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Joint Commission 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.*

What Is NOT Changing

Results of this project did not involve changes to standards or elements of performance (EPs). Already familiar to organizations, the standards and EPs that relate to the high-reliability subdomains (*see* Table 1) remain unchanged.

There is also no change to the survey methods; that is, The Joint Commission will continue to follow the survey agenda with which organizations are already familiar. This means that surveyors and organizations will still engage in activities such as the Opening Conference; Daily Briefings; Individual, System, and Program-Specific Tracers; Leadership Session; and Organization Exit Conference.

Table 1. Five Components of a Safety Culture† and Related Leadership (LD) Requirements

Assessment	Strengthening Systems	Trust/Intimidating Behavior	Identifying Unsafe Conditions	Accountability/ Just Culture
LD.03.01.01, EP 1: Leaders regularly evaluate the culture of safety and quality using valid and reliable tools.	• 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.	LD.03.01.01, EP 4: Leaders develop a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety.	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.	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. (*See also* LD.03.04.01, EP 5; LD.04.04.03, EP 3; PI.01.01.01, EP 8) **Note:** *This EP is intended to minimize staff reluctance to report errors in order to help an organization understand the source and results of system and process failures. The EP does not conflict with holding individuals accountable for their blameworthy errors.*

† 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.

What IS Changing

This project was about improving the survey process. Process improvements include the following expectations:

- An organization will be expected to include its most recent Safety Culture Survey with the required documents listed in the Survey Activity Guide. The surveyors will want to review this prior to the opening conference (or as early in the survey process as possible). Helpful resources for completing a Safety Culture Survey include *Sentinel Event Alert 57*: "The essential role of leadership in developing a safety culture" and the accompanying infographic "11 Tenets of a Safety Culture." These resources suggest tactics such as board engagement, leadership education, goalsetting, staff support, dashboards and reports that routinely review safety data, and other resources that can be used to support safety culture initiatives.
- On Survey Day One, the survey team will provide a link to the five-minute video "Leading the Way to Zero." The team will ask the organization to make the audiovisual arrangements necessary to show the video during the Leadership Session. (Some organizations may ask to view it again at the Organization Exit Conference). Surveyors can also show the video to small groups on their tablets if the organization's technology does not allow for a larger presentation.
- Surveyors will be tracing safety culture as a part of other survey activities and asking questions to assess safety culture. *See* Table 2 for sample questions for assessing a safety culture.

The Joint Commission will continue to evaluate this improved survey process and will keep you informed of any updates. Questions may be directed to your organization's assigned Account Executive. P

Table 2. 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?
Do you have internal or external benchmarks?	When an error occurs, do you have confidence that your leadership will take an appropriate look at how the system or process is accountable versus an individual?
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?

Table 2. Sample Questions for Assessing Safety Culture (continued)

For Leadership	For Staff
Does the board set expectations for improving safety culture?	Does leadership conduct root cause analyses of "close calls/near misses" that are reported?
Have you adopted specific codes of behavior for physicians and staff? Are they the same for everyone? Are your disciplinary procedures equitable and transparent?	
What process do you have in place for reporting a "close call" or an error that occurred but did not reach the patient?	
In the event an error occurs and a patient is harmed, how do you determine whether it is a blameless error (for learning) or a blameworthy error (for discipline)?	

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