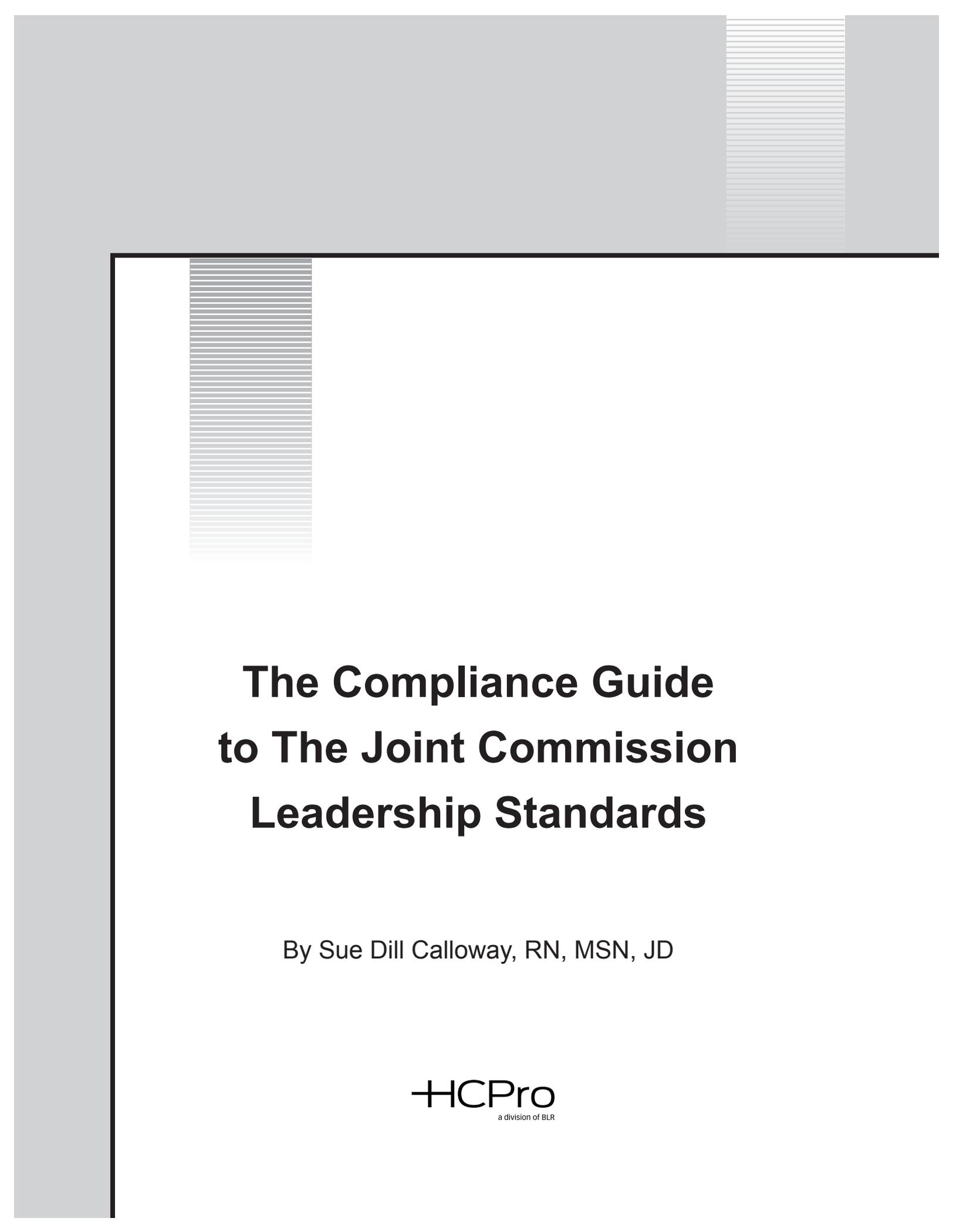


The Compliance Guide to
THE JOINT COMMISSION
LEADERSHIP
STANDARDS



SUE DILL CALLOWAY, RN, MSN, JD



The Compliance Guide to The Joint Commission Leadership Standards

By Sue Dill Calloway, RN, MSN, JD

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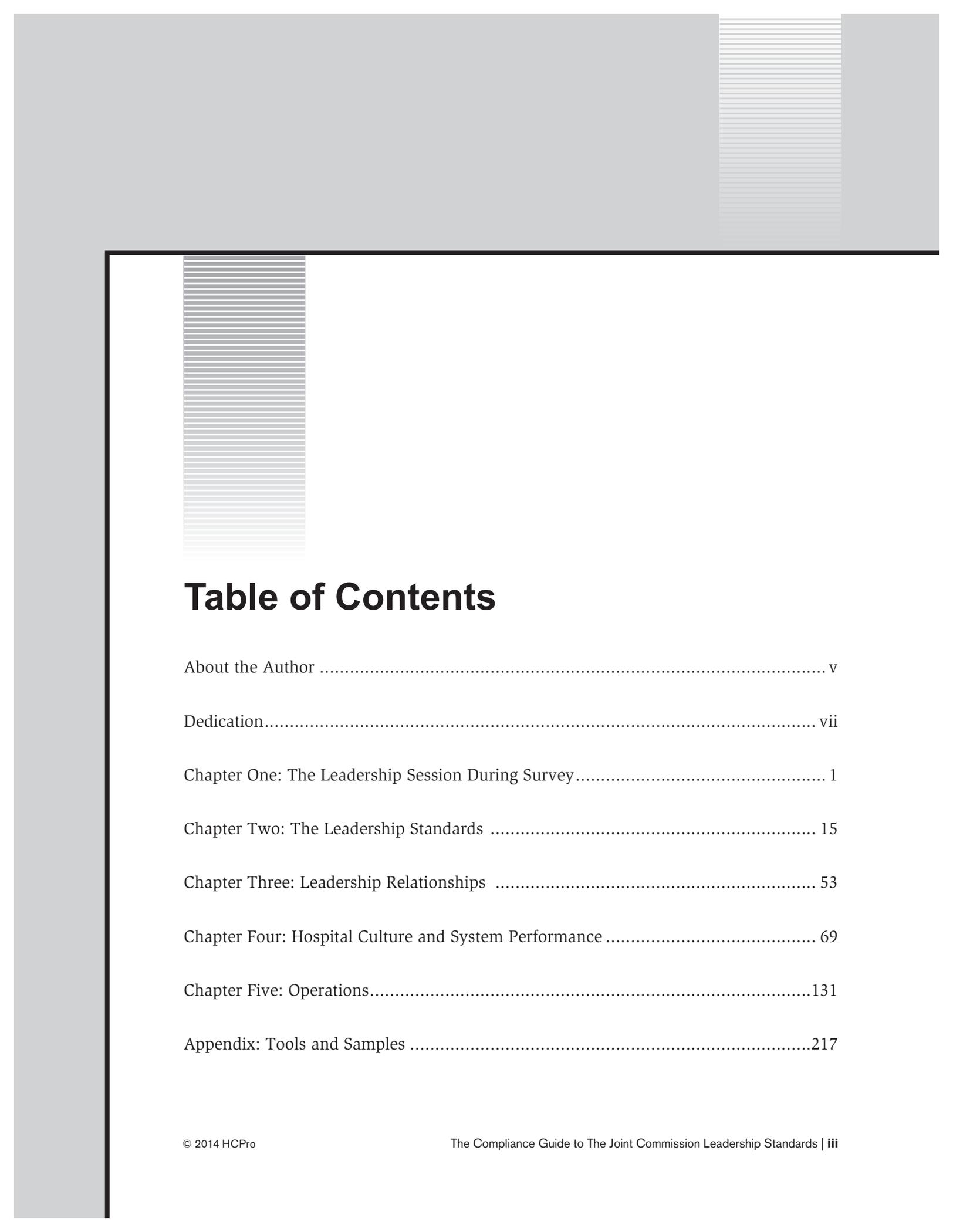


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About the Author

Sue Dill Calloway, RN, MSN, JD, is a well-known speaker, nurse attorney, and president of Patient Safety and Healthcare Consulting and Education. She is the past director of risk management and patient safety for the Doctors Company and the past Chief Learning Officer for the Emergency Medicine Patient Safety Foundation. She has given many presentations locally and nationally to nurses, physicians, and attorneys on medical and legal issues, and has authored more than 1,000 articles and 100 books. She has been a medico-legal consultant for more than 35 years and conducts educational programs for nurses, physicians, and other healthcare providers on topics such as The Joint Commission, CMS, documentation, medication errors, patient safety, legal, and risk management issues.



Dedication

This book is dedicated to my best friend and husband, Ralph E. Dill.

