The Joint Commission

Spotlight on Success

Monarch

Joint Commission standards improve safety outcomes for Monarch North Carolina.

Monarch North Carolina, a statewide mental health and human services agency, transitioned one of its clinics to a Certified Community Behavioral Health Clinic model of care in 2018. The clinic simultaneously partnered with The Joint Commission to improve safety outcomes and care quality.

Created in response to increased community needs for new models of care, Certified Community Behavioral Health Clinics (CCBHCs) ensure access to coordinated comprehensive behavioral health care. The CCBHC model can optimize an organization's scope of services, staffing policies and care coordination activities. Together, those standards raise the bar for the delivery of community-based services.

Monarch North Carolina, a statewide mental health and human services agency, serves over 28,000 people with intellectual and developmental disabilities and supports mental illness and substance abuse. The organization transitioned its Stanly County clinic to the CCBHC model and found great success in community-wide outcomes.

Along with adding programs to achieve CCBHC certification, the Monarch team partnered with The Joint Commission to improve safety outcomes, transform risk management and improve care quality.

Dr. Peggy Terhune, Chief Executive Officer for Monarch North Carolina, and Monique Lucas, Monarch's former Vice President of Integrated Care, shared about the process and results of implementing these changes. Read on to learn how The Joint Commission's standards allowed a newly formed CCBHC to rapidly develop best practices.

The 11 Tenets of Safety Culture

The Joint Commission defines safety culture as, "a sum of what an organization is and does in the pursuit of safety.

To support health care organizations in implementing a safety culture, The Joint Commission has developed these 11 key tenets within its safety culture framework:

1. Apply a transparent, non-punitive approach to reporting and learning from adverse events, close calls and unsafe conditions.
2. Use clear, just and transparent risk-based processes for recognizing and distinguishing human errors and system errors from unsafe, blameworthy actions.
3. CEOs and all leaders adopt and model appropriate behaviors and champion efforts to eradicate intimidating behaviors.
4. Policies support safety culture and reporting of adverse events, close calls and unsafe conditions. These policies are enforced and communicated to all team members.
5. Recognize care team members who report adverse events and close calls, who identify unsafe conditions or who have good suggestions for safety improvements. Share these "free lessons" with all team members (i.e., feedback loop).
6. Determine an organizational baseline measure on safety culture performance using a validated tool
7. Analyze safety culture results from across the organization to find opportunities for quality and safety improvement.
8. Use information from safety assessments and/or surveys to develop and implement unit-based quality and safety improvement initiatives designed to improve the culture of safety.
9. Embed safety culture team training into quality improvement projects and organizational processes to strengthen safety systems.
10. Proactively assess system strengths and vulnerabilities, and prioritize them for enhancement or improvement.
11. Repeat organizational assessment of safety culture every 18 to 24 months to review progress and sustain improvement.

When Monarch North Carolina assessed their current practices within the framework of these 11 tenets, they were able to pinpoint previously unidentified opportunities to improve patient care.

The Science of Safety

When analyzing a failure or breach of protocol, the primary point to understand is that humans have known limitations — they are not perfect. The Joint Commission divides safety errors into three different categories:

1. **Skill-Based Errors:** This refers to attention and memory failures, including omitted tasks.
2. **Rule-Based Errors:** These are misinterpretations or misuses of relevant data, or applying the wrong rule.
3. **Knowledge-Based Errors:** This type of error occurs due to a lack of knowledge or experience with a particular process or situation.

Each of these three types of errors requires different solutions within an organization-wide safety culture. Thus, Monarch's first step when assessing any breach in protocol is to correctly identify how and why the error occurred.

A New Framework for Understanding Safety Culture

The Joint Commission views errors from a systems perspective. This approach assumes that humans are fallible, and it expects errors - as a result, organizations must take steps to address the latent failures that often lead to human error.

Monarch North Carolina uses a number of tools to improve safety culture:

- **Safety Culture Improvement Survey:** This survey offered the Monarch North Carolina team a detailed, verifiable way to gauge what they were doing well, what they weren't doing well and how they could improve.
- **Accountability Decision Tree:** This tool helped the Monarch North Carolina team to determine appropriate next steps when errors occurred. They used their accountability decision tree to take the guesswork out of improving safety culture and to standardize protocols in response to breaches.
- **Hot Topics Newsletter:** Monarch North Carolina implemented a monthly newsletter devoted to safety culture and distributed it to staff.
- **DSP Celebration Week:** Safety culture isn't only about correcting errors and minimizing issues — it's also about highlighting positive metrics. To that end, Monarch North Carolina instituted data-driven appreciation events, like Direct Support Professional's Celebration Week.

Near Misses and the SAFER Matrix

It is just as important to analyze a close call as it is to assess a verified incident. Monarch North Carolina worked with The Joint Commission to identify and address these "near misses" in an effort to achieve greater reduction of adverse outcomes.

In one instance, a therapist identified that a patient was suffering from suicidal ideation. The therapist wanted to make sure that the patient's provider was aware of this occurrence, so the therapist emailed the provider, which was a breach of protocol.

Thankfully, this particular patient did not attempt to hurt themselves. But, by recognizing this near miss, Monarch North Carolina was able to retrain therapists on the appropriate ways to notify a provider of suicidal ideation. **Proactively addressing close calls may minimize an organization's risk of adverse outcomes in the future.**

Monarch North Carolina then sorts near misses into the SAFER matrix. **This matrix identifies the situation's threat level as "high," "moderate" or "low" and classifies the scope of the error as "widespread," "pattern" or "limited."**

The most threatening incidents are classified as "high" and "widespread," and the least threatening occurrences are "low" and "limited." The SAFER matrix is a useful tool when determining how to prioritize errors and systemic failures — and how to begin to correct them.

Using the Tracer Methodology to inform improved practices

Tracer Methodology allows quality management staff to follow a specific patient's journey through the healthcare system, in order to track quality issues, safety issues and efficacy of policies and procedures.

Tracer Methodology empowered Monarch North Carolina to identify deficiencies in care and address them in a timely manner. Tracer Methodology checks performance against both Joint Commission standards as well organizational quality standards.

Continual Readiness

Monarch North Carolina also collaborated with The Joint Commission to implement continual readiness measures, including:

- Developing a Continual Readiness Team
- Regularly publishing informational newsletters for staff
- Conducting tracer updates and support.
- Engaging in "microlearnings," which communicated useful information to the team in just a few minutes

These measures improved Monarch North Carolina's reliability, minimized adverse outcomes and allowed the organization to achieve and maintain a high level of patient care.

Partnering With The Joint Commission

Partnering with The Joint Commission in conjunction with a move to the CCBHC model helped Monarch North Carolina to improve safety outcomes, transform risk management and improve care quality.

Doing so allowed the organization to identify specific areas for improvement and make changes in service of a more holistic safety culture. In turn, these changes led to the best results a health care organization could hope to achieve: improved care quality and patient outcomes.

Learn more about the difference The Joint Commission made for Monarch's move to the CCBHC model, or contact usto take the first step on your journey to transforming patient care quality and safety for your CCBHC clinic.

Explore CCBHC-specific standards, available only with Joint Commission accreditation. Visit us at **Jointcommission.org/ccbhc**