The Joint Commission regularly aggregates standards compliance data to pinpoint areas that present the greatest challenges to accredited organizations and certified programs. These data help The Joint Commission recognize trends and tailor education around challenging standards; National Patient Safety Goals (NPSGs); the Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery™; and Accreditation or Certification Participation Requirements (APRs or CPRs).

The bar graphs on pages 3 to 8 identify the Joint Commission requirements scored most frequently as “not compliant” during accreditation surveys and certification reviews from January 1, 2016, through December 31, 2016. (Data from for-cause surveys and for-cause reviews are not included.) While the principal text of the standards also appears in the bar graphs, the full content of each (including rationales, notes, and elements of performance EPs) is included in the accreditation and certification manuals on E-dition® and in print.

The graphs display the 10 most frequently cited requirements for each program. Percentages indicate the number of organizations that received Requirements for Improvement (RFIs) for the standards shown. Please note that the graph for the behavioral health care program displays more than 10 standards because of a tie in percentage of RFIs. In addition, the graph for health care staffing services displays fewer than 10 standards because the rate of noncompliance for the remainder of those standards was 1% or less.

As a reminder, surveyors and reviewers evaluate compliance with all of the standards in the accreditation and certification manuals. These graphs are provided only to help organizations recognize potential trouble spots.

Standards FAQs are located at http://www.jointcommission.org/Standards/FAQs; questions not addressed on this site may be directed to the Standards Interpretation Group via the online question form at https://web.jointcommission.org/sigsubmission/sigquestionform.aspx.

Continued on page 3
In Sight

This column lists developments and potential revisions that can affect accreditation and certification and tracks proposed changes before they are implemented. Items may drop off this list before the approval stage if they are rejected at some point in the process.

Approved Standards

- Revisions to Environment of Care (EC) and Life Safety (LS) standards for the ambulatory care, critical access hospital, hospital, home care, and nursing care center programs to maintain alignment with Centers for Medicare & Medicaid Services (CMS) requirements (see article on page 18 of this issue)

Policies and Procedures

- Revisions to accreditation decision rules for 2017 (see article on page 8 of this issue)

Currently in Field Review

- Proposed revisions to National Patient Safety Goal NPSG.15.01.01 on suicide prevention for the hospital and behavioral health care programs and proposed addition of NPSG.15.01.01 to the critical access hospital program (field review ends May 1, 2017)

Note: Please visit The Joint Commission website at http://www.jointcommission.org/standards_information/field_reviews.aspx for more information. Field review dates are subject to change.

Currently in Development

- Proposed revisions to requirements for the ambulatory care, behavioral health care, critical access hospital, home care, laboratory, nursing care center, and office-based surgery programs as Phase III of the EP Review component of Project REFRESH

- Proposed consolidations to requirements for the ambulatory care, behavioral health care, critical access hospital, home care, laboratory, nursing care center, and office-based surgery programs as Phase IV of the EP Review component of Project REFRESH

- Proposed new Human Resources (HR) requirement for ambulatory care organizations that provide sleep study services

- Proposed revisions to clarify language of several behavioral health care requirements as the second phase of a maintenance review project

- Proposed revisions for applicable programs to National Patient Safety Goals NPSG.07.01.01, NPSG.07.03.01, NPSG.07.04.01, NPSG.07.05.01, and NPSG.07.06.01 on health care–associated infections

- Proposed new and revised requirements for the home health deemed program to meet new CMS Conditions of Participation

- Proposed new requirements for the critical access hospital, hospital, and ambulatory surgery center programs in response to CMS’s Emergency Management Final Rule

- Proposed revisions to the Medication Management standards for the ambulatory care, behavioral health care, critical access hospital, hospital, home care, nursing care center, and office-based surgery programs

- Proposed new and revised requirements for the hospital program related to pain assessment and management standards

Clarification

An item was erroneously included in the article “CLARIFICATIONS AND EXPECTATIONS: Understanding Key Changes to the Life Safety Standards” in the March 2017 issue of Perspectives. The figure titled “Latch-and-Label Door Assessment Checklist” on page 7 contained inaccuracies and should not have appeared in conjunction with that article. The staff of Perspectives regret the error.
### Top Standards Compliance Data for 2016

#### Ambulatory Care

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Standard Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>53%</td>
<td>IC.02.02.01</td>
<td>The organization reduces the risk of infections associated with medical equipment, devices, and supplies.</td>
</tr>
<tr>
<td>47%</td>
<td>HR.02.01.03</td>
<td>The organization grants initial, renewed, or revised clinical privileges to individuals who are permitted by law and the organization to practice independently.</td>
</tr>
<tr>
<td>37%</td>
<td>EC.02.03.05</td>
<td>The organization maintains fire safety equipment and fire safety building features.</td>
</tr>
<tr>
<td>36%</td>
<td>MM.03.01.01</td>
<td>The organization safely stores medications.</td>
</tr>
<tr>
<td>36%</td>
<td>EC.02.04.03</td>
<td>The organization inspects, tests, and maintains medical equipment.</td>
</tr>
<tr>
<td>32%</td>
<td>EC.02.05.07</td>
<td>The organization inspects, tests, and maintains emergency power systems.</td>
</tr>
<tr>
<td>31%</td>
<td>MM.01.01.03</td>
<td>The organization safely manages high-alert and hazardous medications.</td>
</tr>
<tr>
<td>30%</td>
<td>EC.02.02.01</td>
<td>The organization manages risks related to hazardous materials and waste.</td>
</tr>
<tr>
<td>30%</td>
<td>MM.01.02.01</td>
<td>The organization addresses the safe use of look-alike/sound-alike medications.</td>
</tr>
<tr>
<td>29%</td>
<td>EC.02.05.01</td>
<td>The organization manages risks associated with its utility systems.</td>
</tr>
</tbody>
</table>

**Note:** The data determined for the ambulatory care program were derived from an average of 617 applicable surveys.

#### Behavioral Health Care

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Standard Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>46%</td>
<td>CTS.03.01.03</td>
<td>The organization has a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served.</td>
</tr>
<tr>
<td>31%</td>
<td>HRM.01.02.01</td>
<td>The organization verifies and evaluates staff qualifications.</td>
</tr>
<tr>
<td>28%</td>
<td>NPSG.15.01.01</td>
<td>Identify individuals at risk for suicide.</td>
</tr>
<tr>
<td>22%</td>
<td>HRM.01.06.01</td>
<td>Staff are competent to perform their job duties and responsibilities.</td>
</tr>
<tr>
<td>22%</td>
<td>IC.02.04.01</td>
<td>The organization facilitates staff receiving the influenza vaccination.</td>
</tr>
<tr>
<td>20%</td>
<td>CTS.04.03.33</td>
<td><strong>For organizations providing food services:</strong> The organization has a process for preparing and/or distributing food and nutrition products.</td>
</tr>
<tr>
<td>19%</td>
<td>EC.02.06.01</td>
<td>The organization establishes and maintains a safe, functional environment.</td>
</tr>
<tr>
<td>18%</td>
<td>CTS.02.01.11</td>
<td>The organization screens all individuals served for their nutritional status.</td>
</tr>
<tr>
<td>17%</td>
<td>EC.02.03.05</td>
<td>The organization maintains fire safety equipment and fire safety building features.</td>
</tr>
<tr>
<td>15%</td>
<td>CTS.02.02.05</td>
<td>The organization identifies individuals served who may have experienced trauma, abuse, neglect, or exploitation.</td>
</tr>
<tr>
<td>15%</td>
<td>CTS.02.01.05</td>
<td><strong>For organizations providing care, treatment, or services in non–24-hour settings:</strong> The organization implements a written process requiring a physical health screening to determine the individual’s need for a medical history and physical examination.</td>
</tr>
</tbody>
</table>

