

Advancing Workplace Safety Through Accreditation: Gleneagles JPMC's Journey in Just Culture and Transparent Reporting

Zubir, N. Z.¹, Zainal Abidin, D.H.¹, Can, A. Y.², & Sharbini, A.³

1. Department of Quality and Medical Affairs, Gleneagles JPMC
2. Department of Human Resource, Gleneagles JPMC
3. Health and Environmental Safety Lead, Gleneagles JPMC

Background

Workplace safety is essential for protecting healthcare staff and ensuring high-quality patient care. Since 2020, Gleneagles JPMC has used Joint Commission International (JCI) accreditation to strengthen its safety culture through Just Culture principles and transparent reporting. However, the 2023 Patient Safety Culture Survey showed only **21% of staff perceived a non-punitive response to errors**, 28% below the AHRQ benchmark, indicating a significant gap in psychological safety. JCI standards emphasize confidential, non-punitive reporting systems and the use of incident data for organisational learning and continuous improvement, reinforcing the need to further strengthen Just Culture and transparent reporting practices.

Why it is a Problem?

- Traditional incident reporting systems that escalate cases without considering staff psychological safety and mental health **led to fear of reporting**.
- Fear of blame and punitive responses may lead to **underreporting of incidents and near misses**, resulting in missed opportunities to identify hazards, improve systems, and prevent errors.
- Risk of non-compliance to JCI standards** that emphasizes the importance of just culture, strong reporting systems, and continuous learning.

