Joint Commission top-cited standards: Toughest challenges of the year

The Joint Commission officially announced the most-cited standards for the first half of 2009, and Life Safety standards top the list.

Back in 2007, the Life Safety chapter consisted of only a single standard (EC.5.20) but was subsequently split into seven standards, leading citations for this area to jump from 29% to 45% in 2008. Three of the top 10 most-cited standards (and the two most-cited) fell under the Life Safety chapter.

Environment of Care (EOC) is “a huge fraction of the top 25 citations,” Bud Pate, REHS, vice president of content and development at The Greeley Company, a division of HCPro, Inc., in Marblehead, MA, said during a recent presentation for the Center for Healthcare Accreditation. “Folks who are going to the accrediting side often come from a clinical background and don’t communicate as effectively as they’d like with those with EOC background.”

The top-cited Life Safety Code® (LSC)–related standards are as follows:

➤ LS.02.01.20 (45%)—maintaining means of egress. This standard was the most cited in the first half of 2009.
➤ LS.02.01.10 (43%)—building and fire protection features minimize the effects of fire, smoke, and heat. This was the second most-cited standard.
➤ LS.02.01.30 (36%)—provision and maintenance of building features to protect individuals from the hazards of fire and smoke. This was sixth among the top 10 standards.

There is some historical explanation for jumps in LSC citations, explained Lisa Eddy, RN, CPHQ, CSHA, senior consultant at The Greeley Company, who also spoke during the presentation.

“There is a major jump in LSC findings, basically because in 2007 all of these were nested under EC.5.20. They were divided into seven separate standards in 2008.”

—Lisa Eddy, RN, CPHQ, CSHA

After reading this article, you will be able to:

➤ Identify the top-cited standards of early 2009
➤ Discuss standards that saw major increases in citations in 2009
➤ Identify the most common Environment of Care citations
➤ Discuss the state of the most-cited National Patient Safety Goals

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Having a top-of-the-line code of conduct can bring about improvements across the board. Find out how one facility upgraded its policy and saw major changes.

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Education is always a challenging territory for hospitals, and this month, Jodi Eisenberg, MHA, CPMSM, CPHQ, CSHA, identifies methods to improve education for patients and their families at any facility.

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The Joint Commission’s application for continued deeming authority has been approved—we have the details on this important news.

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said Eddy. “They were divided into seven separate standards in 2008.”

Record of Care standards were found twice in the top 10 list. Verbal orders (RC.02.03.07) was cited 40% of the time, the third most-cited standard, and requirements to maintain complete and accurate medical records (RC.01.01.01), always a trouble area for hospitals, was cited 33% of the time, making it the eighth most-cited standard.

Maintenance of fire safety equipment and fire safety building features (EC.02.03.07) retained a top spot among cited standards at 38%. “All of the EOC issues garnered frequent findings,” said Eddy.

**NPSGs**

The National Patient Safety Goals (NPSG) were cut down significantly for 2010. Requirements for commonly cited NPSGs for critical tests and critical values have been loosened and will not likely appear on future lists of top-cited standards, at least for the time being. In the first half of 2009, however, critical tests/critical values (NPSG.02.03.10) was cited 38% of the time. Another top-cited NPSG in years past, do-not-use entries, has been moved to the standards and out of the NPSGs.

“Due to the sheer volume of entries, it is really hard to fall out of compliance just due to numbers,” she said.

The Universal Protocol™ is another evolving requirement within the NPSGs and has received extensive review by The Joint Commission in 2009. It is the most-cited sentinel event in The Joint Commission’s database, the accrediting body said at its Executive Briefings conference in September 2009. UP.01.03.01, requiring a timeout performed immediately prior to starting a procedure, was the seventh most-cited standard in the first half of 2009, cited 34% of the time. Eddy noted that the requirements for timeouts were reduced to very reasonable levels in September 2009.

Two Medication Management standards rounded out the top 10—MM.03.01.01 (33%), medication storage, and MM.04.01.01 (32%), clear and accurate medication orders.

