Leadership in Healthcare Organizations:

A Guide to Joint Commission Leadership Standards

SECOND EDITION

THE GOVERNANCE INSTITUTE

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A Governance Institute White Paper 2017

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Part One: Introduction and Background

Chapter 1: Leaders and Systems

The Healthcare Organization as a System

Good leadership is important for the success of any organization. In a healthcare organization, good leadership is more than just important—it is absolutely critical to the organization's success. Why is it so critical—but also challenging—in healthcare organizations? Who are the "leaders" in healthcare organizations? What is "good leadership" in healthcare organizations? And what is the "success" that healthcare organizations seek? These are the questions that Joint Commission accreditation standards on leadership attempt to answer and are the focus of this white paper, which serves as a guide to the standards.

The leadership standards discussed in this white paper were published in The Joint Commission *2009 Comprehensive Accreditation Manual for Hospitals* "Leadership" chapter, and became effective January 1, 2009[1]. They are not, however, the first leadership standards issued by The Joint Commission; the importance of the organization's leaders working together has been a theme in the standards since 1994, when the first chapter on "leadership" was added to the standards.

For many years prior to 1994, the standards included chapters on "Management," "Governance," "Medical Staff," and "Nursing Services." In fact, each department in the organization had its "own" chapter of standards, as if the good performance of each unit—governance, management, radiology, dietary, surgery, and so forth—would assure the success of the organization. The Joint Commission sought the advice of some of the nation's leading healthcare management experts and clinical leaders from both practice and academia to redesign this unit-by-unit approach. They were unanimous in their advice: stop thinking of the healthcare organization as a conglomerate of units and think of it as a "system." A system is a combination of processes, people, and other resources that, working together, achieve an end.

Our advisors explained that a healthcare organization, such as a hospital, could be imagined to be like a watch. A watchmaker could gather from around the world the best-in-class components—spring, regulator, bearings, and so forth—to assemble, but the resulting watch would be unlikely to run, let alone keep accurate time. It's how the components work together that creates an accurate watch. In fact, for the watch to work perfectly it may be necessary to make compromises in how each component works; for example, a spring made of the strongest material may not be the best contributor to a delicate, accurate watch if it does not fit well with the other components.

Healthcare organizations are not watches, but the analogy applies. If we want a healthcare organization to succeed, it must be appreciated as a system, the components of which work together to create success. It is not possible to determine what each component should be and do unless it is examined in the light of the goals for the system and the rest of the system's components. For a healthcare organization, the primary goal is to provide high-quality, safe care to those who seek its help, whether they are patients, residents, clients, or recipients of care. (For the sake of simplicity in this white paper, we will refer to these individuals as "patients.") While there are other goals for a healthcare organization, including financial sustainability, community service, and ethical business behavior, The Joint Commission's primary focus is on the organization's goals of providing high-quality, safe care to patients.

> Rather than thinking of the healthcare organization as a conglomerate of units, think of it as a "system"—a combination of processes, people, and other resources that, *working together,* achieve an end.

Of course, this system view of healthcare organizations led to a different perspective on leadership. No longer was the focus to be on the performance of each group of leaders, but rather, on how the leaders in the organization work together to provide *leadership* for the organization that would enable the organization—as a system—to achieve its goals. During the decade following the

1 The Joint Commission updated this manual July 1st, 2016; the standards in this edition reflect the updates made as of 2016. For more information visit www.jointcommission.org/facts_about_joint_commission_accreditation_standards/.

introduction of the first "Leadership" chapter, the remaining standards in the "Governance" and "Management" chapters were fully integrated into the leadership standards and, by 2004, these two chapters disappeared entirely—the roles of the governing body and senior management contributing to the organization's leadership rather than being silos within the organizational system.

The Leaders of the System

Who are the "leaders" and "groups of leaders" in an organization? In most organizations, there are two groups of leaders: the governing body, and the chief executive officer and other senior managers (which may be referred to collectively as the "C-suite"). If the governing body and the senior managers do not work together, the organization's goals are unlikely to be met and, sooner or later, the latter group departs. The same is true in a healthcare organization—the governing body selects the chief executive officer. But most healthcare organizations—certainly hospitals—have a third leadership group: the leaders of the physicians and other licensed independent practitioners (whether employed or "voluntary") who provide patient care in the organization. In a hospital, the physicians and other licensed independent practitioners are organized into a "medical staff" and the leaders of the medical staff contribute to the leadership of the organization. This third group of leaders is unique in the U.S.; it is not found in manufacturing, banking, education, or other service industries. Why this difference in healthcare organizations?

In healthcare, decisions about a patient's diagnosis and treatment are made by "licensed independent practitioners," most commonly physicians, but also including other clinicians such as dentists, podiatrists, or psychologists who have been licensed by the state to diagnose and treat patients. A person without a license who diagnoses and treats a patient through activities that are covered by any of the licenses is deemed to be practicing illegally—"practicing without a license."

This unique role of physicians and other licensed independent practitioners within a healthcare organization has two implications for the organization's ability to reach its goals as a system:

- First, the licensed independent practitioners (for example, physicians) cannot be *clinically* supervised by someone who is not a licensed independent practitioner. If an unlicensed individual were to *clinically* supervise a physician or other licensed independent practitioner, that individual would be "practicing without a license," and, therefore, acting illegally. (Note that a licensed independent practitioner may be *administratively* supervised by a non-licensed independent practitioner [for example, as an employee]; it is *clinical* supervision that can only be provided by someone who is also licensed to practice.)
- The second implication for the healthcare organization is that the clinical decisions licensed independent practitioners make about their patients drive much of the rest of the organization's use of resources—from nursing care to diagnostic imaging to laboratory testing to medication use—and affect the organization's ability to achieve its goal of providing high-quality, safe care.

An organized body of physicians and other licensed independent practitioners has not only the technical knowledge, but also the standing to provide *clinical* supervision and oversight of its members' clinical care and performance. Therefore, to fail to adequately incorporate into the organization's leadership the licensed independent practitioner leaders who can evaluate and establish direction for the *clinical* care and decision making of licensed independent practitioners throughout the organization, is to create a fundamental gap in the leadership's capability to achieve the organization's goals with respect to the safety and quality of care, financial sustainability, community service, and ethical behavior.

For this reason, Joint Commission standards for leadership address three leadership groups:

1. The governing body
2. The chief executive and other senior managers
3. The leaders of the licensed practitioners

In a hospital, this third leadership group comprises the leaders of the organized medical staff and employed physician groups. Only if these three leadership groups work together, collaboratively, to exercise the organization's leadership function, can the organization reliably achieve its goals (as mentioned above: high-quality, safe patient care; financial sustainability; community service; and ethical behavior).

In some organizations, the individuals who comprise these leadership groups may overlap. In small organizations, they may be the same individuals, or even one individual in the smallest organization. But the leadership function is the same, whether performed collaboratively by different or overlapping groups, or by the same group of individuals, or even by one person.

Chapter 2: What Leaders Do

The Goal: Safe, High-Quality Patient Care

The quality and safety of care provided by a healthcare organization depend on many factors. Some of the most important are:

- A culture that fosters safety and quality
- The planning and provision of services that meet the needs of patients
- The availability of resources—human, financial, physical, and information—for providing care
- A sufficient number of competent staff and other care providers
- Ongoing evaluation and improvement of performance

Only the *leaders* of a healthcare organization have the resources, influence, and control to provide for these factors. It is the leaders who can together establish and promulgate the organization's mission, vision, and goals. It is the leaders who can strategically plan for the provision of services, acquire and allocate resources, and set priorities for improved performance. And it is the leaders who establish the organization's culture through their words, expectations for action, and behavior—a culture that values high-quality, safe patient care, responsible use of resources, community service, and ethical behavior; or a culture in which these goals are not valued.

While leadership's responsibility includes *strategically* addressing the organization's culture, planning and provision of services, acquiring and allocating resources, providing sufficient staff, and setting priorities for improvement, the organization's leaders must also actively manage each of these factors. Strategic thinking focuses on *where* to go, while management focuses on *implementing* a plan and sustaining the activities needed to get there. In between the *where* and the *implementation* lies determination of *how* to achieve the strategic goal—a determination that requires both strategic skills and management skills. Therefore, to fulfill its fiduciary responsibilities, leadership of an organization engages in both strategic and management thinking. "Fiduciary," despite starting with "fi," is not the same as "financial"—a confusion that has reigned in boardrooms for many years. A fiduciary responsibility is one of *trust*; it means that one acts to the best of one's ability in the interest of another, not in self-interest. The "other" can *trust* the fiduciary.

The "other" in a healthcare organization includes, as in other industries, the person or agency that has provided the organization with financing: the taxpayer, the bondholder, the stockholder. But in a healthcare organization, whether not-for-profit or for-profit, the *first* fiduciary obligation is to the patient. From Hippocrates on, the primary obligation in healthcare is "first, do no harm." And that ethical obligation has been taken on by those who choose to work in healthcare—not just those trained as clinicians, the doctors and nurses, but also the managers, executives, and trustees.

In a hospital, it is difficult—or, more accurately, impossible—for each leadership group, on its own, to achieve the goals of the hospital system: safe, high-quality care, accompanied by financial sustainability, community service, and ethical behavior. An all-wise governing body, an exceptionally competent chief executive and senior managers, and a medical staff composed of Nobel Prize-winning physicians cannot, each on their own, achieve safe, high-quality care, let alone all of these goals.

An examination of the ingredients for safe care—the "first" obligation—elucidates the need for collaboration among these groups. For years, it had been recognized that unless a physician is both technically competent and committed to his or her patients, he or she is at risk of providing the wrong care: either providing care that is not needed, or failing to provide care that is needed, or providing needed care incorrectly. These personal errors of overuse, underuse, and misuse are to be expected if a physician is incompetent or uncommitted, or both. That is why a hospital medical staff invests so much effort in gathering, verifying, and evaluating the credentials of an applicant for clinical privileges, and why the governing body has the final responsibility for granting the privileges after considering the medical staff's recommendations. Traditionally, when a physician who had been granted clinical privileges made an error, the cause was attributed to the physician—he or she was either incompetent or uncommitted (for example, not attentive), or both. As a result, the credentialing process would be made ever more rigorous to keep such individuals from "slipping through" in the future. But no matter how rigorous a credentialing process and how careful a privileging decision, physicians (and other healthcare practitioners) make errors. Even the most competent and committed make them. The breakthrough came when it was recognized that, truly, "to err is human"—errors are literally built into our cognitive and motor functions. Based on this recognition, careful study of how other high-risk endeavors (such as the commercial passenger airline industry) became reliably safe provided approaches and methods for making safe those processes in healthcare that are highly dependent on fallible humans.

These approaches depend upon "systems thinking"—recognizing that the hospital, or other endeavor, is a system, and that the system can and must be designed to compensate for the errors that are likely to be made by any of its components. In healthcare, although the cognitive and technical skills of physicians are critical to the quality of patient care, these same physicians, no matter how competent and committed, will make errors. The best protection against those errors is generally not to be found in the physicians becoming more competent and more committed, even in those cases in which greater competence or more commitment could be attained. Rather, the protection is to be found in the processes within which the physicians work. These processes can be designed to prevent human errors, to stop the errors before they reach the patient, and to mitigate the errors' effects on the patients they reach. So, achieving safety in patient care requires competent, committed healthcare professionals working in safety-creating processes.

Approaches for building safe processes depend upon "systems thinking"—recognizing that the hospital, or other endeavor, is a system, and that the system can and must be designed to compensate for the errors that are likely to be made by any of its components.

Leaders Working Together

But who is responsible for the design and implementation of the processes in the hospital? The chief executive and other senior managers. Who encourages and motivates the chief executive to invest in these processes? The governing body. If, for example, the governing body consistently asks the chief executive *only* about the bottom line (that is, about the hospital's financial sustainability), the chief executive is likely to focus both his or her—and the hospital's—attention and resources primarily on that goal. But, if the governing body repeatedly asks the chief executive about patient safety, the chief executive will focus attention and allocate resources to designing and implementing safety-creating processes throughout the organization. If the redesigned processes through which clinicians work are to effectively create safety, this redesign cannot be accomplished without the involvement of the clinicians and their leaders, whose (all too human) errors are to be prevented, stopped, or mitigated.

Therefore, adopting a systems approach to creating patient safety—a primary goal of the hospital—means that all three leadership groups must be involved. The same reasoning applies to achieving the other goals of the hospital: financial sustainability, community service, and ethical behavior. The governing body, the chief executive and other senior managers, and the leaders of the medical staff must collaborate to achieve these goals.

It is now recognized that a *team* delivers patient care in the hospital and consequently, there is a growing emphasis on the *teamwork* of the patient care team—the clinical "microsystem." Even the patient and the patient's family are now recognized as part of this microsystem. Teamwork also describes the desired state of collaboration among the leadership groups of the hospital. Studies of well-functioning teams have identified certain universal characteristics:

- A shared vision and goal among members
- A shared plan among members to achieve the goal
- Clarity about each member's role
- Each member's individual competence
- Understanding other members' roles, strengths, and weaknesses
- Effective communication
- Monitoring other members' functions
- Stepping in to back up other members as needed
- Mutual trust

Over time, team members develop these individual skills and attitudes and the team improves its collective function. The "Leadership" standards are intended to facilitate and generate teamwork among the leadership groups—teamwork to achieve safe, high-quality care.