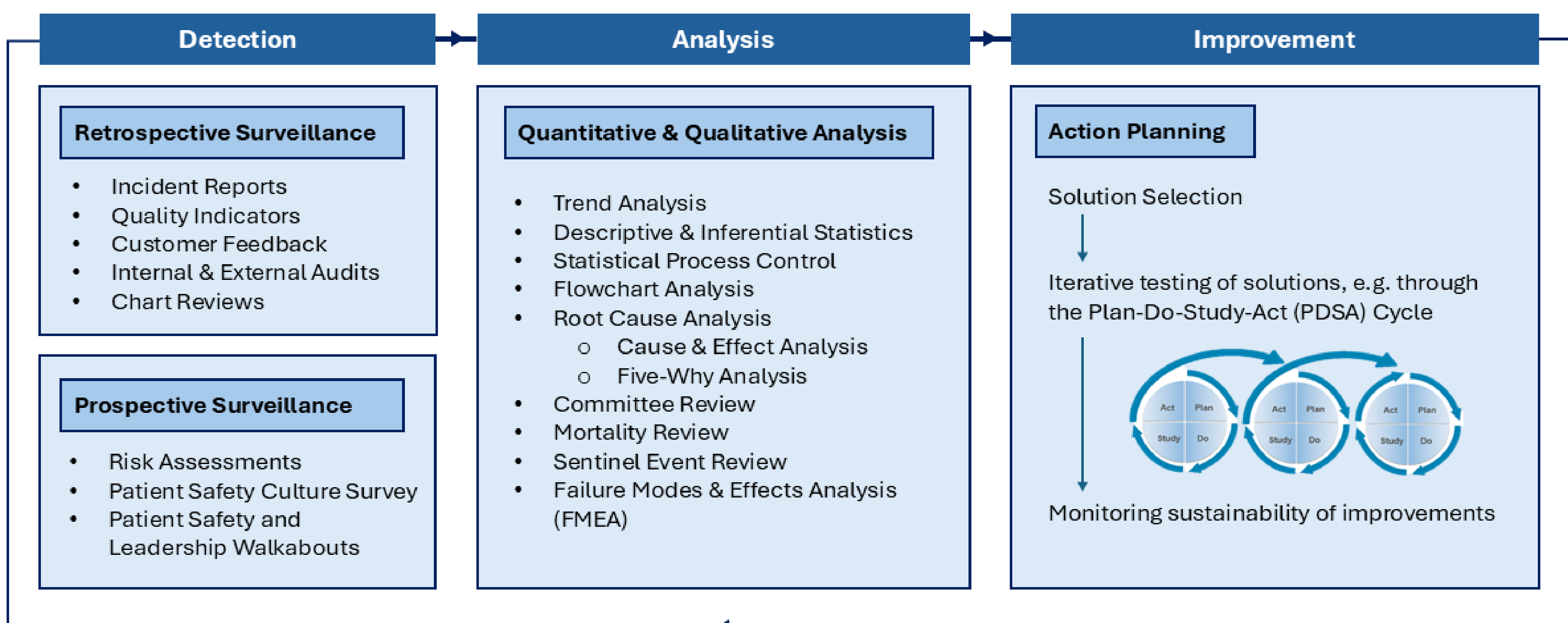
Aim Statement

To describe how JCI accreditation frameworks and authority regulations were leveraged to strengthen workplace safety culture, transparent incident reporting, and just culture practices in a tertiary cardiac specialty hospital.

Measures

- To evaluate trends in staff engagement with voluntary incident reporting.
- To describe organizational strategies supporting non-punitive systems.
- To explore leadership and mental health initiatives contributing to workforce safety.
- To demonstrate how accreditation standards can operationalize sustainable safety culture practices.

QUALITY AND PATIENT SAFETY FRAMEWORK



Methodology

Study Design
A descriptive retrospective review of workplace safety and organizational culture initiatives implemented between 2021 and 2025 at Gleneagles JPMC.

Setting
A JCI-accredited tertiary cardiac specialty hospital in Brunei Darussalam.

Framework
The study utilized JCI accreditation standards, AHRQ and SHENA workplace safety regulation as the organizational framework for workplace safety and safety culture enhancement.

Data Sources
Incident reporting database (Riskman), 2023 Patient Safety culture survey findings, Organizational quality reports, Occupational health records, Internal safety program documentation.

Analysis
Descriptive analysis was conducted to evaluate reporting trends, workforce participation, and implementation outcomes.

Key Interventions Implemented

Structured Risk Management

- Use of **systematic investigation** and **proactive risk** methodologies including:
- Root Cause Analysis (RCA)
 - 5 Whys Analysis
 - Fishbone (Ishikawa) Diagrams
 - Failure Mode and Effects Analysis (FMEA)
 - Hazard Vulnerability Assessment (HVA)
 - ✓ Training of staff including Head of Departments to use the tools

Started Jan 2021

Leadership & Safety Engagement

- Leadership **Bi-monthly walkabouts** led by CEO/COO/Director of Nursing /Quality/HR/Safety
- Quarterly Environmental Audit covers **all departments (Gemba Walk)**
- Biennial AHRQ Patient Safety Culture Surveys

Jan 2022 - current

Workforce Wellbeing & Safety

- Mental health support through the **Intellect platform**
- Development of **Mental Health First Aiders** among GJPMC staff – 22 certified by 2025
- Workplace violence and injury management program** that includes verbal abuse and workplace bullying
- Quarterly proactive **environmental surveillance**

