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Accreditation and certification

Get in compliance: Learn tips for most challenging requirements for NCCs in first half of 2017

The Joint Commission collects data on organizations’ compliance with standards, National Patient Safety Goals (NPSGs), and Accreditation and Certification Participation Requirements to identify trends and focus education on challenging requirements. The table identifies the Top 4 Joint Commission requirements identified most frequently as “not compliant” during surveys and reviews for Nursing Care Center Accreditation from Jan. 1, 2017, through June 30, 2017. The data represents citations only from organizations due to be surveyed during this time period — that is, data from for-cause surveys and for-cause reviews are not included.

<table>
<thead>
<tr>
<th>Requirement Percentage</th>
<th>Standard/NPSG</th>
<th>Program</th>
</tr>
</thead>
<tbody>
<tr>
<td>56% HR.02.01.04</td>
<td>Nursing Care Center Accreditation</td>
<td></td>
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<tr>
<td>38% MM.03.01.01</td>
<td>The organization permits licensed independent practitioners to provide care, treatment, and services.</td>
<td></td>
</tr>
<tr>
<td>30% PC.01.02.03</td>
<td>The organization safety stores medications.</td>
<td></td>
</tr>
<tr>
<td>24% IC.02.01.01</td>
<td>The organization implements its infection prevention and control plan.</td>
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Human Resources (HR) standard HR.02.01.04 — The organization permits licensed independent practitioners to provide care, treatment, and services — was the most challenging requirement of the first half of 2017, with a noncompliance rate of 56 percent.

A licensed individual practitioner (LIP) is permitted by law and by your organizational policy to provide care, treatment and services without direction or supervision. An LIP must work within the scope of their license. For example, an organization wouldn’t ask a dentist to provide foot care. The scope of practice for an LIP is usually defined by the state boards. The organization should have a process in place to verify an LIP’s credentials. The verification process should include:
- Seeing the LIP’s license.
- Verifying the LIP’s identity.
- Checking the LIP’s name through the National Practitioner Data Bank.
- Reviewing an LIP’s license every two years to make sure it hasn’t lapsed.

The National Practitioner Data Bank provides information about an LIP’s medical malpractice payments; adverse license, clinical privileging, state licensing or peer review actions; and negative findings from private accrediting organizations or certification authorities. The organization’s medical director should evaluate the data and list limitations to treatment or care that the LIP is permitted to perform. This can be
as simple as a checklist, which should be given to the organization’s governing board for deliberation. A process should also be available for an LIP to appeal, if needed.

Medication Management (MM) requirement MM.03.01.01 — The organization safely stores medications — was the second most challenging requirement.

It should be noted that the best medication management systems in the country are those in which the pharmacy — and pharmacist — is heavily involved. A pharmacist can advise and help with storage and other aspects of medication management in the facility. The goal is to maintain the integrity of medications and mitigate the risk of medication errors or diversion, while making medications available in a safe manner within the facility. Some tips include:

- Locking medication carts or refrigerators when they are unattended.
- Controlling the medicines that patients bring from home when first admitted to facility.
- Providing for safe storage, including proper refrigeration when needed.

An organization should develop policies and procedures for storage and control of medications so that medicines are stored according to manufacturer’s guidelines, and protections are in place to prevent access by unauthorized individuals. Also, a process should be in place to remove damaged and expired medications. The Joint Commission encourages the organization to define the timeframe within which stored medications are inspected for expiration, damage or contamination.

Provision of Care, Treatment, and Services (PC) requirement PC.01.02.03 — The organization assesses and reassesses the patient or resident and his or her condition according to defined time frames — was the third most frequently cited standard.

When patients come into a facility, there needs to be a time frame (defined by the organization) in which the patient is assessed. The needs of the patient should be assessed from an interdisciplinary point of view, meaning not only the physical assessment but also a psychological, social and spiritual assessment. In particular, for nursing homes that elect the Post-Acute Care Certification option, the standards specify that patients are assessed within the first hour of admission to determine immediate care needs. Also, no later than eight hours after admission, patients need to be assessed for pain, fall risk, skin condition, assistance needed in activities of daily living (ADLs), and risk for re-hospitalization.

The fourth most cited standard was the Infection Control (IC) requirement IC.02.01.01 — The organization implements its infection prevention and control plan. This plan should be used every day and should make sense for the organization. Some questions to help guide development of the plan include:

- What are the infection risks at the organization?
- What types of infection does the organization see most often?
- How do we communicate responsibilities for preventing and controlling infections to staff? Patients/residents? Visitors?
- What processes are in place for reducing infection risks with medical equipment, devices and supplies?

Focus efforts at your organization on the infections identified by your surveillance, the infection risks in your community, and the care, treatment and services provided in your organization. For more information, see the September issue of Perspectives or the Standards Frequently Asked Questions. (Contact: Standards Interpretation Group, 630-792-5900 or online question form)

Redesigned ESC form launched for all programs
The Evidence of Standards Compliance (ESC) form has been redesigned to help organizations focus on describing the critical aspects of corrective actions they have taken to resolve Requirements for Improvement (RFIs) and ensure sustainability of those actions. The new form was rolled out to all accreditation and certification programs this summer.
Organizations utilize the redesigned ESC form after any type of survey that results in RFIs. The improved ESC form — redesigned as part of Project REFRESH — has numerous benefits, including:

- New formatting that clearly and concisely states expectations for successful completion.
- A simplified layout that enables organizations to provide relevant information that better aligns with proven performance improvement methodologies.
- Flexibility that allows for organizations to implement corrective actions within their unique environment; however, it also provides guidance to hone in on key elements of effective compliance.
- Provisions of clear, concise and acceptable program-specific examples.
- An enhanced focus on sustained compliance.

