2018 Joint Commission Hospital Accreditation Update

A JCR Custom Education Program for the New Jersey Hospital Association

October 29, 2018

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The Joint Commission

Mobile Devices

- Please turn off audible ringers as a courtesy to other participants.

Thank you.

Publications and Record Restrictions

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Disclosure Statement

- The following staff and speakers have disclosed that neither they nor their spouses/partners have any financial arrangements or affiliations with corporate organizations that either provide educational grants to this program or may be referenced in this activity:
  - Randy Blanchard
- Furthermore, each of the previously named speakers has also attested that their discussions will not include any unapproved or off-label use of products.

Successful Program Completion

- Attendance at this program, in its entirety, is required in order to obtain the available CEs.
- You may receive an e-mail from

  support@feedback.satmetrix.com

  inviting you to complete our evaluation form.
  - Please watch for it – it's not spam!
  - We want to know what we did right and what we can do better.

Program Objectives

Upon completion of this program, participants will be able to:

1. Describe the most commonly-cited findings for 2018
2. Discuss the pending accreditation changes for 2019
3. Discuss significant challenges associated with The Joint Commission accreditation standards and elements of performance
4. Articulate strategies to engage leadership in continuous accreditation readiness

It is not about the survey.

It is about always being

ready for the next patient

Accreditation Updates and Changes

New and/or Notable

Inclusion of Physician Practices

- Only if the physician practice is included in the hospital's Medicare cost report (under the same CCN#)
- Hospitals may choose to include physician practices in the survey

Text Messaging

- CMS Survey & Certification Letter 18-10 (1/5/2018)
  - Texting of patient orders is prohibited regardless of the platform used
  - Texting of patient information between members of the care team is permissible if accomplished through a secure platform
  - CPOE is the preferred method of entry of orders by a provider

** *Applicable to Hospitals and CAHs*

Top 2018 Findings – Hospital

LS.02.01.35	88%	The hospital provides and maintains systems for extinguishing fires.
EC.02.05.01	80%	The hospital manages risks associated with its utility systems.
IC.02.02.01	74%	The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.
EC.02.06.01	73%	The hospital establishes and maintains a safe, functional environment. Note: The environment is constructed, arranged, and maintained to foster patient safety, provide facilities for diagnosis and treatment, and provide for special services appropriate to the needs of the community.
LS.02.01.30	72%	The hospital provides and maintains building features to protect individuals from the hazards of fire and smoke.
LS.02.01.10	69%	Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.
LS.02.01.20	66%	The hospital maintains the integrity of the means of egress.
EC.02.05.05	64%	The hospital inspects, tests, and maintains utility systems. Note: At times, maintenance is performed by an external service. In these cases, hospitals are not required to possess maintenance documentation but must have access to such documentation during survey and as needed.
IC.02.01.01	61%	The hospital implements its infection prevention and control plan.
EC.02.02.01	61%	The hospital manages risks related to hazardous materials and waste.

Change Effective July 2018

- **The hospital assesses and reassesses its patients, PC.01.02.01**
- 14, For hospitals that provide obstetric services: Upon admission to labor and delivery, the mother's status of the following diseases (during the current pregnancy) is documented in the mother's medical record:
  - Human immunodeficiency virus (HIV)
  - Hepatitis B
  - Group B streptococcus (GBS)
  - Syphilis

Change Effective July 2018 cont.

- 15. For hospitals that provide obstetric services: If the mother had no prenatal care or the disease status is unknown, testing for the following diseases are performed and the results documented in the mother's medical record:
  - Human immunodeficiency virus (HIV)
  - Hepatitis B
  - Group B Streptococcus (GBS)
  - Syphilis

  Note: Because GBS test results may not be available for 24-48 hours, organizations may elect not to perform this test but instead administer prophylactic antibiotics to the mother.
- 16. For hospitals that provide obstetric services: If the mother tests positive for human immunodeficiency virus (HIV), hepatitis B, group B streptococcus (GBS), or syphilis when tested in labor and delivery or during the current pregnancy, that information is also documented in the newborn's medical record after delivery.

Changes Effective Jan 2019

- NPSG.01.01.01, EP 3; Use distinct methods of identification for newborn patients
- EC.02.04.03 The hospital inspects, tests, and maintains medical equipment
  - 21/34 CT quality control
- HR.01.05.03 Staff participate in ongoing education and training
  - 14. definition of who performs CT
  - 15. required CE for persons performing fluoroscopy

Changes Effective Jan 2019

- LD.04.01.05; The hospital effectively manages its programs, services, sites, or departments
  - 25. Designate a radiation safety officer
- PC.01.02.15; The hospital provides for diagnostic testing
  - Documentation of cumulative dosing for fluoroscopy
- PC.01.03.01; The hospital plans the patient's care
  - 25. CT protocols revision

Changes Effective Jan 2019

- PC.02.01.01; The hospital provides care, treatment, and services for each patient
  - 30. Fluoroscopy skin exposure review requirements
- PI.02.01.01; The hospital compiles and analyzes data
  - 20. Review excess fluoroscopy exposures

Changes Effective Jan 2019

- Significant Changes:
  - Medication Management
  - Nursing
  - Provision of Care

https://www.jointcommission.org/standards_information/prepublication_standards.aspx

Medication Management

- Changes in information available to the provider
- Definition of formulary includes list of medications available for use
- Process to acquire medications not on formulary
- Emergency medications EPs consolidated into 1 EP, leaders and providers define emergency medications to stock
- New requirements for medication order elements
- Consolidation of EPs regarding pharmacist review of medication orders

Medication Management cont.

- Requirements for therapeutic duplication
- Requirements for medication labeling
- Obtaining medications when the pharmacy is closed
- Medication administration
- Review of the medication process

Nursing

- EP consolidation for nursing executive oversight of services
- EP consolidation regarding standards of care
- EP consolidation regarding guidelines for nursing care

Provision of Care

- EP consolidation for hospitals accepting patients for care, treatment and services
- EP consolidation for timeframe for initial assessment
- EP consolidation for abuse and neglect assessment
- EP consolidation for patients being treated for alcoholism and substance abuse
- EP consolidation for patients being treated for behavioral management

Provision of Care

- Revision to requirements for responding to changes in patient condition
- EP consolidation regarding care coordination
- Enhanced definition of learning needs assessment
- EP consolidation regarding equipment available for sedation/anesthesia
- EP consolidation regarding tissue specimens removed during surgery
- EP consolidation regarding ECT
- Additional requirements for care after DC/Transfer

High Risk Areas for Continued Accreditation

- Infection Control
- High Level Disinfection & Sterilization
- Ligature Hazards & Suicide Prevention

Infection Prevention and Control (IC)

Infection Control Risk Points

- HAND HYGIENE
- Staff unable to speak to LLD process/requirements
- Not following IC policies and procedures
- Identification of clean vs. dirty
- Storage on the floor, under the sink, bottom shelf with no solid liner
- Mixing clean and dirty items
- Adherence to infectious precautions i.e.. Contact, airborne, droplet

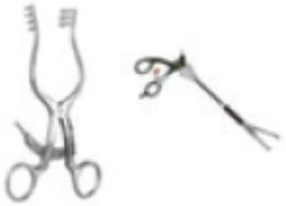
High Level Disinfection & Sterilization

Seeing The Big Picture

Infection Prevention & Control
Medical Equipment, Devices and Supplies

- IC.02.02.01 Implement infection prevention and control activities related to:
  - EP1 Cleaning and performing low-level disinfection
  - EP2 Performing intermediate and high-level disinfection and sterilization
  - EP3 Disposing of medical equipment, devices, and supplies
  - EP4 Storing medical equipment, devices, and supplies

The Spaulding Classification System

Patient Contact	Examples	Device Classification	Minimum Disinfection Level
Intact Skin		Non-Critical	Low Level or Intermediate Level Disinfection
Mucous Membranes or non-intact skin		Semi-Critical	High Level Disinfection
Sterile areas of the body, vascular system		Critical	Sterilization

Sterilization

Instrument Scoring Changes

From Standards Interpretation Group

New scoring revisions for IC.02.02.01

Visible bioburden and dried blood found on instruments	• Wiping / flushing of soiled instruments is not observed during a case in the operating room or procedure room and it is clinically appropriate • Item that is ready for use on a patient is visibly soiled

New scoring revisions for IC.02.02.01

Enzymatic solution was not applied to maintain moisture on instruments	• There is no process for keeping used instruments moist • Manufacturer instructions for products used to keep instruments moist were not followed • The facility policy for keeping instruments moist was not followed

New scoring revisions for IC.02.02.01

Instruments were not transported from the point of use in a leak-proof puncture-resistant container with the biohazard symbol or color red	• Sharps are being transported in a manner that violates OSHA requirements (e.g., sharps not placed in puncture-resistant container that is red or labeled biohazardous) • Non-sharps are transported in a way that could lead to contamination of staff or other people

New scoring revisions for IC.02.02.01

Instruments in the closed position	• Packaged instruments awaiting sterilization are in the closed/ratcheted position • Items that have just undergone sterilization are on the trolley or in the sterilizer in the closed/ ratcheted position • Items in preparation and packaging that have come through the washer or pass-through window have not been disassembled in accordance with manufacturer instructions

New scoring revisions for IC.02.02.01

Instruments are released prior to the biologic indicator being read	• Routine sterilizer monitoring with a biologic indicator required by the state or per evidence-based guideline is not followed and recorded • Non-implant load is released without physical monitoring of cycle and external and internal chemical indicators

New scoring revisions for IC.02.02.01

Instruments are released prior to the biologic indicator being read	• Implant loads are released without routine sterilizer monitoring, a biologic indicator and a type 5 integrating indicator (aka integrator) • Biologic indicator not read before implant release (unless allowed in emergent situations by facility policy and policy was followed)

New scoring revisions for IC.02.02.01

Items in the high level-disinfected area that are stored in drawers	• Container or location of storage is visibly soiled or staff are observed contaminating other high level-disinfected products • Storage is not consistent with the items intended use (e.g., items that require minimum of high-level disinfection may be stored in a way that protects from contamination even if they were sterilized)

New scoring revisions for IC.02.02.01

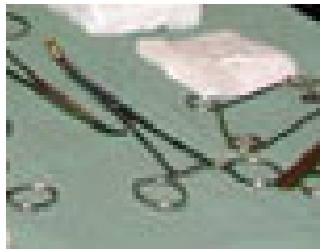
Items in the high level-disinfected area that are stored in drawers	• Item is not stored in accordance with manufacturer instructions for use (IFU) • Item is not stored in accordance with facility risk assessment / policy if no guidance was provided by the item's manufacturer IFU

New scoring revisions for IC.02.02.01

Stored scopes exceeded the hang time	• Facility is not following manufacturer IFU for drying • Facility is not following manufacturer IFU for frequency of reprocessing Will NOT score any finding related to hang time under IC standards

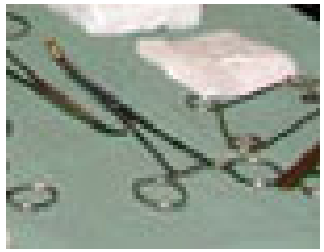
Have Manufacturer Instructions for Use Immediately Available

Flow of an instrument



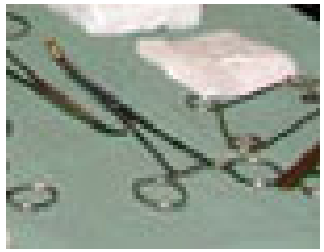
- Initial Cleaning
  - Breaking down bio-burden
    - Enzymatic spray – Enough to cover and wet
    - Keeping ~~wet~~ **Moist**
    - PPE
    - Manufacturer's instructions
    - Timely cleaning
    - Who does this?
    - Training
    - Monitoring

Flow of an instrument

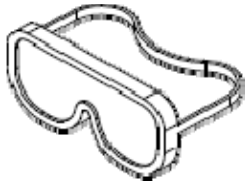


- Transport After Use
  - Covered
    - Case carts
    - Basins and caskets
    - Leak-proof
  - Timely
    - Decentralized systems
  - Labeled
  - PPE

Flow of an instrument

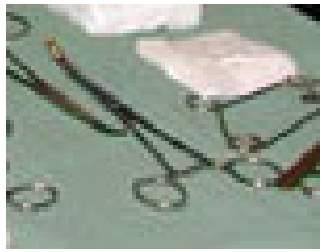


Decontamination



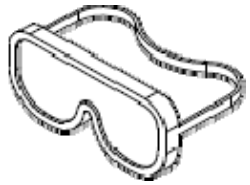
- Air Flow
- PPE
  - High cuffed, industrial gloves, impermeable gowns, mask, eye protection
  - Enzymatic cleaner, brushes, cloths
- Traffic control
- Supplies
- Doors
- Windows
- Workflow

Flow of an instrument

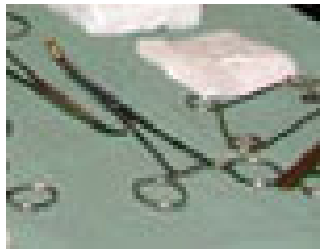


Decontamination

- Cleaning Process
  - Demonstrate
  - Concentration of enzymatic solution
  - Labeling of sinks
  - Standard work with low/no variation
    - Job aids
  - Manufacturer's instructions
  - Training & Competency



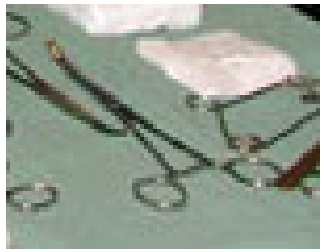
Flow of an instrument



Washers

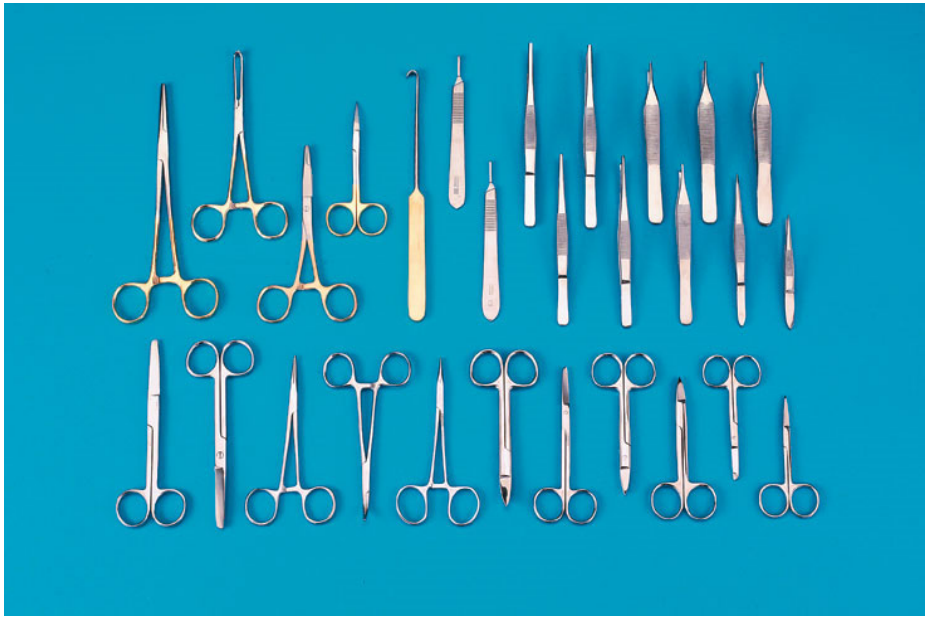
- Sonic Washers
  - Daily routine maintenance & QC
  - Manufacturer's guidelines
- Upright Washers
  - TOSI testing
  - How often? Frequency?
  - Documentation
  - If no testing, how do you ensure that the instrumentation is clean after processing?

