Patient Safety Systems (PS)

Introduction
The quality of care and the safety of patients are core values of The Joint Commission accreditation process. This is a commitment The Joint Commission has made to patients, families, health care practitioners, staff, and practice leaders. This chapter exemplifies that commitment.

The intent of this “Patient Safety Systems” (PS) chapter is to provide practice leaders with a proactive approach to designing or redesigning a patient-centered system that aims to improve quality of care and patient safety, an approach that aligns with the Joint Commission’s mission and its standards.

The Joint Commission partners with accredited practices to improve health care systems to protect patients. The first obligation of health care is to “do no harm.” Therefore, this chapter is focused on the following three guiding principles:

1. Aligning existing Joint Commission standards with daily work in order to engage patients and staff throughout the practice system, at all times, on reducing harm.
2. Assisting health care practices with advancing knowledge, skills, and competence of staff and patients by recommending methods that will improve quality and safety processes.
3. Encouraging and recommending proactive quality and patient safety methods that will increase accountability, trust, and knowledge while reducing the impact of fear and blame.

Quality and safety are inextricably linked. Quality in health care is the degree to which its processes and results meet or exceed the needs and desires of the people it serves.¹² Those needs and desires include safety.

The components of a quality management system should include the following:

- Ensuring reliable processes

¹The Institute of Medicine defines quality as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. **Source:** 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, ed. Washington, DC: The National Academies Press, 1990.
Decreasing variation and defects (waste)
Focusing on achieving better outcomes
Using evidence to ensure that a service is satisfactory

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. Safety is what patients, families, staff, and the public expect from Joint Commission–accredited practices. While patient safety events may not be completely eliminated, harm to patients can be reduced, and the goal is always zero harm. This chapter describes and provides approaches and methods that may be adapted by a practice that aims to increase the reliability of its complex systems while making risk of patient harm apparent and removing that risk. Joint Commission–accredited practices should be continually focused on eliminating systems failures and human errors that may cause harm to patients, families, and staff.¹²

The ultimate purpose of The Joint Commission’s accreditation process is to enhance quality of care and patient safety. Each requirement or standard, the survey process, the Sentinel Event Policy, and other Joint Commission initiatives are designed to help practices reduce variation, reduce risk, and improve quality. Practices should have an integrated approach to patient safety so that high levels of safe patient care can be provided for every patient in every care setting and service.

Practices are complex environments that depend on strong leadership to support an integrated patient safety system that includes the following:

- Safety culture
- Validated methods to improve processes and systems
- Standardized ways for interdisciplinary teams to communicate and collaborate
- Safely integrated technologies

In an integrated patient safety system, staff and leaders work together to eliminate complacency, promote collective mindfulness, treat each other with respect and compassion, and learn from their patient safety events, including close calls and other system failures that have not yet led to patient harm.

What Does This Chapter Contain?
The “Patient Safety Systems” (PS) chapter is intended to help inform and educate practices about the importance and structure of an integrated patient safety system. This chapter describes how existing requirements can be applied to achieve improved patient
safety; it does not contain any new requirements. It is also intended to help all health care workers understand the relationship between Joint Commission accreditation and patient safety.

This chapter does the following:

- Describes an integrated patient safety system
- Discusses how practices can develop into learning practices
- Explains how practices can continually evaluate the status and progress of their patient safety systems
- Describes how practices can work to prevent or respond to patient safety events (Sidebar 1, below, defines key terminology)
- Serves as a framework to guide practice leaders as they work to improve patient safety in their practices
- Contains a list of standards and requirements related to patient safety systems (which will be scored as usual in their original chapters)
- Contains references that were used in the development of this chapter

This chapter refers to a number of Joint Commission standards. Standards cited in this chapter are formatted with the standard number in boldface type (for example, “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 see the Appendix beginning on page PS-22.

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**Sidebar 1: Key Terms to Understand**

- **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.
- **Sentinel event:** † A subcategory of Adverse Events, 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 any of the following:
  - Death
  - Permanent harm

†For a list of specific patient safety events that are also considered sentinel events, see page SE-1 in the “Sentinel Events” (SE) chapter of this manual.
Becoming a Learning Practice

The need for sustainable improvement in patient 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 practice. A learning practice is one in which people learn continuously, thereby enhancing their capabilities to create and innovate. Learning practices 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. In a learning practice, patient safety events are seen as opportunities for learning and improvement. Therefore, leaders in learning practices adopt a transparent, nonpunitive approach to reporting so that the practice can report to learn and can collectively learn from patient safety events. In order to become a learning practice, a practice 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 practice leaders.

