

Leadership Standards

Essential to Engage Staff, Support Operations and Provide Quality Care



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Objectives

- Identify the section requiring a hospital to create a conflict of interest policy.
- Describe the patient flow standards and how they reduce boarding and overcrowding.
- Explain how not instituting a code of conduct can affect the culture of safety negatively.
- Explain new and revised standards, regulations, and laws put forth by CMS, TJC, DNV and the federal government.
- Evaluate compliance requirements and penalties.

History

- Joint Commission has had a leadership standard since 1995
- Now 32 LD standards and 32 sections
- **21 EPs were deleted in 2016** and all but one were deleted because routine part of operations
- Focus is on accountability for the quality safety of care instead of relative authorities
- Although ultimate responsibility of quality and safety reside with governing board
 - Has an overview and proactive risk assessment section

21 Leadership EPs Deleted

- The Joint Commission deleted **131** requirements that were identified as having become a routine part of operations and clinical practice
 - Or no longer necessary for quality or patient safety
 - Some were covered elsewhere
 - Effective July 1, 2016
 - Called Project Refresh
- Will delete a total of **225** requirements all together
- These deletions were the result of a multi-phased project to improve the accreditation and certification process

131 EPs Deleted July 1, 2016



• Issued April 25, 2016 •

Prepublication Requirements

The Joint Commission has approved the following revisions for prepublication. While revised requirements are published in the semiannual updates to the print manuals (as well as in the online E-dition®), accredited organizations and paid subscribers can also view them in the monthly periodical The Joint Commission Perspectives®. To begin your subscription, call 800-746-6578 or visit <http://www.jcrinc.com>.



Standards and Elements of Performance Deletions for Hospital

APPLICABLE TO HOSPITAL

Effective July 1, 2016

EC.01.01.01

The hospital plans activities to minimize risks in the environment of care.

Note: One or more persons can be assigned to manage risks associated with the management plans described in this standard.

Elements of Performance for EC.01.01.01

2. Leaders identify an individual(s) to intervene whenever environmental conditions immediately threaten life or health or threaten to damage equipment or buildings.

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Rationale: Implicit in EP 1 of this standard

EC.02.01.03

The hospital prohibits smoking except in specific circumstances.

Deletes 21 LD Elements of Performance

LD.01.02.01

The hospital identifies the responsibilities of its leaders.

Elements of Performance for LD.01.02.01

2. The governing body establishes a process for making decisions when a leadership group fails to fulfill its responsibilities and/or accountabilities.

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Rationale: Issue that should be left to the discretion of the organization

LD.01.03.01

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

Elements of Performance for LD.01.03.01

7. The governing body provides a system for resolving conflicts among individuals working in the hospital.

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Rationale: Issue should be left to the discretion of the organization. Conflict among leaders addressed on LD.02.04.01, EP 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.

LD.01.04.01

A chief executive manages the hospital.

Elements of Performance for LD.01.04.01

11. When the chief executive is absent from the hospital, a qualified individual is designated to perform the duties of this position.

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Rationale: Issue should be left to the discretion of the organization

LD.01.07.01

The governing body, senior managers, and leaders of the organized medical staff have the knowledge needed for their roles in the hospital or they seek guidance to fulfill their roles.

The CMS Conditions of Participation (CoPs)

- TJC now applies for deemed status and many changes were made to bring them into compliance with CMS CoPs
- Many revisions to CMS hospital CoP since published in 1986 and updates more frequently now
 - CMS does not a separate leadership section but sprinkled throughout such as contracts, board, medical staff, etc.
 - Email questions to CMS at **hospitalscg@cms.hhs.gov**
- First regulations are published in the **Federal Register** then CMS publishes the **Interpretive Guidelines** and some have **survey procedures** ²
 - Hospitals should check this website once a month for changes

¹

<http://www.gpo.gov/fdsys/browse/collection.action?collectionCode=FR>₂www.cms.hhs.gov/SurveyCertificationGenInfo/

[PMSR/list.asp](http://www.cms.hhs.gov/SurveyCertificationGenInfo/PMSR/list.asp)

Location of CMS Hospital CoP Manual

Medicare State Operations Manual Appendix

Questions to hospitalscg@cms.hhs.gov

- Each Appendix is a separate file that can be accessed directly from the SOM Appendices Table of Contents, as applicable.
- The appendices are in PDF format, which is the format generally used in the IOM to display files. Click on the red button in the 'Download' column to see any available file in PDF.
- To return to this page after opening a PDF file on your desktop, use the browser "back" button. This is because closing the file usually will also close most browsers

New website

www.cms.hhs.gov/manuals/downloads/som107_Appendixtoc.pdf

App. No.	Description	PDF File
A	Hospitals	 2,185 KB
AA	Psychiatric Hospitals	 606 KB

Location of CMS Hospital CoP Manuals

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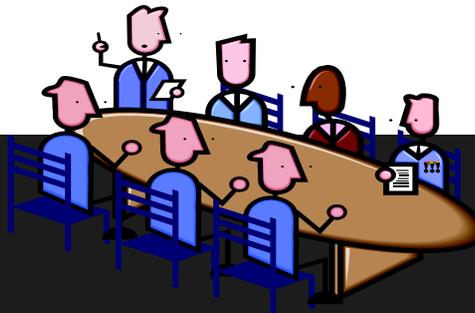
CMS Hospital CoP Manuals **new** address

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The Joint Commission Leadership Standards

What every hospital should know about the Leadership Standards.

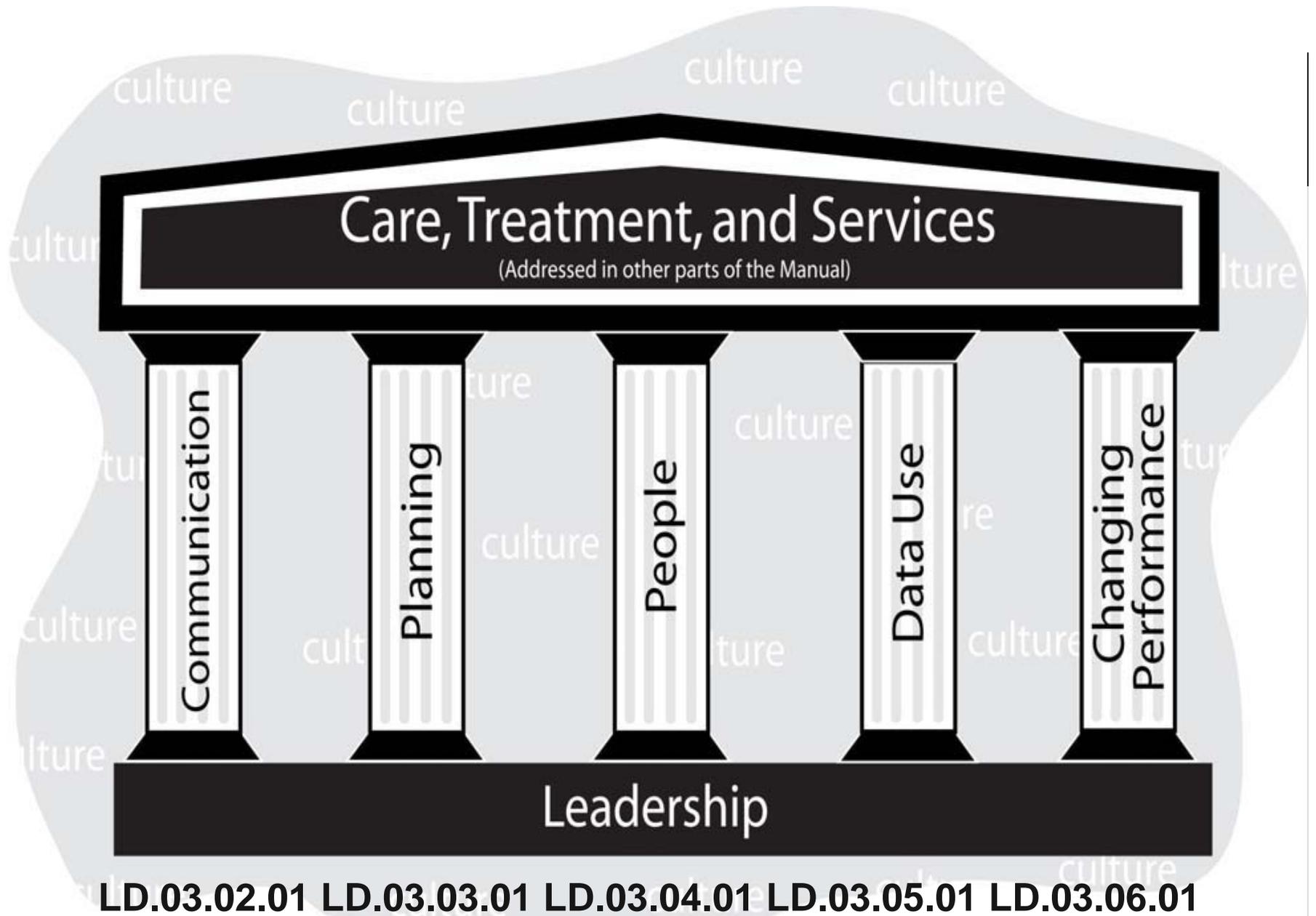


TJC LD Organized Into 4 Sections

- There are 4 key sections which support effective performance;
- Leadership Structure,
- Leadership Relationships,
- Hospital culture and system performance expectations,
- Operations.

Leadership Structure Section 1 of 4

- Leadership Structure (LD.01.01.01)
- Leadership Responsibilities (LD.01.02.01)
- Governance Accountabilities (LD.01.03.01)
- The Chief Executive Responsibilities (LD.01.04.01)
- Medical Staff Accountabilities (LD.01.05.01)
- Not applicable to hospitals (LD.01.06.01)
- Leaders' Knowledge (LD.01.07.01) **Deleted**



Leadership Structure

- Each organization has structured leadership
- Governing board is responsible for safety and quality of care
- Structure of medical staff covered in MS chapter
- Look at how well leaders work together
- Leaders from **governance (Board), CEO and senior management**, and the organized **medical staff**
- These are the 3 groups of leaders
- Final decision are ultimate responsibility of the Board

Leadership Structure

- Leadership group is composed of individuals in senior leadership positions with clearly defined responsibilities
 - Could be governance, management, MS, and clinical staff
- Most hospitals have a document to identify the lines of authority such as an organizational chart
- This means that leaders from all groups have the opportunity to participate in discussions and have their voices heard
- This also includes accountability of leaders

Leadership Structure

- How leadership is structured and the leaders' responsibilities can directly affect how care and treatment is provided to the patients
- This section identifies what the leadership duties are
- And individual and interdependent responsibilities and accountabilities of each group
- NQF has a book on 34 Safe Practices for Better Healthcare (updated April 2010 and March 2011) that dovetails nicely with the TJC leadership standards

Leadership Structure NQF

- NQF contains a section on leadership structure (www.qualityforum.org)
- Leadership structure needs to be in place to ensure organizational wide awareness of patient safety
- Staff should be engaged in patient safety across the organization
- Need to have accountabilities set up in the leadership structure and systems
- Everyone's involvement to close performance gaps
- Direct accountability includes setting patient safety goals and monitoring progress toward these goals

Leadership Structure and IHI

- Institute for Healthcare Improvement also has many excellent resources on topic of leadership at www.ihl.org,
- Good resources for board members on quality and safety,
- Including Getting Started Kit: Governance Leadership “Boards on Boards.”
- Works with Center for Healthcare Governance, Centers for Medicare and Medicaid Services (CMS), Estes Park Institute, National Center for Leadership, National Quality Forum, and the Governance Institute,

1. Leadership Structure Board

- **LD.01.0.01: There is a leadership structure.**
- Rationale; Hospital has a LD structure to support operations. It is usually formed by 3 LD groups; Board, Senior Management and Organized MS,
- EP1: Hospital identifies those responsible for governance,
- EP 2: Governing body (board, board of trustees, board of governance) identify those responsible for planning, management, and operations,
- EP 3: Governing body identifies those responsible for the provision of care, treatment, and services

How to Comply

- This standard is pretty straight forward
- Usually leadership structure is made up of the 3 groups; board, CEO and senior leaders and physician leaders
- Identified in documents such as an organizational chart and written document to identify how it is governed
- Board has board bylaws includes information on this also

1. Leadership Structure

- LD.01.02.01 Hospital needs to identify the responsibilities of its leaders
- EP1 The 3 leadership groups work together to define their shared and individual responsibilities and accountabilities
- EP2 Board (governing body) establishes a process for making decisions when the leadership group fails to perform its responsibilities or accountabilities **Deleted**
- EP4 CEO, MS, and Nurse Executive make sure hospital wide PI and training programs address problems identified by infection preventionist and do corrective action (DS) and make sure successfully implemented

PI Must be Hospital Wide LD.01.02.01

ACCEPTED: New and Revised Requirements to Align with CMS CoPs

The Centers for Medicare & Medicaid Services (CMS) final rule “Reform of Hospital and Critical Access Hospital Conditions of Participation [CoPs],” issued in May, resulted in CoP changes that became effective July 16, 2012 (*see July 2012 Perspectives*, page 6, for an article highlighting the changes). After reviewing these changes, The Joint Commission developed some new and revised elements of performance (EPs) for—and deleted others from—the **hospital** and **critical access hospital** programs. However, because many of the CoP revisions support The Joint Commission’s existing standards and survey process, changes to Joint Commission requirements were not necessary in all cases and resulted in the elimination of requirements in other cases.

