Safety Culture and Leadership: A View from The Joint Commission

Barbara I. Braun PhD
Associate Director, Health Services Research
The Joint Commission

NIOSH NORA Healthy Work Design in the HCSA Sector Workshop, Washington DC
12/6/18

The Joint Commission

Overview

- What is The Joint Commission
- One framework: High Reliability
  - Design “make it easy to do the right thing at the right time”
  - Applies to staff, patients and all
- Evaluating leadership and safety culture

THE JOINT COMMISSION

The Joint Commission

About The Joint Commission

- An independent, not-for-profit organization founded in 1951
- The nation's oldest and largest standards-setting and accrediting body in health care
- Evaluates and accredits more than 21,000 health care organizations and programs in the United States

The Joint Commission's Mission and Vision

- Mission: To continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value.

- Vision: All people always experience the safest, highest quality, best-value health care across all settings.

The Joint Commission's Governance

- Governed by a 32-member Board of Commissioners including physicians, administrators, nurses, employers, quality experts, a consumer advocate, and educators
- Corporate members:
  - American College of Physicians
  - American College of Surgeons
  - American Dental Association
  - American Hospital Association
  - American Medical Association

Three arms of the Enterprise

The Joint Commission

The Joint Commission	Center for Transforming Healthcare	Joint Commission Resources
• Accreditation and certification operations • Standards development and interpretation • Performance Measurement • Research • Communications	• Robust Process Improvement (RPI) trained staff “belts” • Targeted Solution Tools • High reliability-focused self-assessment & resources (ORO™ 2.0) • Education and training	• Publications • Software • Education programs • Consultation • Joint Commission International: standards development, accreditation & certification

How The Joint Commission is…

LEADING the way to ZERO™

- Set global standards for quality and safety
  - Set rigorous standards and share best practices
- Strengthen and integrate care across the continuum of care settings
  - Only accrediting body that accredits and certifies across all types of healthcare provider settings
- Accelerate progress through collaboration, consultation
  - Convener of influential healthcare stakeholders to focus on critical industry issues
- Provide knowledge, expertise to help organizations move beyond accreditation toward high reliability

HIGH RELIABILITY FRAMEWORK

What is High Reliability in Health Care?

- **High reliability** describes organizations and industries that maintain high levels of quality and safety over long periods with very few or no adverse or sentinel events, despite the potential for large-scale harm

- **High reliability in health care** has been defined as “maintaining consistently high levels of safety and quality over time and across all health care services and settings”

Chassin MR, Loeb JM. High-Reliability Health Care: *Getting There from Here*. *Milb Q* 2013;91(3):459-90

HRO Characteristics

- HROs have systems in place that enable it to withstand operational dangers and hazards, yet still achieve its goals and objectives.*