Flow of an instrument

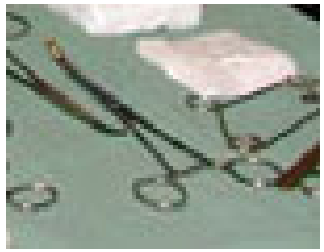


Sterile Processing

- Airflow
  - Doors
  - Windows
  - Traffic control
- Temperature
- Humidity
- Attire
- PPE
- Emergency Management and Fire Plans

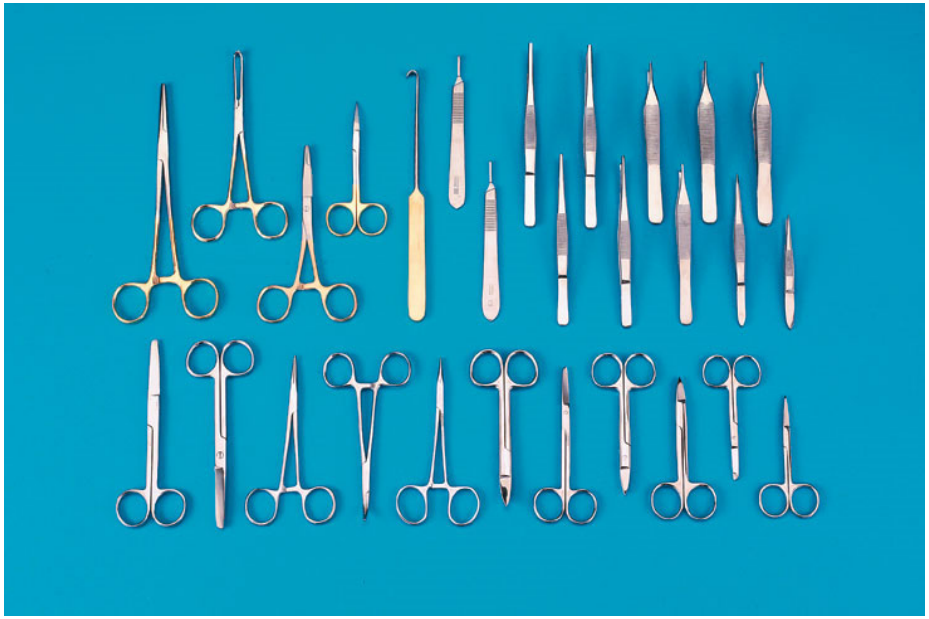


Flow of an instrument

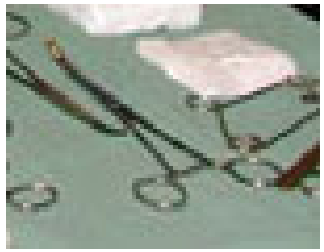


Prep & Pack

- Inventory
- Tips
- Stringing
- Open vs. closed
- Peel packaging
- Folds and taping
- Implants
- Indicators
  - Spacing
  - Internal & external



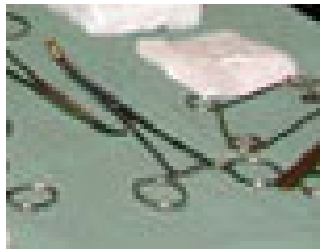
Flow of an instrument



Sterilizers

- Load management
  - Inventory
  - Biological indicators
  - Bowie Dick
  - Printouts
  - Competency
  - Knowledge and ability to discuss
- Maintenance of Sterilizers
- Storage in area

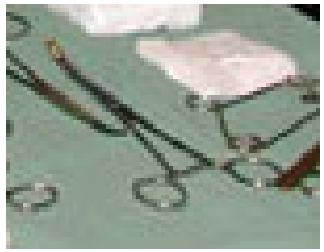
Flow of an instrument



Storage after Sterilization

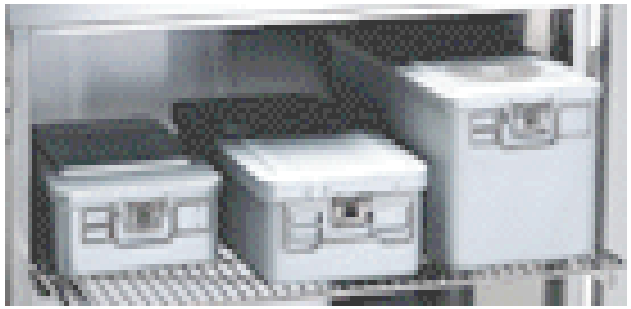
- Cooling
- Biological Indicator Resulting
  - Documentation
  - Timeliness
  - Completeness
  - BI control testing
    - Weekly Minimum
    - Matching lot numbers for control/test-manufacturer?
- Release of trays – Management of Risk

Flow of an instrument

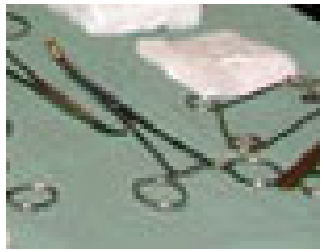


Sterile Processing

- Storage of Sterile Trays
- Segregation of Sterile and Unsterile
  - Visual cues
  - Workflow, Traffic, and Access Control
- Temperature & Humidity
- Airflow
- Alternate storage sites
  - OB
  - 'Sterile' Core
  - Hallways



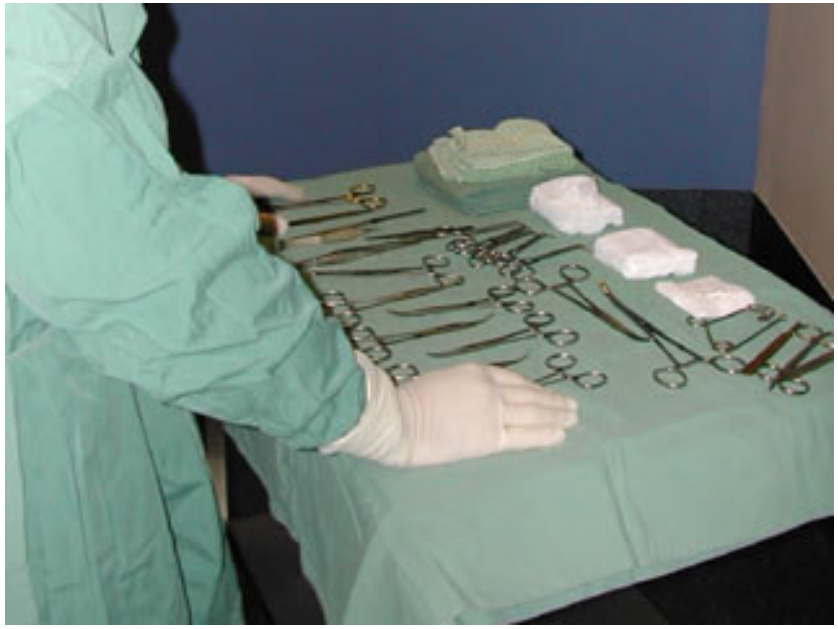
Flow of an instrument



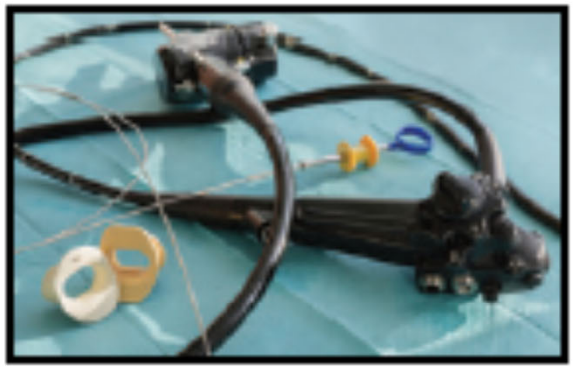
- Immediate Use Sterilization (IUS)
- Vendor Trays
- Emergent and Add-on Cases
- Reprocessing of single-use items

Open Sterile Fields

- Sterile fields with instruments and trays opened
- Attendance and monitoring
- Not covered
- AORN standards



High Level Disinfection



Endoscope*

Bronchoscope

Laryngoscope Blades

High Level Disinfection (HLD)

- Manufacturer's Recommendations
  - Posted; Current
  - Cleaning
  - PPE
  - Policies and Procedures
    - Written
    - Includes preventive maintenance, storage, cleaning, processing, handling, transport, documentation
    - Disinfection and cleaning product instructions for use, testing, and maintenance

High Level Disinfection (HLD)

- Cleaning and Processing areas
  - Decontamination and cleaning in negative vented room
  - Dirty to clean
  - Designated areas for processes and placement

High Level Disinfection (HLD)

- Endoscope processing
  - Point of Use
    - Immediate Pre-cleaning
    - Wipe and flush with enzymatic detergent/water-manufacturer?
  - Transport
    - In a container to prevent environmental contamination
    - Labeled as biohazardous
    - Based on manufacturer's instructions and evidence based guidelines

High Level Disinfection (HLD)

- Endoscope processing
  - Cleaning/Decontamination
    - Leak Testing
    - Manufacturer's instructions
    - Concentration of enzymatic solution
    - Scrub, brush, soak all parts in appropriate detergent
    - Suction valve
    - Accessories

High Level Disinfection (HLD)

- Endoscope processing
  - Cleaning/Decontamination
    - Immerse, flush and clean
    - Brush all accessible channels
    - Elevator cleaning
    - Rinse after cleaning

Flow of a scope

- High Level Disinfection Processes
  - Cidex/Rapicide
  - Medivators
  - Sterrad
  - Endoscope Processors
  - Trophon (H2O2)

High Level Disinfection (HLD)

- Endoscope HLD processing
  - Management of HLD solution & monitoring
    - FDA approved
    - Temperature, soak times per instructions
    - Tested for efficacy
  - Test strips
    - Expiration dates
  - Rinsed thoroughly
  - Dried before storage
- Documentation Processing & Maintenance Logs

High Level Disinfection (HLD)

- Endoscope Automated Reprocessing
  - Management of HLD solution & monitoring
    - FDA approved
    - Concentration; tested
  - Test strips
    - Expiration dates
  - Connect per instructions
  - Accessories; connections
  - Dried before storage

High Level Disinfection (HLD)

- Endoscope Automated Reprocessing
  - Cycle run
  - Rinse per instructions
  - Drying process
  - Flush channels, alcohol and compressed air
- Documentation
  - Processing Logs
    - ***Include patient information***
  - Preventive Maintenance Logs

High Level Disinfection (HLD)

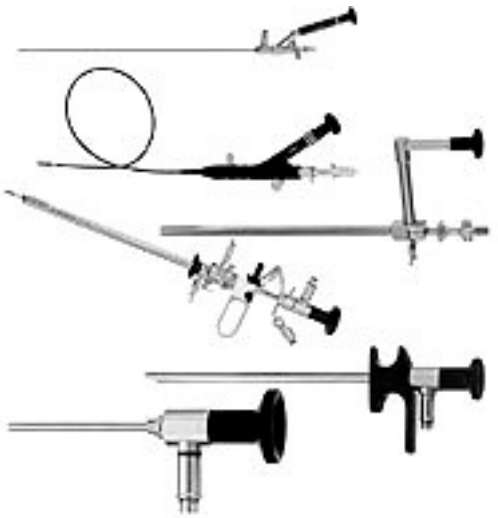
- Endoscope processing
  - Storage
    - Hung vertically to dry
    - No looping
    - ~~**No touching**~~
    - Reprocessing according to guidelines, manufacturer, and **organizational policy**
    - Prevent breakage and damage
    - Protected from recontamination

High Level Disinfection (HLD)

- Other HLD Instruments and equipment
  - Transvaginal US probes
    - Cleaning
      - Wipes
      - Rinsed
    - HLD
      - Cidex/Rapicide
      - Trophon
    - Stored covered
      - Do not use the procedure cover for storage

High Level Disinfection (HLD)

- Other HLD Instruments and equipment
  - Laryngoscopes
  - Rigid scopes
  - Scopes without lumens
    - ENT
    - TEE



- Protect from recontamination!