Leaders, staff, licensed independent practitioners, and patients in a learning practice realize that every patient safety event (from close calls to events that cause major harm to patients) must be reported. When patient safety events are continuously reported, experts within the practice can define the problem, identify solutions, achieve sustainable results, and disseminate the changes or lessons learned to the rest of the practice. In a learning practice, the practice provides staff with information regarding improvements based on reported concerns. This helps foster trust that encourages further reporting.
The Role of Practice Leaders in Patient Safety

Practice leaders and staff provide the foundation for an effective patient safety system by doing the following:\(^9\)

- Promoting learning
- Motivating staff to uphold a fair and just safety culture
- Providing a transparent environment in which quality measures and patient harms are freely shared with staff
- Modeling professional behavior
- Addressing intimidating behavior that might undermine the safety culture
- Providing the resources and training necessary to take on improvement initiatives

For these reasons, many of the standards that are focused on the practice’s patient safety system appear in the Joint Commission’s Leadership (LD) standards, including Standard **LD.03.09.01** (which focuses on having a practice-wide, integrated patient safety program).

Without the support of practice leaders, practice-wide changes and improvement initiatives are difficult to achieve. Leadership engagement in patient safety and quality initiatives 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.\(^4\) Thus, leadership should take on a long-term commitment to transform the practice.\(^10\)

Safety Culture

A strong safety culture is an essential component of a successful patient safety system and is a crucial starting point for striving to become a learning practice. In a strong safety culture, the practice 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 practice. 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 the practice.

The safety culture of a practice is the product of individual and group beliefs, values, attitudes, perceptions, competencies, and patterns of behavior that determine the practice’s commitment to quality and patient safety. Practices 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. Practices 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.
- Safety as everyone’s first priority.
- Behaviors that undermine a culture of safety are not acceptable, and thus should be reported to practice leadership by staff, patients, and families for the purpose of fostering risk reduction.
- 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 a patient may be harmed. 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.
- 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 patient safety events. 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 patient safety event.
- By reporting and learning from patient safety events, staff create a learning practice.

A safety culture operates effectively when the practice fosters a cycle of trust, reporting, and improvement. In practices that have a strong safety culture, health care providers trust their coworkers and leaders to support them when they identify and report a patient safety event. When trust is established, staff are more likely to report patient safety events, and practices can use these reports to inform their improvement efforts. In the trust-report-improve cycle, leaders foster trust, which enables staff to report, which enables the practice to improve. In turn, staff see that their reporting contributes to actual improvement, which bolsters their trust. Thus, the trust-report-improve cycle reinforces itself. (See The Trust-Report-Improve Cycle with Robust Process Improvement® [RPI®].)
In the trust-report-improve cycle, trust promotes reporting, which leads to improvement, which in turn fosters trust.

Leaders and staff need to ensure that intimidating or unprofessional behaviors within the practice are addressed, so as not to inhibit others from reporting safety concerns. 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 disrupt the culture of safety and prevent collaboration, communication, and teamwork, which is required for safe and highly reliable patient care. Disrespect is not limited to outbursts of anger that humiliate a member of the health care team; it can manifest in many forms, including the following:

- Inappropriate words (profane, insulting, intimidating, demeaning, humiliating, or abusive language)
- Shaming others for negative outcomes
- Unjustified negative comments or complaints about another provider’s care
- Refusal to comply with known and generally accepted practice standards, the refusal of 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 practices nationwide. In a 2013 survey of hospitals by the Institute for Safe Medication Practices (ISMP), 73% of 4,884 respondents reported encountering negative comments about colleagues or leaders during the previous year. In addition, 68% reported condescending language or demeaning comments or insults; while 77% of respondents said they had encountered reluctance or refusal to answer questions or return calls. Further, 69% report that they had encountered impatience with questions or the hanging up of the phone.

Nearly 50% of the respondents indicated that intimidating behaviors had affected the way they handle medication order clarifications or questions, including assuming that an order was correct in order to avoid interaction with an intimidating coworker. Moreover, 11% said they were aware of a medication error during the previous year in which behavior that undermines a culture of safety was a contributing factor. The respondents included nurses, physicians, pharmacists, and quality/risk management personnel.

Only 50% of respondents indicated that their practices had clearly defined an effective process for handling disagreements with the safety of an order. This is down from 60% of respondents to a similar ISMP survey conducted in 2003, which suggests that this problem is worsening. While these data are specific to medication safety, their lessons are broadly applicable: Behaviors that undermine a culture of safety have an adverse effect on quality and patient safety.

