Comply with the new Patient Safety Systems chapter with *The Compliance Guide to The Joint Commission’s Patient Safety Systems Chapter*. This book guides you through the accredditor’s patient safety requirements. It covers how to become a learning organization, the role of hospital leaders in patient safety, use of data and reporting systems, conducting proactive risk assessments, and patient involvement. This book will help you put together an integrated patient safety system in your facility.
The Compliance Guide to 
THE JOINT COMMISSION’S 
PATIENT SAFETY 
systems chapter

Sena Blickenstaff, RN, BSN, MBA
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About the Author

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Blickenstaff’s most recent leadership experiences include serving in both interim and full-time healthcare leadership roles, including chief nurse executive, vice president of patient care services, and service line administrator. In these roles, she focused on service line and program and service development, physician/medical staff engagement and alignment, and patient flow/continuum of care strategies. The overarching goal in these initiatives focused on positively impacting quality and safety, reducing readmissions and length of stay, enhancing the overall patient experience, and ensuring alignment with overall organizational strategic goals and objectives.
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Understanding The Joint Commission’s Patient Safety Systems Chapter

An Overview

For the first time in several years, The Joint Commission released a new chapter in its hospital accreditation process called the “Patient Safety Systems” (PS) chapter. The chapter became effective January 2015 and, according to The Joint Commission, will help guide healthcare organizations on their journey toward high reliability, especially as it relates to promoting and fostering high-quality, safe patient systems of care.

The PS chapter focuses on three overarching tenets: 1) aligning existing Joint Commission standards with current daily work activities to reduce harm; 2) assisting with knowledge, skills, and competence of staff and patients by recommending methods to improve quality and safety; and 3) recommending proactive, evidence-based quality and safety methodology to increase accountability and reduce fear and blame, which promotes a just culture within the organization.

Along with this, The Joint Commission recommends an effective quality management system. Patient safety, as defined by the World Health Organization, is the prevention of errors and adverse effects to patients that are associated with healthcare and is a fundamental expectation of patients, families, and those who visit healthcare organizations. According to the PS chapter, an effective quality system must include:

- Reliable processes.
- A reduction in variation and defects (waste).
- A focus on improving outcomes.
Chapter 1

- Systematically using evidence to ensure that a service is satisfactory. An effective quality system is key to effective patient safety.

Although the new PS chapter does not include new accreditation requirements, it does focus sharply on several existing standards and Elements of Performance (EP). Again, there are no new standards or EPs that healthcare organizations will be required to demonstrate compliance with. Rather, the PS chapter refers to several existing Joint Commission standards and describes how those existing standards will be used to drive enhanced quality and safety. The chapter turns a sharp focus on senior leadership and how it develops, promotes, and fosters a culture of safety and systems of care.

For example, having a culture of safety is not a new concept and has been a standing requirement under The Joint Commission’s Leadership standard LD.03.01.01, which speaks to leaders creating and maintaining a culture of safety. What The Joint Commission has done with this new PS chapter is essentially codified this concept of systems of care and overarching leadership expectations with corresponding existing standards and EPs that are anticipated to be more critically evaluated during the accreditation survey. These existing standards and EPs can be scored when issues are identified during an accreditation survey and when it appears that there are systemic deficiencies around patient safety systems, a culture of safety, and perhaps senior leadership oversight.

Some of the key existing standards referenced in the PS chapter that healthcare organizations will want to pay particular attention to moving forward include the following.

**Leadership and a culture of safety**

**LD.03.01.01**—Which refers to healthcare leaders having a safety culture throughout their organization, including all departments and locations, services, and programs, both inpatient and outpatient

**LD.04.01.05**—Which refers to the healthcare organization maintaining a just culture and holding individuals accountable

**LD.04.04.05**—Which refers to the healthcare organization having a patient safety program that is woven into the hospital’s quality assurance/performance improvement program and is inclusive of all departments, locations, services, and programs, both inpatient and outpatient

**Effective use of data: Collecting and analyzing data**

**EC.04.01.01**—Which refers to the healthcare organization collecting information and data to effectively manage its environment
IC.01.03.01—Which refers to the healthcare organization, based on and in collaboration with its performance improvement program and activities, proactively finding health risks for its employee and patient populations