Standardize Work Practices

- Determine process/best practice – Standardize to it using evidenced based guidelines
- Involve frontline staff
- Develop P&P
- Train/Re-educate/Annual Competencies
- Follow-up to assure sustainability and provide feedback

Measure Process Performance

- Identify key process steps
  - Volumes, turn-around time, documentation logs
  - Breaches in workflow or process
  - Competency completion
- Identify key outcomes
  - SSI, days without failed trays or loads
  - Observations from tracers
- Obtain a baseline – set targets
- Track and report to leadership
- *Measure what you value*

Safe Management of the Patient at Risk for Self-Harm

Safe Environments for Psychiatric Patients

- **Effective March 1, 2017**
  - The Joint Commission placed added emphasis on the assessment of ligature, suicide and self-harm observations in psychiatric hospitals and inpatient psychiatric patient areas in general hospitals.
    - National concern about the number of suicides in hospitals
    - (CMS) “Zero Suicide” campaign to eliminate suicides in health care
    - Suicide is among the Top 5 sentinel events in the Joint Commission database.

EC.02.06.01
Safe Environments for Psychiatric Patients

- **EP 1** Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment and services provided.
  - **Ligature/self harm risks (apparent environmental risk identified)**
    - Best Practice Guidelines
      - Design Guide for the Built Environment of Behavioral Health Facilities OR VA Guidelines for Mental Health Facilities
    - Designated Psychiatric Care sites
      - Psychiatric units/hospitals
      - Designated areas for suicidal/psychiatric patients in EDs and patient care units

Ligature Risks – Psychiatric Settings

- Inpatient Psychiatric and Designated Psychiatric areas in non-behavioral settings for treatment
  - Ligature and self-harm risks identified and eliminated
  - No additional time beyond 60 days from last day of survey

See also *Joint Commission Online, May 24, 2017*
www.jointcommission.org/issues

CFR Title 42: Public Health… §488.28(d)

- ***Ordinarily a provider or supplier is expected to take the steps needed to achieve compliance within 60-days of being notified of the deficiencies***, but the State survey agency may recommend that additional time be granted by the Secretary in individual situations, if in its judgment, it is not reasonable to expect compliance within 60-days, for example, a facility must obtain the approval of its governing body, or engage in competitive bidding

Ligature Risks – Psychiatric Settings

- Process: self-harm risks identified
  - Determination if previously identified (risk assessment)
  - Evaluate existing plans for removing the risks
  - Evaluate the environmental risk assessment process
- Further evaluation
  - Plans and policies on mitigation of harm posed by risks while removal occurs
  - Adequacy of staffing patterns to complete the mitigation plans
  - The patient suicide risk assessment process

See also *Joint Commission Online, May 24, 2017*
www.jointcommission.org/issues

Ligature Risks – Psychiatric Settings

- Further evaluation
  - Policies and practices related to actions needed for patients identified at risk
  - Policies and processes of ensuring staff awareness of a patient's level of risk
  - The organization's internal processes for improvement, including:
    - The history of patient safety events and the process for root cause analysis of these events

Ligature Risks – Psychiatric Settings

- Further evaluation
  - The organization's internal processes for improvement, including:
    - The organization's process for monitoring its compliance with its policies
    - Actions taken when noncompliance was identified

See also *Joint Commission Online, May 24, 2017*
www.jointcommission.org/issues

Ligature Risks – Non-Designated Psychiatric Settings

- Non-designated Psychiatric Settings
  - Temporary location for psychiatric patient
    - Ligature/self-harm issues must be identified
    - Remove physical risks not required for treatment
    - Implement surveillance if risks remain
    - P&Ps adequately guide staff in assessment
    - Implement measures based on patient needs

Joint Commission
Suicide Risk Expert Panel – June 9, 2017

- The Joint Commission convened an expert panel with representation across various health care settings and various fields of expertise to debate and discuss courses of action as well as make recommendations related to suicide risk reduction.
- Focus of this meeting was on environment of care issues and ligature risk to:
  - Provide guidance to organizations and our surveyors
  - Get everyone on the same page moving forward
  - Set an agenda for moving forward

Ligature Resistant Definition

- Ligature resistant*: Without points where a cord, rope, bed sheet or other material can be looped or tied to create a point of attachment that may result in self harm or loss of life.

Source: Facility Guidelines Institute
(proposed glossary term for the 2018 Guidelines)

Recommendation #1:

- Inpatient psychiatric units must be ligature resistant* which includes:
  - Patient Rooms
  - Patient Bathrooms
  - Patient corridors
  - Common patient care areas

**Exception: Nurses station; areas behind self-locking doors*

Recommendation #2:

- The recommendation in #1 applies to both psychiatric units in a psychiatric hospital AND psychiatric units or rooms in a General/Acute setting.

Recommendation #3:

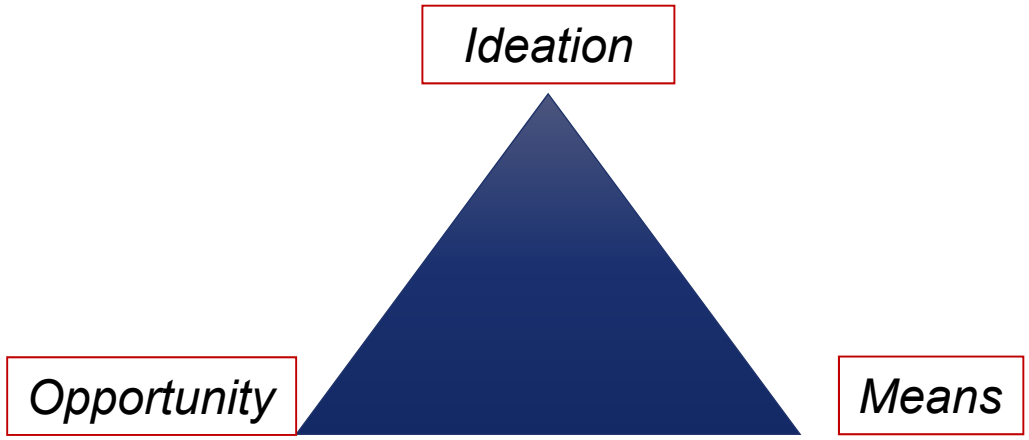
- The Joint Commission will hold off on citing traditional toilet seats verifying that traditional toilet seats are noted on the risk assessment along with a mitigation plan on inpatient psychiatric units. The mitigation plan must be appropriate for the population being served.
- *CMS has the ability to write citations on this issue. This is a Joint Commission recommendation.*

Recommendation #4:

- In a general medical inpatient setting, ligature risk will not be cited. If risk for suicide or self-harm is high for a patient, the patient should be assessed and mitigating strategies must be put into place and documented in order to monitor the patient appropriately.

What Can be Done to Improve Safety for These Patients

- Research has shown that many suicide attempts are impulsive. There is little disagreement that a facility that can eliminate environmental risks is reducing the ***means and opportunities*** for patients to commit suicide and/or harm themselves.



What Can be Done to Improve Safety for These Patients

- Assign competent staff to address the environment and monitor the patient
  - Triage
  - RN
  - Sitters
  - Others
- Assessment of risk and needs
  - Evidence based tools (e.g. C-SSRS Columbia Suicide Severity Rating Scale)
  - Screening
  - Assessment
  - Monitoring

What Can be Done to Improve Safety for These Patients

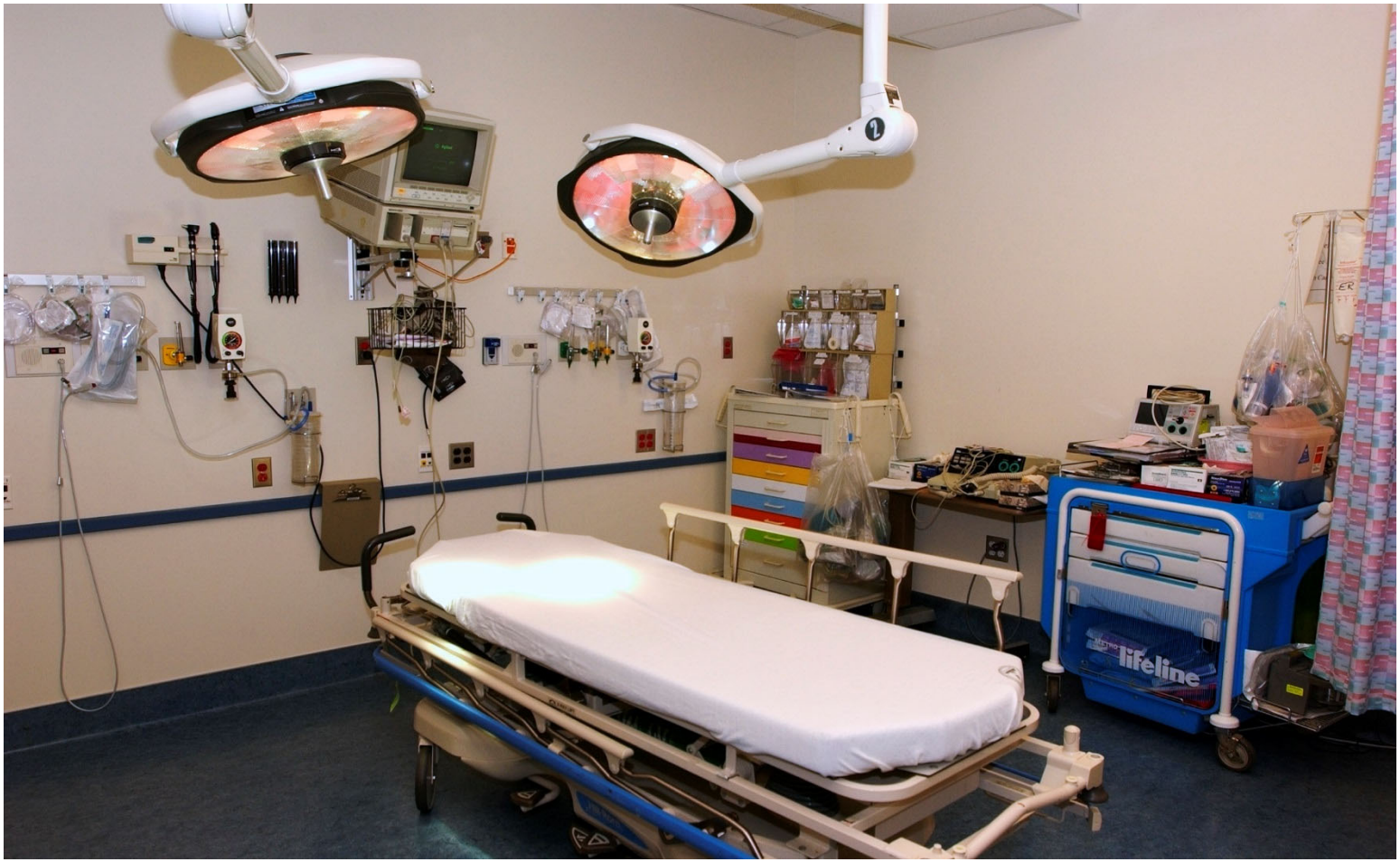
- Immediate modification of the environment
  - Remove anything not needed to care for the patient
  - Location matters
  - Remove belongings – contraband – valuables
  - Visitors and traffic
  - Plan for routine needs
    - Toileting
    - Food service
    - Housekeeping
    - Other

What Can be Done to Improve Safety for These Patients

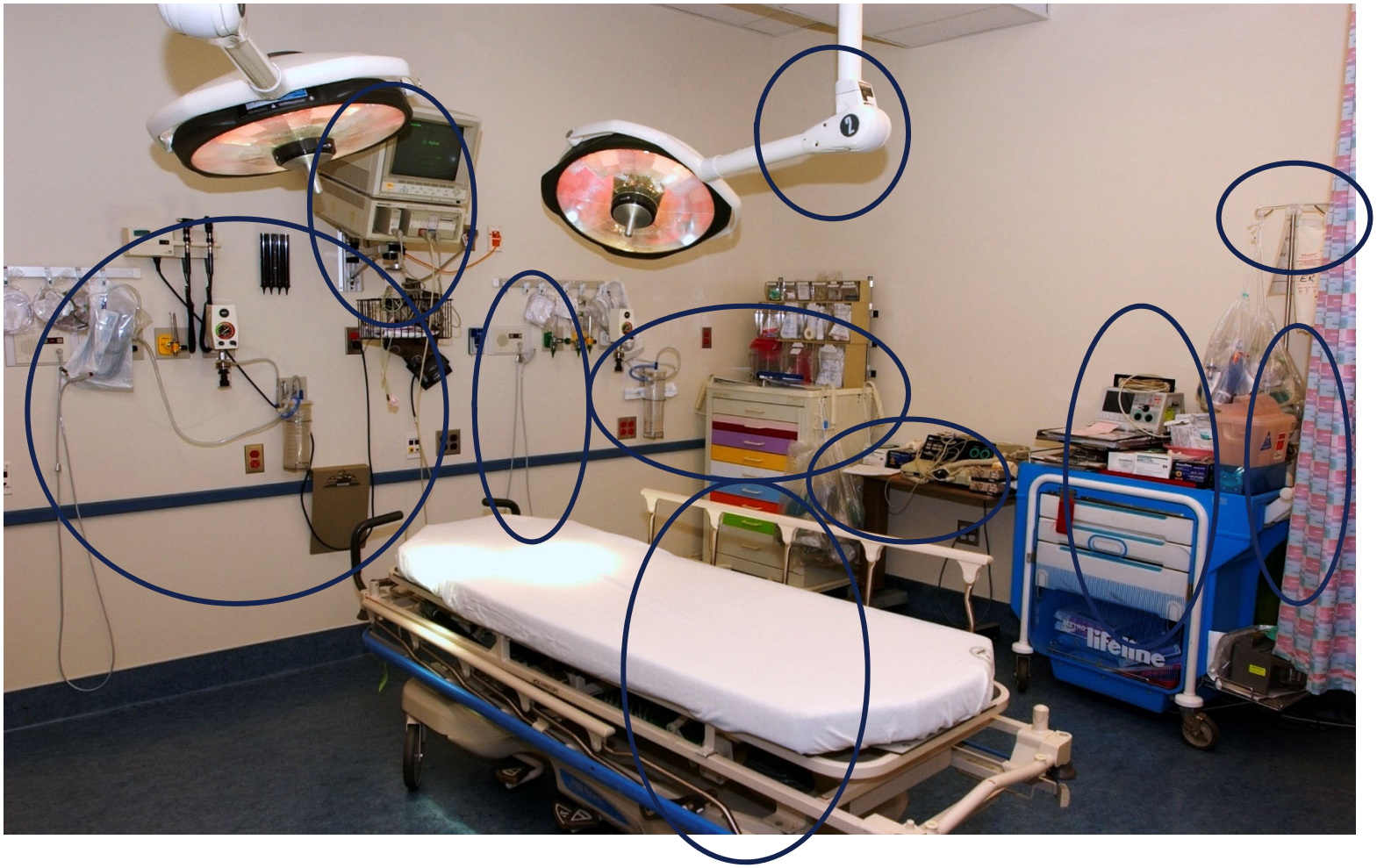
- Mitigate risks that cannot be removed:
  - Equipment
  - Beds
  - Furniture
  - Existing traffic
  - Bathrooms

- Those not removable  1:1 Sitter

How Many Ligature Risks Do You See?



