians, pharmacists, and quality/risk management personnel.

Approximately half (51%) of the respondents had asked colleagues to help interpret a medication order or validate its safety to avoid interacting with a particular prescriber.[19] Moreover, 27% said they were awpointe.47%0 Td (interacting)Tj3 Td (inl0 Td (safety)Tj 25.5d (1

Sidebar 2. ***(continued)***

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Data Use and Reporting Systems

An effective culture of safety is evidenced by a robust reporting system and use of measurement to improve. When hospitals adopt a transparent, nonpunitive approach to reports of patient safety events or other concerns, the hospital begins reporting to learn—and to learn collectively from adverse events, close calls, and hazardous conditions. While this section focuses on data from reported patient safety events, it is but one type of data among many that should be collected and used to drive improvement.

When there is continuous reporting for adverse events, close calls, and hazardous conditions, the 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 hospitals to collect data to monitor their performance, and Standard LD.03.02.01, which requires hospitals to use data and information to guide decisions and to understand variation in the performance of processes supporting safety and quality.

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

Effective Use of Data

Collecting Data

When 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. The effective use of data enables hospitals to identify problems, prioritize issues, develop solutions, and track performance to determine success.[16] 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.[19,23]

The Joint Commission and the Centers for Medicare & Medicaid Services (CMS) both require 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 hospitals to do the following:

- » Collect information to monitor conditions in the environment (Standard EC.04.01.01)
- » Identify risks for acquir(data)[illegible])T())Tj ET 5 Tf 30.7

Statistical Process Control (SPC) Chart	An advanced data chart, plotted in time order, used to

In a proactive risk assessment, the 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 could happen if the process fails.

The Joint Commission addresses proactive risk assessments at Standard LD.03.09.01, EP 7, which requires hospitals to select one high-risk process and conduct a proactive risk assessment at least every 18 months. Hospitals should recognize that this standard represents a minimum requirement. Hospitals working to become

[†] 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, and services to patients).
- *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, leadership, lack of strategic risk assessment.

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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.
- 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 readmissions. 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 hospitals assess and enhance patient activation. Achieving this requires leadership engagement in the effort to establish patient-centered care as a top priority throughout the hospital. 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 hospital 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.

Hospitals 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[35].

A number of Joint Commission standards address patient rights and provide an excellent starting point for hospitals seeking to improve patient activation. These standards require that hospitals 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)

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