LD.03.02.01—Requires that data and information be used in decision-making to enhance quality and safety and to reduce variation in the organization’s ongoing performance improvement activities

LD.04.04.05—Which refers to the healthcare organization having a hospitalwide patient safety program that is inclusive of all departments and services, inpatient and outpatient, and that is incorporated into its quality assurance/performance improvement program and systems

MM.08.01.01—Which refers to the healthcare organization assessing how effective its medication management systems and processes are in relationship to quality, safe patient care, and patient safety systems of care

PI.01.01.01—Which refers to the healthcare organization ensuring that data are collected to analyze its ongoing performance when it comes to patient quality and safety

PI.02.01.03—Which refers to the healthcare organization ensuring continuous process improvement efforts in its ORYX core measure efforts and maintaining accountability and sustainability

PI.03.01.01—Which refers to the healthcare organization continuously improving its performance, especially as it relates to quality, safe patient care

PC.03.05.19—Which refers to the hospital reporting deaths of patients who were recently in restraints or in seclusion

*Using data to drive improvement: Enhancing process improvement and proactively identifying and mitigating risk*

LD.03.01.01—Which refers to healthcare leaders having a safety culture throughout their organization, including all departments and locations and services and programs, both inpatient and outpatient

LD.03.04.01—Which refers to the need for information to be transparent and spread throughout the organization appropriately from frontline to the board

LD.03.05.01—Which refers to leaders initiating changes in current systems and processes to enhance performance throughout the organization

LD.04.04.01—Which refers to leaders establishing priorities for performance improvement

LD.04.04.05—Which refers to the healthcare organization having a hospitalwide patient safety program that is inclusive of all departments and services, inpatient and outpatient, and that is incorporated into its quality assurance/performance improvement program and systems
LD.04.04.05, EP 10—Which requires the healthcare organization, no less than every 18 months, to proactively perform an assessment of a high-risk process within its organization.

For those healthcare organizations that use Joint Commission accreditation for deemed status purposes, there will be the additional expectation that the healthcare organization demonstrates compliance with the Centers for Medicare & Medicaid Services Conditions of Participation (CoP) during the accreditation visit. Throughout this book, reference will be made to key CoPs that are the focus of public reporting initiatives and/or financial incentives or disincentives, as the case may be, as well as where deemed status compliance would be an expectation as it relates to the topic at hand.
The Role of Leadership in Patient Safety Systems

Healthcare leaders comprise the cornerstone of any successful patient safety system. And to achieve the highest level of reliability in quality and safety and, more importantly, to demonstrate a sustainable culture of quality and safety, according to The Joint Commission in its new “Patient Safety Systems” (PS) chapter, healthcare leaders must do the following:

- Encourage an ongoing culture of education and training—competency enhancement throughout the organization
- Promote and foster an accountable culture of safety throughout the organization
- Create an environment within the healthcare organization where quality and patient safety incident information is transparent and shared among staff
- Lead by example
- Address unprofessional, unacceptable, and/or intimidating behavior
- Ensure that the necessary tools, training, and/or resources are available for process improvement initiatives

The first step in this journey to a transparent, sustainable, just culture of quality and safety begins with an effective, aligned leadership team.
Impact of Leadership on Today’s Healthcare Environment

The importance of effective leadership in healthcare is becoming increasingly apparent. With a nationally and federally driven emphasis on transparency, public reporting of key performance metrics, and mandated requirements to improve the quality and clinical, financial, and operational outcomes of healthcare delivered in hospitals and healthcare systems, healthcare leaders must consider new leadership approaches to address these issues. As public reporting of clinical outcomes and patient satisfaction scores increases in healthcare, the healthcare industry will see a shift in consumer choice, including the way in which patients and insurers select providers and hospitals. Although the need to improve quality and efficiency in healthcare exists, healthcare leaders continue to struggle in achieving and sustaining organizational success. There remains untapped a tremendous potential for leveraging sustainable quality outcomes and enhanced efficiencies in healthcare through the application of evidence-based leadership methodology.

The governance responsibilities of a healthcare organization’s board, through its CEO and senior leadership designees, include establishing policy, rules, and bylaws consistent with the mission, vision, and purpose of the organization. The governing board also provides operational oversight through the CEO, who reports to the board. In turn, the board acts as a steward for the organization and is responsible to the local community that typically elected the individual board members, by statute to the state that granted the organization’s charter, and to the federal government under federal laws, rules, and regulations applicable to a nonprofit entity.