A Fair and Just Safety Culture

A fair and just safety culture is needed for staff to trust that they can report patient safety events without being treated punitively. In order to accomplish this, practices should provide and encourage the use of a standardized reporting process for staff to report patient 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 patients are harmed, and reactive risk reduction...
attempts to prevent the recurrence of problems that have already caused patient harm.\textsuperscript{10,15}

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.\textsuperscript{14,18,19}

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.

\begin{center}
\textbf{Sidebar 2. Assessing Staff Accountability}
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The aim of a safety culture is not a “blame-free” culture but one that balances learning with accountability. To achieve this, it is essential that leaders assess errors and patterns of behavior in a manner that is applied consistently, with the goal of eliminating behaviors that undermine a culture of safety. There has to exist within the practice 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.\textsuperscript{1–10}

There are a number of sources for information (some of which are listed immediately below) that provide rationales, tools, and techniques that will assist a practice in creating a formal decision process to determine what events should be considered blameworthy and require individually directed action in addition to systems-level corrective actions. The use of a formal process will reinforce the culture of safety and demonstrate the practice’s commitment to transparency and fairness.

Reaching answers to these questions 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 other formal decision process can help make determinations of culpability more transparent and fair.\textsuperscript{5}

\textbf{References}

Sidebar 2. (continued)


Data Use and Reporting Systems

An effective culture of safety is evidenced by a robust reporting system and use of measurement to improve. When practices adopt a transparent, nonpunitive approach to reports of patient safety events or other concerns, the practice begins reporting to learn—and to learn collectively from adverse events, close calls, and hazardous conditions. This section focuses on data from reported patient safety events. Practices should note that this 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, the practice can analyze the patient safety events, change the process or system to improve safety, and disseminate the changes or lessons learned to the rest of the practice.20–24
In addition to those mentioned earlier in this chapter, a number of standards relate to the reporting of safety information, including Performance Improvement (PI) Standard **PI.01.01.01**, which requires practices to collect data to monitor their performance, and Standard **LD.03.02.01**, which requires practices to use data and information to guide decisions and to understand variation in the performance of processes supporting safety and quality.

Practices can engage frontline staff in internal reporting in a number of ways, including the following:

- Create a nonpunitive approach to patient safety event reporting
- Educate staff on identifying patient safety events that should be reported
- Provide timely feedback regarding actions taken on patient safety events
Effective Use of Data

Collecting Data
When practices collect data or measure staff compliance with evidence-based care processes or patient outcomes, they can manage and improve those processes or outcomes and, ultimately, improve patient safety. The effective use of data enables practices 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.

The Joint Commission and the Centers for Medicare & Medicaid Services (CMS) both require practices to collect and use data related to certain patient care outcomes and patient harms. Some key Joint Commission standards related to data collection and use require practices to do the following:

- Collect information to monitor conditions in the environment (Standard EC.04.01.01)
- Identify risks for acquiring and transmitting 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 a practice-wide, integrated patient safety program (Standard LD.03.09.01)
- Evaluate the effectiveness of their medication management system (Standard MM.08.01.01)
- Collect data to monitor their performance (Standard PI.01.01.01)
- Improve performance on an ongoing basis (Standard PI.03.01.01)

Analyzing Data
Effective data analysis can enable practice to “diagnose” problems within its system similar to the way one would diagnose a patient’s illness based on symptoms, health history, and other factors. Turning data into information is a critical competency of a learning practice and of effective management of change. When the right data are collected and appropriate analytic techniques are applied, it enables the practice to monitor the performance of a system, detect variation, and identify opportunities to improve. This can help the practice not only understand the current performance of practice systems but also can help it predict its performance going forward.
Analyzing data with tools such as run charts, statistical process control (SPC) charts, and capability charts helps a practice determine what has occurred in a system and provides clues as to why the system responded as it did. Table 1, following, describes and compares examples of these tools. Please note that several types of SPC charts exist; this discussion focuses on the XmR chart, which is the most commonly used.
### Table 1. Defining and Comparing Analytical Tools

