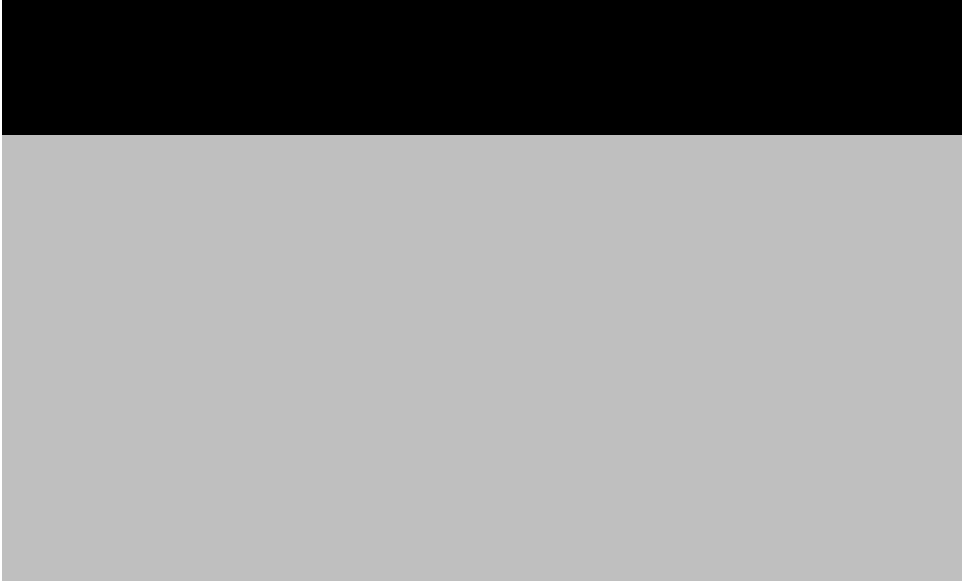CAMTEL,

zero harm (that is, reducing harm to patients and individuals). Joint Commission–

"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 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 safety events with proactive risk assessments

Highlight the critical component of patient activation and engagement in a safety system

Provide a framework to guide organization leaders as they work to improve safety in their organizations

Becoming a Learning Organization

The need for sustainable improvement in 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. Learning organizations uphold five principles:
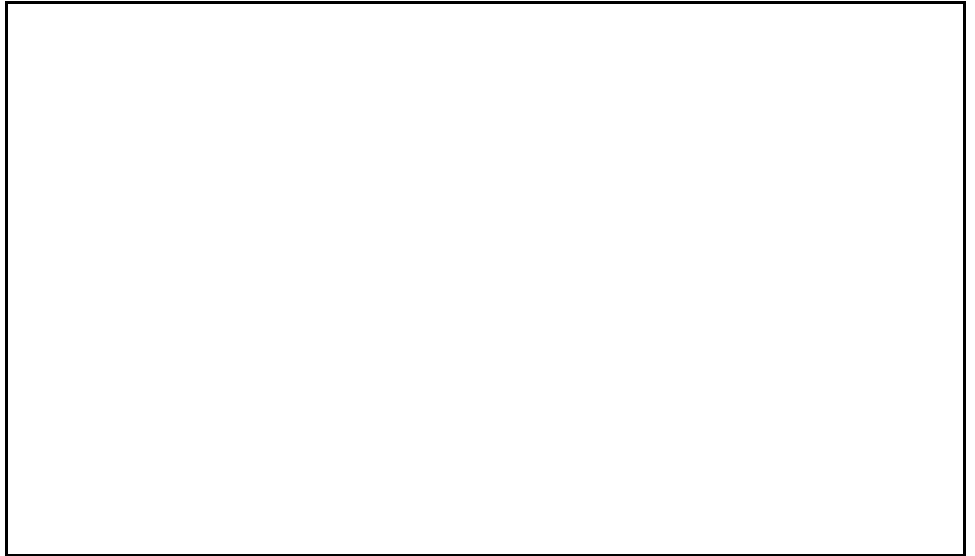
1. Team learning
2. Shared visions and goals
3. A shared mental model (that is, similar ways of thinking)
4. Individual commitment to lifelong learning
5. Systems thinking

In a learning organization, safety events are seen as opportunities for learning and improvement. Therefore, leaders in learning organizations adopt a transparent, nonpunitive approach to reporting so that the organization report to learn and can collectively learn from safety events. In order to become a learning organization, an 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 encouragement of organization leaders.