But Disagreements Arise

The leadership groups in a hospital *should* work as a team in leading the organization—each member (or group) on the team holding a common vision and goal, understanding his or her contribution, stepping in to help when another member struggles or falters, and trusting the other members to do the same. Of course, sometimes leadership groups—the governing body, the chief executive and other senior managers, and the medical staff leaders—may not see eye-to-eye with regard to strategy and management, or even with regard to the organization's mission, vision, or goals. When this occurs, the relationship between the governing body and the chief executive is clear, and the chief executive responds to the governing body's direction, changes the board's mind, or leaves.

But when there is a disagreement between the leaders of the medical staff and the governing body or the chief executive, the relationship is more complex. The governing body has ultimate responsibility: Standard LD.01.03.01 states, "The governing body is ultimately accountable for the safety and quality of care, treatment, and services," and the rationale for this standard is, "The governing body's ultimate responsibility for safety and quality derives from its legal responsibility and operational authority for hospital performance." There is little ambiguity in law or in Joint Commission standards as to where the ultimate responsibility and authority lie—it is with the governing body.

However, as discussed above, the governing body, because it is not a "licensed independent practitioner," cannot clinically supervise the patient care decisions made by the individual physicians on the medical staff. That supervision usually comes through the organized medical staff itself, most of whose

members are licensed independent practitioners. In fact, this supervision and oversight is a primary responsibility of the medical staff. In the "Medical Staff" chapter of standards, Standard MS.03.01.01 says, "The organized medical staff oversees the quality of patient care, treatment, and services provided by practitioners privileged through the medical staff process." In the "Leadership" chapter, Standard LD.01.05.01 says that the "organized medical staff is accountable to the governing body." Consequently, for the governing body to effectively fulfill its accountability for the safety and quality of care, it must work collaboratively with the medical staff leaders toward that goal.

There is little ambiguity in law or in Joint Commission standards as to where the ultimate responsibility and authority lie with respect to safety and quality of care—it is with the governing body. However, as the board is not a "licensed independent practitioner," it cannot clinically supervise patient care decisions. Consequently, to effectively fulfill its accountability for the safety and quality of care, the board *must work collaboratively with the medical staff leaders* toward that goal.

A New Approach to Collaboration

At times the desired collaboration among all three leadership groups is absent. From 2002 through 2004, a series of serious and persistent disagreements between the governing bodies and medical staffs in a few hospitals were publicized in the trade media—and some even reached the mass media. The spirit, let alone the practice, of cooperation seemed to be abating, and many worried about the effect on the quality and safety of patient care. To evaluate and address this problem, in 2005 The Joint Commission appointed a 29-member Leadership Accountabilities Task Force, composed of representatives from hospital governing bodies, hospital managers, medical staff leaders, nursing staff leaders, and state and federal hospital regulators.

The name of the Task Force was significant; rather than focusing on the *rights* of the various parties (the direction the disagreements had taken), the Task Force was asked to focus on both the groups' individual responsibilities and their mutually shared responsibilities. The primary, mutually shared responsibility of all three leadership groups was immediately agreed upon: high-quality, safe patient care. And all three groups agreed that they each contributed to the other shared goals of financial sustainability, community service, and ethical behavior. The Task Force helped frame a revised "Leadership" chapter for hospitals that, with some alterations, was also applicable to other types of accredited healthcare organizations such as ambulatory care, behavioral healthcare, home care and hospice, laboratory and long-term care organizations, and even office-based surgery. The proposed standards revisions that emanated from the Task Force's deliberations focused on seven issues:

- The organization identifies its leaders and their shared and unique accountabilities (this requirement recognizes that different organizations might identify different individuals as their leaders, and might assign accountabilities differently among those leaders).
- The leaders are all aligned with the mission and goals related to the quality and safety of care.
- The leaders share the goal of meeting the needs of the population served by the organization.
- The leaders communicate well with each other and share information to enable them all to collaborate in making evidence-based decisions.
- The leaders are provided with the knowledge and skills that enable them to function well as organizational leaders.
- The leaders have a process to manage conflicts between leadership groups in their decision making.
- The leaders demonstrate mutual respect and civility with the goal of building trust among themselves.

The "Leadership" Chapter

As the revised chapter was being developed, additional related issues were identified. Further, when The Joint Commission focused on the ingredients necessary for patient safety, its national advisory group—the Sentinel Event Advisory Group, recently renamed Patient Safety Advisory Group—recommended that two additional issues be addressed in the leadership standards:

- Creation and nurture of a culture of safety
- Elimination of intimidating ("disruptive") behavior that prevents open communication among all staff

The advisors were unanimous in their opinion that the leaders of an organization are the most powerful force in changing the organization's culture and in eliminating intimidating behavior. The leaders do this by what they communicate to the organization's physicians and staff, by modeling desired behavior ("walking the talk"), and by establishing policies that encourage, facilitate, and reward the desired changes in attitudes and behavior throughout the organization.

Other non-substantive changes were made in the standards to clarify language and eliminate redundant or non-essential standards.

The proposed "Leadership" chapter was then sent to the field twice for comments, and based in part on the results of these field reviews, other revisions were proposed. The revised "Leadership" chapter was adopted in mid-2007, and published on The Joint Commission Web site (www.jointcommission.org) and in The Joint Commission's 2008 comprehensive accreditation manuals. The effective date of the new requirements in the revised chapter was delayed until January 1, 2009 in order to give healthcare organizations and their leadership groups ample time—18 months—to learn about the revised standards and to determine how they would meet the new requirements.

The revised "Leadership" chapter is structured in four sections, as follows:

I. Leadership Structure
   - Leadership structure
   - Leadership responsibilities
   - Governance accountabilities
   - The chief executive responsibilities
   - Medical staff accountabilities
   - Leaders' knowledge

II. Leadership Relationships
   - Mission, vision, and goals
   - Conflict of interest among leaders
   - Communication among leaders
   - Conflict management

III. Hospital Culture and System Performance
   - Culture of safety and quality
   - Using data and information
   - Organization-wide planning
   - Communication
   - Change management and performance improvement
   - Staffing

IV. Leadership Operations
   - Administration
   - Ethical issues
   - Meeting patient needs
   - Managing safety and quality

The four sections of the "Leadership" chapter are reproduced in the following four chapters of this white paper. Each of the next four chapters addresses one section of the "Leadership" chapter, and each includes every standard, its rationale (when not self-evident), and its "element(s) of performance" (that are scored by the surveyor) in that section. The standard, its rationale, and its element(s) of performance (EPs) are in italics. **[On occasion, there is a gap in the numbering of the elements of performance . This occurs when an element of performance that is applicable to another type of accredited organization (for example, ambulatory care, home care, long-term care) is not applicable to hospitals.]** Annotations about background, intent, or implementation—especially with regard to governance—are often added to assist in the standard's use as guidance for the hospital's leaders.

Part Two:
The Joint Commission Leadership Standards

Chapter 3: Leadership Structure

Standard LD.01.01.01
The hospital has a leadership structure.

Rationale
Every hospital has a leadership structure to support operations and the provision of care. In many hospitals, this structure is formed by three leadership groups: the governing body, senior managers, and the organized medical staff. In some hospitals there may be two leadership groups, and in others only one. Individual leaders may participate in more than one group.

Elements of Performance
1. *The hospital identifies those responsible for governance.*
2. *The governing body identifies those responsible for planning, management, and operational activities.*
3. *The governing body identifies those responsible for the provision of care, treatment, and services.*

As described in Chapters 1 and 2, a hospital has three leadership groups: a governing body, a chief executive and other senior managers, and the leaders of the medical staff. An individual may be a member of more than one leadership group. For example:
- A physician on the medical staff may also be a member of the governing body.
- The chief executive may be a member of the governing body.
- A chief medical officer may be a member of both the senior managers and the medical staff.
- The chief executive may be a voting member of the medical staff's executive committee.

The assignment of individuals to one or more of these leadership groups may differ from hospital to hospital, depending on the hospital's functions, size, complexity, and history. Regardless of how the assignments of individuals are made, those who are responsible for governance must be clearly identified. This standard and the following two standards (Standard LD.01.02.01 and Standard LD.01.03.01) focus on the specific responsibilities of the *governing body* for assigning responsibilities for the organization's leadership functions—governance; administration (that is, planning, management, and operational activities); and provision of care.

Two specific leadership groups are directly responsible for overseeing the activities of those who provide patient care: medical staff leader(s) and the nurse executive. These two organizational leaders are responsible for oversight of the quality of care, respectively, of the physicians and other licensed independent practitioners, and of the nursing staff. The role of the medical staff leaders has been discussed in previous chapters and will be further addressed below, especially with regard to Standard LD.01.05.01.

The "Nursing" chapter of standards in the *2009 Comprehensive Accreditation Manual for Hospitals* recognizes the critical role that the nursing leader—who usually reports through the chief executive—plays in the organization's leadership. Nurses are at the front line of patient care, and nurses should work as a team among themselves and with other caregivers, including physicians and the patient's family. Standard NR.01.01.01 in the "Nursing" chapter sets the expectation that the nurse executive not only directs the delivery of nursing care, but also is a member of the hospital's leadership, functioning at the senior leadership level, and assuming "an active leadership role with the hospital's governing body, senior leadership, medical staff, management, and other clinical leaders in the hospital's decision-making structures and processes" (EP 3). While the nurse executive's attendance at governing body meetings is at the option of the governing body, including the nurse executive in leadership decisions around the quality and safety of care and in established meetings of the senior clinical and managerial leaders is required.

Standard LD.01.02.01
The hospital identifies the responsibilities of its leaders.

Rationale
Many responsibilities may be shared by all leaders. Others are assigned by the governing body to senior managers and the leaders of the organized medical staff. Hospital performance depends on how well the leaders work together to carry out these responsibilities.

Elements of Performance
1. *Senior managers and leaders of the organized medical staff work with the governing body to define their shared and unique responsibilities and accountabilities.*
4. *For hospitals that use Joint Commission accreditation for deemed status purposes: the chief executive officer, medical staff, and nurse executive make certain that the hospital-wide quality assessment and performance improvement and training programs address problems identified by the individual responsible for infection prevention and control and that corrective action plans are successfully implemented.*

Because the governing body of different hospitals may assign responsibilities differently to each of the leadership groups—there is no "one size fits all" set of assignments—each hospital must identify the responsibilities of the leaders in the hospital. While many of these responsibilities may be shared across leadership groups, other responsibilities are assigned to a specific group. Although the governing body is ultimately responsible for the quality and safety of care provided by the hospital, many of the evaluations and decisions about the quality and safety of care and how to improve them require collaboration—teamwork—among the leadership groups. For example, the governing body grants clinical privileges to individual physicians, but is dependent upon an evaluation of the applicant by and recommendations from the medical staff, based on criteria that the governing body has approved, to make its decision. Likewise, the nurse executive is responsible for a staffing plan for nurses that is an ingredient in the leader's maintenance of sufficient qualified staff to meet patients' needs.

Assignment of leadership responsibilities, while ultimately part of the governing body's activities, should be done collaboratively with the other hospital leaders. But what if there is conflict among the leadership groups about the assignments? Management of these conflicts is discussed below (Standard LD.02.04.01).

Even more troublesome, however, would be the failure of a leadership group to fulfill its assigned unique or collaborative responsibilities. If the chief executive and senior managers fail to fulfill their responsibilities, there is a course laid out in a contract, employment agreement, or human resource policies that may be implemented. If the leaders of the medical staff fail to fulfill the medical staff's responsibility to oversee the quality and safety of care provided by physicians (for example, by failing to make recommendations to the governing body for or against renewal of a physician's privileges), the governing body may have to step in and seek assistance for the medical staff functions from outside the hospital's medical staff. Here is where teamwork becomes important. Any member of a team may at some point fail to fulfill a responsibility. In well-functioning teams, this is not the cause for allegations and recriminations. Rather, the response is for other team members to step in and help the faltering member, either themselves or by enlisting outside assistance. When the immediate problem passes, the team then explores the causes of the problem and identifies how a similar problem can be averted in the future and, if it were to recur, how the team may respond even more effectively.

Standard LD.01.03.01
The governing body is ultimately accountable for the safety and quality of care, treatment, and services.

Rationale
The governing body's ultimate responsibility for safety and quality derives from its legal responsibility and operational authority for hospital performance. In this context, the governing body provides for internal structures and resources, including staff that supports safety and quality.

