The Joint Commission E-dition

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Program: Hospital

Chapter: # Leadership

Overview:

The safety and quality of care, treatment, and services depend on many factors, including the following:
- A culture that fosters safety as a priority for everyone who works in the hospital
- The planning and provision of services that meet the needs of patients
- The availability of resources—human, financial, and physical—for providing care, treatment, and services
- The existence of competent staff and other care providers
- Ongoing evaluation of and improvement in performance

Management of these important functions is the direct responsibility of leaders; they are, in effect, responsible for the care, treatment and services that the hospital provides to its patients. In hospitals with a governing body, governance has ultimate responsibility for this oversight. In larger hospitals, different individuals or groups may be assigned different responsibilities, and they bring with them different skills, experience and perspectives. In these situations, the way that the leaders interact with each other and manage their assigned accountabilities can affect overall hospital performance. In smaller hospitals, these responsibilities may be handled by just one or two individuals. This chapter addresses the role of leaders in managing these diverse and, at times complex, responsibilities.

Leaders shape the hospital's culture, and the culture, in turn, affects how the hospital accomplishes its work. A healthy, thriving culture is built around the hospital's mission and vision, which reflect the core values and principles that the hospital finds important. Leaders must ask some basic questions in order to provide this focus: How does the hospital plan to meet the needs of its population(s)? By what ethical standards will the hospital operate? What does the hospital want to accomplish through its work? Once leaders answer these questions, the culture of the hospital will begin to take shape. Leaders also have an obligation to set an example of how to work together to fulfill the hospital's mission. By dedicating themselves to upholding the values and principles of the hospital's mission, leaders will be modeling to others how to collaborate, communicate, solve problems, manage conflict, and maintain ethical standards, essential practices that contribute to safe health care.

On a more practical level, leaders oversee operations and guide the hospital on a day-to-day basis. They keep operations running smoothly so that the important work of the hospital—serving its population—can continue.

To meet their obligations effectively, leaders must collaborate, which means working together in a spirit of collegiality to achieve a common end. Many hospitals have three leadership groups—the senior managers, governing body, and organized medical staff—who work together to deliver safe, high quality care. The senior managers direct the day-to-day operations of the hospital; the governing body determines what resources the hospitals needs and then secures those resources. The members of the organized medical staff are licensed to make independent decisions about the diagnosis and treatment of their patients and, in doing so, influence the choice and use of many of the hospital's resources.

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.

About This Chapter:

This chapter is divided into four sections: "Leadership Structure," "Leadership Relationships," "Hospital Culture and System Performance Expectations," and "Operations." The hospital's culture, systems, and leadership structure and relationships all come together to shape and drive its operations.

The standards in the 'Leadership Structure" section identify and define the various leadership groups and their responsibilities. The standards in "Leadership Relationships" address not only relationships, which include the leaders' combined accountabilities, but also communication among leaders, conflict management and the development of the hospital's mission, vision, and goals. The standards in the "Hospital Culture and System Performance Expectations" section focus on the framework for the hospital's culture and systems. These standards also demonstrate how leaders help shape the culture of a hospital and how culture, in turn, affects important systems within the hospital (for example, data use, planning, communication, changing performance, staffing). The standards in the "Operations" section address the functions that are important to patient safety and high-quality care, treatment, and services. Some leaders may not be directly involved in the day-to-day operations of the hospital, but the decisions they make and the initiatives they implement do affect operations.

Standard description, Rationale and Elements of Performance:

KEY: **A** indicates scoring category A; **C** indicates scoring category C; ▲2 indicates situational decision rules apply; ⚠3 indicates direct impact requirements apply; Ⓜ indicates Measure of Success is needed; Ⓓ indicates that documentation is required; **ESP-1** indicates that EP is part of early survey process; ❗ indicates a critical change for most recent update

Introduction to Standard LD.04.04.05:

This standard describes a safety program that integrates safety priorities into all processes, functions, and services within the hospital, including patient care, support, and contract services. It addresses the responsibility of leaders to establish a hospital-wide safety program; to proactively explore potential system failures; to analyze and take action on problems that have occurred; and to encourage the reporting of adverse events and near misses, both internally and externally. The hospital's culture of safety and quality supports the safety program (refer to Standard LD.03.01.01).

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

LD.04.04.05

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

Elements of Performance:

	DESCRIPTION	MOS	CR	DOC	SC	ESP
1	The leaders implement a hospital-wide patient safety program.				A	
2	One or more qualified individuals or an interdisciplinary group manages the safety program.				A	
3	The scope of the safety program includes the full range of safety issues, from potential or no-harm errors (sometimes referred to as near misses, close calls, or good catches) to hazardous conditions and sentinel events.				A	
4	All departments, programs, and services within the hospital participate in the safety program.				A	
5	As part of the safety program, the leaders create procedures for responding to system or process failures. Note: Responses might include continuing to provide care, treatment, and services to those affected, containing the risk to others, and preserving factual information for subsequent analysis.				A	

6	The leaders provide and encourage the use of systems for blame-free internal reporting of a system or process failure, or the results of a proactive risk assessment. (See also LD.03.01.01, EP 8; LD.03.04.01, EP 5; LD.04.04.03, EP 3; PI.01.01.01, EP 8)		A	
7	The leaders define "sentinel event" and communicate this definition throughout the organization. Note: At a minimum, the organization's definition includes those events subject to review in the "Sentinel Events" (SE) chapter of this manual. The definition may include any process variation that does not affect the outcome or result in an adverse event, but for which a recurrence carries significant chance of a serious adverse outcome or result in an adverse event, often referred to as a near miss.		A	ESP -1
8	The hospital conducts thorough and credible root cause analyses in response to sentinel events as described in the "Sentinel Events" (SE) chapter of this manual.	3	A	
9	The leaders make support systems available for staff who have been involved in an adverse or sentinel event. Note: Support systems recognize that conscientious health care workers who are involved in sentinel events are themselves victims of the event and require support. Support systems provide staff with additional help and support as well as additional resources through the human resources function or an employee assistance program. Support systems also focus on the process rather than blaming the involved individuals.		A	
10	At least every 18 months, the hospital selects one high-risk process and conducts a proactive risk assessment. (See also LD.04.04.03, EP 3) Note: For suggested components, refer to the Proactive Risk Assessment section at the beginning of this chapter.		A	
11	To improve safety and to reduce the risk of medical errors, the hospital analyzes and uses information about system or process failures and the results of proactive risk assessments. (See also LD.04.04.03, EP 3)		A	
12	The leaders disseminate lessons learned from root cause analyses, system or process failures, and the results of proactive risk assessments to all staff who provide services for the specific situation. (See also LD.03.04.01, EP 5)		A	
13	At least once a year, the leaders provide governance with written reports on the following: - All system or process failures - The number and type of sentinel events - Whether the patients and the families were informed of the event - All actions taken to improve safety, both proactively and in response to actual occurrences - For hospitals that use Joint Commission accreditation for deemed status purposes: The determined number of distinct improvement projects to be conducted annually - All results of the analyses related to the adequacy of staffing (See also PI.02.01.01, EP 14)	D	A	
14	The leaders encourage external reporting of significant adverse events, including voluntary reporting programs in addition to mandatory programs. Note: Examples of voluntary programs include The Joint Commission Sentinel Event Database and the U.S. Food and Drug Administration (FDA) MedWatch. Mandatory programs are often state initiated.		A	