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FOR JOINT COMMISSION COMPLIANCE STRATEGIES



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The Private Diagnostic Clinic (PDC) shares how its senior leadership used TeamSTEPPS® training for ambulatory care to create customized tools that met the needs of its multispecialty clinic environment. With input from clinic leaders, education, and training, PDC was able to build and sustain a model for teamwork that improved communications systemwide.

6 Call for Papers on Telehealth

The rapid shift from in-person to virtual care during the COVID-19 pandemic has prompted a steep learning curve for some health care organizations. In response, *The Joint Commission Journal on Quality and Patient Safety* is seeking manuscript submissions on telehealth, including retrospective analyses of quality and safety issues and prospective studies of strategies to improve quality, safety, and access to care. This article links potential authors to submission guidelines.

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A Model for Teamwork in Ambulatory Health Care

TEAMSTEPPS® AT DUKE PRIVATE DIAGNOSTIC CLINIC

By Kimberly Denty, MSN, RN, CPPS, and Sanne Holbrook Henninger, EdD, LCSW

The Private Diagnostic Clinic (PDC) is an independent, integrated multispecialty physician practice accredited by The Joint Commission under the ambulatory health care program setting. The organization delivers high-quality, patient-centered health care with 1,854 physician members and 550 advanced practice providers in more than 100 clinics throughout central and eastern North Carolina.

Recently, the PDC developed and implemented a team training program that began as a result of its leadership acknowledging that without high-functioning teams, it is impossible to improve patient safety, achieve operational efficiency, and consistently comply with Joint Commission standards. With this performance improvement initiative in mind, PDC looked to the Team Strategies & Tools to Enhance Performance & Patient Safety methodology—commonly known as [TeamSTEPPS®](#)—for structured, evidence-based, team-building strategies to meet this objective.

What Is TeamSTEPPS?

TeamSTEPPS was developed jointly by the US Department of Defense (DoD) and the [Agency for Healthcare Research and Quality \(AHRQ\)](#) to improve institutional collaboration and communications related to patient safety. Although AHRQ offered a basic program for office-based care settings, it was not robust enough to address the unique needs of a complex multispecialty clinic, such as PDC. For example, unlike the typical office-based care clinic, at PDC, team membership is more unified and tends to be long term, patient volumes are high and fast paced, evaluations and instructions are complex, patients may have multiple medical issues, and detailed communications are required for complicated surgeries. Building high-functioning teams at PDC required training and focus to address these unique features.

All senior leaders were certified in the TeamSTEPPS ambulatory care program to get a baseline understanding of the methodology and its tools. Although the program contained a solid foundation for team building, PDC identified key gaps in the basic office-based care program. These gaps included tools and strategies to support conflict management, leadership development and alignment, performance improvement, and interpersonal skills. This prompted PDC to implement the lessons from TeamSTEPPS and adapt and customize the training tools for its own specialized needs.

Key Tool Development

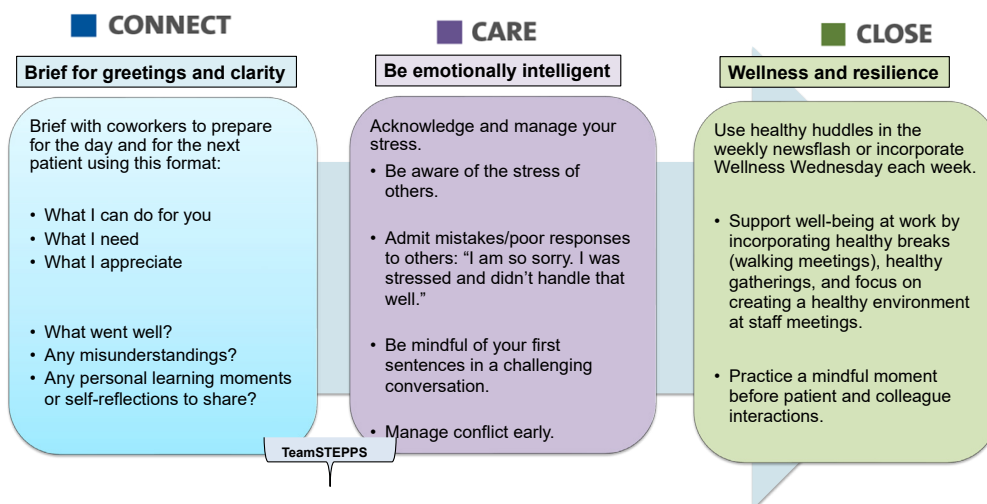
All the tools were created with input from clinic leaders and sustained through ongoing education and training. Not all the tools are addressed in this article, but many were created or customized to address leadership alignment, performance improvement, and conflict management, including the following:

