Patient Safety Systems (PS)

Why a Patient and Resident Safety Chapter?

The quality of care and the safety of patients and residents are core values of The Joint Commission accreditation process. This is a commitment The Joint Commission has made to patients, 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 patients and 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. Nursing care centers should have an integrated approach to safety so that safe care can be provided for every patient or resident in every care setting and service.

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

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

[illegible] 1 [illegible]

- **[illegible]***[*] An event, incident, or condition that could have resulted or did result in harm to a patient.
- **[illegible]** 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.
- **[illegible]** 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.
- **[illegible]** A patient safety event that did not cause harm but posed a risk of harm. Also called *near miss* or *good catch*.
- **[illegible]** A circumstance (other than a patient's own disease process or condition) that increases the probability of an adverse event. Also called *unsafe condition*. AlsoTj ET BT /F1 8..5 Tf 100 Tz 0 0 0 rg 23.8 277.4 319(

Quality and safety in health care are inextricably linked. *Quality*, as defined by the Institute of Medicine, is the

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[*] In the term *patient safety event,* the word patient encompasses both patients and residents in nursing care centers.

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.*

patient or resident safety events may not be completely eliminated, the goal is always zero harm (that is, reducing harm to patients and residents). Joint Commission accredited organizations should be continually focused on eliminating system failures and human errors that may cause harm to patients, residents, families, and staff.

Scope of the Chapter

This Patient Safety Systems (PS) chapter provides health care organizations with a proactive approach to maintaining or redesigning a patient- and resident-centered system that aims to improve quality of care and patient and resident 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 and residents. The first obligation of health care is to *do no harm*. Therefore, this chapter focuses on the following three guiding

Throughout this chapter, we will do the following:

- Discuss how nursing care centers can develop into learning organizations
- Identify the role leaders have to establish a safety culture and ensure staff accountability
- Explain how nursing care centers can continually evaluate the status and progress of their patient and resident safety systems
- Describe how nursing care centers can work to prevent or respond to patient or resident safety events with proactive risk assessments
- Highlight the critical component of patient activation and engagement in a patient and resident safety system
- Provide a framework to guide nursing care center leaders as they work to improve patient and resident safety in their facilities

Building a Learning Organization

The need for sustainable improvement in patient and resident 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[3]. 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 or resident 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 or resident safety events. In order to become a learning organization, a nursing care center 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 health care organization's leaders.

Leaders, staff, patients, and residents in a learning organization realize that *every* patient or resident safety event (from close calls to events that da

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 or resident safety events are continuously reported, experts

Safety Culture

A strong safety culture is an essential component of a successful patient and resident safety system and is a crucial starting point for nursing care centers striving to become learning organizations. In a strong safety culture, the health care organization has an unrelenting commitment to safety and to do no harm. Among the most critical responsibilities of nursing care center 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 organization.

The *safety culture* of a nursing care center is the product of individual and group beliefs, values, attitudes, perceptions, competencies, and patterns of behavior that determine the organization's commitment to the quality and safety of its patients and residents. Nursing care centers that have a robust safety culture are characterized by communications founded on mutual

Intimidating and disrespectful behaviors disrupt the culture of safety and prevent collaboration, communication, and teamwork, which is required for safe and highly reliable patient and resident 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 provider's care
- Refusal to comply with known and generally accepted practice standards, which may prevent other providers 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 returning pages or calls promptly

These issues are still occurring in health care organizations 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.[19] 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 aware of a medication error during the previous year in which behavior that undermines a culture of safety was a contributing factor. Nearly 200 events were described, many of which involved high-alert medications (e.g., neuromuscular blocking agents, anticoagulants, insulin, chemotherapy) and led to significant delays in care and/or adverse events.

Of the respondents who indicated that their organizations had clearly defined and effective processes for handling disagreements with the safety of an order, only 41% said that the process for handling disagreements allows them to bypass a typical chain of command, if necessary.[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 the quality and safety of patients and residents.