These revisions address the following issues:

- Deletion of the requirement regarding qualifications of staff administering blood transfusions and intravenous medications (HR.01.02.01)
- Hospital-wide quality assessment (LD.01.02.01;

MM.07.01.03)

- The inclusion of a doctor of podiatric medicine to be responsible for the organization and conduct of the medical staff (LD.01.05.01)
- Responsibility for outpatient services (LD.04.01.05)
- Pre-printed and electronic standing orders, order sets, and protocols for medication orders (MM.04.01.01)
- Verbal or written medication or other orders of a practitioner other than a licensed independent practitioner (MM.05.01.07; PC.02.01.03)
- Reporting requirements regarding death of a patient in restraints (PC.03.05.19)
- Authentication of a verbal or written order by the ordering practitioner or another practitioner who is responsible for the care of the patient (RC.01.02.01)
- Elimination of the requirement for authentication of a verbal order within 48 hours (RC.02.03.07)

Continued on page 6

LD.01.02.01 How to Comply

- Running and operating a hospital has many responsibilities
- It is important to know who is responsible and for what
- The question of defining roles and responsibilities of the board and senior leadership are reoccurring themes in governance theory and practice
- Governance experts have observed that boards and management define their roles and responsibilities in different ways based on the uniqueness of their organization

LD.01.02.01 How to Comply

- Boards become more involved when their hospital is in crisis
- Board members who have a deep understanding of quality and patient safety will interact differently
- With all changes in LD chapter that is all about patient safety and quality, one would expect the board to interact differently in this new era
- TJC has patient safety system chapter

LD.01.02.01 How to Comply

- NQF said boards should be trained in patient safety and quality issues
- NQF recommends that board members should receive a dedicated period of training in teamwork, communication, and patient safety every year
- IHI recommends that all board members undertake six key governance leadership activities to improve quality and reduce patient harm
 - What are the roles such as setting policy, promoting patient safety, quality improvement, ensuring financial stability, infection control, providing for the organization's management and planning

Examples of Compliance

- Boards have stated writing P&P requiring specific training, evaluation of board performance, and board member performance criteria such as board quality curriculum that is offered by different organizations such as the Center for Healthcare Governance
- Bottom line is that in today's environment boards have different and more expanded roles and responsibility than just a decade ago
- A key component of board work should be related to patient safety and quality
- Now the CEO and board leaders need to work together to define roles and responsibilities balance

1. Leadership Structure Board

- **LD.01.03.01:** Board is ultimately accountable for safety and quality
- EP1: Puts in writing its responsibilities
- EP2: Provides for management and planning
- EP3: Approves written scope of services
 - Must comply with CMS CoP if emergency services are provided
- EP4: Selects a CEO to manage the hospital
- EP5: Provides resources to maintain safety, quality, care, treatment, and services,

Board Accountability for PS & Quality of Care

- EP6: Work with senior managers and MS leaders to annually evaluate hospital's performance in relation to its mission, vision, and goals,
- EP7: Provide a system for resolving conflicts among individuals working in the hospital, **Deleted**
- EP8: Provides the organized MS with the opportunity to participate in governance,
- EP9: Provides MS with the opportunity to be represented at board meetings (through attendance and voice) by one or more of its members, as selected by the organized MS,
- EP10: MS members are eligible for full membership in the board, unless legally prohibited,
- EP 20 Regarding primary care medical home (see standard)

Board Accountability for PS & Quality of Care

- EP 21 The governing body is responsible for making sure that PI activities reflect the complexity of the hospital's organization and services,
- Involve all departments and services,
- And include services provided under contract. (DS)
- Effective July 2, 2014

 <p>Joint Commission Requirement</p>	<h2>Standards Revisions Related to the Centers for Medicare & Medicaid Services (CMS)</h2>
<p>APPLICABLE TO HOSPITALS</p>	<p>to evacuate to areas of refuge. (See also EC.02.03.03, EP 5; EC.03.01.01, EP 2; and HR.01.04.01, EP 2)</p>
<p>Effective July 2, 2014</p>	<p>Note: For additional guidance, see NFPA 101, 2000 edition (Sections 18/19.7.1 and 18/19.7.2).</p>
<p><u>Environment of Care (EC)</u></p>	
<p>Standard EC.02.02.01 The hospital manages risks related to hazardous materials and waste.</p>	<p>Standard EC.02.05.03 The hospital has a reliable emergency electrical power source.</p>

Examples of Compliance 01.03.01

- Bylaws for Board and board policies that state the board is responsible for establishing P&P, maintaining quality and planning
- Define the goals and **scope of services** in a document (different departments and services available at the hospital) and minutes to show it was approved
- Organizational chart with lines of authority
- Board minutes when new CEO is hired to show their selection of CEO

Examples of Compliance 01.03.01

- Include in bylaws a statement of MS right to be represented and heard at the board meetings
- Strategic action plans
- Board has important job to make sure there are resources needed for safety and quality of care
- Do you have CPOE, bar coding, automated dispensing unit, patient safety officer, patient safety committee, and enough people to get the job done (meaningful use requirements for EHR)?

1. Leadership Structure CEO

- **LD.01.04.01:** A chief executive (CEO) manages the hospital. CEO establishes and maintains the following;
- EP1: Information and support systems
- EP2: Recruiting and retaining staff
- EP3: Physical and financial assets
- EP5: CEO identifies nurse leaders at executive level that participates in decision making (see NR.01.01.01 for nurse leader responsibilities)
- E11: When CEO is absent from the hospital a qualified person is designated to perform the duties of this position **Deleted**

Examples of Compliance LD.01.04.01

- Most Boards select person in charge to be CEO/President
 - Board minutes to show selection of CEO
- CEO needs to ensure CNO is part of senior leadership team
- CEO formulates and evaluates recruitment and retention plan
- Recruitment and retention is important to retain good staff
- Shortage of pharmacists can impact the medication management process and result in increased error

Examples of Compliance LD.01.04.01

- Staffing is tied to providing appropriate care and outcomes
- Turnover can result in staffing shortages
- Use nursing as one example
- One source said \$30-\$60,000 to replace a typical nurse and \$185,000 to replace critical care nurse (www.highretention.com/nursing.html)
- 3 recent studies show nurse staffing important to provide good quality care
- Staffing shortages results in more medication errors, more falls, longer lengths of stay, more pressure ulcers, etc.,

Nurse Staffing

- Study said patients who want to survive their new hospital visit should look for low nurse-patient ratio,
- Less mortality, better outcomes, etc.
- 1 of 3 primary evidenced based research
- Nurse Staffing and Quality of Patient Care, AHRQ, Evidence Report/Technology Report Number 151, March 2007, AHRQ Publication No. 07-E005 at <http://www.ahrq.gov/downloads/pub/evidence/pdf/nursestaff/nursestaff.pdf>

Nursing Linked to Safety

- IOM also linked Adequate staffing levels to patient outcomes,
- Limits to number of hours worked to prevent fatigue,
- Suggests no mandatory overtime for nurses,
- Never work over **12 hours** or **60 hours** in one week (or will have 3 times the error),
- Also showed medication error rate, falls, pressure ulcers, UTI, surgery site infections etc. linked to staffing,
- Redesigning the work force,
- See Keeping Patients Safe: Transforming the Work Environment of Nurses 2004, Institute of Medicine,
- www.nap.edu/openbook/0309090679/html/23/html,

Nursing Linked to Safety

- AHRQ 2008 has published 3 volume, 51 chapter handbook for nurses,
- Nurse Staffing and Patient Care Quality and Safety,
- Again shows the patient safety and quality is affected by short staffing,
- Shows evidenced based research on increased falls, longer LOS, more medication errors, UTIs, pneumonia, increased codes, increased mortality rates, etc.,
- Patient Safety and Quality: An Evidence-Based Handbook for Nurses, 2008, AHRQ website at <http://www.ahrq.gov/qual/nursesfdbk>

Examples of Compliance LD.01.04.01

- CEO must provide for information and support systems
- The information systems has collected, processed, stored and disseminated data in the form of information to help staff carry out their jobs and the functions of management
- The information and decision support system is important to the smooth flow of hospital operations
- Need data for patient safety and quality

1. Leadership Structure MS

LD.01.05.01: Hospital has an organized MS that is accountable to the board

- Moved from MS chapter and amended July 2009
- EP2: MS is self governing
 - See MS section

EP3: MS conforms to medical staff guiding principles

EP4: Board approves MS structure

LD Structure MS LD.01.05.01

EP5: MS oversees quality of care and treatment of those with clinical privileges

EP6: MS is accountable to the board

EP7: MD or DO (podiatrist or dentist) is responsible for the organization and conduct of the medical staff

- DS or for hospitals that use TJC for deemed status so most hospitals but not VA Hospitals
- CMS CoP requirement 044 and 347 and MS section starts at tag number 338 and board at 43

EP8: There is a single MS (DS) **CMS changes and can have shared intragrated MS

Compliance with LD.01.05.01

- Written document on MS guiding principles and includes mission and vision statements
- This is written to provide high level of patient care and could include guiding principles such as compassion, commitment, responsibility, quality, patient safety, responsibility and continuous improvement
- Could be to deliver high quality care, patient safety, patient satisfaction, to create a healing environment, or have a positive community impact

Compliance with LD.01.05.01

- MS bylaws address accountability and self governance
- MS bylaws can discuss role and show clear accountability in patient safety and quality
- Board approves how MS structured such as Med Executive Committee
- Needs to be a single medical staff
 - CMS now allows a **shared medical staff** for hospitals in systems and change went into effect September 26, 2014

1. Leadership Structure Knowledge

LD.01.07.01: Leaders have knowledge needed for their roles (Board, MS, and Senior LD)

- **Entire section is deleted**
- Important for leaders to work together as a team
- EP1: Work together to identify the skills required of individual leaders **deleted**
- EP2: Leaders are oriented to the mission, vision, hospital safety and quality goals, budget as well as how to read and understand financial statements, population served by hospitals and issues related to that population, individual responsibilities and **deleted**

Leaders Knowledge to do Their Jobs

- Accountabilities as they relate to support the mission of the hospital and to providing safe and quality care; and knowledge of applicable laws and regulations
 - Includes board, senior managers and MS leaders
- EP3: Board needs to provide leaders with access to information and training in areas where they need additional skills or expertise **deleted**

Leadership Relationships II of IV

Leadership Relationships

- A. Mission, Vision, and Goals (revised LD.02.01.01)
- B. Conflict of Interest Among Leaders (revised LD.02.02.01)
- C. Communication Among Leaders (revised LD.02.03.01).
- D. Conflict Management (revised LD.02.04.01).

