and how easily a failure can be detected.[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.
- 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 for more information.
- 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 and https://digital.ahrq.gov/health-it-tools-and-resources/evaluation-resources/workflow-assessment-health-it-toolkit
- 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.

Strategies for conducting an effective proactive risk assessment, no matter the strategy chosen, should address the following:

- Promote a blame-free **reporting** culture (a blame-free **reporting** culture should be differentiated from the term *blame-free* in relation to *accountability* and *Just Culture* principles) (*see also* Sidebar 1).
- Describe the chosen process (for example, through use of 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 patients 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 comprehensive systematic analysis such as root cause analysis.
- Design or redesign the process and/or the underlying systems to minimize the risk of the effects on patients.
- Test and implement the newly designed or redesigned process.
- Monitor the effectiveness of the newly designed or redesigned process.

Encouraging Patient Activation

To achieve the best outcomes, patients and families must be more actively engaged in decisions about their health care and must have broader access to information and support. Patient activation is a critical component of patient safety. Activated patients are less likely to experience harm and unnecessary hospital readmissions.

Patients who are less activated suffer poorer health outcomes and are less likely to follow their physician's or other licensed practitioner's advice.[31,32] A patient-centered approach to care can help hospitals assess and enhance patient activation. Achieving this requires leadership engagement in establishing patient-centered care as a top priority throughout the hospital. This includes adopting the following principles[33]:

- Patient safety guides all decision-making.
- Patients and families are partners at every level of care.
- Patient- and family-centered care is verifiable, rewarded, and celebrated.

- The physician or other licensed practitioner responsible for the patient's care, or the physician's or other licensed practitioner's designee, discloses to the patient and family any unanticipated outcomes of care, treatment, and services in accordance with the organization's policy on disclosure (**Standard PCC.02.03**).
- Transparent communication when harm occurs. Although Joint Commission International standards do not require apologies or disclosure in all circumstances, evidence suggests that patients benefit psychologically and are less likely to pursue litigation when physicians disclose harm, express sympathy, and apologize.[34]
- Staffing levels are sufficient, and the staff has the necessary tools and skills.
- The hospital has a focus on measurement, learning, and improvement.
- Staff must be fully engaged in patient- and family-centered care as demonstrated by their skills, knowledge, and competence in compassionate communication.

Hospitals can adopt a number of strategies to support and improve patient activation, including promoting culture change, adopting transitional care models, and leveraging health information technology capabilities.[33]

Several JCI standards address patient rights and provide an excellent starting point for hospitals seeking to improve patient activation. These standards require that hospitals do the following:

- Respect, protect, and promote patient rights (**Standards PCC.01.00** and **PCC.01.01**).
- Respect the patient's right to receive information in a manner the patient understands (**Standard PCC.01.01**).
- Respect the patient's right to participate in decisions about their care, treatment, and services (**Standard PCC.02.00**).
- Honor the patient's right to give or withhold informed consent (**Standard PCC.03.00**).
- Address patient decisions about care, treatment, and services received at the end of life (**Standards PCC.02.01** and **COP.08.00**).
- Inform the patient about their responsibilities related to their care, treatment, and services (**Standard PCC.02.01**).

Beyond Accreditation: Joint Commission International Is Your Patient Safety Partner

To assist hospitals on their journey toward creating highly reliable patient safety systems, Joint Commission International (JCI) provides many resources, including the following:

- *JCI Quality and Patient Safety Department:* An internal Joint Commission department that offers hospitals guidance and support when an organization experiences a sentinel event or when a safety event is reported that may require analysis or improvement work JCIQuality@jcrinc.com.
- *Standards Interpretation Group*: An internal Joint Commission International department that helps organizations with their questions about Joint Commission International standards. Organizations can submit questions about standards to the Standards Interpretation Group by submitting a question to: https://www.jointcommissioninternational.org/standards/submit-a-jci-standards-interpretation-question/.
- *International Patient Safety Goals:* Joint Commission International gathers information about emerging patient safety issues from widely recognized experts and stakeholders to create the International Patient Safety Goals® (IPSG), 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 Goals, go to the IPSG chapter in the *Joint Commission International Accreditation Standards for Hospitals,* 8th Edition.
- *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:* Joint Commission Resources offers free and fee-based webinars and podcasts on various accreditation and patient safety topics.