

# This Month at The Joint Commission

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## **This Month becomes weekly e-newsletter beginning July 8**

Beginning July 8, *This Month* and [Joint Commission Online](#) will be combined and become a weekly electronic newsletter. The e-newsletter, *Joint Commission Online*, will consolidate all Joint Commission enterprise news. Readers can expect a new issue each Wednesday with news from both The Joint Commission and Joint Commission Resources. The goal of the new publication is to decrease the number of e-mails you receive from The Joint Commission enterprise, as well as to make the news you receive more relevant and timely. **If you currently receive *This Month* only by mail, you will need to sign up for electronic delivery of *Joint Commission Online* by clicking [here](#).** If you already receive *Joint Commission Online* or *This Month* via e-mail, no further action is required. (Contact: Caron Wong, [cwong@jointcommission.org](mailto:cwong@jointcommission.org))

## **Accreditation**

### **Survey of staffing effectiveness standards suspended; interim EPs being field reviewed**

Effective immediately, survey of the Staffing Effectiveness standards (PI.04.01.01 for hospitals and HR.1.30 for long term care organizations) has been suspended. The Joint Commission has developed two interim elements of performance, EPs 12 and 13 at PI.02.01.01 (PI.2.10 for Long Term Care), that are being [field reviewed](#) as the first step in transitioning to more effective requirements for evaluating staffing in health care organizations:

- EP 12 focuses on the use of outcomes data to guide analysis of staffing effectiveness.
- EP 13 is similar to current leadership requirements and calls for leadership to review analyses of data related to staffing issues.

These interim EPs are scheduled to be reviewed for approval by The Joint Commission's Standards and Survey Procedures Committee at its July 31 meeting.

Accredited organizations have indicated that compliance with the current staffing effectiveness requirements does not significantly impact the quality and safety of care and consumes a substantial amount of resources. This field review is an important part of a process that The Joint Commission has started to address the field's concerns. The Joint Commission will seek out alternative approaches for evaluating effective staffing from health care organizations, and professional groups. In the meantime, it is critical that organizations continue to focus on effective staffing as it relates to the quality and safety of patient care. The following current requirements that also relate to effective staffing will continue to be surveyed: LD.03.06.01, EPs 3 and 4; and NR.02.03.01, EPs 4 and 7 (hospitals only). (Contact: Carol Gilhooley, [cgilhooley@jointcommission.org](mailto:cgilhooley@jointcommission.org))



## Steam sterilization update

The Joint Commission has been in discussion with professional, trade and government organizations and experts in the field about the common and proper use of sterilization using steam. Some decisions have been made which will affect the interpretation of standards as well as the survey process. The Joint Commission has decided to refocus its survey efforts on all of the critical processes included in steam sterilization. Surveyors will, among other activities:

- Observe instruments from the time they leave one operating room to when they are returned to the next.
- Ask health care workers to provide the manufacturers' instructions for instrument sterilization, and to describe and demonstrate how instruments are being cleaned and decontaminated according to those written instructions.
- Observe the cleaning of instruments. Rinsing is rarely enough to properly remove soil from instruments; meticulous cleaning is needed.
- Verify that staff members are wearing appropriate personal protective equipment.
- Observe the sterilization process. The surveyor will ask for the manufacturer's instructions for the following items: the sterilizer, wrapping or packing, and the instruments.
- Review sterilization logs. Surveyors will ask about parametric, chemical and biological indicators.
- Observe the return of instruments to the sterile field and verify that they are being protected from recontamination.

For more information, including an overview of the three critical steps of reprocessing, visit The Joint Commission [Web site](#) or see the [CDC/HICPAC guideline](#). (Contact: Louise Kuhny, [lkuhny@jointcommission.org](mailto:lkuhny@jointcommission.org))

## Accreditation report changes stemming from hospital deeming application

Beginning in July, hospital accreditation reports will include any Medicare standard-level or condition-level deficiencies found during the survey. This stems from the changes made to the accreditation process related to The Joint Commission's application to the Centers for Medicare & Medicaid for continued hospital deeming authority. A **standard-level deficiency** indicates noncompliance within a particular Medicare standard or substandard which does not substantially limit a hospital's capacity to provide adequate care, or which would not jeopardize or adversely affect the health or safety of patients if the deficient practice recurred. Standard-level deficiencies must be addressed in an Evidence of Standards Compliance (ESC) report within 45 or 60 days (depending upon whether the finding relates to a direct impact or indirect impact element of performance).