Elements of Performance
1. *The governing body defines in writing its responsibilities.*
2. *The governing body provides for organization management and planning.*
3. *The governing body approves the hospital's written scope of services.*

   Note: For hospitals that use Joint Commission accreditation for deemed status purposes: if emergency services are provided at the hospital, the hospital complies with the requirements of 42 CFR 482.55.
4. *The governing body selects the chief executive responsible for managing the hospital.*
5. *The governing body provides for the resources needed to maintain safe, quality care, treatment, and services.*
6. *The governing body works with the senior managers and leaders of the organized medical staff to annually evaluate the hospital's performance in relation to its mission, vision, and goals.*
8. *The governing body provides the organized medical staff with the opportunity to participate in governance.*
9. *The governing body provides the organized medical staff with the opportunity to be represented at governing body meetings (through attendance and voice) by one or more of its members, as selected by the organized medical staff.*
10. *Organized medical staff members are eligible for full membership in the hospital's governing body, unless legally prohibited.*
20. *For hospitals that elect The Joint Commission Primary Care Medical Home option: the primary care medical home evaluates the effectiveness of how the primary care clinician and the interdisciplinary team partner with the patient to support continuity of care and comprehensive, coordinated care.*

21. *For hospitals that use Joint Commission accreditation for deemed status purposes: the governing body is responsible for making sure that performance improvement activities reflect the complexity of the hospital's organization and services, involve all departments and services, and include services provided under contract. (For more information on contracted services, see Standard LD.04.03.09.)*

This standard focuses on the governing body's unique responsibilities. Some are self-evident or already discussed. The governing body's ultimate accountability for the safety and quality of care is reflected in its approval of the hospital's written scope of services (EP 3), its selection of the chief executive (EP 4), and its provision of needed resources (EP 5). The phrase "provides for" is used in EPs 2 and 5; this phrase was chosen to indicate that the governing body must itself take responsibility for these issues, but may do so through assignment to others, accompanied by oversight of the others' performance.

EP 6 requires collaboration among all three leadership groups to annually evaluate the hospital's performance with regard to achieving its mission, vision, and goals. As will be discussed in Chapter 4 of this white paper, the three leadership groups are to collaborate to create a mission, vision, and goals for the organization in order for all three groups to have an investment in their achievement (Standard LD.02.01.01).

Later (Standard LD.02.04.01), a method for managing conflict between *leadership groups* is described. However, conflicts can, and do, regularly occur between other individuals working in the hospital—whether between clinicians in the same discipline or different disciplines, or between clinical and non-clinical staff, or between non-clinical staff. Any such conflicts can be destructive of the teamwork that is necessary to achieve the goals of safe, high-quality care, financial sustainability, community service, and ethical behavior. For that reason, the governing body should provide a system for resolving these conflicts. The elements of such a system can be adapted from the guidance provided in Standard LD.02.04.01.

EPs 8, 9, and 10 are intended to provide a framework for the leaders of the medical staff to collaborate with the governing body in the leadership of the organization. EP 9 describes one element of the framework: the governing body provides an opportunity for the medical staff to select one (or, at the governing body's discretion, more than one) member(s) of the medical staff to attend, *with voice,* all governing body meetings in order to represent the medical staff's views. This medical staff member(s) need not be a member of the governing body; however, in some hospitals, the medical staff will select one or more individuals to be full, voting members of the governing body. In this case, the governing body member(s) can also fulfill the role of medical staff representative, although it should be clear that the individual's fiduciary duty in his or her voting (that is, in decision *making*) is as a governing body member, not as a representative of the medical staff.

In Chapter 4, on leadership relations, Standard LD.02.02.01 addresses conflicts of interest involving leaders. The governing

body and the other leadership groups are to develop a policy on such conflicts, which is to be implemented when conflicts are identified. This policy would apply not only to members of the governing body, but also to other participants, such as this medical staff representative, in governing body meetings.

Standard LD.01.04.01
A chief executive manages the hospital.

Elements of Performance
1. *The chief executive provides for information and support systems.*
3. *The chief executive provides for physical and financial assets.*
5. *The chief executive identifies a nurse leader at the executive level who participates in decision making.*

EP 1 requires the chief executive to provide for an *information system(s)* in the hospital. With the increasing recognition of the role that information technologies can play in enabling safer, higher-quality, more efficient care, the role of the chief executive in providing for information systems is increasingly important. Guidance for the functioning of an effective information system can be found in the "Information Management" chapter of the *2009 Comprehensive Accreditation Manual for Hospitals.* The governing body should educate itself on the enabling role of information technology and support the chief executive's efforts to improve it.

However, information and other technologies can introduce new risks to patient safety that are often not fully appreciated by those who enthusiastically propose their installation. In accordance with the governing body's fiduciary responsibilities to "first, do no harm" to the hospital's patients, and to sustain the hospital's financial health, its members should question how these risks will be recognized and mitigated.

EP 5 requires the chief executive to appoint a nurse executive. If the hospital has decentralized services and/or geographically distinct sites, each service or site may have its own nurse executive. However, in these circumstances, the chief executive should appoint a single nurse executive that works with the other senior leaders to oversee nursing care *throughout* the hospital.

Safe Use of Health Information Technology

The following information on the risks that can be posed by the introduction of information technology is adapted with permission from "Safe use of health information technology," a Joint Commission *Sentinel Event Alert* [Issue 54, March 31, 2015]. For space purposes, original citations from this publication were omitted here. Refer to the original at www.jointcommission.org/sea_issue_54/ for additional details and complete references.

Health information technology (health IT) is rapidly evolving and its use is growing, presenting new challenges to healthcare organizations. This alert builds upon Sentinel Event Alert #42 on safely implementing health information and converging technologies (published in 2008) to take a broader look at health IT, particularly the socio-technical factors having an impact on its safe use. This alert's suggested actions center on safety culture, process improvement, and leadership.

Incorrect or miscommunicated information entered into health IT systems may result in adverse events. In some cases, interfaces built into the technology contribute to the events. The following examples obtained from ECRI Institute show a few ways adverse events may occur through the use of electronic health records (EHRs) and related technologies:

- A chest X-ray was ordered for the wrong patient when the wrong patient room number was accidentally clicked. The orderer noticed the error right away and promptly discontinued the order, but not in time for the X-ray technician to see that the order was withdrawn. The technician performed the test on the wrong patient.
- A drug was ordered as an intramuscular injection when it was supposed to be administered intravenously. The physician did not choose the appropriate delivery route from the drop-down menu.
- A nurse noted that a patient had a new order for acetaminophen. After speaking with the pharmacist, the nurse determined that the order was placed for the wrong patient. The pharmacist had two patient records open, was interrupted, and subsequently entered the order for the wrong patient.

These examples show the risks inherent in health IT, and studies have documented mixed results in EHRs' ability to detect and prevent errors. On the positive side, however, well-designed and appropriately used EHRs coupled with strong clinical processes can improve and monitor healthcare quality and safety through their ability to access important medical history data, provide clinical decision support tools, and facilitate communication among providers and between providers and patients. EHRs have demonstrated the ability to reduce adverse events, particularly EHRs with clinical data repository, clinical decision support, computerized provider order entry (CPOE) and provider documentation functionalities.

Factors potentially leading to health IT-related sentinel events

EHRs introduce new kinds of risks into an already complex healthcare environment where both technical and social factors must be considered. An analysis of sentinel event reports received by The Joint Commission between January 1, 2010 and June 30, 2013 identified 120 sentinel events that were health IT-related. Factors contributing to the 120 events were placed into categories corresponding to eight socio-technical dimensions necessary to consider for safe and effective health IT described by Sittig and Singh. Listed by order of frequency, factors potentially leading to health IT sentinel events involved the following dimensions:

1. Human-computer interface (33 percent)—ergonomics and usability issues resulting in data-related errors
2. Workflow and communication
3. (24 percent)—issues relating to health IT support of communication and teamwork
4. Clinical content (23 percent)—design or data issues relating to clinical content or decision support
5. Internal organizational policies, procedures and culture (6 percent)
6. People (6 percent)—training and failure to follow established processes
7. Hardware and software (6 percent)—software design issues and other hardware/software problems
8. External factors (1 percent)—vendor and other external issues
9. System measurement and monitoring (1 percent)

While good performance on any of the eight dimensions may improve patient safety, each dimension may interact with others

to compromise patient safety, as well. For example, data integrity may be compromised (mismatched, wrong, missing, or delayed data) due to human-computer interface issues, communication errors, hardware or software issues, or other dimensions. Healthcare organizations may use Sittig's and Singh's eight dimensions model as a framework when creating and maintaining well-integrated, fully- functioning and safe health IT systems.

As health IT adoption spreads and becomes a critical component of organizational infrastructure, the potential for health IT-related harm will likely increase unless risk-reducing measures are put into place.

Actions suggested by The Joint Commission

This alert's suggested actions center on the three crucial areas of safety culture, process improvement, and leadership, consistent with The Joint Commission's past guidance.

1. Safety Culture

Create and maintain an organizational-wide culture of safety, high reliability, and effective change management, with these characteristics:

- A *collective mindfulness* focused on identifying, reporting, analyzing, and reducing health IT-related hazardous conditions, close calls, or errors. Report these instances internally, preferably at early stages, before a patient is harmed. Also report health IT-related adverse events externally, to contribute to aggregate data collection, and to facilitate the identification of risks and hazards not readily apparent to any single organization. Report and interact on safety issues as appropriate with organizations such as patient safety organizations (PSOs), The Joint Commission through its Sentinel Event policy and procedures (voluntarily reported), the FDA, and/or the Veterans Administration's National Center for Patient Safety. Maintain records of all reports. Reporting within a transparent environment of care provides opportunities for learning and solving systemic problems contributing to or causing the events, rather than blaming individuals involved in the events.
- *Comprehensive systematic analysis of each adverse event causing patient harm* to determine if health IT contributed to the event in any way. If so, consider the eight dimensions to understand how health IT contributed to the event and what can be done to prevent a similar event from recurring. Gather as much information as possible, as soon as possible, from individuals involved with the event, as well as from IT staff members and vendors/developers who can provide necessary technical information and address system faults. Health IT as a contributing factor may not be evident initially; that's why all eight dimensions should be investigated.
- *Shared involvement and responsibility* for the safety of health IT among the healthcare organization, clinicians, and vendors/developers. Clearly define and document the roles and responsibilities of all.

2. Process Improvement

Develop a proactive, methodical approach to health IT process improvement that includes assessing patient safety risks. Use the SAFER Guides for EHRs checklists, Failure Mode and Effects Analysis, or a similar method to identify potential system failures before they occur.

The following recommendations (adapted from the High Priority SAFER Guides) can be used as checklists to conduct a proactive risk assessment.

Make health IT hardware and software safe and free from malfunctions:

- Back up data and applications and have redundant hardware systems.
- Create, make available, and regularly review health IT downtime and reactivation policies.
- Use standardized coded data elements to record allergies, problem lists, and diagnostic test results.
- Make evidence-based standard order sets (approved by the organization), clinical guidelines, and charting templates available for common conditions, procedures, and services. See the Institute for Safe Medication Practice's Guidelines for Standard Order Sets.
- Before going live and as appropriate after implementation, conduct extensive testing, including downtime drills and involving frontline staff end-users on hardware and software and system-to-system interfaces to assure data are not lost or incorrectly entered, displayed, or transmitted. Assign responsibility for this testing, as well as for ongoing monitoring and maintenance of the system's performance and safety.

- Ensure that embedded clinical content, including pharmacy dictionaries and medication libraries, is correctly loaded and regularly reviewed, particularly when changes are made to related systems. Assign responsibility for the ongoing management of this content.

Make the use of health IT by clinicians, staff, and patients safe and appropriate:

- Configure the IT system to ensure the clear display of accurate patient identity information on all screens and printouts at each step of the clinical workflow.
- Limit the number of patient records that can be displayed on the same computer at the same time to one unless all subsequent patient records are opened as "read only" and are clearly differentiated to the user.
- Have the capability to track orders in the organization's EHR system.
- Provide clinicians with capability to override computer-generated clinical interventions when necessary. Configure systems to allow clinicians to easily correct accidental clicks, typos, or drop-down choices.
- Maximize use of the EHR to order medications, diagnostic tests, and procedures.
- Provide training, testing, and support for clinical EHR users particularly in relation to the capabilities and limitations of the system. Have users demonstrate competence before they can access the system, and ensure prompt attention to problems encountered by users.
- Establish order sets for common medications and diagnostic testing.
- Maintain clinical oversight when order entry, medication reconciliation, or documentation tasks are delegated.
- Provide patients access to their electronic records via portals, particularly for review of history and test results. While encouraging patient engagement and activation, portal access also enables patients to review their records for accuracy.

Use health IT to monitor and improve safety:

- Monitor key EHR safety metrics via dashboards. Metrics can include help desk use, system uptime and downtime, alert overrides, number of EHR-related legal claims, and the percentage of prescriptions entered through CPOE.
- Engage clinicians and vendors in ongoing optimization and decision making regarding the safe use of EHRs.
- Consider using ongoing safety assessment tools for EHRs in operation to assure their safe performance.

3. Leadership

Within a culture of safety and process improvement described earlier in this alert, enlist multidisciplinary representation and support in providing leadership and oversight to health IT planning, implementation, and evaluation. Useful resources include the Information Governance Principles for Healthcare and the Organizational Responsibilities SAFER Guide.