2. Leadership Relations Managing Conflict

- This section looks at how well the leaders (board, MS, and senior LD) work together
- And how they manage conflict that affect the hospital's performance
- The board must involve both in governance and management function
- Good relationships thrive when everyone works together to develop the mission, vision, and goals
- And when honest and open communication is encouraged
- And when conflicts of interest are addressed

Framework to Governance

- IHI has a document on Framework to Governance (www.ihi.org)
- Discusses how to establish a mission, vision, and strategy
- Board needs to monitor the culture of quality and safety
- Board needs to spend more than 25% of their time on quality and safety
- Some says at least 50%

2. Leadership Relations Mission, Vision

LD.02.01.01: There needs to be a mission, vision, and goals that support safety and quality of care

- EP1: Three work together to create the hospital's mission, vision and goals
- EP2: The mission, vision and goals guide the actions of leaders
- EP3: Mission, vision, goals are communicated to staff and the population the hospital serves

Examples of Compliance

- Have mission, vision, and goals statement
- Include information in orientation and skills lab on mission, vision, and goals
- Can include on website, letter head, and policy on same, name badges, wall signs, marketing material
- Surveyor may ask staff if they know how their jobs support the hospital's mission
- I keep the room clean to prevent germs (ES)
- I provide medications to my patients to make sure they are pain free (RN)

Mission Statements

- The Mission is to improve the health status of the people of our community by improving access to care and providing high quality services at a reasonable cost
- The mission is to provide quality, cost effective health services that are responsive to the needs and values of patients in our community
- Provide quality care that will improve the health of those we serve
- To be the hospital of choice for our community

Vision Statements

- To be one of the best hospitals in America and be consistently recognized for clinical and service excellence
- Our vision is to treat the whole individual - mind, body and spirit - through a team approach to patient-centered care, and ultimately to become the most healing hospital in the world
- To be the best place to receive care, best place to practice medicine, and best place to work
- To provide the **patient the right care at the right time every time**

Value Statements

- **Integrity**-being consistent, honest and fair in everything we do
- **Excellence**- exceeding the standards in service, clinical and financial performance
- **Innovation**- promoting creativity to enhance patient care and organization performance through a team environment
- **Leadership**- We have a culture that facilitates and promotes innovation. We foster an organizational climate that encourages advancement of knowledge through education, experience and leadership
- **Accountability**- taking responsibility and ownership for our actions and their outcomes or we fulfill our responsibilities to our patients and their families

Value Statements

- **Teamwork**-We foster an atmosphere of trust, collegiality, collaboration, openness and cooperation or teamwork represents the dedication and willingness of all staff working together to achieve our mission of high-quality and compassionate health care or we have found the best outcomes are achieved when we work together. The diverse skills and knowledge of our hospital family can be brought together to fulfill our service objectives
- **Job Knowledge & Accountability** –Hospital recognizes that job knowledge and accountability are essential towards our vision of excellence. We demonstrate a sense of ownership and pride

2. Leadership Relations Conflict of Interest

- **LD.02.02.01:** The three leaders address any conflict of interest involving individual members of leadership groups that affects or has the potential to affect the safety or quality of care
 - See conflict of interest under LD.04.02.01
- This standard addresses conflict of interest involving individual members of leadership groups
- Conflicts of interest among staff and licensed independent practitioners (LIPs) who are not members of leadership groups are discussed under LD.04.02.01

LD.02.02.01 Conflicts of Interest

- EP1: The 3 leaders work together to define, in writing, what constitutes a conflict of interest, that could effect quality and safety
- EP2: They also work together to develop a policy that defines how conflict of interest will be addressed
- EP3: Conflicts of interest are disclosed as defined by the hospital

Sample Conflict of Interest Policy
(From Form 1023 Instructions, Appendix A)

Note: Items marked *Hospital Insert - for hospitals that complete schedule C* are intended to be adopted by hospitals.

Article I
Purpose

The purpose of the conflict of interest policy is to protect this tax-exempt organization's (Organization) interest when it is contemplating entering into a transaction or arrangement that might benefit the private interest of an officer or director of the Organization or might result in a possible excess of benefit transaction. This policy is intended to supplement but not replace any applicable state and federal laws governing conflict of interest applicable to nonprofit and charitable organizations.

Article II
Definitions

1. Interested Person

Any director, principal officer, or member of a committee with governing board delegated powers, who has a direct or indirect financial interest, as defined below, is an interested person.

[Hospital Insert - for hospitals that complete Schedule C

If a person is an interested person with respect to any entity in the health care system of which the organization is a part, he or she is an interested person with respect to all entities in the health care system.]

2. Financial Interest

A person has a financial interest if the person had, directly or indirectly, through business, investment, or family:

- a. An ownership or investment interest in any entity with which the Organization has a transaction or arrangement,
- b. A compensation arrangement with the Organization or with any entity or individual with which the Organization has a transaction or arrangement, or
- c. A potential ownership or investment interest in, or compensation arrangement with, any entity or individual with which the Organization is negotiating a transaction or arrangement.

DEPARTMENT: Ethics and Compliance	POLICY DESCRIPTION: Conflict of Interest
PAGE: 1 of 2	REPLACES POLICY DATED: 12/1/2004; 1/1/2006
EFFECTIVE DATE: March 1, 2007	REFERENCE NUMBER: EC.021

SCOPE: All Company-affiliated facilities, including but not limited to, hospitals, ambulatory surgery centers, home health agencies, physician practices, service centers and all Corporate departments, Groups, Divisions and Markets.

PURPOSE: To enable affected individuals to understand, identify, manage and appropriately disclose actual, potential or perceived conflicts of interest.

POLICY: Consistent with our Code of Conduct, no Company colleague may enter into any employment, transaction or other arrangement that may cause or be perceived to cause a conflict of interest.

Affected individuals, as defined below, are required to complete a Conflict of Interest Certificate (attached). Within 90 days of becoming an affected individual, such individual must review this policy and complete the attached Conflict of Interest Certification. At least annually thereafter, affected individuals must review the conflict of interest policy.

Nothing in this policy prohibits a facility from defining “affected individuals” to include more

Code Of Conduct includes Conflict of Interest

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What is a Conflict of Interest?

- Doctor at prestigious university writes article stating drug A increases risk of heart attacks while working on behalf of that drug's competitor?
- Board member has financial interest in company that holds land that hospital wants to buy to expand?
- Director of purchasing buys products from company her husband has a ownership interest?
- Hospital recommends 1,200 operations to correct atrial fibrillation that uses Company A equipment and hospital owns \$7 million dollars of their stock

Examples of Compliance

- Have a conflict of interest policy and update every year developed or input by all 3 leaders
 - All employees receive a copy and sign they have no conflict of interest and understand policy
 - Board sign conflict of interest policy every year
- When there is a conflict of interest it is addressed so document this to show compliance

2. Leadership Relations Communication

- **LD.02.03.01** Three **communicate** regularly on issues of safety and quality
- Open communication will result in trust and mutual respect
- Leaders need to communicate on matters affecting the hospital and those it serves
- EP1: Leaders discuss issues that affect the hospital including: performance improvement activities

2. Leadership Relations Communication

- PI, Reported safety and quality issues;
- Proposed solutions and their impact on the hospital's resources
- Reports on key quality measures and safety indicators
- Safety and quality issues specific to the population served; and input from the population served
- EP2: Hospital establishes timeframes for the discussion of these issues

Examples of Compliance

- What key quality measures and safety indicators do you collect and monitor? How are these communicated!
- CMS, AHRQ, and NQF all have quality initiatives
 - NQF has 29 serious reportable errors or never events
 - CMS has hospital acquired conditions (HACs) for no additional payment in Medicare patients,
 - AHRQ has 28 patient safety indicators (pressure ulcers, failure to rescue, post-op hip fracture, anesthesia complications, transfusion reaction, accidental puncture and laceration, post-op hemorrhage etc.
 - http://www.qualityindicators.ahrq.gov/psi_overview.htm

AHRQ Patient Safety Indicators

1. Hospital-level Patient Safety Indicators (20 Indicators)

- Complications of anesthesia (PSI 1)
- Death in low mortality DRGs (PSI 2)
- Decubitus ulcer (PSI 3)
- Failure to rescue (PSI 4)
- Foreign body left in during procedure (PSI 5)
- Iatrogenic pneumothorax (PSI 6)
- Selected infections due to medical care (PSI 7)
- Postoperative hip fracture (PSI 8)
- Postoperative hemorrhage or hematoma (PSI 9)
- Postoperative physiologic and metabolic derangements (PSI 10)
- Postoperative respiratory failure (PSI 11)
- Postoperative pulmonary embolism or deep vein thrombosis (PSI 12)
- Postoperative sepsis (PSI 13)
- Postoperative wound dehiscence in abdominopelvic surgical patients (PSI 14)
- Accidental puncture and laceration (PSI 15)
- Transfusion reaction (PSI 16)
- Birth trauma -- injury to neonate (PSI 17)
- Obstetric trauma -- vaginal delivery with instrument (PSI 18)
- Obstetric trauma -- vaginal delivery without instrument (PSI 19)
- Obstetric trauma -- cesarean delivery (PSI 20)

2. Area-level Patient Safety Indicators (7 Indicators)

- Foreign body left in during procedure (PSI 21)
- Iatrogenic pneumothorax (PSI 22)
- Selected infections due to medical care (PSI 23)
- Postoperative wound dehiscence in abdominopelvic surgical patients (PSI 24)
- Accidental puncture and laceration (PSI 25)
- Transfusion reaction (PSI 26)

www.qualityindicators.ahrq.gov/psi_overview.htm

NQF Safe Practices for Better Healthcare

- Recommends all 3 groups of leaders are updated on activities that been defined as mitigation of risks and hazards
- Hospital should close safety gaps for Falls, Malnutrition, Pneumatic tourniquets, Aspiration, Workforce fatigue, Iatrogenic pneumothorax, Delirium, and Legionnaires' disease
- Need to have system in place for continuous flow of information

Examples of Compliance

- Management meetings, Med Ex meetings, board minutes consist of review and discussion of PI activities, key quality measures and safety indicators
- Key is communication between the 3 groups
- Leaders attend PI meetings
- Communication of these such as staff and managers get board meeting summary or hospital meeting after board to communicate issues of importance

2. Leadership Relations Conflict Management

- LD.02.04.01 Hospital manages conflict between leadership groups to protect the quality and safety of care.
- EP1: Three work together to develop an ongoing process for managing conflict among leadership groups,
- EP2: Board body approves the process for managing conflicts, **deleted**
- EP3: Individuals who help the organization implement the process, are skilled in conflict management, whether from inside or outside the hospital (**Eliminated 7-1-10**)

2. Leadership Relations Manage Conflict

- EP4: Conflict Management Process includes: **deleted**
 - Meeting with the involved parties as early as possible to identify the conflict
 - Gathering information regarding the conflict
 - Working with the parties to manage and resolve the conflict when possible
 - Protecting the safety and quality of care
- EP5 Hospital implements process when a conflict arises which if not managed could adversely affect patient safety and quality of care

Conflict Management Policy

CONFLICT MANAGEMENT RESOLUTION POLICY

I. POLICY

Conflicts can arise in many circumstances, and may relate to professional or business relationships. Together, leaders address actual and potential conflicts that could interfere with fulfilling the hospital's mission of providing superior healthcare in a safe, compassionate environment.

II. PURPOSE

The following policy outlines the process which the governing body has approved for resolving conflicts among leaders and the individuals under their leadership at General Hospital.

