Joint Commission introduces patient safety chapter
CAMH addition turns focus on leadership involvement

The Joint Commission recently released a new chapter to the Comprehensive Accreditation Manual for Hospitals (CAMH) entitled Patient Safety Systems. The chapter is intended to encourage organizations to build more high-reliability environments, specifically working to promote and foster high-quality, safe patient care.

The Joint Commission refers to this as a patient-centered model.

“But for those healthcare organizations who truly aspire to be top performers in today’s healthcare market, being merely patient-centered may not be sufficient,” says Sena Blickenstaff, BSN, MBA, principal with Compass Clinical Consulting, and a former Joint Commission and CMS deemed status surveyor.

“The pursuit of high-quality, safe patient care must be patient-centric,” Blickenstaff says. “Patient-centric moves beyond the patient being merely a participant in their healthcare. Patient-centric means the patient is the driver and intimately involved every step of the way, to the fullest extent possible, and that there are systems of care throughout the organization designed to continuously enhance quality and safety at the patient level.”

The Joint Commission announced the release of its new Patient Safety Systems chapter at its annual Hospital Executives Briefing conference in September, noting that the chapter would be a focus for future accreditation surveys. The chapter concentrates on three overarching concepts:

- Aligning existing standards with daily work to reduce harm
- Assisting with knowledge, skills, and competence of staff and patients by recommending methods to improve quality and safety
- Recommending a proactive quality and safety methodology to increase accountability and reduce fear and blame, thereby promoting an organizational just culture
While there are no new standards or elements of performance (EP) in this chapter, Blickenstaff notes, the chapter turns a sharp focus on senior leadership.

“Having a culture of safety is not a new concept. This expectation has been around for a long time,” she says. “But what The Joint Commission has done with this new Patient Safety Systems chapter is essentially codified this concept with corresponding standards and EPs that can be scored where issues are identified during an accreditation survey that suggest there are systemic deficiencies around the organization’s culture of safety.”

This means there is an expectation that healthcare leaders focus their infrastructure, their systems and processes, to enhance quality and safety throughout their organizations.

“When surveyors arrive, they will be looking more closely at those systems of care. If they identify systemic issues that are adversely impacting quality and safety, they will be looking more closely at leadership,” says Blickenstaff.

Interestingly, this may have an impact on how the top cited standards released by The Joint Commission play out in the coming year. “Currently, when you look at the top cited list of standards as reported by The Joint Commission, you rarely see leadership cited,” says Blickenstaff. “When I see this new chapter and how heavily it references leadership standards and EPs, I can’t help but wonder if we won’t see leadership show up as a more frequently cited standard in the future.”

Data collection and use

The new Patient Safety Systems chapter not only focuses on leadership, but also emphasizes how the organization collects, analyses, and uses its data to improve quality and safety.

“Certainly leadership expectations have been clearly outlined when it comes to a culture of safety and systems of care, but the new PS chapter also highlights data collection and analysis expectations when it comes to enhancing quality and safety. That is, how is the healthcare organization using data to not only improve quality and safety, but to proactively identify and mitigate risks around quality and safety,” says Blickenstaff. “Additionally, there is the expectation that the organization is collecting and analyzing data effectively. This needs to be looked at more closely and perhaps in a different light than it has in the past.”

Organizations need to consider what kind of analysis they are performing on their data and whether they are using the right analytical tools, notes Blickenstaff. Does the analysis diagnose the problem correctly, and are the appropriate, sustainable solution(s) to that problem being implemented?

Again, leadership’s role in ensuring that the organization is collecting, analyzing, and using data effectively to enhance quality and safety as outlined in the new chapter is clear.
“The Patient Safety Systems chapter references several Leadership standards that can be cited relative to how the organization collects, analyzes, and uses its data to drive quality and safety,” Blickenstaff notes. “For instance, there are leadership standards that require information be presented in a clear manner; information be shared with appropriate groups throughout the organization; opportunities for improvement and actions to be taken be clearly articulated; and the need for leadership to provide staff with the time, resources, and opportunities to participate in improvement efforts as part of daily work.”