There has been much legal and legislative activity following the failure of boards to effectively oversee publicly held organizations. The Sarbanes-Oxley Act (SOX), or the Public Company Accounting Reform and Investor Protection Act of 2002, as it is also referred to, and more intense scrutiny by the Internal Revenue Service have established new levels of accountability and responsibility for publicly held organizations. Although SOX was directed at publicly held organizations, according to the American Bar Association, “at least two criminal provisions apply to nonprofit organizations: provisions prohibiting retaliation against whistleblowers and prohibiting the destruction, alteration or concealment of certain documents or the impediment of investigations.”

Likewise, under increasing pressure and scrutiny, many states have adopted SOX to address the growing concerns around governance and accountability in the nonprofit sector.

Concern for the management of nonprofit organizations, such as nonprofit hospitals and health systems, has put hospital governing boards on notice and raised the bar in terms of their accountability for hospital operations and outcomes. Add to this today’s healthcare mandates through the Affordable Care Act (ACA), and the role of senior leadership in today’s healthcare organization in ensuring high quality and safety is at its most financially imperative.
Beginning in fiscal year (FY) 2015, the Hospital-Acquired Condition reduction program, mandated by the ACA, requires the Centers for Medicare & Medicaid Services (CMS) to reduce hospital payments by 1% for hospitals that rank among the lowest-performing 25% with regard to hospital-acquired conditions (HAC). HACs are those conditions that patients acquire while receiving treatment for another condition in an acute care health setting. Additionally, of the three penalty programs created by the ACA, the hospital readmissions reductions program is perhaps the most significant for FY 2015 inpatient programs in terms of financial disincentives. When the program was initiated in FY 2013, it cut up to 1% of Medicare inpatient payments for hospitals with excess readmissions for patients with acute myocardial infarctions (AMI), heart failure, and pneumonia. In FY 2014, the maximum penalty increased to 2%. In 2015, the maximum penalty for excess readmissions is 3%, which is the highest maximum amount allowed under the ACA. And for the first time, the program will consider readmissions for chronic obstructive pulmonary disease (COPD) and knee and hip arthroplasty.

As a senior healthcare leader, providing the level of leadership and guidance that can achieve and sustain organizational success when it comes to quality, safe patient care, and regulatory compliance is a key leadership skill that requires further development through information literacy and the application of evidence-based leadership. Additionally, emphasizing the need to apply evidence-based leadership within the healthcare system would facilitate the industry’s ability to achieve and sustain quality outcomes. By investing in current and future leadership, fostering an environment of information literacy and effective communication, and promoting evidence-based leadership, the achievement of quality outcomes and enhanced organizational efficiency within the healthcare industry can be realized.

Normative decision theory

Wren (1995) discusses varying styles of the contingency leadership theory, including the normative decision theory presented by Vroom and Yetton. The normative decision theory includes a range of decision-making styles, from autocratic, where the leader acts alone in decision-making, to consultative, where the leader consults with his or her followers and retains decision-making control, to group decision-making, where the leader collaborates with followers in the decision-making process. Of importance to the normative decision theory style is that it is contingent upon the characteristics of each situation, which then prompts the leader to use the leadership style he or she believes would be most appropriate.

Situational leadership theory

Chen and Silverthorne (2005) discuss the situational leadership theory, noting that “leadership effectiveness is thought to be enhanced if a manager uses the style of leadership that best matches the readiness, ability, and willingness of subordinates and that a good match between leadership style and subordinate readiness leads to a higher level of subordinate satisfaction and performance.” In this
context, an entry-level employee may require a more direct, autocratic leadership approach, where a licensed healthcare professional would benefit from empowerment and a higher level of autonomy. The situation itself might also dictate the leadership style used. For example, if a new regulatory mandate requires all physicians to engage in a certain practice within a certain time frame, although physicians are highly educated professionals, the leadership approach best suited would be more autocratic as opposed to democratic.

The normative and situational leadership styles can be effective in healthcare with entry-level or frontline employees, where regulatory requirements dictate outcomes that must be achieved in the interest of patient safety. This could include clearly articulating the requirements, setting specific performance standards and expectations, and implementing an outcomes-based approach with rewards or penalties as indicated to monitor performance and adherence to the requirements. However, the normative and situational leadership styles might prove less effective when working with highly educated and licensed clinical professionals who, by virtue of the clinical decision-making necessary to perform their jobs, are granted high levels of autonomy regarding the work they perform and how it is accomplished.

