

Joint Commission Update for Ambulatory Clinics

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Objectives:

- Participants will understand the 2016 revision to Joint Commission standards as well as the 2017 National Patient Safety Goals.
- Attendees will participate in discussion of best practice in meeting several of the new or revised standards, as well as reviewing the top 10 fallouts from previous JC surveys.
- Attendees will review tools to assist in keeping staff prepared for a Joint Commission survey.

What is new

- The Joint Commission has deleted 225 elements of performance (EPs).
- They have eliminated “C” or the rate-based EPs as well as the indirect or direct EPs.
- The opportunity for improvement section of the JC report is eliminated. Any single observation is going to result in a finding.

Survey Analysis for Evaluating Risk (SAFER)

- A matrix developed to identify and communicate risk levels associated with deficiencies cited during a survey.
- The SAFER approach provides additional information related to risk of deficiencies to help prioritize and focus corrective actions.
- The placement of the EP on the matrix shows the likelihood to harm a patient/staff/visitor and the scope of the deficiency.

SAFER cont....

- This is part of the survey report received at the conclusion of the survey.

Statement of Conditions

- Plans for Improvement (PFI) are eliminated from the survey process.
- Starting August 1, any self-reported deficiencies will be listed as a Requirement for Improvement (RFI) and be given exactly 60 days for correction.

Risk Assessments: How and When

- (EC.02.01.01) TJC is not prescriptive in how risk assessments are to be performed.
 - Develop assessment methods that best suit your circumstances and preferences.
 - Examples include root cause analysis, failure mode and effect analysis, plan/do/check/ act process.
 - All assessment results should be reported to the multi-disciplinary team responsible for the Environment of Care Committee and the Infection Control Committee.

Risk Assessments: How and When

- An organizational policy/practice should be generated, appropriate staff trained/notified, and some method to assess effectiveness implemented.
- The survey process will review the risk assessment and associated policy/practice for effectiveness, and the tracer process will validated proper implementation.

What is new:

- Starting January 1, 2017, The Joint Commission has gotten rid of its clarification process. That means facilities will be expected to have their documentation readily available during survey if they want to avoid a finding.
- Even if the documentation exists, surveyors will still consider it “not done” if you send it to them later.
- 50% of hospital accreditation programs request clarifications.

Antimicrobial Stewardship Standard

MM.09.01.01 – effective 1/1/17, 8 EPs.

- Leaders establish antibiotic stewardship as an organizational priority.
- Educate staff and LIPs.
- Educate patients and their families regarding appropriate use of antimicrobials.
- Hospital develops a multidisciplinary team.
- Crosses several standards, including NPSG 7.

Preliminary denial of accreditation:

- TJC and CMS have built a “crosswalk” linking JC standards with CMS Conditions of Participation.
- Certain scored standards will trigger a CMS condition-level finding; level of severity and some spread across the organization.
- There will be a follow-up survey in 45 days to validate that the issues are resolved.

2017 National Patient Safety Goals

- Background:
 1. Established in 2002, 1st set was effective 1/1/2003.
 2. The Patient Safety Advisory Group advises TJC on development and updating of these goals.
 3. Revisions for this year include implementation of evidence based practice to prevent healthcare associated infections due to multidrug-resistant organisms.

NPSG 1: Identify patients correctly

- 01.01.01 – use at least 2 patient identifiers when providing care, treatment, and services.
- 01.03.01 – eliminate transfusion errors related to patient misidentification.

NPSG 2: Improve effective communication.

- 02.02.02: Report critical results of tests and diagnostic procedures on a timely basis.

NPSG 3: Safety of using medications.

- 03.04.01 – label all meds and containers, and other solutions on and off the sterile field.
- 03.05.01 – reduce the likelihood of patient harm associated with anticoagulant therapy.
- 03.06.01 – maintain and communicate accurate patient medication information.

NPSG 6: Reduce harm associated with clinical alarm systems.

- 06.01.01 – improve the safety of clinical alarm systems.

NPSG 7: reduce the risk of health care associated infections.

- 07.01.01 – Comply with either the CDC or WHO hand hygiene guidelines.
- 07.03.01 – Implement evidence-based practice to prevent infections due to MDROs in the hospital.
- 07.04.01 – prevention of central line infections.
- 07.05.01 – prevention of surgical site infections.
- 07.06.01 – prevention of CAUTI.