- **Leadership Alignment Tool.** The purpose of the leadership alignment tool is to unify clinic leaders in their philosophy, communications, and messaging to staff. The tool lists targeted questions on key topics to prompt discussions about staff relationships with the strategic goal to show a united front. The tool is used for all levels of leadership teams—newly formed, those with changing members, and those that are performing poorly. Some questions to prompt discussion include the following: What are your preferred methods of communication with your team? What is your philosophy for managing employee performance issues? Is there anything about our roles that is unclear? What are some of our greatest safety culture challenges right now?
- **Performance Improvement Alignment Tools.** The office-based care version of TeamSTEPPS supports performance improvement initiatives that include scientific problem solving, clear communication standards, standard work, and huddles and huddle boards for organizing data, changes, and progress. At PDC, scientific thinking was applied to solve a problem with incorrectly administered medication orders. A handoff checklist from physician to clinical staff members was created using the situation, background, assessment, recommendation (SBAR) technique for framing communication about medication orders. The checklist helps facilitate prompt and accurate handoff communications related to this important safety issue.
- **Action Plan Worksheets.** Action plan worksheets outline barriers, offer intervention options, and prompt questions to guide improvement decisions and next steps. Worksheets include best practices adaptable to each clinic's need and senior leadership guidance. For example, a clinic of five practitioners has a leadership team that includes a nurse manager, a medical director, and clinical staff members and that blends both new and long-term employees. Using an action plan worksheet, the leadership team develops interventions, meets to ensure team alignment, discusses solutions to problems, plans education and communications training, and develops team values.
- **Team Values (Norms) Development Activity.** Team values are the root of team culture. Value differences can lead to negativity and conflict. Through facilitation of questions about behavioral values, a development activity was designed during which the team collectively decides what values are important. It then defines those values in statements such as the following: We will not be negative; instead, we will look to determine what we can change and make a plan for change. We will show appreciation and gratitude. When conflict arises, we will speak to each other and not about each other. These norms are reviewed regularly at staff meetings and used to facilitate discussions about team progress, assist in performance management, and provide a safe space to discuss team climate and safety culture.
- **Conflict Management for Leaders.** Although TeamSTEPPS addresses challenging conversations, it lacks conflict management guidelines for leaders. So PDC developed guidelines for leaders to manage conflict among employees using a series of questions that must be answered in advance of a conflict meeting with a leader. The tool prompts employees to come to conflict

negotiations prepared to discuss the following: What is my part in this conflict? What do I think the other person needs? What do I need? What do I appreciate?

- **Psychological Safety Module.** Improvement processes require that employees are empowered, confident, and comfortable in their roles and in sharing ideas, calling out errors and near misses, and asking questions. A psychological safety training module was developed for leaders to enhance the safety culture at PDC and help ensure that all employees feel comfortable speaking up without fear of punishment or backlash.
- **Customized Briefs and Debriefs.**
 - Briefs. In pairs, practitioners with clinical staff standardized a daily brief to share understanding of patients' needs, clarify roles, and recap the previous day. Standardized agendas keep meetings to 3–5 minutes by focusing on the following: What is left from yesterday? What is critical today? What do you need from me? Here is what I appreciate about you.
 - Debriefs. For processing emotional events, sharing lessons learned, and reviewing successes or opportunities, standardized debriefs were developed to include traumatic events, conflict incidents, safety errors and near misses, staff appreciation, review of new ideas or processes, unfinished items, and ideas for improved efficiency.
- **Connect, Care, and Close.** Originally developed to improve communication between staff and patients, this model also proved useful for promoting teamwork and communication among staff. TeamSTEPPS concepts were organized into the three-part model shown in the figure below. This model encourages all staff to communicate with one another and with patients, keeping three overarching principles in mind: (1) How can we connect better? (2) How can we show we care? and (3) How can we close a conversation or interaction in a kind and meaningful way?

