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
- Standardized ways to communicate and collaborate within or outside of the organization
- Safely integrated technologies

In an integrated safety system, staff and leaders work together to eliminate complacency, promote collective mindfulness, treat each other with respect and compassion, and learn from safety events, including close calls and other system failures that have not yet led to the harm of an individual. Sidebar 1 defines these and other key terms.

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Sidebar 1. Key Terms

- **patient safety event**[*]   An event, incident, or condition that could have resulted or did result in harm to a patient.
- **adverse event** A patient safety event that resulted in harm to a patient. Adverse events should prompt notification of organization leaders, investigation, and corrective actions. An adverse event may or may not result from an error.
- **sentinel event**[†]   A sentinel event is a patient safety event (not primarily related to the natural course of the patient's illness or underlying condition) that reaches a patient and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm). Sentinel events are a subcategory of adverse events.
- **close call** A patient safety event that did not cause harm but posed a risk of harm. Also called *near miss* or *good catch*.
- **hazardous condition** A circumstance (other than a patient's own disease process or condition) that increases the probability of an adverse event. Also called *unsafe condition*.

Quality and safety in the delivery of care, treatment, or services are inextricably linked. *Quality*, as defined by the Institute of Medicine, is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.[1] It is achieved when processes and results meet or exceed the needs and desires of the people it serves.[2,3] Those needs and desires include safety.

To ensure quality and safety, components of the management system should include the following:
- Ensuring reliable processes
- Decreasing variation and defects (waste)
- Focusing on achieving positive measurable outcomes
- Using evidence to ensure that care, treatment, or services are satisfactory

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[*]In the term *patient safety event,* the word "patient" corresponds to "individual served" in the behavioral health care and human services settings.
[†]For a list of specific patient safety events that are also considered sentinel events, *see* the "Sentinel Event Policy" (SE) chapter in E-dition® or the *Comprehensive Accreditation Manual.*

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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 served and staff throughout the system, at all times, on reducing harm.
2. Assisting organizations to become learning organizations by advancing knowledge, skills, and competence of staff and individuals served by recommending methods that will improve quality and safety processes.
3. Encouraging and recommending proactive quality and safety methods that will increase accountability, trust, and knowledge while reducing the impact of fear and blame.

It informs and educates accredited organizations about the importance and structure of an integrated safety system for the individuals they serve and helps staff understand the relationship between Joint Commission accreditation and the safety of individuals served. It offers approaches and methods that may be adapted by any organization that aims to increase the reliability and transparency of its complex systems while removing the risk of harm to individuals served.

The SSIS chapter refers to specific Joint Commission standards, describing how existing requirements can be applied to improve the safety of individuals served. 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

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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 to lifelong learning
5. Systems thinking[4]

In a learning organization, 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 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 an organization's leaders.

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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 investigated.[5-9] It is impossible to determine if there are practical prevention or mitigation countermeasures available for a 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 events that have caused or could have caused harm are continuously reported, experts within the 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 organization.[5-9] In a learning organization, the 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 Safety

Leaders provide the foundation for an effective safety system for the individual served 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 harm to individuals 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 organization's safety system appear in the Joint Commission's Leadership (LD) standards, including Standard **LD.03.01.01** (which focuses on having a culture of safety).

Without the support of leaders, organizationwide changes and improvement initiatives are difficult to achieve. Leadership engagement in safety and quality initiatives for individuals is imperative because 75% to 80% of all initiatives that require people to change their behaviors fail in the absence of leadership managing the change.[5] Thus, leadership should take on a long-term commitment to transform their organization.[11]

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 **LD.03.01.01**, which requires leaders to create and maintain a culture of safety and quality throughout their organization.

