Resident Safety Systems (RSS)

Quality and Safety in Assisted Living Communities

The quality of care and the safety of residents are core values of The Joint Commission accreditation process. This is a commitment The Joint Commission has made to 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 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. Assisted living communities should have an integrated approach to safety so that safe care can be provided for every resident throughout the community.

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

[*] In the term *patient safety event,* the word "patient" corresponds to "resident" in the assisted living community setting.
[†] For a list of specific patient safety events that are also considered sentinel events, *see* the "Sentinel Event PolicyAccre®.09

and the public expect from Joint Commission–accredited organizations. While safety events may not be completely eliminated, the goal is always zero harm (that is, reducing harm to residents). Joint Commission–accredited organizations should be continually focused on eliminating systems failures and human errors that may cause harm to residents, families, and staff.

Goals of This Chapter

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

The Joint Commission partners with accredited health care organizations to improve the ability of health care systems to protect residents. 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 residents and staff throughout the health care system, at all times, on reducing harm.
2. Assisting organizations to become learning organizations by advancing knowledge, skills, and competence of staff and residents by recommending methods that will improve quality and safety processes.
3. Encouraging and recommending proactive quality and resident safety methods that will increase accountability, trust, and knowledge while reducing the impact of fear and blame.

It informs and educates assisted living communities about the importance and structure of an integrated resident safety system and helps staff understand the relationship between Joint Commission accreditation and 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 resident harm.

The RSS chapter refers to specific Joint Commission standards, describing how existing requirements can be applied to achieve improved resident 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 assisted living communities can develop into learning organizations
- Identify the role leaders have to establish a safety culture and ensure staff accountability
- Explain how assisted living communities can continually evaluate the status and progress of their resident safety systems
- Describe how assisted living communities can work to prevent safety events with proactive risk assessments
- Provide a framework to guide assisted living community leaders as they work to improve resident safety in their facilities

Becoming a Learning Organization

The need for sustainable improvement in 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.[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, safety events are seen as opportunities for improvement (are) Tj 14.390 Td (s

continuously reported, experts within the assisted living community 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 facility.[5-9] In a learning organization, the assisted living community 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 Resident Safety

Assisted living community leaders provide the foundation for an effective resident 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 resident 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 organization's resident 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 assisted living community leaders, organizationwide changes and improvement initiatives are difficult to achieve. Leadership engagement in resident 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 organization.[11]

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

assisted living community 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 an assisted living community 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 residents. Assisted living communities 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, residents, 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 on finding hazardous conditions or close calls at early stages before a resident may be harmed.[11] 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.[11,14]
- 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 safety events.[7] 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 safety event.[7,15]
- By reporting and learning from safety events, staff create a learning organization.

A safety culture operates effectively when the assisted living community fosters a cycle of trust, reporting, and improvement.[11,16] In organizations that have a strong safety culture, health care providers trust their coworkers and leaders to support them when they identify and report a resident safety event.[11] When trust is established, staff are more likely to report safety events, and assisted living communities can use these reports to inform their improvement efforts. In the trust-report-improve cycle, leaders foster trust, which enables staff to report, which enables the organization to improve.[11] In turn, staff see that their reporting contributes to actual improvement, which bolsters their trust. Thus, the trust-report-improve cycle reinforces itself.[11] (*See* Figure 1.)

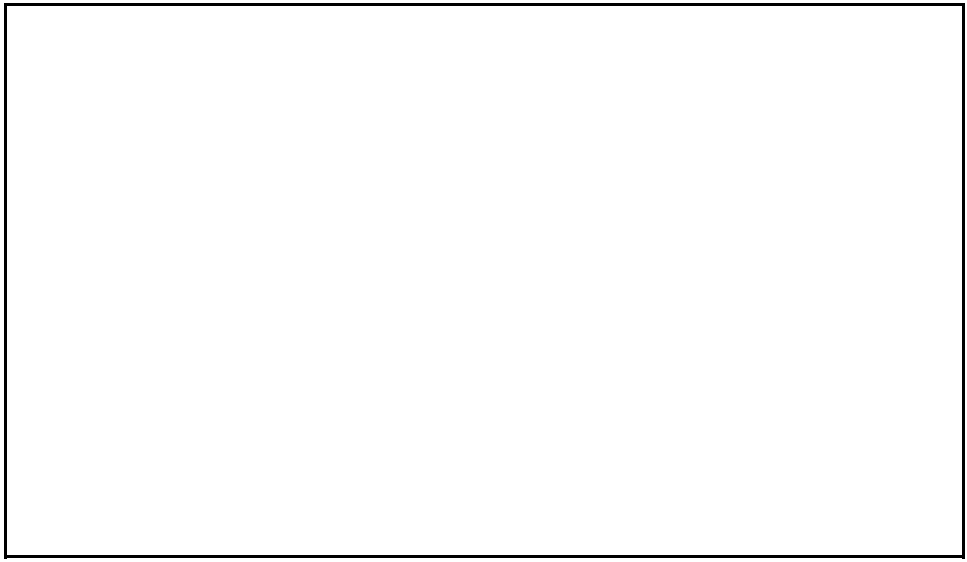
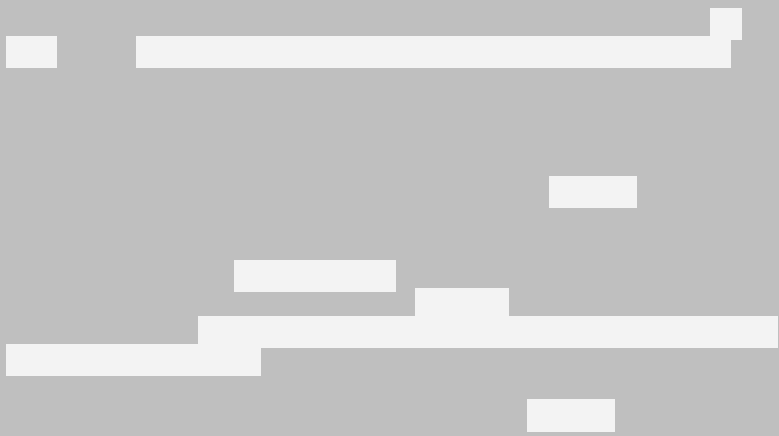