“The medication storage climb is due to highlighting CMS’ Interpretive Guidelines, we feel,” said Eddy. She suggested focusing on whether the right people are
authorized for access to medication storage areas when assessing your organization’s policies. Regarding medication orders, Eddy said this appears to be a top-cited standard mostly due to PRN (as-needed) medications.

Verbal orders were cited in a massive percentage of hospitals in 2009.

“Verbal and telephone orders were cited at a whopping 40% in 2009, and RC.01.01.01 is a direct impact standard—always clarify verbal orders,” said Eddy.

Pain assessment and reassessment found itself on the list this year.

“The jump is mainly due to the scoring change—now we only have two observations,” said Eddy. “It used to be three, but now two requirements are going to throw it out of compliance.”

Among the top-cited standards in 2009, unsurprisingly, were those regarding focused and ongoing professional practice evaluation.

“Many facilities are struggling with this,” said Eddy.

Finally, nursing credentialing documentation was hit hard last year. However, the year’s biggest challenges can be boiled down to two main areas. “There are really two large buckets: clinical documentation and EOC,” said Pate. “We’ve listed seven things tied to EOC, and if you include flash sterilization, it’s eight. This has a huge impact on the number of RFIs.”

Note: LD.04.04.05 discusses an expectation for a very detailed risk assessment once every 18 months for a patient care process. This is widely known as the failure mode and effects analysis (FMEA) standard. Please don’t confuse what we’re suggesting with an FMEA. We’re discussing a one- or two-page document that supports suicide opportunities in behavioral healthcare units, use of fanny packs to transport medications, and scores of other issues. It’s time, therefore, to review how to perform and document these assessments.

A risk assessment should be performed when any of the following applies:

➤ An assessment is specifically required by the standard, including risk assessments and risk reduction strategies related to the environment of care, emergency management, and infection and leadership

➤ A frequently cited or problematic issue exists for which there are no specific regulatory requirements

➤ Your approach to compliance is unusual, making it likely that surveyors will question why you chose your approach to the item of focus
Risk assessments < continued from p. 3

your position related to a frequently cited issue: something that takes surveyor preference out of the compliance equation.

How to document a risk assessment

We’ve posted a sample risk assessment on the open blog of the Association of Healthcare Accreditation Professionals. Although this sample functions as a general guide for documenting risk assessments, it also happens to address the blanket warmer issue. This sample document can be found at http://tinyurl.com/yeajk8a. We recommend that you take a moment to download the blanket warmer risk assessment before continuing with this article.

Ready? Okay, let’s look at the sample:

➤ Section 1: State the issue clearly and simply. In the blanket warmer example, we stated the issue as a series of questions.

➤ Section 2: Take a look at federal and state law and Joint Commission standards related to the issue. Specifically reference applicable standards so that anyone who questions your decision, including surveyors, can see for themselves what the regulations really say.

➤ Section 3: Summarize relevant literature. Include references.

➤ Section 4: Summarize relevant information from internal safety and quality monitoring.

➤ Section 5: Take a look at the operational effect of the various options. What would the cost and path to implementing change be?

➤ Section 6: Take a stance. Clearly articulate the organization’s final position on the issue.

➤ Section 7: Indicate when the issue was approved.

That’s it—you’re done. It’s only about two pages. Let’s walk through the blanket warmer sample again in more detail:

➤ Section 1—Issue: Hospitals have been frequently cited related to blanket warming temperatures, raising a series of questions. Should there be a maximum temperature? Who should monitor the temperature?

➤ Section 2—Regulations: You’ll note that there is no regulation that sets a maximum temperature for blanket warmers.

➤ Section 3—Literature: The Emergency Care Research Instituterecommends a maximum temperature of 130ºF but does not support this recommendation with data. Other literature with better data suggests that higher temperatures are safe and desirable.

➤ Section 4—Internal information: In this example, we indicate a lack of relevant incidents and a tie-in with patient care and satisfaction.

➤ Section 5—Operations: There is an acknowledgment that temperature monitoring is difficult to implement and is typically not successful. Better are processes that build in a margin of safety for the patient.

➤ Section 6—Conclusion/position: This fictitious institution decided not to set a maximum temperature for blanket warmers but, instead, to reinforce preventive maintenance. It also decided to prohibit the storage of IV fluids in blanket warmers.