III. DEFINITIONS

POSSIBLE SOURCES OF CONFLICT OR ETHICAL CONCERN

Although it is impossible to list all sources of concerns some sources of conflict or ethical concern may include but is not limited to:

- Religious conflicts
- Working with family members or friends
- Business relationships
- End of life care issues
- Issues with informed consent
- Healthcare errors

Examples of Compliance

- Develop a conflict management policy
- Use evidenced based research to assist in drafting of policy
- Many hospitals put it in the HR manual
- Develop a process to address what you do when a conflict arises
- Ensure input from all three leaders on policy and process to be followed
- Educate all staff on your policy and procedure

Examples of Compliance

- Process must include all required steps such as gather information and work with parties to resolve
- Have education and provide resources to leaders on conflict resolution and management
- Consider using an outside organization that specializes in this,
- Consider using person skilled in managing conflict
- Managers and senior leadership review articles and summarize for team members

Hospital Culture and System Performance III of IV

- III. Organization Culture and System Performance
 - A. Culture of Safety and Quality (revised LD.03.01.01)
 - B. Using Data and Information (revised LD.03.02.01)
 - C. Organization-wide Planning (revised LD.03.03.01)
 - D. Communication (revised LD.03.04.01)
 - E. Change Management and Performance Improvement (revised LD.03.05.01)
 - F. Staffing (revised LD.03.06.01)

3. Hospital Culture and System Performance

- The culture reflects the beliefs, attitudes, and priorities of its staff
- Culture directly influences behavior
- Focus is on **safety** and **quality**
- In culture of safety everyone is focused on maintaining excellence in performance
- Everyone accepts safety and quality as personal responsibilities
- They work together to minimize harm

3. Culture and System Performance



- There are 5 key systems that influence effective performance of the hospital,
- Using data
- Planning
- Communicating
- Changing performance and
- People (staffing)

3. Culture and System Performance

- These serve as the **pillar** on which many process based such as medication management
- Need strategies to improve performance
- You have a high fall rate, pressure ulcer rate or high restraint use-what do you do about it? Create a process, structure or program?
- Do you have non-punitive environment and use systems approach?
- The LS standards are cited when patterns of performance suggest hospital wide issues

Patient Safety and Quality

- Does your hospital have meaningful reports with dashboards and scorecards to show quality and patient safety issues?
- CEO is identified as person with biggest impact on quality
- There are better outcomes in hospitals board receives formal quality performance reports
- One hospital promised to provide healthcare that is safe, that works, and that leaves no one behind
- Put human face to the harm
- Trigger tool use by hospitals

Disruptive Behavior



- LD.03.01.01 Leaders create and maintain a culture of safety and quality throughout the hospital
- Disruptive behavior intimidates staff, helps lead to error, affects morale, and leads to staff turnover
- Only 4 EPs left

Definition



- **Disruptive behavior** is described as a style of interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care . . . that tends to cause distress among other staff and affect overall morale within the work environment, undermining productivity and possibly leading to high staff turnover or even resulting in ineffective or substandard care.
- AMA Report of the Council on Ethical and Judicial Affairs

Disruptive Behavior LD.03.01.01

- EP 1: Leaders regularly evaluate the culture of safety and quality using valid and **reliable tools**
- In the LD standards states **regularly** evaluates this
- What tool do you use to measure quality and patient safety?
- Now called behavior that **undermines a culture of safety**
- AHRQ has document on hospital survey on patient safety culture
- <http://www.ahrq.gov/qual/patientsafetyculture/>



You Are Here: [AHRQ Home](#) > [Quality & Patient Safety](#) > [Medical Errors & Patient Safety](#) > [Surveys on Patient Safety Culture](#)

Surveys on Patient Safety Culture

[Sign Up for Surveys on Patient Safety Culture E-mail Updates](#)

As part of its goal to support a culture of patient safety and quality improvement in the Nation's health care system, the Agency for Healthcare Research and Quality (AHRQ) sponsored the development of patient safety culture assessment tools for hospitals, nursing homes, and ambulatory outpatient medical offices.

Three surveys on patient safety culture are available:

- [Hospital Survey on Patient Safety Culture](#)
- [Medical Office Survey on Patient Safety Culture](#)
- [Nursing Home Survey on Patient Safety Culture](#)

Health care organizations can use these survey assessment tools to:

- Raise staff awareness about patient safety.
- Diagnose and assess the current status of patient safety culture.
- Identify strengths and areas for patient safety culture improvement.
- Examine trends in patient safety culture change over time.
- Evaluate the cultural impact of patient safety initiatives and interventions.
- Conduct internal and external comparisons.

[Frequently Asked Questions.](#)

Pharmacy Services Safety Culture Survey Under Development

Disruptive Behavior

2. Changes identified by the evaluation are prioritized and implemented
3. There are opportunities for all individuals who work in the hospital to participate in safety and quality initiatives. ~~deleted~~

EP4 and EP5 Revised July 1, 2012

- EP 4 Leaders develop a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety
 - Removed “disruptive, and inappropriate behaviors”
- EP5 Leaders create and implement a process for behaviors that undermine a culture of safety.
 - Removed “managing disruptive and inappropriate behaviors”
- Again change the wording in your P&P and code of conduct to exactly match this wording and mandatory documentation need since it has a D

EP4 and EP5 July 1, 2012

- The term disruptive behavior has been revised to behaviors that undermine a culture of safety
- Initially, TJC used the term disruptive behavior as commonly used in the literature
- However, TJC discovered the term is not viewed favorably by some in healthcare and is considered ambiguous by others
- So changed from disruptive behavior to behavior that undermines a culture of safety

Perspective Changes Effective 7-1-12

Leadership Standard Clarified to Address Behaviors That Undermine a Safety Culture

Effective **July 1, 2012**, the term *disruptive behaviors* in the glossary and in a Leadership standard in the *Comprehensive Accreditation Manuals* has been revised to *behaviors that undermine a culture of safety*. This change is applicable to the **ambulatory care, behavioral health care, critical access hospital, home care, hospital, laboratory, long term care, and office-based surgery** accreditation programs.

The Joint Commission introduced revisions in 2009 to the LD chapter, which included the addition of new Standard LD.03.01.01 regarding the culture of safety. Elements of performance (EPs) 4 and 5 of this standard include language about “acceptable, disruptive, and inappropriate behavior” of individuals working in health care organizations. Despite the language of these EPs, the concept is often abbreviated in the field as simply “disruptive behavior.”

The Joint Commission decided to use the term *disruptive*

behavior because it was commonly used in the literature and recognized by most individuals in the workplace. However, Joint Commission staff have since learned that the term *disruptive behavior* is not viewed favorably by some health care practitioners and is even considered ambiguous for some audiences. For example, some physicians have expressed that strong advocacy for improvements in patient care can be characterized as disruptive behavior. Also, the phrase *disruptive behavior* may be used in the context of a care environment that has become temporarily unsettled by the behavior of a patient, a resident, or an individual served. Using the language *behaviors that undermine a culture of safety* offers a better way to describe the problem addressed by the standard.

This change will appear in the *2012 Update 1* to the *Comprehensive Accreditation Manuals* and the E-dition, which are scheduled for publication in the spring of 2012. 



Official Publication of Joint Commission Requirements

Revision to LD.03.01.01, EPs 4 and 5

Effective July 1, 2012

Standard LD.03.01.01

Leaders create and maintain a culture of safety and quality throughout the [organization].

Elements of Performance for LD.03.01.01

APPLICABLE TO AMBULATORY CARE, CRITICAL ACCESS HOSPITAL,

A 5. Leaders create and implement a process for managing ~~disruptive and inappropriate behaviors~~ behaviors that undermine a culture of safety. 

APPLICABLE TO BEHAVIORAL HEALTH CARE PROGRAM

A 4.  Leaders develop a code of conduct that defines

Disruptive Behavior

6. Education is provided that focuses on safety and quality for all individuals
deleted
7. A team approach must be established among all levels of staff deleted
8. Issues of safety and quality are openly discussed deleted

Disruptive Behavior

9. Literature and advisories relevant to patient safety are available to individuals who work in the hospital
deleted

10. Leaders define how members of the population served can help manage issues of safety and quality within the organization **deleted**

Examples of Compliance

- Have a definition of disruptive behavior (AMA definition is good, 2009)
- Have a P&P on disruptive behavior
- Educate staff on what to do if disruptive behavior occurs
- Should provide education in orientation and consider updates on annual basis
- Include in your code of conduct specific examples of what is good and bad conduct (yelling, throwing things, not answering pages timely, intimidating behavior, name calling, pinching, disrespect)

Examples of Compliance

- Have MS, staff and board sign that they have received and understand the hospital's disruptive behavior policy and process
- Have a special incident report form to document incident
- Make sure process supports system where safety and quality are openly discussed and include in P&P

Examples of Compliance

- Make sure any changes made that are identified by the evaluation are documented in meeting minutes
- Consider patient safety champion in each department and patient safety officer
- Patient safety committee seeks input from all staff on patient safety
- Use AHRQ culture survey tool to assess culture of safety in your hospital

Examples of Compliance

- NQF recommends you do the culture survey every year
- Need to evaluate results carefully and put into place plan and monitor results
- Hospitals can go to their AHRQ Culture Survey website
- The survey tool allows hospitals and other healthcare organizations to track changes over time

Hospital Survey Toolkit

Download Information

The survey forms, User's Guide, and Feedback Report Template are available in different formats. Your browser may support downloading the files from this page by using the links below. Right click on the link and then select "Save Target As" (Internet Explorer) or "Save Link As" (Firefox® or Netscape®).

Hospital Survey Toolkit

[Frequently Asked Questions](#)

Survey Forms

- Hospital version ([PDF Version](#), 243 KB; [Word Version](#), 271 KB; [Text Version](#)).
- Image-scannable Hospital version ([PDF Version](#), 57 KB; [Word Version](#), 188 KB).
- Image-scannable Facility version: For hospitals and/or ambulatory and outpatient facilities ([PDF Version](#), 57 KB; [Word Version](#), 191 KB).

Survey User's Guide

- [Survey User's Guide](#) ([PDF File](#), 1.6 MB; [Word File](#), 2.5 MB).

Survey Feedback Report Template

- Templates—Help explain survey results; can be customized ([PowerPoint® File](#), 300 KB; [Text Version](#)).

Year 1 Comparative Database

- [2007 Comparative Database Report](#)

Year 2 Comparative Database

- [2008 Comparative Database Report](#)
- [Submission Information](#)—For hospitals interested in submitting their hospital patient safety culture survey data in Year 2.
- Data Use Agreement ([PDF File](#), 145 KB; [PDF Help](#))—States how data submitted by hospitals will be used and provides confidentiality assurances.

Free Viewers

How to Meet Compliance

- Teamwork and communication are important
- Teamwork training should be provided to board and all senior leaders
- Such as crew resource management (CRM) training or TeamSTEPPs (resources at end)
- Ensure an environment where all who work in the hospital can openly discuss patient safety
- Safety board where anyone can pose questions or makes suggestions
- Have patient safety resources available to those who work in the hospital
- Patient safety committee can monitor websites and report monthly on their initiatives

www.ahrq.gov/qual/errorsix.htm

[Resident Duty Hours: Enhancing Sleep, Supervision, and Safety: Institute of Medicine report](#) 
[Safe Practices for Better Healthcare: Summary: National Quality Forum Consensus Report](#)
[Web Chat Transcript: Patient Safety Research](#)
[Web M&M: Fact Sheet](#)

Communication & Teamwork

[Is Our Pharmacy Meeting Patients' Needs?](#)
[Medical Teamwork and Patient Safety: The Evidence-based Relation](#)
[Strategies to Improve Communication Between Pharmacy Staff and Patients](#)
[TeamSTEPPS™: National Implementation \(Web Site\)](#)
[TeamSTEPPS™ Tools](#)

Design & Working Conditions

[AHRQ Resources on System Design](#)
[The Effect of Health Care Working Conditions on Patient Safety: Evidence Report](#)
[Resident Duty Hours: Enhancing Sleep, Supervision, and Safety: Institute of Medicine report](#) 
[The Hospital Built Environment: What Role Might Funders of Health Services Research Play?](#)
[Transforming Hospitals: Designing for Safety and Quality](#)
[DVD Available](#)

Implementation & Transformation

[10 Patient Safety Tips for Hospitals](#)
[30 Safe Practices for Better Health Care](#)
[Advances in Patient Safety: New Directions and Alternative Approaches](#)
[Advances in Patient Safety: From Research to Implementation](#)
[AHRQ Resources on System Design](#)