A **condition-level deficiency** may be due to noncompliance with requirements in a single Medicare standard or several standards within the condition or with a single part representing a severe or critical health or safety breach. Condition-level deficiencies require an unannounced follow-up survey to evaluate the extent to which the condition-level deficiencies have been corrected and if the provider is in substantial compliance with applicable Medicare requirements. If there are no condition-level deficiencies at the time of the follow-up survey, The Joint Commission will issue a recommendation for Medicare certification after any standard-level deficiencies have been corrected. A condition-level deficiency does not automatically lead to Conditional Accreditation. Conditional Accreditation is a category of Joint Commission accreditation that an organization receives based on a survey and after review and determination by the Accreditation Committee. (Contact: Kevin Hickey, [khickey@jointcommission.org](mailto:khickey@jointcommission.org) and Patricia Kurtz, [pkurtz@jointcommission.org](mailto:pkurtz@jointcommission.org))

## Field reviews

The Joint Commission invites comment on the following field reviews:

- [Proposed hospital requirements to advance effective communication, cultural competence and patient-centered care](#): Comments will be gathered for six weeks, beginning on June 8, 2009. While effective communication is necessary for patient safety, it can be inhibited by language, culture, hearing or visual impairment, health literacy, cognitive impairments, and disease or disability. In addition, racial and ethnic health disparities are linked to poorer health outcomes and lower quality care. As the diversity of our nation continues to grow, there is a need to provide hospitals with more robust guidance to address the needs of the populations they serve. (Contact: Christina Cordero, [ccordero@jointcommission.org](mailto:ccordero@jointcommission.org))
- [Proposed requirements related to Staffing Effectiveness standards](#): Comments are appreciated before July 10, 2009; however, the field review will remain open until July 22, 2009. See related article, "Survey of staffing effectiveness standards suspended; interim EPs being field reviewed." (Contact: Laura Smith, [lsmith@jointcommission.org](mailto:lsmith@jointcommission.org))

## Definition of “physician” changes for hospital program

Effective July 1, 2009, the definition of “physician” will change for The Joint Commission’s hospital accreditation program in order to more accurately reflect the Centers for Medicare & Medicaid Services’ (CMS) expectations for deemed status purposes. Previously, the hospital manual defined physician as: a doctor of medicine or osteopathy, or as defined by CMS in section 482.12(c)(1) of the hospital conditions of participation. The revised definition is found in Section 1861(r) of the Social Security Act. In general, the term includes the following individuals: doctor of medicine or osteopathy, doctor of dental surgery or dental medicine, doctor of podiatric medicine, doctor of optometry, and chiropractor. As a result of these changes, certain elements of performance have been changed to indicate specifically when the task or responsibility described requires a doctor of medicine or osteopathy and when it requires a physician as defined by CMS in Section 1861(r) of the Social Security Act. Affected EPs are:

MM.04.01.01, EP 14	MS.05.01.01, EP 17	PC.03.05.11, EPs 1, 2
MM.07.01.03, EP 6	MS.06.01.05, EP 6	PC.03.05.15, EP 1
MS.01.01.01, EP 20	PC.03.05.05, EPs 1, 3, 5	PC.04.01.03, EP 3
MS.03.01.01, EP 9	PC.03.05.07, EP 1	RI.01.04.01, EPs 1, 2
MS.03.01.03, EPs 1, 4	PC.03.05.09, EPs 1, 2	

After July 1, these changes can be found in [Update 1](#) to the 2009 *Comprehensive Accreditation Manual for Hospitals* on The Joint Commission Web site. (Contact: Kelly Fugate, [kfugate@jointcommission.org](mailto:kfugate@jointcommission.org))

## Reminders regarding July hospital standard updates

On July 1, the automated Periodic Performance Review (PPR), the E-dition and the Accreditation Manager Plus (AMP) will be updated with standards information related to The Joint Commission’s submitted application to the Centers for Medicare & Medicaid Services (CMS) for hospital deeming authority. In addition, Update 1 to the 2009 *Comprehensive Accreditation Manual for Hospitals* will publish. The updates include the following four major areas of change in the requirements:

- The 2008 restraint and seclusion standards (PC.03.05.01-PC.03.05.19) were replaced with CMS behavioral-based decision making requirements. However, if a hospital is not using accreditation for deemed status, the current standards PC.03.02.01 – PC.03.03.01 apply to restraint and seclusion.
- History and physical standards (MS.01.01.01, EP 20; PC.03.01.03, EP 18; PC.03.01.07, EPs 7 and 8)
- Preanesthesia and postanesthesia evaluations (PC.03.01.03, EP 18; PC.03.01.07, EPs 7 and 8)
- Blood transfusions (PC.02.01.01, EP 15)

These changes align Joint Commission standards more effectively with the Conditions of Participation. In most cases, Joint Commission standards already covered these topics, just not in the specificity now required by CMS. (Contact: Patricia Kurtz, [pkurtz@jointcommission.org](mailto:pkurtz@jointcommission.org) or Kevin Hickey, [khickey@jointcommission.org](mailto:khickey@jointcommission.org))