**Note:** The data determined for the behavioral health care program were derived from an average of 897 applicable surveys. More than 10 standards are displayed because some were tied in their percentage of RFIs.
### Critical Access Hospitals

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Standard</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>67%</td>
<td>EC.02.05.01</td>
<td>The critical access hospital manages risks associated with its utility systems.</td>
</tr>
<tr>
<td>64%</td>
<td>IC.02.02.01</td>
<td>The critical access hospital reduces the risk of infections associated with medical equipment, devices, and supplies.</td>
</tr>
<tr>
<td>64%</td>
<td>EC.02.06.01</td>
<td>The critical access establishes and maintains a safe, functional environment.</td>
</tr>
<tr>
<td>54%</td>
<td>EC.02.03.05</td>
<td>The critical access hospital maintains fire safety equipment and fire safety building features.</td>
</tr>
<tr>
<td>50%</td>
<td>LS.02.01.30</td>
<td>The critical access hospital provides and maintains building features to protect individuals from the hazards of fire and smoke.</td>
</tr>
<tr>
<td>50%</td>
<td>LS.02.01.35</td>
<td>The critical access hospital provides and maintains systems for extinguishing fires.</td>
</tr>
<tr>
<td>46%</td>
<td>EC.02.02.01</td>
<td>The critical access hospital manages risks related to hazardous materials and waste.</td>
</tr>
<tr>
<td>46%</td>
<td>LS.02.01.10</td>
<td>Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.</td>
</tr>
<tr>
<td>44%</td>
<td>LS.02.01.20</td>
<td>The critical access hospital maintains the integrity of the means of egress.</td>
</tr>
<tr>
<td>32%</td>
<td>EC.02.03.03</td>
<td>The critical access hospital conducts fire drills.</td>
</tr>
</tbody>
</table>

**Note:** The data determined for the critical access hospital program were derived from 90 applicable surveys.

### Disease-Specific Care Certification

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Standard</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>27%</td>
<td>DSDF.3</td>
<td>The program is implemented through the use of clinical practice guidelines selected to meet the patient’s needs.</td>
</tr>
<tr>
<td>19%</td>
<td>DSDF.2</td>
<td>The program develops a standardized process originating in clinical practice guidelines (CPGs) or evidence-based practice to deliver or facilitate the delivery of clinical care.</td>
</tr>
<tr>
<td>16%</td>
<td>DSDF.1</td>
<td>Practitioners are qualified and competent.</td>
</tr>
<tr>
<td>12%</td>
<td>DSCT.5</td>
<td>The program initiates, maintains, and makes accessible a medical record for every patient.</td>
</tr>
<tr>
<td>10%</td>
<td>DSSE.3</td>
<td>The program addresses the patient’s education needs.</td>
</tr>
<tr>
<td>8%</td>
<td>DSDF.4</td>
<td>The program develops a plan of care that is based on the patient’s assessed needs.</td>
</tr>
<tr>
<td>7%</td>
<td>DSPM.5</td>
<td>The program evaluates patient satisfaction with the quality of care.</td>
</tr>
<tr>
<td>6%</td>
<td>DSPR.1</td>
<td>The program defines its leadership roles.</td>
</tr>
<tr>
<td>4%</td>
<td>DSPR.5</td>
<td>The program determines the care, treatment, and services it provides.</td>
</tr>
<tr>
<td>4%</td>
<td>DSPM.1</td>
<td>The program has an organized, comprehensive approach to performance improvement.</td>
</tr>
</tbody>
</table>

**Note:** The data determined for the disease-specific care program were derived from an average of 1,816 applicable surveys (not including those for Advanced Certification for Lung Volume Reduction Surgery or Advanced Certification for Ventricular Assist Device Destination Therapy).
**TOP STANDARDS COMPLIANCE DATA FOR 2016**

**HEALTH CARE STAFFING SERVICES CERTIFICATION**

<table>
<thead>
<tr>
<th>Standard</th>
<th>Percentage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSHR.1</td>
<td>7%</td>
<td>The HCSS firm confirms that a person’s qualifications are consistent with his or her assignment(s).</td>
</tr>
<tr>
<td>HSHR.6</td>
<td>7%</td>
<td>The HCSS firm evaluates the performance of clinical staff.</td>
</tr>
<tr>
<td>CPR 5</td>
<td>6%</td>
<td>The staffing firm submits performance measurement data to The Joint Commission on a routine basis.</td>
</tr>
<tr>
<td>HSPM.4</td>
<td>4%</td>
<td>The HCSS firm analyzes its data.</td>
</tr>
<tr>
<td>HSPM.3</td>
<td>3%</td>
<td>The HCSS firm collects data to evaluate processes and outcomes.</td>
</tr>
<tr>
<td>HSLD.5</td>
<td>3%</td>
<td>The HCSS firm provides services to customers according to a written agreement.</td>
</tr>
<tr>
<td>HSLD.9</td>
<td>2%</td>
<td>The HCSS firm addresses emergency management.</td>
</tr>
<tr>
<td>HSHR.2</td>
<td>2%</td>
<td>As part of the hiring process, the HCSS firm determines that a person’s qualifications and competencies are consistent with his or her job responsibilities.</td>
</tr>
</tbody>
</table>

**Note:** The data determined for the health care staffing services program were derived from 193 applicable surveys. Only 8 standards are displayed because the rate of noncompliance for the rest of the standards was 1% or less.

**TOP STANDARDS COMPLIANCE DATA FOR 2016**

**HOME CARE**

<table>
<thead>
<tr>
<th>Standard</th>
<th>Percentage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>PC.02.01.03</td>
<td>41%</td>
<td>The organization provides care, treatment, or services in accordance with orders or prescriptions, as required by law and regulation.</td>
</tr>
<tr>
<td>PC.01.03.01</td>
<td>34%</td>
<td>The organization plans the patient’s care.</td>
</tr>
<tr>
<td>HR.01.06.01</td>
<td>26%</td>
<td>Staff are competent to perform their responsibilities.</td>
</tr>
<tr>
<td>IC.02.01.01</td>
<td>26%</td>
<td>The organization implements the infection prevention and control activities it has planned.</td>
</tr>
<tr>
<td>RC.02.01.01</td>
<td>26%</td>
<td>The patient record contains information that reflects the patient’s care, treatment, or services.</td>
</tr>
<tr>
<td>IC.02.04.01</td>
<td>25%</td>
<td>The organization offers vaccination against influenza to licensed independent practitioners and staff.</td>
</tr>
<tr>
<td>HR.01.02.05</td>
<td>25%</td>
<td>The organization verifies staff qualifications.</td>
</tr>
<tr>
<td>EM.03.01.03</td>
<td>20%</td>
<td>The organization evaluates the effectiveness of its Emergency Operations Plan.</td>
</tr>
<tr>
<td>NPSG.07.01.01</td>
<td>18%</td>
<td>Comply with either the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines or the current World Health Organization (WHO) hand hygiene guidelines.</td>
</tr>
<tr>
<td>NPSG.15.02.01</td>
<td>16%</td>
<td>Identify risks associated with home oxygen therapy such as home fires.</td>
</tr>
</tbody>
</table>

