The Joint Commission & Culture of Patient Safety

Alisha Morrison, Business Development Manager
Ambulatory Care Services

February 2020

The Joint Commission

The Joint Commission

The concept of safety culture is increasingly seen as central to the understanding of patient safety in healthcare settings.

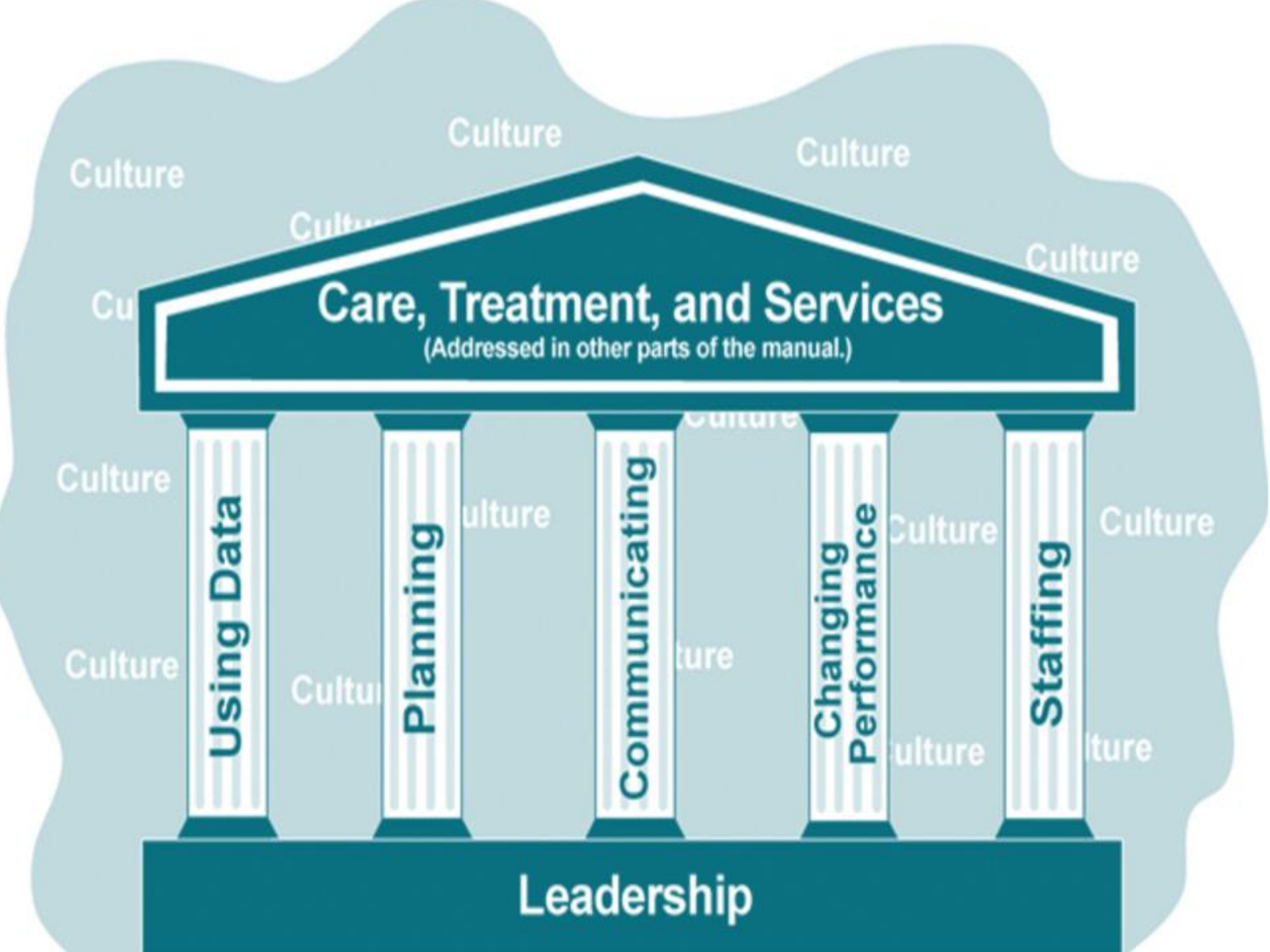
How important is it to The Joint Commission?