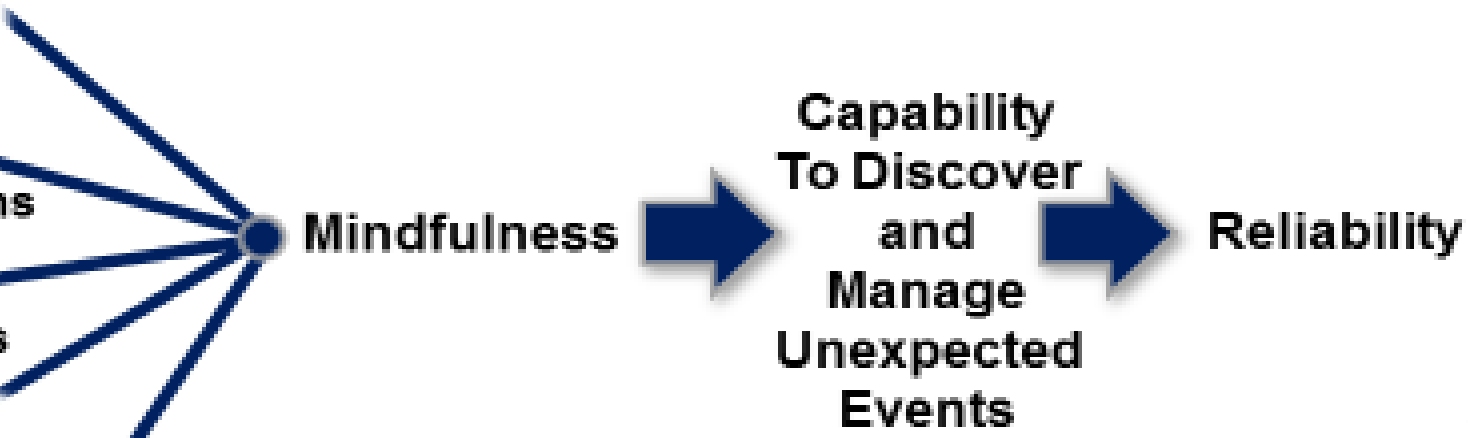

* Reason (2000)