**Note:** The data determined for the home care program were derived from an average of 1,942 applicable surveys.
### Hospital Standards Compliance Data for 2016

**Hospitals**

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Standard Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>68%</td>
<td>EC.02.06.01</td>
<td>The hospital establishes and maintains a safe, functional environment.</td>
</tr>
<tr>
<td>60%</td>
<td>IC.02.02.01</td>
<td>The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.</td>
</tr>
<tr>
<td>57%</td>
<td>EC.02.05.01</td>
<td>The hospital manages risks associated with its utility systems.</td>
</tr>
<tr>
<td>51%</td>
<td>LS.02.01.35</td>
<td>The hospital provides and maintains systems for extinguishing fires.</td>
</tr>
<tr>
<td>50%</td>
<td>LS.02.01.30</td>
<td>The hospital provides and maintains building features to protect individuals from the hazards of fire and smoke.</td>
</tr>
<tr>
<td>49%</td>
<td>LS.02.01.20</td>
<td>The hospital maintains the integrity of the means of egress.</td>
</tr>
<tr>
<td>48%</td>
<td>LS.02.01.10</td>
<td>Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.</td>
</tr>
<tr>
<td>47%</td>
<td>EC.02.02.01</td>
<td>The hospital manages risks related to hazardous materials and waste.</td>
</tr>
<tr>
<td>46%</td>
<td>PC.02.01.03</td>
<td>The hospital provides care, treatment, and services as ordered or prescribed, and in accordance with law and regulation.</td>
</tr>
<tr>
<td>42%</td>
<td>RC.01.01.01</td>
<td>The hospital maintains complete and accurate medical records for each individual patient.</td>
</tr>
</tbody>
</table>

**Note:** The data determined for the hospital program were derived from 1,441 applicable surveys.

### Laboratory and Point-of-Care Testing Standards Compliance Data for 2016

**Laboratory and Point-of-Care Testing**

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Standard Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>43%</td>
<td>HR.01.06.01</td>
<td>Staff are competent to perform their responsibilities.</td>
</tr>
<tr>
<td>32%</td>
<td>QSA.02.08.01</td>
<td>The laboratory performs correlations to evaluate the results of the same test performed with different methodologies or instruments or at different locations.</td>
</tr>
<tr>
<td>31%</td>
<td>DC.02.03.01</td>
<td>The laboratory report is complete and is in the patient’s clinical record.</td>
</tr>
<tr>
<td>31%</td>
<td>QSA.01.03.01</td>
<td>The laboratory has a process for handling and testing proficiency testing samples.</td>
</tr>
<tr>
<td>29%</td>
<td>LD.04.05.07</td>
<td>The laboratory director, technical consultant, and/or technical supervisor are responsible for maintaining laboratory performance.</td>
</tr>
<tr>
<td>27%</td>
<td>QSA.02.10.01</td>
<td>The laboratory performs quality control testing to monitor the accuracy and precision of the analytic process.</td>
</tr>
<tr>
<td>27%</td>
<td>EC.02.04.03</td>
<td>The laboratory inspects, tests, and maintains laboratory equipment.</td>
</tr>
<tr>
<td>27%</td>
<td>QSA.02.03.01</td>
<td>The laboratory performs calibration verification.</td>
</tr>
<tr>
<td>26%</td>
<td>QSA.01.02.01</td>
<td>The laboratory maintains records of its participation in a proficiency testing program.</td>
</tr>
<tr>
<td>25%</td>
<td>QSA.02.04.01</td>
<td>The laboratory develops an individualized quality control plan (IQCP) in an eligible specialty or subspecialty.</td>
</tr>
</tbody>
</table>

**Note:** The data determined for the laboratory program were derived from an average of 724 applicable surveys.
## Top Standards Compliance Data for 2016 Nursing Care Centers

### Note:
The data determined for the nursing care centers program were derived from 292 applicable surveys.

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Standard Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>41%</td>
<td>HR.02.01.04</td>
<td>The organization permits licensed independent practitioners to provide care, treatment, and services.</td>
</tr>
<tr>
<td>26%</td>
<td>MM.03.01.01</td>
<td>The organization safely stores medications.</td>
</tr>
<tr>
<td>20%</td>
<td>PC.01.02.03</td>
<td>The organization assesses and reassesses the patient or resident and his or her condition according to defined time frames.</td>
</tr>
<tr>
<td>16%</td>
<td>PC.01.02.07</td>
<td>The organization assesses and manages the patient’s or resident’s pain.</td>
</tr>
<tr>
<td>16%</td>
<td>WT.03.01.01</td>
<td>Staff and licensed independent practitioners performing waived tests are competent.</td>
</tr>
<tr>
<td>16%</td>
<td>HR.01.02.05</td>
<td>The organization verifies staff qualifications.</td>
</tr>
<tr>
<td>14%</td>
<td>PC.01.03.01</td>
<td>The organization plans the patient’s or resident’s care.</td>
</tr>
<tr>
<td>13%</td>
<td>NPSG.07.01.01</td>
<td>Comply with either the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines or the current World Health Organization (WHO) hand hygiene guidelines.</td>
</tr>
<tr>
<td>12%</td>
<td>EC.02.02.01</td>
<td>The organization manages risks related to hazardous materials and waste.</td>
</tr>
<tr>
<td>12%</td>
<td>EC.02.06.01</td>
<td>The organization establishes and maintains a safe, functional environment.</td>
</tr>
</tbody>
</table>

## Top Standards Compliance Data for 2016 Office-Based Surgery Practices

### Note:
The data determined for the office-based surgery practices program were derived from an average of 88 applicable surveys.

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Standard Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>60%</td>
<td>HR.02.01.03</td>
<td>The practice grants initial, renewed, or revised clinical privileges to individuals who are permitted by law and the organization to practice independently.</td>
</tr>
<tr>
<td>57%</td>
<td>IC.02.02.01</td>
<td>The practice reduces the risk of infections associated with medical equipment, devices, and supplies.</td>
</tr>
<tr>
<td>41%</td>
<td>EC.02.04.03</td>
<td>The practice inspects, tests, and maintains medical equipment.</td>
</tr>
<tr>
<td>24%</td>
<td>IC.01.03.01</td>
<td>The practice identifies risks for acquiring and transmitting infections.</td>
</tr>
<tr>
<td>24%</td>
<td>NPSG.07.01.01</td>
<td>Comply with either the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines or the current World Health Organization (WHO) hand hygiene guidelines.</td>
</tr>
<tr>
<td>23%</td>
<td>IC.01.05.01</td>
<td>The practice plans for preventing and controlling infections.</td>
</tr>
<tr>
<td>22%</td>
<td>IC.02.04.01</td>
<td>The practice offers vaccination against influenza to licensed independent practitioners and staff.</td>
</tr>
<tr>
<td>22%</td>
<td>MM.03.01.01</td>
<td>The practice safely stores medications.</td>
</tr>
<tr>
<td>22%</td>
<td>MM.01.01.03</td>
<td>The practice safely manages high-alert and hazardous medications.</td>
</tr>
<tr>
<td>20%</td>
<td>WT.03.01.01</td>
<td>Staff and licensed independent practitioners performing waived tests are competent.</td>
</tr>
</tbody>
</table>
The Joint Commission Perspectives

Revisions to Decision Rules and the Post-Survey Process

Changes Include Elimination of Contingent Accreditation Decision Category

In order to simplify and streamline the post-survey process and decision rules, The Joint Commission made a few changes effective as of January 1, 2017, for all organizations seeking reaccreditation. First, an organization with a decision of Accreditation with Follow-up Survey will receive notice of full accreditation once it has successfully submitted Evidence of Standards Compliance (ESC). However, a follow-up survey must be conducted within six months to confirm sustained compliance with the ESC.