How Many Ligature Risks Do You See?



What Can be Done to Improve Safety for These Patients

- Additional Strategies:
- Checklists to address risks in rooms
- Standardize handoffs
- Frequent breaks for sitters
  - Sitter fatigue
  - Trained relief
- Risk of any transition or handoff
- Collaborative planning and documentation for RN and Sitters
- Ongoing access to psychiatric SME

Leadership Accountability for Safety
Proactive Risk Assessments as a Dynamic Tool

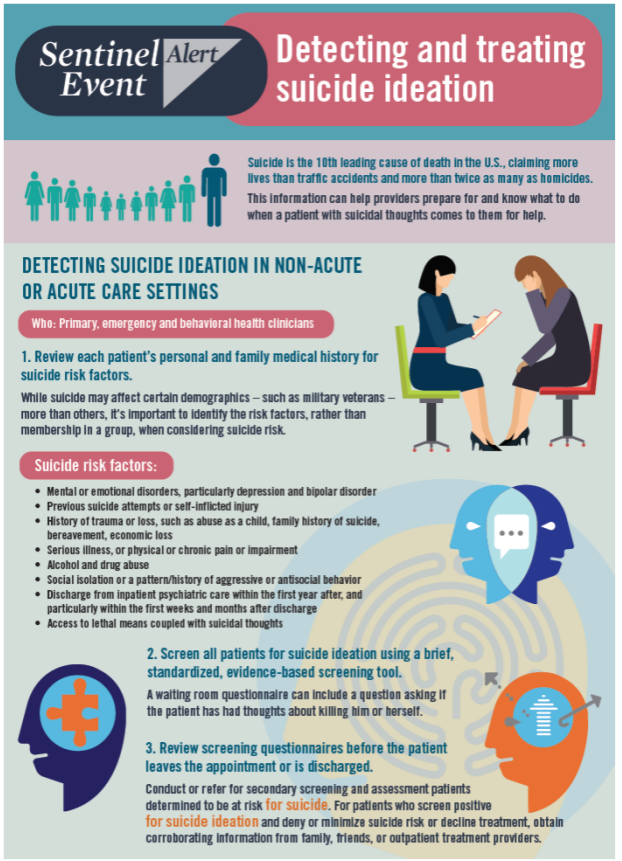
- Oversight of Risks and Patient Safety at the highest level of Leadership
- Ongoing active management of the risk assessment to plan and achieve elimination of risks
  - Identify
  - Plan (staff resources, money, time, materials)
  - Oversight to completion
  - Ongoing steady improvement
- If you can't eliminate the risks quickly, how will you do it in 60 days?

Measuring Safety

- Outcomes:
  - Completed Self-harm events
  - Interrupted Self-Harm events
  - Intensive analysis
    - Learning and improvements
- Monitoring your process
  - Screening and Assessment
  - Training and competency
  - Rounding on patients, locations
  - Tracers

Sentinel Event Alert #56 – February, 2016 Detecting And Treating Suicidal Ideation

- Joint Commission requirements related to suicide update
  - http://www.jointcommission.org/assets/1/6/SEA_suicide_TJC_requirements.pdf
- Infographic
  - http://www.jointcommission.org/assets/1/6/SEA_56_Suicide_Infographic_2_10_16_FINAL.pdf



LUNCH

National Patient Safety Goals (NPSG)

NPSG Background

- The purpose of the National Patient Safety Goals is to improve patient safety. The goals focus on problems in health care safety and how to solve them
  - NPSGs first announced in 2002
  - Goals have been shifted into the standards
  - Program-specific
  - The Joint Commission Patient Safety Advisory Group

NPSG.01.01.01
Patient Identification

- Use at least two patient identifiers when providing care, treatment and services:
  - **First:** Identify the person for whom the test or procedure is intended for

    AND
  - **Second:** Match the intended service or treatment to that person
- Label containers used for blood and other specimen in presence of patient

Use of Two Unique Identifiers

- What do you use for the match? Does it include the 2 identifiers AND the care, treatment, or services to be provided?
  - Lab tests
  - Diagnostic imaging
  - Invasive & non-invasive procedures
  - Medication administration
  - Arm/wrist ID banding
  - Patient rooming
  - Medical records
  - Transport
  - Food trays

NPSG.01.03.01
Patient Identification: Transfusions

- Eliminate transfusion errors related to patient misidentification:
  - Match blood to order
  - Match patient to blood
  - Use two-person verification process or one-person verification process accompanied by automated identification technology (e.g. bar coding)
  - One of 2 persons must be qualified transfusionist

NPSG.02.03.01
Improve Communication

- Report critical results of tests and diagnostic procedures on a timely basis:
  - Define critical results
  - Define by whom and to whom results are reported
  - Define acceptable time from results available to reported
  - Implement the procedures
  - Evaluate timeliness of reporting

NPSG.03.04.01
Medication Safety: Labeling

- Label all medications, medication containers, and other solutions on and off the sterile field:
  - Label when not **immediately** used
  - Label even if only ONE medication or solution
  - Label at time of transfer
  - Include medication/solution and strength
  - Include expiration date/time, if applicable
  - Verification process, especially if the one preparing is NOT the one administering and when change of staff
  - Immediately discard any meds found unlabeled

NPSG.03.05.01
Medication Safety: Anticoagulant Therapy

- Reduce likelihood of harm associated with anticoagulant therapy:
  - Use oral unit-dose, prefilled syringes, or premixed infusion bags when available
  - Use approved protocols for initiation & maintenance
  - For warfarin therapy, use baseline and “current” INR
  - Use authoritative resources to manage potential food and drug interaction for warfarin
  - For heparin, use programmable pumps
  - Provide education to prescribers, staff, patients, families
  - Evaluate anticoagulation safety practices

NPSG.03.06.01
Medication Safety: Information

- Maintain and communicate accurate patient medication information:
  - Document current medication list upon admission or during outpatient encounter
  - Define type of med info collected in non-24 hour setting
  - Compare information with meds ordered to identify and resolve discrepancies
  - Provide written information on meds patient should be taking when discharged or at end of outpatient encounter
  - When only additional meds prescribed are for short duration, medication information provided may include only those meds

Medication Reconciliation <24 HR Settings

- How is the process designed for outpatient settings?
  - IV contrast
  - Infusions (e.g. chemotherapy)
  - OP surgery
  - Clinic or physician office visits
  - Other settings

NPSG.06.01.01
Improve Safety of Clinical Alarm Systems

- Quite complex to address
- Rationale:
  - May compromise patient safety if not well managed
  - Signals may be difficult to detect
  - Staff become desensitized
  - Staff miss, ignore, disable
  - Default settings not at actionable levels
  - Universal solutions have yet to be identified

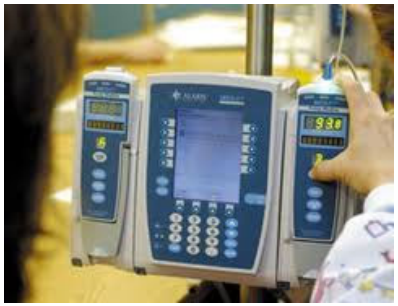
Defining the Problem

- Medical alarm systems are out of control
  - Hundreds of auditory alarm signals
  - Tens of thousands in every hospital
- ECRI Top Health Technology Hazard for several years
- FDA four year period
  - 500 patient deaths
  - 2010: 2,500 adverse events with ventilators
    - 1/3 alarm system-related issues

Defining the Problem

- Major contributing factors to deaths related to alarms:
  - Absent or inadequate alarm system
  - Improper alarm settings
  - Alarm signals not audible in all areas
  - Alarm settings inappropriately turned off

Types of Alarms

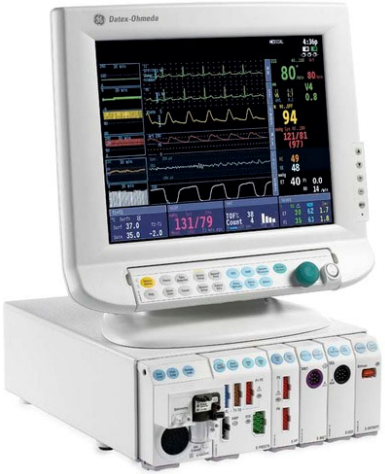


Infusion Pumps

Feeding Pumps

Pulse Oximeter

Cardiac Monitors



Bed alarms

NPSG.6.01.01
Clinical Alarm Safety

- **EP 1:** Leaders establish alarm system safety as a hospital priority
- **EP 2:** The most important alarm signals to manage are identified based on the following:
  - Input from med staff and clinical departments
  - Risk to patients, if the alarm signal is not attended to or if it malfunctions
  - Whether specific alarm signals are needed or unnecessarily contribute to alarm noise and alarm fatigue
  - Potential for patient harm based on internal incident history
  - Published best practices and guidelines

(More info on managing med equipment risk, see EC.02.04.01)

NPSG.6.01.01
Clinical Alarm Safety

- EP 3: Establish policies and procedures for managing the alarms identified in EP 2, at a minimum, address the following:
  - Clinically appropriate settings for alarm signals
  - When alarm parameters can be disabled
  - When alarm parameters can be changed
  - Who in the organization has the authority to set alarm parameters
  - Who in the organization has the authority to change alarm parameters
  - Who in the organization has the authority to set alarm parameters "off"
  - Monitoring and responding to alarm signals
  - Checking individual alarm signals for accurate settings, proper operation, and detectability

NPSG.6.01.01
Clinical Alarm Safety

- EP 4: Educate staff and licensed independent practitioners about the purpose and proper operation of alarm systems for which they are responsible

Goal 7
Healthcare-Associated Infections

- NPSG.07.01.01
  - Hand Hygiene
- NPSG.07.03.01
  - Multiple Drug Resistant Organisms (MDRO)
- NPSG.07.04.01
  - Central Line-Associated Bloodstream Infection Prevention (CLABSI)
- NPSG.07.05.01
  - Surgical Site Infection (SSI) Prevention
- NPSG.07.06.01
  - Catheter-Associated Urinary Tract Infections (CAUTI)

HAI Reduction Goals

- Provide surveillance data to key stakeholders (not required for CAUTI)
  - Leaders, licensed independent practitioners, nursing staff, and other clinicians
- Implement policies and practices aimed at reducing the risk of infections
- Measure and monitor prevention processes and outcomes

Evidence-Based Practice

- A limited number of National Patient Safety Goals contain requirements for practices that reflect current science and medical knowledge
- In these cases, the element of performance refers to a practice that is cited in scientific literature or endorsed by professional organizations

Requirements for CLABSI, CAUTI, SSI, & MDRO

- Periodic risk assessments
  - (refer to LD chapter overview)
- Implement evidence-based practices
- Educate staff and LIPs at hire, initial privileging, and *periodically* (exception CAUTI)
- *Educate* patient and family education (except CAUTI)
- Implement surveillance programs based on risk assessments

Requirements for CLABSI, CAUTI, SSI, & MDRO

- Targeted Surveillance Expectation
  - MDROs
  - Surgical Site Infections
  - Catheter-Associated Urinary Tract Infection
- Total Surveillance Expectation
  - Central Line Associated Bloodstream Infections

NPSG.15.01.01
Suicide Risk Assessment

- Identify patients at risk for suicide
  - *Applies only to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals*

D

  - Conduct risk assessment that identifies specific patient characteristics & environmental features that may increase or decrease risk for suicide
  - Address immediate safety needs and most appropriate setting for treatment
  - When at risk, provide suicide prevention information (such as crisis hotline) to patient & family

NPSG.15.01.01
Patients at Risk for Suicide

- Applicability Scenarios
  - Patient seen in ED for sustained fracture in the act of attempting suicide
  - Patient admitted to ICU for detoxification
- Check out Sentinel Event Alert #46 Suicide Risks in the Med-Surgical Setting Suicide BoosterPak™
  - Describes NPSG and implementation suggestions
  - Describes survey discussion re: NPSG, including the documents needed for review
  - FAQs for suicide risk
  - Defines key terms and supporting documentation, evidence, value and historical information

Universal Protocol for Preventing Wrong Site, Wrong Procedure, Wrong Person Surgery™

- Applies to all surgical & nonsurgical invasive procedures
- Three components
  - Conducting a Pre-procedure Verification Process (UP.01.01.01)
  - Marking the Procedure Site (UP.01.02.01)
  - Performing a Time-Out (UP.01.03.01)

Conducting a Pre-procedure Verification Process (UP.01.01.01)

1. Implement a pre-procedure process to verify the correct procedure, for the correct patient, at the correct site.
2. Identify the items that must be available for the procedure and use a standardized list to verify their availability. At a minimum, these items include the following:

   Relevant documentation (e.g. H&P, consent form, nursing assessment, and pre-anesthesia assessment), labeled diagnostic and radiology test results (e.g. radiology images and scans, or pathology and biopsy reports) that are properly displayed, any required blood products, implants, devices, and/or special equipment for the procedure
3. Match the items that are to be available in the procedure area to the patient

Marking the Procedure Site (UP.01.02.01)

1. Identify those procedures that require marking of the incision or insertion site. At a minimum, sites are marked when there is more than one possible location for the procedure and when performing the procedure in a different location would negatively affect quality or safety.
2. Mark the procedure site before the procedure is performed and, if possible, with the patient involved.
3. The procedure site is marked by a licensed independent practitioner who is ultimately accountable for the procedure and will be present when the procedure is performed.

