



## Were You Aware? C&A Newsletter Column Recap

### December 2010 – Were You Aware?

1. In accordance with CMS requirements, all organizations will be surveyed by The Joint Commission no later than 36 months after their last full accreditation survey. This shortens the survey window from 18-39 months down to 18-36 months. This change is effective January 1, 2011. So, an organization last surveyed on January 15, 2008 can expect their survey by January 15, 2011.
2. After a very comprehensive review, which included extensive field testing, of the Medication Reconciliation requirements have been revised and will be effective July 1, 2011. These less prescriptive requirements still establish parameters to assure patient safety, but decrease some of the burden on healthcare organizations.
3. We have noticed a trend in organizations away from labeling IV bags. Organizations are reminded that IV fluids are considered medication and, thus, fall under the medication management requirements. While it is not necessary to duplicate information, i.e., product name, strength, etc., that is pre-printed on the bag, it is necessary to label IVs with additives to include such information as name, strength and amount of all additives, as well as date prepared, revised expiration date and diluent. Any IV individualized for a patient must include patient's name, room location, directions for use, storage requirements and any other elements as required by hospital policy.
4. When developing Evidence of Standards Compliance (ESC) during the post-survey process, organizations need to include a statement that describes not only who is responsible for implementation, but also how they will assure that staff continue to remain compliance with the corrective action (i.e., new or revised policy and procedure) submitted. Consider using existing accountability processes and monitoring systems.

### October 2010 – Were You Aware?

1. At last count (October 2010), there were 296 Standards and 1,717 Elements of Performance (EP) in The Joint Commission Comprehensive Accreditation Manual for Hospitals. The Provision of Care chapter holds the most EPs with 282, but the related chapters of Environment of Care, Emergency Management and Life Safety combined contain 483 EPs. The volume of requirements requires an ongoing approach to accreditation readiness.
2. Reminder that the definition of "tissue" that falls under TJC's requirements for transplant and tissue safety (TS) is quite broad. Refer to the accreditation manual for a complete list.

3. As we approach the end of the year, where does your organization stand with these new expectations in the hospital accreditation program?
  - a. MS.01.01.01, EPs 1-36 related to medical staff structure, bylaws and rules and regulations become effective March 31, 2011. Due to the lead time required to get the required approvals for changes to these documents, organizations should be well into that process at this time. See the August edition of C&A News for more guidance on these requirements.
  - b. Patient-Centered Communication requirements become effective January 1, 2011. However, 2011 will be “learning year” and RFIs related to these requirements will not play into accreditation decisions until 2012. New and revised EPs can be found in the Human Resources, Provision of Care, Record of Care and Patient Rights chapters. Look to an upcoming edition of C&A News for more information on this issue.
4. Related to new requirements, don’t forget about the new Care, Treatment and Services (CTS) chapter in the behavioral health accreditation program. Those requirements are effective January 2011.
5. Organizations seeking Initial Accreditation from TJC should create a timeline to assure key milestones, such as policy and procedure development, staff education and facilities assessment and improvements, are achieved.

## September 2010 – Were You Aware?

1. Some changes to the TJC accreditation decision categories have been made for 2011:
  - a. The Provisional Accreditation category will be eliminated
  - b. To eliminate the confusion between TJC’s Conditional Accreditation decision category and the term Condition-Level findings related to CMS requirements, Conditional Accreditation will be eliminated and the following categories implemented:
    - i. Accredited with Follow-Up Survey
      1. Requires follow-up survey (either related to a TJC requirement OR because a CMS Condition-Level deficiency was identified)
      2. Between 30 days – six months
      3. Example: first failed Condition-Level deficiency
    - ii. Contingent Accreditation
      1. Requires follow-up survey within 30 days
      2. Example: Second failed Condition-Level deficiency survey
  - c. Preliminary Accreditation, Accreditation with or without Requirements for Improvement, Preliminary Denial of Accreditation and Denial of Accreditation categories will remain unchanged
  - d. See the attached example for an organization with Condition-Level findings and look for a future edition of *C&A News* for more information and guidance on these accreditation decision categories and the follow-up survey process.
2. CMS requires that accrediting organizations review the greater of 30 medical records or 10% of the hospital’s average daily census. For some smaller hospitals this means the survey includes closed medical record review.

