CAMHC

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.

Goals of This Chapter

This "Patient Safety Systems" (PS) chapter provides home 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 home care organizations to improve their ability 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 home 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 home care organizations 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 health care 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, we will do the following:

- Discuss how home care organizations can develop into learning organizations

Identify the role leaders have to establish a safety culture and ensure staff accountability
Explain how home care organizations can continually evaluate the status and progress of their patient safety systems
Describe how home care organizations can work to prevent patient/client 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 home care organization leaders as they work to improve patient safety in their organizations

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 home care organization 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 active engagement of home care organization leadership to support and nurture the just and safe culture.

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 home care organization 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 home care organization.[5-9] In a learning organization, the home care organization 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 Patient Safety

Organization leaders provide the foundation for an effective patient 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 patient 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 home care organization's patient safety system appear in the Joint Commission's Leadership (LD) standards98(Addressi(take)Tj19.110T50Td(()Tj(')Tj2.50Td(s)Tj0TTd(beha29.540TSTd((0.5Tf

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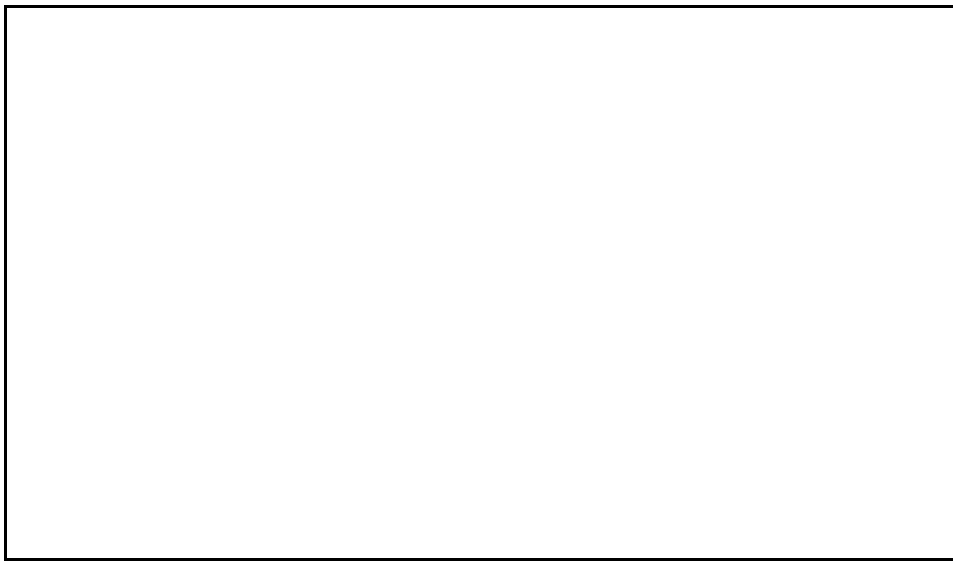
A strong safety culture is an essential component of a successful patient safety system and is a crucial starting point for home care organizations striving to become learning organizations. In a strong safety culture, the home care organization has an unrelenting commitment to safety and to do no harm.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

The safety culture of a home care organization is the product of individual and group beliefs, values, attitudes, perceptions, competencies, and patterns of behavior that determine the organization's commitment to quality and patient safety. Home care organizations 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, patients, 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 patient 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 patient safety events.[7] Staff know that their leaders will focus not on blaming those involved in errors but on the systems issues that contributed to or enabled the patient safety event.[7,15]
- By reporting and learning from patient safety events, staff create a learning organization.

A safety culture operates effectively when the home care organization fosters a cycle of trust, reporting, and improvement.[11,16] In home care organizations that have a strong safety culture, health care staff trust their coworkers and leaders to support them when they identify and report a patient safety event.[11] When trust is established, staff are more likely to report patient safety events, and home care organizations 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 home care organization to improve.[11] In turn, staff see that their reporting contributes to actual care



A fair and just safety culture is needed for staff to trust that they can report patient safety events without being treated punitively.[3,9] In order to accomplish this, home care organizations should provide and encourage the use of a standardized reporting process for staff to report patient 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/clients are harmed, and reactive risk reduction attempts to prevent the recurrence of problems that have already caused patient 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.03.09.01, 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, 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 organization 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 basic840Td(time9l)94)Tj11s090Td.Tj55.930Td(To)pp0Tdj16.268i28.6601)Tj42.21(leaders)Tj29

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Sidebar 2. Assessing Staff Accountability (continued)

Numerous sources (*see* references below) are available to assist an organization in creating a formal decision

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Sidebar 2. Assessing Staff Accountability (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

Data Use and Reporting Systems

An effective culture of safety is evidenced by a robust reporting system and use of measurement to improve. When home care organizations adopt a transparent, nonpunitive approach to reports of patient 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 safety events, it is but one type of data

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Analyzing data with tools such as run charts, statistical process control (SPC) charts, and capability charts helps a home care organization 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.

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	

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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.

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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Sidebar 3. (continued)

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 admissions. 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 home care organizations assess and enhance patient activation. Achieving this requires leadership engagement in the effort to establish patient-centered care as a top priority throughout the home care organization. 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, 8990Td(disclose)Tj33.35T

Home care organizations 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.[33]

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

Beyond Accreditation: The Joint Commission Is Your Patient Safety Partner

To assist home care organizations on their journey toward creating highly reliable patient safety systems, The Joint Commission provides many resources, including the following:

- Office of Quality and Patient Safety. An internal Joint Commission department that offers home care organizations guidance and support when an organization experiences a sentinel event or when (a)Tj6.790Tdr7E6Td(organ[.(organirs)Tj25.4705jETBTle)T

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 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, .430Td(incident,)Tj38.33hiETBT/Fd(more)T.join

Infection Prevention and Control
Suicide Prevention
Workplace Violence Prevention

References

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, 2010.
3. American Society for Quality. *Glossary and Tables for Statistical Quality Control*, 4th ed. Milwaukee: American Society for Quality Press, 2004.

14. Weick KE, Sutcliffe KM. Managing the Unexpected. 2nd ed. San Francisco: Jossey-Bass, 2007.
15. Reason J, Hobbs A. Managing Maintenance

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 health care. 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.