© Copyright, The Joint Commission

A Mindful Infrastructure for High Reliability

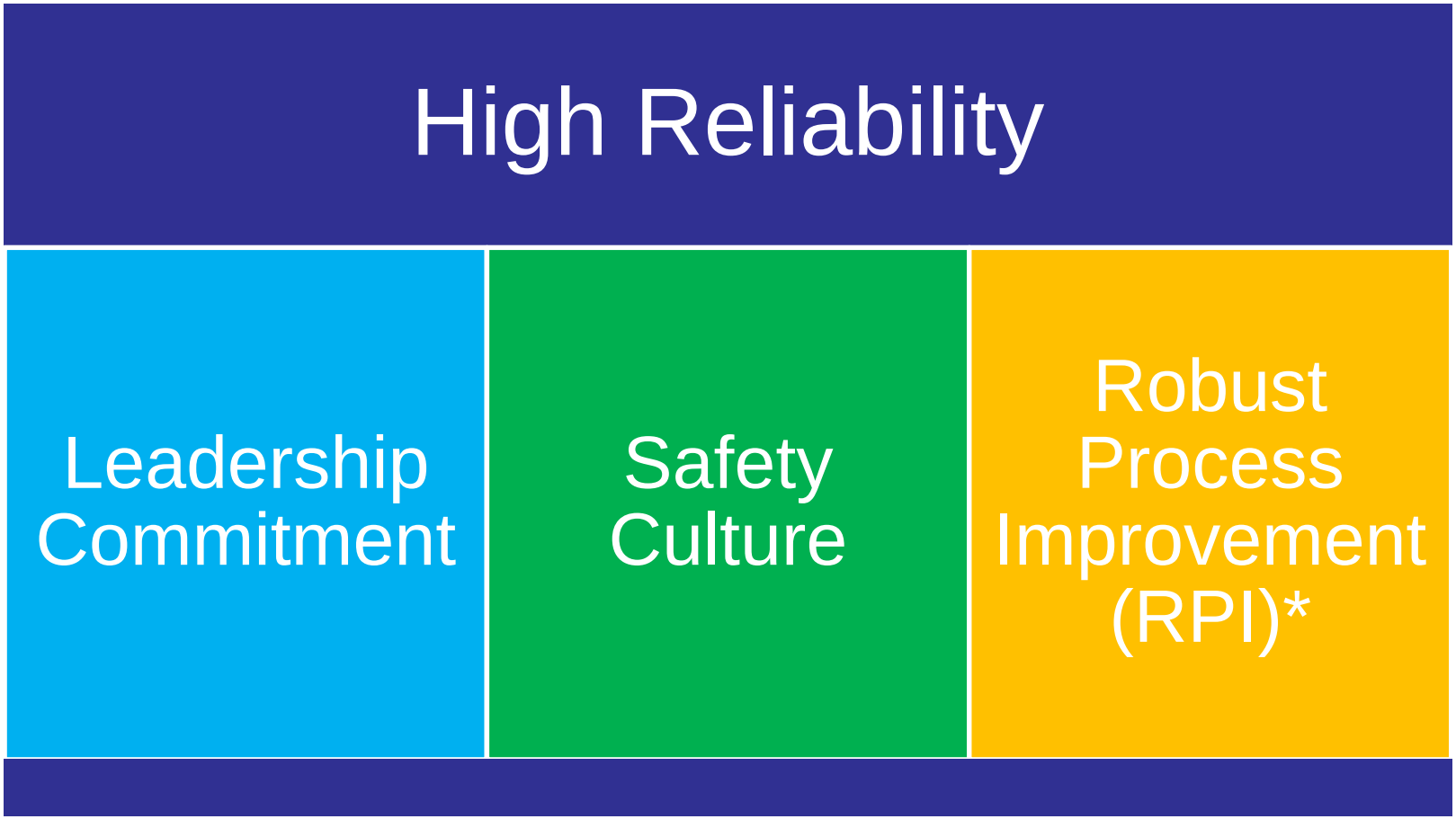
5 PROCESSES

1) Preoccupation with Failure
2) Reluctance to Simplify Interpretations
3) Sensitivity to Operations
4) Commitment to Resilience
5) Underspecification of Structures



Weick, Sutcliffe & Obstfeld (1999)

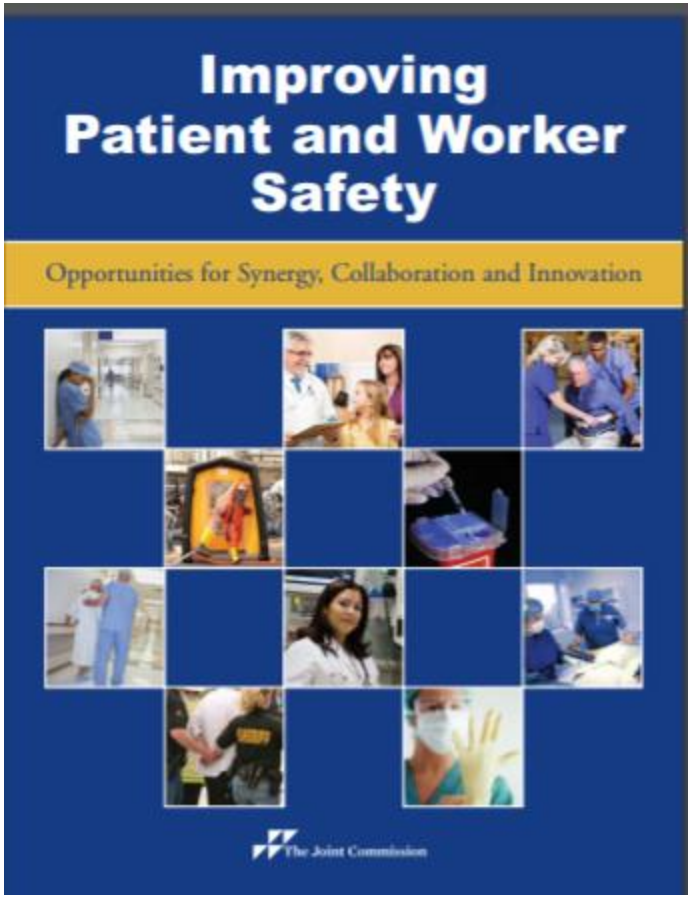
Three imperatives to becoming a high reliability organization



*RPI is a way to improve business, operational, financial and clinical performance by focusing on specific processes of production. RPI incorporates Lean Six Sigma and formal change management methods.

Source: Chassin and Loeb 2013

Safety culture applies to staff



- NIOSH NORA developed monograph 2012
- "The organizational culture, principles, methods, and tools for creating safety are the same, regardless of the population whose safety is the focus."