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

A safety culture operates effectively when the organization fosters a cycle of trust, reporting, and improvement.[11,16] In organizations that have a strong safety culture, staff trust their coworkers and leaders to support them when they identify and report a safety event.[11] When trust is established, staff are more likely to report safety events, and organizations can use these reports to inform their improvement efforts. In the trust-

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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.)
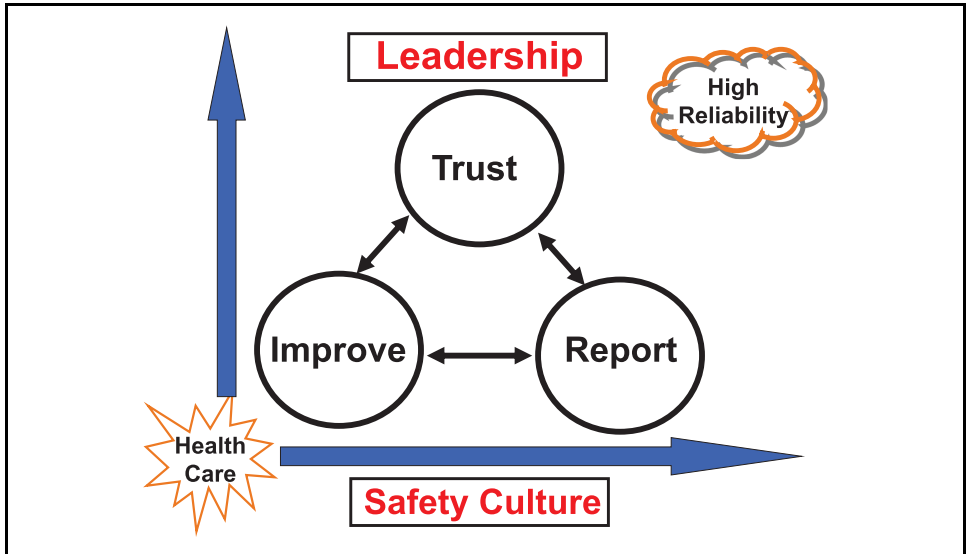

Figure 1. *The Trust-Report-Improve Cycle. In the trust-report-improve cycle, trust promotes reporting, which leads to improvement, which in turn fosters trust.*

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

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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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 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]

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Sidebar 2. *(continued)*

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Data Use and Reporting Systems

An effective culture of safety is evidenced by a robust reporting system and use of measurement to improve. When accredited organizations adopt a transparent, nonpunitive approach to reports of 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 safety events, it is but one type of data among many that should be collected and used to drive improvement.

When there is continuous reporting for adverse events, close calls, and hazardous conditions, organizations 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.[21–25]

A number of standards relate to the reporting of safety information, including Performance Improvement (PI) Standard **PI.01.01.01**, which requires accredited organizations to collect data to monitor their performance, and Standard **LD.03.02.01**, which requires accredited 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:

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- 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 outcomes for individuals served, they can manage and improve those processes or outcomes and, ultimately, improve safety for individuals. The effective use of data enables organizations to identify problems, prioritize issues, develop solutions, and track performance to determine success.[10] Objective data can be used to support decisions as well as to influence people to change their behaviors and to encourage compliance with evidence-based care guidelines.[10,23]

The Joint Commission requires accredited organizations to collect and use data related to outcomes from care, treatment, or services provided to the individuals served, including any sustained harm. Some key Joint Commission standards related to data collection and use require organizations to do the following:

- Collect information to monitor conditions in the environment (Standard **EC.04.01.01**)
- Identify risks for acquiring and spreading infections (Standard **IC.01.03.01**)
- 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 safety program within any performance improvement activities (Standard **LD.03.09.01**)
- If applicable, evaluate the effectiveness of the medication management system (Standard **MM.08.01.01**)
- Document the use of restraint and seclusion or from physical holding of a child/youth (Standard **RC.02.01.05**)
- Use measurement-based care to track progress in care, treatment, or services (Standard **CTS.03.01.09**)
- Collect data to monitor performance (Standard **PI.01.01.01**)
- Improve performance on an ongoing basis (Standard **PI.03.01.01**)

Analyzing Data

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

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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 (in accordance with the requirements shown):[26-28]