TeamSTEPPS Tip Sheet



Courtesy of The Private Diagnostic Clinic. Used with permission.

Sustainable Improvement Results

PDC sustains teamwork by orienting all new employees, providing tools and interventions regularly at manager meetings, and incorporating Connect, Care, and Close into all initiatives. We build customized evidence-based plans specific to researched or observed needs for problem solving and performance improvement. We offer quarterly training for new leaders and include the communications model in annual employee training. We also developed live and online training to address conflict management, communication, change management, and emotional intelligence.

The results have been broad and long standing. Because safety culture surveys rarely have questions directly related to the aims of tools, our measure of success relies on how our efforts to develop customized training and build high-functioning teams support PDC's organizational initiatives. According to the results of a [Clinician & Group Consumer Assessment of Healthcare Providers and Systems \(CG-CAHPS\)](#) survey, after implementing the training and using the tools, all PDC clinics showed improvements in communication breakdowns, managing disagreements, and staff comfort with speaking up.

The training was successful as revealed in survey results, patient experience scores, and staff perceptions of team functions. The TeamSTEPPS program was short, accessible, continuous, aligned with other trainings, and customizable to our needs. *TeamSTEPPS* is not simply a word for a teamwork training program at PDC; it is how we manage our safety culture for a safe and positive patient experience. 

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Call for Papers on Telehealth

In early 2020 the COVID-19 pandemic necessitated the closure of many outpatient facilities and the cancellation or postponement of nonurgent appointments. To continue providing care to patients without increasing infection risk, health care providers turned to telehealth. Although telehealth is not a new concept, the rapid shift from in-person to virtual appointments during the past year put many health care organizations on a steep learning curve with little advance preparation. This challenging transition has given rise to many questions related to health care quality and patient safety, from the effect the shift toward telehealth has had on care disparities, to how to best provide virtual care to visually impaired and hearing impaired patients, to how telehealth visits can be optimally integrated with in-person appointments.

To begin answering these questions, *The Joint Commission Journal on Quality and Patient Safety* is seeking manuscript submissions on telehealth, including retrospective analyses of quality and safety issues and prospective studies of strategies to improve quality, safety, access to care, and utilization.

[Click here](#) for complete submission guidelines and instructions for authors. To learn more about *The Joint Commission Journal on Quality and Patient Safety*, [click here](#). 



Improving the Medication Reconciliation Process

Scenario: A 42-year-old female patient with a history of epilepsy and high cholesterol presented to the emergency department with abdominal pain and was found to have obstructing gallstones. She was admitted to the hospital and was awaiting surgery the next day, so she was not allowed anything to eat or drink (NPO orders). The admitting nurse compiled the patient's current medication list, which accurately documented that the patient was currently taking lamotrigine (an anticonvulsant) 150 mg twice a day by mouth, simvastatin 20 mg every night by mouth, as well as a multivitamin. Because the patient was awaiting surgery and was not able to eat or drink, the physician held all oral medications. The physician, however, did not order a substitution for the anticonvulsant by IV. The patient went to surgery the next day and had a seizure in the postanesthesia recovery unit.

The purpose of medication reconciliation is to identify medication discrepancies at multiple points along the patient's continuum of care and prevent medication errors that would cause patient harm. As such, medication reconciliation is not simply obtaining an accurate and thorough list of the patient's current medications upon initial interaction with that patient. The purpose of medication reconciliation is to obtain knowledge of what medications the patient is taking prior to arrival at a facility to allow the health care team to do the following:

- Determine what medications should be continued or stopped
- Ensure that no medications are accidentally omitted
- Review all medication, including home medications and newly prescribed medications, for any interactions

In addition, medication reconciliation includes processes to ensure that medication needs and orders are communicated with the patient and with other providers caring for the patient. The Joint Commission defines its requirements for medication reconciliation through its National Patient Safety Goal (NPSG) NPSG.03.06.01 and standards in the "Provision of Care, Treatment, and Services" (PC) chapter. These requirements are included in the box on the following page.

Breakdowns in the Process

As demonstrated in the scenario, the medication reconciliation process is complex and can result in breakdowns that can harm patients. Poor communication, errors in transcription or order entry, incorrect or illegible information on patient lists, incomplete clinical assessments or critical thinking processes, and errors during discharge can contribute to medication reconciliation errors.