  Paul Schyve MD

https://www.jointcommission.org/assets/1/18/TJC-ImprovingPatientAndWorkerSafety-Monograph.pdf

Similar topics in staff and patient safety culture instruments

Table 1-2: Common Dimensions Across Safety Culture Tools

Major Dimensions	Examples of Topic Areas: Worker Safety Culture Tools	Examples of Topic Areas: Patient Safety Culture Tools
Leadership and management	Leadership and management support for staff safety; degree of supervision, leadership hierarchy, policies and procedures	Perceptions of management; leadership and management support for patient safety; nonpunitive response to errors, policies, and procedures; adequacy of training
Group behaviors and relationships	Workgroup relations, conflict vs. cooperation, social relations, coworker trust, supportiveness	Teamwork within and across units; quality of hand-offs and transitions
Communications	Openness of communication, formal and informal methods, conflict resolution approaches	Feedback and communication about error; reporting mechanisms
Quality of work life: structural attributes; working conditions	Staffing adequacy, job satisfaction, team satisfaction, security; work pressure, rewards, job security, forced overtime, benefits	Staffing adequacy, job satisfaction, team satisfaction; resource availability; stress recognition

https://www.jointcommission.org/assets/1/18/TJC-ImprovingPatientAndWorkerSafety-Monograph.pdf

