Safety Culture and Leadership: A View from The Joint Commission

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The Joint Commission

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

- Accreditation and certification operations
- Standards development and interpretation
- Performance Measurement
- Research
- Communications

Center for Transforming Healthcare

- Robust Process Improvement (RPI) trained staff “belts”
- Targeted Solution Tools
- High reliability-focused self-assessment & resources (ORO™ 2.0)
- Education and training

Joint Commission Resources

- Publications
- Software
- Education programs
- Consultation
- Joint Commission International: standards development, accreditation & certification
How The Joint Commission is...

- 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.”

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)
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

Mindfulness → Capability to Discover and Manage Unexpected Events → Reliability

Weick, Sutcliffe & Obstfeld (1999)
Three imperatives to becoming a high reliability organization

High Reliability

Leadership Commitment  Safety Culture  Robust Process Improvement (RPI)*

*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

[Link to the monograph: https://www.jointcommission.org/assets/1/18/TJC-ImprovingPatientAndWorkerSafety-Monograph.pdf]
Similar topics in staff and patient safety culture instruments

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<tbody>
<tr>
<td>Leadership and management</td>
<td>Leadership and management support for staff safety; degree of supervision, leadership hierarchy, policies and procedures</td>
<td>Perceptions of management; leadership and management support for patient safety; nonpunitive response to errors, policies, and procedures; adequacy of training</td>
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<tr>
<td>Group behaviors and relationships</td>
<td>Workgroup relations, conflict vs. cooperation, social relations, coworker trust, supportiveness</td>
<td>Teamwork within and across units; quality of handoffs and transitions</td>
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<tr>
<td>Communications</td>
<td>Openness of communication, formal and informal methods, conflict resolution approaches</td>
<td>Feedback and communication about error; reporting mechanisms</td>
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<td>Quality of work life: structural</td>
<td>Staffing adequacy, job satisfaction, team satisfaction, security; work pressure, rewards, job security, forced overtime,</td>
<td>Staffing adequacy, job satisfaction, team satisfaction; resource availability; stress recognition</td>
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<td>working conditions</td>
<td>benefits</td>
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https://www.jointcommission.org/assets/1/18/TJC-ImprovingPatientAndWorkerSafety-Monograph.pdf
The inseparable relationship between leadership and safety culture
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

“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 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

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

(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.

## Components of a safety culture and related hospital leadership (LD) standards

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<th>Component</th>
<th>Description</th>
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<td><strong>Assessment</strong></td>
<td>LD.03.01.01, EP 1: Leaders regularly evaluate the culture of safety and quality using valid and reliable tools.</td>
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<td><strong>Strengthening Systems</strong></td>
<td>LD.03.01.01, EP 2: Leaders prioritize and implement changes identified by the evaluation [of safety culture].</td>
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<td>LD.03.01.01, EP 5: Leaders create and implement a process for managing behaviors that undermine a culture of safety.</td>
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<td><strong>Trust/Intimidating Behavior</strong></td>
<td>LD.03.01.01, EP 4: Leaders develop a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety.</td>
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<td><strong>Identifying Unsafe Conditions</strong></td>
<td>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.</td>
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<td><strong>Accountability/Just Culture</strong></td>
<td>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.</td>
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† 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
## Sample questions for assessing safety culture

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

Questions?

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References

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