Joint Commission Requirements Related to Medication Reconciliation

NPSG.03.06.01 Maintain and communicate accurate patient medication information.

- Make a good faith effort to obtain an accurate list of the patient's current medications. (Element of Performance [EP] 1)
- Define the types of medication information to be collected in different settings, including the medication name, dose, route, frequency, and purpose. (EP 2)
- A qualified individual, identified by the organization, compares the medication list with medications ordered to resolve discrepancies, including omissions, duplications, contraindications, unclear information, and changes. (EP 3)
- Provide the list of medications (including name, dose, route, frequency, and purpose) to be taken upon discharge to the patient (or family member). (EP 4)
- Explain the importance of managing medication information to the patient. (EP 5)

Providers must also coordinate medication information and communicate with other providers during transitions in care both within and outside of the organization (as required by Standards **PC.02.02.01** and **PC.04.02.01**).

Up to 67% of patients admitted to the hospital have unintended medication discrepancies that can persist to discharge.^{1,2} In addition, 66% of adverse events that occur after hospital discharge are related to adverse drug events (ADEs).³ Although it is uncommon for these medication discrepancies to be clinically significant and translate to patient harm,^{1,2} a recent [study](#) by the [Patient Safety Authority](#) in Harrisburg, Pennsylvania, identified 93 serious events related to medication reconciliation errors reported by Pennsylvania hospitals from January 2015 to August 2020.

“When we were looking at the breakdowns in the medication reconciliation process,” says Amy Harper, PhD, RN, an infection prevention analyst for the Patient Safety Authority, “the most common breakdown was related to the transcription/order entry process at admission. Medications the patient was taking from home were incorrectly transcribed, resulting in either a wrong dosage or decimal place error. Sometimes the medication was missed altogether. There were also issues with duplicate therapy involving duplicate orders for the same medication or medications with similar actions.”

As a result of these reconciliation errors, patients and their family members suffer. Says Elizabeth Kukiela, PharmD, MA, RPH, patient safety analyst at the Patient Safety Authority, “All these medication reconciliation errors led to changes in the patients' conditions, many of which lengthened hospital stay or caused a readmission. There were also two deaths and one case of permanent harm where a patient had a stroke that caused neurological deficits.”

According to Harper, patient harm was most often related to the class of medication involved in the error. “The largest group of medication reconciliation

errors involved neurologic medications, specifically anticonvulsants,” says Kukielka. “Patients may have missed doses of those medications and then would suffer a seizure.” According to Kukielka, other medication classes identified in the study that resulted in patient harm, included the following¹:

- *Cardiovascular medications*—Harm related to changes in heart rate or blood pressure
- *Anticoagulants*—Harm resulting in blood clotting or bleeding, depending on whether the patient received too much of an anticoagulant or missed doses

Strategies for Improvement

As a result of this study, the Patient Safety Authority identified five strategies to improve the medication reconciliation process. “We designed strategies based on evidence from the literature and the serious event reports that we reviewed,” says Harper. These strategies are as follows:

1. Define Roles and Responsibilities

Based on the Patient Safety Authority study, the most frequently reported breakdown in the medication reconciliation process involves the transcription and order entry process. “Considering that patients or family members may not have an accurate medication list with them at the time of admission or that the patient may not remember or be able to communicate the list of medications with accurate dosages, having a dedicated person to invest the time to follow up on the medication list for additional information is beneficial,” says Harper.

Many health care organizations include pharmacists in the medication reconciliation process, either at admission, discharge, or during transitions in care.³ Pharmacists are particularly adept at looking for potential drug-related symptoms, drug-related problems, or inappropriate drug use.⁴ One systematic review of pharmacists involved in the medication reconciliation process for more than 15,000 patients found that pharmacists effectively reduced medication discrepancies, particularly when they were involved at admission and discharge.⁴ “Involving a pharmacist enhances the critical thinking component of the reconciliation process and helps identify potential mistakes,” says Harper. “And pharmacists can provide additional education to patients during their hospital stay, which is especially helpful during the discharge process.”