Another change is that the category of Contingent Accreditation has been eliminated, leaving only four possible decision outcomes for currently accredited organizations: Accredited, Accreditation with Follow-up Survey, Preliminary Denial of Accreditation, and Denial of Accreditation. In addition, the category of Preliminary Denial of Accreditation (PDA) includes the following new decision rules:

- **PDA06**—The organization with a decision of Accreditation with Follow-up Survey has failed to resolve all Requirements for Improvement (RFIs) after two opportunities to submit ESCs.
- **PDA09**—The organization fails its second Medicare follow-up survey as a result of one or more Conditions of Participation [Conditions for Coverage, for ambulatory surgical centers] scored as a Condition-level deficiency.
- **PDA10**—The organization’s patients have been placed at risk for a serious adverse outcome because there is some evidence that the organization may have engaged in possible fraud or abuse.

All of the 2017 decision rules can be found on the Joint Commission Connect™ extranet in the “What’s New” section.

Changes to the Post-Survey Process

The post-survey process for organizations with a decision of PDA02 has changed. A PDA02 decision is made when an organization may have placed patients at risk for serious adverse outcomes due to patterns, trends, and/or repeat findings. Instead of submitting ESC within 60 days, organizations

Continued on page 12
New Alert Focuses on Safety Culture in Health Care

The recently released Joint Commission Sentinel Event Alert Issue 57 emphasizes that the health of an organization’s safety culture is determined by leadership’s commitment to making it a priority. Effective leaders understand that systemic flaws exist, and that each step in a care process has the potential for failure simply because humans make mistakes. The Alert describes actions leaders can take, and resources they can use, to help health care organizations establish and continuously improve upon key components of safety culture.

Safety culture is the product of individual and group beliefs, values, attitudes, perceptions, competencies, and patterns of behavior that determine an organization’s commitment to quality and patient safety. According to the Joint Commission Center for Transforming Healthcare, insufficient support for reporting patient safety events, intimidation of staff who report events, and refusal to consistently prioritize and implement safety recommendations are some of the factors that contribute to poor safety culture.

Sentinel Event Alert Issue 57 is part of a series issued by The Joint Commission. Previous Alerts have addressed issues such as suicide prevention, patient falls, health information technology, tubing misconnections, misuse of vials, unintended retention of foreign objects, medical device alarm safety, risks associated with opioid use, health care worker fatigue, diagnostic imaging risks, violence in health care facilities, anticoagulants, behaviors that undermine a culture of safety, pediatric medication errors, and surgical fires. Sentinel Event Alerts on these and other topics are available on The Joint Commission website at http://www.jointcommission.org/sentinel_event.aspx.

Sentinel Event Alert 57: The Essential Role of Leadership in Developing a Safety Culture

In any health care organization, leadership’s first priority is to be accountable for effective care while protecting the safety of patients, employees, and visitors. Competent and thoughtful leaders* contribute to improvements in safety and organizational culture.1–2 They understand that systemic flaws exist and each step in a care process has the potential for failure simply because humans make mistakes.3–5 James Reason compared these flaws—latent hazards and weaknesses—to holes in Swiss cheese. These latent hazards and weaknesses must be identified and solutions found to prevent errors from reaching the patient and causing harm.6 Examples of latent hazards and weaknesses include poor design, lack of supervision, and manufacturing or maintenance defects.

The Joint Commission’s Sentinel Event Database reveals that leadership’s failure to create an effective safety culture is a contributing factor to many types of adverse events—from wrong-site surgery to delays in treatment.7

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

• Insufficient support of patient safety event reporting
• Lack of feedback or response to staff and others who report safety vulnerabilities
• Allowing intimidation of staff who report events
• Refusing to consistently prioritize and implement safety recommendations
• Not addressing staff burnout10–11

In essence, a leader who is committed to prioritizing

* The Joint Commission accreditation manual glossary defines a leader as “an individual who sets expectations, develops plans, and implements procedures to assess and improve the quality of the organization’s governance, management, and clinical and support functions and processes. At a minimum, leaders include members of the governing body and medical staff, the chief executive officer and other senior managers, the nurse executive, clinical leaders, and staff members in leadership positions within the organization.”

Published for Joint Commission–accredited organizations and interested health care professionals, Sentinel Event Alerts identify specific types of sentinel and adverse events and high-risk conditions, describe their common underlying causes, and recommend steps to reduce risk and prevent future occurrences.

Accredited organizations should consider information in an Alert when designing or redesigning processes and consider implementing relevant suggestions contained in the Alert or reasonable alternatives.

Please route this issue to appropriate staff within your organization. Sentinel Event Alerts may be reproduced if credited to The Joint Commission. To receive by e-mail or to view past issues, visit http://www.jointcommission.org.
Understanding Key Changes to the Life Safety Standards

The Joint Commission has identified the need to increase the field’s awareness and understanding of the Life Safety Code® (NFPA 101-2012). To address this need, Perspectives publishes the column Clarifications & Expectations, authored by George Mills, MBA, FASHE, CEM, CHFM, CHSP, director, Department of Engineering, The Joint Commission. This column clarifies standards expectations and provides strategies for challenging compliance issues, primarily in life safety and the environment of care, but also in the vital area of emergency management. You may wish to share the ideas and strategies in this column with your organization’s facilities leadership.

The Joint Commission has rewritten the “Life Safety” (LS) chapter to align with the 2012 edition of the National Fire Protection Association’s (NFPA’s) Life Safety Code (NFPA 101-2012) and Health Care Facilities Code (NFPA 99-2012), and it has made changes to the “Environment of Care” (EC) chapter as well. In September 2016 the US Centers for Medicare & Medicaid Services (CMS) issued its K-tags. In response, The Joint Commission is creating a second iteration of EPs that it expects to publish in late 2017 or early 2018.

This is the fifth installment in a series of columns addressing the updated standards and covering general requirements at LS.02.01.10. This and all subsequent columns address both the January 2017 elements of performance (EPs) and proposed forthcoming EPs. These proposed EPs are still in draft form, pending edits and review, and may differ from their final language.

To distinguish the January 2017 EPs from the proposed EPs, the draft language for proposed forthcoming requirements appears in italics. EP language currently in effect does not appear in italics.

