The Savvy PSC: Review of the 2014 Primary Stroke Certification Standards

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Introduction

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DSC Advanced Primary Stroke Standards

- Standards chapters
  - CPR – certification participation requirements
  - DSPR – program management
  - DSDF – delivering or facilitating care
  - DSSE – Supporting self management
  - DSCT – Clinical information management
  - DSPM – performance management
2014 Standards Update Background


A group of clinical subject matter experts, provided expertise to The Joint Commission and our American Heart Association partners to provide recommendations for the newly published standards.
2014 PSC Standards Updates

The most significant changes impacted the following areas:

- Endovascular procedures for the treatment of acute ischemic stroke when outside the window for IV thrombolytic therapy

- Necessary diagnostic tests prior to the administration of IV thrombolytic therapy

- The time frame for the administration of IV thrombolytic therapy
Standard DSPR.1 EP 1

The program defines its leadership roles.

The program identifies members of its leadership team.

The organization appoints a primary stroke center (PSC) medical director.

Note: A PSC medical director does not have to be board-certified in neurology or neurosurgery, but must have sufficient knowledge of cerebrovascular disease to provide administrative leadership, clinical guidance, and input to the stroke program.
The program defines the accountability of its leader(s).

a. *Written* documentation shows support of the primary stroke center by hospital or health system administration
DSPR 1 EP 4

- The program leader(s) identifies, in writing, the composition of the interdisciplinary team.
  - a. The primary stroke center documents the roles and responsibilities for members of the core stroke team.

Note: We will look for written materials such as a job description to demonstrate this requirement.
Standard DSPR.3 EP 4

- The program meets the needs of the target population.
- The services provided by the program are relevant to the target population.
  - a. The primary stroke center collaborates with (EMS) providers to make certain of the following:
    - The program has access to treatment protocols utilized by EMS providers personnel for emergency stroke care.
    - The program has stroke patient destination protocols utilized by EMS providers that address transport of stroke patients to primary stroke centers, in accordance with law and regulation.
b. Primary stroke centers that provide support to remote area hospitals have protocols that address the following:

- Prompt diagnosis and emergency treatment of stroke patients at remote sites
- Transfer of stroke patients to the primary stroke center
c. The primary stroke center has either a stroke unit or designated beds for the acute care of stroke patients.

Note: Stroke units can be defined and implemented in a variety of ways. The stroke unit does not have to be a specific enclosed area with beds designated only for acute stroke patients; it may be a specified unit or number of beds to which most stroke patients are admitted.
d. The primary stroke center has the ability to perform computed tomography (CT) of the head on site 24 hours a day, 7 days a week.

Note: A brain magnetic resonance imaging (MRI) may be performed in lieu of a head CT, if the same time parameters can be met in the acute setting.
e. For post-acute stroke patients, brain MRI and vascular imaging with a magnetic resonance angiogram (MRA) or computed tomography angiogram (CTA) are available when clinically indicated to determine or guide treatment choices.

f. At least one modality for cardiac imaging, such as echocardiography, is available to all patients admitted for a stroke.
The program determines the care, treatment, and services it provides.

The program defines in *writing* the care, treatment, and services it provides.

a. The organization’s formulary or medication list must include an IV thrombolytic therapy medication for ischemic stroke that is approved by the U.S. Food and Drug Administration.
a. The program provides care, treatment, and services to patients in a planned and timely manner.

Requirement(s) Specific to Primary Stroke Center Certification

a. The primary stroke center has the ability to complete initial laboratory tests on site 24 hours a day, 7 days a week.

Note: Laboratory tests include a complete blood cell count with platelet count, coagulation studies (Prothrombin Time, International Normalized Ratio), blood chemistries, and troponin.
The program has a process to provide emergency/urgent care.

a. The primary stroke center has designated practitioners knowledgeable in the diagnosis and treatment of stroke who are responsible for responding to patients with an acute stroke 24 hours a day, 7 days a week.

b. The organization has written documentation on the process used to notify the designated practitioners who respond to patients with an acute stroke.
c. At least one of the designated practitioners is able to respond to the patient’s bedside within 15 minutes of notification.