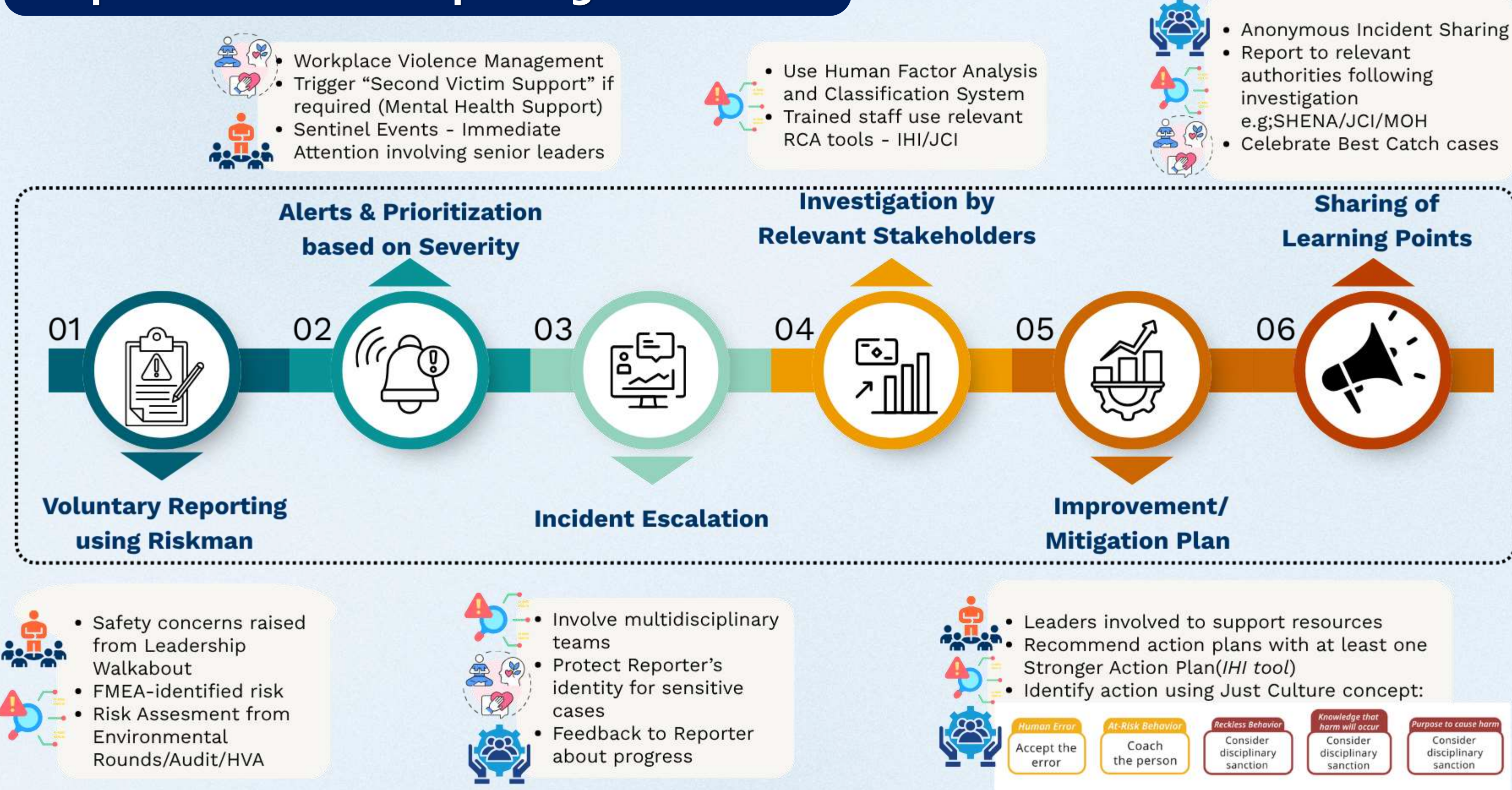
May 2023 - current

Just Culture & Transparent Reporting

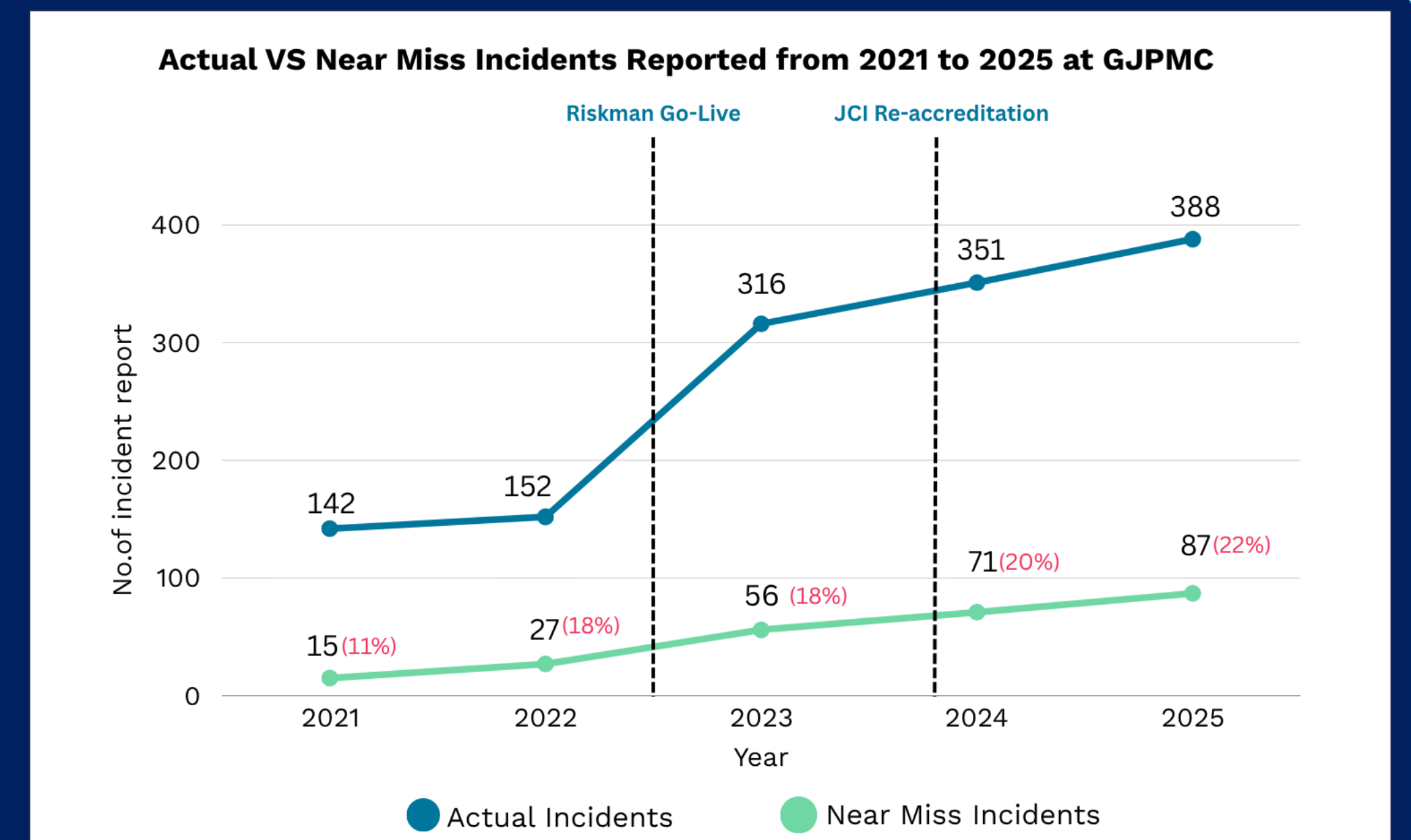
- Implementation of a **voluntary non-punitive** reporting system
- Encourage reporting of adverse events, near misses, hazards, and unsafe conditions
- Recognition programs for staff preventing incidents – **Best Catch Awards**
- Train **management team** on Just Culture

Jun 2024 - current

Improved Incident Reporting Process



Post-Intervention Data



Increasing trend in near-miss reporting from 11% in 2021 to 22% in 2025, indicating improved transparency and a stronger speaking-up culture. Aim to increase near-miss reporting to 45% by 2030.