Standards Connection

LS.02.01.10, EP 6

In buildings, exit stairs connecting three or fewer floors are fire rated for 1 hour; exit stairs connecting four or more floors are fire rated for 2 hours. (For full text, refer to NFPA 101-2012: 7.1.3.2.1)

Understanding LS.02.01.10 General Requirements

Exit Stair Ratings

The Life Safety Code has a provision in Chapter 7 that allows existing non-high rise buildings to have one-hour fire-rated enclosures (exit stairs) greater than three stories. Sections 7.1.3.2.1(3)(a) and (3)(b) allow existing stair enclosures in existing non-high rise buildings or in existing sprinklered buildings (regardless of height) to be one-hour fire-resistance rated. In new construction, exit stairs connecting four or more floors are rated for two hours. This is expected to be clarified in the Life Safety standards, which, if approved, will become effective in 2018; proposed language follows:

For new construction, exit stairs connecting three or fewer floors are fire rated for one hour; exit stairs connecting four or more floors are fire rated for two hours. In existing buildings that are not high rise, the exit stair shall have at least one-hour fire-resistance rating. (Refer to NFPA 101-2012: 7.1.3.2.1)

Fire-Rated Doors

The term fire rating appears throughout the Life Safety Code. It means simply that the subject has been tested by an approved testing agency such as Underwriters Laboratory (UL) or Factory Mutual Global (FM Global).

EP 7 defines criteria for opening protectives in a fire-rated door. To comply with this requirement, all hardware must work as designed and tested. For example, if the fire door has two rods and one extends upward into the top of the jamb and the second downward into a socket in the floor, both must function as designed. If carpet is installed, the socket cannot be removed or carpeted over; the socket must work as designed. Any modification that occurs to the fire-rated door may void the fire rating.

This EP also requires latching and self-closing or automatic closing devices. The latch must keep the door closed when pressure is applied to the door surface. If the door is open, it must automatically close. For example, if a fire door is held open using a magnetic hold-open device (coordinated with the fire alarm system) that releases the door when the fire alarm system is activated, the door will automatically close, and the latch will engage when the closing is completed.

*Life Safety Code® is a registered trademark of the National Fire Protection Association, Quincy, MA.*
Nothing should restrict the fire door from closing when required to do so, and therefore the EP clearly states that the fire door is not to be blocked or wedged open (see also NFPA 80-2010, 5.2.13.3). After the door is closed and latched, there must not be an undercut greater than ¾ inch at the bottom edge of the door, measured from the floor to the bottom edge of the door.

Fire-rated doors are not allowed to have unapproved protective plates greater than 16 inches from the bottom edge of the door. However, Section 19.3.2.1.4 allows existing health care occupancies to install nonrated factory or field-applied protective plates extending not more than 48 inches above the bottom of the door.1

**Door Surface Coverings**

Only informational signage is allowed on a fire door surface, and informational signs must be applied with adhesive only. This signage may not exceed 5% of the door face. The fire door integrity is so crucial that using screws or nails to affix a sign is not allowed. Also, decorations or coverings are not allowed. As discussed previously, the door fire-resistance rating is decreased from the fire barrier because fire loading typically does not occur at the door location, so adding combustion load to the door is not allowed.

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**Standards Connection**

**LS.02.01.10, EP 7**

Fire-rated doors within walls and floors have functioning hardware, including positive latching devices and self-closing or automatic-closing devices (either kept closed or activated by a release device complying with 7.2.1.8.2). Gaps between meeting edges of door pairs are no more than ½ inch wide, and undercuts are no larger than ½ inch. Fire-rated doors within walls do not have unapproved protective plates greater than 16 inches from the bottom of the door. Blocking or wedging open fire-rated doors is prohibited. (For full text, refer to NFPA 101-2012: 8.3.3.1; NFPA 80-2010: 4.8.4.1; 5.2.13.3; 6.3.1.7; 6.4.5)

In addition, some buildings have opening protectives that are rated higher than the application would require. For example, a contractor may purchase only 90-minute fire-rated doors for a project as a cost-saving strategy (via purchasing leverage of one door type and installation consistency) and install them in all cross-corridor settings. This would include placing a 90-minute door in a 60-minute smoke barrier. Some facilities managers question whether this is acceptable.

In *Life Safety Code* Section 1.4, equivalency provisions allow systems, methods, and devices of equivalent or superior quality, strength, fire resistance, effectiveness, durability, and safety over those prescribed by this code. However, Section 4.6.12.3 states that existing life safety features obvious to the public, if not required by the code, shall either be maintained or removed.1 Therefore, if the organization has doors that exceed *Life Safety Code* specifications, they could be allowed in the assembly. Also, The Joint Commission would require that these doors are identified on the life safety drawings, by annotating the drawing with the barrier rating and the door assembly rating. These doors must be maintained as per the barrier assembly requirement, organization policy, and be in good working order at all times. In other words, the doors must be maintained as intended for the barrier in which they are installed. For example, 18/19.3.7.8(2) states latching hardware is not required on smoke barrier doors, so if the organization installed a fire-rated door in a smoke barrier, the latching hardware would not be required to be functional. However, the unrequired latching hardware must not prevent the door from operating as required while serving as a smoke barrier door.

**Penetrations**

**Dampers** are the opening protectives that are inside ducts that penetrate rated barriers. These ducts may penetrate both horizontal and vertical barriers, such as floors and walls. In the same manner as a door opening, the damper must be rated to maintain the integrity of the barrier. NFPA 90A-2012 is clear that a barrier rated for three or more hours is to be protected with a three-hour fire-rated damper.2 Typically, barriers rated for three or more hours are designed to protect the building features. For barriers that are rated for less than three hours, a damper with a 90-minute rating is required. Ducts and dampers must be installed according to manufacturer recommendations or a recognized testing agency system, such as UL or FM Global. A good depiction of fire and smoke damper requirements can be found in Figure A.5.3 of NFPA 90A-2012.2

Penetrations in rated barriers occur in buildings to accommodate utilities and other building components. When a penetration occurs, the created opening must be properly protected with firestop material approved by testing agencies such as UL or FM Global. The firestop product itself is typi-
Clarifications and Expectations: Understanding Key Changes to the Life Safety Standards (continued)

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Standards Connection

LS.02.01.10, EP 9
Ducts penetrating the walls or floors with a fire-resistance rating of less than 3 hours are protected by dampers that are fire rated for 1½ hours; ducts penetrating the walls or floors with a fire-resistance rating of 3 hours or greater are protected by dampers that are fire rated for 3 hours. (For full text, refer to NFPA 101-2012: 8.3.5.7; 9.2.1; NFPA 90A-2012: 5.4.1; 5.4.2)

Standards Connection

LS.02.01.10, EP 10
The spaces around pipes, conduits, bus ducts, cables, wires, air ducts, or pneumatic tubes penetrating the walls or floors are protected with an approved fire-rated material.

Note: Polyurethane expanding foam is not an accepted fire-rated material for this purpose. (For full text, refer to NFPA 101-2012: 8.3.5)

Standards Connection

LS.02.01.10, EP 11


References


This month’s column also appears in the April 2017 issue of Environment of Care® News.

Revisions to Decision Rules and the Post-Survey Process (continued)

Continued from page 8

with a PDA02 decision are now required to submit a Plan of Correction within 10 business days of the posting of the final report. A survey to validate the implementation of the Plan of Correction will occur within two months. If the validation survey does not confirm implementation of the Plan of Correction, the decision will remain as PDA and the organization may seek an appeal. For more information on this new process for PDA02 decisions, please see the “Important Updates” tab on your Joint Commission Connect extranet site.