Note: The organization may choose to maintain a consistent team or group of practitioners for this purpose, or it may choose to rotate this responsibility as needed. These practitioners may include physicians, nurses, nurse practitioners, and physician assistants from any unit or department as determined by the organization.
d. Emergency department licensed independent practitioners have 24-hour access to a timely, informed consultation about the use of IV thrombolytic therapy, which is obtained from a physician privileged in the diagnosis and treatment of ischemic stroke.

Note: For the purpose of The Joint Commission’s Primary Stroke Center Certification, an informed consultation includes bedside consultation or telemedicine consultation from a privileged physician.
The program provides the number and types of practitioners needed to deliver or facilitate the delivery of care, treatment, and services.

a. Neurosurgical coverage is documented in a written plan and is approved by the covering neurosurgeon(s), stroke program leaders, and any involved facilities.

A neurosurgical call schedule is readily available in the emergency department and to primary stroke center staff.
DSPR 5 EP 7 continued

b. For sites that transfer patients for neurosurgical emergencies, there is a written protocol for transfer.

c. For sites that do not transfer patients for neurosurgical emergencies, the primary stroke center has the following:

- A fully functional operating room (OR) facility that is staffed 24 hours a day, 7 days a week with the necessary staff for neurosurgical services.
- All OR equipment necessary to perform neurosurgical procedures.
- The OR facility and staff for neurosurgical services are available within two hours.
Standard DSPR.6 EP 1

- The program has current reference and resource materials.

- Practitioners have access to reference materials, including clinical practice guidelines, in either hard copy or electronic format.

  a. Protocols and care paths (preprinted or electronic documents) are available in the emergency department, acute care areas, and stroke unit for the acute assessment and treatment of patients with ischemic or hemorrhagic stroke.
Standard DSDF.1 EP 1

- Practitioners are qualified and competent.
- Practitioners have education, experience, training, and/or certification consistent with the program’s scope of services, goals and objectives, and the care provided.

- a. The organization’s clinical staff has knowledge of the process used to notify designated practitioners of the need to respond to patients with an acute stroke.
b. Emergency department practitioners demonstrate knowledge of IV thrombolytic therapy protocols for acute stroke, including the following:

- Treatment during the first three hours after the patient was last known to be well
- Indications for use of IV thrombolytic therapy
- Contraindications to IV thrombolytic therapy
- Education to be provided to patients and families regarding the risks and benefits of IV thrombolytic therapy
- Signs and symptoms of neurological deterioration post IV thrombolytic therapy
c. Eighty percent of emergency department practitioners can do the following:

- Demonstrate knowledge of the communication system used with inbound EMS
- Demonstrate knowledge of the location and application of stroke-related protocols
- Demonstrate knowledge of the care of patients with acute stroke, including pathophysiology, presentation, assessment, diagnostics, and treatment
DSDF 1 EP1 continued

- Demonstrate competency in the diagnosis of acute stroke
- Demonstrate utilization of protocols for stroke triage
- Demonstrate competency in treatment options for acute stroke
- Utilize protocols for the monitoring of an acute stroke patient

d. The organization is required to have staff trained to perform and interpret cardiac imaging tests, such as echocardiography.
Ongoing in-service and other education and training activities are relevant to the program’s scope of services.

a. Members of the core stroke team, as defined by the organization, receive at least eight hours annually of continuing education or other equivalent educational activity.

b. Emergency department staff, as identified by the organization, participates in educational activities related to stroke diagnosis and treatment a minimum of twice a year.
Standard DSDF.2

- The program develops a standardized process originating in clinical practice guidelines (CPGs) or evidence-based practice to deliver or facilitate the delivery of clinical care.

EP 2

- The selected clinical practice guidelines are based on evidence that is determined to be current by the clinical leaders.
  
  a. The primary stroke center has written protocols based on clinical practice guidelines, including:
     
     - Protocols for emergent care of patients with ischemic stroke
     - Protocols for emergent care of patients with hemorrhagic stroke
b. The dysphagia screen used by the program is an evidence-based bedside testing protocol approved by the organization.

c. Protocols for IV thrombolytic therapy, when indicated, are reflected in the order sets or pathways and utilized in the acute care of the stroke patient.

d. Time parameters for stroke workup are included in a stroke assessment protocol or the emergency department stroke protocol.
The program leader(s) and practitioners review and approve clinical practice guidelines prior to implementation.

a. Protocols for emergent care of patients with ischemic and hemorrhagic strokes are reviewed for current evidence at least annually using an interdisciplinary approach.
DSDF 2 EP 4

Practitioners are educated about clinical practice guidelines and their use.

a. The organization demonstrates that eighty percent of emergency department practitioners are educated in the primary stroke center’s acute stroke protocol(s).
Standard DSDF 3

- The program is implemented through the use of clinical practice guidelines selected to meet the patient's needs.