**Transactional and transformational leadership theories**

Two additional theories of leadership that continue to be predominant in the literature include transactional leadership and transformational leadership. Sarros and Santora (2001) say transactional leadership revolves around rewards and punishments, and transformational leadership is a style that can articulate a vision and in turn motivate and energize individuals to facilitate the success of that vision. Within the healthcare industry, where the focus is on achieving quality clinical outcomes, the transformational model is most visible. This does not suggest that the two models are mutually exclusive within their application in the healthcare industry. For example, regulatory requirements and state and federal laws specific to the healthcare industry mandate certain performance expectations and outcomes. A transactional approach can be effective in relaying the rules or guidelines and setting performance expectations, as well as rewards or penalties, based on outcomes. At the same time, a transformational approach to facilitate success in achieving these performance expectations would be by articulating a vision—based on what the rule or regulation requires—and inviting individuals to share in process improvement planning to achieve the overarching goal.

Couto (2002), in his work noted in *Transformational and Charismatic Leadership: The Road Ahead* (2008), discusses Bass’s (1999) and Bass and Avolio’s (1990) continuing studies on transformational leadership as the foremost approach to gaining committed followers. Bass and Avolio identify four components of transformational leadership identified as idealized influence (desire to trust and model the leader), inspirational motivation (desire to do well), intellectual stimulation (desire to think), and individualized consideration (desire to grow and develop). A transformational leader articulates a vision and inspires, or motivates, followers to commit to the success of that vision. In the process of
turning that vision into a reality, a transformational leader empowers followers to experience professional growth and development and a sense of ownership and pride in the work and with their leader. Bartram and Casimir (2007)⁸ provide an analysis of follower empowerment as a key leadership attribute that facilitates organizational success. The authors relate, “It is noteworthy that the in-role performance of followers was more closely related to empowerment than to trust in the leader. It stands to reason that empowering followers helps them to perform their jobs more so than does trust in the leader, because empowerment involves behaviors that directly influence how followers perceive and perform their work.”¹⁹

**Emotional intelligence and leadership**

Two additional areas that impact effective leadership are emotional intelligence and effective communication. George (2000) discusses emotional intelligence and leadership, describing the former as “the ability to understand and manage moods and emotions in the self and others.”¹⁰ The author also discusses the role of using positive emotions to stimulate and generate “creativity, integrative thinking, and inductive reasoning”¹¹ within the workforce. Madlock et al. (2007) discuss communication as a means to influence the leader-member exchange, proposing that “friendly, relaxed, and attentive communicator styles”¹² can be predictive as to the effectiveness of the leader-member exchange. For an organization to achieve success, both the skill sets of followers and leaders are needed and, within this paradigm, effective communication is critical.

**The healthcare environment—a reality check**

In its “Quality Letter” section, Quality Letter for Healthcare Leaders discusses Studer’s nine principles of excellence. Principle one speaks directly to the need for healthcare organizations to commit to quantifiable excellence as a way to enhance organizational success. Principle four discusses the need to create and enhance leadership as a way to achieve and sustain that excellence. To drive and sustain best practice, effective healthcare leadership must support information literacy in the context of quality outcomes as well as leadership development as a required pillar of success when establishing organizational strategic goals and objectives. Achieving and sustaining best practice in healthcare outcomes and organizational success is directly contingent upon effective leadership that is information literate.

In addition to emotional intelligence, effective communication, and information literacy, the successful healthcare leader must promote and foster an environment of teamwork and collaboration. D’Andrea-O’Brien and Buono (2006)¹³ in their article, “Building Effective Learning Teams: Lessons from the Field,” note that successful organizations of the future will rely on a horizontal working environment, as opposed to the vertical, or top-down, leadership environment seen in most healthcare organizations. The horizontal organization, as described by D’Andrea-O’Brien and Buono, “will be (1)
organized around processes rather than tasks, (2) driven by customer needs and inputs, and (3) dependent on team performance” (p. 4).

Endnotes


7. Ibid.


9. Ibid.


11. Ibid.


14. Ibid.
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