The ESC form is available on an organization’s Joint Commission Connect™ secure extranet site, which includes resources to aid in successful completion of the new ESC form, such as:

- Updated ESC guidelines and instructions.
- A preventative analysis resource guide.
- Specific examples for each program on acceptable ESC responses.
- Updated ESC FAQs.

Questions about the redesigned ESC form can be directed to your organization’s Joint Commission account executive.

Patient safety

Sentinel event statistics released through June 30, 2017

The Joint Commission has reviewed a total of 13,346 reports of sentinel events, from January 1995 to June 30, 2017, documented in its Sentinel Event Database. This data collected and analyzed through The Joint Commission’s review of sentinel events includes causes and outcomes, and provides critical information that can help guide local efforts to mitigate future risk.

Data from the 10,417 incidents reported from 2005 through June 30, 2017 show that these events affected a total of 10,748 patients, leading to death for 5,687 patients (52.9 percent), unexpected additional care for 2,791 (26.0 percent), and permanent loss of function for 838 (7.8 percent), among other outcomes.

The Joint Commission reviewed a total of 400 sentinel events during the first six months of 2017. The Top 10 most frequently reported types of events are shown in the table. The majority of these — 354 (89 percent) — were voluntarily self-reported to The Joint Commission by an accredited or certified entity.

An estimated fewer than 2 percent of all sentinel events are reported to The Joint Commission. Therefore, these data are not an epidemiologic data set and no conclusions should be drawn about the actual relative frequency of events or trends in events over time. For more information, call the Office of Quality and Patient Safety at 630-792-3700 or visit The Joint Commission website.

Sentinel Event Alert focuses on inadequate hand-offs, tips to improve them

Health care professionals work diligently to meet patient needs and provide the best care possible. Unfortunately, too often, this effort and attentiveness falter when a patient is handed off, or transitioned, to another health care provider for continuing care, treatment or services. A common problem regarding these hand-offs, or hand-overs, centers on communication.
This problem is the focus of Sentinel Event Alert, Issue 58: Inadequate hand-off communication, and an accompanying infographic, “8 Tips for High-Quality Hand-Offs.” This alert provides advice to senders and receivers of hand-off communication, including communication between:
- Caregivers within hospitals and other health care settings.
- Hospital caregivers and those not located in a hospital.

While it sounds simple, a high-quality hand-off is complex. Failed hand-offs are a long-standing, common problem in health care. Read the Sentinel Event Alert.

New video: Joint Commission president explains how safety culture can protect patients
Mark R. Chassin, MD, FACP, MPP, MPH, president and chief executive officer of The Joint Commission, explains in a new video how years of survey and patient safety experiences led The Joint Commission to conclude that a strong safety culture can eliminate a wide variety of patient safety risks.

In the video, Dr. Chassin touches on the concepts covered in Sentinel Event Alert 57: The essential role of leadership in developing a safety culture, in order to engage health care leaders to promote and improve patient safety in their organizations. Leadership is crucial to achieving and maintaining a safety culture in an organization, as it sets the cultural tone for the whole organization. Dr. Chassin dove deeper into this topic in the webinar Building Your Safety Culture: A Job for Leaders.

Resources

MMWR: Flu vaccination rates of health care personnel lowest among long-term care workers
According to an opt-in survey in a September issue of the Centers for Disease Control and Prevention’s (CDC) Morbidity and Mortality Weekly Report (MMWR), 78.6 percent of health care personnel (HCP) respondents reported receiving an influenza vaccination during the 2016-2017 season. But vaccination coverage continued to be lower among health care personnel in long-term care settings (68 percent). This is notable because the vaccine’s effectiveness is generally lowest in the elderly.

The survey — “Influenza Vaccination Coverage Among Health Care Personnel — United States, 2016–17 Influenza Season” — included responses from 2,438 HCP, and showed vaccination coverage was highest among physicians (95.8 percent) and pharmacists (93.7 percent).

Influenza vaccination is addressed in The Joint Commission’s Infection Prevention and Control (IC) standards:
- IC.02.04.01 — The organization offers vaccination against influenza to licensed independent practitioners and staff. Note: This standard is applicable to staff and licensed independent practitioners only when care, treatment, or services are provided on site. When care, treatment, or services are provided off site, such as with telemedicine or telephone consultation, this standard is not applicable to off-site staff and licensed independent practitioners.
- IC.02.04.03 — The organization provides the influenza vaccination to at-risk patients and residents.

The Joint Commission has several resources and education on influenza vaccination:
- Infection Prevention and HAI Portal
  - Influenza (internal)
  - Influenza (external)
  - Vaccination
- Speak Up: Prevent the Spread of Infection (video)

Read the MMWR.