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Regulations

Joint Commission survey standards tighten for 2017

Beginning January 1, 2017, the Joint Commission is "making significant changes in its survey methods and its standards manual," says John R. Rosing, MHA, FACHE, executive vice president and principal, Patton Healthcare Consulting, Milwaukee, Wisconsin, and OR managers need to be prepared for them.

The reason, he says, is that the Centers for Medicare & Medicaid Services (CMS) has for the past few years driven the Joint Commission to lower its "disparity rating," which is a measure of the difference in results between a Joint Commission and CMS survey of the same organization.

Anyone who has had a CMS survey knows its surveyors are "less forgiving," he says. "A single episode of noncompliance gets written up in the CMS report. It's not consultative at all."

CMS is pushing the Joint Commission to survey similarly.

Changes for 2017

The Joint Commission's changes for 2017 include the following:

- There are no longer any "C" or rate-based elements of performance (EPs). "They initially had to find three defects in a rate-based process before they'd cite you," says Rosing. "Several years ago they ratcheted it back to two, and now it's one. A single observation of noncompliance going forward will result in a finding."
- There are no longer indirect or direct EPs. "They are all the same at this point," he says. "There used to be elements of performance that had an "R" next to them, meaning they were higher risk. That's also gone."
- The postsurvey measures of success process is gone. "Previously, if a facility had a finding in a survey, there was a requirement on many of the C elements of performance that an audit would be done for 4 months afterward to monitor the success of the corrective action," says Rosing. "That's no longer going to be required. You still have to have a monitoring plan, but they no longer specify how to conduct the monitoring, nor will you need to submit the results of monitoring."
- The opportunities for improvement (OFI) section of the report will be eliminated. "Many years ago, the Joint Commission had a scoring category called "supplemental findings," he says. It went away, but was resurrected a few years ago under the term "opportunities for improvement." Starting in 2017, OFIs have been eliminated; any single observation is going to result in a finding.

The Joint Commission also is developing a Survey Analysis for Evaluating Risk (SAFER) Matrix™ to enhance the survey reports prepared at the conclusion of a survey.

"Instead of a 30-page report that leaves you wondering about the relative degree of severity of the observations they have made, the Joint Commission is providing a new grid that visually risk-stratifies each finding," Rosing explains (https://www.jointcommission.org/safer_matrix_new_scoring_methodology/). For example, a finding limited to one department with a low probability of harm would be in the lower left-hand corner of the grid. A widespread finding with a high probability of harm would be in the upper right-hand corner.

"If your survey report pinpoints 20 findings and 19 of them are in the lower left

corner and one is in the middle of the grid, this presents an effective visual for your leadership and others to say, 'okay, we had 20 findings, but most are non-systemic, isolated incidents and relatively insignificant.' I think this is going to be a helpful enhancement to the report," he says.

Surveyors will have a scoring algorithm to help pinpoint where on the grid a finding should rest, but thus far, little is known about the algorithm.

John R. Rosing, MHA, FACHE

The top 10 most frequently scored standards for 2015 were released in the April issue of the Joint Commission Perspectives. Many on the list are familiar and have been mentioned repeatedly in the past. Number 9 (PC.02.01.03) is new to the top 10 (sidebar, p 6).

Starting January 1, 2017, every observation will be a finding, and every finding will require evidence of standards compliance (ESC) within 60 days of a survey. Even single observation findings will require an ESC.

More detail in the ESC about leadership's involvement in the corrective action and a corrective action sustainability analysis will also be required for medium- and high-risk findings, and corrective actions will receive extra scrutiny during your next survey.

There will be no changes to "immediate threat to life" procedures. "This is something that hopefully no one will encounter," notes Rosing. CMS has a similar category called "immediate jeopardy."

Postsurvey clarification of findings will undergo some change. Postsurvey, there will no longer be an opportunity, except in rare instances, to clarify or refute findings, which is similar to CMS survey policies.

"You don't get a chance to argue with CMS, and for the most part it's going to happen that way with the Joint Commission as well," says Rosing. "You should try to clarify [findings] when the team is still onsite," he advises.