Safety Culture Assessment

Defined

The Joint Commission defines safety culture as the product of individual and group beliefs, values, attitudes, perceptions, competencies, and patterns of behavior that determine the organization's commitment to quality and patient safety.

Our Center for Transforming Healthcare has found inadequate safety culture to be a significant contributing factor to adverse outcomes.


Culture
Culture
Culture
Culture
Culture
Culture
Culture
Culture
Culture
Culture
Culture
Culture
Care, Treatment, and Services
(Addressed in other parts of the manual.)
Using Data
Planning
Communicating
Changing Performance
Staffing
Leadership

The Joint Commission

What are some initiatives that The Joint Commission is doing to examine and foster a patient safety culture?

Through existing standards…

- *Assessment* LD 03.01.01, EP 1. Leaders ***regularly*** evaluate the culture of safety and quality ***using valid and reliable tools***.
- *Strengthening Systems* LD 03.01.01, EP 2. Leaders prioritize and implement changes identified by the evaluation (of safety culture). LD 03.01.01, EP 5. Leaders create and implement a process for managing behaviors that undermine a culture of safety.
- *Trust/Intimidating Behavior* LD 03.01.01, EP 4. Leaders develop a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety.

Through existing standards…

- *Identifying Unsafe Conditions –* LD 04.04.05, EP 3. The scope of the safety program includes the full range of safety issues, from potential or no-harm errors to hazardous conditions and sentinel events.
- *Accountability/Just Culture –* LD 04.04.05, EP 6. 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.

Through enhancing survey process…

- *Leadership Session –* The purpose of the Leadership Session is to *explore where the organization is on the journey to high reliability*. This is a facilitated discussion of the characteristics of a high reliability organization, specifically:
    - Leadership commitment to improvement of quality and safety
    - Creating a culture of safety
    - Robust Process Improvement®
    - Survey findings that suggest underlying system issues
- *Tracer Methodology –* Using tracer methodology from the Opening Conference, through individual and system tracers, to the Leadership Session and Exit.

The Joint Commission

When a center is being surveyed, are surveyors asking the center if they are measuring patient safety culture?

Where are the biggest opportunities and improvements noted by the surveyors?

- Organizations will have varying levels of safety culture, but all should be working toward a safety culture that has the following qualities:

  - Staff and leaders that value
    - ✓ Transparency
    - ✓ Accountability
    - ✓ Mutual respect

Sample Questions

Leadership Session

- How do you assess the culture of safety in your organization?
- What instrument are you using?
- What is the mechanism for reporting results to your organization?
- Do you include safety culture improvement goals in performance expectations for leaders? What about middle management?
- What have you done to try to eradicate intimidating behavior?
- In the event an error occurs and a patient is harmed, do you have a process in place to determine whether this was a system error or whether the person responsible should be held accountable?

Sample Questions

Staff Interviews

- Have you ever completed a safety culture survey? Have you ever seen the results of the safety culture survey? Overall or for your unit?
- Would you feel comfortable reporting intimidating behavior?
- When an error takes place, do you have confidence your leadership will take an appropriate look at how the system or process is accountable versus an individual?
- What process do you have in place for reporting “close calls/near misses” or an error that occurred but did not reach the patient?

The Joint Commission

Are surveyors looking for projects, data, benchmarking related to the development of having a patient safety culture?

The Joint Commission doesn't have requirements that mandate a specific project, but we want to know what is your process is, for example:

- What does your safety culture look like?
- How do you monitor it?
- Anonymous staff surveys?

The Joint Commission

In 2004, AHRQ released survey on patient safety culture. What do you see being done well?

- The Joint Commission does not mandate the use of AHRQ; it’s an excellent tool
- Provide a much better understanding of what safety culture is and how to assess
- Having an increased awareness is an opportunity to create a comprehensive plan of how to increase safety culture

What is the best way to receive buy-in at the ASCs?

Establish trust

Encourage reporting

Eliminate fear of punishment

Examine errors, close calls & hazardous conditions

Contact Information:
Alisha Morrison, Business Development Manager
The Joint Commission, Ambulatory Care Services
amorrison@jointcommission.org
630-792-5234