Finally, the governance structure of The Joint Commission has transitioned accreditation decision making from an Accreditation Committee to an executive team. Joint Commission executive leaders are now responsible for making accreditation decisions and for taking into consideration the survey report, follow-up activities, staff recommendations, and any unusual or unique issues raised by the organization seeking accreditation.

“The Accreditation Process” (ACC) chapter will be updated to reflect these changes as of the spring E-dition release of the Comprehensive Accreditation Manuals (as well as the print publications of 2017 Update 1 for the manuals for ambulatory care organizations, behavioral health care organizations, home care organizations, and hospitals). For more information on any of these topics, please send an email to postsurveyprocess@jointcommission.org.
and making patient safety visible through everyday actions is a critical part of creating a true culture of safety. Leaders must commit to creating and maintaining a culture of safety; this commitment is just as critical as the time and resources devoted to revenue and financial stability, system integration, and productivity. Maintaining a safety culture requires leaders to consistently and visibly support and promote everyday safety measures. Culture is a product of what is done on a consistent and visible basis. Hospital team members measure an organization’s commitment to culture by what leaders do, rather than what they say should be done.

The Joint Commission introduced safety culture concepts in 2008 with the publication of a Sentinel Event Alert on behaviors that undermine a culture of safety. Further emphasis was made the following year with a Sentinel Event Alert on leadership committed to safety (this Alert replaces and updates that one) and the establishment of a Leadership (LD) standard requiring leaders to create and maintain a culture of safety. The “Patient Safety Systems” (PS) chapter of The Joint Commission’s Comprehensive Accreditation Manual for Hospitals emphasizes the importance of safety culture. As of January 1, 2017, the chapter expanded to critical access hospitals and to ambulatory care and office-based surgery settings.

Safety Culture Foundation

Safety culture is the sum of what an organization is and does in the pursuit of safety. The PS chapter defines safety culture as the product of individual and group beliefs, values, attitudes, perceptions, competencies, and patterns of behavior that determine the organization’s commitment to quality and patient safety. Organizations that have a robust safety culture are characterized by communications founded on mutual trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of preventive measures. The safety culture concept originated in the nuclear energy and aviation industries, which are known for their use of strategies and methodologies designed to consistently and systematically mitigate risk, thereby avoiding accidents. The Institute of Nuclear Power Operations defined safety culture characteristics that are adaptable to the health care environment:

1. Leaders demonstrate commitment to safety in their decisions and behaviors.
2. Decisions that support or affect safety are systematic, rigorous, and thorough.
3. Trust and respect permeate the organization.
4. Opportunities to learn about ways to ensure safety are sought out and implemented.
5. Issues potentially impacting safety are promptly identified, fully evaluated, and promptly addressed and corrected commensurate with their significance.
6. A safety-conscious work environment is maintained where personnel feel free to raise safety concerns without intimidation, harassment, discrimination, or fear of retaliation.
7. The process of planning and controlling work activities is implemented so that safety is maintained.

Leaders can build safety cultures by readily and willingly participating with care team members in initiatives designed to develop and emulate safety culture characteristics. Effective leaders who deliberately engage in strategies and tactics to strengthen their organization’s safety culture see safety issues as problems with organizational systems, not their employees, and see adverse events and close calls (“near misses”) as providing “information-rich” data for learning and systems improvement. Individuals within the organization respect and are wary of operational hazards, have a collective mindfulness that people and equipment will sometimes fail, defer to expertise rather than hierarchy in decision making, and develop defenses and contingency plans to cope with failures. These concepts stem from the extensive research of James Reason on the psychology of human error. Among Reason’s description of the main elements of a safety culture are the following:

- **Just culture**—People are encouraged, even rewarded, for providing essential safety-related information, but clear lines are drawn between human error and at-risk or reckless behaviors.

- **Reporting culture**—People report their errors and near-misses.

- **Learning culture**—The willingness and the competence to draw the right conclusions from safety information systems, and the will to implement major reforms when their need is indicated.

In an organization with a strong safety culture, individuals within the organization treat each other and their patients with dignity and respect. The organization is characterized by staff who are productive, engaged, learning, and collaborative. Having care team members who gain joy and meaning through their work has been found to have an important role in establishing and maintaining a safe culture. The Lucien Leape Institute’s Joy & Meaning in Workforce Safety initiative addresses clinician burnout, which is at record highs. Clinician burnout is associated with lower perceptions of patient safety culture and may directly or indirectly affect patient outcomes.

Joy and meaning will be created when the workforce feels valued, safe from harm, and part of the solutions for change.

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When team members know that their well-being is a priority, they are able to be meaningfully engaged in their work, to be more satisfied, less likely to experience burnout, and to deliver more effective and safer care.11,21 Leaders who encourage transparency in response to reports of adverse events, close calls and unsafe conditions, and who have established processes that ensure follow-up to ensure reports are not lost or ignored (or perceived to be lost or ignored), help mitigate intimidating behaviors because transparency of action itself discourages such behavior. On the opposite end of the spectrum, intimidating and unsettling behaviors causing emotional harm, including the use of inappropriate words and actions or inactions, has a detrimental impact on patient safety10 and should not occur in a safety culture. This includes terminating, punishing, or failing to support a health care team member who makes an error (the “second victim”).

Unfortunately, as attention to the need for a culture of safety in hospitals has increased, “so have concomitant reports of retaliation and intimidation targeting care team members who voice concern about safety and quality deficiencies,” according to a National Association for Healthcare Quality mine organizational safety culture.28 The Incident Decision Tree, from the United Kingdom’s National Patient Safety Agency, is one example that supports the aim of creating an open, fair, and accountable culture, where employees feel able to report patient safety incidents without undue fear of the consequences, and health care organizations know where to draw the accountability line.

3. To advance trust within the organization, CEOs and all leaders must adopt and model appropriate behaviors and champion efforts to eradicate intimidating behaviors.18,25,26 These behaviors include demonstrating respect in all interactions, personally participating in activities and programs aimed at improving safety culture, and by making sure safety-related feedback from staff is acknowledged and, if appropriate, implemented. Leadership must maintain a fair and equitable measure of accountability to all.

4. Establish, enforce, and communicate to all team members the policies that support safety culture and the reporting of adverse events, close calls, and unsafe conditions.19

5. Recognize care team members who report adverse events and close calls, who identify unsafe conditions, or who have good suggestions for safety improvements. Leaders can recognize “good catches”—in which adverse events are avoided—and share these “free lessons” with all team members (i.e., feedback loop).29 The Joint Commission Center for Transforming Healthcare’s Safety Culture project found that two effective ways of reporting back to team

Actions Suggested by The Joint Commission

The Joint Commission recommends that leaders take actions to establish and continuously improve the five components of a safety culture defined by Chassin and Loeb: trust, accountability, identifying unsafe conditions, strengthening systems, and assessment.18 These actions are not intended to be implemented in a sequential manner. Leaders will need to address and apply various components to the workforce simultaneously, using tactics such as board engagement, leadership education, goalsetting, staff support, and dashboards and reports that routinely review safety data.12

1. Absolutely crucial is a transparent, non-punitive approach to reporting and learning from adverse events, close calls, and unsafe conditions.16,24 states the “Patient Safety Systems” (PS) chapter of The Joint Commission’s Comprehensive Accreditation Manual for Hospitals. Develop trust and accountability through an organizational-wide and easy-to-use reporting system. This reporting system should be accessible to everyone within the organization. Having this system is essential for developing a culture in which unsafe conditions are identified and reported without fear of punishment or reprisal for unintentional mistakes, leading to proactive prevention of patient harm.14,18,25,26 Leaders can augment voluntary reporting by using other methods, such as trigger tools and observational techniques, to proactively address risk and identify potential errors.