## Performance measurement

### Stroke performance measures to become core measure set for hospital use

Effective October 1, 2009, eight stroke performance measures, endorsed by the National Quality Forum, will become available as a core measure set for meeting the performance measure requirements for hospital accreditation. While Joint Commission certified Primary Stroke Centers must use the stroke performance measure set for certification purposes, this core measure set is an option available for accredited hospitals to fulfill their ORYX® performance measurement requirements. The Centers for Medicare & Medicaid Services is not requiring collection of any of the stroke measures at this time. The eight NQF-endorsed core measures are part of the original 10 standardized stroke performance measures that have been used in The Joint Commission’s advanced Disease-Specific Care Primary Stroke Center Certification Program since January 1, 2008. Through December 31, 2009, Joint Commission certified Primary Stroke Centers are required to collect and submit data on all 10 stroke measures in order to maintain certification. As of January 1, 2010, they are required to collect and submit data only on the eight NQF-endorsed measures. (Contact: Karen Kolbusz, [kkolbusz@jointcommission.org](mailto:kkolbusz@jointcommission.org))

## Extras

### Free monograph offers seasonal influenza vaccination strategies

The Joint Commission released “Providing a Safer Environment for Health Care Personnel and Patients through Influenza Vaccination: Strategies from Research and Practice,” a free [monograph](#), to help health care organizations improve seasonal influenza vaccination rates in health care personnel. The monograph:

- Highlights strategies submitted from health care organizations through the Strategies for Implementing Successful Influenza Immunization Programs for Health Care Personnel Project, a collaboration with leading infection prevention and control professional organizations.

- Provides an overview of evidence-based guidelines, published research studies, legislative and regulatory efforts, and accreditation considerations related to improving seasonal influenza vaccination rates in health care personnel.

The Joint Commission's Division of Quality Measurement and Research authored the monograph in collaboration with The Association for Professionals in Infection Control and Epidemiology, The Centers for Disease Control and Prevention, The National Foundation for Infectious Diseases, and The Society for Healthcare Epidemiology of America. The monograph, supported in part by an unrestricted educational grant provided by sanofi pasteur, is only available by download. (Contact: Linda Kusek, [lkusek@jointcommission.org](mailto:lkusek@jointcommission.org))

## Public information

### GAO releases reports on hospital ED crowding and influenza pandemic preparedness

The Government Accountability Office released these reports:

- [\*Hospital Emergency Departments: Crowding Continues to Occur, and Some Patients Wait Longer than Recommended Time Frames\*](#): The report examined three indicators of emergency department crowding—ambulance diversion, wait times, and patient boarding—and found that ambulance diversions continue, wait times have increased, and reports of boarding in hospital emergency departments persist. According to articles reviewed by GAO and interviews with experts, lack of access to inpatient beds is the main factor contributing to ED crowding. Additional contributing factors include: lack of access to primary care; shortage of available on-call specialists; and difficulties in transferring, admitting or discharging psychiatric patients. (Contact: Patricia Kurtz, [pkurtz@jointcommission.org](mailto:pkurtz@jointcommission.org))
- [\*Influenza Pandemic: Continued Focus on the Nation's Planning and Preparedness Efforts Remains Essential\*](#): Reports on the numerous efforts that are underway to improve the surveillance and detection of pandemics at the federal, state and local levels. In fact, 13 of 23 recommendations made by the GAO in previous reports have been implemented by federal agencies. However, 10 GAO recommendations have not yet been fully implemented and would address the lack of: clearly defined government leadership roles and responsibilities; solid distribution of antivirals and vaccines; and stronger performance monitoring and accountability mechanisms. The GAO recommends that the new administration and Congress devote significant attention to these remaining gaps. (Contact: Jason Ormsby, [jormsby@jointcommission.org](mailto:jormsby@jointcommission.org))

## Joint Commission Resources

### Free online Antibiotic Resistance Toolkit from JCR

A free, downloadable Toolkit is available to help hospitals reduce MDROs (multidrug-resistant organisms). The Toolkit, [\*What Every Health Care Executive Should Know: The Cost of Antibiotic Resistance\*](#), addresses:

- The clinical and financial consequences of antibiotic resistance
- How to prevent the spread of MDROs in hospitals
- Effective antibiotic stewardship programs
- How to get buy-in at your hospital

The Toolkit was developed by Joint Commission Resources and was supported in part by funding from Ortho-McNeil, a division of Ortho-McNeil-Janssen Pharmaceuticals, Inc. (Contact: Karen Iversen, [kiversen@jcrinc.com](mailto:kiversen@jcrinc.com))

### Free “Test drive” of distance education offerings

Joint Commission Resources is offering health care organizations an opportunity to “test drive” its distance education offerings. Distance learning provides a convenient educational experience for health care professionals. JCR's distance learning includes Web-based education courses, audio conferences/Webinars, and satellite/on-line programs. The free offerings are:

- [Free Web-based education course](#)
- [Free audio conference for accreditation managers](#)

You can sign-up for monthly [e-mail updates](#) on distance learning offerings. (Contact: George Riccio, [griccio@jcrinc.com](mailto:griccio@jcrinc.com))

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