Safety Culture

A strong safety culture is an essential component of a successful safety system and is a crucial starting point for organizations 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 leaders is to establish and maintain a strong safety culture within their organization. The Joint Commission's standards address safety culture in Standard 01.01, which requires leaders to create and maintain a culture of safety and quality throughout the organization.

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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 responding to requests for assistance or information, not returning pages or calls promptly

These issues are still occurring in organizations nationwide. In a 2021 survey by the Institute for Saf

reduction attempts to prevent the recurrence of problems that have already caused 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.[17–20] 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, 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 of eliminating behaviors that undermine a culture of safety. There has to exist within the organization a clear, equitable, and transparent process for recognizing and separating the blameless errors that fallible humans make daily from the unsafe or reckless acts that are blameworthy.[1–10]

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 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]

References

Sidebar 2 (continued)

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/

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

When there is continuous reporting for adverse events, close calls, and hazardous conditions, the organization 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.[1-25]

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.

Organizations 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

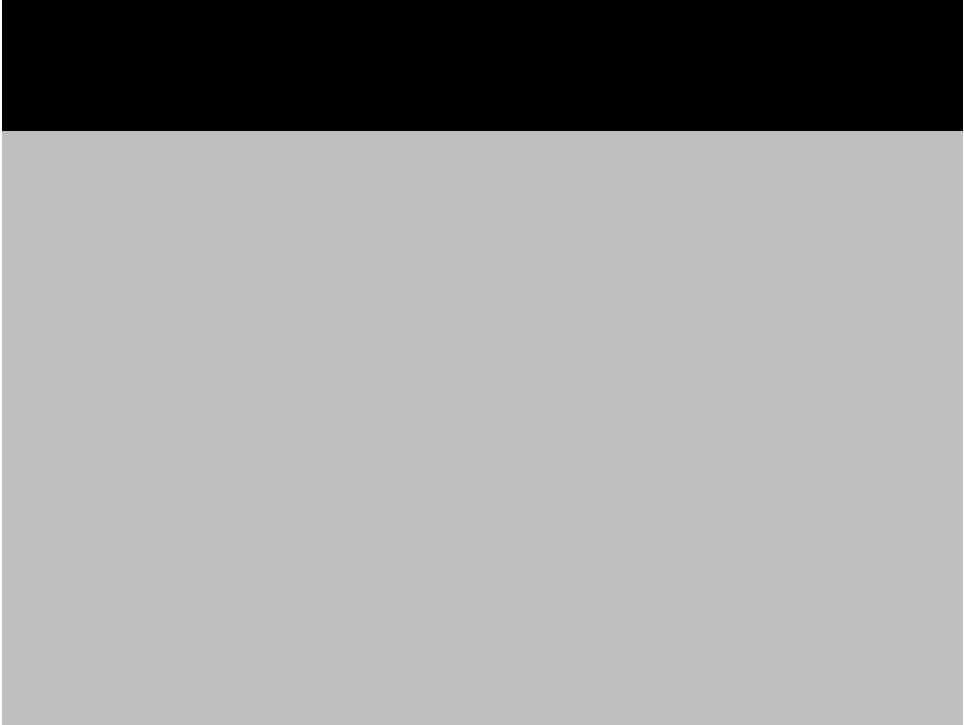Provide timely feedback regarding actions taken on reported safety events

Effective Use of Data

Collecting Data

When organizations collect data or measure staff compliance with evidence-based care processes or patient or individual outcomes, they can manage and improve those processes or outcomes and, ultimately, improve safety. The effective use of data enables organizations to identify problems, prioritize issues, develop solutions, and track performance to determine success.[63] 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.[23]

The Joint Commission requires organizations to collect and use data related to certain patient or individual care outcomes and harm events. Some key Joint Commission standards related to data collection and use require organizations to do the following:

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)

Have an organizationwide, integrated patient safety program (Standard LD.03.09.01)

Collect data to monitor their performance (Standard PI.01.01.01)

Improve performance on an ongoing basis (Standard PI.03.01.01)

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)

Using Data to Drive Improvement

After data has been turned into information, leadership should ensure the following the requirements shown[26,39]:

  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) (Standard LD.03.04.01)
  Opportunities for improvement and actions to be taken are communicated (Standard LD.03.05.01)
  Improvements are celebrated or recognized

A Proactive Approach to Preventing Harm

Proactive risk reduction prevents harm before it reaches the patient or individual ser By engaging in proactive risk reduction, an organization can correct process problem reduce the likelihood of experiencing adverse events. Additional benefits of a proact approach to the safety of patients and individuals served include increased likelihoo the following:

  Identification of actionable common causes
  Avoidance of unintended consequences
  Identification of commonalities across departments/services/units
  Identification of system solutions

In a proactive risk assessment, the organization 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, which recommends using the results of proactive risk assessments to improve safety. Organizations should recognize that this standard represents a minimum requirement. 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 high-risk, high-frequency areas. Areas of risk are identified from internal sources such as ongoing monitoring of the environment, results of previous proactive risk assessments, and results of data collection activities. Risk assessment tools should be accessed from credible external sources such as nationally recognized risk assessment tools and peer review literature.