➤ Section 7—Approvals: This institution had the position approved by the performance improvement committee, the operating room committee, and the leadership council. You can choose the right level of approval for the issue and your organization.

Now just put the analysis in a place where you can find it and you’re set. You don’t have to reassess unless something changes (e.g., a regulation, the literature, incidents, and so forth).

We are comfortable that the approach recommended, assuming the conclusion is consistent with the data in the assessment, will ultimately hold sway over surveyor preference.
New code of conduct improves employee outlook, patient satisfaction

When it comes to certain policies, it’s all about the details.

In 2006, Pam Harmon, RN, legal nurse consultant and chief nursing officer at Fredonia (KS) Regional Hospital (FRH), took a closer look into her facility’s employee code of conduct.

The Commitment to Coworkers policy, as the code of conduct was then known, only pertained to the nursing staff and did not deal with other staff members’ attitudes. However, FRH’s new facility policy stated that the code of conduct’s new purpose was to include everyone—not just the nursing staff—and to change the attitude of every staff member at FRH.

Harmon took matters into her own hands, and with the help of an inservice committee, changed FRH’s code of conduct.

Research

Harmon searched the Web for a variety of examples from facilities across the nation to get a broader perspective on her options. Using keywords such as “standards of performance” and “code of conduct,” Harmon gathered a few examples that she brought to an inservice committee meeting.

Harmon was careful to not try to layer another facility’s policy onto FRH. Instead, she selected items that were applicable to her facility.

“We took a lot of information from other facilities’ examples, only taking what we felt necessary for Fredonia,” says Harmon.

From these examples, Harmon and the inservice committee blended information to fit the needs of FRH and came up with the standards of performance that would include all staff members.

“Throughout the development of the standards of performance, the inservice team and I decided which information would be important enough to feature in the document,” says Harmon. Improving the attitude and quality of patient care along with the attitudes of staff members was the committee’s focus during its review of the information.

Old versus new

Eventually, Harmon and the committee determined the areas the new standards of performance would focus on. These areas included:

➤ Attitude
➤ Personal appearance
➤ Communication
➤ Culture of safety
➤ Commitment to patients
➤ Commitment to coworkers
➤ Customer waiting
➤ Hallway etiquette
➤ Privacy
➤ Safety awareness
➤ Sense of ownership

“The old code of conduct was not as specific and did not pertain to every staff member in the facility,” says Harmon.

The previous code of conduct was a one-page document that only addressed patient care staff members, and there was no requirement to sign any documentation regarding the code.

Now, the standards of performance is a two-page document everyone in the facility—from the CEO all the way down to new hires—has to sign.

“We have been talking about focusing on positive thinking, positive ways to approach people, and we as a committee feel if we could get something everyone could read, sign, and commit to, then we would have a better outcome and performance from all staff members,” says Harmon.
The new standards of performance policy is not only signed by everyone in the facility, but is also reissued annually, so staff members are reminded of the commitment they have to themselves, the patients, and other staff members at FRH.

The policy is also an important part of the hiring process and is one of the main points of information that FRH discusses with each potential employee. During the interview process, the expectations derived from the standards of performance are discussed in great length.

“We ask the potential candidate questions regarding the policy and handling particular situations so they are thinking about these things before they sign in to be a part of our facility,” says Harmon.

No tolerance for negativism

With any new policy, there are staff members who do not take things seriously, and with FRH’s new standards of performance, there were a few teaching moments.

“Over the three years, there have only been a few instances where employees did not abide by the standards of performance policy,” says Harmon.

For a first offense, employees receive a verbal warning if they are not living up to the expectations stated in the policy. A second offense earns a written warning, and if the behavior continues, the staff member might be put on suspension and eventually terminated from FRH.

“We developed a policy that has no tolerance for negativism and a goal of improving customer service by improving the attitude of all our staff,” says Harmon.

Keeping patients and staff members satisfied

To help encourage staff members to keep a positive attitude, Harmon and her committee developed a “kudos board.”

At FRH, patients receive a satisfaction survey that allows them to comment on their stay and rate their overall experience. The survey asks patients to comment on the nurses and whether anyone either went above and beyond the call of duty or fell short of the patient’s expectations.