NPSG 15: Identify safety risks inherent in its patient population.

- 15.01.01 – identify patients at risk of suicide.

Universal Protocol

- UP.01.01.01 – conduct a pre-procedure verification process.
- UP.01.02.01 – Mark the procedure site.
- UP.01.03.01 – A time out is performed before the procedure.

Top 10 Fallouts:

1. EC.02.06.01: Oxygen storage. (62%)
2. IC.02.02.01: Medical equipment infection risk. (59%)
3. EC.02.05.01: Ventilation systems, air exchange. (58%)
4. LS.02.01.20: Maintain egress. (51%)

Top Fallout cont....

5. LS.02.01.30: Fire protection features. (50%)
6. RC.01.01.01: Complete and accurate medical record. (47%)
7. LS. 03.01.35: Maintain system for extinguishing fires. (46%)
8. LS.02.01.10: Fire protection features maintained. (45%)

Top Fallouts cont....

9. PC.02.01.03: Orders for care, treatment, and service. (40%)
10. EC.02.02.01 EP 3 and 5: Hazardous material and eyewash station testing, lead aprons. (39%)

***Every observation will be a finding, and every finding will require evidence of standard compliance within 60 days of the survey.

PC.02.01.03 EP 7

- Protocols; a copy must be entered into the medical record to ensure the record accurately reflects the interventions taken.
- Must be documented as an order, signed, dated and timed by the responsible practitioner.
- Know your state's nurse practice act. If the nurse initiated a protocol without an order from the LIP, show the law or organizations policy.

PC.02.01.03 EP 20

- Verbal orders: documentation such as "VO/RBV" is an example of evidence of compliance but is not required by The Joint Commission.
- If this is a citation it is because the hospital policy is not being followed.

Texting orders

- 2011 this practice was prohibited by TJC.
- As technology has evolved, this decision is overturned May 2016.
- Organizations must develop policy specific to how orders transmitted via text will be dated, timed, confirmed, and authenticated by doc.
- Must have secure sign-on process, encrypted messaging, delivery and read receipts, date and time stamp, customized message retention time frames, and specified contact list for individuals to receive and record orders.

The Survey Days:

- Documents for review: The list of documents that must be available includes items that can be gathered in advance as well as items that will need to be pulled the morning of the survey.
- Closed medical record review session: There is no scheduled closed medical record review; the focus will be on current, open records.
- Competency assessment processes: The surveyors will identify times toward the end of the survey to review documentation of employees' competency and the credentials of staff members with privileges.

The Survey Days:

- Visits to patient care settings and departments: This activity is incorporated into tracers.
- Environment of care review: A formal session will be scheduled to review documents and to discuss issues related to environment of care.
- Emergency management: For hospital surveys, a formal session will be scheduled to review emergency management.
- Daily briefing: This valuable meeting will occur from day two until the last day of the survey.

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The Survey Days:

- Off-shift survey visit: The Joint Commission no longer includes an off-shift visit during reaccreditation surveys, but it reserves the right to conduct such visits in “for cause” surveys.
- Exit conference: Organizations will receive their preliminary survey report at the exit conference.
- Post-survey there will no longer be an opportunity to clarify or question findings – talk to surveyors while they are still on site.

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Keeping staff prepared:

- This is an ongoing process!
- Involve everyone in random mock surveys or mock tracers; check lists for evaluating environment of care.
- Involve everyone in measuring internal compliance.
- Utilize technology for quick tips or larger pieces of education.
- Make TJC a standing agenda item at your All Staff Meetings.
- Develop pocket guides or similar information sheets.
- Celebrate successes.

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Discussion / Questions

Email:

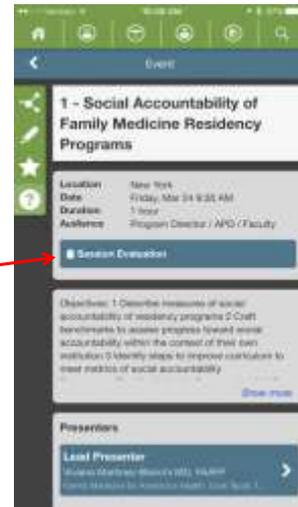
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