- Information is presented in a clear manner (Standard **LD.03.04.01**)
- Information is shared with the appropriate groups throughout the organization (from the staff to governance) (Standards **LD.03.04.01**, **LD.03.09.01**)
- Opportunities for improvement and actions to be taken are communicated (Standards **LD.03.05.01**, **LD.03.07.01**)
- Improvements are celebrated or recognized

A Proactive Approach to Preventing Harm

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

- Identification of actionable common causes
- Avoidance of unintended consequences
- Identification of commonalities across programs/services
- Identification of system solutions
- Sufficient staff
- Completion of environmental risk assessment
- Identification of individuals who may be harmful to themselves or others

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 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 high-risk, high-volume 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 the safety of an individual. A *hazardous condition* is defined as any circumstance that increases the probability of a 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:[29]

- **Preconditions.** Examples include hazardous (or unsafe) conditions in the environment of care (such as noise, clutter, wet floors, and so forth), inadequate staffing levels (inability to effectively monitor, observe, and provide care, treatment, or services to individuals served).

[‡]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.

- **Supervisory influences.** Examples include inadequate supervision, unsafe operations, failure to address a known problem, authorization of activities that are known to be hazardous.
- **Organization influences.** Examples include inadequate staffing, organization culture, lack of strategic risk assessment.

Tools for Conducting a Proactive Risk Assessment

A number of tools are available to help organizations conduct a proactive risk assessment. One of the best known of these tools is the Failure Modes and Effects Analysis (FMEA). An FMEA is used to prospectively examine how failures could occur during high-risk processes and, ultimately, how to prevent them. The FMEA asks "What if?" to explore what could happen if a failure occurs at particular steps in a process.[30]

Other tools to consider using for a proactive risk assessment include the following:
- Institute for Safe Medication Practices Medication Safety Self Assessment®. Available for various health care settings, these tools are designed to help reduce medication errors. Visit https://www.ismp.org/selfassessments/default.asp for more information.
- 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 individuals 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 individuals.
- Test and implement the newly designed or redesigned process.
- Monitor the effectiveness of the newly designed or redesigned process.

Encouraging Participation of Individuals Served

To achieve the best outcomes, individuals served and families must be actively engaged in decisions about their care, treatment, or services and must have broader access to information and support. This also supports trauma-informed and recovery/resilience concepts/principles. Activation of the individual served is inextricably intertwined with the safety of the individual. Individuals who are less activated suffer poorer outcomes and are less likely to follow their provider's advice.[31,32]

An approach to care, treatment, or services that is centered on the individual served can help organizations assess and enhance the activation of the 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:[33]

- Safety for the individual guides all decision making.
- Individuals served and families are partners at every level of care, treatment, or services.

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- 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**)

Beyond Accreditation: The Joint Commission Is Your Safety Partner

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

■ *Office of Quality and Patient Safety*: An internal Joint Commission department that offers organizations guidance and support when an organization experiences a sentinel event or when a safety event is reported that may require analysis or improvement work. The Office of Quality and Patient Safety assesses the thoroughness and credibility of an organization's comprehensive systematic analysis as well as the action plan to help the organization prevent the hazardous or unsafe conditions from occurring again. (*See* the "Sentinel Event Policy" [SE] chapter for more information.)

■ *Standards Interpretation Group*: An internal Joint Commission department that helps organizations with their questions about Joint Commission standards. First, organizations can see if other organizations have had similar questions by accessing the Standards FAQs at https://www.jointcommission.org/standards/standard-faqs/. If an answer cannot be found in the FAQs, organizations can submit questions about standards to the Standards Interpretation Group by clicking a link to complete an online submission form.

■ *National Patient Safety Goals*: The Joint Commission gathers information about emerging 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 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 care, treatment, or services that could compromise the safety of an individual served. (For more information, visit https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/quick-safety/.)

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- *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.
- *Joint Commission 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
  - ❏ Infection Prevention and Control
  - ❏ Suicide Prevention
  - ❏ Workplace Violence Prevention

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