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<thead>
<tr>
<th>Tool</th>
<th>When to Use</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Run Chart</td>
<td>- When the practice needs to identify variation within a system</td>
<td><strong>ED Wait Time: Average per Patient</strong></td>
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<tr>
<td></td>
<td>- When the practice needs a simple and straightforward analysis of a system</td>
<td><img src="image1.png" alt="Run Chart Example" /></td>
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<tr>
<td></td>
<td>- As a precursor to an SPC chart</td>
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<tr>
<td>Statistical Process Control Chart</td>
<td>- When the practice needs to identify variation within a system and find indicators of why the variation occurred</td>
<td><strong>30 Day All Cause Harm Rate per 1000 discharges</strong></td>
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<td></td>
<td>- When the practice needs a more detailed and in-depth analysis of a system</td>
<td><img src="image2.png" alt="Statistical Process Control Chart Example" /></td>
</tr>
<tr>
<td>Capability Chart</td>
<td>- When the practice needs to determine whether a process will function as expected, according to requirements or specifications</td>
<td><strong>Upper and lower specifications or customer requirements</strong></td>
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<td><img src="image3.png" alt="Capability Chart Example" /></td>
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In the example above, the curve at the top of the chart indicates a process that is only partly capable of meeting requirements. The curve at the bottom of the chart shows a process that is fully capable.
Using Data to Drive Improvement
After data has been turned into information, leadership should ensure the following (per the requirements shown): 27–29

- Information is presented in a clear manner (Standard LD.03.04.01)
- Information is shared with the appropriate groups throughout the practice (from the front line to the leader(s)) (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 patient. By engaging in proactive risk reduction, a practice can correct process problems in order to reduce the likelihood of experiencing adverse events.

In a proactive risk assessment the practice 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 practice about the complexities of process design and management—and what could happen if the process fails.

When conducting a proactive risk assessment, practices 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, from results of data collection activities. Risk assessment tools should be accessed from credible external sources such as a Sentinel Event Alert, nationally recognized risk assessment tools, and peer review literature. Benefits of a proactive approach to patient safety includes increased likelihood of the following:

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

Hazardous (or unsafe) conditions provide an opportunity for a practice to take a proactive approach to reduce harm. Practices also 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 conditions that preceded the hazardous condition. (See Sidebar 3, “Strategies for an Effective Risk Assessment.”)

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 in the environment of care (such as noise, clutter, wet floors and so forth) and inadequate staffing levels.
- **Supervisory influences.** Examples include inadequate supervision, planned inappropriate operations, failure to address a known problem, authorization of activities that are known to be hazardous.
- **Practice influences.** Examples include inadequate staffing, inadequate policies, lack of strategic risk assessment.

The Joint Commission addresses proactive risk assessments at Standard **LD.03.09.01**, EP 8, which recommends using the results of proactive risk assessments to improve safety.

Practices should recognize that this standard represents a minimum requirement. Practices working to become learning practices are encouraged to exceed this requirement by constantly working to proactively identify risk.

**Sidebar 3. Strategies for an Effective Risk Assessment**

Although several methods could be used to conduct a proactive risk assessment, the following steps comprise one approach:

- Describe the chosen process (for example, through the use of a flowchart).

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‡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, and not 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.
Sidebar 3. (continued)

- 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.

Tools for Conducting a Proactive Risk Assessment

A number of tools are available to help practices 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.31

Practices have other tools they can consider using in their proactive risk assessment. Some examples include the following:

- Potential problem analysis (PPA) is a systematic method for determining what could go wrong in a plan under development. The problem causes are rated according to their likelihood of occurrence and the severity of their consequences. Visit https://healthit.ahrq.gov/health-it-tools-and-resources/evaluation-resources/workflow-assessment-health-it-toolkit/all-workflow-tools 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 http://healthit.ahrq.gov/health-it-tools-and-resources/workflow-assessment-health-it-toolkit/all-workflow-tools/process-decision-program-chart.

Encouraging Patient Activation
To achieve the best outcomes, patients and families must be more actively engaged in decisions about their health care and must have broader access to information and support. Patient activation is inextricably intertwined with patient safety. Activated patients are less likely to experience harm and unnecessary practice readmissions. Patients who are less activated suffer poorer health outcomes and are less likely to follow their provider’s advice.32,33

A patient-centered approach to care can help practices assess and enhance patient activation. Achieving this requires leadership engagement in the effort to establish patient-centered care as a top priority throughout the practice. This includes adopting the following principles:34

- 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 staff has the necessary tools and skills.
- The practice has a focus on measurement, learning, and improvement.
- Staff 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.