3. Additionally, CMS requires that when a Condition-Level finding is identified during survey, that a Requirement for Improvement (RFI) also be made in the Leadership standards to address governing body oversight.
4. There has been an increase in RFIs under PC.01.02.03 related to histories and physicals. This is partly attributable to the CMS requirement that the H&P update note MUST include the following: the H & P was reviewed, the patient was *examined again and either note no changes or document any changes*. Organizations are encouraged to review policies, procedures and forms related to the H&P update and assure that LIPs understand the importance of these documentation requirements.

## August 2010 – Were You Aware?

1. During survey activity, organizations are held to the highest of the following – Joint Commission standards, CMS requirements, State Department of Health regulations *OR* organizational policy and procedure. Be thoughtful when creating policies that are more restrictive or stringent than accreditation standards or regulatory requirements.
2. The World Health Organization (WHO) has declared that the H1N1 influenza has transitioned into the post-pandemic period. In its briefing note, WHO notes that the virus will continue as a seasonal virus for years to come, but that the intense period of concern is diminished. Visit [www.who.int](http://www.who.int) for more information.
3. COLA (formerly the Commission on Office of Laboratory Accreditation) has voluntarily withdrawn from accrediting organizations in the specialty of Pathology. This withdrawal is limited to Pathology and COLA may continue to accredit laboratories for other specialties (and associated subspecialties) including microbiology, diagnostic immunology, chemistry, hematology and immunohematology. Organizations currently accredited by COLA for pathology services have 60 days from August 11, 2010, the date this notice was posted in the Federal Register, to seek CLIA (Clinical Laboratory Improvement Amendments program) from their state agency or another CMS-approved accrediting organization. See the Federal Register, Vol.75, No. 154, August 11, 2010, page 48698, for more information.
4. CMS has adopted revisions to clarify who can prescribe orders for rehabilitation (Section 482.56) and respiratory (Section 482.57) services. The revisions, outlined in Federal Register, Vol. 75, No. 85, May 4, 2010, page 24050 and approved in Federal Register, Vol. 75, No. 157, August 16, 2010, page 50041, require that:
  - a. Orders for REHABILITATION SERVICES are to be limited to qualified, licensed practitioners who are responsible for the care of the patient, are acting within their state scope of practice, are authorized to do so by the medical staff, and the hospital's policies and procedures.
  - b. Orders for RESPIRATORY SERVICES may be provided by licensed practitioners, including nurse practitioners and physician assistants, provided that such **privileges to order respiratory services** are authorized by the medical staff and are in accordance with hospital policy, state laws and scope of practice requirements.

It is anticipated that further clarification and survey guidance will be provided by CMS in the coming months.

## July 2010 – Were You Aware?

This edition of “Were You Aware” contains a few reminders related to some unique challenges for survey coordinators and quality professionals.

1. Organizations are required to notify The Joint Commission of any changes in “ownership, control, location, capacity or services offered” within 30 days of those changes having occurred. Failure to report such changes can, ultimately, lead to a loss of accreditation. From a practical standpoint, the person responsible for survey coordination is often “the last to know” about these things. It’s important that those responsible for approving additional services, terminating existing services, acquiring new sites of care, including physician practices, be aware of this requirement. If such services or sites are under the same CMS Certification Number and cost report as the accredited organization, they are surveyable!
2. CMS conducts surveys for 100% of patient complaints or allegations submitted to the agency. Be sure that grievance policies and procedures are in accordance with CMS requirements – including timeframes and content of responses to complainants. Once you are surveyed and receive your findings report, remember that your plan of correction must be complete and comprehensive. Here are some guidelines, but see our series, “[Are You Ready for a CMS Survey?](#)” for the full detail!

Each deficiency must be separately addressed and each plan of correction must include the following elements:

- a. The plan for correcting the issue found to be out of compliance which addresses the related processes
- b. How the plan will be implemented in the organization
- c. The date each deficiency will be corrected
- d. A description of how the corrective action will be monitored through the quality assurance/performance improvement (QAPI) structure of the organization
- e. The title of the individual responsible for implementing the corrective action

Some helpful hints:

- f. Plans of correction should be succinct and specific to the COP tag at which they were identified.
  - g. Corrective actions should, whenever possible, be implemented prior to submission of the completed 2567 to CMS. At most you would expect to see a 30 day timeline with the exception of actions requiring significant capital resources.
  - h. Engage leadership and medical staff in development and implementation of action plans to assure appropriate compliance is achieved in the identified timeframe.
  - i. Assure measures of success are included on QAPI agendas and in minutes until compliance is achieved.
3. Organizations that receive findings that note “observed but corrected during survey” are still required to submit Evidence of Standards Compliance (ESC) to TJC. That ESC must include all of the required information: who, when, what and how; including the title of the individual responsible for implementation and ongoing compliance with the correction.