EP 2

- The assessment(s) and reassessment(s) are completed according to the patient's needs and clinical practice guidelines.
a. An emergency department physician performs an assessment for a suspected stroke patient within 15 minutes of patient arrival in the emergency department.

The NIH Stroke Scale (NIHSS) is used for the initial assessment of patients with acute stroke.

Ongoing assessment(s) of the patient are completed in accordance with the program’s acute stroke protocols.

b. A blood glucose level is completed for any patient presenting with stroke symptoms.
c. A computed tomography of the head (head CT) is completed within 25 minutes of patient presentation with stroke symptoms.

d. Interpretation of a head CT by a physician is completed within 20 minutes and documented.

Note: Review of the images does not have to be done on site. Evaluation can be performed through telemedicine.
e. Laboratory tests, electrocardiogram (ECG), and chest x-ray are completed within 45 minutes of patient presentation with stroke symptoms, if ordered by the practitioner.

Note: Laboratory tests may include a complete blood cell count with platelet count, coagulation studies (PT), International normalized ratio), blood chemistries, and troponin.
f. All patients exhibiting stroke symptoms are screened for dysphagia prior to receiving any oral intake of fluids, food, or medication.

g. The stroke unit or designated beds has the capability of continuously and simultaneously monitoring the following:

- BP, Heart rate and rhythm, with automatic arrhythmia detection, Respirations and O2 Saturation via pulse oximetry or another modality.
h. The stroke program provides for early assessment of rehabilitation needs for all patients admitted with stroke.

i. The primary stroke center has a process to notify medical staff and other personnel about the deterioration of a stroke patient, which may include, but is not limited to, changes in vital signs and neurological status.
The program implements care, treatment, and services based on the patient's assessed needs.

- **a.** Brain magnetic resonance imaging (MRI), magnetic resonance angiogram (MRA), and computed tomography angiogram (CTA) scans are interpreted within two hours of completion, if these tests are ordered to be completed as soon as possible.

- **b.** The completion of laboratory tests, electrocardiogram (ECG), and chest x-ray should not delay the administration of IV thrombolytics.
c. Rehabilitation therapy is initiated as indicated by the patient assessment and may include speech language pathology services, physical therapy, occupational therapy, or any combination of these therapies.
The program manages co-morbidities and concurrently occurring conditions and/or communicates the necessary information to manage these conditions to other practitioners.

The program coordinates care for patients with multiple health needs.

a. Protocols for care related to patient referrals demonstrate that the program does the following:

- Addresses processes for receiving transfers
- Addresses processes for transferring patients to another facility
- Evaluates the receiving organization’s ability to meet the individual patient’s and family’s needs
b. Based on prognosis and the patient’s individual needs and preferences, patients are referred to palliative care when indicated.

c. Based on prognosis and the patient’s individual needs and preferences, patients are referred to hospice or end-of-life care when indicated.

d. Based on prognosis, individual needs, and consultation with the family, patients are referred to community resources to facilitate integration into the community such as:
Standard DSDSF.5 EP 1

- Outpatient therapy, including physical therapy, occupational therapy, and speech language pathology services

e. For primary stroke centers that treat and transfer acute stroke patients, written documentation includes time parameters and transfer procedures.
Standard DSDF 6 EP 2

- The program initiates discharge planning and facilitates arrangements for subsequent care, treatment, and services to achieve mutually agreed upon patient goals.

- In preparation for discharge, the program considers the patient’s anticipated needs and goals when identifying the setting and practitioners for continuing care, treatment, and services.

  a. Protocols related to transitions of care: Addresses procedures for transitions of care for patients internally and post hospitalization and procedures for referrals when the organization does not provide post acute, inpatient rehabilitation services.
The program provides education and serves as a resource, as needed, to practitioners who are assuming responsibility for the patient’s continued care, treatment, and services.