He gave me the spirit, support, and encouragement to complete this project.

The Leadership Session During Survey

Introduction

This chapter will discuss what to expect during the leadership session of The Joint Commission's unannounced survey process. This session, which lasts about 60 minutes, requires thoughtful planning by the board, the CEO, and senior leaders. Many leadership responsibilities directly impact the provision of care and treatment throughout the facility, and regardless of the leadership structure, all of these responsibilities must be carried out. Therefore, it is important to evaluate the facility's systems, infrastructure, and processes to ensure quality of care. The leadership session sets the stage for the entire survey process.

As of January 1, 2014, the topics of emergency management and patient flow were added to the leadership session. See the section on patient flow for information regarding questions asked during the patient flow tracer.

The leadership chapter of The Joint Commission's standards comprises four sections. The leadership session focuses on the third section, which is on organizational culture and system performance. Such performance is influenced by the five key pillars that are the foundation of the leadership chapter.

Five Key Pillars

The Joint Commission has identified five key systems that influence the performance of a hospital or healthcare organization. These five pillars, which are the foundation of the leadership chapter, include:

- Using data LD.03.02.01
- Planning LD.03.03.01
- Communication LD.03.04.01
- Changing performance LD.03.05.01
- People (staffing) LD.03.06.01

Leadership FAQs

Hospitals should review a section of The Joint Commission's (TJC) website (www.jointcommission.org/standards_information/jcfaq.aspx) to find answers to frequently asked questions (FAQ) regarding standards.

The website organizes the questions by accreditation manual. Click the tab called "select manual" and then scroll down and click on "hospitals." The Leadership chapter of the *Comprehensive Accreditation Manual for Hospitals* contains only two sections: "Contracted Services" and "Patient Flow and Boarding."

As of January 1, 2014, the topics of emergency management and patient flow were added to the leadership session. See the section on patient flow for information regarding questions asked during the patient flow tracer.

Contracted Services

The information contained in the contracted services FAQ is discussed in the section on contracted services in Chapter 5 of this book. This FAQ was published on April 8, 2010. The FAQ asks whether the standards for contracted services apply if the contracted organization is accredited or not by TJC. The answer to this question is “yes.” TJC must apply for deemed status like all of the other accreditation organizations. There are similar standards under tag numbers 83 to 86 in the Centers for Medicare & Medicaid Services (CMS) hospital *Conditions of Participation (CoP)* manual.

Hospitals can either employ the director of pharmacy as an employee or contract with a company to help run the pharmacy with the director as a contracted employee. Both CMS and Joint Commission would still want to ensure that the same standard of care is met. The hospital would evaluate the pharmacist with performance-based measures to ensure that the pharmacy standards are being met. There are many sources that can be used to evaluate contracted services. These include the following: direct observation of the care provided, review of incident reports, sentinel event analysis review, audit of documentation, review of performance based indicators specified in the contract, review of patient satisfaction surveys, input from medical staff, nurses, and other healthcare providers, collection of data including QAPI data, and review of periodic reports submitted by the individual. These are discussed in more detail in this book in the section on contracted services.

Patient Flow and Boarding

The Patient Flow and Boarding FAQ was added February 4, 2013. It did not use the traditional question and answer format. Instead, TJC just references the R3 Report from Issue 4 that addresses patient flow through the emergency department. R3 reports provide the rationale and references that are used in the development of new requirements. Hospitals can sign up to get new R3 reports when they are published by going to www.jointcommission.org. The initial R3 report was issued December 19, 2012.

The R3 report is discussed under the section of this book on the patient flow standards under LD.04.03.11. It discussed EPs 5, 7, and 8, which were amended January 1, 2013 and EPs 6 and 9, which were amended January 1, 2014. It also references the Provision of Care standards PC.01.01.01, EP 4 and 24, which address the need to board patients such as behavioral health patients. This is also discussed in detail in the book. Behavioral health patients are often seen in the emergency department as the number of inpatient beds has been dramatically decreased over the years. Many hospitals have a number of beds in the emergency department reserved for psychiatric patients awaiting transfer to behavioral health units. Many of these are locked units and staffed by behavioral health professionals.

The R3 report notes that a more focused set of expectations were needed for patients at risk due to prolonged boarding in the emergency department while awaiting placement. These additional standards were needed to promote safe quality care.

