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.

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

[*] 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.*

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,

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.)

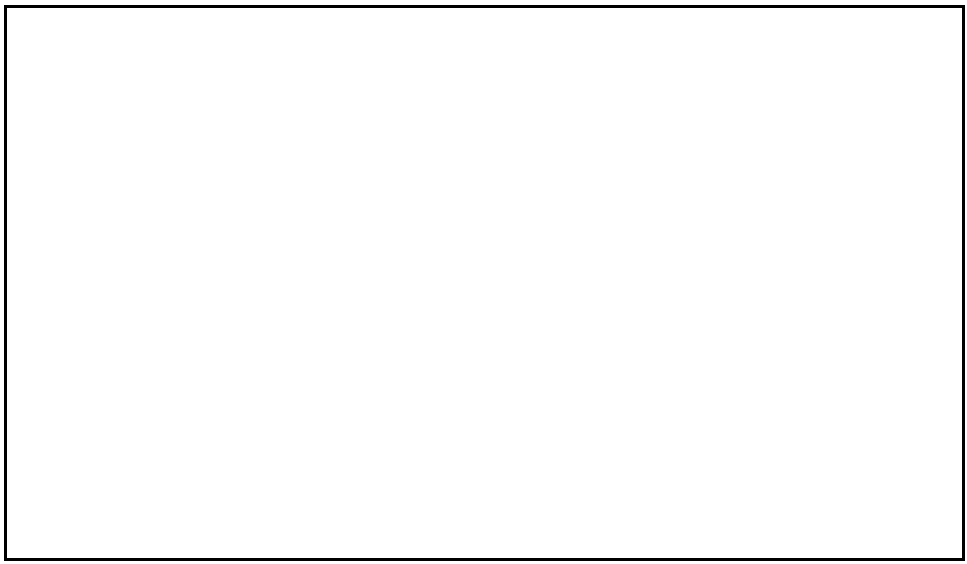

Figure 1. *The Trust-Report-Improve Cycle. In the trust-report-improve cycle, trust promotes reporting, which leads to improvement, which in turn fosters trust.*

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)

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.[1–8]

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]

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)

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).

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, leadership, lack of strategic risk assessment.

Many 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.

[‡] 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.

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, by using 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.

continued on next page

Sidebar 3. *(continued)*

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.
- 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 several 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]

Many Joint Commission standards address the rights of the individual served and provide

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 be30TdG940.75294gu

Joint Commission patient safety portals: Through the Joint Commission website (at http://www.jointcommission.org/resources/patient-safety-topics/), organizations can access web portals with a repository of resources on the following topics:

- Zero Harm
- Emergency Management
- Workforce Safety and Well-Being
- Infection Prevention and Control
- Report a Patient Safety Concern or Complaint
- Suicide Prevention

References

1. 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, editor. Washington, DC: The National Academies Press, 1990.
2. Juran J, Godfrey A. *Quality Control Handbook*, 6th ed. New York: McGraw-Hill, 2010.
3. American Society for Quality. *Glossary and Tables for Statistical Quality Control*, 4th ed. Milwaukee: American Society for Quality Press, 2004.
4. Senge PM. *The Fifth Discipline: The Art and Practice of the Learning Organization,* 2nd ed. New York: Doubleday, 2006.
5. Leape L, et al. A culture of respect, part 2: Creating a culture of respect. *Academic Medicine*. 2012 Jul;87(7):853–858.
6. Wu A, ed. *The Value of Close Calls in Improving Patient Safety: Learning How to Avoid and Mitigate Patient Harm*. Oak Brook, IL: Joint Commission Resources, 2011.
7. Agency for Healthcare Research and Quality. *Becoming a High Reliability Organization: Operational Advice for Hospital Leaders*. Rockville, MD: AHRQ, 2008.
8. Fei K, Vlasses FR. Creating a safety culture through the application of reliability science. *J Healthc Qual*. 2008 Nov–Dec;30(6):37–43.
9. Massachusetts Coalition of the Prevention of Medical Errors: When Things Go Wrong: Responding to Adverse Events. Mar 2006. Accessed Jan 10, 2024. http://www.macoalition.org/documents/respondingToAdverseEvents.pdf
10. The Joint Commission. *The Joint Commission Leadership Standards*. Oak Brook, IL: Joint Commission Resources, 2009.