Safety Systems for Individuals Served (SSIS)

Introduction

The quality of care, treatment, or services and the safety of individuals served are core values of The Joint Commission accreditation process. This is a commitment The Joint Commission has made to individuals served, patients, and families, as well as staff and organization leaders. This chapter exemplifies that commitment.

The intent of this "Safety Systems for Individuals Served" (SSIS) chapter is to provide accredited organizations with a proactive approach to designing or redesigning care, treatment, or services that aim to improve quality and safety for the individual, an approach that aligns with the Joint Commission's mission and its standards.

The Joint Commission partners with accredited organizations to improve the care, treatment, or services delivery to protect individuals served. Therefore, this chapter is focused on the following two guiding principles:

1. Assisting organizations with advancing knowledge, skills, and competence of staff and individuals served by recommending methods that will improve quality and safety processes.
2. Encouraging and recommending proactive quality and safety methods for the individuals served that will increase accountability, trust, and knowledge while reducing the impact of fear and blame.

Quality[*] and safety are inextricably linked. Quality care, treatment, or services is the degree to which its processes and results meet or exceed the needs and goals of the individuals it serves.[1,2] Those needs and goals include safety.

To ensure quality and safety, components of the management system should include the following:

[*] The Institute of Medicine defines quality as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. **Source:** Committee to Design a Strategy for Quality Review and Assurance in Medicare, Institute of Medicine. *Medicare: A Strategy for Quality Assurance*, vol. 1. Lohr KN, ed. Washington, DC: The National Academies Press, 1990.

- Ensuring reliable processes
- Decreasing variation and defects (waste)
- Focusing on achieving positive measurable outcomes
- Using evidence to ensure that care, treatment, or services are satisfactory

Safety of the individual emerges as a central aim of quality. Safety is what individuals served, patients, families, staff, and the public expect from Joint Commission–accredited organizations. While safety events may not be completely eliminated, harm to individuals can be reduced, and the goal is always zero harm. This chapter describes and provides approaches and methods that may be adapted by an organization that aims to increase the reliability of its complex systems while making visible and removing the risk of harm to the individual. Joint Commission–accredited organizations should be continually focused on eliminating system and process failures and human errors that may cause harm to individuals served, patients, families, and staff.[1,2]

The ultimate purpose of The Joint Commission's accreditation process is to enhance quality of care, treatment, or services and safety for individuals served. Each requirement or standard, the survey process, the Sentinel Event Policy, and other Joint Commission initiatives are designed to help organizations reduce variation, reduce risk, and improve quality. Behavioral health care and human services organizations should have an integrated approach to safety so that high levels of safe care, treatment, or services can be provided for every individual in every setting(s).

Organizations depend on strong leadership to support an integrated safety system that includes the following:

- Safety culture
- Validated methods to improve processes and systems
- Standardized ways to communicate and collaborate within or outside of the organization
- Safely integrated technologies

In an integrated safety system, staff and leaders work together to eliminate complacency, promote collective mindfulness, treat each other with respect and compassion, and learn from their safety events, including close calls and other system failures that have not yet led to the harm of an individual.

What Does This Chapter Contain?

"Safety Systems for Individuals Served" (SSIS) chapter is intended to help inform and educate accredited organizations about the importance and structure of an integrated safety system for the individuals they serve. **This chapter describes how existing requirements can be applied to achieve improved safety of the individuals served; it does not contain any new requirements.** It is also intended to help all organizations understand the relationship between Joint Commission accreditation and the safety of the individual.

This chapter does the following:

- Describes an integrated safety system that focuses on the individual
- Discusses how organizations can develop into learning organizations
- Explains how organizations can continually evaluate the status and progress of their safety systems
- Describes how organizations can work to prevent or respond to safety events (Sidebar 1 defines key terminology)
- Serves as a framework to guide organization leaders as they work to improve safety for individuals in all settings
- Contains a list of standards and requirements related to safety systems (which will be scored as usual in their original chapters)
- Contains references that were used in the development of this chapter

This chapter refers to a number of Joint Commission standards. Standards cited in this chapter are formatted with the standard number in boldface type (for example, "Standard **RI.01.01.01**") and are accompanied by language that summarizes the standard. For the full text of a standard and its element(s) of performance (EP), please *see* the Appendix.

Sidebar 1. Key Terms to Understand

- *Safety event:*[†] An event, incident, or condition that could have resulted or did result in harm to an individual served or a patient.
- *Adverse event:* A safety event that resulted in harm to an individual served.

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[†]The term "safety event" has been adapted for use in this chapter.

Sidebar 1. *(continued)*

- *Sentinel event:*[‡] A subcategory of adverse events, a sentinel event is a safety event (not primarily related to the natural course of an illness or underlying condition of the individual served) that reaches an individual and results in any of the following:
  - Death
  - Permanent harm
  - Severe temporary harm
- *No-harm event*: A safety event that reaches the individual served but does not cause harm.
- *Close call* (or *near miss*, or *good catch*): A safety event that did not did not reach the individual served.
- *Hazardous* (or *unsafe*) *condition(s)*: A circumstance (other than an individual's own disease process or condition) that increases the probability of an adverse event.

Note: *It is impossible to determine if there are practical prevention or mitigation countermeasures available without first doing an event analysis. An event analysis will identify systems-level vulnerabilities and weaknesses and the possible remedial or corrective actions that can be implemented.*

Becoming a Learning Organization

The need for sustainable improvement in the safety and quality of care, treatment, or services an individual receives has never been greater. One of the fundamental steps to achieving and sustaining this improvement is to become a learning organization. A *learning organization* is one in which people learn continuously, thereby enhancing their capabilities to create and innovate.[3] Learning organizations uphold five principles: team learning, shared visions and goals, a shared mental model (that is, similar ways of thinking), individual commitment to lifelong learning, and systems thinking.[3] In a learning organization, safety events are seen as opportunities for learning and improvement.[4] Therefore, leaders in learning organizations adopt a transparent, nonpunitive approach to reporting so that the organization can *report to learn* and can collectively learn from safety events. In order to become a learning organization, an

[‡]For a list of specific safety events that are also considered sentinel events, *see* page SE-1 in the "Sentinel Events" (SE) chapter of this manual.

organization must have a fair and just safety culture, a strong reporting system, and a commitment to put that data to work by driving improvement. Each of these require the support and encouragement of an organization's leaders.

Leaders, staff, and individuals served in a learning organization realize that *every* safety event (from close calls to events that cause major harm to individuals) must be reported.[4-8] When events that have caused or could have caused harm are continuously reported, experts within the organization can define the problem, identify solutions, achieve sustainable results, and disseminate the changes or lessons learned to the rest of the organization.[4-8] In a learning organization, the organization provides staff with information regarding improvements based on reported concerns. This helps foster trust that encourages further reporting.

The Role of Leaders in Safety (of the Individual Served)

Leaders provide staff the foundation for an effective safety system for the individual served by doing the following:[9]

- Promoting learning
- Motivating staff to uphold a fair and just safety culture
- Providing a transparent environment in which quality measures and harm to individuals are freely shared with staff
- Modeling professional behavior
- Addressing intimidating behavior that might undermine the safety culture
- Providing the resources and training necessary to take on improvement initiatives

For these reasons, many of the standards that are focused on the organization's safety system appear in the Joint Commission's Leadership (LD) standards, including Standard **LD.03.09.01** (which focuses on having an organizationwide, integrated safety program).