Culture and safety

The hospital's culture reflects the beliefs, attitudes, and priorities of the staff and directly impacts how effectively the staff performs, which in turn impacts patient safety. When he was the director of the Institute for Healthcare Improvement (IHI), Don Berwick once said that every system is perfectly designed to achieve exactly the results it gets. Lucian Leape, MD, a leader in patient safety, commented that management must manage for patient safety just as they manage for efficiency and profit maximization, and safety must become one of the elements on which the hospital or healthcare organization prides itself. Both leaders highlight the importance of the role that culture plays in patient safety.

Culture is the way things are done around the organization, and patient safety is the product of those individual and group values, attitudes, and perceptions. It is influenced by competencies and patterns of behavior, which affect the staff's commitment to managing health and safety as outlined by the hospital.

Patient safety also impacts culture. It creates the impetus for such behaviors as providing feedback on and communicating about changes that have been put into place; providing non-punitive responses to system errors; actively making changes to improve safety; instilling a sense of teamwork within units; and allowing staff members to communicate openly if something negatively impacts patient care. It requires that the facility have enough staff members to handle the workload. Hospital management staff need to provide support for patient safety. Good teamwork and cooperation are also important across units.

Another way that organizations can emphasize patient safety is by focusing on handoffs or handovers and transitions. They can help ensure that details don't fall through the cracks when transferring patients to another unit or giving a report to the oncoming staff.

Some dimensions of safety are affected by the quality of the leadership team. Good leaders are respectful and self-aware, they acknowledge fallibility, and they also focus on communication. They may institute executive walkrounds and open discussions of safety. They have a clear reporting infrastructure and support organizational learning.

Leaders who have an integrated patient safety program throughout their organization can reduce the risk of system failure. This can include continuous testing and change, as well as rapid cycle improvement, Six Sigma, or high-reliability organizational design. These methods can be used to help create a culture that approaches safety systematically, which is optimal for success.

Leadership Quality of High-Performing Hospitals

At a meeting late in 2008, the National Patient Safety Foundation focused on organizational characteristics associated with high performance in quality and safety. They performed a study to find out which medical centers demonstrated top performance on a broad-based measure of those attributes. The study looked at a number of areas, such as the Agency for Healthcare Research and Quality (AHRQ) safety indicators, the AHRQ inpatient quality indicators, and The Joint Commission core measures on heart attacks, heart failure, pneumonia, and postsurgical readmission rates. Researchers also sought to analyze disparities in core measures based on race, gender, and socioeconomic status.

To conduct the study, this team was given the names of the two top-, middle-, and bottom-performing hospitals, without being told which was which. The team visited these hospitals to conduct site assessments and see whether they could determine where each hospital placed.

During the site visit, the team looked at board and leadership engagement, strategic planning and goal setting, the hospital's ability to translate strategy into tactics, systems for accountability, organizational expertise in quality and safety, professionalism and cultural competencies, the culture of quality and safety, the use of information technology to advance quality and safety, communication strategies and practices, and patient centeredness in planning and strategy.

The team correctly identified the performance status of all six hospitals. The highest-performing hospitals exhibited a shared sense of purpose. Hospital leaders articulated and reinforced the vision that patient care came first. This sort of culture allowed these hospitals to define new levels of excellence in service, quality, and safety. The CEO and senior leaders at these hospitals played a critical role in clarifying this shared purpose, and that is what effective leadership is all about.

In addition, these hospitals had implemented accountability systems geared toward service quality and safety. Chairs accepted responsibility for quality and safety in their departments, and there was accountability, innovation, and redundancy at the unit level.

The top performers relentlessly worked to improve, and they measured themselves against external standards to determine their level of success. Collaboration enabled the employees at these hospitals to value each other's critical knowledge when solving problems. Leaders recognized employee contributions frequently, and at every level. The study also found that each high-performing hospital had a CEO who was passionate about service, quality, and safety and had an authentic, hands-on style.

The principles of the high performers are reflected in The Joint Commission's five key areas of leadership. The high performers would likely do well during the leadership session.

Who Should Attend the Leadership Session?

Leadership should attempt to have at least one member of the board at the leadership session, even if only by telephone. Hospitals may want to determine ahead of time which board members have more flexible schedules.

The CEO and senior leaders should also be in attendance. These include the C-suite people such as the chief operating officer, chief financial officer, chief information officer, chief medical officer, and chief nursing officer. The lab medical director, VP of clinical services, directors of patient services, and senior leaders from home care, behavioral health, ambulatory care, and nursing care center should also attend. Elected and appointed leaders of the medical staff, as well as the directors of human resources, staff development, and performance improvement, are also expected to attend the leadership session.