## June 2010 – Were You Aware?

1. According to TJC, the following 5 documents and processes require governing body approval:
  - a. Hospital Scope of Service (LD.01.03.01, EP3)
  - b. Structure of the Medical Staff (LD.01.05.01, EP4)
  - c. Leadership Conflict Management Process (LD.02.04.01, EP2)
  - d. Medical Staff Bylaws (MS.01.01.01, EP3)
  - e. Annual Operating and Long-Term Capital (when needed) Budgets (LD.04.01.03, EP4)

Note that in the April 2010 edition of “Were You Aware,” C&A News reported, as a result from a communication with TJC staff, that Environment of Care Plans also required governing board approval. This is not required as clarified by TJC leadership. **Updated from April 2010.**

2. To provide further clarification on the requirements of PPR Option 1, we have clarified with TJC that organizations must submit an attestation that they have completed a self-assessment against the standards and have selected Option 1. TJC has indicated that organizations may enter their data into the PPR tool if they choose and that data will not transmit to TJC. However, organizations selecting Option 1 are not required to enter the data into the PPR tool. **Updated from April 2010.**
3. CMS has recently proposed revisions to the regulatory language related to the requirements for respiratory orders and credentialing and privileging of telemedicine physicians and practitioners. Final changes will be published in the Federal Register and we’ll summarize those changes in a future edition of C&A News.
4. Top scoring standards remain consistent (see May 2010 edition of *The Joint Commission Perspectives*), with several Life Safety and Environment of Care EPs in the top ten (see October 2009 edition of “Were You Aware.”) Several other hot topics remain challenging for organizations:
  - a. Dating and timing medical record entries (RC.01.01.01) receipt, recording and authenticating of verbal orders (RC.02.03.07)
    - i. Organizations may consider several strategies to improve compliance with these challenges (**Check out our tips in appendix 1**).
  - b. Safe storage of medications (MM.03.01.01)
    - i. Assure appropriate temperature controls are in place and that medications are stored in accordance with manufacturer guidelines
    - ii. Maintain security of medications
      1. Assure access to only authorized individuals
      2. Be aware of areas that close on off-shifts and weekends
      3. Round, frequently, for expired meds
      4. Assure all appropriate staff are oriented, and have competency determined, for their role in the medication process (i.e., delivery personnel)
  - c. Medication ordering (MM.04.01.01)
    - i. Assure medication orders contain all required (by policy) elements
    - ii. Any incomplete or illegible orders to be clarified before being acted upon
  - d. Time-out (UP.01.03.01)

- i. Assure that all members of the surgical team *actively* participate in the time-out and that, at least, correct patient, site and procedure is verified
- ii. If more than one procedure will be performed and the proceduralist will change, a second time-out must be conducted
- iii. Required Measures of Success (MOS) have been removed from several Elements of Performance. In addition, some EPs have changed from Category C to Category A requirements. Refer to the June 2010 edition of *The Joint Commission Perspectives*.