Without the support of leaders, organizationwide changes and improvement initiatives are difficult to achieve. Leadership engagement in safety and quality initiatives for individuals is imperative because 75% to 80% of all initiatives that require people to change their behaviors fail in the absence of leadership managing the change.[4] Thus, leadership should take on a long-term commitment to transform their organization.[10]

Safety Culture

A strong safety culture is an essential component of a successful safety system and is a crucial starting point for organizations striving to become learning organizations. In a strong safety culture, the organization has an unrelenting commitment to safety and to do no harm. Among the most critical responsibilities of leaders is to establish and maintain a strong safety culture within their organization. The Joint Commission's standards address safety culture in Standard **LD.03.01.01**, which requires leaders to create and maintain a culture of safety and quality throughout their organization.

The *safety culture* of an organization is the product of individually held and group beliefs, values, attitudes, perceptions, competencies, and patterns of behavior that determine the organization's commitment to quality and safety for individuals. 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.[11] Organizations will have varying levels of safety culture, but all should be working toward a safety culture that has the following qualities:

- Staff and leaders that value transparency, accountability, and mutual respect.[4]
- Safety as everyone's first priority.[4]
- Behaviors that undermine a culture of safety are not acceptable, and thus should be reported to organizational leadership by individuals served, patients, staff, and families for the purpose of fostering risk reduction.[4,10,12]
- Collective mindfulness is present, wherein staff realize that systems always have the potential to fail and staff are focused on finding hazardous conditions or close calls at early stages before an individual may be harmed.[10] Staff do not view close calls as evidence that the system prevented an error but rather as evidence that the system needs to be further improved to prevent any defects.[10,13]
- Staff who do not deny or cover up errors but rather want to report errors to learn from mistakes and improve the system flaws that contribute to or enable safety events.[6] Staff know that their leaders will focus not on blaming providers involved in errors but on the systems issues that contributed to or enabled the safety event.[6,14]
- By reporting and learning from safety events, staff create a learning organization.

A safety culture operates effectively when the organization fosters a cycle of trust, reporting, and improvement.[10,15] In organizations that have a strong safety culture, staff trust their coworkers and leaders to support them when they identify and report a safety event.[10] When trust is established, staff are more likely to report safety events, and organizations can use these reports to inform their improvement efforts. In the trust-

report-improve cycle, leaders foster trust, which enables staff to report, which enables the organization to improve.[10] In turn, staff see that their reporting contributes to actual improvement, which bolsters their trust. Thus, the trust-report-improve cycle reinforces itself.[10] (*See* Figure 1.)

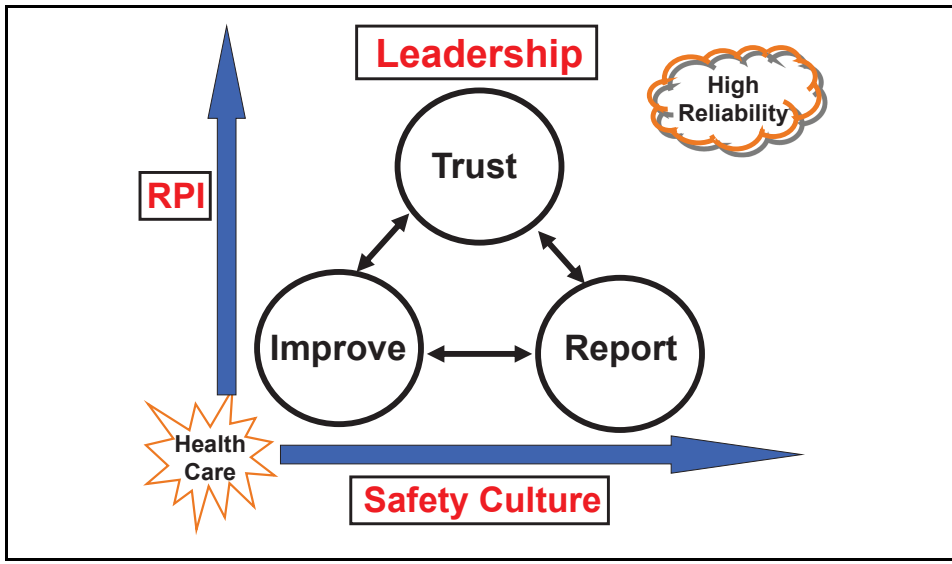

Figure 1. *The Trust-Report-Improve Cycle with Robust Process Improvement® (RPI).*

In the trust-report-improve cycle, trust promotes reporting, which leads to improvement, which in turn fosters trust.

Leaders and staff need to ensure that intimidating or unprofessional behaviors within the organization are addressed, so as not to inhibit anyone inside the organization from reporting safety concerns.[16] Leaders should both educate staff and hold them accountable for professional behavior. This includes the adoption and promotion of a code of conduct that defines acceptable behavior as well as behaviors that undermine a culture of safety. The Joint Commission's Standard **LD.03.01.01**, EP 4, requires that leaders develop such a code.

Intimidating and disrespectful behaviors by staff or leaders disrupt the culture of safety and prevent collaboration, communication, and teamwork, which is required for the safe and highly reliable care, treatment, or services of individuals served.[17] Disrespect is not limited to outbursts of anger that humiliate a member of the care team; it can manifest in many forms, including the following:[4,12,17]

- Inappropriate words (profane, insulting, intimidating, demeaning, humiliating, or abusive language)
- Shaming staff for negative outcomes
- Unjustified negative comments or complaints about another provider's care
- Refusal to comply with known and generally accepted practice standards, the refusal of which may prevent other providers from delivering quality care
- Not working collaboratively or cooperatively with other members of the interdisciplinary team
- Creating rigid or inflexible barriers to requests for assistance or cooperation
- Not returning pages or calls promptly

A Fair and Just Safety Culture

A fair and just safety culture is needed for staff to trust that they can report safety events without being treated punitively.[2,8] In order to accomplish this, organizations should provide and encourage the use of a standardized reporting process for staff to report safety events. This is also built into the Joint Commission's standards at Standard **LD. 03.09.01**, EP 3, which requires leaders to provide and encourage the use of systems for blame-free reporting of a system or process failure or the results of proactive risk assessments. Reporting enables both proactive and reactive risk reduction. *Proactive risk reduction* solves problems before individuals served are harmed, and *reactive risk reduction* attempts to prevent the recurrence of problems that have already caused harm to an individual served.[10,15]

A fair and just culture takes into account that people are human, fallible, and capable of mistakes, and that they work in systems that are often flawed. In the most basic terms, a fair and just culture holds people accountable for their actions but does not punish them for issues attributed to flawed systems or processes.[14,18,19] Refer to Standard **LD.04.01.05**, EP 4, which requires that staff are held accountable for their responsibilities.

It is important to note that for some actions for which a person is accountable, he or she should be held culpable and some disciplinary action may then be necessary. (*See* Sidebar 2 for a discussion of tools that can help leaders determine a fair and just response to a safety event.) However, staff should never be punished or ostracized for **reporting** the event, close call, hazardous condition, or concern.

Sidebar 2. Assessing Staff Accountability

The aim of a safety culture is not a "blame-free" culture but one that balances learning with accountability. To achieve this, it is essential that leaders assess errors and patterns of behavior in a manner that is applied consistently, with the goal of eliminating behaviors that undermine a culture of safety. There has to exist within the organization a clear, equitable, and transparent process for recognizing and separating the blameless errors that fallible humans make daily from the unsafe or reckless acts that are blameworthy.[1–10]

There are a number of sources for information (some of which are listed immediately below) that provide rationales, tools, and techniques that will assist an organization in creating a formal decision process to determine what events should be considered blameworthy and require individually directed action in addition to systems-level corrective actions. The use of a formal process will reinforce the culture of safety and demonstrate the organization's commitment to transparency and fairness.