Practices can adopt a number of strategies to support and improve patient activation, including promoting culture change, adopting transitional care models, and leveraging health information technology capabilities.34
A number of Joint Commission standards address patient rights and provide an excellent starting point for practices seeking to improve patient activation. These standards require that practices do the following:

- Respect, protect, and promote patient rights (Standard RI.01.01.01)
- Respect the patient’s right to receive information in a manner he or she understands (Standard RI.01.01.03)
- Respect the patient’s right to participate in decisions about his or her care, treatment, and services (Standard RI.01.02.01)
- Honor the patient’s right to give or withhold informed consent (Standard RI.01.03.01)
- Inform the patient about his or her responsibilities related to his or her care, treatment, and services (Standard RI.02.01.01)

**Beyond Accreditation: The Joint Commission Is Your Patient Safety Partner**

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

- **Office of Quality and Patient Safety:** An internal Joint Commission department that offers practices guidance and support when they experience a sentinel event. Practices can call the Sentinel Event Hotline (630-792-3700) to clarify whether a patient safety event is considered to be a sentinel event (and therefore reviewable) or to discuss any aspect of the Sentinel Event Policy. The Office of Quality and Patient Safety assesses the thoroughness and credibility of a practice’s comprehensive systematic analysis as well as the action plan to help the practice prevent the hazardous or unsafe conditions from occurring again.

- **Joint Commission Center for Transforming Healthcare:** A Joint Commission not-for-profit affiliate that offers highly effective, durable solutions to health care’s most critical safety and quality problems to help practices transform into high reliability practices. For specific quality and patient problems, the Center’s Targeted Solutions Tool® (TST®) guides practices through a step-by-step process to measure their practice’s performance, identify barriers to excellence, and direct them to proven solutions. To date, a TST has been developed for each of the following: hand hygiene, hand-off communications, and wrong-site surgery. For more information, visit http://www.centerfortransforminghealthcare.org.
Standards Interpretation Group: An internal Joint Commission department that helps practices with their questions about Joint Commission standards. First, practices can see if other practices have asked the same question by accessing the Standards FAQs at http://www.jointcommission.org/standards_information/jcfaq.aspx. Thereafter, practices can submit questions about standards to the Standards Interpretation Group by completing an online form at https://web.jointcommission.org/sigsubmission/sigonlineform.aspx.

National Patient Safety Goals: The Joint Commission’s yearly patient safety requirements based on data obtained from the Joint Commission’s Sentinel Event Database and recommended by a panel of patient safety experts. (For a list of the current National Patient Safety Goals, go to 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 http://www.jointcommission.org/sentinel_event.aspx.)

Quick Safety: Quick Safety is a monthly newsletter that outlines an incident, topic, or trend in health care that could compromise patient safety.

Joint Commission Resources: A Joint Commission not-for-profit 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.jcrlnc.com.)

Webinars and podcasts: The Joint Commission and its affiliate, Joint Commission Resources, offer free 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.)

Standards BoosterPaks™: Available for accredited practices through Joint Commission Connect, practices can access BoosterPaks that provide detailed information about a single standard or topic area that has been associated with a high volume of inquiries or noncompliance scores. Recent standards BoosterPak topics have included credentialing and privileging in nonhospital settings, waived testing, management of hazardous waste, environment of care (including Standard EC.04.01.01), and sample collection.
Leading Practice Library: Available for accredited or certified practices through Joint Commission Connect, practices can access an online library of solutions to help improve safety. The searchable documents in the library are actual solutions that have been successfully implemented by practices and reviewed by Joint Commission standards experts.

Joint Commission web portals: Through The Joint Commission website, practices can access web portals with a repository of resources from The Joint Commission, the Joint Commission Center for Transforming Healthcare, Joint Commission Resources, and Joint Commission International on the following topics:
- Emergency management: http://www.jointcommission.org/emergency_management.aspx
- Workplace violence prevention resources: https://www.jointcommission.org/workplace_violence.aspx

References


Shading indicates a change effective July 1, 2019, unless otherwise noted in the What's New.


Appendix. Key Patient Safety Requirements
A number of Joint Commission standards have been discussed in the “Patient Safety Systems” (PS) chapter. However, many Joint Commission requirements address issues related to the design and management of patient safety systems, including the following examples:
Accreditation Participation Requirements (APR)

Standard APR.09.01.01
The practice notifies the public it serves about how to contact its practice management and The Joint Commission to report concerns about patient safety and quality of care.

**Note:** Methods of notice may include, but are not limited to, distribution of information about The Joint Commission, including contact information in published materials such as brochures and/or posting this information on the practice’s website.

Elements of Performance for APR.09.01.01

1. The practice informs the public it serves about how to contact its management to report concerns about patient safety and quality of care.
2. The practice informs the public it serves about how to contact The Joint Commission to report concerns about patient safety and quality of care.