Hazardous (or unsafe) conditions also provide an opportunity for an organization to take a proactive approach to reduce harm. Organizations benefit from identifying hazardous conditions while designing any new process that could impact patient safety. A hazardous condition is defined as any circumstance that increases the probability of a patient safety event. A hazardous condition may be the result of a human error or violation, may be a design flaw in a system or process, or may arise in a system or process in changing circumstances.[†] A proactive approach to such conditions should include an analysis of the systems and processes in which the hazardous condition is found, with a focus on the climate that preceded the hazardous condition.

A proactive approach to hazardous conditions should include an analysis of the related systems and processes, including the following aspects:

Preconditions. Examples include hazardous (or unsafe) conditions (such as noise, clutter, wet floors, loss of utilities/electricity, unstable Internet connection or inability to send and receive information, and so forth), inadequate staffing levels (inability to effectively monitor, observe, and provide care/treatment to patients or individuals served), and technological issues (loss of utilities/electricity, unstable Internet connection, poor cybersecurity).

[†] 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 healthcare. Am J Med Qual. 2014 May–Jun;29(3)181–190.

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 Participation of Patients or Individuals Served

To achieve the best outcomes, patients, individuals served, and families must be more actively engaged in decisions about their health care and must have broader access to information and support. Activation of the patient or individual served is inextricably intertwined with patient safety. Activated patients or individuals are less likely to experience harm and unnecessary organization readmissions. Patients or individuals who are less activated suffer poorer health outcomes and are less likely to follow their provider's advice.[30,32]

An approach to care, treatment, and services centered on the patient or individual served can help organizations assess and enhance the activation of the patient or individual. Achieving this requires leadership engagement in the effort to establish person-centered care as a top priority throughout the organization. This includes adopting the following principles when applicable[51]:

Safety guides all decision making.

Patients, individuals served, and families are partners at every level of care.

Patient- or individual- and family-centered care is verifiable, rewarded, and celebrated.

The licensed practitioner responsible for the care of the patient or individual, or the licensed practitioner's designee, discloses to the patient, individual served, 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 and individuals benefit—and are less likely to pursue litigation—when physicians disclose harm, express sympathy, and apologize.[29]

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 as demonstrated by their skills, knowledge, and competence in compassionate communication.

Organizations can adopt a number of strategies to support and improve patient or individual activation, including promoting culture change, adopting transitional care models, and leveraging health information technology capabilities.[30]

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

Respect, protect, and promote the rights of patients and individuals served (Standard RI.01.01.01)

Respect the right of the patient or individual served to receive information in a manner they understand (Standard RI.01.01.03)

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

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

Inform the patient or individual served 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 organizations on their journey toward creating highly reliable patient safety systems, The Joint Commission provides many resources, including the following:

Webinars and podcasts: The Joint Commission and its affiliate, Joint Commission Resources, offer free and fee-based webinars and podcasts on various accreditation and patient safety topics.

Speak Up™ program: The Joint Commission's campaign to educate patients 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 patient safety 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
> 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.

4. Senge PM. The Fifth Discipline: The Art and Practice of the Learning Organization, 2nd ed. New York: Doubleday, 2006.

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, 2008.

8. Fei K, Vlasses FR. Creating a safety culture through the application of reliability science. J Healthc Qual. 2008 Nov–Dec;30(6):37–43.

9. Massachusetts Coalition of the Prevention of Medical Errors: When Things Go Wrong: Responding to Adverse Events. Mar 2006. Accessed Jan 10, 2024. http://www.macoalition.org/documents/respondingToAdverseEvents.pdf
10. The Joint Commission The Joint Commission Leadership Standards. Oak Brook, IL: Joint Commission Resources, 2009.
11. Chassin MR, Loeb JM. High-reliability healthcare: Getting there from here. Milbank Q. 2013 Sep;91(3):459–490.
12.

23. The Joint Commission. The essential role of leadership in developing a safety culture.Sentinel Event Alert. Mar 1, 2017. Accessed Jan 11, 2024. https://www.jointcommission.org/-/media/tjc/documents/resources/patient-safety-topics/sen