Reaching answers to these questions requires an initial investigation into the safety event to identify contributing factors. The use of the Incident Decision Tree (adapted by the United Kingdom's National Patient Safety Agency from James Reason's culpability matrix) or another formal decision process can help make determinations of culpability more transparent and fair.[5]

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Sidebar 2. *(continued)*

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Data Use and Reporting Systems

An effective culture of safety is evidenced by a robust reporting system and use of measurement to improve. When accredited organizations adopt a transparent, nonpunitive approach to reports of safety events or other concerns, the organization begins reporting to learn—and to learn collectively from adverse events, close calls, and hazardous conditions. This section focuses on data from reported safety events. Organizations should note that this is but one type of data among many that should be collected and used to drive improvement.

When there is continuous reporting for adverse events, close calls, and hazardous conditions, organizations can analyze the safety events, change the process or system to improve safety, and disseminate the changes or lessons learned to the rest of the organization.[20–24]

In addition to those mentioned earlier in this chapter, a number of standards relate to the reporting of safety information, including Performance Improvement (PI) Standard **PI.01.01.01**, which requires accredited organizations to collect data to monitor their

performance, and Standard **LD.03.02.01**, which requires accredited organizations to use data and information to guide decisions and to understand variation in the performance of processes supporting safety and quality.

Organizations can engage frontline staff in internal reporting in a number of ways, including the following:

- Create a nonpunitive approach to safety event reporting
- Educate staff on identifying safety events that should be reported
- Provide timely feedback regarding actions taken on safety events

Effective Use of Data

Collecting Data

When organizations collect data or measure staff compliance with evidence-based care processes or outcomes for individuals served, they can manage and improve those processes or outcomes and, ultimately, improve safety for individuals.[25] The effective use of data enables organizations to identify problems, prioritize issues, develop solutions, and track to determine success.[9] Objective data can be used to support decisions, influence people to change their behaviors, and to encourage compliance with evidence-based care guidelines.[9,26]

The Joint Commission requires accredited organizations to collect and use data related to outcomes from care, treatment, or services provided to the individuals served, including any sustained harm. Some key Joint Commission standards related to data collection and use require organizations to do the following:

- Collect information to monitor conditions in the environment (Standard **EC.04.01.01**)
- Identify risks for acquiring and spreading infections (Standard **IC.01.03.01**)
- Use data and information to guide decisions and to understand variation in the performance of processes supporting safety and quality (Standard **LD.03.02.01**)
- Have an organizationwide, integrated safety program within any performance improvement activities (Standard **LD.03.09.01**)
- If applicable, evaluate the effectiveness of the medication management system (Standard **MM.08.01.01**)
- Document the use of restraint and seclusion or from physical holding of a child/youth (Standard **RC.02.01.05**)

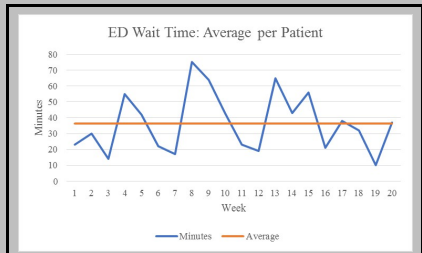
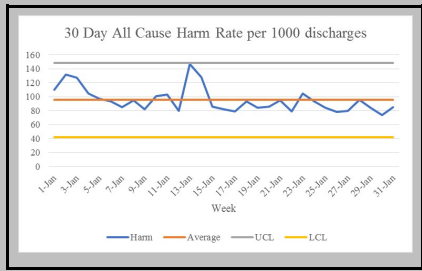
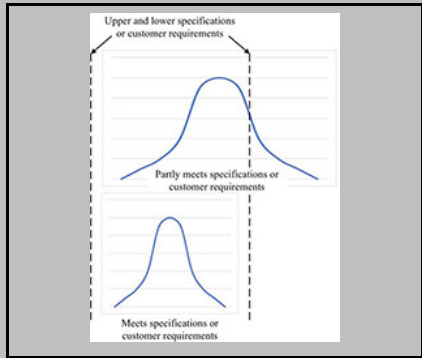
- Use measurement-based care to track progress in care, treatment, or services (Standard **CTS.03.01.09**)
- Collect data to monitor performance (Standard **PI.01.01.01**)
- Improve performance on an ongoing basis (Standard **PI.03.01.01**)

Analyzing Data

Effective data analysis can enable an organization to better assess problems within its systems or organization similar to how providers assess the condition of an individual served based on behaviors, history, and other factors. Turning data into information is a critical competency of a learning organization and of effective management of change. When the right data are collected and appropriate analytic techniques are applied, it enables the organization to monitor the performance of a system, detect variation, and identify opportunities to improve. This can help the organization not only understand the current performance of organizationwide systems but also can help it predict its performance going forward.[23]

Analyzing data with tools such as run charts, statistical process control (SPC) charts, and capability charts helps an organization determine what has occurred in a system and provides clues as to why the system responded as it did.[23] Table 1 describes and compares examples of these tools. Please note that several types of SPC charts exist; this discussion focuses on the XmR chart, which is the most commonly used.

Table 1. Defining and Comparing Analytical Tools

Tool	When to Use	Example
Run Chart	■ When the organization needs to identify variation within a system ■ When the organization needs a simple and straightforward analysis of a system ■ As a precursor to an SPC chart	
Statistical Process Control Chart	■ When the organization needs to identify variation within a system and find indicators of why the variation occurred ■ When the organization needs a more detailed and in-depth analysis of a system	
Capability Chart	■ When the organization needs to determine whether a process will function as expected, according to requirements or specifications	 In the example above, the curve at the top of the chart indicates a process that is only partly capable of meeting requirements. The curve at the bottom of the chart shows a process that is fully capable.

Using Data to Drive Improvement

After data has been turned into information, leadership should ensure the following (in accordance with the requirements shown):[27–29]

- Information is presented in a clear manner (Standard **LD.03.04.01**)
- Information is shared with the appropriate groups throughout the organization (from the staff to governance) (Standards **LD.03.04.01**, **LD.03.09.01**)
- Opportunities for improvement and actions to be taken are communicated (Standards **LD.03.05.01**, **LD.03.07.01**)
- Improvements are celebrated or recognized

A Proactive Approach to Preventing Harm

Proactive risk reduction prevents harm before it reaches the individual served. By engaging in proactive risk reduction, an organization can correct process problems in order to reduce the likelihood of experiencing adverse events.

In a proactive risk assessment, the organization evaluates a process to see how it could potentially fail, to understand the consequences of such a failure, and to identify parts of the process that need improvement. 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.

When conducting a proactive risk assessment, organizations should prioritize high-risk, high-volume areas. Areas of risk are identified from internal sources such as ongoing monitoring of the environment, results of previous proactive risk assessments, from results of data collection activities. Risk assessment tools should be accessed from credible external sources such as a *Sentinel Event Alert*, nationally recognized risk assessment tools, and peer review literature. Benefits of a proactive approach to the safety of individuals includes increased likelihood of the following:

- Identification of actionable common causes
- Avoidance of unintended consequences
- Identification of commonalities across programs/services
- Identification of system solutions
- Sufficient staff
- Completion of environmental risk assessment
- Identification of individuals who may be harmful to themselves or others

Hazardous (or unsafe) conditions provide an opportunity for an organization to take a proactive approach to reduce harm. Organizations also benefit from identifying hazardous conditions while designing any new process that could impact the safety of an individual. A hazardous condition is defined as any circumstance that increases the probability of a safety event. A hazardous condition may be the result of a human error or violation, may be a design flaw in a system or process, or may arise in a system or process in changing circumstances.[§] A proactive approach to such conditions should include an analysis of the systems and processes in which the hazardous condition is found, with a focus on conditions that preceded the hazardous condition. (*See* Sidebar 3.)