Standard APR.09.02.01
Any individual who provides care, treatment, or services can report concerns about safety or the quality of care to The Joint Commission without retaliatory action from the practice.

Elements of Performance for APR.09.02.01

1. The practice educates its staff and other persons who provide care, treatment, or services that concerns about the safety or quality of care provided in the organization may be reported to The Joint Commission.
2. The practice informs its staff that it will take no disciplinary or punitive action because an employee or other individual who provides care, treatment, or services reports safety or quality-of-care concerns to The Joint Commission.
3. The practice takes no disciplinary or punitive action against employees or other individuals who provide care, treatment, or services when they report safety or quality-of-care concerns to The Joint Commission.
Environment of Care (EC)

**Standard EC.04.01.01**
The practice collects information to monitor conditions in the environment.

**Elements of Performance for EC.04.01.01**
1. The practice establishes a process(es) for internally reporting and investigating occupational illnesses and staff injuries.

Based on its process(es), the practice reports and investigates the following:

4. Occupational illnesses and staff injuries.

Infection Prevention and Control (IC)

**Standard IC.01.03.01**
The practice identifies risks for acquiring and transmitting infections.

**Elements of Performance for IC.01.03.01**
1. The practice identifies infection risks based on the following:
   - Its geographic location, community, and population served
   - The care, treatment, or services it provides
   - The analysis of its infection surveillance and control data

3. The practice prioritizes the identified risks for acquiring and transmitting infections. These prioritized risks are documented.

Leadership (LD)

**Standard LD.02.01.01**
The mission, vision, and goals of the practice support the safety and quality of care, treatment, or services.

**Elements of Performance for LD.02.01.01**
1. Leaders work together to create the practice’s mission, vision, and goals.

2. The practice’s mission, vision, and goals guide the actions of leaders.
3. Leaders communicate the mission, vision, and goals to staff and the population(s) the practice serves.

**Standard LD.03.01.01**

Leaders create and maintain a culture of safety and quality throughout the practice.

**Elements of Performance for LD.03.01.01**

1. Leaders regularly evaluate the culture of safety and quality.
2. Leaders prioritize and implement changes identified by the evaluation.
3. Leaders develop a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety.
4. Leaders create and implement a process for managing behaviors that undermine a culture of safety.

**Standard LD.03.02.01**

The practice uses data and information to guide decisions and to understand variation in the performance of processes supporting safety and quality.

**Elements of Performance for LD.03.02.01**

1. Leaders set expectations for using data and information for the following:
   - Improving the safety and quality of care, treatment, or services
   - Creating a culture of safety and quality
   - Decision making that supports the safety and quality of care, treatment, or services
   - Identifying and responding to internal and external changes in the environment
2. Leaders evaluate how effectively data and information are used throughout the practice.

**Standard LD.03.03.01**

Leaders use practice-wide planning to establish structures and processes that focus on safety and quality.

**Elements of Performance for LD.03.03.01**

1. Planning activities focus on the following:
- Improving patient safety and health care quality
- Supporting a culture of safety and quality
- Adapting to changes in the environment

2. Planning is practicewide, systematic, and involves designated individuals and information sources.

3. Leaders evaluate the effectiveness of planning activities.

**Standard LD.03.04.01**

The practice communicates information related to safety and quality to those who need it, including staff, patients, families, and external interested parties.

**Elements of Performance for LD.03.04.01**

1. Communication processes are effective in doing the following:
   - Fostering the safety of the patient and his or her quality of care
   - Supporting a culture of safety and quality
   - Meeting the needs of internal and external users
   - Informing those who work in the practice of changes in the environment

2. Leaders evaluate the effectiveness of communication methods.

**Standard LD.03.05.01**

Leaders manage change to improve the performance of the practice.

**Elements of Performance for LD.03.05.01**

1. The practice has a systematic approach to change and performance improvement.

2. Structures for managing change and performance improvement do the following:
   - Foster the safety of the patient and the quality of care, treatment, or services
   - Support a culture of safety and quality
   - Adapt to changes in the environment

3. Leaders evaluate the effectiveness of processes for the management of change and performance improvement.
Standard LD.03.06.01
Those who work in the practice are focused on improving safety and quality.

Elements of Performance for LD.03.06.01

1. Leaders design work processes to focus individuals on safety and quality issues.
2. Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, or services. *(See also IC.01.01.01, EP 3)*
3. Those who work in the practice are competent to complete their assigned responsibilities.
4. Leaders evaluate the effectiveness of those who work in the practice to promote safety and quality.
5. Those who work in the practice adapt to changes in the environment.