If a patient comments that a nurse exceeded his or her expectations, the nurse's name is displayed on the kudos board for all staff members to see. In addition, the nurse receives a thank-you gift card that’s good for a snack in the cafeteria.

“As the results from our satisfaction survey improve, it is important to continue to build up staff morale and praise good behavior,” says Harmon.

To help with patient satisfaction, nursing supervisors at FRH now call patients two to three days after they are discharged from the hospital to check how they are doing. The nursing supervisors also answer any questions that patients may have and ensure that they have made follow-up appointments with their doctors.

Helpful piece of advice

Overall, Harmon is satisfied with the new standards of performance policy and does not think it is necessary to make any changes. Patients and staff members are satisfied, and the morale of both groups is continuing to improve.

“A few weeks ago, I saw one of the unit clerks placing a handwritten thank-you card into one of their colleague’s lockers,” says Harmon. “It’s nice to know that the staff members are carrying out this behavior amongst themselves.”

To other facilities that are looking to improve upon their own code of conduct or tweak their policy, Harmon emphasizes how important it is to address all areas of the facility.

“It has to pertain to everyone: how you communicate and act toward your peers, your patients, their families,” she says. “It needs to not just be employee-to-employee or employee-to-patient. Everyone has to be viewed as the customer because there can be doctors who are coming from an outside source. Everyone is the customer, and not just the patient.”
Fredonia Regional Hospital employee standards of performance

Attitude
My job is to serve all our customers by providing quality service with care and courtesy. I know that my customers are the patients, their family members, the medical staff, volunteers, the public/services we have daily contact with, and my peers. I will always thank our customers for choosing Fredonia Regional Hospital and try to exceed all our customers’ expectations.

Personal appearance
I will present myself in a professional manner, always welcoming and greeting patients, visitors, and employees. I will follow the department’s dress code policy, wear my employee badge at all times, and keep it secure when not being worn.

Communication
I will communicate with others in a positive manner, striving to find a way to compliment and uplift all persons. I will be responsive in all workplace interactions, listening to my customers whether they are patients, family members, or other members of the workforce. I will smile and be aware of my body language and nonverbal communication. I will provide an interpreter for a second-language patient or family member.

I will identify myself when talking on the telephone and provide the correct number and get the caller’s permission before transferring his or her call. I will answer all calls as quickly as possible. I will take the initiative to express concerns and suggestions to benefit the team as a whole.

Safety culture
I understand the commitment of the organization to a culture of safety and fearless communication. I will be responsible for reporting any issue to the proper person and will do so with the understanding that the organization has a policy of nonpunitive reporting. If there is ever an occasion where I feel I have been made to feel uncomfortable for reporting, I will bring this to the attention of my director or the HR director.

Commitment to patients
I will acknowledge patients’ questions and concerns immediately. I will always address patients with respect and dignity while making their needs first priority. I will provide a pleasant environment to promote healing, keeping a holistic perspective. I will provide continuity of care by reporting to coworkers before change of shift.

Nursing: I will acknowledge patient call lights in a timely manner and anticipate the patients’ needs before leaving the room to decrease their need to use the call light.

Commitment to coworkers
I will welcome all newcomers to make their adjustment as a team player to the hospital and department as pleasant as possible, remembering that I was once in their shoes. I will demonstrate a strong work ethic by showing that I care about myself, my job, and my coworkers by being on time and lending a helping hand whenever possible. I will treat my coworkers as professionals deserving courtesy, honesty, respect, and cooperation in the same manner as I would expect to be treated. I will respond to pages, requests, e-mails, and phone calls in a timely and professional manner.

In addition, I will acknowledge other departments’ policies and procedures that relate to me and follow their rules and regulations. All attempts will be made to work out any problems between coworkers on a personal basis in a timely manner before involving supervisors with the attempts being documented.

Customer waiting
I will acknowledge the patients/families that are waiting by checking in on them periodically according to department policies. I will offer an apology if the wait is longer than anticipated, always thanking the customer for waiting. I will try to make their wait comfortable, offering chairs if possible.