2. Include Medication Indication

The Patient Safety Authority believes that the practice of including the purpose of a medication throughout the reconciliation process facilitates critical thinking. “Being able to link the patient’s diagnosis with the medications ordered helps the providers critically think and consider the big picture for the patient,” says Harper. “In addition, including the goal for the medication therapy, along with medication indications, can help providers determine if patients should continue taking the medication during their hospital stay, if potential drug interactions or adverse drug events could occur, or if a medication was inadvertently omitted, duplicated, or incorrectly ordered.”

Furthermore, the medical diagnosis provides an additional check to ensure that a medication is dosed correctly. “For example, at low doses, antipsychotic

medications can be used to help with agitation for patients with dementia, but this is a very different dose than that used for a patient being treated for bipolar disorder or schizophrenia,” says Kukielka.

3. Standardize Processes

“Standardizing the medication reconciliation process helps providers and clinicians routinely follow best practices from admission through discharge and will help to optimize the process,” says Harper.

Some ways to standardize the medication reconciliation process include the following¹:

- Standardize the interview questions used to collect the current medication list, including prompts for over-the-counter medications, patches, implants, intra-uterine devices, herbals, supplements, minerals, vitamins, and other drug or alcohol use.
- Educate patients and family members about the importance of managing their medication information and updating other providers or community pharmacists about any medication changes.
- Create a standardized format for discharge medication lists that clearly highlights new medications or changes from previous medication regimens.
- Communicate any changes in medications directly to the patient’s community pharmacy and verify if the patient needs any written prescriptions.
- Update any medication changes on the patient portal.

Patient identification should also be hardwired into the medication reconciliation process, including when patients or other health care organizations provide paper copies of medication lists that may not initially include the patient’s identifying information, reminds Harper.

4. Include Triggers and Alerts for High-Alert Medications

It is important to have processes for reducing medication reconciliation errors related to high-alert medications, such as alerts within the electronic health record (EHR) or bundled orders that ensure appropriate monitoring for certain medications. According to Harper, organizations should come up with their own individualized lists of high-alert medications for their care setting, including medications from the Institute for Safe Medicine Practices’ (ISMP’s) [High-Alert Medications](#). “Often, the ISMP’s high-alert medications were the medications involved in our study,” says Harper. “Although anticonvulsants are not on the ISMP’s high-alert medication list, the same types of management for additional triggers or alerts could also work for anticonvulsants as they do for high-alert medications.”

5. Develop Shared Electronic Medication Lists

As EHRs become more interoperable, having a shared electronic medication list that all health care providers and patients can see and update in real time will become a reality. “Currently, larger hospital systems have shared medication lists

within their system, but being able to share that list with other hospital systems or community pharmacies is still very limited,” says Harper. “One way we can have shared electronic medication lists is through patient portals. And one of the key parts of the patient portal is that patients can review their medications and make sure they are correct.” 

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Hallmarks of Effective Home Health and Hospice Care Plans

By Kathy Kaiser, MBA, BSN, RN, CJCP, Joint Commission Resources Home Care Consultant

The Challenge

The Joint Commission Provision of Care, Treatment, and Services (PC) standards focus on integrated and cyclical processes for care, treatment, or services according to each patient's unique needs and the organization's scope of service. Furthermore, the elements of performance (EPs) corresponding to these standards often demand a collaborative, interdisciplinary approach to coordinate a written plan of care (POC) that meets the patient's goals in a timely way that is conducive to optimal patient outcomes.

For home health and hospice organizations, these requirements related to the care plan continue to be among the top Joint Commission compliance challenges. According to data from a Joint Commission 2020 report, 5 of the top 10 noncompliant findings for the Home Care Accreditation Program were related to the POC, as shown in the table below.

Most Challenging Plan of Care Requirements for Home Care Organizations in 2020		
Standard	Element of Performance (EP)	% Noncompliant
PC.01.03.01 The organization plans the patient's care.	EP 10 For home health agencies that elect to use The Joint Commission deemed status option: The individualized plan of care specifies the care and services necessary to meet the needs identified in the comprehensive assessment...	48.76
	EP 5 The written plan of care is based on the patient's goals and the time frames, settings, and services required to meet those goals.	20.69
	EP 18 For hospices that elect to use The Joint Commission deemed status option: The plan of care includes all services needed for the palliation and management of the terminal illness and related conditions....	42.93
	EP 55 For home health agencies that elect to use The Joint Commission deemed status option: There is a plan for the patient that provides instructions if there is an emergency . . . that might disrupt the care treatment or service provided by the organization....	23.67
PC.02.01.03 The organization provides care, treatment, or services in accordance with orders or prescriptions, as required by law and regulation.	EP 8 For home health agencies that elect to use The Joint Commission deemed status option: The organization follows physician or allowed practitioner orders when administering medications or providing care, treatment, or services.	34.63