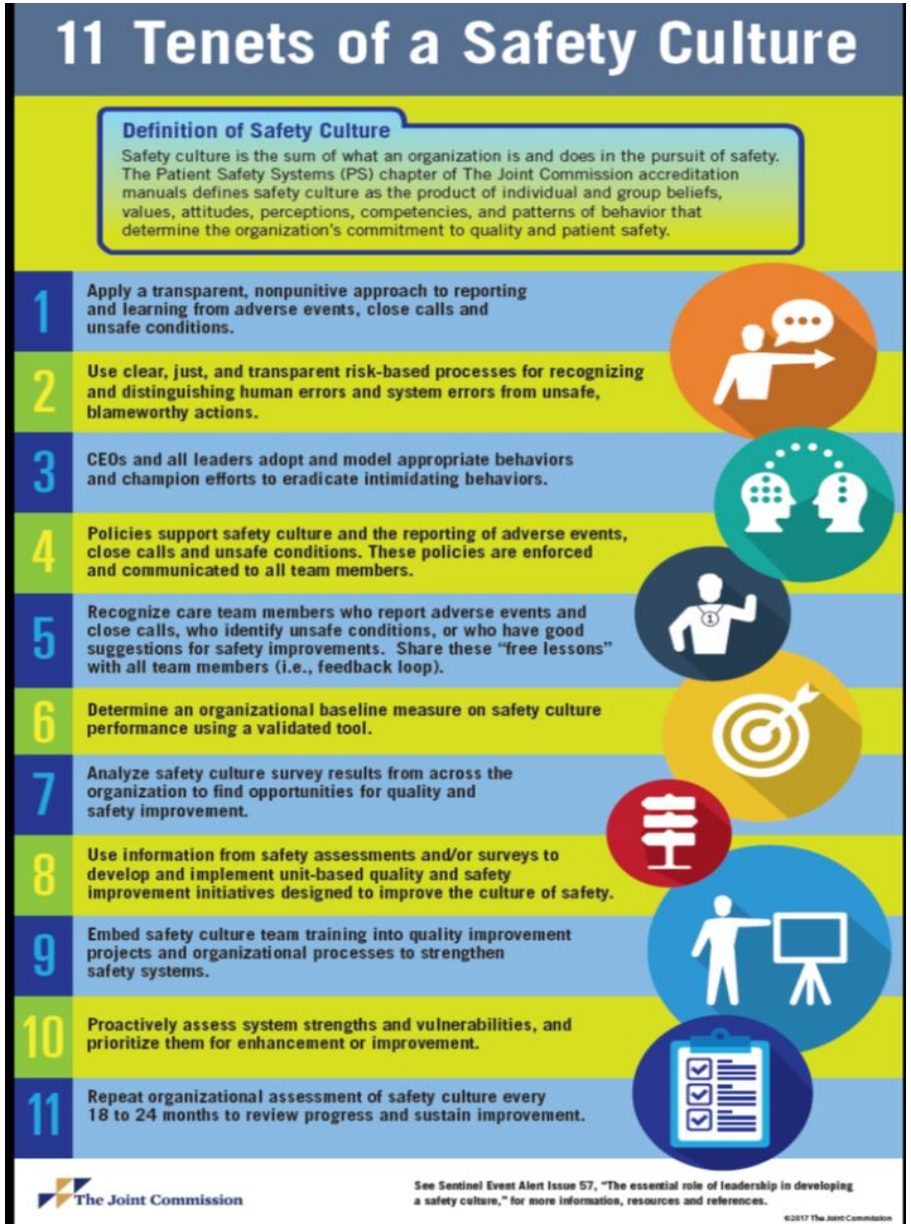
The inseparable relationship between

Leadership and safety culture

The Joint Commission

Leadership and culture: raising awareness

- Sentinel Event Alert 57: The essential role of leadership in developing a safety culture (3/17)
  - "In any health care organization, leadership's first priority is to be accountable for effective care while protecting the safety of patients, employees, and visitors"
  - Infographic at https://www.jointcommission.org/assets/1/18/SEA_57_Safety_Culture_Leadership_0317.pdf



Related Recent Sentinel Event Alerts

Sentinel Event Alert 59: Physical and verbal violence against health care workers

April 16, 2018

Download This File

"I've been bitten, kicked, punched, pushed, pinched, shoved, scratched, and spat upon," says Lisa Tenney, RN, of the Maryland Emergency Nurses Association. "I have been bullied and called very ugly names. I've had my life, the life of my unborn child, and o my other family members threatened, requiring security escort to my car."

Situations such as these describe some of the types of violence directed toward health care workers. Workplace violence is not merely the heinous, violent events that make the news; it is also the everyday occurrences, such as verbal abuse, that are often overlooked.

Additional Resources:

- Joint Commission requirements relevant to physical and verbal violence against health care workers
- View Infographic: Take a stand: No more violence to health care workers

Sentinel Event Alert Issue 48: Health care worker fatigue and patient safety

June 20, 2018

Download This File

Re-issue from 2011

(Addendum, May 2018) The link between health care worker fatigue and adverse events is well documented, with a substantial number of studies indicating that the practice of extended work hours contributes to high levels of worker fatigue and reduced productivity. These studies and others show that fatigue increases the risk of adverse events, compromises patient safety, and increases risk to personal safety and well-being. While it is acknowledged that many factors contribute to fatigue, including but not limited to insufficient staffing and excessive workloads, the purpose of this *Sentinel Event Alert* is to address the effects and risks of an extended work day and of cumulative days of extended work hours.

See Addenda on Pages 2 and 3.

Joint WPV Webinar with OSHA July 2018 plus resources available at https://www.jointcommission.org/workplace_violence_prevention_implementing_strategies_for_safer_healthcare_organizations_/

Components of a safety culture and related hospital leadership (LD) 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.
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 (sometimes referred to as close calls [“near misses”] or good catches) 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.

† These components of a safety culture were identified by Joint Commission senior leadership in the following article: Chassin MR and Loeb JM. High-reliability health care: getting there from here. Milbank Q.2013;91(3):459–490.

