Safety Systems for Individuals Served (SSIS)

Quality and Safety in Care, Treatment, or Services

The quality of care, treatment, or services and the safety of individuals served are core values of The Joint Commission accreditation process. This is a commitment The Joint Commission has made to individuals served, patients, and families, as well as staff and organization leaders.

The ultimate purpose of The Joint Commission's accreditation process is to enhance quality of care, treatment, or services and safety for individuals served. 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. Behavioral health care and human services organizations should have an integrated approach to safety so that safe care, treatment, or services can be provided for every individual in every setting.

Organizations depend on strong leadership to support an integrated safety system that includes the following:

- Safety culture
- Validated methods to improve processes and systems
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Safety of the individual emerges as a central aim of quality. Safety is what individuals served, patients, families, staff, 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 individuals served). Joint Commission–accredited organizations should be continually focused on eliminating system and process failures and human errors that may cause harm to individuals served, patients, families, and staff.

Goals of This Chapter

This "Safety Systems for Individuals Served" (SSIS) chapter provides accredited organizations with a proactive approach to designing or maintaining care, treatment, or services that aim to improve quality and safety for the individual, 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 deliver care, treatment, or services in a way that protects individuals served. Therefore, this chapter focuses on the following three guiding principles:

1. Aligning existing Joint Commission standards with daily work to engage individuals

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 organizations can develop into learning organizations
- Identify the role leaders have to establish a safety culture and ensure staff accountability
- Explain how organizations can continually evaluate the status and progress of their safety systems
- Describe how organizations can work to prevent or respond to safety events with proactive risk assessments
- Highlight the critical component of activation and engagement of individuals served in an integrated safety system
- Provide a framework to guide organization leaders as they work to improve safety for individuals in all settings

Becoming a Learning Organization

The need for sustainable improvement in the safety and quality of care, treatment, or services an individual receives 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 30Td(cosTj3[illegible]

Leaders, staff, and individuals served in a learning organization realize that *every* safety event (from close calls to events that cause major harm to individuals) must be reported and

A strong safety culture is an essential component of a successful safety system and is a crucial starting point for

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.)

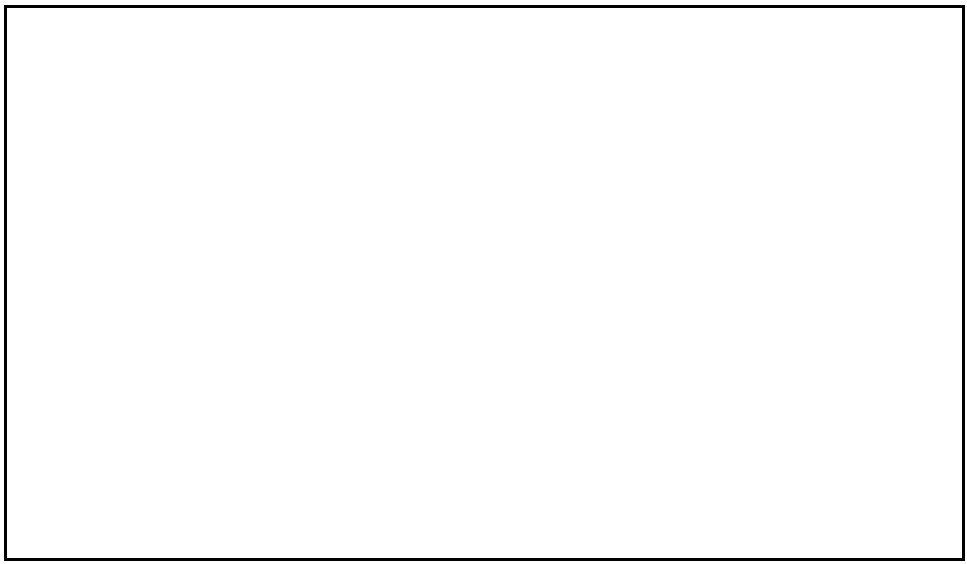


Figure 1. *The Trust-Report-Improve Cycle. In the trust-report-improve cycle, trust promotes reporting, which leads to improvement, which in turn fosters trust.*