Hallway etiquette
Courtesy and professionalism will be extended to patients, visitors, and each other in the hallways and will be a top priority of the employees of Fredonia Regional Hospital. I will make eye contact, smile, and say hello to visitors, patients, and coworkers. I will never be too busy to help someone or ask whether help is needed. Talking to coworkers in...
Fredonia Regional Hospital employee standards of performance (cont.)

the hallways will be kept to a minimum, and I will never be so involved in a conversation that I overlook a visitor needing help. If someone is lost, I will walk him or her to where they need to be. I will open doors cautiously and use the safety mirrors provided. I will continually strive to exceed the expectations of others as I pass through the halls.

Privacy
I am committed to the protection of my fellow employees as well as the patient’s rights to personal and informational privacy. I fully understand that I have the responsibility to ensure that all communication and records inclusive of demographic, clinical, and financial information is treated and maintained as confidential. I will do this in the hospital as well as in the community. I am committed to the value of providing care and communication in an environment that respects privacy. I will be considerate in all interactions and in the provision of care at all times and under all circumstances with the highest regard for a person’s personal privacy and dignity. I expect, of other employees and myself, behavior that represents the expressed value in honoring and protecting everyone’s right for privacy and personal safety.

Signature  Date
________________________________   _______________________________
Print name  Department
________________________________   _______________________________

Source: Fredonia (KS) Regional Hospital. Reprinted with permission.

Safety awareness
I will complete all yearly mandatory training as required by Fredonia Regional Hospital. I have a personal responsibility to be familiar with and follow the safety policies and procedures. If I observe any unsafe condition or safety hazard, I will correct it if possible or report it immediately. I understand the importance of reporting all accidents and/or incidents promptly.

Sense of ownership
I will accept all the rights and responsibilities of being part of the hospital’s team by living the hospital’s mission, vision, and values. I am an example to others and I will be a leader in providing excellent customer service both in the hospital and community. I will hold the people and property of the hospital in high regard. I will be responsible for my own work area. If I see or make a mess, litter, or spill, I will clean it up or get appropriate help when necessary.

I have read Fredonia Regional Hospital’s employee standards of performance and will perform them to the best of my ability.
Editor’s note: This feature explores problematic Joint Commission standards with expert advice from BOJ advisors. This month’s edition is written by Jodi Eisenberg, MHA, CPMSM, CPHQ, CSHA, program manager of accreditation and clinical compliance at Northwestern Memorial Hospital in Chicago.

Patient and family education is one of those problematic standards and requirements for improvement that boggles my mind. In the course of patient care, every patient/family interaction is an opportunity to educate. The primary objective of patient education is to help patients and families to understand their rights and responsibilities in their care, treatment, and services.

Patients receive education and training specific to their needs and appropriate to the care, treatment, and services provided.

Incorporate patient teaching into your hands-on care. Some examples of organizational initiatives include the following:

➤ “New” (first dose) medication monitoring—engage the patient in the process
➤ Medication administration and reconciliation—a great opportunity for patient teaching
➤ Advance directives—referrals to chaplains, social workers, or the patient representative department
➤ Infection control/hand hygiene—share key points with patients as you take these actions

You do not have to be an expert on every topic to begin teaching. Instead:

➤ Ask the patient to review information and ask or write down questions. Go over the questions with the patient; answer what you know and defer other questions to clinical experts as appropriate.
➤ For select topics, use teaching guides to help you.
➤ Refer complex questions to clinical experts (e.g., advanced practice nurses and physicians).

Prioritize teaching topics by focusing on “need to know” instead of “nice to know” topics. Identify family members or significant others to involve in patient teaching.

The goal of discharge instructions is to provide the needed information to patients, family members, or significant others so patients will be safe and comply with the recommended medical regimen until they reach the next level of care (e.g., clinic visit). Focus on:

➤ Actions patients need to take (e.g., medicines, activities, diet, appointments)
➤ Whom to call with questions
➤ Signs and symptoms to report to a physician or when to seek immediate medical treatment

Know your resources. Remember:

➤ Patient education
➤ Communication aids (e.g., interpreter services or language line)

Know your patient and make a difference. To do the latter:

➤ During handoffs between departments or levels of care, or during the change of shift report, share outstanding patient education requirements
➤ Include important patient education components while developing competencies, policies, and procedures

While patient education is happening, remind staff members to take credit for their teaching by:

➤ Documenting each patient education interaction
➤ Reviewing education provided daily and supplying follow-up teaching as needed

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Problematic standards < continued from p. 9

Things to consider

Keep the following in mind:
➤ Who provides patient education? All clinical disciplines do!
➤ It’s important to determine whether your patients communicate in English, have barriers to learning (e.g., fear or anger about the illness), or have questions or concerns.