A proactive approach to hazardous conditions should include an analysis of the related systems and processes, including the following aspects:[30]

- **Preconditions.** Examples include hazardous (or unsafe) conditions in the environment of care (such as noise, clutter, wet floors and so forth) and inadequate staffing levels.
- **Supervisory influences.** Examples include inadequate supervision, failure to address a known problem, authorization of activities that are known to be hazardous.
- **Organizational influences.** Examples include inadequate staffing, inadequate policies, lack of strategic risk assessment.

Organizations should recognize that this standard represents a minimum requirement. Organizations working to become learning organizations are encouraged to exceed this requirement by constantly working to proactively identify risk.

Sidebar 3. Strategies for an Effective Risk Assessment

There are several methods of conducting proactive risk assessments, including the following:

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[§]Human errors are typically skills based, decision based, or knowledge based, whereas violations could be either routine or exceptional (intentional or negligent). *Routine violations* tend to include habitual "bending of the rules," often enabled by management. A routine violation may break established rules or policies, and yet be a common practice within an organization. An *exceptional violation* is a willful behavior outside the norm that is not condoned by management, engaged in by others, and not part of the individual's usual behavior. **Source:** Diller T, et al. The human factors analysis classification system (HFACS) applied to health care. *Am J Med Qual.* 2014 May–Jun;29(3)181–190.

Sidebar 3. *(continued)*

- Promote a blame-free reporting culture and provide a reporting system to support it.
- Describe the chosen process (for example, through the use of a flowchart).
- Identify ways in which the process could break down or fail to perform its desired function, which are often referred to as "failure modes."
- Identify the possible effects that a breakdown or failure of the process could have on individuals and the seriousness of the possible effects.
- Prioritize the potential process breakdowns or failures.
- Determine why the prioritized breakdowns or failures could occur, which may involve performing a hypothetical root cause analysis.
- Design or redesign the process and/or underlying systems to minimize the risk of the effects on individuals.
- Test and implement the newly designed or redesigned process.
- Monitor the effectiveness of the newly designed or redesigned process.

Tools for Conducting a Proactive Risk Assessment

A number of tools are available to help organizations conduct a proactive risk assessment. One of the best known of these tools is the Failure Modes and Effects Analysis (FMEA). An FMEA is used to prospectively examine how failures could occur during high-risk processes and, ultimately, how to prevent them. The FMEA asks "What if?" to explore what could happen if a failure occurs at particular steps in a process.[31]

Organizations have other tools they can consider using in their proactive risk assessment. Some examples include the following:

- Institute for Safe Medication Practices Medication Safety Risk Assessment: This tool is designed to help reduce medication errors. Visit https://www.ismp.org/selfassessments/default.asp for more information.
- Contingency diagram: The contingency diagram uses brainstorming to generate a list of problems that could arise from a process. Visit https://digital.ahrq.gov/health-it-tools-and-resources/evaluation-resources/workflow-assessment-health-it-toolkit/all-workflow-tools/contingency-diagram.

- Potential problem analysis (PPA) is a systematic method for determining what could go wrong in a plan under development. The problem causes are rated according to their likelihood of occurrence and the severity of their consequences. Visit https://digital.ahrq.gov/health-it-tools-and-resources/evaluation-resources/workflow-assessment-health-it-toolkit/all-workflow-tools/potential-problem-analysis for more information.
- Process decision program chart (PDPC) provides a systematic means of finding errors with a plan while it is being created. After potential issues are found, preventive measures are developed, allowing the problems to either be avoided or a contingency plan to be in place should the error occur. Visit https://digital.ahrq.gov/health-it-tools-and-resources/evaluation-resources/workflow-assessment-health-it-toolkit/all-workflow-tools/process-decision-program-chart.

Encouraging Participation of Individuals Served

To achieve the best outcomes, individuals served and families must be actively engaged in decisions about their care, treatment, or services and must have broader access to information and support. This also supports trauma-informed and recovery/resilience concepts/principles. Activation of the individual served is inextricably intertwined with the safety of the individual. Individuals who are less activated suffer poorer outcomes and are less likely to follow their provider's advice.[32,33]

An approach to care, treatment, or services that is centered on the individual served can help organizations assess and enhance the activation of the individual. Achieving this requires leadership engagement in the effort to establish person-centered care as a top priority throughout the organization. This includes adopting the following principles:[34]

- Safety for the individual guides all decision making.
- Individuals served and families are partners at every level of care, treatment, or services.
- Person- and family-centered care, treatment, or services is verifiable, rewarded, and celebrated.
- The staff responsible for the care, treatment, or services of the individual served discloses to the individual, or his or her designee, and the family any unanticipated outcomes of care, treatment, or services.

- Though Joint Commission standards do not require apology, evidence suggests that individuals served benefit—and are less likely to pursue litigation—when organizations disclose harm, express sympathy, and apologize.
- Staffing levels are sufficient, and staff has the necessary tools and skills.
- The organization has a focus on measurement, learning, and improvement.
- Staff must be fully engaged in person- and family-centered care, treatment, or services as demonstrated by their skills, knowledge, and competence in compassionate communication.
- Staff are educated on trauma-informed/recovery/resilience concepts/principles.

Organizations can adopt a number of strategies to support and improve the activation of individuals served, including promoting culture change, adopting transitional care, treatment, or services models, and leveraging health information technology capabilities.[34]

A number of Joint Commission standards address the rights of the individual served and provide an excellent starting point for organizations seeking to improve the activation of these individuals. These standards require that organizations do the following:

- Respect, protect, and promote the rights of the individual (Standard **RI.01.01.01**)
- Respect the right of the individual served to receive information in a manner he or she understands (Standard **RI.01.01.03**)
- Respect the right of the individual to collaborate in decisions about his or her care, treatment, or services (Standard **RI.01.02.01**)
- Honor the right of the individual to give or withhold informed consent (Standard **RI.01.03.01**)
- Inform the individual about his or her responsibilities related to his or her care, treatment, or service (Standard **RI.02.01.01**)

Beyond Accreditation: The Joint Commission Is Your Safety Partner

To assist organizations on their journey toward creating highly reliable safety systems for individuals, The Joint Commission provides many resources, including the following:

- *Office of Quality and Patient Safety*: An internal Joint Commission department that offers organizations guidance and support when they experience a sentinel event. The Office of Quality and Patient Safety assesses the thoroughness and credibility of

an organization's comprehensive systematic analysis as well as the action plan to help the organization prevent the hazardous or unsafe conditions from occurring again.

- *Joint Commission Center for Transforming Healthcare*: A Joint Commission not-for-profit affiliate that offers highly effective, durable solutions to some of health care's most critical safety and quality problems to help organizations transform into high reliability organizations. For specific quality and safety issues the Center's Targeted Solutions Tool® (TST) guides organizations through a step-by-step process to measure their organization's performance, identify barriers to excellence, and direct them to proven solutions. Two TSTs include hand hygiene and handoff communications. For more information, visit http://www.centerfortransforminghealthcare.org.
- *Standards Interpretation Group*: An internal Joint Commission department that helps organizations with their questions about Joint Commission standards. First, organizations can see if other organizations have asked the same question by accessing the Standards FAQs at https://www.jointcommission.org/standards/standard-faqs/. Thereafter, organizations can submit questions about standards to the Standards Interpretation Group by completing an online form at https://web.jointcommission.org/sigsubmission/sigonlineform.aspx.
- *National Patient Safety Goals*: The Joint Commission's yearly patient safety requirements based on data obtained from the Joint Commission's Sentinel Event Database and recommended by a panel of patient safety experts. (For a list of the current National Patient Safety Goals, go to http://www.jointcommission.org/standards_information/npsgs.)
- *Sentinel Event Alert*: The Joint Commission's periodic alerts with timely information about similar, frequently reported sentinel events, including root causes, applicable Joint Commission requirements, and suggested actions to prevent a particular sentinel event. (For archives of previously published *Sentinel Event Alerts*, go to http://www.jointcommission.org/sentinel_event.aspx.)
- *Quick Safety*: Quick Safety is a monthly newsletter that outlines an incident, topic, or trend in care, treatment, or services that could compromise the safety of an individual served. https://www.jointcommission.org/resources/news-and-multimedia/newsletters/newsletters/quick-safety/
- *Joint Commission Resources*: A Joint Commission affiliate that produces books and periodicals, holds conferences, provides consulting services, and develops software products for accreditation and survey readiness. (For more information, visit http://www.jcrinc.com.)

