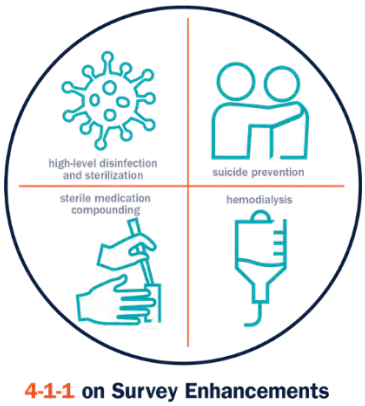
Joint Commission Online

Sept. 5, 2018

Accreditation and Certification

4-1-1 on Survey Enhancements: New scoring revisions for IC.02.02.01 now in effect



4-1-1 on Survey Enhancements

Infection Control (IC) standard IC.02.02.01 — which requires hospitals to reduce the risk of infections associated with medical equipment, devices and supplies — continues to be one of the most commonly cited standards listed as noncompliant. In 2017, 72 percent of surveyed hospitals and critical access hospitals were found to be noncompliant with this standard.

After a careful evaluation of high-level disinfection (HLD) and sterilization process steps, The Joint Commission has refined its scoring to focus on the process steps that pose the highest risk to patients if they fail.

These revisions are the focus of the latest **4-1-1 on Survey Enhancements** — a series that takes a deeper look at four high-risk areas that are evaluated by Joint Commission surveyors. The first 4-1-1 was on sterile medication compounding, this 4-1-1 focuses on HLD and sterilization, and the remaining 4-1-1s will focus on suicide prevention and hemodialysis.

These Infection Control scoring revisions (see table below) are intended to help hospitals hone in on the highest-risk process steps to become more compliant with IC.02.02.01, and they went into effect Sept. 1, 2018.

The Joint Commission will continue to score IC.02.02.01 as noncompliant whenever manufacturer instructions are not followed. Over the next several months, The Joint Commission will closely monitor the revisions to ensure consistent scoring.

Please note: IC.02.02.01 findings recorded before Sept. 1, 2018 will not be removed. Hospitals that are in the clarification window or that are preparing their Evidence of Standards Compliance (ESC) report should document compliance based upon the refined scoring guidelines. If your organization received an adverse decision and received only one finding from one of the seven areas, please contact the Standards Interpretation Group. (Contact: Sylvia Garcia-Houchins, sgarcia-houchins@jointcommission.org)

Effective immediately: New scoring revisions for IC.02.02.01	
Previously Scored	**New Scoring**
Visible bioburden and dried blood found on instruments	• Wiping / flushing of soiled instruments is not observed during a case in the operating room or procedure room and it is clinically appropriate • Item that is ready for use on a patient is visibly soiled
Enzymatic solution was not applied to maintain moisture on instruments	• There is no process for keeping used instruments moist • Manufacturer instructions for products used to keep instruments moist were not followed • The facility policy for keeping instruments moist was not followed
Instruments were not transported from the point of use in a leak-proof puncture-	• Sharps are being transported in a manner that violates OSHA requirements (e.g., sharps not placed in puncture-resistant container that is red or labeled biohazardous)

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resistant container with the biohazard symbol or color red	• Non-sharps are transported in a way that could lead to contamination of staff or other people
Instruments in the closed position	• Packaged instruments awaiting sterilization are in the closed/ratcheted position • Items that have just undergone sterilization are on the trolley or in the sterilizer in the closed/ ratcheted position • Items in preparation and packaging that have come through the washer or pass-through window have not been disassembled in accordance with manufacturer instructions
Instruments are released prior to the biologic indicator being read	• Routine sterilizer monitoring with a biologic indicator required by the state or per evidence-based guideline is not followed and recorded • Non-implant load is released without physical monitoring of cycle and external and internal chemical indicators • Implant loads are released without routine sterilizer monitoring, a biologic indicator and a type 5 integrating indicator (aka integrator) • Biologic indicator not read before implant release (unless allowed in emergent situations by facility policy and policy was followed)
Items in the high level-disinfected area that are stored in drawers	• Container or location of storage is visibly soiled or staff are observed contaminating other high level-disinfected products • Storage is not consistent with the items intended use (e.g., items that require minimum of high-level disinfection may be stored in a way that protects from contamination even if they were sterilized) • Item is not stored in accordance with manufacturer instructions for use (IFU) • Item is not stored in accordance with facility risk assessment / policy if no guidance was provided by the item's manufacturer IFU
Stored scopes exceeded the hang time	• Facility is not following manufacturer IFU for drying • Facility is not following manufacturer IFU for frequency of reprocessing Will NOT score any finding related to hang time under IC standards

Comment on proposed pain standards revisions for behavioral health organizations
The Joint Commission is interested in receiving your comments on proposed revisions to the pain assessment and management standards for accredited Behavioral Health Care organizations. These revisions are being developed to further promote patient safety and quality of care, as well as to align requirements with current recommendations from scientific, professional, governmental literature and reports.

Please note: The proposed new requirements have limited applicability based on the programs or services provided by an organization. A note or a lead-in statement at the beginning of the element of performance (EP) clarifies the setting or circumstances under which the EP is applicable to an organization.