Data Use LD.03.02.01

- LD : Hospital uses data to guide its decisions and the understand variances in the performance of processes supporting quality and safety
- Effective organizations measure and analyze their performance and outcomes
- Performance on safety and quality initiatives, patient satisfaction, staff perceptions, staff effectiveness, and hospital priorities.
- Need data to look for opportunities for improvement; lower medication errors, time to thrombolytics for MI, timely antibiotics in pneumonia, reduce surgical infections, reduce septicemia, VAP, central line infections, blood transfusion errors, decubitus, falls, R&S etc.,

Data Use

- EP1: Leaders set expectations for using data to improve the safety and quality of care and treatment,
- EP2: Leaders are able to describe how data are used to create a culture of safety and quality (**Eliminated July 1, 2010**)
- EP3: Hospital uses processes to support systematic data use

Data Use

- EP4: Leaders provide the resources needed for data use, including staff, equipment, and information systems
- EP5: The hospital uses data in decision-making that supports the safety and quality of care and treatment
- EP6: Data are used to identify and respond to internal and external changes in the environment
- EP7: Leaders evaluate the effective use of data

Examples of Compliance

- Leaders must know what data is being collected on quality and safety
- Have a dashboard of quality initiatives and trends
- Resources are needed so budget funds data collection adequately
- Document in meeting minutes when data shows a problem and what changes are made
- So what data do you collect and why? CMS hospital compare , patient satisfaction, 29 NQF never events, restraint and seclusion, falls, medication errors, pressure ulcers

www.hospitalcompare.hhs.gov/staticpages/for-professionals/poc/Technical-Appendix.aspx#POC3

Hospital Process of Care Measure Set

List of Current Measures

Heart Attack (Acute Myocardial Infarction or AMI) and Chest Pain

- Aspirin at Arrival
- Aspirin at Discharge
- Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) for Left Ventricular Systolic Dysfunction
- Beta Blocker at Discharge
- Fibrinolytic Medication Within 30 Minutes Of Arrival
- Percutaneous Coronary Intervention (PCI) Received Within 90 Minutes of Hospital Arrival
- Smoking Cessation Advice/Counseling
- Five new outpatient heart attack and chest pain measures were added in June 2010. Information about them will be included in the next update of Hospital Compare.

Heart Failure

- Evaluation of Left Ventricular Systolic (LVS) Function
- Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) for Left Ventricular Systolic Dysfunction
- Discharge Instructions
- Smoking Cessation Advice/Counseling

Pneumonia

- Initial Antibiotic Timing
- Pneumococcal Vaccination
- Influenza Vaccination
- Blood Culture Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital
- Appropriate Initial Antibiotic Selection

Pneumonia

- Initial Antibiotic Timing
- Pneumococcal Vaccination
- Influenza Vaccination
- Blood Culture Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital
- Appropriate Initial Antibiotic Selection
- Smoking Cessation Advice/Counseling

Surgical Care Improvement Project

- Prophylactic Antibiotic Received Within 1 Hour Prior to Surgical Incision
- Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time
- Prophylactic Antibiotic Selection
- Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered
- Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery
- Cardiac Surgery Patients With Controlled 6 A.M. Postoperative Blood Glucose
- Surgery Patients with Appropriate Hair Removal
- Surgery Patients on a Beta Blocker Prior to Arrival Who Received a Beta Blocker During the Perioperative Period
- Two new outpatient Surgical Care Improvement Project measures were added in June 2010. Information about them will be included in the next update of Hospital Compare.

Children's Asthma Care

- Children receiving reliever medication (like albuterol) while hospitalized for asthma
- Children receiving systemic corticosteroid medication (oral and IV medication that reduces inflammation and controls symptoms) while hospitalized for asthma
- Children and their caregivers receiving a Home Management Plan of Care Document While Hospitalized for Asthma

Examples of Compliance

- TJC ORYX performance indicators, VAP, etc.,
- TJC NPSGs,
- CMS HACs with no additional pay surgical site infections following certain elective procedures such as after knee replacement, extreme blood sugar derangement (diabetic coma delirium), ventilator-associated pneumonia (VAP), deep vein thrombosis/pulmonary embolism (DVT/PE),

Planning LD.03.03.01

- LD: Leaders use hospital-wide planning to establish structures and processes that focus on safety and quality
- Planning is needed to meet short and long term goals
- Planning is need to create communication channels
- Planning improves performance and helps to met the challenges of external change
- Planning broken down into design, implementation, and results

Planning to Establish Structures/Processes

Design:

- EP1: Planning focuses on improving patient safety and health care quality
- EP2: Leaders can describe how planning supports a culture of safety and quality, (**Eliminated 7-01-10**)
- EP3: Planning is systematic, and it involves appropriate individuals and information sources

Planning

Implementation:

EP4: Leaders provide the resources necessary to support the safety and quality of care and treatment,

EP5: Safety and quality planning is hospital-wide

Results:

EP6: Planning adapts to changes in the environment

EP7: Leaders evaluate the effectiveness of planning

How to Comply

- NQF 34 Safe Practices for Better Healthcare has recommendations for structures and systems
- Need to formally set aims for hospital to meet
- Can be written in quality or patient safety plan
- Patient safety officer and committee and involves every department
- Make sure RCA are done (CMS may ask for 3 RCA's)
- Structure in place to publicly disclose compliance with public reporting requirements
- Restraint death reporting to CMS regional office except internal log if patients dies with 2 soft wrist restraints

How to Comply

- Leadership needs to provide resources and needed support for patient safety and quality
- Specific budget allocations for initiatives to drive patient safety should be designated
- The Center for Healthcare Governance has published a monograph in 2008 on “Putting Quality First: How Boards Can Make Quality Improvement a High Priority”
- Board set performance measurement goals by obtaining feedback, doing performance appraisals, and pay for performance

How to Comply

- The CEO and the senior leadership should systematically designate a certain amount of time for patient safety activities
- Senior leaders should conduct weekly walkabouts or WalkRounds (AHA has free toolkit on how to do these and IHI great resources at www.ihl.org/IHI/Topics/PatientSafety/SafetyGeneral/Tools/Patient+Safety+Leadership+WalkRounds™+%28IHI+Tool%29.htm).
- There should be regular patient safety sessions at board meetings and senior leadership meetings

Patient Safety Walk Rounds IHI

Patient Safety Leadership WalkRounds™

Patient Safety Leadership WalkRounds™

By using Patient Safety Leadership WalkRounds™ weekly, senior leaders of health care organizations can demonstrate to staff the organization's commitment to building a culture of safety. WalkRounds are conducted in patient care departments (such as the Emergency Department, Radiology Department, and operating rooms), the pharmacy, and laboratories. They provide an informal method for leaders to talk with front-line staff about safety issues in the organization and show their support for reporting of errors.

This tool describes the format for WalkRounds, suggests questions to ask staff, and indicates which senior leaders should participate and where to conduct the rounds. Review and modify the instructions as needed for your organization before initiating this program. Many organizations that have conducted WalkRounds™ in conjunction with Safety Briefings have achieved greater success in changing the culture than organizations that use either tool alone. Focusing solely on safety during these rounds is a more successful strategy for promoting creating a culture of safety than digressing to other topics such as budgets and patient satisfaction.

This tool contains:

-  Background
-  Why Should Organizations Implement WalkRounds™ ?
-  Aims
-  Measures of Success
-  Instructions for WalkRounds™
-  Senior Leaders Script for WalkRounds™

Patient Safety Walk Rounds AHA



Transforming health care through research and education.

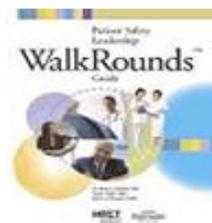
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Programs > [Implementing Patient Safety Leadership WalkRounds™](#)

Now Available:



The WalkRounds Guide, an implementation manual designed to give providers step-by-step guidance in putting this proven culture change tool into practice.

Call (312) 422-2640 today to order copies.

Implementing Patient Safety Leadership WalkRounds™

The WalkRounds process is designed to accomplish the following goals:

- Increase awareness of safety issues among all clinicians and leaders.
- Make safety a high priority for senior leadership.
- Educate staff about patient safety concepts such as a “just culture.”
- Obtain information collected from staff about barriers to safety.
- Act, after careful analysis, on information collected from staff.
- Consistently give feedback to frontline providers and leadership on processes.

In preparation to implement WalkRounds:

1. Identify the core WalkRounds team. This group should consist of at least one senior executive, a patient safety officer/manager, a scribe (usually a member of patient safety or administrative staff), and the manager or director of each unit to be visited on the rounds.
2. Establish formal methods for reporting feedback from the rounds to senior executives, physician leaders, patient safety/quality committees, and the Board.

Communication LD.03.04.01

- **LD:** Information on safety and quality need to be communicated to those who need it
 - This includes staff, physicians and LIPs, patients and families and other interested parties from the outside
- **Rationale:** Poor communication can lead to adverse events so it is a safety issue
- Communication is necessary among all the individuals and groups within the hospital and external parties
- Communication needs to be timely

Design

- EP1: Communication processes foster patient safety and the quality of care
- EP2: Leaders describe how communication supports a culture of safety and quality.
(Eliminated 7-01-10)
- EP3. Communication is designed to meet the needs of internal and external users

Communication

Implementation:

- EP 4: Resources need to be provided by leaders for communication and are based on the needs of patients, community, physicians, staff, and management
- EP 5: Communication supports safety and quality throughout the hospital

Communication Results

Results:

- EP 6: The hospital uses communication effectively when there are changes in the environment
- EP 7: Leaders evaluate the effectiveness of communication methods

How to Comply

- What processes are in place to time communicate relevant information throughout the hospital
- Communication is one of the five pillars of leadership foundation
- One hospital has monthly department manager meeting morning after the board meetings
- Newsletters, emails, pay stub messages, communication books, education, department staff meetings
- When first drafted unanticipated outcomes disclosure policy how did you communicate it?

How to Comply

- When Heparin was recalled, how did your facility communicate this?
- How does hospital communicate anticoagulant policy and process under TJC NPSGs?
- How do you communicate important things to patients?
- In patients rights statement, PCA by proxy flier and sign, pain fliers in admission packet

Examples of Compliance

- Use a tool to measure effectiveness of communication such as survey or PI
- Provide resources for communication of patients such as fliers on patient rights, PCA, involvement in medications, infection control etc.,
- There is a data management system tracer that looks at medication management, infection control (MRSA, VRE rate), pro-active risk assessment (FMEA), monitoring of NPSGs, and hand hygiene compliance, organ donor rate, patient flow data

Changing Performance LD 03.05.01 PI

LD Leaders implement changes in existing processes and directions to improve the performance of the hospital

- Rationale: Leaders need to be able to manage change
- Change is inevitable in today's healthcare system
- Especially change for PI
- Need to integrate change into processes and then assess and measure to see how well you have done

Changing Performance Design

- EP1: There needs to be structures for managing change and PI that supports the patient safety and the quality
- EP2: Leaders can describe how the hospital's approach to PI supports the capacity for change to support safety and quality(**Eliminated 7-1-10**)
- EP3: The hospital has a systematic approach to implement change in PI process

Changing Performance Implementation

- 4. Resources need to be provided to implement the process of change in PI processes to support patient safety and quality
 - Including sufficient staff, access to information, and training
- 5. The management of change needs to support both safety and quality throughout the hospital

Changing Performance PI Results

Results:

- EP6: The internal structures can adapt to changes in the environment
- EP7: Leaders evaluate the effectiveness of processes for the management of change and PI

How to Comply

- Leaders need to set expectations in quality and safety
- What is your PI plan
- Need system to respond rapidly to changes when needed
- TJC adds new core measures and CMS new indicators to Hospital Compare
- NQF discusses quality indicators that should be presently at the monthly board meeting
- Previously discussed (falls, malnutrition, iatrogenic pneumothorax etc)
- Also recommends SE analysis event reporting to identify problems, RCA, closed claims analysis, patient safety indicators, trigger tools, and external source input

How to Comply

- AHRQ also periodically changes their prevention quality indicators that are ones to help identify hospital admissions that could have been avoided. (http://www.qualityindicators.ahrq.gov/general_faq.htm). Also 28 patient safety indicators
- Such as asthma if primary care physician fails to follow CPGs or patients with appendicitis rupture if surgery not readily available
- Do you measure any or all of 29 never events (retained FB, wrong site surgery, transfusion error, serious medication error, etc. See list at end)

How to Comply

- AHRQ has a section on studies and projects on measuring healthcare quality at <http://www.ahrq.gov/qual/measurix.htm>.
- It has information on the National Healthcare Quality Report
- AHRQ quality indicators, quality indicator learning institute, quality tools, and more.
 - Accountability Measures to Promote PI
 - Using Workforce Practiced to Drive PI, Guide for Hospitals, AHA Publication June 2010,

www.ahrq.gov/qual/measurix.htm

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Highlights

- ▶ 2009 National Healthcare Quality & Disparities Reports
- ▶ 2008 State Snapshots Quality Information & Comparisons
- ▶ NHQRDRnet Online Data Query System

Staffing LD.03.06.01

LD : Those who work in the hospital focus on improving safety and quality

- Rational:
- Standard applies to all those who work in the hospital including LIPs, volunteers, and students
- Safety and quality are dependent upon the people who work in the hospital
- Mission, scope and complexity of services define the skills and number of individuals needed.