Marking the Procedure Site (UP.01.02.01)

4. The method of marking the site and the type of mark is unambiguous and is used consistently throughout the hospital.
5. A written, alternative process is in place for patients who refuse site marking or when it is technically or anatomically impossible or impractical to mark the site (for example, mucosal surfaces or perineum).

Performing a Time-Out (UP.01.03.01)

1. Conduct a time-out immediately before starting the invasive procedure or making the incision.
2. The time-out is standardized
3. When two or more procedures are being performed on the same patient, and the person performing the procedure changes, perform a time-out before each procedure is initiated.
4. During the time-out, the team members agree, at a minimum, on the following: Correct patient identity, the correct site, the procedure to be done
5. Document the completion of the time-out. D

Knowledge Check

- A patient visits your organization to get a HgA1c, cholesterol panel, CXR, and to pick up a refill of metformin and insulin lancets.

  Q. Would NPSG.03.06.01 apply in this situation?

  Q. Why or why not?

If You Were The Surveyor…

- The 2nd year surgical resident does the informed consent, site marking, time out, and initial incision. The attending physician enters the room after the procedure has started. The organization says that another time out is not required.

  Q. What do you think?

  Q. What follow-up questions would you ask?

Provision of Care, Treatment, and Services (PC)

Provision of Care, Treatment, and Services (PC)

- Accepting patient for care, treatment and services
- Assessing and reassessing
- Planning care
- Providing care
- Coordinating care
- Providing education
- Planning for high risk or operative procedures/sedation
- Protecting patients in restraint and seclusion
- Planning continuing care after discharge/transfer

Challenging Standards

PC.01.02.03

- Assessment and reassessment

PC.01.03.0

- Plans of care

PC.03.01.03

- Anesthesia care

PC.01.02.07

- Pain Management

Acceptance of Patients

- PC.01.01.01
  - Written process for accepting patient with criteria for eligibility and procedure for acceptance
  - Written plan for referral of mental health
  - Decisions coordinated for patients under legal or correctional restrictions

Acceptance of Patients

- PC.01.01.01
  - EP 24 – Safety for boarded patients who have behavioral health emergencies in the following areas:
    - Environment of Care (safe location, free from harm)
    - Staffing competency (ex., med protocols, de-escalation, etc.)
    - Assessment, reassessment, and care according to identified needs

Assess and Reassess

- PC.01.02.01
  - Defines in writing
    - Scope and content of screening, assessment, and reassessment
    - When additional assessments are performed
  - Defines when nutritional plans are developed

Defined Assessment Timeframes

- PC.01.02.03
  The hospital assesses and reassesses the patient according to defined time frames
  - **EP 1:** Define timeframes in writing
  - **EP 2:** Assess within defined time frames
  - **EP 3:** Reassessed as needed
  - **EP 6:** RN completes nursing assessment within 24 hours

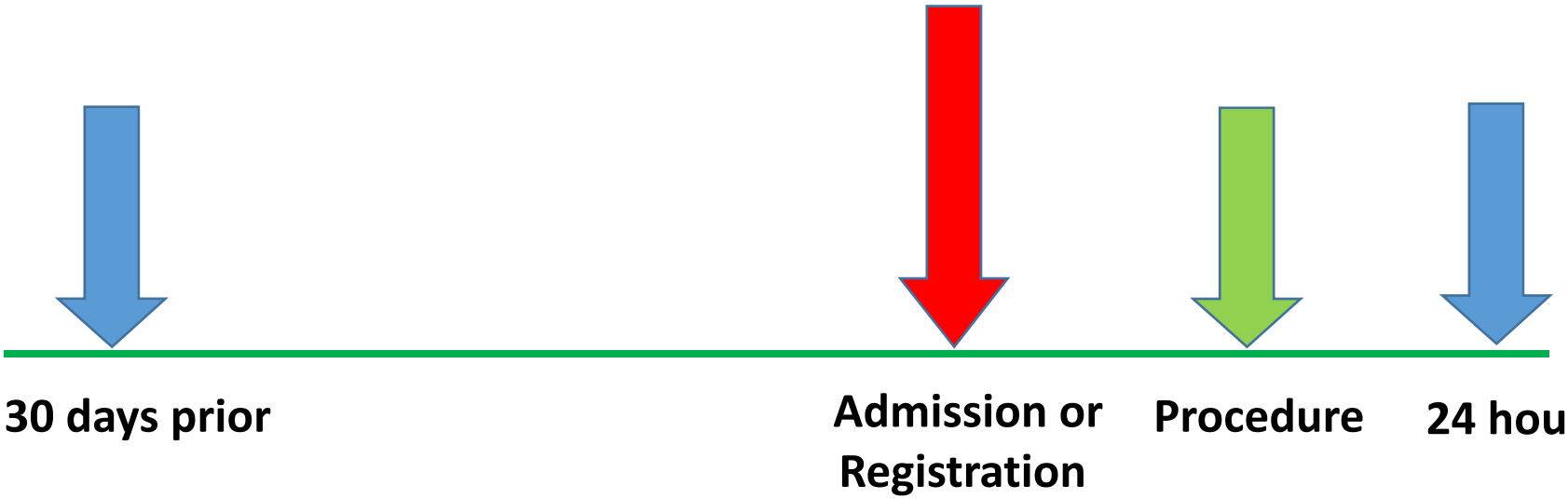
…Continued

Defined Assessment Timeframes

- **EP 4:** medical history and physical examination no more than 30 days prior to, or within 24 hours after registration or inpatient admission but prior to surgery or procedure requiring anesthesia services (MS.01.01.01)
- **EP 5:** Update to the H&P documenting any changes is done within 24 hours after admission (MS.01.01.01)
  - CoPs require documentation of the examination and any changes
    - Medical Staff: 482.22(c)(5)(ii)
    - Medical Records: 482.24(c)(2)(i)(b)
    - Surgical Services: 482.51(b)(1)(ii)

Surgical Services: 482.51(b)(1)(ii)

- A medical history and physical examination must be completed and documented within 30 days prior to or 24 hours after …….



Assess and Manage Pain

- PC.01.02.07
  - Define criteria to screen, assess, and reassess pain
  - Screen patients for pain during relevant visits and at admission
  - Uses appropriate pain assessment methods
  - Address pain or refer-THIS DOES NOT REQUIRE A RX

Assess and Manage Pain

- PC.01.02.07
  - Develop pain treatment plan
    - Realistic expectations and measurable goals
    - Providing education
  - Monitor patients at high-risk for adverse outcomes
  - Reassess
    - Evaluate and document response
    - Progress toward goals
    - Side effects of treatment
    - Risk factors

The Joint Commission

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Friday 7:14 CST, May 5, 2017

Pain Management

It is estimated that in the United States more than 76 million people suffer from pain. Pain can be chronic or acute, such as post-surgical pain. This page highlights a variety of resources related to effective pain management and patient safety.

History of The Joint Commission Pain Standards

In a recent editorial in JAMA, Dr. David W. Baker, MD, MPH, Executive Vice President, Healthcare Quality Evaluation, discussed the implications of the pain standards for the current opioid epidemic:

- The History of the Joint Commission's Pain Standards: *Lessons for Today's Efforts to Address the Prescription Opioid Epidemic*

Pain Standards

- Original 2001 Standards and Examples of Implementation
- Draft 2017 Standards
- 2016 Technical Advisory Panel Members for the revised pain standards
- 2016 Standards Review Panel Members

Video: Debunking Pain Standard Myths

In the environment of today's prescription opioid epidemic, everyone is looking for someone to blame. Often, The Joint Commission's pain standards take that blame. We are encouraging our critics to look at our exact standards, along with the historical context of our standards, to fully understand what our accredited organizations are required to do with regard to pain.

Joint Commission Resources

- Pain Management: A Systems Approach to Improving Quality and Safety

Sentinel Event Alerts

- Sentinel Event Alert Issue 49: Safe use of opioids in hospitals
- Sentinel Event Alert, Issue 33: Patient controlled analgesia by proxy

Resource

- Common myths about The Joint Commission pain standards

Speak Up Pain Videos

Speak Up: About Your Pain

PLAY

View More

Podcasts

Take 5: Effective Pain Management and Patient Safety

By Joint Commission

View More

Pain Standards FAQs

- Does The Joint Commission require that all patients get assessed for pain?
- Does The Joint Commission consider pain the fifth vital sign?
- Do The Joint Commission standards recommend or encourage doctors to prescribe opioids?
- Did The Joint Commission pain standards cause or contribute to the current prescription opioid

FAQ

Q: Does The Joint Commission require that all patients are assessed for pain?

A: No

- PC.01.02.07 EP 1 states "the hospital has defined criteria to screen, assess, and reassess pain that are consistent with the patient's age, condition, and ability to understand"
  - EP 2 – The hospital screens patients for pain during emergency department visits and at the time of admission

FAQ

Q: Do The Joint Commission standards recommend or encourage doctors to prescribe opioids?

A: No. The standards do not recommend any specific type of treatment. The Introduction to standard PC.01.02.07 states:

- Pain management strategies should consider the patient's current presentation, past medical history, and input on treatment options in addition to the health care provider's clinical judgment and the risks and benefits associated with the strategies

Assess Falls

- PC.01.02.08
  - Assesses patient risk for falls based on patient population and setting
  - Implements interventions to reduce falls

Assesses for Abuse

- PC.01.02.09
  - Written criteria to identify victims of abuse
  - Maintain a list of agencies
  - Educates staff how to recognize abuse and neglect and roles in follow-up
  - Uses criteria to identify victims on entry to hospital and ongoing basis
  - Internally reports cases
  - Reports cases to external agencies according to law

Diagnostic Testing

- **PC.01.02.15**
  - **EP 2:** Testing and procedures are performed as ordered within time frames define by the hospital
    Clarified: performed as ordered
  - **EP 5:** Documents the radiation dose index, dose length product, or size specific dose estimate for CT examination.

. . . *Continued*

Diagnostic Testing

- **EP 10:** Prior to CT, MRI, PET or NM services the hospital verifies the following:
  - Correct patient
  - Correct imaging site
  - Correct patient positioning
  - For CT only: Correct imaging protocol
  - For CT only: Correct scanner parameters
- **EP 12:** Hospital considers patient age and recent imaging exams when deciding on type of imaging exam

Plan Patient Care

- PC.01.03.01
  - Care is planned based on needs identified by assessment
  - Plan of care is based on the patient's goals
  - Based on the goals established in the patient's plan of care, staff evaluate the patient's progress
  - Revises plans and goals for care, treatment, and services based on the patient's needs

Plan Patient Care

- EP 25: CT protocols based on current standards of practice
- EP 26: CT protocols reviewed and kept current with input from:
  - Interpreting physicians
  - Medical physicist
  - Lead imaging tech
- Time frames are identified by the hospital

Compliance Issues

- No plan and/or plan not individualized
- Plan not consistent with patient assessment
- Plan not updated as condition changes
- Plan(s) inconsistent with each other
  - Multiple disciplines
  - Inconsistent communication
- Lack of evidence of adopted CT protocols including the required elements; contrast detail

Provides Care as Ordered

- PC.02.01.03
  - Prior to providing care, treatment, and services, the hospital obtains or renews orders (verbal or written) from a LIP in accordance with professional standards of practice; law and regulation; hospital policies; medical staff bylaws
    - ***Note***: *Outpatient services may be ordered by a practitioner not appointed to the medical staff*
    - ***Note***: *Outpatient services may be ordered by nonmedical staff member according to listed criteria*

…Continued

Provides Care as Ordered

- PC.02.01.03
  - The hospital provides care, treatment, and services using the **most recent patient order(s)**
  - Before taking action on a verbal order or verbal report of a test result, staff uses a record and “read back” process to verify the information

FAQ

Q: Is there a Joint Commission standard that requires all orders to be cancelled, then rewritten following a procedure or when a patient is transferred from one level of care to another?

A: No, there is no specific accreditation requirement that states all orders must be canceled, then rewritten following a procedure or when a patient is transferred from one level of care to the next. Such a requirement would be an organizational decision, or unless specifically required by individual state law/regulation.