- a. The primary stroke center provides educational activities to pre-hospital personnel, as defined by the organization.
- b. The primary stroke center provides at least two stroke public education activities per year.
The program involves patients in making decisions about managing their disease or condition.

a. The patient and family participate in planning post-hospital care.
Standard DSCT.4 EP 2

- The program shares information with relevant practitioners and/or health care organizations about the patient’s disease or condition across the continuum of care.

- The program shares information with relevant practitioners and/or health care organizations to facilitate continuation of patient care.

  a. The following results are communicated and available to the ordering physician and stroke team as applicable:

    - Head computed tomography (CT)
    - Computed tomography angiography (CTA)
    - Brain magnetic resonance imaging (MRI)
    - Magnetic resonance angiography (MRA)
The program initiates, maintains, and makes accessible a medical record for every patient.

EP 4

a. Documentation indicates the reason eligible ischemic stroke patients did not receive IV thrombolytic therapy.
EP 5

The medical record contains sufficient information to document the course and results of care, treatment, and services.

a. Stroke program practitioners document all assessments and interventions provided for stroke patients, including date and time, in accordance with the organization’s policy.
The program has an organized, comprehensive approach to performance improvement.

The program leader(s) identifies goals and sets priorities for improvement in a performance improvement plan.

- The program will select a minimum of two relevant patient care data elements to be monitored for internal or external benchmarking each year.

  Note: The data elements may be chosen from information being monitored and documented in the stroke log.

- The program monitors its performance for administering IV thrombolytics within 60 minutes to eligible patients presenting for stroke care.

- As of March 1, 2015, the program will meet its administration of IV thrombolytic within 60 minutes at least 50% of the time.
The program leader(s) involves the interdisciplinary team and other practitioners across disciplines and/or settings in performance improvement planning and activities.

- a. Stroke performance measures are analyzed by the stroke team and organization’s quality department.

- b. The stroke program has a specified committee that meets a minimum of twice per year to evaluate protocols and practice patterns as indicated.
c. If the primary stroke center performs endovascular therapy for the treatment of ischemic stroke, it will have a multidisciplinary program-level review that will focus on at least the following adverse patient outcomes:

- All causes of death within 72 hours of the endovascular procedure
- Symptomatic intracerebral hemorrhage

Note 1: Endovascular procedures include mechanical thrombectomy and intra-arterial thrombolytics.

Note 2: A multidisciplinary program-level review is defined as a review at the program level to assess causes of patient adverse outcomes with the aim of decreasing the incidence of such outcomes.
The program collects data related to its target population to identify opportunities for performance improvement.

a. The primary stroke center has documentation to reflect tracking of performance measures and indicators.

b. If the primary stroke center performs endovascular procedures for the treatment of ischemic stroke, it will collect data on, at a minimum, the following adverse patient outcomes:

- All causes of death within 72 hours of the endovascular procedure and Symptomatic intracerebral hemorrhage

Note: Endovascular procedures include mechanical thrombectomy and intra-arterial thrombolytics.
The program analyzes its performance measurement data to identify opportunities for performance improvement.

a. The primary stroke center demonstrates a focus in IV thrombolytic therapy in its performance measurement data.

b. The primary stroke center evaluates IV thrombolytic therapy data through the quality improvement process and by the stroke team.
The program documents actions taken to achieve improvement.

a. The primary stroke center has documentation to reflect specific interventions to improve stroke performance measurement data.

b. The primary stroke center has documentation to reflect implementation period and reevaluation point of interventions taken to improve stroke performance measurement data.
The program determines if improvements have been achieved and are being sustained.

a. The primary stroke center has documentation to reflect specific outcomes that improved stroke performance measurement data.
Standard DSPM.3

- The program collects measurement data to evaluate processes and outcomes.
- Note: Measurement data must be internally trended over time and may be compared to an external data source for comparative purposes.

EP 2

- The program collects data related to processes and/or outcomes of care.
- a. The stroke team log includes at least the following information:
  - Practitioner response time to acute stroke patients
Question and Answer Session
Contact us

Standards Interpretation Questions:
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