Purpose of the Leadership Session

The purpose of the leadership session is to explore where the hospital is on its journey toward becoming a high-reliability organization. Reliability in healthcare is defined as patients getting the right tests, medications, information, and procedures at the appropriate time and in accordance with their values and preferences. High-reliability organizations successfully avoid catastrophes and aim for the goal of causing zero patient harm.

In the leadership session, surveyors are instructed to discuss the characteristics of a high-reliability organization, specifically including a discussion of leadership's commitment to improving safety and the quality of care, to creating a culture of safety, and to creating a robust process improvement system. They are also instructed to discuss any survey findings that suggest underlying system issues.

Hospitals should incorporate the characteristics of high reliability from other high-risk industries, such as aviation and nuclear power. System changes can increase reliability and the chances of becoming a high-reliability organization. These changes can include addressing strategic priorities, addressing culture and infrastructure, engaging key stakeholders, communicating and building awareness, establishing and communicating system-level aims, tracking and measuring performance, supporting staff and families (including those impacted by medical errors), aligning system-wide activities and incentives, and redesigning systems.

The Joint Commission has a high reliability resource center (www.jointcommission.org/high-reliability.aspx) that offers free online learning modules along with an index of resources. The Institute of Healthcare Improvement (IHI) has several excellent resources on high-reliability organizations. *The Leadership Guide to Patient Safety* (available at www.ihl.org/resources/Pages/IHIWhitePapers/LeadershipGuidetoPatientSafetyWhitePaper.aspx) lists eight steps that are recommended for leaders to follow to achieve patient safety and high reliability in their organizations. Another reference worth researching is the Institute of High Reliability Organizing (<http://high-reliability.org/>).

The 14 Priority Focus Areas

The Joint Commission has identified the following 14 priority focus areas for the leadership session. It is important to determine how the hospital or organization complies with them:

- Assessment and care and services
- Communication
- Credentialed and privileged practitioners
- Equipment use
- Infection control
- Information management
- Medication management
- Organizational structure
- Orientation and training
- Rights and ethics
- Physical environment
- Quality improvement
- Patient safety
- Staffing

Before July 2014, the priority focus process (PFP) was a data-driven tool that The Joint Commission used to focus on survey activities. Sources that contributed to the PFP were the previous requirements for improvement from past surveys, data, performance measurement data (including ORYX), quality indicator profiles or quality measures, and complaints received, if any. The PFP focused on the issues that were most relevant to patient safety and quality

of care at the particular hospital or organization being surveyed. This process identified an area of priority focus, relevant standards, and appropriate survey activities. Then, it looked at processes, systems, and structures within the hospital or healthcare organization that were known to impact safety and quality. In July 2014, The Joint Commission discontinued Priority Focus Process reports and use of the related Priority Focus Areas and Clinical/Service Groups categories. However, it's important to understand the PFP because the accreditor will continue to review information previously reported by hospitals in their application for accreditation to guide the on-site survey.

The PFP process also guided the selection of tracers, which are still important areas of focus in the survey process. The accreditation survey activity guide is available free from the Joint Commission website; in 2013 and 2014, it was updated in January and July. It lists all of the areas covered in the tracers. The guide lists which tracers are used in each kind of facility, such as hospitals, critical access hospitals, behavioral healthcare, labs, and others. These may include:

- Contract services
- Continuity of care
- Credentialing and privileging
- Discharge planning
- Elopement
- Emergency services
- Environment of care
- Fall reduction
- Food and dietetic services
- Hand hygiene and infection control
- Hospital readmissions
- Laboratory integration
- Medical record content
- Medication management
- Organ, tissue, and eye procurement
- Outpatient services

- Patient flow
- Patient rights
- Performance improvement
- Radiology and nuclear medicine services
- Rehabilitation
- Respiratory care services
- Staffing
- Surgery and anesthesia
- Suicide prevention
- Tele-health
- Tissue
- Storage and issuance
- Violence
- Waived testing

Questions Asked

What questions might the surveyor ask during the leadership session? If the surveyor's findings lead to a priority focus in the area of infection control, he or she will ask questions on this topic, such as: What does the infection control plan look like? Is there a failure on behalf of leadership to plan for infection control? The surveyor would also look for signs demonstrating poor planning and indicating where breakdowns occurred. Like other priority focus areas, infection control is a very important issue in today's healthcare environment, and leadership should ensure that there is adequate staffing to adequately address it (in this case, to prevent, detect, and control infections). Surveyors may ask about the training programs and are instructed to verify that action plans are successfully implemented. Infection control is also important to CMS as demonstrated by the infection control worksheet, with which every hospital should be familiar.