Resuscitation Services

- PC.02.01.11
  - Provided according to policy, procedure, protocol
  - Equipment is available based on population served
  - Evidence-based training to train staff to recognize need for and use of equipment

FAQ

Q: Is it acceptable to position emergency carts secured with a breakaway lock in strategic locations, such as a trauma room in an emergency department or an alcove on a nursing unit or any area staffed 24/7 even though these carts may not be under constant visual surveillance by staff 100 % of the time ?

A: Since emergency departments and nursing units are staffed 24/7, yes, it would be acceptable to place emergency carts in these locations as long as there was a defined process in place to monitor the integrity of the breakaway lock and cart contents.

Changes in Patient Condition

- PC.02.01.19
  - Process for recognizing and responding as soon as a patient's condition appears to be worsening
  - Written criteria describing signs of change and when to seek further assistance

Handoff Communication

- PC.02.02.01
  - Process to receive and share patient information when care is transferred (internal/external)
  - Process for handoff provides opportunity for discussion
  - Coordinates care treatment and services

Food and Nutrition

- PC.02.02.03
  - Prepares food using proper conditions
  - Consistent with care, treatment, services
  - Stores food and nutrition products using proper conditions
  - Current therapeutic diet manual approved by dietician and medical staff is available to all medical, nursing, and food service staff (deemed status)

Patient Education

- PC.02.03.01
  - LEARNING NEEDS ASSESSMENT
  - Coordinates all disciplines education
  - Educates based on condition and assessed needs of patient
  - Evaluates understanding of education
  - Provides education on how to communicate concerns of patient safety

Plans Operative Procedures

- PC.03.01.01 – PC.03.01.07
  - ***These standards apply for <u>sedation and anesthesia</u> care in any setting, for any purpose, by any route:***
    - ***General, spinal, major regional anesthesia***
    - ***Moderate or deep sedation that may result in loss of protective reflexes***
    - ***Deep sedation requires a specific privilege***

Plans Operative Procedures

- PC.03.01.01
  - **Anesthesia administered only by:**
    - Anesthesiologist
    - Doctor of medicine or osteopathy with privileges
    - Doctor of dental surgery or medicine with privileges
    - Doctor of podiatry with privileges
    - CRNA supervised by operating practitioner
    - Anesthesiologist assistant supervised by anesthesiologist
      - **ADDED** immediately available if needed
    - Supervised trainee in approved program

Initiating
Operative or other High-Risk Procedures

- PC.03.01.03
  - Conducts pre-sedation/pre-anesthesia assessment
  - Provides patient with pre-procedural education
  - A **pre-anesthesia** evaluation is completed and documented by an individual qualified to administer anesthesia within 48 hours prior to surgery or a procedure requiring anesthesia services (deemed status)
  - Reevaluates the patient immediately before the administration of moderate/deep sedation or anesthesia

Monitors Patient

- PC.03.01.05
  - During procedures with moderate/deep sedation or anesthesia
    - Oxygenation
    - Ventilation
    - Circulation

    are continuously monitored

After High-Risk Procedures

- PC.03.01.07
  - Assessment of patient physiological status after procedure
  - Monitors patient physiological status, mental status, pain level
  - Patient discharged from recovery or hospital
    - Order
    - Protocol

…Continued

After High-Risk Procedures

- A **post-anesthesia** evaluation is completed and documented by an individual qualified to administer anesthesia no later than 48 hours after surgery or a procedure requiring anesthesia services
- The post-anesthesia evaluation for anesthesia recovery is completed in accordance with law and regulation and policies and procedures that have been approved by the medical staff
- A 48 hour post-sedation evaluation is not required for moderate sedation

Learner Check

- Joint Commission requires organizations to medicate patients who complain of pain?
  A. Yes
  B. No

Scenario

- The patient food refrigerator temperature reads about 8 degrees above the maximum temperature. You would expect the staff member to:
  A. Document the temperature and adjust the thermostat
  B. Adjust the thermostat and reassess the temperature in an hour
  C. Document the temperature, adjust the thermostat and reassess in an hour

Medical Staff (MS)

Credentialing vs. Privileging

- Credentialing gets the provider in the door
- Privileging defines what the provider is permitted to do
- Credentialing does not guarantee privileges

Key Concepts of the Medical Staff Chapter

- Self-governing organized medical staff
- Oversight of quality of care
- Credential and privilege individuals
- Develop and implement bylaws, rules and regulations, and policies
- Works with the governing board
- Medical staff membership does not equal clinical privileges

Organized Medical Staff Structure

- Function to guide and govern members
- Primary function of the organized medical staff is to approve/amend medical staff bylaws and provide oversight of the quality of care provided by privileged practitioners
- Guiding principles
- Self governance
- Primary responsibility to overseeing care

Joint Commission Definition

- Licensed Independent Practitioner (LIP):
  - "An individual permitted by law and by the organization to provide care, treatment, and services without direction or supervision. A LIP operates with the scope of his/her license, consistent with individually granted clinical privileges."

CMS Definition of Physician

- As defined by CMS in Section 1861 (42 USC 1395x) of the Social Security Act:
  - The term ”physician” when used in connection with the performance of any function or action, means:
    1. Doctor of medicine or osteopathy (MD/DO)
    2. Doctor of dental surgery or of dental medicine (DDS/DMD)
    3. Doctor of podiatric medicine (DPM)
    4. Doctor of optometry (OD)
    5. Chiropractor (DC)

MS.01.01.01
Medical Staff Bylaws

- Must address self-governance and accountability to the governing body
  - MS develops medical staff bylaws, rules & regulations, policies
  - Organized MS adopts/amends medical staff bylaws
  - Governing body approves bylaws
  - Required elements in the bylaws
  - Medical staff complies with bylaws
  - Medical bylaws, rules and regulations, and policies and the governing bylaws do not conflict

MS.01.01.01
Medical Staff Bylaws

- **EP 3:** Every requirement listed in EP 12-36 needs to be included in the medical staff bylaws or may reside in other documents
  - This will be scored when any noncompliance cited for EPs 12 through 36
  - Requirements, associated details, policies and procedures
- **EP 5:** The medical staff complies with the medical staff bylaws, rules and regulations and policies

MS.01.01.01
Medical Staff Bylaws

- **EP 16:** Requirements for completing and documenting medical histories and physical examinations. Refer to MS.03.01.01, EPs 6-11
- **EP 20:** The MEC's functions, size, and composition, as determined by the organized medical staff and approved by the governing body; authority of the MEC, and how such authority is delegated
- **EP 21:** The process, as determined by the organized medical staff and approved by the governing body, for selecting and/or electing and removing MEC members

MS.02.01.01
Medical Staff Executive Committee

- Structure and function of the MSEC
- CEO or designee attends with/without a vote
- All members are eligible
- Majority of voting MSEC are MD or DO actively practicing in the hospital
- MSEC acts on behalf of the organized med staff between medical staff meetings.
- Mechanism to recommend med staff membership termination
- Evaluate practitioners
- Make recommendations of membership and privileges

MS.03.01.01
Quality of Care Oversight

- **Oversees** the quality of patient care, treatment, and services provided by practitioners
  - **EP 2:** Practitioners practice within scope of privileges
  - **EP 6:** Minimal content of medical H&P's
  - **EP 7:** Monitors quality of H&P's
  - **EP 8:** Performs H&P's and updates
  - **EP 10:** Define when H&P must be validated and countersigned by a LIP with appropriate privileges

MS.03.01.01
Quality of Care Oversight

- EP 16: Medical staff determines qualifications of radiology staff who use equipment and administer procedures
- EP 17: Medical staff approve nuclear services director qualification, training, functions, responsibility of nuclear medicine staff

MS.03.01.03
Management and Coordination

- Physicians and clinical psychologists with appropriate privileges manage and coordinate patient's care
- Hospital educates all LIPs on assessing and managing pain
- Patient's general medical condition is managed and coordinated by a MD or DO.
- Determine the circumstances for when consultations is requested
- MD or DO on duty or on call at all times
- Patient admitted on the decision of a licensed practitioner permitted by the state to admit patients to hospital

MS.04.01.01
Professional Graduate Medical Education

- Defined process for supervision by a LIP with appropriate clinical privileges of each participant in the program to carry out patient care responsibilities
- Written description of the roles, responsibilities and patient care activities of the GME participant
- Delineate who may write orders, when they can write orders, and which orders need countersignature
- Communication between GME, medical staff, and GB
- Clinical rotation site communication with core program
- Compliance with residency review committee citation

MS.05.01.01
Role in Performance Improvement

- Provide leadership for measuring, assessing, and improving processes that primarily depend on activities of one or more LIP and others credentialed and privileged through the med staff process
- The medical staff is actively involved in measuring, assessing and improving (see next slide)
- **Deemed Status:** Attempts to secure autopsies in all cases of unusual deaths and cases of med, legal, and educational interest, and inform med staff (specifically the attending physician or clinical psychologist) of autopsies that the hospital intends to perform

MS.05.01.01
Role in Performance Improvement

- Medical staff is actively involved in measurement, assessment, and improvement (see PI.03.01.01 EP 2 & 4)
  - Assessment and treatment of patients
  - Use of information from adverse privileging decisions
  - Use of medications
  - Use of blood and blood components
  - Operative and invasive procedures
  - Appropriateness of clinical practice patterns
  - Significant department from established patterns of clinical practice
  - Use of developed criteria for autopsies
  - Sentinel event data
  - Patient safety data

MS.05.01.01
Role in Performance Improvement

- The medical staff is actively involved in pain assessment, pain management, and safe opioid prescribing through the following:
  - Participation in establishment of protocols and quality metrics
  - Reviewing performance improvement data

MS.06.01.01
Participates in Performance Improvement

- **EP 1:** There is a process to determine whether sufficient space, equipment, staffing, and financial resources are in place or available within a specified time frame to support each requested privilege.
- **EP 2:** The hospital consistently determines the resources needed for each requested privilege.

Credentialing vs. Privileging

- Credentialing is the process for verifying the individual's credentials:
  - Licensure
  - Training
  - Current competencies
  - Ability to perform clinical privileges requested
- Privileging is the process whereby specific scope and content of patient care services (that is clinical privileges) are authorized for a health care practitioner by a health care organization based on evaluation of the individual's credentials and performance.

Primary Source Verification

- **Primary Source:**
  - The original source or an approved agent of that source of a specific credential that can verify the accuracy of a qualification reported by an individual practitioner.
- **Primary Source Verification (PSV):**
  - Verification of an individual practitioner's reported qualifications by the original source or an approved agent of that source.

Credentials Verification Organization (CVO)

- Any organization that provides information on an individual's professional credentials. An organization that bases a decision in part on information obtained from a CVO should have confidence in the completeness, accuracy, and timeliness of information.
- The 10 principles are listed in Glossary (Page GL-9)
- Entities can be a company or another Joint Commission-accredited organization

MS 06.01.03
Credentialing

- **EP 2:** Credentialing process is based on recommendations by the organized medical staff.
- **EP 3:** Credentialing process is approved by the GB
- **EP 4:** Credentialing process is outlined in the med staff bylaws
- **EP 5:** The hospital verifies that the practitioner requesting approval is the same practitioner identified in the credentialing documents by viewing one of the following:
  - A current picture hospital ID card
  - A valid picture ID issue by a state or federal agency (e.g. driver's license or passport)

MS 06.01.03
Credentialing

- **EP 6:** The credentialing process requires that the hospital verifies in writing and from the primary source whenever feasible or from a credentials verification organization (CVO), the following information:
  - The applicant's current licensure at the time of initial granting, renewal and revision of privileges, and at the time of license expiration
  - The applicant's relevant training
  - The applicant's current competence

MS 06.01.05
Privileging

- **EP 2**: The hospital, based on recommendations by the organized medical staff and approved by the governing body, establishes criteria that determine a practitioner's ability to provide patient care within the scope of the privilege(s) requested. Evaluation of all of the following are included:
  - Current licensure and/or certification, as appropriate, verified with the primary source
  - Specific relevant training, verified with the primary source
  - Evidence of physical ability to perform the requested privileges
  - Data from OPPE by an organization(s) that currently privilege the applicant, if available
  - Peer and/or faculty recommendation
  - When renewing privileges, review of the practitioner's OPPE

MS 06.01.05
Privileging

- **EP 4:** The hospital has a clearly defined procedure for processing applications for the granting, renewal, or revision of clinical privileges
- **EP 5:** The procedure for processing applications for granting, renewal, or revision of clinical privileges is approved by the organized med staff
- **EP 6:** Health statement to perform privileges requested
- **EP 7:** Queries NPDB initial, renewal and when new privileges are requested

MS 06.01.05
Privileging

- **EP 8:** Peer recommendation includes written information regarding the practitioner's current:
  - Medical/technical knowledge
  - Technical and clinical skills
  - Clinical judgement
  - Interpersonal skills
  - Communication skills
  - Professionalism
- *Note: Peer recommendation may be in the form of written documentation reflecting informed opinions on each applicant's scope and level of performance or a written peer evaluation of practitioner-specific data collected from various sources for the purpose of validating current competence*

MS 06.01.05
Privileging

- **EP 9:** Before recommending privileges, med staff evaluates eight items
- **EP 10:** Hospital has a process to determine whether there is sufficient clinical performance info to make a decision to grant, limit, or deny requested privileges.
- **EP 11:** Action within time period specified in MS bylaws
- **EP 15:** **Deemed status**: Surgical services maintains a current roster listing each practitioner's surgical privileges

MS 06.01.07
Analysis of Information

- **EP 2:** The hospital, based on recommendations by the organized medical staff and approved by the governing body, develops criteria that will be considered in the decision to grant, limit, or deny a requested privileges
- **EP 8:** The governing body or delegated governing body committee has final authority for granting, renewing, or denying privileges
- **EP 9:** Privileges are granted for a period not to exceed two years

MS.06.01.09 Decision Communication to Requesting Practitioner

- Requesting practitioners are notified regarding granting decision
- In case of denial, the practitioner is informed of reason for denial
- Decision is disseminated and made available to all appropriate internal and external persons or entities, as defined by hospital and applicable law
- Dissemination decision is approved by organized medical staff
- Practitioner is aware of fair hearing and appeals process in the event of an adverse decision

MS.06.01.11
Expedited GB Approval

- The organized med staff develops criteria for an expedited process for granting privileges
  - To expedite initial appointments to membership and granting of privileges, reappointments, renewal or modifications of privileges, the GB may delegate to a committee consisting of at least two voting members of the GB
  - There are a number of conditions of ineligibility

MS.06.01.13
Temporary Privileges

- Important patient care need for the period defined in the MS bylaws
- When important care need, the organized med staff verifies current licensure and current competence
- New privileges may be granted while awaiting review and approval by the organized medical staff upon verification of ten items

MS.06.01.13
Temporary Privileges

- All temporary privileges are granted by CEO or authorized designee
- All temporary privileges are granted on recommendation of the medical staff president or designee
- Temporary privileges for applicants for new privileges are granted for no more than 120 days

MS.07.01.01
Oversight of Medical Staff Membership

- Medical staff develops criteria for medical staff membership
- Professional criteria are designed to assure the medical staff and governing body that patients receive quality care, treatment, and services
- The medical staff uses the criteria to appoint members to the medical staff, not to exceed two years

MS.07.01.01
Oversight of Medical Staff Membership

- Gender, race, creed, and national origin are not used in making decisions regarding the granting or denying of medical staff membership
- Membership is recommend by the medical staff and granted by the GB

You are the Surveyor!