Figure 1. *The Trust-Report-Improve Cycle. In the trust-report-improve cycle, trust promotes reporting, which leads to improvement,*

Sidebar 2. *(continued)*

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.



When there is continuous reporting for adverse events, close calls, and hazardous conditions, the assisted living community 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 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.

Assisted living communities can engage frontline staff in internal reporting in a number of ways, including the following:

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

When assisted living communities collect data or measure staff compliance with evidence-based care processes or resident outcomes, they can manage and improve those processes or outcomes and, ultimately, improve resident safety. The effective use of data enables 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 requires assisted living communities to collect and use data related to certain outcomes regarding care and harm to residents. Some key Joint Commission standards related to data collection and use require organizations 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)

Statistical Process Control (SPC) Chart	An advanced data chart, plotted in time order, used to show the performance and stability of a process over time. The chart includes a center line (process mean) and upper and lower control limits (process variation), based on the data plotted, that show both positive and negative patterns, trends, and variation in a process. Action is taken when a point goes beyond a control limit or points form a pattern or trend.	When the organization needs to determine if a process is stable, to identify variation within a process, or find indicators of why the variation occurred When the organization needs a more detailed and in-depth analysis of a process
Capability Chart	A chart used to assess the capability of a process to meet specifications based on the voice of the customer. The chart shows upper and/or lower specifications (that is, customer requirements or targets).	When the organization needs to determine whether a process will function as expected, according to specifications (requirements or targets) When the organization needs to determine how capable their process is for meeting customer specifications (requirements or target)

After data has been turned into information, leadership should ensure the following (in accordance with the requirements shown):[26–28]

- Information is presented in a clear manner (Standard LD.03.04.01)
- 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 resident. By engaging in proactive risk reduction, an assisted living community can correct process problems to reduce the likelihood of experiencing adverse events. Additional benefits of a proactive approach to resident 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

‡ 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

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 to residents).

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, lack of strategic risk assessment.

A number of tools are available to help organizations conduct a proactive risk assessment. One of the best known of these tools is the Failure Modes and Effects Analysis (FMEA). An FMEA is used to prospectively examine how failures could occur during high-risk processes and, ultimately, how to prevent them. The FMEA asks "What if?" to explore what could happen if a failure occurs at particular steps in a process.[30]

Other tools to consider using for a proactive risk assessment include the following:

Institute for Safe Medication Practices Medication Safety Self Assessment®. Available for various health care settings, these tools are designed to help reduce medication errors. Visit https://www.ismp.org/selfassessments/default.asp for more information.

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/tools/contingency-diagram for more information.

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 residents 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 residents.

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

Resident safety guides all decision making.

Residents and families are partners at every level of care.

Resident- and family-centered care is verifiable, rewarded, and celebrated.

Those caring for the resident must disclose any unauthenticated outcomes of care, treatment, or services.

Transparent communication when harm occurs. Although Joint Commission standards do not require apology, evidence suggests that residents benefit—and are less likely to pursue litigation—when care providers disclose harm, express sympathy, and apologize.[34]

Staffing levels are sufficient, and staff has the necessary tools and skills.

The assisted living community has a focus on measurement, learning, and improvement.

Staff must be fully engaged in resident- and family-centered care as

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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,

19. Institute for Safe Medication Practices. Unresolved disrespectful behavior

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.