

Patient Safety

- As part of its mission, The Joint Commission is committed to improving health care safety for the public
- The Joint Commission demonstrates its commitment to patient safety through numerous efforts

Standards: A majority of Joint Commission standards are related to safety, addressing medication use, infection control, surgery and anesthesia, transfusions, restraint and seclusion, staff competence, fire safety, medical equipment, emergency management, and security. The manuals include a [Patient Safety Systems chapter](#) that describes how leaders can use existing requirements to achieve improved quality of care and patient safety, and the importance of an integrated patient-centered system to achieve these goals.

Sentinel Event Policy: Implemented in 1996, The Joint Commission's [Sentinel Event Policy](#) was revised in 2014 to incorporate contemporary patient safety concepts and clarify Joint Commission processes. Any time a sentinel event occurs, the health care organization is expected to conduct thorough and credible comprehensive systematic analyses (for example, root cause analyses), make improvements to reduce risk, and monitor the effectiveness of those improvements. The analyses are expected to drill down to underlying organization systems and processes that can be altered to reduce the likelihood of a failure in the future and to protect patients from harm when a failure does occur. Accredited organizations are strongly encouraged, but not required, to [report sentinel events](#) to The Joint Commission's Office of Quality and Patient Safety.

Complimentary publications: The Joint Commission publishes two complimentary publications that address safety issues: [Sentinel Event Alert](#) identifies specific patient safety problems, describes their common underlying causes, and suggests steps to reduce risk or prevent future occurrences; and [Quick Safety](#) helps Joint Commission accredited organizations recognize potential safety issues.

Patient safety events: The Joint Commission receives reports of patient safety events from patients, families, government agencies, the public, staff employed by organizations, and the media. This information is used to help improve the quality and safety of accredited and certified organizations. Patient safety events can be reported [online](#), by fax 630-792-5636, or mail: The Office of Quality and Patient Safety, The Joint Commission, One Renaissance Blvd., Oakbrook Terrace, Illinois, 60181.

Patient safety research: The Joint Commission's Department of [Research](#) works with external collaborators to investigate and evaluate interventions related to patient safety. Current initiatives include work with the Pew Charitable Trust and Centers for Disease Control and Prevention (CDC) to improve on the implementation of antibiotic stewardship and work with Occupational Safety and Health Administration (OSHA) to explore the relationship between health care workplace violence and worker/patient safety.

The Joint Commission FACT SHEET

Read more

- [National Patient Safety Goals](#)
- [Universal Protocol for Preventing Wrong Site, Wrong Procedure and Wrong Patient Surgery™](#)
- [Patient Safety Advisory Group](#)
- [Speak Up™](#) patient safety program
- [Public information](#)
- [Joint Commission Resources](#) (education, publications, consulting)

Legislative efforts: The Joint Commission monitors legislative initiatives at the state and federal levels, and advocates for passage of measures leading to improved patient safety. On the state level, The Joint Commission works with state regulatory and patient safety authorities to reduce duplicative expectations for accredited organizations subject to voluntary or mandatory reporting requirements; and engages state regulatory agencies to advocate for the reliance on accreditation in lieu of routine state licensure inspections. Federal legislative and regulatory priorities include modernizing standards and processes to enhance quality and patient safety.

Patient safety collaborations: The Joint Commission and JCR collaborate with a number of organizations to promote patient safety.

- National Patient Safety Collaborative, established in January 2018, is a voluntary collaborative of prominent, national patient safety organizations that works collectively on mutually identified safety concerns. Member organizations are: Association for the Advancement of Medical Instrumentation; ECRI Institute; Institute for Safe Medication Practices; Institute for Healthcare Improvement; and The Joint Commission.
- [National Coordinating Council on Medication Error Reporting & Prevention \(NCC-MERP\)](#) is a coalition of member organizations that develop principles for constructing patient safety reporting programs.
- [National Quality Forum](#) works to create consensus around nationally agreed-upon measures for quality and safety.
- [Consumers Advancing Patient Safety](#) is a national consumer-led organization formed to be a collective voice for individuals, families and healers who suffer harm in health care encounters.
- [Association for the Advancement of Medical Instrumentation Foundation](#) works toward the development, management, and use of safe and effective healthcare technology.