Special Privileges

Description: Must also meet Required Qualifications for Core Privileges

Request ☐	***Request all privileges listed below.*** *Uncheck any privileges that you do not want to request.*	Service Chief Rec ☐
☐	Administration of Sedation	☐
☑	Treatment of patients in outpatient clinics	☐
☐	Admit, treat, evaluate or provide follow-up care for inpatients ages 14 years or younger	☐
☑	Fiberoptic sigmoidoscopy - with biopsy	☐
☑	Cervix - biopsy	☐
☑	Cervix - cryocautery	☐
☑	Colposcopy	☐
☑	Hemorrhoidal rubber banding	☐
☐	Newborn circumcision	☐

Published: 12/11/2013

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☐	
☐	
☐	

You are the Surveyor!

Department of Psychiatry – Privilege List - Delineation of Privileges

NAME: J S

Documentation of Volume Criteria for Special privileges	# of procedures performed last 2 years	# of procedures performed last 5 years	Hospitals where performed
Ketamine Infusion Therapy	N/A	N/A	N/A
Transcranial Magnetic Stimulation (TMS)	N/A	N/A	N/A
Vagus Nerve Stimulation (VNS)	N/A	N/A	N/A

Please be prepared to supply verification of volume performance if requested.

PHYSICIAN'S SIGNATURE _____

Acknowledgment of Practitioner: I understand that (a) in exercising clinical privileges granted, I am constrained by Medical Staff Policies and Procedures, Rules and Regulations, and (b) any restriction on the clinical privileges granted to me is waived in an emergency situation and in such situation my actions are governed by the applicable section of the Medical Staff Bylaws.

I hereby attest to having performed the stipulated number of procedures as indicated above, thereby meeting the criteria for those privileges I have requested.

****

COMMITTEE APPROVALS

y QI/Administrative Committee Date: 9/2016

Or Dept Chief (in lieu of mtg) _____

Credentials Committee Date: 9/14/2016

Medical Executive Committee Date: 10-5-2016

Board of Directors Date: _____

TEMPORARY PRIVILEGE APPROVAL

Department Chief: _____

Date: _____

Document Approvals:
Department of Psychiatry: 11/22/11
Credentials Committee: 12/13/11
Medical Executive Committee: 12/20/11
Board of Directors: 01/9/12

MS.07.01.03
Peer Recommendations

- Recommendations from peers are obtained and evaluated for all new applicants for privileges
- Upon privilege renewal, when insufficient practitioner-specific data are available, the medical staff obtains and evaluates peer recommendations

MS.07.01.03
Peer Recommendations

- Peer recommendations include the following information:
  - Medical/clinical knowledge
  - Technical and clinical skills
  - Clinical judgement
  - Interpersonal skills
  - Communication skills
  - Professionalism
- Peer recommendations are obtained from a practitioner in the same professional discipline as the applicant with personal knowledge of the applicant's ability to practice

Focused Professional Practice Evaluation

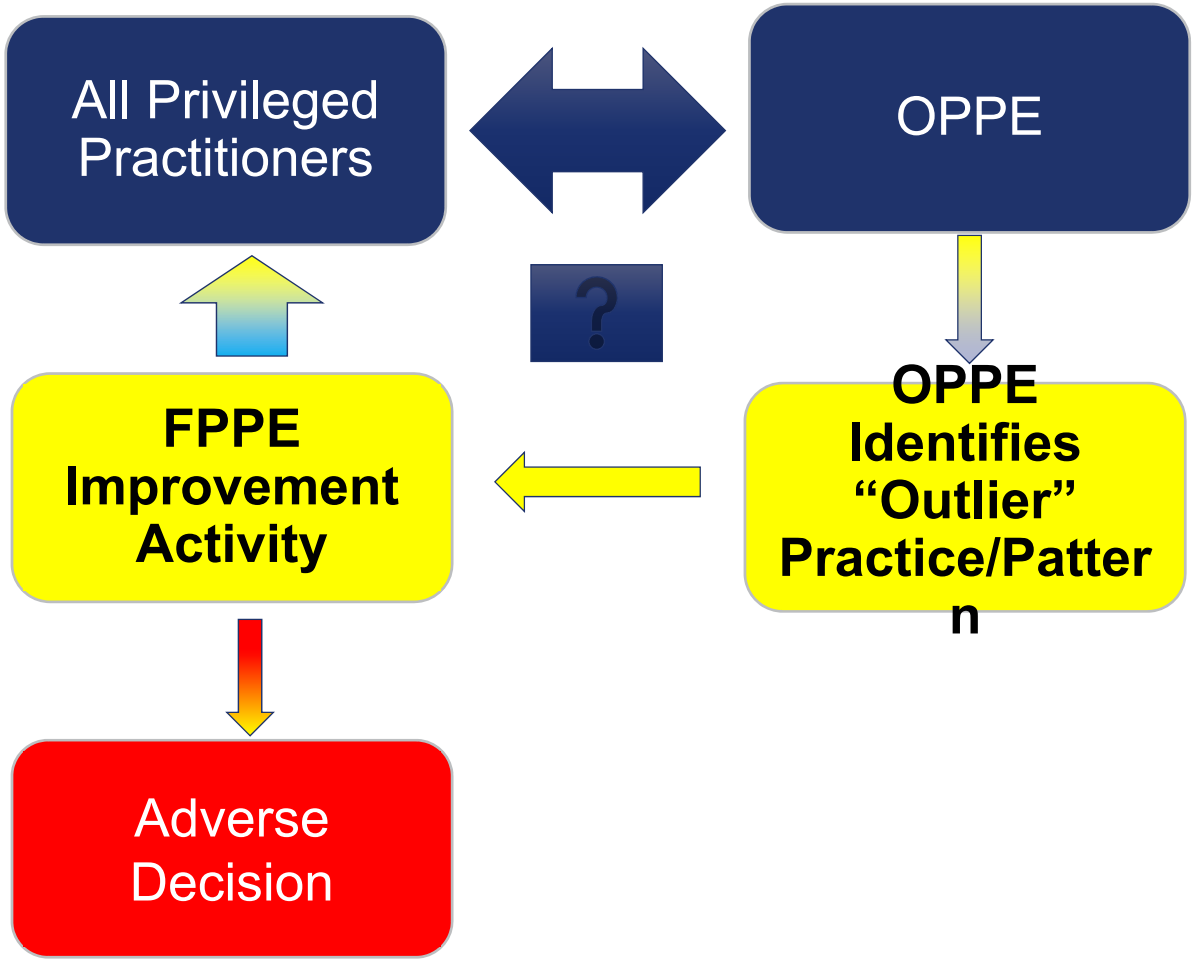
Initial Privileges

- All new practitioners
- All new privileges

Performance Improvement

- Criteria based
- Triggers: single incidents or trends (OPPE)

Dynamic Relationship between OPPE and FPPE



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Specialty-Specific Data

- Indicators are *defined by each specialty* and approved by the organized medical staff
- Do not forget non-MD, DO, DPM & DDS that are privileged
- Methodologies for collecting data include:
  - Periodic chart review
  - Direct observation (proctoring)
  - Monitoring of diagnostic and treatment techniques
  - Input from other individuals involved in care

Sample Departmental Report

	136	213	1009	380	254P	653	289	402	900	Target
HgA1c-Provider	8.03%	8.01%	8.00%	6.45%	6.83%	6.39%	7.09%	7.13%	5.93%	
HgA1c-Dept	7.10%	7.10%	7.10%	7.10%	7.10%	7.10%	7.10%	7.10%	7.10%	<6.5%
DM screening-Provider	100%	99%	97%	100%	97%	100%	99%	91%	100%	
DM screening-Dept	98%	98%	98%	98%	98%	98%	98%	98%	98%	100%
Abx prior to sx-Provider	98%	92%	97%	100%	99%	100%	100%	99%	100%	
Abx prior to sx-Dept	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
Complications-provider	0.00%	0.50%	2.12%	0.00%	0.00%	0.05%	0.33%	1.01%	0.02%	
Complications-Dept	0.45%	0.45%	0.45%	0.45%	0.45%	0.45%	0.45%	0.45%	0.45%	<1.00%
Readmission-Provider	1.00%	0.25%	0.75%	2.40%	4.00%	0.33%	0.68%	1.99%	2.00%	
Readmission-Dept	1.49%	1.49%	1.49%	1.49%	1.49%	1.49%	1.49%	1.49%	1.49%	<2.00%
Sentinel Events-Provider	0	0	0	0	0	0	0	0	0	
Sentinel Events-Dept	0	0	0	0	0	0	0	0	0	0

Low/No Volume Practitioners

- More accurate term is “little/no data” practitioners
  - Mid-levels
  - Non-proceduralists / surgeons
  - Primary care/non-hospitalists
  - No activity practitioners
- Use of data from other organization only supplements
- Little/no data is information
- Biggest issue is attribution or validity
- Input from others within the organization

Summary

- FPPE is a *brief* period of looking at the basic safety and competence in exercising ALL privileges for new medical staff members or if something gets triggered
- OPPE is an *ongoing* period of looking at just a *few* indicators of quality for EACH practitioner – it touches on something he/she does, but not everything

MS.09.01.01
Reports of Concern

- Hospital, based on med staff recommendation and GB approval, a clearly defined process for collecting, investigating, and addressing clinical practice concerns
- Reported concerns regarding a privileged practitioner's professional practice are uniformly investigated and addressed as defined by the hospital and applicable laws.

MS.10.01.01
Fair Hearing and Appeals

- A fair process that may differ for members and nonmembers of the medical staff
- Mechanism to schedule a hearing of such requests
- Identified the procedures for the hearing to follow
- Identifies the composition of the hearing committee as a committee that includes impartial peers
- With the governing body, provides a mechanism to appeal adverse decisions as provided in the MS bylaws

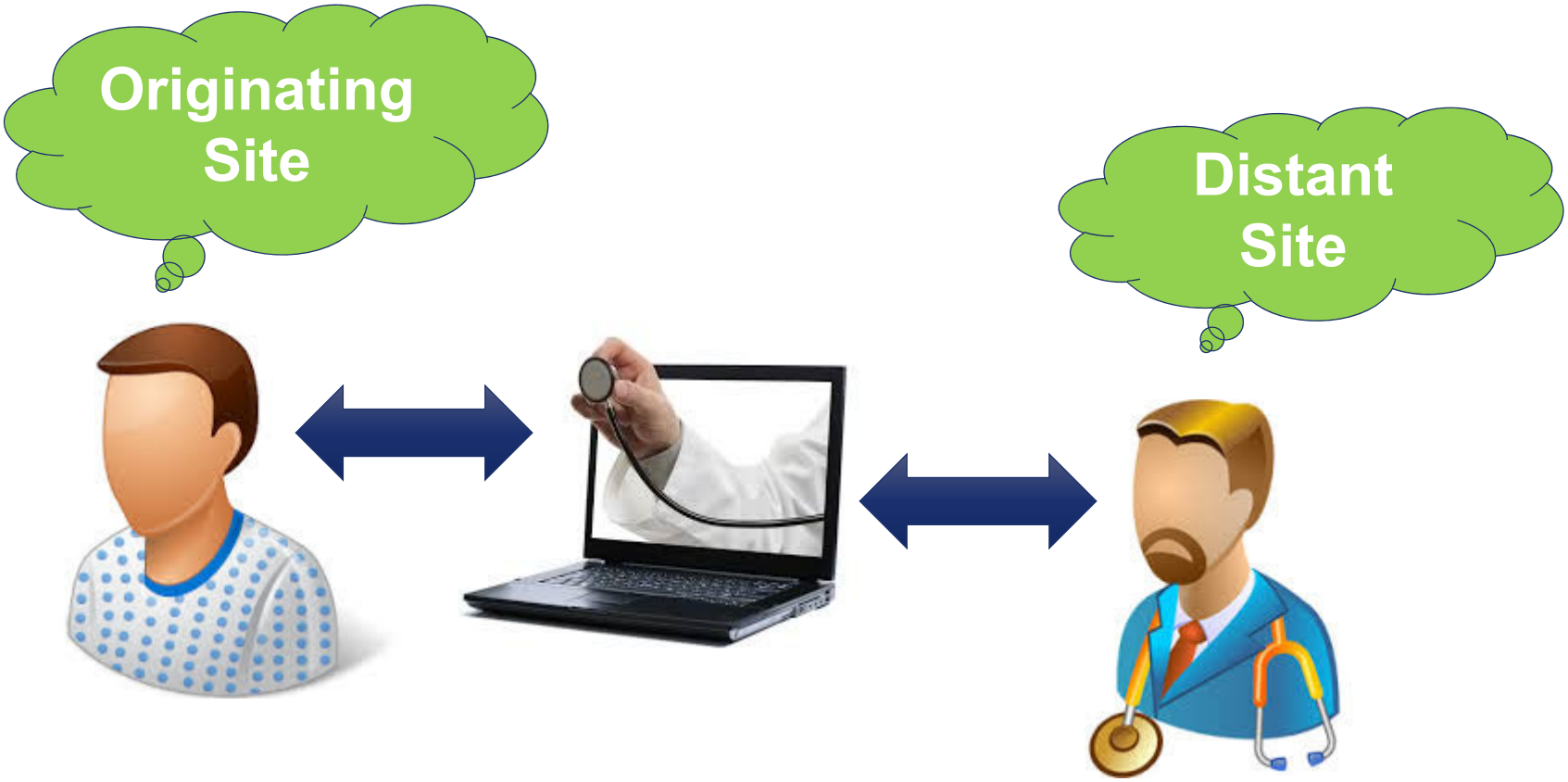
MS.11.01.01
LIP Health

- Education of LIP and other staff about illness and impairment recognition issues specific to LIP
- Self referral by a LIP
- Referral by others and maintaining informer confidentiality
- Referral of a LIP to appropriate professional resources for evaluation, diagnosis and treatment