Staffing Design

- EP1. Work processes are designed to focus on safety and quality issues
- EP2. Leaders are able to describe how those who work in the hospital support a culture of safety and quality. (Eliminated 7-1-10)
- EP3. A sufficient number of individuals support the services provided by the hospital. (IC.01.01.01 EP 3)
 - The number and mix of individuals must be appropriate to the scope and complexity of the services offered

Staffing Implementation Results

- EP4. Those who work in the hospital are competent to complete their assigned responsibilities
- EP5. Those who work in the hospital adapt to changes in the environment
- EP6. Leaders evaluate the effectiveness of individuals to promote safety and quality

Examples of Compliance

- Practice staffing tracers
- Leadership should monitor staffing effectiveness data
- Leadership should know how many nurses missed lunch,
- Short staffing results in longer LOS, more falls, more medication errors, more codes, etc.,
- Have a good nursing education department that can ensure staff are competent and assess competency

Examples of Compliance

- Leadership should be able to articulate staffing patterns
- Should also be able to talk about hospital's recruitment and retention program
- Leadership should have knowledge of vacancy rates
- Knowledge and skill level of staff involved in care such as skill and competency of an ICU nurse
- Remember studies that show inadequate staffing results in longer LOS, more UTI, post-op infections, pressure ulcers, pneumonia, GI bleeding, cardiac arrests, and death,

Operations IV of IV

- IV. Operations
 - A. Administration (revised LD.04.01.01, LD.04.01.03, LD.04.01.05, LD.04.01.07, LD.04.01.11)
(revised LD.04.01.09 is not Applicable to Hospital)
 - B. Ethical Issues (revised LD.04.02.01, LD.04.02.03, LD.04.02.05)
 - C. Meeting Patient Needs (revised LD.04.03.01, LD.04.03.07, LD.04.03.09, LD.04.03.11)
(revised LD.04.03.03 and LD.04.03.05 are not Applicable to Hospital)
 - D. Managing Safety and Quality (revised LD.04.04.01, LD.04.04.03, LD.04.04.05, LD.04.04.07)
(revised LD.04.04.09 is not Applicable to Hospital)
 - E. Not Applicable to Hospital (revised LD.04.05.01 through LD.04.05.15)

4. Operations

- Some leaders may not be involved with the day to day hands on operations
- However, their work effects every aspect of the operations
- Leaders establish P&P
- Leaders secure resources and services that support patient care
- P&P and resources are influenced by the culture of the hospital

4. Operations LD.04.01.01 Laws and Regulations

LD : The hospital complies with law and regulation

- EP1. The hospital is licensed or certified as required by applicable law and regulation, to provide the care and treatment for which the hospital is seeking accreditation. (must have CLIA certificate)
- EP2. Care and treatment are provided in accordance with licensure requirements, laws, and rules and regulations
- EP3. Leaders act on or comply with reports or recommendations from external authorized agencies, such as accreditation, certification, or regulatory bodies

Utilization Review Plans

- 3 EPs went into effect January 1, 2011
 - LD.04.01.01 EP 16 for psychiatric hospitals (DS)
 - LD.04.01.01 EP 17 and 18 for hospitals (DS)
- EP 16 The psychiatric hospital is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill patients
- By or under the supervisions of physicians
- Must maintain medical records on all patients to show the degree and intensity of treatments
- Must also meet the staffing requirements and all CMS requirements

Utilization Review Plans

- LD.04.01.01 EP 17: The hospital (and CAH distinct units) has a utilization review plan 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 (DS)
 - Unless the hospital has agreed to binding review by the QIO
- LD.04.01.01 EP 18: Utilization review activities are implemented by the hospital/critical access hospital in accordance with the plan
 - Unless the hospital has agreed to binding review by the QIO

Examples of Compliance

- Some state hospital association have a manual of state laws or educational programs
- Federal laws can be accessed via internet
- Any time new law in state is passed, hospital should implement P&P to explain to staff
- Someone at hospital should sign up to get reports from agencies like FDA and CDC, ISMP, FDA Safety Alert, ASHP newsletters etc.,
- This is also a CMS Hospital CoP requirement

4. Operations LD.04.01.03 Budget

LD: The hospital develops an annual operating budget and a long-term capital expenditure plan when needed

- EP1. Leaders solicit comments from those who work in the hospital when developing the operational and capital budgets
- EP3. The operating budget reflects the hospital's goals and objectives,

4. Operations Budget

- EP4. The governing body approves an annual operating budget and, when appropriate, a long-term capital expenditure plan
- EP5. The leaders monitor the implementation of the budget and long-term capital expenditure plan
deleted
- EP6. An independent public accountant conducts an annual audit of the hospital's finances, unless otherwise provided by law

Examples of Compliance

- Develop an annual operating budget with documentation that it has been approved by Board
- Include long term planning component
- Also CMS hospital CoP requirement
- Input into the budget from board, MS, and senior leaders
- Budget reflects the hospital's goals and how does it compare with your Plan for the Provision of Care
- Document completion of annual audit by independent public accountant (compliance issue)

4. Operations LD.04.01.05 Dept Directors

LD : Hospital programs, services, sites, or departments are effectively managed

- Leaders at the program, service, or department level create a culture to allow hospital to meet its mission and goals
- They support staff and instill a sense of ownership in their work
- Leaders delegate to qualified staff
 - However, department directors are still accountable for care provided in their area
- CMS changed requirement to have one person over outpatients no matter where they were located

One Person Over All Outpatients Dropped

ACCEPTED: New and Revised Requirements to Align with CMS CoPs

The Centers for Medicare & Medicaid Services (CMS) final rule “Reform of Hospital and Critical Access Hospital Conditions of Participation [CoPs],” issued in May, resulted in CoP changes that became effective July 16, 2012 (*see* July 2012 *Perspectives*, page 6, for an article highlighting the changes). After reviewing these changes, The Joint Commission developed some new and revised elements of performance (EPs) for—and deleted others from—the **hospital** and **critical access hospital** programs. However, because many of the CoP revisions support The Joint Commission’s existing standards and survey process, changes to Joint Commission requirements were not necessary in all cases and resulted in the elimination of requirements in other cases.

These revisions address the following issues:

- Deletion of the requirement regarding qualifications of staff administering blood transfusions and intravenous medications (HR.01.02.01)
- Hospital-wide quality assessment (LD.01.02.01;

MM.07.01.03)

- The inclusion of a doctor of podiatric medicine to be responsible for the organization and conduct of the medical staff (LD.01.05.01)
- **Responsibility for outpatient services (LD.04.01.05)**
- Pre-printed and electronic standing orders, order sets, and protocols for medication orders (MM.04.01.01)
- Verbal or written medication or other orders of a practitioner other than a licensed independent practitioner (MM.05.01.07; PC.02.01.03)
- Reporting requirements regarding death of a patient in restraints (PC.03.05.19)
- Authentication of a verbal or written order by the ordering practitioner or another practitioner who is responsible for the care of the patient (RC.01.02.01)
- Elimination of the requirement for authentication of a verbal order within 48 hours (RC.02.03.07)

Continued on page 6

4. Operations Dept Directors

- EP1. The program, service, site, or department leaders oversee operations
- EP2. Programs, services, sites, or departments providing patient care are directed by one or more qualified professionals or by a qualified LIP with clinical privileges
- EP3. The hospital defines in writing the responsibility for administrative and clinical direction of these programs, services, sites, or departments

4. Operations Dept Directors

- EP4. Staff are held accountable for their responsibilities
- EP5. The hospital coordinates care, treatment, and service among the different programs, services, sites, or departments
- EP6. Emergency services are directed and supervised by qualified member of the MS (DS)

LD.04.01.05 Manage Programs/Services

- EP7 Qualified doctor directs (DS);
 - Anesthesia (CMS 1000),
 - Nuclear medicine (CMS 1028)
 - And respiratory care (CMS 1153),
- EP8 Hospital assigns one or more persons responsible for outpatient services (DS, CMS Tag 1078 and CMS **changed** July 16, 2012)
- EP9 Anesthesia services is responsible for all anesthesia administered in the hospital (DS)
 - CMS rewrote anesthesia standards December 11, 2009 February 5, 2010, May 21, 2010 and January 14, 2011, Transmittal Dec 2011

Examples of Compliance

- EP 10 Psych hospitals must have a director of social work services that monitors and evaluations the social work service furnished
- Make sure directors are competent and qualified when you hire them which is also a CMS hospital CoP requirement
- Written job descriptions for department directors
- Coordination of patient care is important
- Review medical records to determine impact of social services and discharge planning

LD.04.01.05 Leader Accountability 2014

- EP 12 Leaders need to identify an individual to be accountable for the following;
 - Staff to implement the four phases of EM or emergency management
 - Mitigation, preparedness, response, and recovery)
 - Must implement EM across 6 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 EM hospital wide
 - Identify and collaborate with community response partners

LD.04.01.06 Primary Care Medical Home

- Qualified individuals must serve in the role of primary care clinician
- EP1 Primary care clinicians have the educational background and broad based knowledge and experience to handle most medical and other healthcare needs of the patients who selected them
 - This includes resolving conflicting recommendations for care

4. Operations LD.04.01.07 P&P

- Standard LD: Policies and procedures (P&P) guide and support patient care, treatment, and services
- EP1. Leaders review and approve policies and procedures that guide and support patient care and treatment
- 2. The hospital oversees the implementation of P&P

Examples of Compliance

- Process to ensure that all required P&P are present
- P&P committee
- Policies go through proper approval channels with approved signature
- Staff need to know what P&P exist
- Provide orientation to new employees on important one
- Provide staff education when changes made to P&Ps

Examples of Compliance

- Recent studies show that many errors occur because of staff's lack of knowledge of P&P
- Have P&P easily accessible and understandable
- Have list of required policies (unanticipated outcomes, restraint and seclusion, falls, organ donation and procurement, infection control etc.,
- CMS in the hospital CoP has many required P&Ps
- Have index of all policies and provide reference on P&Ps

4. Operations LD.04.01.11 Space Equipment

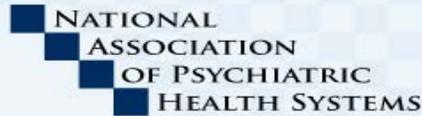
LD: Space and equipment is available as needed for the provision of care, treatment, and services. (no EP1)

- 2. The arrangement and allocation of space supports safe, efficient, and effective care and treatment
- 3. The interior and exterior space provided for care, treatment, and services reflects the needs of the patients
- 4. The grounds, equipment, and special activity areas are safe, maintained, and supervised
- 5. The leaders provide for adequate equipment and other resources

Examples of Compliance

- Make sure space is arranged and allocated to allow care and treatment to be provided in an efficient and effective manner
- Publication on the Build of Behavioral Health Department to reduce risk of suicide
- AHA publishes book on space to help ensure interior and external space is appropriate for patient ages and characteristics
- Ld makes sure there is adequate equipment such as IV pumps for patients on Heparin or other high risk drugs, PCA pumps, wheelchairs, or mini infusers

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Facility Guidelines Institute Is New Publisher for *Design Guide for Behavioral Health Facilities*

Updated 7.0 edition now available on the FGI website

(May 12, 2015)...The National Association of Psychiatric Health Systems (NAPHS) and the Facility Guidelines Institute (FGI) are pleased to announce a transfer of the Internet home for the Design Guide for the Built Environment of Behavioral Health Facilities. Formerly housed on the NAPHS website, the Design Guide is now available on the FGI website at www.fgiguide.org/beyond. The Design Guide authors are James M. Hunt, AIA, NCARB, and David M. Sine, DrBE, ARM, CSP, CPHRM.