Standard LD.03.07.01
Leaders establish priorities for performance improvement. *(Refer to the “Performance Improvement” [PI] chapter.)*

Elements of Performance for LD.03.07.01

2. As part of performance improvement, leaders do the following:
   - Set priorities for performance improvement activities and patient health outcomes *(See also PI.01.01.01, EPs 1 and 2)*
   - Give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities *(See also PI.01.01.01, EPs 3, 5, 6, 12, and 13)*
   - Reprioritize performance improvement activities in response to changes in the internal or external environment

Standard LD.03.09.01
The practice has an organizationwide, integrated patient safety program.

Elements of Performance for LD.03.09.01

1. The leaders implement a practicewide patient safety program as follows:
   - One or more qualified individuals manage the safety program.
The scope of the safety program includes the full range of safety issues, from potential or no-harm errors (sometimes referred to as close calls [“near misses”] or good catches) to hazardous conditions and sentinel events.

2. As part of the safety program, the leaders create procedures for responding to system or process failures.

**Note:** Responses might include continuing to provide care, treatment, or services to those affected, containing the risk to others, and preserving factual information for subsequent analysis.

3. The leaders provide and encourage the use of systems for blame-free internal reporting of a system or process failure, or the results of a proactive risk assessment.

**Note:** This EP is intended to minimize staff reluctance to report errors in order to help an organization understand the source and results of system and process failures. The EP does not conflict with holding individuals accountable for their blameworthy errors.

4. The leaders define patient safety event and communicate this definition throughout the organization.

**Note:** At a minimum, the organization’s definition includes those events subject to review as described in the “Sentinel Events” (SE) chapter of this manual.

5. The practice conducts thorough and credible comprehensive systematic analyses (for example, root cause analyses) in response to sentinel events as described in the “Sentinel Events” (SE) chapter of this manual.

6. The leaders make support systems available for staff who have been involved in an adverse or sentinel event.

**Note:** Support systems recognize that conscientious health care workers who are involved in sentinel events are themselves victims of the event and require support. Support systems provide staff with additional help and support as well as additional resources through the human resources function or an employee assistance program. Support systems also focus on the process rather than blaming the involved individuals.

8. To improve safety, the practice analyzes and uses information about system or process failures and, when conducted, the results of proactive risk assessments.
9. The leaders disseminate lessons learned from comprehensive systematic analyses (for example, root cause analyses), system or process failures, and the results of proactive risk assessments to all staff who provide services for the specific situation.

10. ☐ At least once a year, the leaders provide practice leaders with written reports on the following:
   - All system or process failures
   - The number and type of sentinel events
   - Whether the patients and the families were informed of the event
   - All actions taken to improve safety, both proactively and in response to actual occurrences

11. The leaders encourage external reporting of significant adverse events, including voluntary reporting programs in addition to mandatory programs.

   **Note:** Examples of voluntary programs include The Joint Commission Sentinel Event Database and the US Food and Drug Administration (FDA) MedWatch. Mandatory programs are often state initiated.

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**Standard LD.04.01.01**

The practice complies with law and regulation.

**Elements of Performance for LD.04.01.01**

1. ☐ The practice is licensed, is certified, or has a permit, in accordance with law and regulation, to provide the care, treatment, or services for which the practice is seeking accreditation from The Joint Commission.
Note 1: Each service location that performs laboratory testing (waived or nonwaived) must have a Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88) certificate as specified by the federal CLIA regulations (42 CFR 493.55 and 493.3) and applicable state law. (See also WT.01.01.01, EP 1; WT.04.01.01, EP 1)

Note 2: For more information on how to obtain a CLIA certificate, see http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/How_to_Apply_for_a_CLIA_Certificate_International_Laboratories.html.

2. The practice provides care, treatment, or services in accordance with licensure requirements, laws, and rules and regulations.

Medication Management (MM)

Standard MM.08.01.01
The practice evaluates the effectiveness of its medication management system.

Note: This evaluation includes reconciling medication information. (Refer to NPSG.03.06.01 for more information)

Elements of Performance for MM.08.01.01

1. Collects data on the performance of its medication management system. (See also PI.01.01.01, EPs 12 and 13)

   Note: This element of performance is also applicable to sample medications.

5. Based on analysis of its data, as well as review of the literature for new technologies and best practices, the practice identifies opportunities for improvement in its medication management system.