- *Webinars and podcasts*: The Joint Commission and its affiliate, Joint Commission Resources, offer free webinars and podcasts on various accreditation and safety topics.
- *Speak Up™ program*: The Joint Commission's campaign to educate individuals served and patients about processes and potential safety issues and encourage them to speak up whenever they have questions or concerns about their safety. (For more information and education resources, go to http://www.jointcommission.org/speakup.)
- *Joint Commission web portals*: Through the Joint Commission website, organizations can access web portals with a repository of resources from The Joint Commission, the Joint Commission Center for Transforming Healthcare, Joint Commission Resources, and Joint Commission International on the following topics:
  - Emergency management: https://www.jointcommission.org/resources/patient-safety-topics/emergency-management/
  - High reliability: http://www.jointcommission.org/highreliability.aspx
  - Infection prevention and health care–associated infections (HAI): http://www.jointcommission.org/hai.aspx
  - Transitions of care, treatment, or services: http://www.jointcommission.org/toc.aspx
  - Workplace violence prevention resources: https://www.jointcommission.org/resources/patient-safety-topics/workplace-violence-prevention/

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Appendix. Key Safety Systems Requirements

A number of Joint Commission standards have been discussed in the "Safety Systems for Individuals Served" (SSIS) chapter. However, many Joint Commission requirements address issues related to the design and management of safety systems, including the following examples.

Environment of Care (EC)

Standard EC.04.01.01

The organization collects information to monitor conditions in the environment.

Elements of Performance for EC.04.01.01

1. The organization establishes a process(es) for continually monitoring, internally reporting, and investigating the following:
   - Injuries to individuals served or others within the organization's facilities
   - Occupational illnesses and staff injuries
   - Incidents of damage to its property or the property of others in locations it controls
   - Security incidents involving individuals served, staff, or others in locations it controls
   - Fire safety management problems, deficiencies, and failures

   Note 1: *All the incidents and issues listed above may be reported to staff in quality assessment, improvement, or other functions. A summary of such incidents may also be shared with the person designated to coordinate safety management activities.*

   Note 2: *Review of incident reports often requires that legal processes be followed to preserve confidentiality. Opportunities to improve care, treatment, or services, or to prevent similar incidents, are not lost as a result of following the legal process.*

Based on its process(es), the organization reports and investigates the following:

2. Problems and incidents related to each of the environment of care management plans.

3. Injuries to individuals served or others within the organization's facilities.
4. Occupational illnesses and staff injuries.

   Note: *This requirement applies to issues in the workplace, such as back injuries or allergies. It does not apply to communicable diseases.*

5. Incidents of damage to its property or the property of others in locations it controls.

14. The organization monitors environmental deficiencies, hazards, and unsafe practices.

15. Ⓓ Every 12 months, the organization evaluates each environment of care management plan, including a review of the plan's objectives, scope, performance, and effectiveness.

    Note: *By evaluating the management plans, the organization can make sure that they remain relevant and useful guides for managing the environment of care. A review of the plans' scope includes a determination of whether any new services, programs, or sites added in the past year need to be addressed by the plans or if new hazards have been introduced into the environment that now need to be covered. A review of the plans' effectiveness could be accomplished through a review of incident reports as well as evaluation of other known problems that are not found on the incident reports (such as problems identified in the critique of a fire drill). A review of the plans' objectives would include a determination of whether the previous year's objectives were met and if any new objectives should be established to address problems identified in the review of the plans' effectiveness.*

Standard EC.04.01.03

The organization analyzes identified environment of care issues.

Elements of Performance for EC.04.01.03

2. The organization uses the results of data analysis to identify opportunities to resolve environmental safety issues.

Standard EC.04.01.05

The organization improves its environment of care.

Elements of Performance for EC.04.01.05

1. The organization takes action on the identified opportunities to resolve environmental safety issues.

Infection Prevention and Control (IC)

Standard IC.01.03.01

The organization identifies risks for acquiring and spreading infections.

Elements of Performance for IC.01.03.01

1. The organization identifies infection risks based on the following:
   - Its setting and population served
   - The care, treatment, or services it provides
   - **For 24-hour care settings:** Its monitoring of infection prevention and control activities and/or tracking and analyzing the occurrence of infections

   Note 1: *The infections that should be tracked are those that are most relevant to the organization's setting, services, and population(s). The organization may contact its local health department for statistics and other information on some infections, and track other infections internally. For example, an organization may decide to track conjunctivitis itself but rely on health department statistics related to tuberculosis.*

   Note 2: *The risk of infection will vary across behavioral health care or human services settings. For example, infection risks in group homes, day treatment programs, foster care homes, and couples counseling will vary by hours of contact, number of individuals served, and location and type of service.*

3. Ⓓ The organization establishes priorities among the risks it identified. The organization documents priority risk(s).

Leadership (LD)

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

1. Leaders regularly evaluate the culture of safety and quality.
2. Leaders prioritize and implement changes identified by the evaluation.
4. Ⓓ Leaders develop a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety.
5. Leaders create and implement a process for managing behaviors that undermine a culture of safety.
8. All who work in the organization are able to openly discuss issues of safety and quality. (*See also* LD.03.09.01, EP 3)

Standard LD.03.02.01

The organization uses data and information to guide decisions and to understand variation in the performance of processes supporting safety and quality.

Elements of Performance for LD.03.02.01

1. Leaders set expectations for using data and information for the following:
   - Improving the safety and quality of care, treatment, or services
   - Creating a culture of safety and quality
   - Decision making that supports the safety and quality of care, treatment, or services
   - Identifying and responding to internal and external changes in the environment
2. Leaders evaluate how effectively data and information are used throughout the organization.

Standard LD.03.04.01

The organization communicates information related to safety and quality to those who need it, including staff, individuals served, families, and external interested parties.

Elements of Performance for LD.03.04.01

1. Communication processes are effective in doing the following:
   - Fostering the safety of the individual served and his or her quality of care
   - Supporting a culture of safety and quality
   - Meeting the needs of internal and external users
   - Informing those who work in the organization of changes in the environment
2. Leaders evaluate the effectiveness of communication methods.

Standard LD.03.07.01

Leaders establish priorities for performance improvement. (Refer to the "Performance Improvement" [PI] chapter.)