Top 10 Joint Commission scored standards

1. EC.02.06.01: Oxygen storage (62%). "This is one of those that is easily detected during a survey: If an oxygen "E" cylinder is not in a holder or rack, but just sitting on the floor, it is unsafe," says John Rosing, MHA, FACHE, executive vice president and principal, Patton Healthcare Consulting, Milwaukee, Wisconsin. "You can't argue it." Likewise, if an empty or partially-filled oxygen cylinder is stored in a rack intended for full cylinders, a finding will result.
2. IC.02.02.01: Medical equipment infection risk (59%). Elements of performance in this standard include low-level disinfection of countertops, surfaces, and equipment, as well as high-level disinfection and sterilization.
   "A single misstep in a high-level disinfection or sterilization process often results in a condition-level finding and 45-day follow-up survey because of the way the scoring algorithm works," says Rosing. Examples include failing to keep used instruments moist while they are awaiting transport to decontamination, incomplete quality control documentation, or improper storage of endoscopes or sterile instruments.
3. EC.02.05.01: Ventilation system, pressure, air exchange (58%). "This standard also deals with ventilation, pressure, air exchanges, temperature, and humidity in critical areas—such as ORs, central sterile decontam, sterile prep, and cleaning rooms—and the storage room," he says.
4. LS.02.01.20: Maintain egress (51%). This includes blocked corridors.
5. LS.02.01.30: Fire protection features maintained to protect patients, mostly door issues (50%). This includes doors that don't latch.
6. RC.01.01.01: Complete/accurate medical record (47%), failure to date or time entries.
7. LS.03.01.35: Maintain system for extinguishing fire (46%). This includes sprinkler heads that are blocked and missing exit signs.
8. LS.02.01.10: Fire protection features maintained (45%). This includes penetrations in smoke barrier walls that are discovered.
9. PC.02.01.03: Orders for care, treatment, and service (40%). "The hospital provides care, treatment, and services as ordered or prescribed, and in accordance with law and regulation" has not been in the top 10 in the past. There are three elements of performance: one requiring obtaining orders before providing care, a second to use the most recent orders, and a third to use a read-back process for verbal or telephone orders and critical results.
10. EC.02.02.01 EP 3 & 5: Hazardous materials and eye wash station testing, lead aprons, hot lab (39%).

FAQs renamed

The Joint Commission has renamed "frequently asked questions" (FAQs) on its website as "standards of interpretations."

FAQs have been an important part of survey preparation because they have provided specific, detailed answers to hospital leaders' questions about a standard. The information is still available, only in a new format and under a new name, according to Rosing.

"At times, the standard itself can be a very benign, nebulous statement, and you may not fully understand what is required of the standard or element of performance," notes Rosing.

"The devil in the details is often revealed in these interpretations on the Joint Commission website."

Rosing suggests that accreditation coordinators look at each standard of interpretation to see how it applies to their hospitals.

Preliminary denial of accreditation

The Joint Commission and CMS have built a "crosswalk" linking Joint Commission standards with CMS Conditions of Participation, says Rosing.

When certain standards are scored by the Joint Commission, it automatically triggers a CMS condition-level finding. This means an issue has been identified that has some level of severity and some level of spread across the organization. It's not just an isolated event.

In these instances, the facility will have a follow-up survey within 45 days to validate that the issues cited under the standard have been fixed. "It's a 'hold your feet to the fire' expectation," says Rosing.

Preliminary denial of accreditation (PDA) happens when there are five or six of these condition- level issues.

"It ratchets up to a higher level of expectation and puts you in another mode of follow up survey," Rosing says.

The Joint Commission's newest process steps for PDA include:

- ESCs have to be submitted in 30 days. Following approval, there will be a follow-up survey.
- If there are condition-level findings, normally a follow-up survey would be in 45 days.
- ESC and condition-level findings follow-up surveys may be combined.
- If the ESC follow-up survey is clean, the decision changes to accreditation with follow-up survey.
- A conference call with the Joint Commission and hospital leadership is conducted.
- The hospital is required to participate in the intracycle monitoring process, which occurs at 12 and 24 months.
- The next triennial survey will occur in the earlier segment of the 18- to 33-month window.
- If the hospital receives a repeat PDA, it progresses to denial of accreditation.

225 EPs deleted

Effective July 1, 2016, the Joint Commission deleted 225 EPs. These are covered elsewhere, required by law, or were widely implemented already.

Of these deleted EPs, 90 were related to restraint use. The Joint Commission and CMS both had similar, but different, restraint standards.

The key to deletion was, if a hospital was using Joint Commission accreditation for purposes of getting Medicare payment (ie, deemed status), it had to use the CMS standards. Non-deemed hospitals, like Veterans Affairs hospitals, that don't receive Medicare payments followed only the Joint Commission's standards. Now there is just one set of restraint standards. ✣

–Judith M. Mathias, MA, RN

Reference

Rosing J R. Joint Commission, CMS, and DNV-GL: Mastering standards and regulations for successful surveys. Workshop. OR Manager Conference 2016.