For Joint Commission–accredited organizations, the home health and hospice POC requirements are driven by the home health and hospice agencies’ own policies and procedures, the Joint Commission home care standards in the *Comprehensive Accreditation Manual for Home Care (CAMHC)* or its *E-dition*® counterpart, and the Centers for Medicare & Medicaid Services (CMS) Conditions of Participation (CoPs). In addition, payment for services is often based on payer review of the content and timeliness of the plans of care.

As noted in the table, in 2020, 48.76% of organizations surveyed failed to comply with all requirements for PC.01.03.01, EP 10, for home health agencies that elect to use the Joint Commission deemed status option. This EP requires organizations to meet multiple patient needs, which should be identified during a comprehensive patient needs assessment.

Within this standard, another requirement, commonly scored for noncompliance, is related to patient goals. EP 5 states that the “written plan of care is based on the **patient’s goals** and the time frames, settings, and services required to meet those goals.” A recent Joint Commission *Heads-Up Report* on the topic of care plans in the home care setting provides examples of survey observations related to patient goals, including the following:

- POC goals did not have time frames for achieving goals.
- POC had goals, but they were not measurable (objective).
- POC failed to address the patient’s anxiety (psychosocial issue) or confusion (mental status).
- POC established goals for diabetic management, but the patient is not diabetic.
- POC established goals for diabetic management but failed to address patient education.

These examples emphasize a few challenges organizations encounter with the written POC, namely, goals without time frames, non-measurable goals, missing goals, and non-individualized goals.

The requirement for **measurable goals (objectives or outcomes)** demands that home care clinicians identify and then document how they will know whether the patient meets the identified goal. For example, it is common to see a written goal in a plan that states a symptom will be controlled or managed without including any details as to *how* it will be controlled or managed. Without more information that specifies how the symptom will be controlled, the goal is not measurable. For example, a patient’s high blood sugar, due to diabetes, will be managed by diet and insulin, as evidenced by a reported fasting blood sugar for 3 consecutive days greater than 65 mg/dL and less than 100 mg/dL within 2 weeks. Or, for example, a patient’s edema will be controlled by medication and ACE™ wraps, as evidenced by no more than 2+ edema or less within 5 days.

It may seem simple, but **following the written plan of care** is also a common area of noncompliance. Written POCs should incorporate physician orders for the frequency and duration of visits, individualized plans for interventions and patient education, orders for medication monitoring and administration, and hands-on

nursing and therapy treatment orders. Standard PC.02.01.01, EP 1, and Standard PC.02.01.03, EP 8, address following the individualized plan and providing care, treatment, or services in accordance with orders or prescriptions, as required by law and regulation, respectively. However, some examples of noncompliance from survey observations related to failure to comply with physician orders or the individualized plan of care include the following:

The physical therapist did not follow the orders for frequency of visits, the wound care orders were not followed, and an 18 Fr Foley catheter was ordered, but a 16 Fr Foley catheter was inserted.

The organization did not review orders and prescriptions for appropriateness and accuracy before providing care, treatment, or services; for example, an insulin order was missing the times to administer the medication.

Strategies for Effective Care Plans

Effective, compliant care plans for home health and hospice organizations must be **patient centered, individualized, and updated** as changes occur. In addition to specific regulatory content requirements, care plans should include at least the following:

- Problem statements/headings for all interventions provided
- Individualized **measurable** outcomes **with time frames** for each problem statement that addresses all disciplines providing care (aide, volunteer, and so forth)
- Interventions (for example, medications, treatments, education, personal care, counseling)
- Frequency orders for each discipline providing care (including hospice volunteers)

Updating the Plan

Each time medication, treatment, or frequency orders are received or updated, the clinician should review the POC and, if necessary, update it to include not only new orders for care but also related problem information, expected measurable outcomes of implementing the order, and the time frame for meeting that outcome. Recording the order alone does not update the related measurable outcome, time frame, or any updated frequency orders. For example, when a new or changed medication is ordered for the patient, the related clinical problem may already be included in the plan of care; however, the measurable outcome and time frame related to the need to change the medication often need to be updated to address the patient's expected response to the change. In other words, one change to the POC may lead to another change, which is often missed.