Leaders and staff need to address intimidating or unprofessional behaviors within the organization, so as not to inhibit anyone inside the organization 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 by staff or leaders disrupt the culture of safety and prevent collaboration, communication, and teamwork, which is required for the safe and highly reliable care, treatment, or services of individuals served.[18] Disrespect is not limited to outbursts of anger that humiliate a member of the care team; it can manifest in many forms, including the following:[5,13,18]

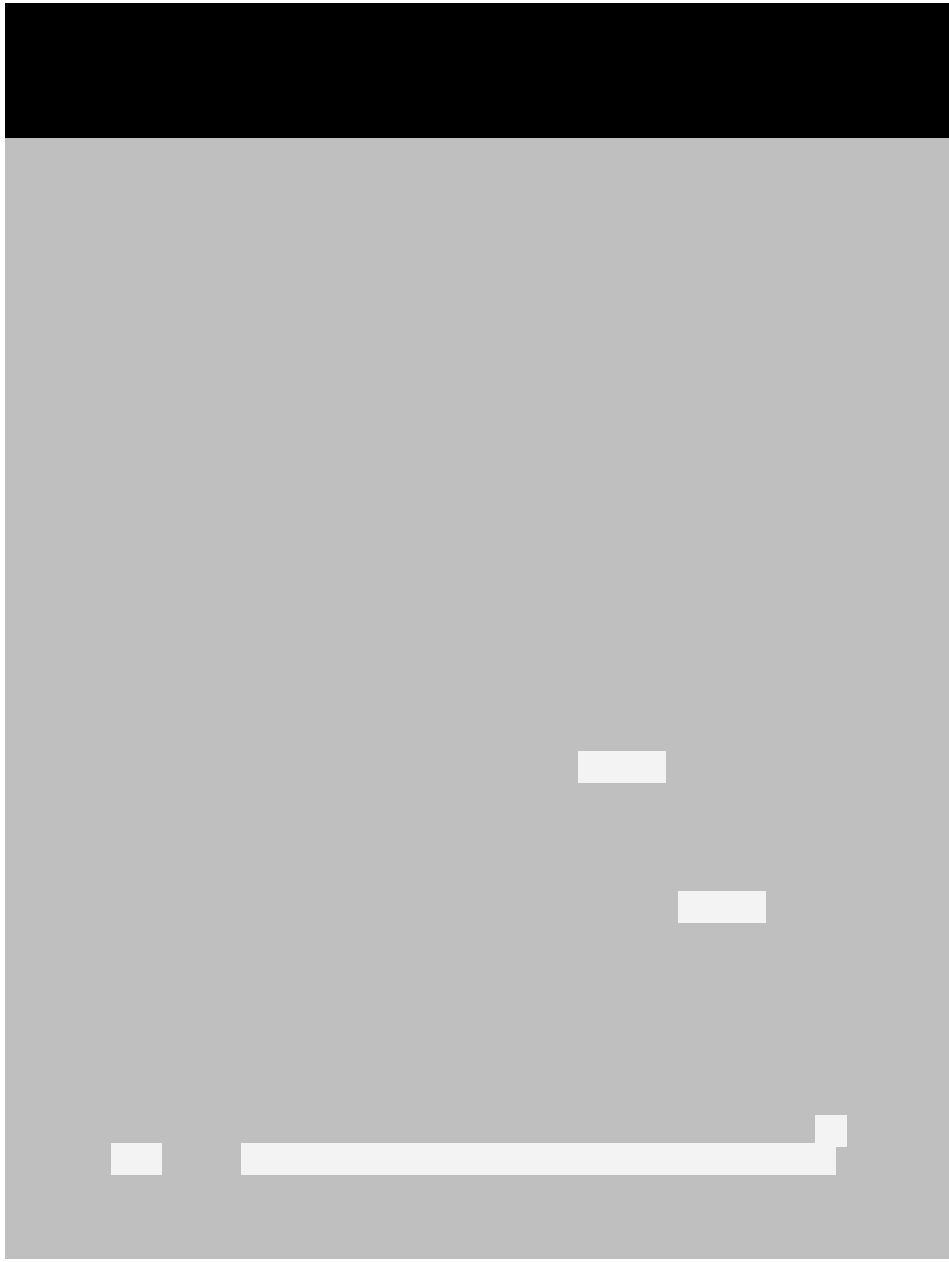
- Inappropriate words (profane, insulting, intimidating, demeaning, humiliating, or abusive language)