Elements of Performance for LD.03.07.01

1. Performance improvement occurs organizationwide.
2. As part of performance improvement, leaders do the following:
   - Set priorities for performance improvement activities and patient health outcomes
   - Give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities
   - Reprioritize performance improvement activities in response to changes in the internal or external environment

   Note 1: *For child welfare agencies, patient health outcomes for children and youth might include placement in permanent family homes, long-term functional outcomes, contact with family members, parent satisfaction, child and youth satisfaction, and foster parent satisfaction.*

   Note 2: *For child welfare agencies, examples of high-volume, high-risk, or problem-prone process include multiple placements (placement instability), elopement/runaway, and aggressive/violent behaviors.*

   *(*See also *CTS.03.01.09, EP 3; PI.01.01.01, EPs 1, 2, 12, 13, 20)*

21. **For organizations that elect The Joint Commission Behavioral Health Home option:** Leaders set priorities for physical health care performance improvement activities and outcomes. (*See also* PI.01.01.01, EP 28)

    Note: *As an example, activities and outcomes may be related to individuals with multiple chronic physical health conditions.*

22. **For organizations that elect The Joint Commission Behavioral Health Home option:** Leaders involve individuals served in performance improvement activities related to integrated care.

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

Standard LD.03.09.01

The organization has an organizationwide, integrated safety program for individuals served.

Elements of Performance for LD.03.09.01

1. The leaders implement an organizationwide safety program for individuals served as follows:
   - One or more qualified persons manage the safety program.
   - All programs and services within the organization participate in the safety program.
   - The scope of the safety program includes the full range of safety issues, from potential or no-harm errors (sometimes referred to as close calls ["near misses"] or good catches) to hazardous conditions and sentinel events.
2. As part of the safety program, the leaders create procedures for responding to system or process failures.

   Note 1: *Responses might include continuing to provide care, treatment, or services to those affected, containing the risk to others, and preserving factual information for subsequent analysis.*

   Note 2: ***For opioid treatment programs:*** *Examples of reportable patient deaths include the following:*
   - *Drug-related deaths*
   - *Methadone or buprenorphine deaths*
   - *Unexpected or suspicious deaths*

- *Treatment-context deaths that raise individual, family, community, or public concern*

3. 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.03.08.01, EP 1)

   Note: *This EP is intended to minimize staff reluctance to report errors in order to help an organization understand the source and results of system and process failures. The EP does not conflict with holding individuals accountable for their blameworthy errors.*

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

   Note: *At a minimum, the organization's definition includes those events subject to review as described in the "Sentinel Events" (SE) chapter of this manual.*

5. The organization conducts thorough and credible comprehensive systematic analyses (for example, root cause analyses) in response to sentinel events as described in the "Sentinel Events" (SE) chapter of this manual.

6. The leaders make support systems available for staff who have been involved in an adverse or sentinel event.

   Note: *Support systems recognize that staff 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 staff.*

8. To improve safety, the organization analyzes and uses information about system or process failures and, when conducted, the results of proactive risk assessments. (*See also* LD.03.08.01, EP 1)

9. The leaders disseminate lessons learned from comprehensive systematic analyses (for example, root cause analyses), system or process failures, and the results of proactive risk assessments to all staff who provide care, treatment, or services related to the specific situation.

10. Ⓓ 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 individuals served and the families were informed of the event
- All actions taken to improve safety, both proactively and in response to actual occurrences

11. The leaders encourage external reporting of significant adverse events, including voluntary reporting programs in addition to mandatory programs.

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

Standard LD.04.01.05

The organization effectively manages its programs or services.

Elements of Performance for LD.04.01.05

4. Staff are held accountable for their responsibilities.

Medication Management (MM)

Standard MM.08.01.01

The organization evaluates the effectiveness of its medication management system.

Note 1: *This evaluation includes reconciling medication information. (Refer to NPSG.03.06.01 for more information)*

Note 2: *This standard is applicable only to organizations that prescribe, dispense, or administer medications.*

Elements of Performance for MM.08.01.01

1. **For organizations that prescribe, dispense, or administer medications:** As part of its evaluation of the effectiveness of medication management, the organization does the following: R
    - Collects data on the performance of its medication management system (*See also* PI.01.01.01, EPs 12 and 13)
    - Analyzes data on its medication management system
    - Compares data over time to identify risk points, levels of performance, patterns, trends, and variations of its medication management system

Note: *This element of performance is also applicable to sample medications.*

5. **For organizations that prescribe, dispense, or administer medications:** Based on analysis of its data, the organization identifies opportunities for improvement in its medication management system. R

6. **For organizations that prescribe, dispense, or administer medications:** When opportunities are identified for improvement of the medication management system, the organization does the following: R
   - Takes action on improvement opportunities identified as priorities for its medication management system (Refer to PI.03.01.01, EP 2)
   - Evaluates its actions to confirm that they resulted in improvements

   Note: *This element of performance is also applicable to sample medications.*

8. **For organizations that prescribe, dispense, or administer medications:** The organization takes additional action when planned improvements for its medication management processes are either not achieved or not sustained. R

16. Ⓓ When automatic dispensing cabinets (ADCs) are used, the organization has a policy that describes the types of medication overrides that will be reviewed for appropriateness and the frequency of the reviews. A 100% review of overrides is not required.

Performance Improvement (PI)

Standard PI.01.01.01

The organization collects data to monitor its performance.

Elements of Performance for PI.01.01.01

1. The leaders set priorities for and identify the frequency of data collection. (*See also* LD.03.07.01, EP 2)

The organization collects data on the following:

12. Significant medication errors. (*See also* LD.03.07.01, EP 2; MM.08.01.01, EP 1)

13. Significant adverse medication reactions. (*See also* LD.03.07.01, EP 2; MM.08.01.01, EP 1)

14. The organization collects data on the following:
    - Whether the individual served was asked about treatment goals and needs
    - Whether the individual served was asked if his or her treatment goals and needs were met
    - The view of the individual served regarding how the organization can improve the safety of the care, treatment, or services provided

    (*See also* RI.01.01.01, EP 17, for opioid treatment programs)

    Note: *Collecting data from the individual served supports the concepts of being focused on trauma-informed care, recovery, and resilience and is a significant data source for organization performance improvement.*

20. The organization collects data to measure the performance of high-risk, high-volume, problem-prone processes provided to high-risk or vulnerable populations, as defined by the organization. (*See also* LD.03.07.01, EP 2)

    Note 1: *Examples of such processes include the use of restraints, seclusion, suicide watch, and behavior management and treatment.*

    Note 2: *For child welfare agencies, examples of high-risk, high-volume, or problem-prone populations include individuals with a history of multiple placements (that is, placement instability), elopements, or aggressive/violent behaviors.*

22. **For child welfare:** The agency collects data on the following:
    - Its performance, including the safety of the placement and the maintenance or improvement of the individual's level of functioning.
    - The permanency of the placement and the permanency of outcome when they are within the organization's scope of services.

27. **For opioid treatment programs:** The program collects data about treatment outcomes and processes.

    Note: *Examples of data collected include the following:*
    - *Use of illicit opioids, illegal drugs, and the problematic use of alcohol and prescription medications*
    - *Criminal activities and entry into the criminal justice system*
    - *Behaviors contributing to the spread of infectious diseases*
    - *Restoration of physical and mental health and functional status*
    - *Retention in treatment*
    - *Number of patients who are employed*

- *Abstinence from drugs of abuse*

For organizations that elect The Joint Commission Behavioral Health Home option: The organization collects data on the following:

28. Disease management outcomes. (*See also* LD.03.07.01, EP 21)

29. The individual's access to care within time frames established by the organization.

30. Ⓓ **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization collects data on the following:
    - The individual's experience and satisfaction related to access to care, treatment, or services and communication
    - The individual's perception of the comprehensiveness of care, treatment, or services
    - The individual's perception of the coordination of care, treatment, or services
    - The individual's perception of the continuity of care, treatment, or services

    (Refer to PI.01.01.01, EP 14)

31. **For organizations that elect The Joint Commission Behavioral Health Home option:** All staff who are part of the behavioral health home actively participate in performance improvement activities.