2. Establish clear, just, and transparent risk-based processes for recognizing and separating human error and error arising from poorly designed systems from unsafe or reckless actions that are blameworthy.16 Mistakes, lapses, omissions, and other human errors are opportunities for improvement and lessons learned from them should be shared. Punishing, terminating, or failing to support an employee who makes a mistake during the course of an adverse event can erode leadership’s credibility and undermine organizational safety culture.29
members who raised safety issues were through 1) shift and unit huddles, and 2) visual management boards. They found that care team members stopped making suggestions when they received no feedback from team or hospital leaders. Also useful toward recognizing safety initiatives and promoting safety culture are activities involving leaders, such as team safety briefings and planning sessions, about safety threats or issues, debriefs to learn from identified errors or safety defects, and safety rounds or walkarounds.

6. Establish an organizational baseline measure on safety culture performance using the Agency for Healthcare Research and Quality (AHRQ) Patient Safety Culture (HSOPS) or another tool, such as the Safety Attitudes Questionnaire (SAQ). A summary of these tools can be found in the Resources section of this alert.

7. Analyze safety culture survey results from across the organization to find opportunities for quality and safety improvement. Analyzing data in this manner enables an organization to find improvement opportunities and solutions in line with organizational priorities and needs. This analysis must drill down to local unit levels so that unit-specific solutions can be developed and implemented. Share the results with frontline staff throughout the organization and with governing bodies, including the board.

8. In response to information gained from safety assessments and/or surveys, develop and implement unit-based quality and safety improvement initiatives designed to improve the culture of safety. Examples from Joint Commission–accredited organizations include the following:

- An obstetrics service line created a multidisciplinary code of professionalism as a mechanism to address unprofessional behavior. Physicians, nurses, and support staff underwent education that addressed why and how to report unprofessional behavior. Leadership followed up on all reports concerning unprofessional behavior with coaching. As a result of the education, reporting and coaching, statistically significant improvement was shown on the following AHRQ Hospital Survey on Patient Safety Culture dimensions: teamwork within units, management support, organizational learning, and frequency of events reported.

- The Rhode Island Intensive Care Unit (ICU) Collaborative conducted a study to examine the impact of a Safety Attitudes Questionnaire Action Plan (SAQAP) on ICU central-line associated blood stream infections (CLABSIs) and ventilator-associated pneumonia (VAP) rates. Teams that developed SAQAPs improved their unit culture and clinical outcomes. Units that developed SAQAPs demonstrated higher improvement rates in all domains of the SAQ, except working conditions. Improvements were close to statistical significance for teamwork climate (+18.4% in SAQAP units versus –6.4% in other units, p = .07) and job satisfaction (+25.9% increase in SAQAP units versus +7.3%, p = .07). Units with SAQAPs decreased the CLABSI rates by 10.2% in 2008 compared with 2007, while those without SAQAP had a 2.2% decrease in rates (p = .59). Similarly, VAP rates decreased by 15.2% in SAQAP units, while VAP rates increased by 4.8% in units without SAQAP (p = .39).

- An academic medical center developed a comprehensive unit-based safety program that included steps to identify hazards, partnered units with a senior executive to fix hazards, learned from defects, and implemented communication and teamwork tools. In 2006, 55% of units achieved the SAQ-measured safety climate goal of meeting or exceeding a 60% positive score or improving the score by 10 or more percentage points. In 2008, 82% of units achieved the goal. For teamwork climate, the two-year improvement was 61% to 83%. Scores improved in every SAQ domain except stress recognition.

- Many other examples of successful and measurable safety culture initiatives can be found in health care literature. Some of these initiatives successfully used tactics such as walkarounds, huddles, employee engagement, team safety briefings and planning sessions, debriefs to learn from identified errors or safety defects, and safety ambassadors to improve various aspects of safety culture. Improvement on safety culture measures is associated with positive outcomes, such as reduced infection rates, fewer readmissions, decreased care team member turnover, better surgical outcomes, reduced adverse events, and decreased mortality. Health care organizations in which care team members have positive perceptions of safety culture tend to have positive assessments of care from patients as well.

9. Embed safety culture team training into quality improvement projects and organizational processes to strengthen safety systems. Team training derived from evidence-based frameworks can be used to enhance the performance of teams in high-stress, high-risk areas of the organization—such as operating rooms, ICUs, and emergency departments—and has been implemented at many health care facilities across the country.

10. Proactively assess system (such as medication management and electronic health records) strengths and improvements.

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vulnerabilities and prioritize them for enhancement or improvement.18,58

11. Repeat organizational assessment of safety culture every 18 to 24 months to review progress and sustain improvement.38 Ensure that the assessment drills down to unit levels,43 and make these assessments part of strategic measures reported to the board.18

Related Joint Commission Requirements

Many Joint Commission standards address issues related to the design and management of patient safety systems. These requirements and elements of performance, which include the following, can be found in the “Patient Safety Systems” (PS) chapter of The Joint Commission’s accreditation manuals for hospitals and critical access hospitals, and for ambulatory care and office-based surgery settings:

LD.03.01.01: Leaders create and maintain a culture of safety and quality throughout the organization.

EP 1. Leaders regularly evaluate the culture of safety and quality using valid and reliable tools.
EP 4. Leaders develop a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety.
EP 5. Leaders create and implement a process for managing behaviors that undermine a culture of safety.

Resources

Hospital Survey on Patient Safety Culture (HSOPS)—Identifies 12 dimensions of safety culture (10 climate dimensions and two outcomes variables):53
- Communication openness
- Feedback and communication about error
- Frequency of events reported
- Handoffs and transitions
- Management support for patient safety
- Non-punitive response to error
- Organizational learning (continuous improvement)
- Overall perceptions of safety
- Staffing
- Supervisor/manager expectations and actions promoting safety
- Teamwork across units
- Teamwork within units

United Kingdom’s National Patient Safety Agency’s Incident Decision Tree—Supports the aim of creating an open culture, where employees feel able to report patient safety incidents without undue fear of the consequences. The approach does not seek to diminish health care professionals’ individual accountability, but encourages key decision makers to consider systems and organizational issues in the management of error.28

Institute for Healthcare Improvement’s Joy in Work Initiative—Addresses clinician burnout.

The Joint Commission Center for Transforming Healthcare’s Oro™ 2.0 High Reliability Organizational Assessment and Resources application—High-reliability organizations routinely self-assess. This self-assessment tool is intended for hospital leadership teams. It can be used in combination with tools (such as HSOPS and SAQ) that measure the perceptions of staff at all levels of the organization. The tool evaluates the following: leadership commitment, safety culture, and performance improvement.