## April 2010 – Were You Aware?

1. The Joint Commission has provided a clarification regarding the requirement at IM.02.02.01, EP2 that organizational policies include hospital-approved terminology, definitions and abbreviations as well as prohibited abbreviations in the April 21<sup>st</sup> edition of *Joint Commission Online*. It is not TJC's intent that organizations create a list of approved abbreviations. The language for this EP will be clarified effective July 1, 2010 and require organizations to use "standardized terminology, definitions, abbreviations, acronyms, symbols, and dose designations."
2. ~~It is expected that all Environment of Care management plans and objectives be reviewed and approved by the governing body of the organization.~~ **Updated June 2010:** TJC leadership has confirmed that EC management plans do not require governing body approval. The following documents and processes do require governing body approval:
  - a. Hospital Scope of Service (LD.01.03.01, EP3)
  - b. Structure of the Medical Staff (LD.01.05.01, EP4)
  - c. Leadership Conflict Management Process (LD.02.04.01, EP2)
  - d. Medical Staff Bylaws (MS.01.01.01, EP3)
  - e. Annual Operating and Long-Term Capital (when needed) Budgets (LD.04.01.03, EP4)
3. Organizations selecting Periodic Performance Review (PPR) Option 1 are no longer required to seek legal counsel for that selection. In addition, hospitals selecting Option 1 ~~must~~ use the online PPR tool to input their self-assessment findings and action plans. See the *Comprehensive Accreditation Manual for Hospitals, 2010* for the current requirements regarding this PPR option. **Updated June 2010:** Organizations selecting Option 1 are not required to enter data into the PPR tool.
4. TJC has published several new Frequently Asked Questions (FAQ) during the first several months of 2010. To access the full content of all FAQs, visit <http://www.jointcommission.org/Standards/FAQs/>. FAQs not only provide guidance to organizations as to how to comply with challenging standards but also are used in determining compliance during survey. Some brief highlights include:
  - Leadership – Contracted Services:
    - These requirements pertain to contracted services directly related to the provision of patient care
    - Organizations must evaluate services provided by contract and address issues where performance does not meet expectations
  - Medical Staff – Ongoing Professional Practice Evaluation:

- The frequency of data collection and review is to be defined by the organization. It is noted that 12 months would not be acceptable.
- Data must be collected on all practitioners – including those who don’t “fall out” on screening criteria
- For practitioners performing a low volume of procedures or services at an organization, data from another organization may be used as supplemental information, however, organization-specific data must also be collected and reviewed
- National Patient Safety Goals – Medication Labeling
  - Labeling must occur in all procedural settings – including OR, prep and pre-op locations, PACU, imaging services, endoscopy, dental services and anywhere procedures are done – including those done at bedside
  - “Immediate use” means the medication is removed from its original container and used immediately – without any break in process.
  - Pre-filled, pre-labeled syringes, as purchased, are acceptable. Pre-labeling syringes and other containers for filling at a later time is not acceptable – i.e., marking basins as “saline.”
- Human Resources – Qualifications & Primary Source Verification for Lab Personnel
  - Applicable to laboratory and point-of-care testing personnel
  - Qualifications must be consistent with CLIA requirements
  - Primary source verification is required for licensure for non-waived testing. It is not required for education. Primary source verification is only required in some situations for professional credentials – i.e., where the credential is required by state or federal regulations.

## March 2010 – Were You Aware?

1. The Joint Commission has published [revised standards for MS.01.01.01](#) (formerly MS.2.10). This standard, and the associated elements of performance, has been under review by a task force for approximately two years. This standard relates to self-governance of the medical staff and its relationship and accountability to the governing body of the healthcare organization. See a future edition of C&A News for detailed information on how to apply these requirements, which become effective March 31, 2011, in your organization.
2. Medical records must be completed within 30 days of discharge. This is both a CMS and TJC requirement. Healthcare organizations should track their medical record statistics using TJC’s form which also describes the scoring methodology for RC.01.03.01, EP4. (This form can be downloaded from TJC’s website or from the C&A Client Library.) It should be noted that the situational decision rule previously associated with medical record delinquencies has been removed.
3. Related to TS.03.01.01, for procedures in which a tissue-based or cellular-based product is aspirated or otherwise retrieved from a patient, processed by an external lab or other company and then reimplanted (i.e., chondrocytes), the hospital is not considered a distributor. (Courtesy of a response from the TJC Standards Interpretation Group)

4. Reminder! Organizations are required to provide The Joint Commission, through their Account Representative, with information regarding changes to their application within 30 days of that change. This includes information related to change in ownership or location, significant increases or decreases in volume, additions or deletions of a type of service or site of care, and acquisition or deletion of an organizational component. Joint Commission will review this information and make a determination if an extension (or intra-cycle) survey is necessary. Failure to alert TJC of these changes could result in loss of accreditation.
5. Medical equipment brought into the hospital by patients for their own use, i.e., insulin pumps, ventilators, etc., are subject to some of the same medical equipment requirements as hospital-owned equipment, including EC.02.04.01, EP3 and EC.02.04.03, EPs 2 and 3. If organizations allow the use of patient-owned medical equipment policies need to define the parameters associated with that and address these elements of performance. Consideration should also be given to staff competency and availability of resources to fix equipment should it become broken and other safety issues.