- Examine workflow processes and procedures for risks and inefficiencies and resolve these issues prior to any technology implementation. Involving representatives of all disciplines—whether they be clinical, clerical, or technical—will help in the examination and resolution of these issues.
- Involve frontline health IT users in system planning, design, selection, modification, and potential hazard identification.
- Choose and optimize systems with interfaces that easily align with and support the cognitive work of clinicians, organizational safety goals, and related technologies. Strongly consider vendor/developer performance and commitment in regard to safety in selection and evaluation.
- Continually improve the ability of organizational health IT systems to reliably and accurately exchange data with each other and with external systems, particularly in regard to the ability to send and receive critical information. *(Note: See the ONC website for information about external health information exchanges, which facilitate the transfer of health information from one organization to another.)*
- Make modifications to the health IT system in a controlled manner.
- Monitor the system's effectiveness according to metrics established by the organization.

Standard LD.01.05.01
The hospital has an organized medical staff that is accountable to the governing body.

Elements of Performance

1. *For hospitals that do not use Joint Commission accreditation for deemed status purposes: there is a single organized medical staff unless criteria are met for an exception to the single medical staff requirements.*
2. *The organized medical staff is self-governing.*
3. *The medical staff structure conforms to medical staff guiding principles.*
4. *The governing body approves the structure of the organized medical staff.*
5. *The organized medical staff oversees the quality of care, treatment, and services provided by those individuals with clinical privileges.*
6. *The organized medical staff is accountable to the governing body.*
7. *For hospitals that use Joint Commission accreditation for deemed status purposes: a doctor of medicine or osteopathy, or, if permitted by state law, a doctor of dental surgery or dental medicine, or a doctor of podiatric medicine, is responsible for the organization and conduct of the medical staff.*
8. *For hospitals that use Joint Commission accreditation for deemed status purposes: there is a single organized medical staff.*

This standard summarizes the role of the organized medical staff and its relationship to the governing body, as described in Chapter 1 (of this white paper) on leaders and systems. The "Medical Staff" chapter in the *2009 Comprehensive Accreditation Manual for Hospitals* contains more details about the medical staff's responsibilities, which include, among others:

- Oversight of care provided by physicians and other licensed independent practitioners in the hospital
- A role in graduate medical education programs, when the hospital has one (or more)
- A leading role in performance improvement activities to improve the quality of care and patient safety
- Collection, verification, and evaluation of each licensed independent practitioner's credentials
- Recommending to the governing body that an individual be appointed to the medical staff and be granted clinical privileges, based on his/her credentials
- Participating in continuing education

The "Medical Staff" chapter requires that the governing body and the medical staff agree on the rules for and parameters of their collaborative relationship, and that they document these rules and parameters in medical staff bylaws and rules and regulations which both the medical staff and the governing body agree to follow. The specific issues that these documented agreements must, at a minimum, include are listed in Standard MS.01.01.01 in the "Medical Staff" chapter.

EP 2 states that the medical staff is "self-governing," and EP 6 says that it is "accountable to the governing body." Self-governance means that the medical staff:

- Initiates, develops, and approves medical staff bylaws and rules and regulations
- Approves or disapproves amendments to the medical staff bylaws and rules and regulations
- Selects and removes medical staff officers
- Determines the mechanism for establishing and enforcing criteria and standards for medical staff membership
- Determines the mechanism for establishing and enforcing criteria for delegating oversight responsibilities to practitioners with independent privileges
- Determines the mechanism for establishing and maintaining patient care standards and credentialing and delineation of clinical privileges
- Engages in performance improvement activities

For the performance of each of these responsibilities, the medical staff is accountable to the governing body. In some hospitals, the medical staff may engage members of the governing body or senior administrators in these activities—teamwork, again—although the decisions lie with the medical staff members, and final approval lies with the governing body.

EP 3 states that the medical staff should be structured in conformance with "medical staff guiding principles." These guiding principles are:

- Designated members of the organized medical staff who have independent privileges provide oversight of care provided by practitioners with privileges. (Note: A "practitioner with privileges" is, for all practical purposes, equivalent to a "licensed independent practitioner" who provides care in the hospital.)
- The organized medical staff is responsible for structuring itself to provide a uniform standard of quality patient care, treatment, and services.
- The organized medical staff is accountable to the governing body.
- Applicants for privileges need not necessarily be members of the medical staff.

Chapter 4: Leadership Relationships

Standard LD.02.01.01
The mission, vision, and goals of the hospital support the safety and quality of care, treatment, and services.

Rationale
The primary responsibility of leaders is to provide for the safety and quality of care, treatment, and services. The purpose of the hospital's mission, vision, and goals is to define how the hospital will achieve safety and quality. The leaders are more likely to be aligned with the mission, vision, and goals when they create them together. The common purpose of the hospital is most likely achieved when it is understood by all who work in or are served by the hospital.

Elements of Performance
1. *The governing body, senior managers, and leaders of the organized medical staff work together to create the hospital's mission, vision, and goals.*
2. *The hospital's mission, vision, and goals guide the actions of leaders.*
3. *Leaders communicate the mission, vision, and goals to staff and the population(s) the hospital serves.*

This chapter on leadership relationships addresses issues such as communication among the leaders, management of conflict among the leaders, and conflict of interest with respect to each leader's roles and responsibilities. These issues, however, are meaningful within the organization only if the leadership groups have a shared understanding of what they want to achieve and why, and how they want to achieve it. These are the questions that are answered and codified by the development of the organization's mission, vision, and goals. The greater the alignment among the leadership groups with respect to the hospital's mission, vision, and goals, the more likely they can effectively function as a team to achieve those goals. And alignment is more likely to result when the mission, vision, and goals are developed collaboratively.

However, in a hospital, especially one with "voluntary" rather than employed medical staff members, not all goals may be shared. For example, if the physicians on the medical staff all have clinical privileges and provide care at two hospitals in the community, they may not share a goal with the chief executive and the governing body of one of those hospitals to become the dominant community provider. Despite the fact that complete alignment would facilitate teamwork and success in achieving the goals, for many hospitals complete alignment, especially of strategies and goals, may be beyond reach.

That is why this standard and rationale focus on the relationship of the mission, vision, and goals to the *safety and quality of care,* rather than to any other potential goals of the hospital. The more engaged all the leadership groups are in creating the mission, vision, and goals, the more likely they will be aligned with respect to the shared goals of safe and high-quality care and strategies of how to achieve them.

EPs 2 and 3 address a common failing in all types of organizations: after thoughtful development of a mission, vision, and goals, they are placed on the shelf, guiding neither the activities of the leaders nor the work of staff throughout the organization. Unless they guide activities throughout the organization, the development of the mission, vision, and goals is a wasted effort. For this reason, the hospital's mission, vision, and goals are to be communicated to staff and used to guide the actions of the leaders.

But what is the rationale for communicating the mission, vision, and goals to the population the hospital serves? If the hospital is not only to provide safe, high-quality care, but also to be financially sustainable, serve its community, and behave ethically, it needs to be transparent to those it serves and solicit their input and feedback. The most successful hospitals engage in "teamwork" not only internally, but also with the individuals and communities they serve.

Standard LD.02.02.01
The governing body, senior managers, and leaders of the organized medical staff address any conflict of interest involving leaders that affect or could affect the safety or quality of care, treatment, and services.

Note: This standard addresses conflict of interest involving individual members of leadership groups. For conflicts of interest among staff and licensed independent practitioners who are not members of leadership groups, see Standard LD.04.02.01.

Rationale
Conflicts of interest can occur in many circumstances and may involve professional or business relationships. Leaders create policies that provide for the oversight and control of these situations. Together, leaders address actual and potential conflicts of interest that could interfere with the hospital's responsibility to the community it serves.

Elements of Performance
1. *The governing body, senior managers, and leaders of the organized medical staff work together to define, in writing, conflicts of interest involving leaders that could affect safety and quality of care, treatment, and services.*
2. *The governing body, senior managers, and leaders of the organized medical staff work together to develop a written policy that defines how conflicts of interest involving leaders will be addressed.*
3. *Conflicts of interest involving leaders are disclosed as defined by the hospital.*

Every governing body experiences conflicts of interest among its members, and such conflicts can arise even more readily

between leadership groups. A *conflict* of interest for a governing body member exists when a (usually) personal financial interest could impair the individual's objectivity with regard to decisions related to his/her fiduciary obligation to the hospital or its patients. Conflicts of interest within him- or herself, or within family members are often unrecognized by an individual. For this reason, organizations increasingly provide individuals with a list of specific types of conflicts for the individual to review, with the expectation that the individual is more likely to recognize if he or she has one of the listed conflicts than to spontaneously identify the conflict if the inquiry is open-ended. The response to conflicts of interest (for example, from disclosure to recusal to resignation) should be identified in the conflict-of-interest policy. The policy should address which conflicts of interest should be disclosed, to whom they should be disclosed, and by what method they should be disclosed.

A *duality* of interest can arise if the governing body member has fiduciary obligations to more than one party (for example, to patients and to the hospital). Each of these obligations could lead to different actions and decisions. Both the hospital as an organization and the hospital's patients each *trust* a member of the governing body to act, respectively, in the hospital's and the patient's best interest, not in another party's (or the governing body member's) interest. A duality of interest, especially when it arises from fiduciary obligations to multiple parties, can create a classical *ethical* dilemma or uncertainty. It can be, in fact, an ethical challenge for the individual, and should be resolved as such. It is part of the hard and sometimes uncomfortable work of being a governing body member. While decisions are often driven by *values,* the decisions should be as fully informed as possible by *evidence*.[2]

Standard LD.02.04.01

The hospital manages conflict between leadership groups to protect the quality and safety of care.

Elements of Performance

1. *Senior managers and leaders of the organized medical staff work with the governing body to develop an ongoing process for managing conflict among leadership groups.*
5. *The hospital implements the process when a conflict arises that, if not managed, could adversely affect patient safety or quality of care.*

Conflict among the leadership groups occurs commonly—even in well-functioning hospitals—and, in fact, can be a productive stimulus for positive change. However, conflicts among leadership groups with regard to accountabilities, policies, practices, and procedures that are not managed effectively have the potential to threaten the safety and quality of patient care. Therefore, hospitals need to manage these conflicts so that the safety and quality of care are protected. A conflict-management process is designed to meet this need.

The elements of performance require that leadership groups—the governing body, the chief executive and senior managers, and leaders of the medical staff—together develop a conflict-management process, which must be approved by the governing body. Implementation of this process allows hospitals to identify conflict quickly, and to manage it before it escalates to compromise the safety and quality of care.

To facilitate the management of conflict, hospital leaders should identify an individual with conflict-management skills who can help the hospital implement its conflict-management process. This skilled individual within the hospital can often assist the hospital to manage a conflict without needing to seek assistance from outside the hospital. This individual can also help the hospital to more easily manage, or even avoid, future conflicts. The skilled individual can be from the hospital's own leadership groups, can be an individual from other areas of the hospital (for example, human resources management or administration), or can be from outside the hospital. Conflict-management skills can be acquired through various means including experience, education, and training. If the hospital chooses to train its own leaders, it may offer external training sessions to key individuals or it may bring in experts to teach conflict-management skills.

Conflict can be successfully managed without being "resolved." The goal of this standard is not that all conflicts be resolved, but rather that hospital leaders develop and implement a conflict-management process so that conflict does not adversely affect patient safety or quality of care.

2 Further guidance on conflicts of interest for governing body members is available in *Conflicts of Interest and the Non-Profit Board: Guidelines for Effective Practice,* a Governance Institute white paper (2008).

Chapter 5: Hospital Culture and System Performance[3]

A hospital's culture[4] reflects the beliefs, attitudes, and priorities of the staff, including clinicians, throughout the organization. It influences the effectiveness of the hospital's performance including its ability to achieve the goals of high-quality, safe care, financial sustainability, community service, and ethical behavior. Although there may be a dominant culture, in many larger hospitals diverse cultures exist that may or may not share all of the same values. In fact, diverse cultures can exist even in smaller hospitals. Despite these diverse cultures, the hospital's performance with respect to its goals can still be effective if the cultures are compatible and aligned with respect to their overall goals. Successful hospitals will work to develop a culture of safety and quality that pervades all of its diverse cultures.

In a culture of safety and quality, every individual is focused on maintaining excellence in performance. Each accepts the safety and quality of patient care as a personal responsibility and everyone works together to minimize any harm that might result from unsafe or poor care. Leaders create this culture by demonstrating in their communication and in their individual and collective behavior a commitment to safety and quality, and by taking actions to achieve the desired culture. In a culture of safety and quality, one finds teamwork, open discussions of concerns about safety and quality, and encouragement of and reward for internal and external reporting of safety and quality issues. The focus of attention is on the performance of systems and processes instead of the individual, although reckless behavior and a blatant disregard for safety are not tolerated. The hospital is committed to ongoing learning and has the flexibility to accommodate changes in technology, science, and the environment.

To create a culture of safety and quality, the leaders must sustain a focus on safety and quality. Leaders plan, support, and implement key systems critical to this effort. Five key systems influence the hospital's effective performance with respect to improving the safety and quality of patient care—and sustaining these improvements. The systems are:

- Using data
- Planning
- Communicating
- Changing performance
- Staffing

These five key systems serve as pillars that are based on a foundation set by leadership, and in turn support the many hospital-wide processes (such as medication management) that are important to the safety and quality of patient care. Culture permeates this entire structure—the base of leadership; the pillars of using data, planning, communicating, changing performance, and staffing; and the superstructure of patient care activities.