What should organizations be aware of while preparing to address the new chapter?

“They will want to be aware of the filter with which surveyors on-site will be conducting their accreditation survey in light of this new chapter,” says Blickenstaff.

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Again, if the surveyors identify systemic issues that would suggest there are problems with the culture of safety, they will bring these issues up, most likely during the leadership session. For example, “if I am a surveyor and I see low- and high-level dust, or cleanliness concerns throughout the organization possibly suggesting a resource issue, not simply as an isolated finding, my conversation would move from an isolated infection control issue to leadership’s role in providing adequate resources,” says Blickenstaff.

Healthcare leaders will want to look closely at their own data as they prepare to be surveyed under the new Patient Safety Systems chapter. They will want to look proactively, and begin having that conversation long before surveyors ever arrive on their doorstep.

“What does our data tell us? That is, are there issues the leadership team should be addressing now, prior to their next accreditation survey,” says Blickenstaff.

One specific example of this is immediate use, or flash sterilization. If a surveyor finds a high rate of flash or immediate use sterilization, the question will arise: Why? Is there a lack of equipment, or was it an anomaly on survey day? If it is a lack of equipment and therefore a resource issue, what is leadership doing to address the issue? Any data that suggests an opportunity for improvement should be scrutinized. In
particular, if a goal has been set, yet the organization continues to fail in its efforts to achieve its own quality and safety benchmarks, this situation should be thoroughly reviewed.

**Balancing pillars**

Another example of leadership and systems of care that may surface during a survey can come up during discussions with staff when they talk about different organizational initiatives for enhancement of quality and safety. It’s not unusual, notes Blickenstaff, to hear staff talk about “pillars”—quality pillars, safety pillars, patient satisfaction pillars, and financial pillars.

“Under the financial pillar we’ll often see staffing and productivity,” says Blickenstaff. “With that often comes certain performance metrics for staffing and productivity.” This can often be at odds with quality and safety if not managed appropriately—fiscal responsibility has a different, competing set of interests. And while fiscal responsibility is important, so too is the need to find ways to ensure that the other pillars are fostered as well.

If surveyors come in and find, for example, systemic infection control issues, or any quality and/or safety issues, they will look at the reason for the problems, including whether they possibly indicate a resource concern—which would fall under a leadership finding.

“As a leadership team, if you’re going to cut resources to achieve a financial benchmark, you have to help your staff learn how to work more efficiently with less, without compromising quality or safety,” says Blickenstaff. “This is often where we will see a disconnect, as with any change comes the need to monitor for cause and effect.”

Data collection and analysis, especially with a reduction in FTEs, is critical to ensure that quality and safety have not been compromised. “We are again looking at how leadership is promoting and fostering a culture of safety, and effectively collecting and analyzing data, to ensure quality and safety at all levels throughout the organization is maintained with any decisions made,” she says.

And this is where the Patient Safety Systems chapter can come into play. When leadership decisions are made, under any pillar or for any reason, what is the end result for quality and safety?

The new chapter also touches on the Leadership requirement for a proactive risk assessment of a high-risk process and briefly touches upon “The Joint Commission’s preferred FMEAs [Failure Mode Effects Analyses], but that’s just one proactive risk assessment process,” says Blickenstaff.

There are other proactive risk assessment methodologies out there that hospitals can use to examine their data and get ahead of the curve when it comes to proactively identifying and mitigating risks. The important thing to keep in mind is that as a high-reliability organization, it is a requirement and best practice to conduct proactive risk assessments.
when establishing new programs or services, when expanding existing programs or services, or when reviewing stratified data from incident reports to enhance quality and safety proactively.

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While the new Patient Safety Systems chapter focuses on Leadership and Data Collection and Analysis, other key patient safety requirements are also referenced, including Accreditation Participation, Patient Rights, Performance Improvement, Medical Staff, Medication Management, and Human Resources standards, notes Blickenstaff.