Both of these points must be considered for each patient. Can you think of examples describing how they apply to your patients?

When planning patient education, consider:
➤ Medication administration, dose, purpose, side effects
➤ Food/diet/nutrition therapy
➤ Medical equipment use
➤ Drug-food interaction

Finally, as the patient prepares for discharge, consider:
➤ Access to community resources, if needed
➤ Rehabilitation techniques
➤ Patient/family responsibilities for care, including follow-up care and signs and symptoms to report to the doctor
➤ How to obtain further treatment or resources if needed (discharge instructions)
➤ Modified diet at home

Additional items to consider

The following are some resources you can use in patient education:
➤ Patient TV stations for specific populations
➤ Health education classes and support groups
➤ Written educational materials
➤ Preoperative teaching by clinical specialists
➤ Outpatient services
➤ Computer programs

How do you know whether patient education is effective? Try the following:
➤ Ask the patient to verbalize (e.g., describe medication, side effects, dosage or planned procedure, risks, benefits, or alternatives)
➤ Listen carefully to questions
➤ Ask family members to be alert for unanswered questions
➤ Check with prior clinician at shift change regarding open questions

Finally, where and how do you document patient education? Capturing the education provided in the clinical record is the biggest challenge.

CMS approves Joint Commission’s application for deeming authority

The Joint Commission’s hospital accreditation program has been approved for continued deeming authority by CMS through July 15, 2014. “We are honored that CMS has renewed our deeming authority. This validates their confidence in The Joint Commission, the predominant hospital accrediting body in the U.S.,” says Mark G. Pelletier, RN, MS, executive director of hospital programs and accreditation and certification services at The Joint Commission.

Deeming authority means that hospitals accredited by an organization with such a credential can elect to be

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“deemed” as meeting CMS requirements based on their successful accreditation. An official announcement can be found in the November 27, 2009, Federal Register (Vol. 74, No. 227).

CMS conducted an on-site administrative review of The Joint Commission’s corporate policies; financial and human resources available to accomplish surveys; procedures for training, monitoring, and evaluating its surveyors; ability to investigate and respond to complaints levied against accredited facilities; and the survey review and decision-making process for accreditation.

CMS compared The Joint Commission’s hospital accreditation requirements and survey process with the Medicare Conditions of Participation (CoP) and the survey process outlined in the State Operations Manual. The Joint Commission made several revisions to its elements of performance (EP) during the application process to meet various CoP requirements. Areas that were revised include:

➤ Credentialing and privileging for telemedicine
➤ Medical staff requirements
➤ Documentation of medical history and physical examinations
➤ Reporting of drug administration errors
➤ Requirements regarding infection control officers

All changes made to the EPs are listed in the Federal Register.

“I’m very pleased, not only having worked for The Joint Commission but also having watched them excel under the new leadership,” says Elizabeth Di Giacomo-Geffers, RN, MPH, CSHA, a healthcare consultant in Trabuco Canyon, CA. “I love the changes they’re making. I’m very excited they now have deeming authority, but I had no question they wouldn’t—they’ve always excelled in advocating what’s right for the patient and the organizations they accredit.”

To provide a little background, the Medicare Improvements for Patients and Providers Act of 2008 included a provision that changed The Joint Commission’s deeming authority status with CMS. The law removed a unique statutory deeming authority given to The Joint Commission via CMS since 1965, requiring instead that the accrediting body (as well as any other accrediting bodies seeking deeming status) apply through CMS to be awarded that authority. Fellow accrediting organizations Det Norske Veritas, Inc., and the Healthcare Facilities Accreditation Program currently undergo this application process as well.