36. **For organizations that provide eating disorders care, treatment, or services:** The organization collects data about care, treatment, or services outcomes. Examples of such data include the following:
    - If conducting follow-ups, confirmation of whether the individual is engaged in aftercare services and, if so, the type and frequency of those services.
    - Data collected from valid and reliable instruments used at admission and discharge that are self-administered by individuals served. Examples of such instruments include the Beck Depression Inventory (BDI), Eating Disorder Quality of Life (EDQOL), the SF-36, and Eating Disorder Inventory-3 (EDI-3).
    - Data collected from individuals' satisfaction questionnaires.

Standard PI.03.01.01

The organization improves performance.

Elements of Performance for PI.03.01.01

2. The organization takes action on improvement priorities. (*See also* MM.08.01.01, EP 6)

4. The organization takes action when it does not achieve or sustain planned improvements.

11. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization uses the data it collects on the individual's perception of the safety and quality of care, treatment, or services to improve its performance. This data includes the following:
    - The individual's experience and satisfaction related to access to care, treatment, or services and communication
    - The individual's perception of the comprehensiveness of care, treatment, or services
    - The individual's perception of the coordination of care, treatment, or services
    - The individual's perception of the continuity of care, treatment, or services

Record of Care, Treatment, and Services (RC)

Standard RC.02.01.05

The clinical/case record contains documentation of the use of restraint and/or seclusion and documentation of physical holding of a child or youth.

Elements of Performance for RC.02.01.05

3. The organization documents the use of restraint and/or seclusion for behavioral health purposes in the clinical/case record, including the following:
    - Each episode of restraint and/or seclusion
    - The circumstances that led to the use of restraint and/or seclusion
    - Consideration or failure of nonphysical interventions
    - The rationale for the type of physical intervention used
    - Written orders for the use of restraint and/or seclusion
    - Each verbal order received from a licensed independent practitioner
    - Each in-person evaluation and reevaluation of the individual served

- Each 15-minute assessment of the status of the individual served
- Continuous monitoring of the individual served
- Any preexisting medical conditions or any physical disabilities that would place the individual served at greater risk during restraint and/or seclusion
- Any history of sexual or physical abuse that would place the individual at greater psychological risk during restraint and/or seclusion
- That the individual served and/or his or her family was informed of the organization's policy on the use of behavioral restraint and/or seclusion
- That the individual served was notified of the use of restraint and/or seclusion
- Behavior criteria for discontinuing restraint and/or seclusion
- That the individual served was informed of the behavior criteria he or she needed to meet in order for restraint and/or seclusion to be discontinued
- Assistance provided to the individual served to help him or her meet the behavior criteria for discontinuing the use of restraint and/or seclusion
- Debriefing the individual served with staff following an episode of restraint and/or seclusion
- Any injuries the individual served sustained and the treatment for these injuries
- The death of the individual served while in restraint or seclusion

4. The method(s) used to document restraint and/or seclusion facilitates the collection and analysis of data for performance improvement activities.

5. Ⓓ The organization documents the use of physical holding of a child or youth for behavioral health purposes in the clinical/case record, including the following:
   - Each episode of physical holding
   - The circumstances that led to the use of physical holding
   - Attempt at or failure of nonphysical interventions
   - The rationale for the use of physical holding
   - Names of the staff members who participated in the use of physical holding, including who did the holding and who observed the child's or youth's physical well-being
   - Any preexisting medical conditions or any physical disabilities that would place the individual served at greater risk during physical holding
   - Any history of sexual or physical abuse or other trauma that would place the individual at greater psychological risk during physical holding
   - That the individual served and/or his or her family was informed of the organization's policy on the use of physical holding

- That the individual's parent(s) or guardian was notified of the use of physical holding
- Behavior criteria for discontinuing physical holding
- That the individual served was informed of the behavior criteria he or she needed to meet in order for physical holding to be discontinued
- Assistance provided to the individual served to help him or her meet the behavior criteria for discontinuing the use of physical holding
- Debriefing the individual served with staff following an episode of physical holding
- Any injuries the individual served sustained and the treatment for these injuries
- The death of the individual served while in a physical hold

6. The method(s) used to document physical holding facilitates the collection and analysis of data for performance improvement activities.

Rights and Responsibilities of the Individual (RI)

Standard RI.01.01.01

The organization respects the rights of the individual served.

Elements of Performance for RI.01.01.01

1. Ⓓ The organization has written policies on the rights of the individual served.
2. The organization informs the individual served of his or her rights. (*See also* RI.01.01.03, EPs 1–3)
3. If an individual served is disoriented or lacks capacity to understand rights at the time of entry, he or she is informed again when he or she is able to understand.
4. The organization treats the individual served in a respectful manner that supports his or her dignity.
6. The organization respects the cultural and personal values, beliefs, and preferences of the individual served.
7. The organization respects the right of the individual served to privacy.

Note: *This element of performance (EP) addresses the personal privacy of the individual served. For EPs addressing security and safety, refer to EC.02.01.01, EP 3 and EC.02.06.01, EP 1. For EPs addressing the privacy of clinical/case information, refer to Standard IM.02.01.01. (*See also *IM.02.01.01, EPs 1, 3, 4)*

9. In 24-hour settings, the organization accommodates the right of the individual to pastoral and other spiritual services.

   Note: *The spiritual services of individuals are varied and may take place in the setting or outside of the setting, and may require special considerations regarding scheduling, space, or other accommodations. Within its capabilities, the organization accommodates this right.*

10. In accordance with law and regulation, the organization allows the individual served to access and request amendment to his or her clinical/case information and to obtain information on disclosures of this information.

14. **For opioid treatment programs:** The program reviews rights and responsibilities with the patient at admission, at the end of the stabilization period, and when any changes have been made to the list of rights and responsibilities.

15. **For opioid treatment programs:** The program treats women respectfully and safely.

16. **For opioid treatment programs:** The medication schedule (dosing times/program hours) is the least intrusive and disruptive schedule for the majority of patients.

17. **For opioid treatment programs:** Satisfaction surveys allow patients to provide feedback on program policies and services. (*See also* PI.01.01.01, EP 14)

18. In 24-hour settings, individuals served are informed about the organization's policies and procedures regarding the handling of medical emergencies. (*See also* RI.01.02.01, EP 2)

20. Ⓓ **For opioid treatment programs:** The program obtains written acknowledgement from patients that they received a copy of their rights and that these rights were discussed with them.

22. The organization informs the individual served of the program rules.

24. **For opioid treatment programs:** The program informs patients about the financial aspects of treatment, including the consequence of nonpayment of fees.

25. Ⓓ **For opioid treatment programs:** The program posts patients' rights and responsibilities at the treatment site in a manner that makes the posting visible to patients.

26. **For opioid treatment programs:** The program informs patients upon admission about its obligation under state-specific requirements and its own policies and procedures to report suspected child abuse and neglect and other forms of abuse (such as violence against women).

30. **For organizations that provide 24-hour eating disorders care, treatment, or services:** The organization has a policy addressing those situations, if any, in which minors are permitted to leave the facility.

31. **For organizations that provide 24-hour eating disorders care, treatment, or services:** The organization obtains consent from a minor's parent or guardian for the minor to have visitors.

32. **For organizations that provide 24-hour eating disorders care, treatment, or services:** The organization has a policy on Internet access for individuals served.

Standard RI.01.01.03

The organization respects the right of the individual served to receive information in a manner he or she understands.