The five key systems—the pillars—are interrelated and must function well together. The integration of these systems throughout the hospital facilitates the effective performance of the hospital as a whole. Therefore, the hospital's leaders must develop a vision and goals for the performance of each of these systems and must evaluate each system's performance. They then must use the results of these evaluations to develop strategies for future improvements that will better achieve the hospital's overall goals of safe, high-quality care, financial sustainability, community service, and ethical behavior.

Performance of many aspects of these five systems may be directly observable. But for some aspects, a hospital's performance is demonstrated through its performance with respect to other important hospital-wide systems, such as those for information management, infection control, and medication management. For other aspects of the five pillars, the hospital's performance is evident in its patient care processes. While the leaders cannot prevent (or be accountable for) every breach in the performance of the five key processes, they are responsible for *hospital-wide patterns of poor performance*. (In fact, the federal Centers for Medicare and Medicaid Services, in its program to certify hospitals as eligible to receive payments from the Medicare fund, will automatically cite non-compliance with its requirements for the hospital's leaders if non-compliance with individual standards in the federal Conditions of Participation for Medicare is widespread enough that the hospital is found out of compliance with one of the Conditions themselves. In this case, a hospital-wide pattern of poor performance is, in itself, considered evidence of ineffective leadership.)

3 This introduction to the standards on hospital culture and system performance is adapted with permission from the "Leadership" chapter in The Joint Commission's *2009 Comprehensive Accreditation Manual for Hospitals*.

4 A helpful introduction to the characteristics and impact of a culture of safety can be found in the chapter entitled "Safety Culture," in Managing Maintenance Error: A Practical Guide, by J. Reason and A. Hobbs (Hampshire, England: Ashgate Publishing Company, 2003, pp. 145–158).

The effective performance of the five systems enables the hospital to create an organization-wide culture in which safety and quality are a given. The hospital can support this culture through a proactive, non-punitive culture that is monitored and sustained by related reporting systems and improvement initiatives.

Many of the concepts embodied in the five systems are consistent with and complementary to existing approaches to improvement such as the Baldrige National Quality Award criteria, the Toyota Lean Production model, Six Sigma, and ISO 9000.

Standard LD.03.01.01
Leaders create and maintain a culture of safety and quality throughout the hospital.

Rationale
Safety and quality thrive in an environment that supports teamwork and respect for other people, regardless of their position in the organization. Leaders demonstrate their commitment to quality and set expectations for those who work in the organization. Leaders evaluate the culture on a regular basis. Leaders encourage teamwork and create structures, processes, and programs that allow this positive culture to flourish. Disruptive behavior that intimidates others and affects morale or staff turnover can be harmful to patient care. Leaders must address disruptive behavior of individuals working at all levels of the organization, including management, clinical and administrative staff, licensed independent practitioners, and governing body members.

Elements of Performance
1. *Leaders regularly evaluate the culture of safety and quality using valid and reliable tools.*
2. *Leaders prioritize and implement changes identified by the evaluation.*
4. *Leaders develop a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety.*
5. *Leaders create and implement a process for managing behaviors that undermine a culture of safety.*

Board Self-Assessment

Does The Joint Commission require a board self-evaluation/assessment of its own performance?

Whereas the standards contain no specific implicit or explicit requirement for self-assessment of the leadership, including the governing body, processes overall—such an assessment *would be a normal part of what an organization would do in order to improve its results.*

The Leadership Standards include two elements of performance that require leaders, including the governing body, to evaluate how well they both plan and support planning, and how well they manage change and process improvement. They are:
1. *LD.03.03.01, EP 7: Leaders evaluate the effectiveness of planning activities.*
2. *LD.03.05.01. EP 7: Leaders evaluate the effectiveness of processes for the management of change and performance improvement.*

A second group of four requirements specify that the leaders, including the governing body, evaluate how effectively they fulfill their responsibilities for creating and maintaining a culture of safety, for fostering the use of data, for creating and supporting processes for communication, and for designing and staffing work processes to promote safety and quality. These four requirements focus on the results rather than the processes of the leaders' activities:
1. *LD.03.01.01 EP 1: Leaders regularly evaluate the culture of safety and quality using valid and reliable tools.*
2. *LD.03.02.01 EP 7: Leaders evaluate how effectively data and information are used throughout the hospital.*
3. *LD.03.04.01 EP 7: Leaders evaluate the effectiveness of communication methods.*
4. *LD.03.06.01 EP 6: Leaders evaluate the effectiveness of those who work in the hospital to promote safety and quality.*

The Essential Role of Leadership in Developing a Safety Culture

Many experts believe that the quality of leadership is a significant factor in the quality and safety performance of an organization. (The following excerpt on the essential role of leadership in developing a safety culture is adapted with permission from an issue of the Joint Commission *Sentinel Event Alert* on leadership [Issue 57, March 1, 2017]. For space purposes, original citations from this publication were omitted here. Refer to the original at www.jointcommission.org/sea_issue_57/ for additional details and complete references.

In any healthcare organization, leadership's first priority is to be accountable for effective care while protecting the safety of patients, employees, and visitors. Competent and thoughtful leaders contribute to improvements in safety and organizational culture. They understand that systemic flaws exist and each step in a care process has the potential for failure simply because humans make mistakes. James Reason compared these flaws—latent hazards and weaknesses—to holes in Swiss cheese. These latent hazards and weaknesses must be identified and solutions found to prevent errors from reaching the patient and causing harm. Examples of latent hazards and weaknesses include poor design, lack of supervision, and manufacturing or maintenance defects.

The Joint Commission's Sentinel Event Database reveals that leadership's failure to create an effective safety culture is a contributing factor to many types of adverse events—from wrong site surgery to delays in treatment.

In addition, through the results of its safety initiatives, The Joint Commission Center for Transforming Healthcare has found inadequate safety culture to be a significant contributing factor to adverse outcomes. Inadequate leadership can contribute to adverse events in various ways, including but not limited to these examples:

- Insufficient support of patient safety event reporting
- Lack of feedback or response to staff and others who report safety vulnerabilities
- Allowing intimidation of staff who report events
- Refusing to consistently prioritize and implement safety recommendations
- Not addressing staff burnout

In essence, a leader who is committed to prioritizing and making patient safety visible through every day actions is a critical part of creating a true culture of safety. Leaders must commit to creating and maintaining a culture of safety; this commitment is just as critical as the time and resources devoted to revenue and financial stability, system integration, and productivity.

Maintaining a safety culture requires leaders to consistently and visibly support and promote everyday safety measures. Culture is a product of what is done on a consistent daily basis. Hospital team members measure an organization's commitment to culture by what leaders do, rather than what they say should be done.

Actions suggested by The Joint Commission

The Joint Commission recommends that leaders take actions to establish and continuously improve the five components of a safety culture defined by Chassin and Loeb: **trust, accountability, identifying unsafe conditions, strengthening systems, and assessment.** These actions are not intended to be implemented in a sequential manner. Leaders will need to address and apply various components to the workforce simultaneously, using tactics such as board engagement, leadership education, goal setting, staff support, and dashboards and reports that routinely review safety data.

1. Absolutely crucial is a transparent, non-punitive approach to reporting and learning from adverse events, close calls and unsafe conditions.
2. Establish clear, just, and transparent risk-based processes for recognizing and separating human error and error arising from poorly designed systems from unsafe or reckless actions that are blameworthy.
3. To advance trust within the organization, CEOs and all leaders must adopt and model appropriate behaviors and champion efforts to eradicate intimidating behaviors.
4. Establish, enforce, and communicate to all team members the policies that support safety culture and the reporting of adverse events, close calls, and unsafe conditions.
5. Recognize care team members who report adverse events and close calls, who identify unsafe conditions, or who have good suggestions for safety improvements.
6. Establish an organizational baseline measure on safety culture performance using the Agency for Healthcare Research and Quality (AHRQ) Hospital Survey on Patient Safety Culture (HSOPS) or another tool, such as the Safety Attitudes Questionnaire (SAQ).
7. Analyze safety culture survey results from across the organization to find opportunities for quality and safety improvement.
8. In response to information gained from safety assessments and/or surveys, develop and implement unit-based quality and safety improvement initiatives designed to improve the culture of safety.
9. Embed safety culture team training into quality improvement projects and organizational processes to strengthen safety systems.
10. Proactively assess system (such as medication management and electronic health records) strengths and vulnerabilities and prioritize them for enhancement or improvement.
11. Repeat organizational assessment of safety culture every 18 to 24 months to review progress and sustain improvement.

Standard LD.03.02.01
The hospital uses data and information to guide decisions and to understand variation in the performance of processes supporting safety and quality.

Rationale
Data help hospitals make the right decisions. When decisions are supported by data, organizations are more likely to move in directions that help them achieve their goals. Successful organizations measure and analyze their performance. When data are analyzed and turned into information, this process helps hospitals see patterns and trends and understand the reasons for their performance. Many types of data are used to evaluate performance, including data on outcomes of care, performance on safety and quality initiatives, patient satisfaction, process variation, and staff perceptions.

Elements of Performance
1. *Leaders set expectations for using data and information to improve the safety and quality of care, treatment, and services.*
3. *The hospital uses processes to support systematic data and information use.*
4. *Leaders provide the resources needed for data and information use, including staff, equipment, and information systems.*
5. *The hospital uses data and information in decision making that supports the safety and quality of care, treatment, and services.*
6. *The hospital uses data and information to identify and respond to internal and external changes in the environment.*
7. *Leaders evaluate how effectively data and information are used throughout the hospital.*

The leaders of the organization are continuously faced with the need to make decisions that can profoundly affect the hospital's ability to achieve its goals: safe, high-quality patient care; financial sustainability; community service; and ethical behavior. To make the best decisions, the leaders require data that enable them to understand the challenges they are addressing, design and evaluate potential solutions, and measure the impact of their decisions. A commitment by the leadership groups to make data-driven decisions will permeate through the organization. The "Performance Improvement" chapter in the *2009 Comprehensive Accreditation Manual for Hospitals* provides specific guidance on the collection, assessment, and use of data to continuously improve the safety and quality of care.

Standard LD.03.03.01
Leaders use hospital-wide planning to establish structures and processes that focus on safety and quality.

Rationale
Planning is essential to the following:
- *The achievement of short- and long-term goals*
- *Meeting the challenge of external changes*
- *The design of services and work processes*
- *The creation of communication channels*
- *The improvement of performance*
- *The introduction of innovation*

Planning includes contributions from the populations served, from those who work for the hospital, and from other interested groups or individuals.

Elements of Performance
1. *Planning activities focus on improving patient safety and healthcare quality.*
3. *Planning is systematic, and it involves designated individuals and information sources.*
4. *Leaders provide the resources needed to support the safety and quality of care, treatment, and services.*
5. *Safety and quality planning is hospital-wide.*
6. *Planning activities adapt to changes in the environment.*
7. *Leaders evaluate the effectiveness of planning activities.*

Standard LD.03.04.01
The hospital communicates information related to safety and quality to those who need it, including staff, licensed independent practitioners, patients, families, and external interested parties.

Rationale
Effective communication is essential among individuals and groups within the hospital, and between the hospital and external parties. Poor communication often contributes to adverse events and can compromise safety and quality of care, treatment, and services. Effective communication is timely, accurate, and usable by the audience.

Elements of Performance
1. *Communication processes foster the safety of the patient and the quality of care.*
3. *Communication is designed to meet the needs of internal and external users.*
4. *Leaders provide the resources required for communication, based on the needs of patients, the community, physicians, staff, and management.*
5. *Communication supports safety and quality throughout the hospital. (See also LD.04.04.05, EPs 6 and 12.)*
6. *When changes in the environment occur, the hospital communicates those changes effectively.*
7. *Leaders evaluate the effectiveness of communication methods.*

At the core of healthcare is information management—information about the patient; about medical science; about therapeutic interventions; about actions to be taken by patients, their families, nurses, pharmacists, and others on the treatment team. Much of this information management is based upon communication among the participants. In an increasingly multilingual, multicultural society, three barriers to communication between caregivers and patients and their families have been identified: limited English proficiency, cultural differences, and low health literacy. Failure to address these barriers leads to more frequent

adverse events and also, more *serious* adverse events. The leaders of the hospital should attend not only to communication among hospital staff, but also to providing the resources (such as staff education and interpreter services) that enable the treatment team to overcome the barriers to communication with patients and their families.

Standard LD.03.05.01
Leaders implement changes in existing processes to improve the performance of the hospital.

Rationale
Change is inevitable, and agile organizations are able to manage change and rapidly execute new plans. The ability of leaders to manage change is necessary for performance improvement, for successful innovation, and to meet environmental challenges. The hospital integrates change into all relevant processes so that its effectiveness can be sustained, assessed, and measured.