A Fair and Just Safety Culture

A fair and just safety culture is needed for staff to trust that they can report patient or resident safety events without being treated punitively.[3,9] In order to accomplish this, nursing care centers should provide and encourage the use of a standardized reporting process for staff to report patient or resident safety events. This is also built into the Joint Commission's standards at Standard LD.03.09.01, EP 3, which requires leaders to provide and encourage the use of systems for blame-free reporting of a system or process failure or the results of proactive risk assessments. Reporting enables both proactive and reactive risk reduction. Proactive risk reduction solves problems before patients or residents are harmed, and reactive risk reduction attempts to prevent the recurrence of problems that have already caused patient or resident harm.[11,16]

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.[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

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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 or 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]

1. The Joint Commission. Behaviors that undermine a culture of safety. *Sentinel Event Alert*, No. 40, Jul 9, 2008. Accessed Jan 10, 2024. 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 10, 2024. https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/sentinel-event/sea-57-safety-culture-and-leadership-final2.pdf
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 Error.* Farnham, Surrey, United Kingdom: Ashgate Publishing, 2003.
5. Vincent C. *Patient Safety*, 2nd ed. Hoboken, NJ: Wiley-Blackwell, 2010.
6. National Patient Safety Agency. Incident Decision Tree. Accessed Jan 10, 2024. https://www.ahrq.gov/downloads/pub/advances/vol4/meadows.pdf
7. Bagian JP, et al. Developing and deploying a patient safety program in a large health care delivery system: You can't fix what you don't know about. *Jt Com J Qual Patient Saf*. 2001 Oct;27(10):522–532.
8. National Patient Safety Foundation. RCA[2]: Improving Root Cause Analyses and Actions to Prevent Harm. Jun 16, 2015. Accessed Jan 10, 2024. https://www.ashp.org/-/media/assets/policy-guidelines/docs/endorsed-documents/endorsed-documents-improving-root-cause-analyses-actions-prevent-harm.ashx
9. The Joint Commission. Video: *Building Your Safety Culture: A Job for Leaders.* Chassin M. April 27, 2017. Accessed Jan 10, 2024. https://www.jointcommission.org/resources/news-and-multimedia/video-resources/president-and-ceo-discusses-safety-cultures/

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Table 2 (continued)

10. The Joint Commission. *Take 5: Building a Strong Safety Culture - A Job For Leaders.* Benedicto A. May 10, 2017. Accessed Jan 10, 2024. https://www.jointcommission.org/resources/news-and-multimedia/podcasts/#q=Building%20a%20Strong%20Safety%20Culture

Reporting and Learning

An effective culture of safety is evidenced by a robust reporting system and use of measurement to improve. When nursing care centers adopt a transparent, nonpunitive approach to reports of patient or resident safety events or other concerns, the organization 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 or resident 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 nursing care center can analyze 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.

Nursing care centers can engage frontline staff in internal reporting in a number of ways, including the following:

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

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.[24] Table 1 describes and compares examples of these tools.

Table 1. Tools for Analyzing Data

Tool	What It Is	When to Use It
Run Chart	A chart that plots points on a graph to show levels of performance over time. A run chart is used to answer questions about whether performance is static or changing and, if it is changing, whether the change is for better or for worse.	» When the organization needs to identify variation within a system » When the organization needs a simple and straightforward analysis of a system » As a precursor to an SPC chart
Statistical Process Control (SPC) Chart	A visual representation that tracks progress over time that include an upper and lower control limit based on previous data. Action is taken when a point goes beyond a control limit or points form a pattern or trend.	» When the organization needs to identify variation within a system and find indicators of why the variation occurred » When the organization needs a more detailed and in-depth analysis of a system
Capability Chart	An analytical tool that uses upper and lower parameters for acceptable performance of tasks or processes to determine whether a given change in the process is capable of reducing variation in performance.	» When the organization needs to determine whether a process will function as expected, according to requirements or specifications

A Proactive Approach to Health Care

Proactive risk reduction prevents harm before it reaches the patient or resident. By engaging in proactive risk reduction, a nursing care center can correct process problems

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Nursing care centers can adopt a number of strategies to support and improve patient or resident activation, including promoting culture change, adopting transitional care models, and leveraging health information technology capabilities.

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

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

- *Standards Interpretation Group*: An internal Joint Commission department that helps organizations with their questions about Joint Commission standards. First, organizations can see if other organizations have had similar questions by accessing the Standards FAQs at https://www.jointcommission.org/standards/standard-faqs/. 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 and resident 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 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/.)
- *Quick Safety*: Quick Safety is a periodic newsletter that outlines an incident, topic, or trend in health care that could compromise patient safety. (For more information, visit https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/quick-safety/.)
- *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 patients and 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 patient 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

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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

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

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11. Chassin MR, Loeb JM. High-reliability health care: 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 disrespectful behavior by physic 8011.42 05

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 healthcare. *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 11, 2024 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 Jan 11, 2024 https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.0720.