The proposed new requirements are for:

- Care, Treatment, and Services (CTS) standard CTS.02.01.09, EP 3
- Human Resources Management (HRM) standard HRM.01.05.01, EP 11
- Medication Management (MM) standard MM.01.01.01, EP 2

Comment now. The deadline for comment is Oct. 16. (Contact: Mamello Tekateka, mtekateka@jointcommission.org)

Performance measurement

Don't miss out: Plan to attend Sept. 18 Pioneers in Quality Proven Practices webinar
In 2017, The Joint Commission launched the Pioneers in Quality™: Proven Practices Collection, which recognizes organizations that leverage electronic clinical quality measures (eCQMs) and health information technology (IT)

to drive quality improvement. The second installment of this year's webinar series features Vail Health Hospital of Vail, Colorado, and Texas Health of Arlington, Texas.

The webinar, "Pioneers in Quality™ 2018 eCQM Proven Practices: An evolutionary approach and a model of collaboration," is scheduled for Tuesday, Sept. 18, from 11 a.m.-noon (PT)/noon-1 p.m. (MT)/1-2 p.m. (CT)/2-3 p.m. (ET).

Vail Health Hospital and Texas Health were selected because of the overall strength of their eCQM processes and practices, as well as the applicability and replicability for other organizations to improve their implementation of eCQMs and their use of eCQM data to increase the quality of patient care.

Additionally, the Proven Practices webinar series presents an opportunity for organizations to learn from other hospitals and health care systems in order to use this knowledge to make systemic changes. For those who cannot attend the live presentation, by registering you can still receive emailed resources and updates about the webinar.

Register for the webinar.

Quality and safety

September *Journal*: Study on intensive rapid response system treatment in end-of-life care
Rapid response system (RRS) calls are designed to identify and respond to seriously ill patients in acute care hospitals. A new study in the September 2018 issue of the *Joint Commission Journal on Quality and Patient Safety* evaluates whether treatment is beneficial for end-of-life care patients for whom an RRS call is made, describes interventions administered, and measures the cost of hospitalization.

The study — "Who Benefits from Aggressive Rapid Response System Treatment Near the End of Life? A Retrospective Cohort Study," by Magnolia Cardona, PhD, MPH, associate professor of Health Systems Research and Translation, Centre for Research in Evidence-Based Practice, Bond University and Gold Coast Hospital and Health Service, Queensland, Australia, and co-authors — evaluated 733 adult inpatients with data for the period three months before and after their last RRS call. A subgroup analysis of admitted patients aged 80 years and older also was conducted.

The study found that:

- 8.9 percent of patients had a preexisting not-for-resuscitation (NFR) or not-for-RRS order, and none of these patients survived to three months.
- Patients without an NFR or not-for-RRS order had a three-month survival probability of 71 percent.
- Compared with survivors, RRS recipients who died were more likely to be older, to be admitted to a medical ward, and to have a larger mean number of admissions before the RRS.

The study concluded that identifiable risk factors clearly associated with poor clinical outcomes and death can be used as a guide to administer less aggressive treatments, including reconsideration of ICU transfers, adherence to NFR orders and transition to end-of-life management — instead of calls to the RRS team.

An accompanying editorial by Eyal Zimlichman, MD, MSc, chief medical officer, Sheba Medical Center, Tel-Hashomer, Israel, and Michael Ehrenfeld, MD, risk management consultant, Sheba Medical Center, supports the idea that to reduce unnecessary interventions, goals of care should be agreed on as early as possible during hospitalization and in advance of any deterioration.

Both the study and editorial articles are open access. Also featured in the September 2018 issue:

- "Developing a Standard Handoff Process for Operating Room-to-ICU Transitions: Multidisciplinary Clinician Perspectives from the Handoffs and Transitions in Critical Care (HATRICC) Study"
- "Hospital Leadership Diversity and Strategies to Advance Health Equity"

Access the *Journal*.

Resources

Up in the blogosphere with The Joint Commission

- ***Quality Data Download*** — Who Benefits from Aggressive Rapid Response Interventions Near the End of Life? This blog post goes beyond the study, "Who Benefits from Aggressive Rapid Response System Treatment Near the End of Life? A Retrospective Cohort Study," from the September 2018 issue of the *Joint Commission Journal on Quality and Patient Safety*.
- ***Ambulatory Buzz*** — New Executive Director of Ambulatory Care at The Joint Commission: Longtime executive director of The Joint Commission's Ambulatory Health Care Accreditation program, Michael Kulczycki, is retiring. Over the last 17 years, Michael has grown the ambulatory program to become the third-largest among The Joint Commission's programs, writes Pearl Darling, new executive director of the program.
- ***@ Home with The Joint Commission*** — Lessons Learned in Establishing a Strong Palliative Care Program: Organizations building palliative care programs tend to stumble on the same roadblocks, and understanding the common pitfalls is the first step toward a productive survey and smooth re-certification process, writes Mala VonGunten, CRNI, BSN, MBA, associate director, Home Care.

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