Outcomes

Improved Reporting Transparency

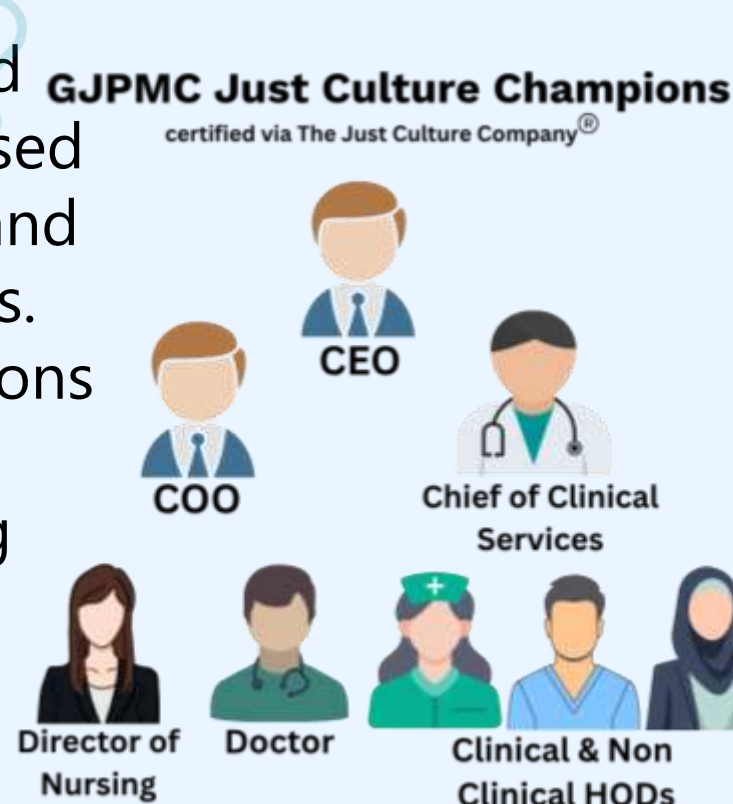
- Near-miss reporting increased substantially from 2021-2025, with 256 reports submitted, reflecting improved staff willingness to report safety concerns and unsafe conditions

Enhanced Staff Competency & Psychological Safety

- Since 2023;
- 38% of total staff trained in Quality Improvement tools using IHI/Lean Six Sigma methodologies
 - 22 staff accredited as Mental Health First Aiders
 - Intellect platform launched to support staff mental well-being.

Strengthened Just Culture

- Transition from blame-focused responses toward systems-based learning improved staff trust and engagement in safety activities.
- Total of 9 Just Culture champions from senior management and influencers completed training and certified.



Enhanced Leadership Visibility

- Leadership walkabouts and active engagement strengthened communication and organizational accountability for workplace safety.
- Staff able to voice out safety concerns openly without fear of retaliation.

Organizational Learning and External Collaboration

- Incident reports prioritizes learning and improvement, not highlighting staff involved.
- Safety reporting and learning extended beyond the institution and to national occupational safety platforms such as Safety, Health & Environment National Authority (SHENA).

References:

- Agency for Healthcare Research and Quality. (n.d.). Surveys on patient safety culture (SOPS). U.S. Department of Health and Human Services. <https://www.ahrq.gov/sops/index.html#text-citation>.
- Joint Commission International. (2025). *JCI accreditation standards for hospitals* (8th ed.). JCI.
- Churruarín, K., Ellis, L. A., Pomare, C., Hogden, A., Bierbaum, M., Long, J. C., & Braithwaite, J. (2021). Dimensions of safety culture: A systematic review of quantitative, qualitative and mixed methods for assessing safety culture in hospitals. *BMJ Open*, 17(7), e043982. <https://doi.org/10.1136/bmjopen-2020-043982>
- Institute for Healthcare Improvement. (2022). *Framework for safe, reliable, and effective care and learning health systems*. <https://www.ihi.org>
- Marx, D. (2001). *Patient safety and the "Just Culture": A primer for health care executives*. Columbia University. <https://www.healthcare.uioowa.edu>
- Yoon, H. B., Shin, J. S., & Kim, J. H. (2023). The relationship between hospital accreditation and patient safety culture: A systematic review. *PLOS ONE*, 18(5), e0285672. <https://doi.org/10.1371/journal.pone.0285672>