It's important to understand the many aspects of the particular priority focus. For example, when considering infection control, it's important to understand that there has been a shift in the paradigm for reimbursement for infections. Traditionally, if a patient was admitted for surgery and then developed an infection, the healthcare facility was reimbursed for performing the surgery and for treating the infection. This model started to erode when the Centers for

Medicare & Medicaid Services (CMS) issued the 2008 hospital inpatient prospective payment rules. CMS implemented eight areas where no additional payment would be made for adverse events for Medicare patients. By 2014, there were 11 hospital-acquired conditions (HAC) for which there would be no additional payment. For example, if a Medicare patient who is admitted for pneumonia falls, sustains a subdural hematoma, and dies after spending four days in the ICU, Medicare will not pay for any of the care related to the fall or the resulting head injury.

CMS continued this trend in the 2009 inpatient prospective payment rules. State hospital associations and others soon started to announce that they would not bill for some or all of the National Quality Forum (NQF) serious reportable errors, which are commonly referred to as *never events*. Then insurance companies jumped on the bandwagon and started to include a provision in their contracts stating they would not pay for certain infections or other conditions, such as pressure ulcers and falls. In 2014, the trend continues. Hospitals are financially penalized for having higher-than-average readmissions. Leaders need to respond to these changes and implement systems and best practices to prevent infections, falls, medication errors, and other adverse events from occurring at all. For a successful leadership session, leaders must thoroughly understand these kinds of complexities and have systems in place for preventing problems.

In addition to addressing priority focus areas, the surveyor may ask open-ended questions that focus on system performance. Their goal is to determine whether there is any vulnerability in the system performance standards, including data use, changing performance, staffing, communication, and planning. Questions may include the following:

- Describe your planning process for _____ (infection control or medication management).
- What has the hospital done to achieve the characteristics of a high-reliability organization?
- We supported efforts to be a high-reliability organization by _____.
- What is your process for using data about _____ once it has been collected?
- How did you approach changing processes and workflow in relationship to _____?
- How does leadership make sure that information about a new process is communicated to the staff members who need to know it?

- When you developed _____ services, how did you determine the competency and qualification of _____?
- Our medical staff is engaged in efforts to achieve and sustain the characteristics of a high-reliability organization by _____.
- Our medical staff is involved in evaluating system performance in the hospital by _____.
- Our leadership’s role in preventing infections is demonstrated by our training programs, which include _____.
- These are some of the actions we have taken in the last year to prevent infections: _____.
- Leadership identifies and reports the number of distinct improvement projects to be conducted annually by _____.
- Our hospital has chosen to have a single organized medical staff or a shared integrated medical staff.
- Our hospital has a system to ensure communication with behavioral health providers and boarded patients by _____.
- We keep our boarded behavioral patients safe until they can be transferred by doing the following: _____.

Finally, the surveyors will review survey observations and potential requirements for improvement. A good way to prepare is to read the series of leadership session tips, as follows.

Tips for Conducting the Leadership Session

Surveyors may begin with positive survey observations. The surveyor may start the discussion with success results, noting high-reliability organizational concepts. This may be followed by discussions of some of the hospital’s less-than-successful efforts.

To have a successful session, leadership should be able to discuss the current status of and future plans to achieve and sustain a culture of safety and quality. The surveyor may ask about the leadership’s vision for the role of the board in those efforts. Questions may include: What is the current role of the medical staff in performance improvement activities and current results? How does leadership manage and monitor the effectiveness of changes made to the five systems? How does the hospital respond to change, and how adaptable and flexible is the hospital in that process?

Additional questions may be asked about the hospital's safety culture. Hospitals are required to do a survey to measure the culture of safety, and the leadership may be asked what process or tool is used to do this. Some hospitals use the Agency for Healthcare Research and Quality's culture tool, while others develop their own. Questions on this topic may include: What changes were made based on the culture of safety assessment? Has the hospital engaged in team training of any departments? How does the hospital manage disruptive behavior (which is referred to as behavior that undermines a culture of safety)? How does the hospital manage adverse events and close calls? How do leaders respond to safety concerns? How does the hospital support a safety culture?