Shaming staff 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

A fair and just safety culture is needed for staff to trust that they can report safety events without being treated punitively.[3,9] In order to accomplish this, organizations should provide and encourage the use of a standardized reporting process for staff to report 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 individuals served are harmed, and reactive risk reduction attempts to prevent the recurrence of problems that have already caused harm to an individual served.[11,16]

A fair and just culture takes into account that people 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 people accountable for their actions but does not punish them 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 a person is accountable, that person 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 and just response to a safety event.) However, staff should never be punished or ostracized for *reporting* the event, close call, hazardous condition, or concern.



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Effective data analysis can enable an organization to better assess problems within its systems or organization similar to how providers assess the condition of an individual served based on behaviors, 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 organization to monitor the performance of a system, detect variation, and identify opportunities to improve. This can help the organization not only understand the current performance of organizationwide 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 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. Defining and Comparing Analytical Tools

Tool	What It Is	When to Use It
Run Chart	A data chart, plotted in time order, used to show the performance of a process over time. It shows both positive and negative patterns, trends, and variation in a process.	When the organization needs to identify changes and variation within a process When the organization needs a simple and straightforward analysis of a process As a precursor to an SPC chart
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

The Joint Commission addresses proactive risk assessments in the "Environment of Care" (EC) and "Leadership" (LD) chapters. Accredited organizations are required to proactively assess the risks to the safety of individuals served and to implement processes to mitigate those risks. Organizations working to become learning organizations are encouraged to exceed this requirement by constantly working to proactively identify risk.

When conducting a proactive risk assessment, organizations should prioritize

‡ 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.

Person- and family-centered care, treatment, or services is verifiable, rewarded, and celebrated.

The staff responsible for the care, treatment, or services of the individual served discloses to the individual, or the individual's designee, and the family any unanticipated outcomes of care, treatment, or services.

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

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

The organization has a focus on measurement, learning, and improvement.

Staff must be fully engaged in person- and family-centered care, treatment, or services as demonstrated by their skills, knowledge, and competence in compassionate communication.

Staff are educated on trauma-informed/recovery/resilience concepts/principles.

Organizations can adopt a number of strategies to support and improve the activation of individuals served, including promoting culture change, adopting transitional care, treatment, or services models, and leveraging health information technology capabilities.[33]

A number of Joint Commission standards address the rights of the individual served and provide an excellent starting point for organizations seeking to improve the activation of these individuals. These standards require that organizations do the following:

Respect, protect, and promote the rights of the individual (Standard RI.01.01.01)

Respect the right of the individual served to receive information in a manner the individual understands (Standard RI.01.01.03)

Respect the right of the individual to collaborate in decisions about their care, treatment, or services (Standard RI.01.02.01)

Honor the right of the individual to give or withhold informed consent (Standard RI.01.03.01)

Inform the individual about their responsibilities related to their care, treatment, or service (Standard RI.02.01.01)

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 individuals served and patients about processes and potential safety issues and encourage them to speak up whenever they have questions or concerns about their safety. For more information and education resources, go to http://www.jointcommission.org/speakup.

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