"Relocation of this popular reference document to the FGI website makes good sense as FGI is the national organization known for establishing consensus standards for health and residential care facilities, and the Design Guide is a great supplement to their work," stated NAPHS President and CEO Mark Covall.

"We at FGI are expanding our mission to publish documents that go beyond the fundamental facility design requirements we are known for," said Douglas Erickson, CEO of FGI. "We are pleased to have been asked to publish this valuable document, which provides information based on the authors' long experience in the field that will help those in behavioral health develop safe and effective care environments for patients and staff."

Whether you are designing a new facility, renovating existing space, or maintaining a facility, the Design Guide is intended to help you think

4. Operations LD.04.02.01 Conflicts of Interest

LD: The leaders address any **conflict of interest** among those individuals who work in the hospital that affects or has the potential to affect the safety or quality of care and treatment

- EP1. The leaders define, in writing, what constitutes a conflict of interest
- EP2. The leaders develop a policy that defines how conflict of interest will be addressed

4. Operations Conflicts of Interest

- EP3. Existing or potential conflicts of interest are disclosed as defined by the hospital
- EP4. Relationships with other care providers, educational institutions, manufacturers, and payors are reviewed to ensure that they are within law and regulation, and to determine if conflicts of interest exist
- 5. P&P 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

Examples of Compliance

- Draft policy on conflict of interests
- Board members sign every year and update
- All employees and MS sign every year and placed in their file
- Document all conflicts of interest in minutes
- Example board member has financial interest in corporation that owns land that the hospital wants to buy to expand
- Board member acknowledges conflict of interest, does not vote on issue and leaves room while discussions take place

4. Operations LD.04.02.03 Ethical PRs

LD: Ethical principles guide the hospital's business practices

- Revisions in 2011 and added 1 EP and in Sept 2014 with new EP 13-16,
- EP1. The hospital has a process that allow staff, patients, and families to address ethical issues or issues prone to conflict
- EP2. Hospital uses its processes to address these conflicts
- EP3. The hospital follows ethical practices for marketing and billing
- EP4. Marketing materials accurately represent the hospital, and address the care and treatment that the hospital provides either directly or by contractual arrangement **deleted**

4. Operations Ethical PRs

- EP5. Care, treatment, and services decisions are based on patient needs, regardless of compensation or financial risk sharing with those who work in the hospital
- EP6. The patient is not negatively affected when an individual is excused from participating in care or treatment **deleted**
- EP7. Patients receive information about charges for which they will be responsible

4. Operations Hospitals with Swing Beds LTC

- EP 13 Notify resident in writing who is entitled to Medicaid services that are covered or not covered as according to state plan
- EP 14 Notify resident what are the charges
- EP 15 Charge resident only what Medicaid allows if becomes eligible after admission
- EP 16 Residents are notified before or at time of admission, and periodically during stay, charges not covered by Medicare or the facility's per diem rate

Examples of Compliance

- Hospitals that have swing beds should look at EP 13-16
- Hospital posts its billing practice on their website and provides copies to patients
- No false claims such as “we have the best cancer survival rates in the country” unless you can substantiate data
 - FTC can enforce this
 - Section in patient rights statement

4. Operations LD.04.02.05 Patient Needs

LD; The needs of patients guide decisions about the ongoing provision of care, treatment, and services, discharge, or transfer, when internal or external review results in denial of care or treatment

- Hospital is ethically and professionally responsible to provide needed care for the patient
- Decision to provide care, discharge or transfer are patient solely on patient's needs

4. Operations Denial of Care

- EP1. Decisions regarding the provision of ongoing care, treatment, and services or discharge are based on the assessed needs of the patient
- EP2. The safety and quality of care, treatment, and services do not depend on the patient's ability to pay ~~deleted~~

4. Operations LD.04.03.01 Needed Services

LD: The hospital provides services that meet patient needs

- Leaders have to decide which services are essential to the population they serve
- Services can be provided directly or
- Can be provided through referral, consultation, contractual arrangements, or other agreements

4. Operations Needed Services

- EP1. The needs of the population served guide decisions about which services will be provided directly or through referral, consultation, contractual arrangements, or other agreements
- EP2. Essential services include at least the following: diagnostic radiology; dietary, ED, nuclear medicine, nursing care; pathology and clinical laboratory; pharmaceutical; physical rehabilitation; respiratory care*; and social work
 - *Not required for hospitals that provide only psychiatric and substance use services.

4. Operations Needed Services

- EP3. In addition, the hospital has at least one of the following acute-care clinical services: child, adolescent, or adult psychiatry; medicine; OB and gynecology; pediatrics treatment for substance abuse/use; and surgery
 - *When the hospital provides surgical or OB services, anesthesia services are also available.
 - Determine what diagnostic tests or rehab or therapeutic services are needed by the community (MRI, mammograms, etc.),
- Hospital services are based on needs of the patient

LD.04.03.01

- EP14 Psychiatric hospitals provide psychological services, social work services, psychiatric nursing, and therapeutic activities (DS)
 - Added 2011
- EP26 Emergency lab services are available at all times,
 - 24 hours and 7 days a week
 - Deemed status
 - CMS 576-583,

Examples of Compliance

- Community health needs assessment can assist in determining what the needs of the population are (teen pregnancy program, outpatient Coumadin clinic, more OB beds, telemetry beds, inpatient behavioral health beds etc.)
- Scope of Services document should reflect essential services that are required
- Include optional services that hospital has
- Hospital must decide if required services will be provided directly or under contract

4. Operations LD.04.03.07 Same Level of Care

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

- 1. Patients with similar needs receive the same standard of care and treatment throughout the hospital
 - Variances in staff, setting or payment source do not affect outcome of care
- 2. Care and treatment are consistent with the hospital's mission, vision, and goals **deleted**

Examples of Compliance

- Called the same level of care or the same standard of care
- Clear policy that patients with similar needs receive the same standard of care
- Care is not based on the ability to pay but based on the patient's acuity
- EMTALA determines all patients who come to the ED will have a MSE

4. Operations LD.04.03.09 Contract Definition

- **Definition** of contractual agreement: An agreement with any organization, group, agency, or individual for services or personnel to be provided by, to, or on behalf of the organization
- Such agreements are defined in a contract or in some other form of **written** agreement
- Such as a letter of agreement, memorandum of understanding, contract, contracted services, contractual services, or written agreement

4. Operations LD.04.03.09 Contracts

LD: Care and treatment provided through contractual agreement are provided safely and effectively

- EP1. Clinical leaders and MS have an opportunity to provide advice about the sources of clinical services that are to be provided through contracts
- EP2. The nature and scope of services provided through contracts are described in writing
- EP3. Designated leaders approve contracts

4. Operations Contracts

- EP4. Leaders monitor contracts by establishing expectations for the performance of the contracted services
 - Most LIPs through a contractual agreement must be C&P through the MS process
 - When the organization contracts with another accredited organization, verify that all LIPs who will be providing patient care and treatment, **have appropriate privileges** by obtaining, for example, a copy of the list of privileges
 - All must be within scope of their privileges
 - Board monitors contracted services and ensure all LIPs via a telemedicine link are C&P at the originating site

CMS Interpretive Guidelines on Telemedicine

- Were published in the Policy and Memos to States and Regions website on July 15, 2011
 - www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage
- 27 pages long
- Hospitals can still choose to do full C&P of practitioners with telemedicine privileges
- Hospitals can still choose to use a third party credentials verification organization or CVO
 - Board is still legally responsible for privileging decisions



Center for Medicaid, CHIP, and Survey & Certification/Survey & Certification Group

Ref: S&C: 11-32- Hospital/CAH

DATE: July 15, 2011

TO: State Survey Agency Directors

www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage

FROM: Director
Survey and Certification Group

SUBJECT: Telemedicine Services in Hospitals and Critical Access Hospitals (CAHs)

Memorandum Summary

- ***Telemedicine Rules Adopted for Hospitals/CAHs:*** New and amended rules effective July 5, 2011 permit hospitals and CAHs to provide telemedicine services to their patients through written agreements with a distant-site hospital or a distant-site telemedicine entity
- ***Streamlined Credentialing & Privileging for Telemedicine Physicians & Practitioners.*** Hospitals and CAHs may rely, when granting telemedicine privileges, upon the privileging decisions of a distant-site hospital or telemedicine entity with which they have a written agreement that meets Medicare requirements.

On May 5, 2011, the Centers for Medicare & Medicaid Services (CMS) published a final rule (76 FR 25550), effective July 5, 2011, governing the agreements under which a hospital or CAH may provide telemedicine services to its patients. "Telemedicine," as the term is used in this rule, means the provision of clinical services to patients by physicians and practitioners from a distance via electronic communications. The distant-site telemedicine physician or practitioner provides clinical services to the hospital or CAH patient either simultaneously, for example, as in teleICU services, or non-simultaneously, as is the case with many teleradiology services.

Telemedicine

- MS makes recommendations to accept the C&P decision of the distant-site
- Board must agree and must have a written agreement
- Agreement must say that the distant-site will C&P in a manner that allows the hospital to comply with the telemedicine standards
- Physicians and practitioners must be licensed
- Distant-site gives hospital a copy of their privileges
- Hospital notifies hospital if any complaints or AEs

4. Operations Contracts

- EP5. Leaders monitor contracted services by communicating the expectations in writing to the provider of the contracted services
- EP6. Leaders monitor contracted services by evaluating the contracted services in relation to the expectations
- EP7. The leaders take steps to improve contracted services that do not meet expectations
 - This could be increased monitoring, consultation or training to contractor, terminate contract or apply defined penalties.

