Patient Safety Systems chapter: A must-read

Note from Ronald M. Wyatt, MD, MHA, patient safety officer and medical director, Division of Healthcare Improvement: In recognition of Patient Safety Awareness Week, March 13-19, 2016, The Joint Commission reminds health care providers about the valuable information in the Patient Safety Systems chapter of the hospital accreditation manual. The chapter was included for the first time in the 2015 manual. This article highlights sections of the chapter, as well as helpful resources, indicated with a star (★).

Overview:
The purpose of the Patient Safety Systems (PS) chapter is to inform and educate leaders about the importance and structure of an integrated patient-centered system that aims to improve quality of care and patient safety. There are no new requirements in the PS chapter; the standards are culled from existing chapters. The standards highlighted in the PS chapter are intended to assist leaders in creating a culture of safety that fosters an environment where care teams and leaders work together to eliminate complacency, promote collective mindfulness, treat one another with respect and learn from patient safety events. The chapter is oriented to leadership, because leader engagement is imperative to the trust-report-improve cycle of establishing a safety culture.1

The PS chapter, available online for everyone, has three guiding principles:
- Aligning existing Joint Commission standards with daily work in order to engage patients and care teams throughout the health care system, at all times, on reducing the risk for patient harm.
- Assisting health care organizations with advancing knowledge, skills and competence of care team members and encouraging patient activation by recommending methods that will improve quality and safety processes.
- Encouraging and recommending proactive methods and models of quality and patient safety that will increase accountability, trust and knowledge while reducing the impact of fear and blame.

Issue:
Patient safety emerges as a central aim of quality. Patient safety, as defined by the World Health Organization, is the prevention of errors and adverse effects to patients that are associated with health care. High quality, safe care is what patients, families, care teams, and the public expect from Joint Commission-accredited organizations. While patient safety events may not be completely eliminated, harm to patients can be reduced, and the goal is always zero harm.

Highlights of the Patient Safety Systems chapter

Becoming a learning organization: A learning organization is one in which people learn continuously, thereby enhancing their capabilities to create and innovate.2 Learning organizations uphold five principles: team learning, shared visions and goals, a shared mental model (that is, similar ways of thinking), individual commitment to lifelong learning, and systems thinking.2

The role of hospital leaders in patient safety: Leadership engagement in patient safety and quality initiatives is imperative because 75 to 85 percent of all initiatives that require people to change their behaviors fail in the absence of leadership managing the change.3 Hospital leaders provide the foundation for an effective patient safety system by:4
- Promoting learning

(Cont.)
• Motivating care teams to uphold a fair and just safety culture
• Providing a transparent environment in which quality measures and patient harms are freely shared with care teams
• Modeling professional behavior
• Removing intimidating behavior that might prevent safe behaviors
• Providing the resources and training necessary to take on improvement initiatives

Safety culture: Organizations will have varying levels of safety culture, but all should be working toward a safety culture that has the following qualities:
• Care teams and leaders that value transparency, accountability and mutual respect.
• Safety as everyone’s first priority.
• Behaviors that undermine a culture of safety are not acceptable, and thus should be reported to organizational leadership by care team members, patients and families for the purpose of fostering risk reduction.
• Collective mindfulness is present, wherein care teams realize that systems always have the potential to fail, and care teams are focused on finding hazardous conditions or close calls at early stages before a patient may be harmed. The care team does 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.
• Care team members 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. The care team knows that their leaders will focus not on blaming providers involved in errors but on the systems issues that contributed to or enabled the patient safety event.
• By reporting and learning from patient safety events, care team members create a learning organization.

A fair and just safety culture: A fair and just safety culture is needed for care teams to trust that they can report patient safety events without being treated punitively. 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. 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. However, care team members should never be punished or ostracized for reporting the event, close call, hazardous condition, or concern.

In the PS chapter, see sidebar on Page PS-9, “Assessing staff accountability.”

Data use and reporting systems: An effective culture of safety is evidenced by a robust reporting system and use of measurement to improve. When there is continuous reporting for adverse events, close calls, and hazardous conditions, the organization can analyze the patient safety events, change the process or system to improve safety, and disseminate the change or lessons learned to the rest of the organization. Organizations can engage frontline care team members in internal reporting in a number of ways, including:
• Create a nonpunitive approach to patient safety event reporting.
• Educate care team members on identifying patient safety events that should be reported.
• Provide timely feedback regarding actions taken on patient safety events.

Effective use of data: The effective use of data enables organizations to identify problems, prioritize issues, develop solutions, and track to determine success. Objective data can be used to support decisions, influence people to change their behaviors and to comply with evidence-based care guidelines. 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 understand the current performance of its systems and help predict its performance moving forward. 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. After data has been turned into information, leadership should ensure the following:18-20

- Information is presented in a clear manner
- Information is shared with the appropriate groups throughout the organization (from the frontline care teams to the board)
- Opportunities for improvement and actions to be taken are clearly articulated
- Leadership provides care teams with time, resources and opportunities for participating in improvement efforts as part of daily work
- Improvements are celebrated or recognized

★ See Table 1 on Page PS-13 in the PS chapter for examples of analytical tools

**A proactive approach to preventing harm:** Proactive risk reduction prevents harm before it reaches the patient. By engaging in proactive risk reduction, an organization can correct process problems in order to reduce the likelihood of experiencing adverse events. 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. A proactive approach to hazardous conditions should include an analysis of the related systems and processes, including preconditions, supervisory influences and organizational influences.21

★ Examples of preconditions, supervisory influences and organizational influences are on Page PS-15 of the PS chapter, “Strategies for an effective risk assessment” are described in the sidebar on Page PS-15, and Page PS-16 includes a section about “Tools for conducting a proactive risk assessment.”

**Encouraging patient activation:** Patient activation is inextricably intertwined with patient safety. Activated patients are less likely to experience harm and unnecessary hospital readmissions. Patients who are less activated suffer poorer health outcomes and are less likely to follow their provider’s advice.22,23 A patient-centered approach to care can help 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 organization. This includes adopting the following principles:24

- 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 licensed independent practitioner responsible for the patient’s care, or his or her designee, discloses to the patient and family any unanticipated outcomes of care, treatment and services.
- Though Joint Commission standards do not require apology, evidence suggests that patients benefit — and are less likely to pursue litigation — when physicians disclose harm, express sympathy and apologize.
- Staffing levels are sufficient, and care teams have the necessary tools and skills.
- The organization has a focus on measurement, learning and improvement.
- Care team members and licensed independent practitioners must be fully engaged in patient- and family-centered care, as demonstrated by their skills, knowledge and competence in compassionate communication.

**Beyond accreditation: The Joint Commission is your patient safety partner:** To assist hospitals on their journey toward creating highly reliable patient safety systems, The Joint Commission provides many resources.

★ See Page PS-18 through PS-20 for the complete list of resources.

**Safety Actions to Consider:**

- Read the PS chapter of the hospital accreditation manual. Other health care settings may benefit from applying the PS strategies provided in the chapter.
- Apply the principles and follow the standards in the PS chapter in your daily work, as applicable.
• Organizations should distribute the PS chapter to its care teams and leaders, and facilitate discussions about how to implement the concepts and principles.
• When designing or redesigning patient-centered systems, follow the guidance provided in the PS chapter.

Resources:

*Note: This is not an all-inclusive list. See the Patient Safety Systems (PS) chapter of the hospital accreditation manual for a full list of references as well as the patient safety-related standards.*