## February 2010 – Were You Aware?

1. In accordance with NPSG.03.04.01, organizations must label all medications with the following elements: medication name, strength, quantity, diluent and **volume**, preparation date, expiration date (when not used within 24 hours) and expiration time when expiration occurs in less than 24 hours. Within Element of Performance (EP) 3, The Joint Commission (TJC) provides a note that date and time may not be required for short procedures as defined by the organization. A few words of caution about this NPSG:
  - Labeling as described in this EP is required even for routine solutions created from single dose containers, i.e., saline and Hibiclens.
  - Organizations must define what constitutes “short procedures,” keeping in mind their patient population, nature of procedures, etc.
  - To assure safe medication practices, define procedures for discarding unused medications
  - Volume cannot be determined by having the original “single dose” containers as a reference for how much solution was placed in the large container on the sterile field  
(Courtesy of a response from the TJC Standards Interpretation Group)
2. The Joint Commission has received approval from the Centers for Medicare & Medicaid Services (CMS) as a designated accreditor of advanced diagnostic imaging centers. Such centers must receive accreditation by a CMS-designated accrediting organization in order to bill for MRI, PET, CT and nuclear medicine services to Medicare beneficiaries. Note: it is not necessary for hospital based services to undergo separate accreditation.
3. TJC provided a further revision to the 2010 Universal Protocol related to site marking to clarify that marking is not required for procedures for which insertion sites are not predetermined. (See the February 2010 edition of *The Joint Commission Perspectives*.)

4. Leaders in the healthcare field have recently published a perspective on today's healthcare environment that is a "must read" for all of us in the field. Click here to access, "[Cottage industry to postindustrial care – the revolution in health care delivery](#)," published in the January 20, 2010 edition of The New England Journal of Medicine.

## January 2010 – Were You Aware?

1. The Joint Commission (TJC) has released the 2010 Survey Activity Guide. Download the document from [www.jointcommission.org](http://www.jointcommission.org). This version includes, for all programs, updated document lists, survey readiness notes and a survey activity list. In an effort to continue to improve customer and surveyor satisfaction, TJC has implemented a new process for developing the survey agenda. The survey team will work with the organization, while onsite, to develop an agenda that meets survey requirements and the needs of the organization. (See the January 2010 edition of *The Joint Commission Perspectives* for more information.)
2. Just another reminder about "pre-charting." Any orders for post-procedure medications, treatment and other care that are written pre-procedure must be activated post procedure for use with the patient. This means, for example, if an anesthesiologist completes a pre-anesthesia evaluation and writes post-procedure orders at that time, prior to the procedure, the orders would have to be activated after the procedure or should be signed, dated and timed after the procedure to indicate they are now active for use with the patient. (Courtesy of TJC's Standards Interpretation Group (SIG) 12/30/10.)
3. The Centers for Medicare & Medicaid Services (CMS) have published revised [Anesthesia Services Interpretive Guidelines](#) to clarify which anesthesia services fall under this Condition of Participation (COP) and provide further details on pre, intra, and post-operative anesthesia requirements. See a future edition of C&A News for a summary of the revisions to these Interpretive Guidelines.
4. TJC has published revised interim staffing effectiveness requirements that become effective July 2, 2010. These revisions are applicable to the Hospital and Long Term Care programs and focus on the adequacy of staffing based on number, skill mix and staff competency. (See the January edition of *Perspectives*.) These requirements are expected to help organizations focus on assuring appropriate staffing to provide safe care without the onerous burden of the previous prescriptive staffing effectiveness data requirements.

## **Tips for Compliance with Signing, Dating & Timing Medical Record Entries and Verbal Order Authentication**

1. Educate on CMS and TJC requirements
2. Leaders must set the expectation for compliance
3. Define those permitted to accept verbal orders
4. Publicize expectations in Physician Newsletter
5. Provide reminders: on the medical record, posters, in medical staff areas
6. Provide concurrent review mechanisms and flag entries immediately
7. For electronic systems, use alerts that force completion of previous orders before new orders can be written
8. Include as part of Professional Practice Evaluation and set minimum expectations (90%)
9. Track success rates and use methods to alert resistant providers
10. Develop enforcement mechanisms – approved and enforced by the medical staff.
11. Reward compliance - use many methods such as recognition in public forums, newsletters, bulletin boards, special pins, chance to win dinner for two at the best restaurant in town, etc.