Elements of Performance for RI.01.01.03

1. The organization provides information to the individual served in a manner tailored to his or her language and ability to understand. (*See also* CTS.06.02.03, EP 9; RI.01.01.01, EP 2)

2. The organization provides interpreting and translation services, as necessary. (*See also* RI.01.01.01, EP 2)

   Note: ***For organizations that elect The Joint Commission Behavioral Health Home option:*** *Language interpreting options may include trained bilingual staff, contract interpreting services, or employed language interpreters. These options may be provided in person or via telephone or video. The documents that are translated, and the languages into which they are translated, are dependent on the population(s) served by the organization.*

3. The organization communicates with the individual served who has vision, speech, hearing, or cognitive impairments in a manner that meets the needs of that individual. (*See also* RI.01.01.01, EP 2)

Standard RI.01.02.01

The organization respects the right of the individual served to collaborate in decisions about his or her care, treatment, or services.

Elements of Performance for RI.01.02.01

1. The organization involves the individual served in making decisions about his or her care, treatment, or services.

   Note: *This involvement goes beyond mere presence at the time of discussion or decision making. Involvement connotes a collaborative process in which the organization actively engages the individual served in decision making regarding his or her care, treatment, or services.*

2. When an individual served is unable to make decisions about his or her care, treatment, or services, or chooses to delegate decision making to another, the organization involves the surrogate decision-maker in making these decisions. (*See also* RI.01.03.01, EP 1; RI.01.01.01, EP 18)

4. The organization respects the right of the individual served or surrogate decision-maker to refuse care, treatment, or services, in accordance with law and regulation.

5. When an individual refuses care, treatment, or services, the organization fully informs the individual about its responsibility, in accordance with professional standards, to terminate the relationship with the individual upon reasonable notice, or to seek orders for involuntary treatment or other legal alternatives.

8. The individual served has the right to involve his or her family in decisions about care, treatment, or services. When there is a surrogate decision-maker, he or she can exercise the right to involve the family on behalf of the individual served, in accordance with law and regulation.

9. The organization accommodates the right of the individual served to request the opinion of a consultant.

   Note: *This element of performance does not require the organization to pay for consultant services.*

10. The organization accommodates the right of the individual served to request an internal review of his or her plan of care, treatment, or services.

11. The organization has a process for resolving disagreements about therapeutic issues.

20. The organization provides the individual served or surrogate decision-maker with the information about the following:
    - Outcomes of care, treatment, or services that the individual needs to participate in current and future decisions about his or her care, treatment, or services
    - Unanticipated events related to the individual's care, treatment, or services that are sentinel events as defined by The Joint Commission (Refer to the Glossary for a definition of sentinel event.)

28. **For opioid treatment programs:** The program allows for patient choice in seeking alternative therapies and provides support to patients who choose to explore these alternatives.

    Note: *Programs may provide culturally appropriate or popular and nonharmful alternative therapies, such as acupuncture or providing a space for a sweat lodge.*

31. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization provides the individual served or surrogate decision-maker with the information about the outcomes of care, treatment, or services that the individual needs in order to participate in current and future physical health care decisions.

32. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization respects the individual's right to make decisions about the management of his or her care, treatment, or services.

33. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization respects the individual's right and provides him or her the opportunity to do the following:
    - Obtain care from other clinicians of the individual's choosing within the behavioral health home
    - Seek a second opinion from a clinician of the individual's choosing
    - Seek specialty care

Note: *This element of performance does not imply financial responsibility on the part of the organization for any activities associated with these rights.*

34. **For opioid treatment programs:** The program provides the patient with information about providers in the community who are able to address any of the patient's needs that the program cannot meet.

35. **For opioid treatment programs:** The program provides the patient with information about providers in the community should the patient be dissatisfied with the services received from the program.

Standard RI.01.03.01

The organization honors the right of the individual served to give or withhold informed consent.

Elements of Performance for RI.01.03.01

1. Ⓓ The organization follows a written policy on informed consent that describes the following:
   - The specific care, treatment, or services that require informed consent
   - Circumstances that would allow for exceptions to obtaining informed consent, such as situations involving threat of harm to self or others, child abuse, or elder abuse
   - When a surrogate decision-maker may give informed consent (*See also* RI.01.02.01, EP 2)

2. The informed consent process includes a discussion about the following:
   - The proposed care, treatment, or services for the individual served.
   - The goals and potential benefits and risks of the proposed care, treatment, or services.
   - Reasonable alternatives to the individual's proposed care, treatment, or services. The discussion encompasses risks and benefits related to the alternatives and the risks related to not receiving the proposed care, treatment, or services.

3. Ⓓ The organization obtains and documents informed consent in advance if it makes and uses recordings, films, or other images of individuals served for internal use other than the identification, diagnosis, or treatment of the

individual (for example, performance improvement and education). This informed consent includes an explanation of how the recordings, films, or other images will be used.

Note 1: *The term "recordings, films, or other images" refers to photographic, video, digital, electronic, or audio media.*

Note 2: *This element of performance does not apply to the use of security cameras.*

16. **For opioid treatment programs:** Before administering medication, the program obtains voluntary, written, informed consent from the patient for the prescribed medication-assisted treatment. The program's informed consent policy makes certain that each patient voluntarily chooses maintenance treatment and that all relevant facts concerning the use of the opioid drug are clearly and adequately explained to the patient. Within 30 days post-admission, an appropriate program staff member reviews all relevant facts concerning the use of the opioid drug with the patient.

17. **For opioid treatment programs:** The program informs patients that the goal of medication-assisted treatment is to stabilize functioning.

18. **For opioid treatment programs:** The program informs patients that the provider will periodically discuss with them their present level of functioning, course of treatment, and future goals.

    Note: *These discussions are not intended to place pressure on the patient to either withdraw from medication or remain on medication maintenance.*

19. **For opioid treatment programs:** Patients are informed about their disease's natural progression, including statistics about success after withdrawing from methadone.

20. **For opioid treatment programs:** The program informs patients about potential medication interactions with and adverse reactions to other substances, including those related to the use of alcohol, licit and illicit drugs, other prescribed or over-the-counter pharmacological agents, other medical procedures, and food.

    Note: *The program should provide the patient with information about potential medication interactions throughout the course of care, treatment, or services, such as at the time of the treatment plan review and at the time there are changes to the patient's medication dose.*

21. **For opioid treatment programs:** The program informs all pregnant patients with concurrent HIV infection that HIV medication treatment is currently recommended to reduce perinatal transmission, and it provides pregnant patients with appropriate referrals and case management for this treatment.

Standard RI.01.05.01

For organizations that elect The Joint Commission Behavioral Health Home option: The organization addresses decisions made by the individual served about physical health care, treatment, or services received at the end of life. (For more information, refer to Standard CTS.01.04.01.)

Elements of Performance for RI.01.05.01

1. Ⓓ **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization follows a written policy on physical health advance directives that address the following:
   - Whether the organization will honor physical health advance directives
   - Communicating its policy on physical health advance directives to the individuals it serves
   - **For organizations that elect The Joint Commission Behavioral Health Home option:** Informing all members of the integrated care team when an individual served has a physical health advance directive, and how to access it

10. **For organizations that elect The Joint Commission Behavioral Health Home option:** Upon request, the organization shares with the individual possible sources of help in formulating physical health advance directives.

Standard RI.02.01.01

The organization informs the individual served about his or her responsibilities related to his or her care, treatment, or services.

Elements of Performance for RI.02.01.01

2. The organization informs the individual served about his or her responsibilities.

   Note: *Information about the individual's responsibilities can be shared verbally, in writing, or both.*

3. Ⓓ **For opioid treatment programs:** The program obtains written acknowledgement from the patient that patient responsibilities were explained.