In order to prevent any breaks in accreditation for Joint Commission–accredited hospitals, a two-year transition period was included in the provision for The Joint Commission to apply for deeming authority through CMS. The Joint Commission completed its application and was approved well within that two-year window.

During the application process, organizations such as the American Hospital Association (AHA) urged CMS to approve The Joint Commission’s application.

“The Joint Commission’s set of accreditation standards go beyond the minimum requirements of the Medicare Conditions of Participation and focus on key functional areas within the hospital, such as patient rights, patient care, and infection control,” Rick Pollack, executive vice president of the AHA, stated in a letter to CMS in July 2009.

Hospitals do not need to be accredited—it is a voluntary option, as is being “deemed” through an accrediting organization. Hospitals can elect to be surveyed by state surveyors working on behalf of CMS as an alternative to a review by an organization such as The Joint Commission.

The Joint Commission also has deeming authority for ambulatory surgery centers, critical access hospitals, durable medical equipment suppliers, home health, hospice, and laboratories.

“The Joint Commission is proud of its tradition of collaboration with CMS to provide quality oversight of hospitals,” Pelletier says. “Accreditation is a proven method for improving the care of Medicare beneficiaries.”
Internally assessing standards compliance

Editor’s note: The following is adapted from the newly released Survey Coordinator’s Handbook, 11th Edition, by Patricia Pejakovich, RN, BSN, MPA, CPHQ, CSHA. For more information on this book, please visit http://tinyurl.com/y8d6fn8.

Changes are forthcoming regarding the periodic performance review (PPR). Below is a summary of information provided by the speakers at The Joint Commission’s September 2009 Executive Briefings.

A complete revision of the PPR is in process. The torturous process of filling out the PPR will be eliminated as a hospital accreditation requirement; however, the PPR tool will remain on the Joint Commission extranet for organizations that wish to use it for self-assessment purposes.

There will be a newly defined assessment process that will be mandatory for each organization and will include a feature referenced as “touch points.” Touch points were described as time periods (currently proposed at six months and 18 months) in which the organization would have an option of an on-site visit or a telephone call with The Joint Commission. If a telephone call is selected, the organization’s account executive and a member of the Standards Interpretation Group (SIG) would represent The Joint Commission. So how would this be structured?

Six months after the final survey report is posted, The Joint Commission will contact your organization to ensure that the evidence of standards compliance and the submitted action plans were implemented and resulted in resolution of noncompliant elements of performance (EP) previously identified during the on-site survey. At that time, The Joint Commission would elicit feedback regarding the survey process, provide an update of the electronic application, and determine the date for the next touch point to occur in 18 months. The option of an on-site visit or telephone call would also be offered for the 18-month touch point.

During the time between the first touch point and the scheduled second touch point, the organization would be required to complete portions of the PPR that address the structure EPs (primarily the category A EPs), previous problem areas (from previous PPR findings), and organizational risks identified as primary focus areas or data included in the Strategic Surveillance System (S3) score.

At the 18-month time period, an on-site visit or call with the organization’s representative and a member of the SIG would be held, where top issues of organizational concern, issues from “like” organizations, top issues from the organization’s outcomes data (S3, sentinel events, etc.), implementation ideas, and leading practices that The Joint Commission had gleaned from other organizations would be shared and the electronic application updated, if necessary.

There would be no charge for the touch point process, and it would replace the PPR as it has been known.

The touch point PPR process would be framed under “shared responsibility for continuously meeting quality standards” and has not been published at the time of this writing.

What does this mean to the reader? It means you should change nothing until The Joint Commission prints the official word. If you have specific questions about a PPR that is due fairly soon, contact your account executive and discuss your situation.

Regardless of whether the PPR process changes, the value of performing an internal assessment cannot be underestimated. The concept is not new. While we await the finalization of the PPR requirements, I will reference the PPR as an internal assessment within this chapter. Whenever procedural changes occur in any industry, the initial step to determining what changes may need to occur is to perform a gap analysis. You can see that the basics are to determine where you are so that you know where you have to go. Use this approach whenever The Joint Commission publishes a change in requirements.

To manage the paper process and keep track of changes as they apply to your organization, print the change and make note of the gap analysis on the printout.