Safety Systems for Patients and Individuals Served (SSPIS)

Quality and Safety in Health Care

The quality of care and the safety of patients and individuals served are core values of The Joint Commission accreditation process. This is a commitment The Joint Commission has made to patients, individuals served, families, health care practitioners, staff, and health care organization leaders.

The ultimate purpose of The Joint Commission's accreditation process is to enhance quality of care and safety of patients and 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. Organizations should have an integrated approach to patient and individual safety so that safe care can be provided for every patient and individual served in every care setting and service.

Organizations are complex environments that depend on strong leaders to support an integrated patient and individual safety

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Sidebar 1. *(continued)*

adverse event A safety event that resulted in harm to a patient or individual served. 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 safety event (not primarily related to the natural course of the illness or underlying condition of the patient or individual) that reaches a patient or individual 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 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 or individual's own disease process or condition) that increases the probability of an adverse event. Also called *unsafe condition*.

Quality and safety in health care are inextricably linked. *Quality*, as defined by the National Academy of Medicine (known as the Institute of Medicine until

* For a list of specific safety events that are also considered sentinel events, *see* the "Sentinel Event Policy" (SE) chapter in E-dition® or the *Comprehensive Accreditation Manual.*

zero harm (that is, reducing harm to patients and individuals). Joint Commission–accredited organizations should be continually focused on eliminating systems failures and human errors that may cause harm to patients, individuals served, families, and staff.

Goals of This Chapter

This "Safety Systems for Patients and Individuals Served" (SSPIS) chapter provides organization leaders with a proactive approach to designing or maintaining care, treatment, or services that aim to improve quality of care and safety for the patient or 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 protect patients and individuals served. The first obligation of health care is to "do no harm." Therefore, this chapter focuses on the following three guiding principles:

1. Aligning existing Joint Commission standards with daily work to engage patients, individuals served, and staff throughout the health care system, at all times, on reducing harm.
2. Assisting health care organizations to become learning organizations by advancing knowledge, skills, and competence of staff, patients, and individuals served 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.

It informs and educates organizations about the importance and structure of an integrated safety system and helps health care workers understand the relationship between Joint Commission accreditation and the safety of the patient or individual served. It offers approaches and methods that may be adapted by any health care organization that aims to increase the reliability and transparency of its complex systems while removing the risk of harm to the patient or individual.

The SSPIS chapter refers to specific Joint Commission standards, describing how existing requirements can be applied to achieve improved safety of patients and 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

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.)

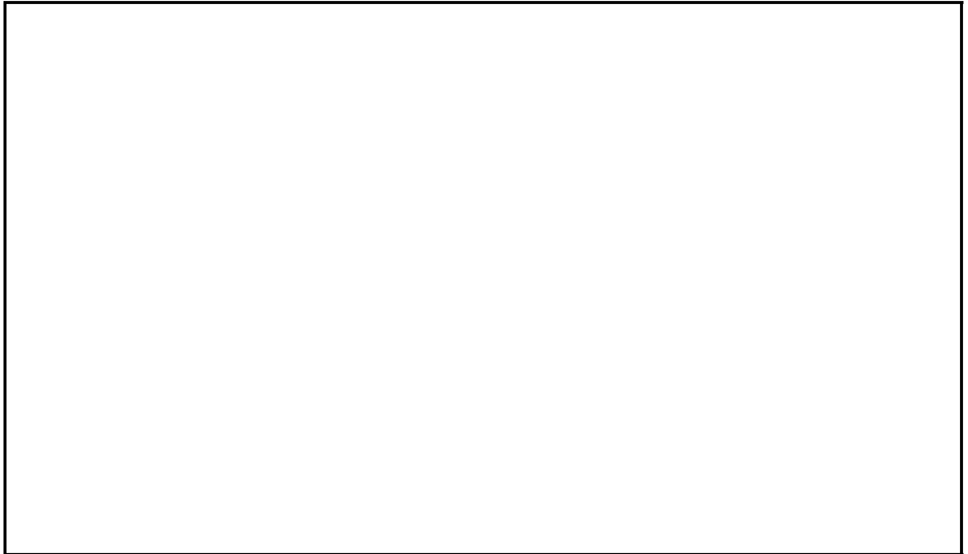

Figure 1. *The Trust-Report-Improve Cycle. In the trust-report-improve cycle, trust promotes reporting, which leads to improvement, which in turn fosters trust.*

Leaders and staff need to address intimidating or unprofessional behaviors within the organization, so as not to inhibit others 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 disrupt the culture of safety and prevent collaboration, communication, and teamwork, which is required for safe and highly reliable care.[18] Disrespect is not limited to outbursts of anger that humiliate a member of the health care team; it can manifest in many forms, 11.09ap0Td5Td(limitedhiTd(is)Tj8spect)

- 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 responding to requests for assistance or information, not returning pages or calls promptly

These issues are still occurring in organizations nationwide. In a 2021 survey by the Institute for Safe Medication Practices (ISMP), 79% of 1,047 respondents reported personally experiencing disrespectful behaviors during the previous year. In addition, 60% reported witnessing disrespectful behaviors.[19] The respondents included nurses, physicians, pharmacists, and quality/risk management personnel.

Approximately half (51%) of the respondents had asked colleagues to help interpret a medication order or validate its safety to avoid interacting with a particular prescriber.[19] Moreover, 27% 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. Nearly 200 events were described, many of which involved high-alert medications (for example, neuromuscular blocking agents, anticoagulants, insulin, chemotherapy) and led to significant delays in care and/or adverse events.

Of the respondents who indicated that their organizations had clearly defined an effective process for handling disagreements with the safety of an order, only 41% said that the process for handling disagreements allows them to bypass a typical chain of command, if necessary.[19] 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.

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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 6, 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 or individuals are harmed, and reactive risk

Sidebar 2 *(continued)*

2. The Joint Commission. The essential role of leadership in developing a safety culture. *Sentinel Event Alert.* Mar 1, 2017. Accessed Jan 10, 2024.

Shading indicates a change effective January 1, 2025, unless otherwise noted in the What's New.

Organizations can engage frontline staff in internal reporting in many ways, including the following:

- 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

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When organizations collect data or measure staff compliance with evidence-based care processes or patient or individual outcomes, they can manage and improve those processes or outcomes and, ultimately, improve safety. 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 comply with evidence-based care guidelines.[10,23]

The Joint Commission requires organizations to collect and use data related to certain patient or individual care outcomes and harm events. Some key Joint Commission standards related to data collection and use require organizations to do the following:

- 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 patient safety program (Standard LD.03.09.01)
- Collect data to monitor their performance (Standard PI.01.01.01)
- Improve performance on an ongoing basis (Standard PI.03.01.01)

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Effective data analysis can enable an organization 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 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 organization systems but also can help it predict its performance going forward.[24]

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 on a link to complete an online submission form.

National Patient Safety Goals: The Joint Commission gathers information about emerging patient 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 health care 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 https://www.jointcommission.org/ahc_2016_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 Alert*s, 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 health care that could compromise patient safety. (For more information, visit https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/quick-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.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 patient safety topics.

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