Patient Safety Systems (PS)

Quality and Patient Safety in Health Care

The quality of care and the safety of patients are core values of the Joint Commission International (JCI) accreditation process. This is a commitment JCI has made to patients, families, health care practitioners, staff, and health care organization leaders. The ultimate purpose of the JCI accreditation process is to enhance quality of care and patient safety.

Each accreditation requirement, the survey process, the Sentinel Event Policy (https://www.jointcommissioninternational.org/contact-us/sentinel-event-policy/) and other JCI policies and initiatives are designed to help organizations reduce variation, reduce risk, and improve quality. Hospitals should have an integrated approach to patient safety so that safe patient care can be provided for every patient in every care setting and service. Hospitals are complex environments that depend on strong leadership to support an integrated patient safety system that includes the following:

- Safety culture
- Validated methods to improve processes and systems
- Standardized ways for interdisciplinary teams to communicate and collaborate
- Safely integrated technologies

In an integrated patient safety system, staff and leaders work together to eliminate complacency, promote collective mindfulness, treat each other with respect and compassion, and learn from patient safety events, including close calls and other system failures that have not yet resulted in patient harm. The definition of these and other key terms are as follows:

- **Patient Safety Event** – an event, incident, or condition that could have resulted, or did result, in harm to a patient
- **Adverse Event** – a patient safety event that resulted in harm to a patient. Adverse events should prompt notification of hospital leaders, investigation, and corrective actions. An adverse event may or may not be the result of an error.
- **Sentinel Event** – a patient safety event (not primarily related to the natural course of a patient's illness or underlying condition) that reaches a patient 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 (*See* Sentinel Event Policy https://www.jointcommissioninternational.org/contact-us/sentinel-event-policy/)
- **Close Call** – a patient 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 own disease process or medical condition that increases the probability of a patient safety event, adverse event, or sentinel event

Quality and safety in health care are closely linked. *Quality*, as defined by the Institute of Medicine, is the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.[1] It is achieved when processes and results meet or exceed the needs and desires of the people it serves.[2,3] Those needs and desires include safety—meaning protection from harm. The components of a quality management system should include the following:

- Ensuring reliable processes
- Decreasing variation and defects (waste)
- Focusing on achieving positive measurable outcomes
- Using evidence to ensure that a service is satisfactory

Patient safety emerges as a central aim of quality. *Patient safety*, as defined by the World Health Organization, is the prevention of errors and adverse effects to patients that are associated with health care. Safety (protection from harm) is what patients, families, staff, and the public expect from Joint Commission International–accredited organizations. Although patient safety events may not be eliminated, the goal is always zero harm. Joint Commission International–accredited organizations should be continually focused on eliminating systems failures and human errors that may cause harm to patients, families, and staff.

Goals of This Chapter

This "Patient Safety Systems" (PS) chapter provides health care organizations with a proactive approach to maintaining or redesigning a patient-centered system that aims to improve quality of care and patient safety, an approach that aligns with Joint Commission International's mission and its standards.

JCI partners with accredited organizations to improve the ability of health care systems to protect patients. The first obligation of health care is to "do no harm." Therefore, this chapter focuses on the following three guiding principles:

1. Aligning existing JCI standards with daily work to engage patients and staff throughout the health care system on reducing harm
2. Assisting health care organizations to become learning organizations by advancing knowledge, skills, and competence of staff and patients 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 hospitals about the importance and structure of an integrated patient safety system and helps staff understand the relationship between JCI accreditation and patient safety. It offers approaches and methods that may be adapted by any organization that aims to increase the reliability and transparency of its complex systems while removing the risk of patient harm.

The "Patient Safety" (PS) chapter cross-references specific Joint Commission International standards, describing how existing requirements can be applied to achieve improved patient safety. It does not contain any new requirements for accreditation, and the PS chapter is not intended as a stand-alone chapter for accreditation survey purposes. Standards referenced in this chapter are formatted with the standard number in boldface type (for example, "**Standard PCC.01.00**") and are accompanied by language that summarizes the standard. For the full text of a standard and its measurable elements (MEs), please refer to the *Joint Commission International Accreditation Standards for Hospitals,* 8th Edition.

Throughout this chapter, we will do the following:

- Discuss how hospitals can develop into learning organizations.
- Identify the role of leaders to establish a safety culture and ensure staff accountability.
- Explain how hospitals can continually evaluate the status and progress of their patient safety systems.
- Describe how hospitals can work to prevent patient safety events with proactive risk assessments.
- Highlight the critical component of patient activation and engagement in a patient safety system.
- Provide a framework to guide hospital leaders as they work to improve patient safety in their hospitals.