Leaders may also be asked about internal and external reporting: Is there a process to report unsafe conditions, and how does the hospital ensure a proper response? What is leadership's expectation on reporting of system failures? Are a proactive risk assessment or failure mode and effect analysis done when indicated, along with a thorough and credible root cause analysis (RCA)? When reports are made, are they made in a way that is meaningful for the reader? What are the types of issues reported, and to whom are those reports made?

The surveyor may ask questions to gauge whether there is a leadership commitment to and focus on quality and patient safety issues. The surveyors want to see involvement of the board, the medical staff, and senior leaders in quality and patient safety issues. Does the hospital make it a priority to prevent conditions that can lead to an adverse or sentinel event? Can the hospital provide examples of issues that they have examined in the past? How does the hospital make sure that the improvements in performance are maintained? What has the leadership team done to role model and coach others in the facility? How has the use of data led to improvement in the area of patient safety and quality? Surveyors may ask about the physician and clinician's involvement in that performance improvement—they are looking to make sure that the hospital ensures their involvement.

The surveyors may discuss high-reliability concepts related to process improvement, such as evaluation of the root causes of problems when they are identified. Surveyors are looking at the solutions that were devised to ensure that they continue and are effective. The surveyor may discuss internal and external reporting by the hospital. What type of data is reported? Hospitals may report data to the FDA MedWatch program, state cancer registry, stroke or myocardial infarction registry, state department of health, Hospital Compare, infant hearing tests, and many other organizations. Some are required to report data to state agencies like the catheter-associated urinary tract infection rates or certain communicable diseases. The surveyor may ask which external reports are shared with the board.

Case Scenario

In the average life of a hospital, a number of scenarios occur in which leaders need to look at an issue and evaluate the five key pillars. Take, for example, a hospital that receives a complaint survey from CMS stating that the hospital uses restraints unnecessarily and that its nursing units are inadequately staffed.

In this case, the hospital must implement a comprehensive plan to correct the situation. The hospital develops a 10-page action plan that includes revised safety processes to minimize risk and prevent the unnecessary use of restraints and seclusion. It communicates these new initiatives to the staff by holding a mandatory in-service, which also includes instruction on the new policy and procedure.

This hospital may also change which data it collects to monitor restraint use. If its performance improvement data shows a backward trend and noncompliance with restraint standards, leadership will need to respond and implement additional action plans.

In this anecdotal case, hospital data shows that restraints were used more often on weekends, when staffing was determined to be inadequate and agency nurses were used. The data also shows an increased number of falls, more medication errors, longer lengths of stay, and more codes. To resolve these issues, the hospital works to identify the right skill mix and staff size, and educates agency nurses on the restraint standards and the hospital's new policy.

This hospital's plan focuses on communication to ensure the effective transmission of new knowledge regarding restraint standards. It includes a memo to all physicians and other practitioners who order restraints so that they will be aware of the new policy and procedure. The physicians are also told that they must be notified when their patients are placed in restraints since this is both a Joint Commission and CMS hospital *Condition of Participation* requirement. Staff members are educated on new order forms and documentation sheets, and they are taught that they must fill out a form to identify any patient who dies in restraints or who dies within 24 hours of being in a restraint so that a report can be made to the CMS regional office. Reports must also be made to the regional office if the patient dies within seven days when the restraint causes an injury. An exception is made if the patient dies in one or two soft wrist restraints that did not cause the death. The hospital must then fill out an internal log and document that the log has been completed in the patient's medical record.

This brief case study demonstrates the results you can expect when leaders recognize an issue and revise their process to address that issue. In this case, leaders discussed the issue with the staff, education was provided, and new forms were developed to meet the reporting

requirement. Leaders used hospital data in their decision-making process and will continue to use it to monitor the issue.

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The Compliance Guide to The Joint Commission Leadership Standards provides accreditation professionals with in-depth guidance on how to prepare leadership and staff to comply with the accreditor's Leadership standards. The book breaks down the Leadership chapter standard by standard and provides hospitals with a plethora of tools and policies to train leaders and staff on the roles they play in compliance, patient safety, and quality efforts.

This book provides:

- Clear explanations of the Leadership standards
- How-to strategies for developing and implementing a leadership plan
- Tips for creating a culture of safety
- Three customizable and downloadable PowerPoint training presentations
- Updated tools and policies to help compliance

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