Enhanced safety culture survey process

- Same activities: Opening Conference; Daily Briefings; Individual, System, and Program-Specific Tracers; Leadership Session; and Organization Exit Conference.
- Surveyors review SC survey
- Five-minute video “Leading the Way to Zero.”
- Surveyors tracing safety culture asking questions as part of other survey activities

The Joint Commission
Perspectives®

THE OFFICIAL NEWSLETTER OF THE JOINT COMMISSION

Contents

1 Safety Culture Assessment: Improving the Survey Process
5 Improving the Reliability and Consistency of Surveys
7 Accreditation Participation Requirement Added for Deemed Status Organizations
9 Correction Change for Citing Ligature Deficiencies: Same EP, Different CoP
10 OSHA Requires Electronic Submission of Injury and Illness Data
11 Clarifying Survey Team Composition for Pediatric Hospitals
12 Consistent Interpretation
14 Intracycle Monitoring Calls Suspended
15 May JQPS Table of Contents
18 In Sight

Requirement

Safety Culture Assessment: Improving the Survey Process

As part of its commitment to promote high reliability in health care, The Joint Commission urges organizations to establish a safety culture that fosters trust in reporting unsafe conditions to ensure high-quality patient care. A project recently completed by The Joint Commission addressed how to improve the assessment of safety culture during survey. Health care organizations and surveyors responded so positively to the project that The Joint Commission will implement survey process improvements in **June 2018 for hospitals and critical access hospitals** and in **October 2018 for all other programs**.

Background for Improved Process

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."* While existing resources for establishing a safety culture include the work of the Joint Commission Center for Transforming Healthcare and published materials such as the "Patient Safety Systems" (PS) chapter of the *Comprehensive Accreditation Manuals*, feedback from customers and surveyors identified a critical next step in the high-reliability journey: Evaluate and improve how safety culture is assessed during the survey process.

* *The Joint Commission. Comprehensive Accreditation Manuals. "Patient Safety Systems" (PS) chapter. Oak Brook, IL: Joint Commission Resources, 2018.*

http://www.jointcommission.org

Copyright 2018 The Joint Commission
Perspectives®, June 2018, Volume 38, Issue 6

The Joint Commission

Sample questions for assessing safety culture

For Leadership	For Staff
How do you assess the culture of safety in your organization? What instrument are you using?	Have you ever completed a safety culture survey? Have you seen the results of a safety culture survey? Does your supervisor discuss the results?
Do you include safety culture improvement goals in performance expectations for leaders? What about middle management?	Is there a formal mechanism for reporting intimidating behavior? Would you feel comfortable reporting intimidating behavior?
What quality improvement projects have you conducted to improve your scores on safety culture?	What process do you have in place for reporting “close calls/near misses” or an error that occurred but did not reach the patient?
Have you adopted specific codes of behavior for physicians & staff? Are they the same for everyone? Are your disciplinary procedures equitable and transparent?	Does leadership conduct root cause analyses of “close calls/near misses” that are reported?

Conclusion

- The Joint Commission strives to transform health care into a high reliability industry and ensure patients receive the safest, highest quality care
  - Evaluate organizations on safety culture through standards and survey process
- Many aspects of safety culture apply to staff and patient safety
- Emphasis is relatively recent and time will tell if it has an impact

The Joint Commission

Thank you!

- Questions?
- Contact: bbraun@jointcommission.org or 630-792-5928
- References
  - Reason J. Human error: Models and management. BMJ. 2000;320:768–770.
  - Weick KE, Sutcliffe KM, Obstfeld D. Organizing for high reliability: Processes of collective mindfulness. Res Organizational Behav.1999; 21(s 81):23–81.
  - Chassin MR, Loeb JM, High-Reliability Health Care: Getting There from Here. The Milbank Quarterly, Vol. 91, No. 3, 2013 (pp. 459–490)

The Joint Commission

The Joint Commission Disclaimer

- These slides are current as of 11/30/18. The Joint Commission reserves the right to change the content of the information, as appropriate.
- These slides are only meant to be cue points, which were expounded upon verbally by the original presenter and are not meant to be comprehensive statements of standards interpretation or represent all the content of the presentation. Thus, care should be exercised in interpreting Joint Commission requirements based solely on the content of these slides.
- These slides are copyrighted and may not be further used, shared or distributed without permission of The Joint Commission. Distribution of the speaker's presentation other than in PDF format is expressly prohibited.

The Joint Commission