MS.11.01.01
LIP Health

- Maintain confidentiality, unless limited by law, ethical obligation, or when health and safety of a patient is threatened
- Evaluation of the credibility of a complaint, allegation, or concern
- Monitoring of the LIP and safety of patients until rehabilitation is completed and periodically thereafter, if required
- Reporting to med staff leadership In which a LIP is providing unsafe treatment
- Initiate appropriate actions if LIP fail to complete rehabilitation

Telemedicine



MS.13.01.01
Telemedicine

- All LIP's who are responsible for the patient's care, treatment and services via a telemedicine link are credentialed and privileged:
  - At the originating site, according to standards MS.06.01.03 through MS.06.01.13
  - From distant site if Joint Commission-accredited
  - From the distant site if all are met (see next slide)

MS.13.01.01
Telemedicine

- If you use the C&P decision from the distant site to make a final privileging decision if ALL of the following requirements are met:
  - Joint Commission-accredited
  - Practitioner privileged at distant site for services needed
  - **Current list of privileges provided from distant site**
  - Evidence of an ongoing internal review of practitioner performance
  - The distant-site practitioner has a license that is issued or recognized by the state in which the patient is receiving services.
    - Note 1 & 2: Take a look; #2 pertains to Joint Commission for deemed status

Telemedicine

- Usually a contracted service
- Watch how the contract is written, include written performance expectations
  - These can include verification of ID and OPPE for the individual as long as it can be specific to your site
  - Be able to get data from the distant entity.
- Regardless of option, maintain your own file
  - **(CFR Section 482.22(a)(3)**

You're the Surveyor…

- The organization was very proud of their OPPE reports. The Chief Quality Executive explained that the hospital was able to extract approximately 150 indicators and apply that into each departmental profile

  - Which of the following would be your first question?

    A. Sounds good. Where is a good place for dinner?

    B. Sounds great! What software are you using?

    C. Did the departmental chairs sign off on this?

Knowledge Check

- What is the maximum length of time for temporary privileges for an applicant with new privileges?
  A. Based on patient care needs
  B. 120 days
  C. Two years

Continuous Compliance through Leadership Engagement

If your senior leadership team is not engaged in continued compliance readiness, you may be sailing on the Titanic

Getting Leadership Onboard

- Engage at least one senior leader as a sponsor
- Work with sponsor to establish a continuous readiness plan
- Assess your senior team's level of "teamwork"

Sponsor

- Does not have to be your supervisor
- Needs to be a senior leader with a passion for improvement or at least an interest
- Is willing to learn
- Is willing to challenge and engage other senior leaders

Continuous Readiness Plan

- Conduct a gap analysis for all chapters, standards and elements of performance
  - In-house
  - External
- Identify areas of opportunity
- Develop an education plan
- Get senior leaders on board

Getting Leadership On-Board

- Get on senior leadership agenda for at least an hour; leverage your sponsor if necessary
- Prep the program at least two weeks in advance
- Review with sponsor for feedback
- Present with confidence and passion

Leadership Presentation Part 1

- What drives healthcare leadership?
- Present your organization's numbers for adverse events the prior fiscal year
- Discuss the cost of poor reliability and quality
  - What does a fall with injury cost the organization?
  - What does a wrong site surgery cost?
  - What does a serious medication error cost?

Leadership Presentation

- Introduce the concept as to how continuous readiness drives high quality
- Discuss the link between CMS deemed status vs. accreditation
- Joint Commission accreditation defines the basic standards
- Your goal is to get buy-in from leadership to support continuous readiness

Leadership Engagement

Get CEO support for presentation to the hospital board

Readiness Plan

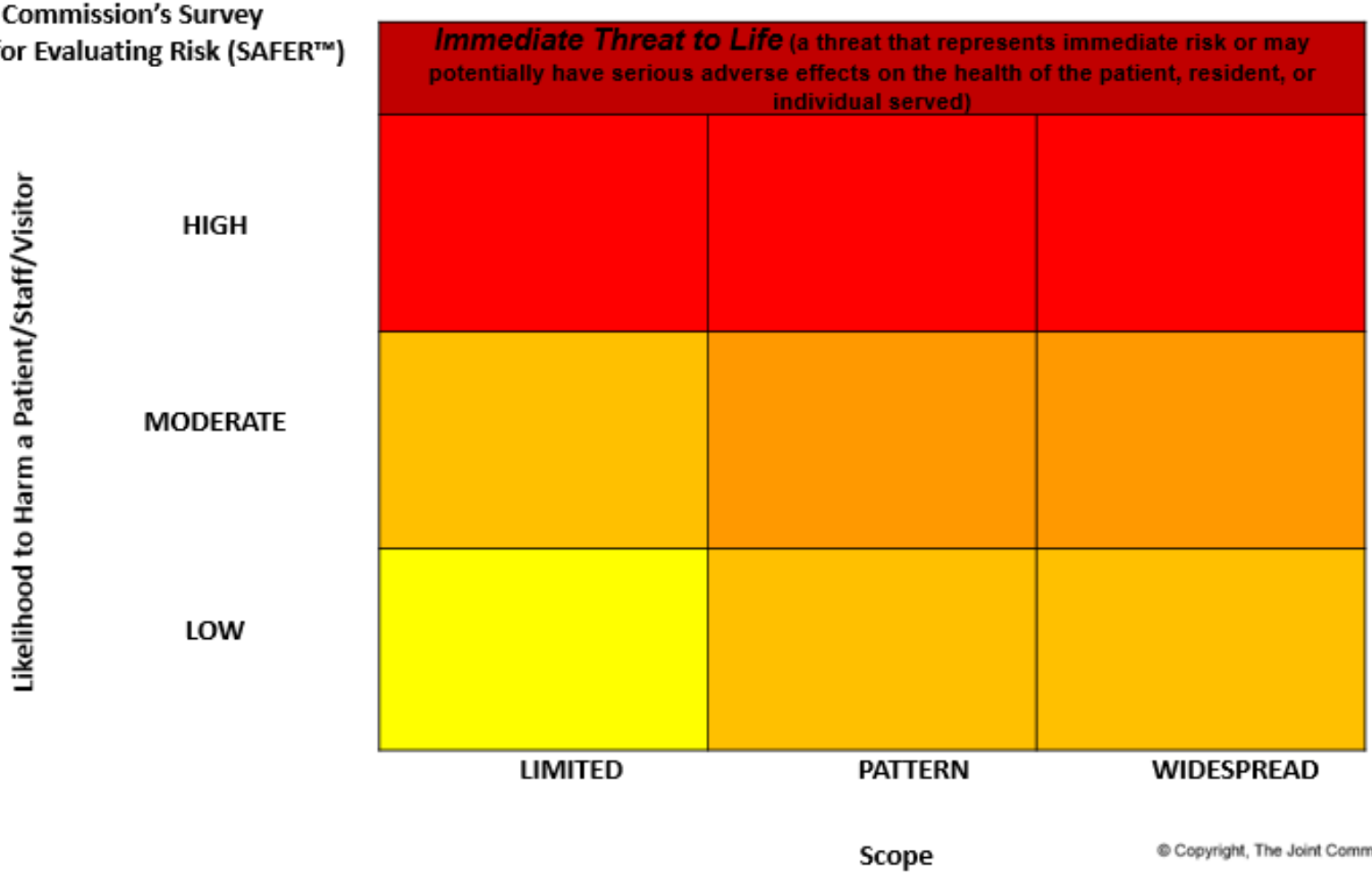
- Educate frontline and middle and senior leaders about The Joint Commission, standards, EP's and (AMP with tracer tools)
- Assign chapter champions (middle leaders) to each Joint Commission chapter – become chapter experts
- Hold tracer training for all levels of leaders
- Evaluate IT support for project management

Readiness Plan

- Establish tracer calendar with assignments
  - Leaders do not trace their own units/departments
  - Can use the tools for monitoring their units
- Frontline/middle leaders trace monthly
- Senior leaders trace quarterly to validate
- Problem areas traced weekly
- Generate a SAFER matrix for tracer findings
- AMP monthly reports to board, senior leadership and quality/regulatory committee

SAFER

The Joint Commission's Survey Analysis for Evaluating Risk (SAFER™) Matrix™



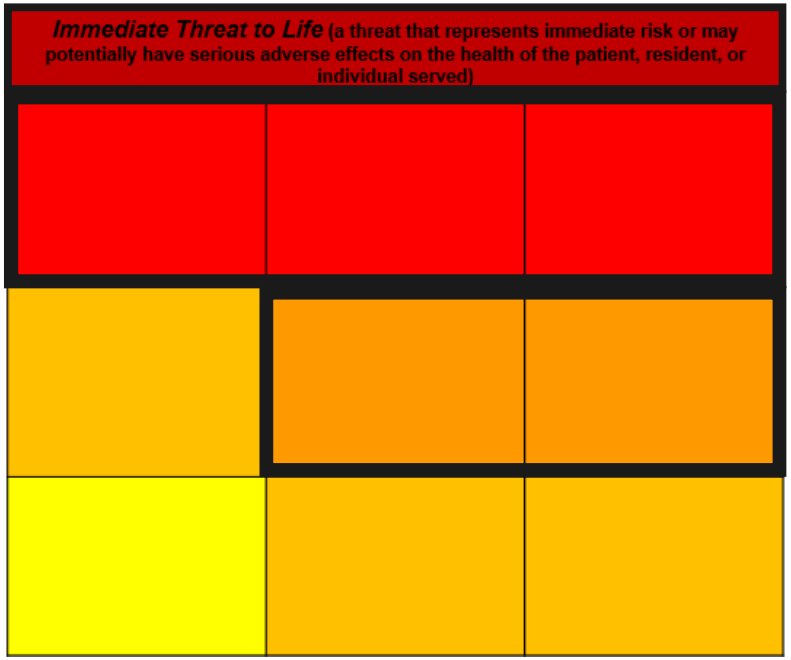
The Joint Commission

Senior Leader Responsibility after Survey

Fix it now or
fix it later

New ESC Fields

- Only for findings cited within the higher risk areas (dark orange and red areas of SAFER matrix)



  - Includes 2 new fields:
    1. Leadership Involvement
    2. Preventive Analysis

Prioritized Follow-up Action

SAFER Matrix™ Placement	Required Follow-Up Activity
HIGH/LIMITED, HIGH/PATTERN, HIGH/WIDESPREAD	• 60 day Evidence of Standards Compliance (ESC) - ESC will include Who, What, When, and How sections • ESC will also include two additional areas surrounding Leadership Involvement and Preventive Analysis • Finding will be highlighted for potential review by surveyors on subsequent onsite surveys up to and including the next full triennial survey
MODERATE / PATTERN, MODERATE/ WIDESPREAD	• 60 day Evidence of Standards Compliance (ESC) - ESC will include Who, What, When, and How sections • ESC will also include two additional areas surrounding Leadership Involvement and Preventive Analysis • Finding will be highlighted for potential review by surveyors on subsequent onsite surveys up to and including the next full triennial survey
MODERATE / LIMITED LOW / PATTERN, LOW / WIDESPREAD	• 60 day Evidence of Standards Compliance (ESC) - ESC will include Who, What, When, and How sections
LOW/LIMITED	• 60 day Evidence of Standards Compliance (ESC) - ESC will include Who, What, When, and How sections

Preventive Analysis

- Ensures the corrective action does not simply fix the issue at hand
- Focuses on identifying and addressing underlying reasons that caused the issue
- Efforts also focused on preventing future occurrences of the high risk issue
- Keeps it from happening again

Continuous Compliance Success Factors

- Organizational priority
- Leadership buy-in & involvement (Not just a Quality thing)
- Structures that facilitate continuous process review & improvement
- Education and communication
- Trained front-line staff, med & house staff
- Periodic compliance reminders
- Practice in little bites of time
- Regular mock surveys & tracers

REMEMBER

- The process does not stop, sans a natural disaster
- Leaders cross-cover tracers when other leaders are away
- The organization is never “too busy”
- Consider designated tracer times i.e.. Tracer Fridays

YOU MUST INSPECT, WHAT YOU EXPECT

Questions?