6. When opportunities are identified for improvement of the medication management system, the practice does the following:
   ■ Takes action on improvement opportunities identified as priorities for its medication management system (Refer to PI.03.01.01, EP 2)
   ■ Evaluates its actions to confirm that they resulted in improvements

   Note: This element of performance is also applicable to sample medications.
8. The practice takes additional action when planned improvements for its medication management processes are either not achieved or not sustained.

Performance Improvement (PI)

**Standard PI.01.01.01**
The practice collects data to monitor its performance.

**Elements of Performance for PI.01.01.01**

1. The leaders set priorities for and identify the frequency of data collection. *(See also LD.03.07.01, EP 2)*

The practice collects data on the following:

2. Performance improvement priorities identified by leaders. *(See also LD.03.07.01, EP 2)*

3. Operative or other procedures that place patients at risk of disability or death. *(See also LD.03.07.01, EP 2)*

4. All significant discrepancies between preoperative and postoperative diagnoses, including pathologic diagnoses.

5. Adverse events related to using moderate or deep sedation or anesthesia. *(See also LD.03.07.01, EP 2)*

6. The use of blood and blood components. *(See also LD.03.07.01, EP 2)*

12. Significant medication errors. *(See also LD.03.07.01, EP 2; MM.08.01.01, EP 1)*

13. Significant adverse drug reactions. *(See also LD.03.07.01, EP 2; MM.08.01.01, EP 1)*

14. Patient perception of the safety and quality of care, treatment, or services.
Standard \textbf{Pl.02.01.01}  
The practice compiles and analyzes data.

**Elements of Performance for Pl.02.01.01**

4. The practice analyzes and compares internal data over time to identify levels of performance, patterns, trends, and variations.

8. The practice uses the results of data analysis to identify improvement opportunities.

Standard \textbf{Pl.03.01.01}  
The practice improves performance.

**Elements of Performance for Pl.03.01.01**

2. The practice takes action on improvement priorities. (See also MM.08.01.01, EP 6)

4. The practice takes action when it does not achieve or sustain planned improvements.

Rights and Responsibilities of the Individual (RI)

Standard \textbf{Rl.01.01.01}  
The practice respects patient rights.

**Elements of Performance for Rl.01.01.01**

6. The practice respects the patient’s cultural and personal values, beliefs, and preferences.

7. The practice respects the patient’s right to privacy. (See also IM.02.01.01, EP 1)

\textbf{Note:} This element of performance (EP) addresses a patient’s personal privacy. For EPs addressing the privacy of a patient’s health information, please refer to Standard IM.02.01.01.
Standard  **RI.01.01.03**  
The practice respects the patient’s right to receive information in a manner he or she understands.

**Elements of Performance for RI.01.01.03**

3. The practice communicates with the patient who has vision, speech, hearing, or cognitive impairments in a manner that meets the patient’s needs.

Standard  **RI.01.02.01**  
The practice respects the patient’s right to participate in decisions about his or her care, treatment, or services.

**Elements of Performance for RI.01.02.01**

1. The practice involves the patient in making decisions about his or her care, treatment, or services.  
2. When a patient is unable to make decisions about his or her care, treatment, or services, the practice involves a surrogate decision-maker in making these decisions. *(See also PC.01.02.07, EP 5)*  
4. The practice respects the patient’s right to refuse care, treatment, or services, in accordance with law and regulation. *(See also PC.01.02.07, EP 5)*  
20. The practice provides the patient or surrogate decision-maker with the information about the following:
   - Outcomes of care, treatment, or services that the patient needs in order to participate in current and future health care decisions
   - Unanticipated outcomes of the patient’s care, treatment, or services that relate to sentinel events as defined by The Joint Commission

Standard  **RI.01.03.01**  
The practice honors the patient’s right to give or withhold informed consent.

**Elements of Performance for RI.01.03.01**

2. The informed consent process includes a discussion about the following:  
   - The patient’s proposed care, treatment, and services.
   - Potential benefits, including potential problems that might occur during recuperation.
Reasonable alternatives to the patient’s proposed care, treatment, or services. The discussion encompasses risks, benefits, and side effects related to the alternatives and the risks related to not receiving the proposed care, treatment, or services.

13. Informed consent is obtained in accordance with the practice’s policy and processes. (*See also* RC.02.01.01, EP 4)

**Standard RI.02.01.01**

The practice informs the patient about his or her responsibilities related to his or her care, treatment, or services.

**Elements of Performance for RI.02.01.01**

2. The practice informs the patient about his or her responsibilities.

   **Note:** Information about patient responsibilities can be shared verbally, in writing, or both.