4. Operations Contracts

- EP8. When contracts are renegotiated or terminated, the continuity of patient care is maintained
- EP9. When using the services of LIP from a TJC accredited ambulatory care organization through a telemedical link for interpretive services, all LIPS are C&P through the origination site (DS) **DELETED**

4. Operations LD Contracts

- EP10. Reference and contract lab services meet the applicable federal regulations for clinical laboratories and maintain evidence of the same (CLIA)
- EP23 (Added 2012) DS
- Changes made July 1, 2012
- EP 23 The originating site has a written agreement with the distant site that specifies the following:

LD.04.03.09 EP 23

- 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 CoPs
- The originating site makes certain through the written agreement that all distant-site telemedicine providers' credentialing and privileging processes meet, at a minimum, the CMS Hospital COPs

LD.04.03.09 EP 23 Changed 7-1-2012

- CFR 482.12(a)(1) through (a)(9) and 482.22(a)(1) through (a)(4).
- See also MS.13.01.01, EP 1
- The governing body of the distant site is responsible for having a process that is consistent with the credentialing and privileging requirements in the “MS chapter (MS.06.01.01-.13)
- The board 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

Examples of Compliance

- Have a contract review policy,
- Determine who has authority to sign contracts,
- File contracts in one central location,
- Have a contract management log,
- Ensure that a list of all the contracts that affect patient care go the Med Executive Team,
- Make sure you have a CLIA license,
- Evaluate person providing contracted services in writing and against performance requirements specified in the contract,

Examples of Compliance

- Monitor patient satisfaction surveys for problems with contracted services (waited 6 weeks to get mammogram when patient had a suspicious lump)
- Develop an evaluation tool to do this
- Contracts should include language about contractor expectations such as will comply with all TJC standards, federal and state and local regulations, etc.
- Consider having a contract committee

4. Operations Contracts

- Same level of care whether you provide the service directly or contract it out
- Leaders need to make sure that services provided are safe and effective, need to provide oversight
- Whether provided directly or contracted out
- This section only applies to **care** and services provided to hospital patients
- Contract for consultation or referrals are not covered by this section

4. Operations Monitoring Contracts

- Monitoring of contracts- no specific monitoring strategy is required but focus on quality
- Should focus review on principles of risk reduction, safety, staff competence, and PI
- CMS asks about contracts in the final QAPI worksheet
- **Sources** to use to **evaluate contracts**: direct observation of care, audit documentation, review incident reports and periodic reports submitted by individual or company contracted with

4. Operations Evaluating Contracts

- Other **sources to evaluate contracts**; data on efficacy of service, input from staff and from patients
- Include review of criteria in the contract
- review of patient satisfaction studies, risk management reports performance reports based on indicators
- If contracted services are not up to snuff then leaders work with contractor to make improvements or terminate or renegotiate the contract so services are not disrupted,

Contracts

- Make sure all contractors are properly licensed, credentialed and privileged
 - Including that all services be within the scope of practices
- A requirement in the contract that all services will be provided in a safe and effective manner
- A requirement that all local, state, federal laws and accreditation (such as TJC) and CMS regulations are met
- A requirement to comply with all applicable hospital policies and procedures

4. Operations LD.04.03.11 Patient Flow

LD: The hospital manages the flow of patients throughout the hospital

- Managing patient flow is very important,
- Patient flow tracer
- Needed to prevent overcrowding that leads to patient safety and quality issues
- Hospital needs to use indicators to monitor process including admitting, assessment, and treatment, patient transfer and discharge

4. Operations Patient Flow LD.04.03.11

- EP1. Processes support the flow of patients throughout the hospital
- EP2. The hospital plans for care of admitted patients who are in temporary-bed locations, such as the PACU and the emergency department (ED)
- EP3. The hospital plans for care to those patients who are placed in overflow locations
- EP4. Criteria guide decisions to initiate ambulance diversion

4. Operations Patient Flow

- EP5. The hospital measures the following components of the patient flow process:
 - The available supply of patient beds;
 - The throughput (efficiency) of areas where patients receive care, treatment, and service; such as inpatient units, PACU, radiology etc.
 - The safety of areas where patients receive care, treatment and service
 - Efficiency of nonclinical services that support patient care (environmental services, transport)
 - Access to support services

Operations Patient Flow

- EP6. Changed January 1, 2014
- The hospital measure and set goals for mitigating and managing boarding of patient who come through the emergency department
 - Boarding of behavioral health patients in the ED or other area after the decision is made to admit
 - Consider goal not to exceed 4 hours
 - Time is calculated from decision to admit is made

Patient Flow

- EP7. The individuals who manage patient flow processes review measurement results to determine if the goals were obtained
- EP8. Leaders take action to improve patient flow when the goals are not achieved
- EP 9 Went into effect January 1, 2014
 - The hospital determines that it has a population at risk for boarding due to behavioral health emergencies
 - Hospital leaders communicate with behavioral health providers

EP 9 Effective January 1, 2014

- When the hospital determines that it has a population at risk for boarding due to behavioral health emergencies, hospital leaders communicate with behavioral health providers and or authorities serving the community to foster coordination of care for this population
- See PC.01.01.01 EP 4 (Jan 2013) that says that hospitals that do not primarily provide psychiatric or substance abuse programs have a written plan that defines the care and treatment or referral process for patient who are emotionally ill, suffer from substance abuse or alcoholism

PC.01.01.01 EP 24

- If a patient is boarded while awaiting care for emotional illness and/or the effects of alcoholism or substance abuse, the hospital does the following:
 - Provides for a location for the patient that is safe, monitored, and clear of items that the patient could use to harm himself or herself or others
 - Provides orientation and training to any clinical and non-clinical staff caring for such patients in effective and safe care, treatment, and services (for example, medication protocols, de-escalation techniques)
 - Conducts assessments, and reassessments, and provides care consistent with the patient's identified needs

Examples of Compliance

- LD should be aware of data to show if overcrowding has occurred
- Are patients camped out in the ED for hours awaiting a bed?
- If so what plans did leadership put in place to help resolve issue
- Was staff provided appropriate cross training?
- Remember patient flow tracer
- Evidence of minutes of patient flow committee

Examples of Compliance

- Are there triggers indicative of a problem?
- Are there delays in the following; assessment of the patient, blood draws, radiological studies, communication and reporting from one area handing the patient off to another and delays in the OR schedule.
- It could result in a delay of the on call surgeon to respond timely or do elective surgery cases when an emergent patient is waiting in the ED.
- Are there misuses of ED such as direct admits or full work ups in the ED by residents,

4. Operations LD.04.04.01 PI

LD: Leaders establish priorities for PI

- EP1. Leaders set priorities for PI activities and patient-health outcomes
- EP2. Leaders give priority to high-volume, high-risk, or problem-prone processes
- EP3. Leaders reprioritize PI activities in response to changes in the internal or external environment
- EP4. PI is hospital-wide

4. Medical Home LD.04.04.01 PI 2014

- EP 5; For hospitals that elect primary care medical home option;
- Need ongoing PI hospital wide to improve quality and patient safety
- EP 6: The interdisciplinary team actively participates in PI activities for hospitals that elect the primary care home option (2015)

Medical Home LD.04.04.01

- EP 24: Leaders involve patients in PI activities such as participating in a quality committee or providing feedback on safety and quality issues
- EP 25: Senior hospital leaders direct implementation of hospital wide improvements in EM based on annual planning reviews, evaluation of the exercised, and which EM improvements will be prioritized for implementation

4. Operations LD.04.04.03 PI

LD: New or modified services or processes are well-designed.

- 1. The design of new or modified services or processes incorporates the needs of patients, staff, and others
- 2. The design of new or modified services or processes incorporates the results of PI activities
- 3. The design of new or modified services or processes incorporates information about potential risks to patients

4. Operations PI

- 4. The design of new or modified services or processes incorporates evidence-based information in the decision-making process (evidence-based information are practice guidelines, successful practices, information from current literature, and clinical standards)
- 5. The design of new or modified services or processes incorporates information about sentinel events
- 6. The design of new or modified services or processes is tested and analyzed to determine whether the proposed design or redesign is an improvement **deleted**
- 7. The leaders involve staff and patients in the design process, **deleted**

Examples of Compliance

- Use information on TJC sentinel events such as MRI safety and Pediatric medication error to change processes
- Have process to test and analyze when new system is put into place for example when hospitals changed program to do timely blood cultures and provide IV antibiotics timely
- We did PI to make sure the new process worked
- Teams can help create new system with appropriate stakeholders to design new system

Operations LD .04.04.05 Patient Safety Program

- LD: The hospital implements an integrated patient safety program throughout the hospital.
- This is the section that requires leaders to develop a hospital wide safety program,
- Must proactively explore potential system failures,
- Must encourage reporting of AE and near misses (good catches),

4. Operations Patient Safety Program

- EP1. There is a hospital-wide, integrated patient safety program
- EP2. One or more qualified individuals or an interdisciplinary group manages the hospital-wide safety program
- EP3. The scope of the program includes the full range of safety issues, from potential or no-harm error (sometimes referred to as near misses, close calls, or good catches) to hazardous conditions and sentinel events, which have serious adverse outcomes

4. Operations Patient Safety Program

- EP4. All departments, programs, and services within the hospital participate in the safety program
- EP5. The hospital creates procedures for responding to system or process failures
 - Such as continuing to provide care, treatment, and services to those affected, containing the risk to others, and preserving factual information for subsequent analysis.

Patient Safety Program

- EP6. The hospital provides and encourages the use of a system approach for blame free reporting of a system or process failure.
 - This also included the results of the proactive risk assessment (FMEA)
- EP7. The hospital defines a sentinel event. This needs to be communicated throughout the hospital
 - Must include events subject to review in the SE chapter
 - EC.02.01.0, EP1. This is the standard that requires the hospital to manage safety and security risks

4. Operations Patient Safety Program

- EP8 A thorough and credible RCA must be done when there is a sentinel event as described in SE chapter.
- EP9. The hospital has support systems available for staff members who have been involved in a sentinel event (SE) or adverse event.
- Good employees who make mistakes are victims too,
- Provide employee assistance programs or counseling,

4. Operations Patient Safety Program

- EP10. The hospital selects one high risk process and conducts a proactive risk assessment at least every 18 months
- EP11 The hospital uses information about system or process failures and the results of the proactive risk assessment to improve patient safety
- EP12. The hospital disseminates lessons learned from RCA, system or process failures, and the results of the FMEA to staff that provide services or are affected by the situation



Overview

Proactive Risk Assessment

By undertaking a proactive risk assessment, a hospital can correct process problems and reduce the likelihood of experiencing adverse events. A hospital can use a proactive risk assessment to evaluate a process to see how it 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 processes that are integral to patient care, such as medication administration.

The processes that have the greatest potential for affecting patient safety should be the primary focus for risk assessments. Proactive risk assessments are also useful for analyzing new processes before they are implemented. Processes need to be designed with a focus on quality and reliability to achieve desired outcomes and protect patients. A hospital's choice of which process it will 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 to 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. Design or redesign the process and/or underlying systems to minimize the risk of the effects on patients.
7. Test and implement the newly designed or redesigned process.
8. Monitor the effectiveness of the newly designed or redesigned process.

4. Operations Patient Safety Program

- EP13. The hospital provides governance at least once a year, with written reports on all system or process failures, on the number and type of SE, on whether the patients and the families were informed of the AEs, and on all actions taken to improve safety, both proactively and in response to actual occurrences
- EP14. The hospital encourages external reporting of significant adverse events, including voluntary reporting programs (TJC SE and FDA MedWatch) in addition to mandatory programs (some states have mandatory reporting and some require reporting of NQF never events)

Examples of Compliance

- Have a patient safety plan
- Do an annual report card, use trigger tools
- Have a patient safety committee
- Many also have separate medication management committee and EOC safety committee
- Do education for staff to make sure they know near misses must be included in definition of medical error
- Do patient safety walkabout rounds by senior leaders

Examples of Compliance

- Ensure MS participation in patient safety
- Board minutes should document safety reports
- Have safety department champion
- Provide literature and articles on patient safety on intranet
- Consider patient safety week fair with local articles in newspaper and patient safety literature
- Board report at least yearly, consider more frequent, written reports of sentinel events, and whether patient informed

Examples of Compliance

- Have one person in charge of internal and external reporting of system failures (required reports, voluntary reports),
- Have a user friendly RCA and FMEA form,
- Consider training many on this process,
- Do more than just one FMEA a year but know why you picked them (transfusion, infant abduction, medication error, inpatient suicide),
- Disseminate information in memo and newsletter re lessons learned RCA,

4. Operations LD.04.04.07 CPG

LD: The hospital considers clinical practice guidelines when designing or improving processes

- CPGs can improve quality of care
- CPGs can help practitioners make decisions about preventing, diagnosing, and treating certain conditions
- Hospital identifies criteria that guide the selection and implementation of CPGs
- Sources include AHRQ (www.ahrq.gov) and National Clearinghouse (www.guideline.gov),

4. Operations CPG

- EP1. The hospital considers using clinical practice guidelines when designing or improving processes
- EP2. When guidelines are used, the hospital identifies criteria to guide their selection and implementation
- EP3. The hospital manages and evaluates the implementation of the guidelines

4. Operations CPG

- EP4. The leaders of the hospital review and approve the CPGs that have been selected for use
- EP5. The organized medical staff reviews the CPGs and modifies them as necessary

Examples of Compliance

- Have someone responsible for CPGs
- Review every year and document review
- Make sure are evidenced based and cite authority
- Have someone or team responsible for creating these
- Ensure MS is involved with process
- Have P&P that describes process, how they are selected and reviewed
- Common for pneumonia, MI, CABG, TKA, THA, CHF

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The End! Questions???



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