“IPatient Safety Systems” (PS) chapter of The Joint Commission’s Comprehensive Accreditation Manual for Hospitals (as of January 1, 2017, also applicable to critical access hospitals, and to ambulatory care and office-based surgery settings)

Safety Attitudes Questionnaire (SAQ)—Measures six culture domains:
- Teamwork climate
- Safety climate
- Perceptions of management
- Job satisfaction
- Working conditions
- Stress recognition

Safety Culture Project, The Joint Commission Center for Transforming Healthcare—Seven participating organizations focused on identifying unsafe conditions before they reached the patient and finding reliable, sustainable solutions. The organizations found that reporting back to team members about how their suggestions improved care increased team
member satisfaction, particularly if the feedback included praise, either public or private as appropriate, for those who spoke up. The project utilized The Joint Commission’s Robust Process Improvement™ (RPI™), a blended approach to improve business and clinical processes and outcomes using Lean, Six Sigma, and change management methodologies. RPI is intended for all staff, including leaders.

Strategies for Creating, Sustaining, and Improving a Culture of Safety in Health Care — Published by Joint Commission Resources, this second edition book expands the idea of “building” a culture of safety by spotlighting the best articles related to this topic from The Joint Commission Journal on Quality and Patient Safety. These articles provide unique perspectives of challenges inherent when establishing and maintaining a culture of safety.

References
37. Safety culture proven to improve quality, must be monitored and measured. Hospital Peer Review. 2016 May;41(5):49–52.

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More Revisions Announced for Environment of Care and Life Safety Chapters


The November 2016 issue of Perspectives introduced the revisions made to the “Environment of Care” (EC) and “Life Safety” (LS) chapters of the Comprehensive Accreditation Manuals for the ambulatory care, behavioral health care, critical access hospital, hospital, home care, and nursing center programs. The revisions incorporated new and revised elements of performance (EPs) that correspond to the 2012 codes and allow for a more logical flow of the requirements for customer and surveyor use. These changes were effective January 9, 2017.

Recently, a few more revisions were made as a result of CMS’s review of the revised EC and LS requirements. These revisions apply to the ambulatory care, critical access hospital, hospital, nursing care center, and home care programs. These changes are effective July 1, 2017, and are posted on The Joint Commission website at http://www.jointcommission.org/standards_information/prepublication_standards.aspx. The revisions will also be reflected in the spring edition release of the Comprehensive Accreditation Manuals for the above programs (as well as the print publications of 2017 Update 1 for the manuals for ambulatory care organizations, home care organizations, and hospitals.)

Looking to the Future

Future standards revisions planned for 2018 will include additional new and revised EPs in the LS and EC chapters. These EPs will encompass the survey procedures (K-Tags) that CMS has written to coincide with the 2012 Life Safety Code (NFPA 101) and Health Care Facilities Code (NFPA 99), which were not available until September 2016. The Joint Commission is currently scoring these requirements from NFPA 101 and NFPA 99 in its more broadly written EPs.

Questions may be directed to Kenneth A. Monroe, PE, MBA, CHC, PMP, associate project director, Department of Standards and Survey Methods, The Joint Commission, at kmonroe@jointcommission.org. *

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**99 Using the Chronic Care Model to Improve Pediatric Chronic Illness Care**—J.S. Adams, L.E. Wisk

The authors discuss the innovative nature of a quality improvement project that entailed care design changes based on the Chronic Care Model that were made by 18 clinical improvement teams in multiple clinical divisions.

**101 Applying the Chronic Care Model to Improve Care and Outcomes at a Pediatric Medical Center**—J. Lail, P.J. Schoettker, D.L. White, B. Mehta, U.R. Kotagal

Cincinnati Children’s Hospital Medical Center launched the Condition Outcomes Improvement Initiative in 2012 to help disease-based teams use the principles of improvement science to implement components of the Chronic Care Model and improve outpatient care delivery for populations of children with chronic and complex conditions.

**113 Timely Care for Sickle Cell**—J.S. Colla, P. Kotini-Shah, S.B. Brown, L.L. Hsu

The authors find an initiative to improve the process of pain management in sickle cell disease to be important because it draws attention to workflow and process barriers that can impede optimal pain management in the emergency department.

**116 A Prospective Emergency Department Quality Improvement Project to Improve the Treatment of Vaso-Occlusive Crisis in Sickle Cell Disease: Lessons Learned**—P. Tanabe, C.E. Freiermuth, D.M. Cline, S. Silva

In a large prospective research and quality improvement project in the emergency departments at two academic medical centers with Level 1 trauma centers, neither site showed significant changes in time between the administration of the first and second opioid doses, total opioid dose administered, or patient satisfaction.

**127 Crossing the Communication Chasm: Challenges and Opportunities in Transitions of Care from the Hospital to the Primary Care Clinic**—N.A. Rattray, J.J. Sico, L.A.M. Cox, A.L. Russ, M.S. Matthias, R.M. Frankel

A qualitative research study was conducted to better understand the communication challenges faced by providers on both sides of the transfer of care for patients with stroke/transient ischemic attack from inpatient to outpatient settings.

**138 Using an Electronic Perioperative Documentation Tool to Identify Returns to Operating Room (ROR) in a Tertiary Care Academic Medical Center**—R.R. Cima, S.R. Dhanorker, C.L. Ostendorf, M. Ntekpe, R.V. Mudundi, E.B. Habermann, C. Deschamps

During the nine-month analysis period in a high-volume, high-complexity academic surgical practice, all returns to operating room (RORs) within 45 days of the index operation were identified; unplanned reoperations were uncommon (n = 830, 2% of all operations), and most of the RORs were planned staged or unrelated returns.

**146 Pediatric Postoperative Pulse Oximetry Monitoring During Transport to the Postanesthesia Care Unit Reduces Frequency of Hypoxemia**—T.J. Caruso, T.E. Mokhtari, M.J. Coughlan, D.S. Wu, J.L. Marquez, M. Duan, H. Freeman, A. Giustini, M. Tweedy, P.J. Sharek

In a study on the standard use of pulse oximetry during the transport of postoperative patients from the operating room (OR) to the postanesthesia care unit (PACU), which was conducted at an academic pediatric hospital, six hypoxic events on arrival to the PACU were identified in 506 patients in the preintervention phase versus zero in the 597 patients in the postintervention period (p = 0.009).
### Ambulatory Care Hot Topics

- **April 19** | An Overview of the 2017 National Patient Safety Goals®
- **June 28** | Managing an Ongoing Continuous Readiness Program
- **August 30** | Risky Business: How To Perform a Risk Assessment
- **October 4** | Medical Staff Issues: Credentialing, Privileging and Peer Review

### Environment of Care/Life Safety

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- **June 14** | New Elements of Performance (EPs) in Life Safety (part 2)

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- **June 15** | Infection Control Risk Assessment (ICRA): Minimizing Risks During Construction
- **September 21** | *Clostridium difficile* and Antimicrobial Stewardship: Meeting the 2017 Joint Commission Standards
- **December 14** | High Level Disinfection and Sterilization

### Medication Management

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- **June 22** | The Joint Commission's New Approach to Pain Management, Opioid Prescribing and Controlled Substance Management in Hospitals
- **September 28** | What Joint Commission Hospitals Need to Know about USP Chapters <797> and <800>
- **November 9** | Medication Management Update for 2018