Elements of Performance
1. *Structures for managing change and performance improvements exist that foster the safety of the patient and the quality of care, treatment, and services.*
3. *The hospital has a systematic approach to change and performance improvement.*
4. *Leaders provide the resources required for performance improvement and change management, including sufficient staff, access to information, and training.*
5. *The management of change and performance improvement supports both safety and quality throughout the hospital.*
6. *The hospital's internal structures can adapt to changes in the environment.*
7. *Leaders evaluate the effectiveness of processes for the management of change and performance improvement.*

Although the "Performance Improvement" chapter in the *2009 Comprehensive Accreditation Manual for Hospitals* contains extensive guidance for the organization's continuous improvement of the safety and quality of care, the leaders collectively have a critical role to play in setting overall priorities for improvement, in providing the resources that enable improvement efforts to succeed, and in evaluating the results of the improvement. Although improvement activities may address a myriad of goals (such as improved financial performances), the leaders must keep the safety and quality of patient care at the center of attention. The leader's goals for and investment in improvement will be translated into the goals and commitment for improvement throughout the organization.

Standard LD.03.06.01
Those who work in the hospital are focused on improving safety and quality.

Rationale
The safety and quality of care, treatment, and services are highly dependent on the people in an organization. The mission, scope, and complexity of services define the design of work processes and the skills and number of individuals needed. In a successful hospital, work processes and the environment make safety and quality paramount. This standard, therefore, applies to all those who work in or for the hospital, including staff and licensed independent practitioners.

Elements of Performance
1. *Leaders design work processes to focus individuals on safety and quality issues.*
3. *Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services.*
   Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered.
4. *Those who work in the hospital are competent to complete their assigned responsibilities.*
5. *Those who work in the hospital adapt to changes in the environment.*
6. *Leaders evaluate the effectiveness of those who work in the hospital to promote safety and quality.*

Chapter 6: Leadership Operations

Standard LD.04.01.01
The hospital complies with law and regulation.

Elements of Performance

1. *The hospital is licensed, certified, or has a permit, in accordance with law and regulation, to provide the care, treatment, or services for which the hospital is seeking accreditation from The Joint Commission.*

   Note: Each service location that performs laboratory testing (waived or non-waived) must have a Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate[5] as specified by the federal CLIA regulations (42 CFR 493.55 and 493.3) and applicable state law.
2. *The hospital provides care, treatment, and services in accordance with licensure requirements, laws, and rules and regulations.*
3. *Leaders act on or comply with reports or recommendations from external authorized agencies, such as accreditation, certification, or regulatory bodies.*
16. *For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes:*
    - *The psychiatric hospital is primarily engaged in providing, by or under the supervision of a doctor of medicine or osteopathy, psychiatric services for the diagnosis and treatment of mentally ill persons.*
    - *The psychiatric hospital meets the hospital conditions of participation specified in 42 CFR 482.1 through 482.23, and 42 CFR 482.25 through 482.57.*
    - *The psychiatric hospital maintains clinical records on all patients to determine the degree and intensity of treatments, as specified in 42 CFR 482.61.*
    - *The psychiatric hospital meets the staffing requirements specified in 42 CFR 482.62.*

17. *For hospitals that use Joint Commission accreditation for deemed status purposes: the hospital has a utilization review plan consistent with 42 CFR 482.30 that provides for review of services furnished by the hospital and the medical staff to patients entitled to benefits under the Medicare and Medicaid programs.*

    Note 1: The hospital does not need to have a utilization review plan if either a Quality Improvement Organization (QIO) has assumed binding review for the hospital or the Centers for Medicare & Medicaid Services (CMS) has determined that the utilization review procedures established by the state under title XIX of the Social Security Act are superior to the procedures required in this section, and has required hospitals in that state to meet the utilization review plan requirements under 42 CFR 456.50 through 42 CFR 456.245.
18. *For hospitals that use Joint Commission accreditation for deemed status purposes: utilization review activities are implemented by the hospital in accordance with the plan.*

    Note 1: The hospital does not need to implement utilization review activities itself if either a Quality Improvement Organization (QIO) has assumed binding review for the hospital or the Centers for Medicare & Medicaid Services (CMS) has determined that the utilization review procedures established by the state under title XIX of the Social Security Act are superior to the procedures required in this section, and has required hospitals in that state to meet the utilization review plan requirements under 42 CFR 456.50 through 42 CFR 456.245.

Standard LD.04.01.03
The hospital develops an annual operating budget and when needed, a long-term capital expenditure plan.

Elements of Performance

1. *Leaders solicit comments from those who work in the hospital when developing the operational and capital budgets.*
3. *The operating budget reflects the hospital's goals and objectives.*
4. *The governing body approves an annual operating budget and, when needed, a long-term capital expenditure plan.*

Standard LD.04.01.05
The hospital effectively manages its programs, services, sites, or departments.

Rationale
Leaders at the program, service, site, or department level create a culture that enables the hospital to fulfill its mission and meet its goals. They support staff and instill in them a sense of ownership of their work processes. Leaders may delegate work to qualified staff, but the leaders are responsible for the care, treatment, and services provided in their areas.

Elements of Performance

2. *Programs, services, sites, or departments providing patient care are directed by one or more qualified professionals or by a qualified licensed independent practitioner with clinical privileges.*
3. *The hospital defines in writing the responsibility of those with administrative and clinical direction of its programs, services, sites, or departments.*

   Note: For hospitals that use Joint Commission accreditation for deemed status purposes: this includes the full-time employee who directs and manages dietary services.
4. *Staff members are held accountable for their responsibilities.*

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5 For more information on how to obtain a CLIA certificate, see www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/How_to_Apply_for_a_CLIA_Certificate_International_Laboratories.html.

5. *Leaders provide for the coordination of care, treatment, and services among the hospital's different programs, services, sites, or departments.*
6. *For hospitals that use Joint Commission accreditation for deemed status purposes: the hospital's emergency services are directed and supervised by a qualified member of the medical staff.*
7. *For hospitals that use Joint Commission accreditation for deemed status purposes: A qualified doctor of medicine or osteopathy directs the following services:*
   - *Anesthesia*
   - *Nuclear medicine*
   - *Respiratory care*

8. *For hospitals that use Joint Commission accreditation for deemed status purposes: the hospital assigns one or more individuals who are responsible for outpatient services.*
9. *For hospitals that use Joint Commission accreditation for deemed status purposes: the anesthesia service is responsible for all anesthesia administered in the hospital.*
10. *For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: the hospital has a director of social work services who monitors and evaluates the social work services furnished.*

    Note: Social work services are furnished in accordance with accepted standards of practice and established policies and procedures.
12. *Leaders identify an individual to be accountable for the following:*
    - *Staff implementation of the four phases of emergency management (mitigation, preparedness, response, and recovery)*
    - *Staff implementation of emergency management across the six critical areas (communications, resources and assets, safety and security, staff responsibilities, utilities, and patient clinical and support activities)*
    - *Collaboration across clinical and operational areas to implement emergency management hospital-wide*
    - *Identification of and collaboration with community response partners.*

      Note: This role addresses matters of emergency management that are not within the responsibilities of the incident commander role.

While the "Leadership" chapter is primarily focused on the three organization-wide leadership groups—the governing body, the chief executive and senior managers, and the leaders of the medical staff—these groups are collectively responsible for the management of its programs, services, sites, and departments throughout the organization. The "leaders" referred to in *this* standard are those who manage these clinical and non-clinical units within the organization. Chapter 1 of this white paper discussed the importance of understanding the hospital as a system rather than as a collection of units (or, as they are often referred to, "silos"). EP 5 emphasizes the role of leaders throughout the organization in setting expectations for and facilitating the integration of the organization's many units into a system that achieves the goals of safe, high-quality care through coordination of patient care.

Standard LD.04.01.06
For hospitals that elect The Joint Commission Primary Care Medical Home option: qualified individuals serve in the role of primary care clinician.

Elements of Performance
1. *For hospitals that elect The Joint Commission Primary Care Medical Home option: primary care clinicians have the educational background and broad-based knowledge and experience necessary to handle most medical and other healthcare needs of the patients who selected them. This includes resolving conflicting recommendations for care. (See also LD.01.05.01.)*

Standard LD.04.01.07
The hospital has policies and procedures that guide and support patient care, treatment, and services.

Elements of Performance
1. *Leaders review and approve policies and procedures that guide and support patient care, treatment, and services.*
2. *The hospital manages the implementation of policies and procedures.*

Standard LD.04.01.11
The hospital makes space and equipment available as needed for the provision of care, treatment, and services.

Rationale
The resources allocated to services provided by the organization have a direct effect on patient outcomes. Leaders should place highest priority on high-risk or problem prone processes that can affect patient safety. Examples include infection control, medication management, use of anesthesia, and others defined by the hospital.

Elements of Performance
3. *The interior and exterior provided for care, treatment, and services meets the needs of patients.*
4. *The grounds, equipment, and special activity areas are safe, maintained, and supervised.*
5. *The leaders provide for equipment, supplies, and other resources.*

Sometimes forgotten in the provision of space and equipment are the special needs of specific patient populations. The governing body may ask, for example:
- Whether equipment sized for infants and children is readily available when needed
- Whether communication assistance devices are available for individuals with impaired hearing, impaired sight, or limited English proficiency

- Whether space and equipment meet the needs of individuals with limited mobility (such as individuals in wheelchairs)

The chapter on "Environment of Care" in the *2009 Comprehensive Accreditation Manual for Hospitals* sets expectations for how the hospital should meet many of these patient needs.

Standard LD.04.02.01
The leaders address any conflict of interest involving licensed independent practitioners and/or staff that affects or has the potential to affect the safety or quality of care, treatment, and services.

Elements of Performance
1. *The leaders define conflict of interest involving licensed independent practitioners or staff. This definition is in writing.*
2. *The leaders develop a written policy that defines how the hospital will address conflicts of interest involving licensed independent practitioners and/or staff.*
3. *Existing or potential conflicts of interest involving licensed independent practitioners and/or staff, as defined by the hospital, are disclosed.*
4. *The hospital reviews its relationships with other care providers, educational institutions, manufacturers, and payers to determine whether conflicts of interest exist and whether they are within law and regulation.*
5. *Policies, procedures, and information about the relationship between care, treatment, and services and financial incentives are available upon request to all patients, and those individuals who work in the hospital, including staff and licensed independent practitioners.*

Standard LD.02.02.01 (discussed in Chapter 4; see page 15) focuses upon conflicts of interest among the members of the three leadership groups—the governing body, the chief executive and senior managers, and the leaders of the medical staff. However, this standard (LD.04.02.01) focuses on conflicts of interest among others in the organization including physicians and other licensed independent practitioners. Of special importance are those conflicts of interest that could affect decisions about a patient's care, such as the potential conflict experienced by a physician who invented and patented a diagnostic or treatment device, receives royalties from its use, and prescribes its use for his or her own patients. While the device may be the best available, and the physician the most experienced in its use, at the least, the conflict-of-interest should be disclosed to the patient, who can take it into consideration in consenting to treatment. Under other circumstances, the conflict-of-interest policy may, for example, forbid ownership in a company that would create a potential conflict. EP 4 recognizes that the hospital itself, as an organization, may have conflicts of interest that should be addressed by the policy.

Standard LD.04.02.03
Ethical principles guide the hospital's business practices.

Elements of Performance
1. *The hospital has a process that allows staff, patients, and families to address ethical issues or issues prone to conflict.*
2. *The hospital uses its process to address ethical issues or issues prone to conflict.*
5. *Care, treatment, and services are provided based on patient needs, regardless of compensation or financial risk-sharing with those who work in the hospital, including staff and licensed independent practitioners.*
13. *For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: each resident who is entitled to Medicaid benefits is informed in writing, either at the time of admission or when the resident becomes eligible for Medicaid, of the following:*
    - *The items and services included in the state plan for which the resident may not be charged*
    - *Those items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services*
14. *For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: residents are informed when changes are made to the services that are specified in LD.04.02.03, EP 13.*
15. *For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: when a resident becomes eligible for Medicaid after admission to the hospital, the hospital charges the resident only the Medicaid-allowable charge.*
16. *For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: residents are informed before or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services not covered under Medicare or by the facility's per diem rate.*

Healthcare is value-laden for patients, families, practitioners, and provider organizations. Consequently, it is common for the values of individuals or groups to come into conflict. It is not so much that the values themselves conflict, but that the available choices of actions (or behaviors) are unable to fully achieve both values at once. For example, activities designed to achieve universal access to care may not also achieve the goal of financial sustainability for the hospital. Resolving this "conflict"—or at least "uncertainty"—is an ethical challenge, not just a business or a clinical decision. Healthcare workers and administrators face these uncertainties daily, and often could benefit from assistance that can help them resolve the uncertainties. The "process" that provides this assistance is, most commonly, an ethics committee, but can also be an ethics consultant or consultation service. Whatever the process, it needs to be readily accessible to staff, physicians and other licensed independent practitioners, and managers. The governing body and its members should also have access to the process—they often face decisions that, at their core, involve competition among values. As

stated in the discussion of Standard LD.02.02.01 in Chapter 4 of this white paper, while governing body decisions are often driven by values, the decision should be as fully informed as possible by *evidence*.

Standard LD.04.02.05
When internal or external review results in the denial of care, treatment, and services or payment, the hospital makes decisions regarding the ongoing provision of care, treatment, and services and discharge, or transfer based on the assessed needs of the patient.

Rationale
The hospital is professionally and ethically responsible for providing care, treatment, and services within its capability and law and regulation. At times, such care, treatment, and services are denied because of payment limitations. In these situations, the decision to continue providing care, treatment, and services or to discharge the patient is based solely on the patient's identified needs.

Elements of Performance
1. *Decisions regarding the provision of ongoing care, treatment, and services, discharge, or transfer are based on the assessed needs of the patient, regardless of the recommendations of any internal or external review.*

Standard LD.04.03.01
The hospital provides services that meet patient needs.

Elements of Performance
1. *The needs of the population(s) served guide decisions about which services will be provided directly or through referral, consultation, contractual arrangements, or other agreements.*
   Note: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: if medical and surgical diagnostic and treatment services are not available within the hospital, the hospital has an agreement with an outside source for these services to make sure that the services are immediately available or an agreement needs to be established for transferring patients to a general hospital that participates in the Medicare program.
2. *The hospital provides essential services, including the following:*
   - *Diagnostic radiology*
   - *Dietary services*
   - *Emergency services*
   - *Medical records*
   - *Nuclear medicine*
   - *Nursing care*
   - *Pathology and clinical laboratory services*
   - *Pharmaceutical services*
   - *Physical rehabilitation*
   - *Respiratory care*
   - *Social work*

Note: Hospitals that provide only psychiatric and addiction treatment services are not required to provide nuclear medicine, physical rehabilitation, and respiratory care services.
3. *The hospital provides at least one of the following acute-care clinical services:*
   - *Child, adolescent, or adult psychiatry*
   - *Medicine*
   - *Obstetrics and gynecology*
   - *Pediatrics*
   - *Treatment for addictions*
   - *Surgery*

Note: When the hospital provides surgical or obstetric services, anesthesia services are also available.

EPs 2 and 3 define the type of acute-care inpatient organizations that can be accredited by The Joint Commission as a hospital under the *2009 Comprehensive Accreditation Manual for Hospitals*.

14. *For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: the psychiatric hospital provides psychological services, social work services, psychiatric nursing, and therapeutic activities.*
    Note: The therapeutic activities program is appropriate to the needs and interests of patients and is directed toward restoring and maintaining optimal levels of physical and psychosocial functioning.
26. *For hospitals that use Joint Commission accreditation for deemed status purposes: emergency laboratory services are available 24 hours a day, seven days a week.*

Standard LD.04.03.07
Patients with comparable needs receive the same standard of care, treatment, and services throughout the hospital.

Rationale
Comparable standards of care means that the organization can provide the services that patients need within established time frames and that those providing care, treatment, and services have the required competence. Organizations may provide different services to patients with similar needs as long as the patient's outcome is not affected. For example, some patients may receive equipment with enhanced features because of insurance situations. This does not ordinarily lead to different outcomes. Different settings, processes, or payment sources should not result in different standards of care.

Elements of Performance
1. *Variances in staff, setting, or payment source do not affect outcomes of care, treatment, and services in a negative way.*

Standard LD.04.03.09
Care, treatment, and services provided through contractual agreement are provided safely and effectively.

Elements of Performance

1. *Clinical leaders and medical staff have an opportunity to provide advice about the sources of clinical services to be provided through contractual agreement.*
2. *The hospital describes in writing the nature and scope of services provided through contractual agreements.*
3. *Designated leaders approve contractual agreements.*
4. *Leaders monitor contracted services by establishing expectations for the performance of the contracted services.*

Note 1: In most cases, each licensed independent practitioner providing services through a contractual agreement must be credentialed and privileged by the hospital using their services following the process described in the "Medical Staff" (MS) chapter.

Note 2: For hospitals that do not use Joint Commission accreditation for deemed status purposes: when the hospital contracts with another accredited organization for patient care, treatment, and services to be provided off site, it can do the following:

- *Verify that all licensed independent practitioners who will be providing patient care, treatment, and services have appropriate privileges by obtaining, for example, a copy of the list of privileges.*
- *Specify in the written agreement that the contracted organization will ensure that all contracted services provided by licensed independent practitioners will be within the scope of their privileges.*

Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: the leaders who monitor the contracted services are the governing body.

5. *Leaders monitor contracted services by communicating the expectations in writing to the provider of the contracted services.*

   Note: A written description of the expectations can be provided either as part of the written agreement or in addition to it.
6. *Leaders monitor contracted services by evaluating these services in relation to the hospital's expectations.*
7. *The leaders take steps to improve contracted services that do not meet expectations.*

   Note: Examples of improvement efforts to consider include the following:
   - *Increase monitoring of the contracted services*
   - *Provide consultation or training to the contractor*
   - *Renegotiate the contract terms*
   - *Apply defined penalties*
   - *Terminate the contract*
8. *When contractual agreements are renegotiated or terminated, the hospital maintains the continuity of patient care.*
9. *For hospitals that do not use Joint Commission accreditation for deemed status purposes: when using the services of licensed independent practitioners from a Joint Commission-accredited ambulatory care organization through a telemedical link for interpretive services, the hospital accepts the credentialing and privileging decisions of a Joint Commission-accredited ambulatory provider only after confirming that those decisions are made using the process described in Standards MS.06.01.03 through MS.06.01.07, excluding MS.06.01.03, EP 2.*
10. *Reference and contract laboratory services meet the federal regulations for clinical laboratories and maintain evidence of the same.*[6]
23. *For hospitals that use Joint Commission accreditation for deemed status purposes: when telemedicine services are furnished to the hospital's patients, the originating site has a written agreement with the distant site that specifies the following:*
    - *The distant site is a contractor of services to the hospital.*
    - *The distant site furnishes services in a manner that permits the originating site to be in compliance with the Medicare Conditions of Participation.*
    - *The originating site makes certain through the written agreement that all distant-site telemedicine providers' credentialing and privileging processes meet, at a minimum, the Medicare Conditions of Participation at 42 CFR 482.12(a)(1) through (a)(9) and 482.22(a)(1) through (a)(4).*

      Note: If the originating site chooses to use the credentialing and privileging decision of the distant-site telemedicine provider, then the following requirements apply:
    - *The governing body of the distant site is responsible for having a process that is consistent with the credentialing and privileging requirements in the "Medical Staff" (MS) chapter (Standards MS.06.01.01 through MS.06.01.13).*
    - *The governing body of the originating site grants privileges to a distant site licensed independent practitioner based on the originating site's medical staff recommendations, which rely on information provided by the distant site.*

The only contractual agreements subject to the requirements in Standard LD.04.03.09 are those for the provision of care, treatment, and services provided to the hospital's patients. This standard does not apply to contracted services that are not directly related to patient care. In addition, contracts for consultation or referrals are not subject to the requirements in Standard LD.04.03.09. However, regardless of whether a contract is subject to this standard, the actual performance of any contracted service is evaluated using other relevant hospital accreditation standards appropriate to the nature of the contracted service.

The expectations that leaders set for the performance of contracted services should reflect basic principles of risk reduction, safety, staff competence, and performance improvement. Ideas for expectations can also come from the EPs found in specific standards applicable to the contracted service. Although leaders have the same responsibility for oversight of contracted services

6 For law and regulation guidance on the Clinical Laboratory Improvement Amendments of 1988, refer to 42 CFR 493.

outside the hospital's expertise as they do for contracted services *within* the hospital's expertise, it is more difficult to determine how to monitor such services. In these cases, information from relevant professional associations can provide guidance for setting expectations.

The EPs do not prescribe the methods for evaluating contracted services; leaders are expected to select the best methods for their hospital to oversee the quality and safety of services provided through contractual agreement. Some examples of sources of information that may be used for evaluating contracted services include the following:

- Review of information about the contractor's Joint Commission accreditation or certification status
- Direct observation of the provision of care
- Audit of documentation, including medical records
- Review of incident reports
- Review of periodic reports submitted by the individual or hospital providing services under contractual agreement
- Collection of data that address the efficacy of the contracted service
- Review of performance reports based on indicators required in the contractual agreement
- Input from staff and patients
- Review of patient satisfaction studies
- Review of results of risk management activities

In the event that contracted services do not meet expectations, leaders take steps to improve care, treatment, and services. In some cases, it may be best to work with the contractor to make improvements, whereas in other cases it may be best to renegotiate or terminate the contractual relationship. When the leaders anticipate the renegotiation or termination of a contractual agreement, planning needs to occur so that the continuity of care, treatment, and services is not disrupted.

In most cases, each licensed independent practitioner providing services through a contractual agreement must be credentialed and privileged by the hospital using their services following the process described in the "Medical Staff" chapter. However, there are three special circumstances when this is *not* required:

- Direct care through a telemedical link: The "Medical Staff" chapter describes several options for credentialing and privileging licensed independent practitioners who are responsible for the care, treatment, and services of the patient through a telemedical link.
- Interpretive services through a telemedical link: EP 9 in this standard describes the circumstances under which a hospital can accept the credentialing and privileging decisions of a Joint Commission-accredited ambulatory care organization for licensed independent practitioners providing interpretive services through a telemedical link.
- Off-site services provided by a Joint Commission-accredited contractor.

Standard LD.04.03.11

The hospital manages the flow of patients throughout the hospital.

Rationale

Managing the flow of patients throughout their care is essential to prevent overcrowding, which can undermine the timeliness of care and, ultimately, patient safety. Effective management of system-wide processes that support patient flow (such as admitting, assessment and treatment, patient transfer, and discharge) can minimize delays in the delivery of care. Monitoring and improving these processes are useful strategies to reduce patient flow problems.

Elements of Performance

1. *The hospital has processes that support the flow of patients throughout the hospital.*
2. *The hospital plans for the care of admitted patients who are in temporary bed locations, such as the post-anesthesia care unit or the emergency department.*
3. *The hospital plans for care to patients placed in overflow locations.*
4. *Criteria guide decisions to initiate ambulance diversion.*
5. *The hospital measures and sets goals for the components of the patient flow process, including the following:*
   - *The available supply of patient beds*
   - *The throughput of areas where patients receive care, treatment, and services (such as inpatient units, laboratory, operating rooms, telemetry, radiology, and the post-anesthesia care unit)*
   - *The safety of areas where patients receive care, treatment, and services*
   - *The efficiency of the nonclinical services that support patient care and treatment (such as housekeeping and transportation)*
   - *Access to support services (such as case management and social work)*
6. *The hospital measures and sets goals for mitigating and managing the boarding of patients who come through the emergency department.*

   Note: Boarding is the practice of holding patients in the emergency department or another temporary location after the decision to admit or transfer has been made. The hospital should set its goals with attention to patient acuity and best practice; it is recommended that boarding time frames not exceed four hours in the interest of patient safety and quality of care.
7. *The individuals who manage patient flow processes review measurement results to determine whether goals were achieved.*
8. *Leaders take action to improve patient flow processes when goals are not achieved.*

   Note: At a minimum, leaders include members of the medical staff and governing body, the chief executive officer and other senior managers, the nurse executive, clinical leaders, and staff members in leadership positions within the organization.
9. *When the hospital determines that it has a population at risk for boarding due to behavioral health emergencies, hospital leaders communicate with behavioral healthcare providers and/or authorities serving the community to foster coordination of care for this population. (Refer to LD.03.04.01, EPs 3 and 6.)*

The history of this standard is instructive. Hospital emergency departments were in crisis: they were overcrowded with patients who had been admitted to the hospital, but were waiting for an inpatient bed to become available. While there were some steps the emergency department staff could undertake to reduce the overcrowding (such as improving the triage system), the experts and practitioners consulted by The Joint Commission quickly concluded that the most significant root causes of the problem were outside the emergency department's control. For example, the rising number of uninsured led more people to use emergency departments as their primary care providers, and inefficiencies in patient flow (for example, the discharge processes) in the rest of the hospital reduced the availability of inpatient beds for patients needing admission.

Recognizing that patient flow was within the hospital's control, Standard LD.04.03.11 was adopted. But addressing patient flow is not within the control of a single department or discipline within the hospital. The solution requires the coordinated work of multiple components of the hospital system including, for example, the emergency department, physicians, nurses, patient transport, housekeeping, information technology, and admissions. It is the need to solve this problem at the *system* level that led to the assignment of responsibility to the collaborative leadership of the organization. In any given hospital, maximizing the effectiveness of the patient flow processes in the system *may even require a decrease in the efficiency of a component in the system* (such as housekeeping). The success of the patient flow process is measured by the results of this integrated process, not by the isolated performance of each component in the process.

Standard LD.04.04.01
Leaders establish priorities for performance improvement.

Elements of Performance

1. *Leaders set priorities for performance improvement activities and patient health outcomes.*
2. *Leaders give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities.*
3. *Leaders reprioritize performance improvement activities in response to changes in the internal or external environment.*
4. *Performance improvement occurs hospital-wide.*
5. *For hospitals that elect The Joint Commission Primary Care Medical Home option: ongoing performance improvement occurs hospital-wide for the purpose of demonstrably improving the quality and safety of care, treatment, or services.*
6. *For hospitals that elect The Joint Commission Primary Care Medical Home option: the interdisciplinary team actively participates in performance improvement activities.*

24. *For hospitals that elect The Joint Commission Primary Care Medical Home option: leaders involve patients in performance improvement activities.*

    Note: Patient involvement may include activities such as participating on a quality committee or providing feedback on safety and quality issues.

25. *Senior hospital leadership directs implementation of selected hospital-wide improvements in emergency management based on the following:*
    - *Review of the annual emergency management planning reviews.*
    - *Review of the evaluations of all emergency response exercises and all responses to actual emergencies.*
    - *Determination of which emergency management improvements will be prioritized for implementation, recognizing that some emergency management improvements might be a lower priority and not taken up in the near term.*

Continuous improvement throughout the organization is one of the characteristics of high-performing organizations. They are never satisfied with the current level of performance, and search for opportunities to improve. Fortunately—or unfortunately, depending on one's point of view—the list of identified opportunities to improve invariably outstrips the resources available to design, test, and implement improvements. Priorities must therefore be set for the investment of the improvement resources, based on their level of risk and their impact—especially on the safety and quality of patient care. This priority-setting for focus and allocation of resources is ultimately the responsibility of the leaders of the organization, and *the wisdom and success of priority setting for improvement must be overseen by the governing body*.

Standard LD.04.04.03
New or modified services or processes are well designed.

Elements of Performance

1. *The hospital's design of new or modified services or processes incorporates the needs of patients, staff, and others.*
2. *The hospital's design of new or modified services or processes incorporates the results of performance improvement activities.*
3. *The hospital's design of new or modified services or processes incorporates information about potential risks to patients. (See also LD.04.04.05, EPs 6, 10–11.)*

   Note: A proactive risk assessment is one of several ways to assess potential risks to patients.
4. *The hospital's design of new or modified services or processes incorporates evidence-based information in the decision-making process.*

   Note: For example, evidence-based information could include practice guidelines, successful practices, information from current literature, and clinical standards.
5. *The hospital's design of new or modified services or processes incorporates information about sentinel events.*

Standard LD.04.04.05
The hospital has an organization-wide, integrated patient safety program within its performance improvement activities.

Elements of Performance

1. *The hospital implements a hospital-wide patient safety program.*

2. *One or more qualified individuals or an interdisciplinary group manages the safety program.*
3. *The scope of the safety program includes the full range of safety issues, from potential or no harm errors (sometimes referred to as near misses, close calls, or good catches) to hazardous conditions and sentinel events.*
4. *All departments, programs, and services within the hospital participate in the safety program.*
5. *As part of the safety program, the hospital creates procedures for responding to system or process failures.*

   Note: Responses might include continuing to provide care, treatment, and services to those affected, containing the risk to others, and preserving factual information for subsequent analysis.
6. *The leaders provide and encourages 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.)*

   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.
7. *The leaders define patient safety event and communicate this definition throughout the organization.*

   Note: At a minimum, the organization's definition may include any process variation that does not affect the outcome or result in an adverse event, but for which a recurrence carries significant chance of a serious adverse outcome or result in an adverse event, often referred to as a close call or near miss.
8. *The hospital conducts thorough and credible comprehensive systematic analyses (for example, root cause analyses) in response to sentinel events.*
9. *The leaders make support systems available for staff who have been involved in an adverse or sentinel event.*

   Note: Support systems recognize that conscientious healthcare workers who are involved in sentinel events are themselves victims of the event and require support. Support systems provide staff with additional help and support as well as additional resources through the human resources function or an employee assistance program. Support systems also focus on the process rather than blaming the involved individuals.
10. *At least every 18 months, the hospital selects one high-risk process and conducts a proactive risk assessment. (See also LD.04.04.03, EP 3.)*
11. *To improve safety and to reduce the risk of medical errors, the hospital analyzes and uses information about system or process failures and the results of proactive risk assessments. (See also LD.04.04.03, EP 3.)*
12. *The leaders disseminate lessons learned from comprehensive systematic analyses (for example, root cause analyses), system or process failures, and the results of proactive risk assessments to all staff who provide services for the specific situation. (See also LD.03.04.01, EP 5.)*
13. *At least once a year, the leaders provide governance with written reports on the following:*
    - *All system or process failures*
    - *The number and type of sentinel events*
    - *Whether the patients and the families were informed of the event*
    - *All actions taken to improve safety, both proactively and in response to actual occurrences*
    - *For hospitals that use Joint Commission accreditation for deemed status purposes: the determined number of distinct improvement projects to be conducted annually*
    - *All results of the analyses related to the adequacy of staffing*
14. *The leaders encourage external reporting of significant adverse events, including voluntary reporting programs in addition to mandatory programs.*

    Note: Examples of voluntary programs include The Joint Commission Sentinel Event Database and the US Food and Drug Administration (FDA) MedWatch. Mandatory programs are often state initiated.

The Safety Program

Standard LD.04.04.05 describes a safety program that integrates safety priorities into all processes, functions, and services within the hospital including patient care, support, and contract services. (This introduction to the standard on safety programs is adapted with permission from the "Leadership" chapter in the *2009 Comprehensive Accreditation Manual for Hospitals*.) It addresses the responsibility of leaders to establish a hospital-wide safety program; to proactively explore potential system failures; to analyze and take action on problems that have occurred; and to encourage the reporting of adverse events and near misses, both internally and externally. The hospital's culture of safety and quality (addressed by Standard LD.03.01.01 in Chapter 5 of this white paper; see page 18) supports the safety program.

This standard does not require the creation of a new structure or office in the hospital. But it emphasizes the need to integrate patient-safety activities, both existing and newly created, with the hospital's leadership, which is ultimately responsible for this integration.

EPs 6 through 9 relate to how the hospital reacts when a serious adverse event occurs—called a "sentinel event" by The Joint Commission. The traditional response was to ask *who* made the error, and then, at best, require "corrective" action and, at worst, fire the person. Now that it is recognized that "to err is human," the desired response is changing. Rather than punishing the "who" (unless of course the error was deliberate despite recognition of the risk), the question has become what processes, or lack thereof, in the hospital caused or enabled the human error.

These processes are considered the *root* causes of the adverse event, and become the focus of improvement efforts, rather than simply exhorting the individual who made the (all too human) error to be more competent and committed.

Unfortunately, the tradition of identifying the "who," and then "naming, blaming, and shaming" the individual has historically resulted in physicians and staff being fearful to report errors that led to harm or even close calls in which an error was made but harm avoided. Without these reports, the organization has a limited ability to identify root causes and redesign its processes to prevent or to halt human error before a patient is harmed. Overcoming this fear requires not only hospital policies that encourage reporting, but also demonstration by all three leadership groups—the governing body, the chief executive and senior managers, and the leaders of the medical staff—through both their *words* and their *behaviors* that reporting is valued, expected, and rewarded rather than punished.

When conscientious physicians or other healthcare professionals make errors that harm patients, they invariably feel badly, not only for the patients but also about themselves. After all, healthcare professionals were trained to believe that harm is their fault because human errors could be avoided if only they were competent and committed enough. So when they make errors, the organization's response should include support—quite in contrast to the traditional response of punishment.

By undertaking a *proactive risk assessment* (EP 10), a hospital can correct process problems and reduce the likelihood of experiencing adverse events. A hospital can use a proactive risk assessment to evaluate processes to see how they could fail, to understand the consequences of such a failure, and to identify parts of the process that need improvement. The term "process" applies broadly to clinical procedures, such as surgery, as well as to processes that are integral to patient care, such as medication administration.

The processes that have the most potential for affecting patient safety should be the primary focus for a risk assessment. Proactive risk assessments are also useful for analyzing new processes before they are implemented. These processes need to be designed with a focus on quality and reliability to achieve desired outcomes and protect patients. A hospital's choice of a process to assess may be based in part on information published periodically by The Joint Commission about frequently occurring sentinel events and processes that pose high risk to patients.

A proactive risk assessment increases understanding within the organization about the complexities of process design and management and what could happen if the process fails. If an adverse event occurs, the organization may be able to use the information gained from the prior risk assessment to minimize the consequences of the event—and avoid simply reacting to them.

Although there are several methods that could be used to conduct a proactive risk assessment, the following steps make up one approach:

1. Describe the chosen process (for example, through the use of a flowchart).
2. Identify ways in which the process could break down or fail to perform its desired function, which are often referred to as "failure modes."
3. Identify the possible effects that a breakdown or failure of the process could have on patients and the seriousness of the possible effects.
4. Prioritize the potential process breakdowns or failures.
5. Determine why the prioritized breakdowns or failures could occur, which may involve performing a hypothetical root-cause analysis.
6. Redesign the process and/or underlying systems to minimize the risk of the effects on patients.
7. Test and implement the redesigned process.
8. Monitor the effectiveness of the redesigned process.

EP 13 is specific to the governing body. [Emphasis added.] The leadership standards and this white paper emphasize the role of the governing body in creating a culture of safety and quality, in holding the medical staff and the chief executive and other senior managers accountable for fulfilling their unique and collaborative responsibilities, and in providing the resources needed to provide safe, high-quality care. But for the governing body to fulfill this role, it needs information. EP 13 identifies some of that information, but should not be seen as *all* the information the governing body should receive. It is a minimum, and the governing body, in fulfilling its fiduciary obligations to both patients and the hospital, should regularly ask questions about the organization's experiences with quality and safety, how the organization's performance compares with that of other organizations, how the organization is using new information to improve, and what the results of its improvement efforts have been.

Standard LD.04.04.07
The hospital considers clinical practice guidelines when designing or improving processes.

Rationale
Clinical practice guidelines can improve the quality, utilization, and value of healthcare services. Clinical practice guidelines help practitioners and patients make decisions about preventing, diagnosing, treating, and managing selected conditions. These guidelines can also be used in designing clinical processes or in checking the design of existing processes. The hospital identifies criteria that guide the selection and implementation of clinical practice guidelines so that they are consistent with its mission and priorities. Sources of clinical practice guidelines include the Agency for Healthcare Research and Quality, the National Guideline Clearinghouse, and professional organizations.

Elements of Performance
1. *The hospital considers using clinical practice guidelines when designing or improving processes.*
2. *When clinical practice guidelines will be used in the design or modification of processes, the hospital identifies criteria to guide their selection and implementation.*
3. *The hospital manages and evaluates the implementation of the guidelines used in the design or modification of processes.*
4. *The leaders of the hospital review and approve the clinical practice guidelines.*
5. *The organized medical staff reviews the clinical practice guidelines and modifies them as needed.*

The use of clinical practice guidelines can contribute to safer, higher-quality patient care. But their contribution is dependent upon a number of factors, including:
- The guidelines need to be evidence-based, not arbitrary standardization.
- The use of the guidelines must take into account the need to tailor care to the unique aspects of each patient, patient's disease, and patient's environment and resources.
- The successful implementation of guidelines in patient care requires their acceptance by both the physicians on the medical staff and the managers of the hospital processes in which the physicians work.
- The more the guidelines are embedded into integrated protocols (or pathways) of care for use by the entire treatment team (that is, not just for the physician), the more effectively they can be routinely implemented.

Because successful guideline implementation requires collaboration between physicians and hospital managers, all three leadership groups—the governing body, the chief executive and senior managers, and the leaders of the medical staff—must jointly embrace and encourage their use.

Conclusion

The governing body of a healthcare organization has the same responsibilities as the governing body of any enterprise, whether for-profit or not-for-profit: strategic and generative thinking about the organization and its mission, vision, and goals, and oversight of the organization's functions, especially its financial sustainability, in the board's fiduciary responsibility to the organization's "owners." But in healthcare organizations, the governing body has an additional fiduciary obligation to continuously strive to provide safe and high-quality care to the patients who seek health services from the organization. And, if the healthcare organization is a 501(c)(3) not-for-profit—as most hospitals are—the governing body has a responsibility to benefit the community, often called "community benefit."

The challenge for governing body members is that actions designed to meet one of these responsibilities may compromise meeting another of the responsibilities. While the obligation toward patients to "first, do no harm" is paramount, it is also true that the organization must be financially sustained in order to provide healthcare services—as is often said, "no margin, no mission." The decisions facing governing body members may truly be "life and death" decisions, far beyond the business decisions of most boards. That is why they often rise to become ethical dilemmas and uncertainties, either between governing body members or even within a member's mind. That is why policies on conflict of interest, managing conflict, and accessible mechanisms to resolve ethical concerns are necessary to enable the governing body to function effectively.

But healthcare organizations also have a rather unique characteristic. That is, the chief executive is not the only part of the organization's leadership that is directly accountable to the governing body. In healthcare, because of the unique professional and legal role of licensed independent practitioners within the organization, the organized licensed independent practitioners—in hospitals, the medical staff—are also directly accountable to the governing body for the patient care provided. So the governing body has the overall responsibility for the quality and safety of care, and has an oversight role in integrating the responsibilities and work of its medical staff, chief executive, and other senior managers into a system that achieves the goals of safe, high-quality care, financial sustainability, community service, and ethical behavior. This is also the reason that all three leadership groups—the governing body, chief executive and senior managers, and leaders of the medical staff—must collaborate if these goals are to be achieved.

The members of the governing body of a healthcare organization face both extra challenges and extra rewards. The rewards can not only outweigh the challenges, but can be fulfilling to a degree not often experienced in other endeavors.