Examples of triggers to update the written POC include new, changed, or discontinued medications and treatments, resumption of care following hospitalization, hospice change in level of care, when additional disciplines are ordered (such as chaplain, aide, volunteer), increased or decreased visit frequencies, new or

changing symptoms, admission to a hospital or other health care facility, or a change in caregiver or home environment.

Measurable Outcomes and Timeliness

When developing measurable outcomes for the care plan, words that are frequently considered **non-measurable**—without additional clarifying information—include *comfortable, maintained, manageable, optimal, and controlled*. These words should be avoided, or additional information should be included in an outcome statement such as “controlled as evidenced by a reported pain level of 3 within 48 hours.” Outcome statements should include how the clinician will know the patient has met the goal. For example, the patient will *verbalize, demonstrate, participate, access, list, or obtain*.

The time frame for meeting the expected outcome should be based on when the clinician determines that the plan will need to be addressed again if the outcome is not met. For example, if the patient is experiencing a clinical symptom that is not controlled, such as blood pressure, blood sugar, or nausea/vomiting, the time frame for the new outcome statement would be when the clinician plans to contact or visit again to evaluate the results of the medication change, and/or contact the ordering provider if the medication change does not have the expected result—that is, to improve blood pressure or blood sugar levels or prevent nausea/vomiting.

Review Care Plans for High-Risk Patients

Although it is not a Joint Commission requirement, to enhance compliance with care plans for this setting, a quarterly review or audit of plans that focuses on a sampling of high-risk patients is recommended as a good practice. High-risk patients may include those with wounds or infections; infusion patients; patients with pleural, peritoneal, or urinary catheters; patients using oxygen in the home; or those at high risk for hospitalization. Records of care for patients receiving nursing and therapeutic hands-on procedures that require sterile or clean processes and those with frequent care changes should be targeted for review. A record of care audit tool is included on [page 16](#).

In addition to targeted chart audits, the organization could do mock tracer visits to assess plans of care for the same high-risk patients as a way to observe hands-on care whenever possible. When conducting tracer activities or during supervisory visits, it is important to observe sterile procedures, review the care plan, and review related treatment orders prior to the tracer activity or visit. This helps ensure that the POC is complete. It is also an ideal way to identify during the tracer visit whether the plan is based on current assessed needs and is being followed. **TS**

Additional Resources

- Centers for Medicare & Medicaid Services. [Home Health Services Plan of Care / Certification Template](#).
- Centers for Medicare & Medicaid Services. [Home Health Agency \(HHA\) Interpretive Guidelines](#).
- Centers for Medicare & Medicaid Services. [Hospice Center](#) webpage.

Tool Time

PLAN OF CARE AUDIT TOOL FOR HOME HEALTH AND HOSPICE ORGANIZATIONS

<i>This audit tool can be used to help improve Joint Commission compliance with plans of care for home health and hospice organizations. Although a regular review of plans of care is not a Joint Commission requirement, a periodic evaluation of care plans for high-risk patients and residents, related to compliance with the following topics, can help identify gaps and ensure care plans are complete.</i>		
HOME HEALTH — Certification / Recertification Plan of Care	Joint Commission Standard / Medicare COP	Met / Not Met
Are all pertinent diagnoses for the patient included in the plan of care?	PC.01.03.01 EP 10 (484.60(a)(2)(i))	
Does the plan of care include the patient's: ☐ Prognosis? ☐ Durable medical equipment/supplies (if applicable)? ☐ Functional limitations? ☐ Nutritional requirements? ☐ Permitted activities? ☐ Safety measures? ☐ Mental status? ☐ Rehabilitation potential?	PC.01.03.01 EP 10 (484.60(a)(2)(v))	
Are all medication orders complete, including dose, route, frequency, <i>prn</i> (as the need arises), and reason? (oxygen, saline or heparin infusion flushes)	PC.01.03.01 EP 5, 10, PC.02.01.03 EP 1 484.60(a)(2)(x)	
Are all treatment orders complete (for example, therapy, IV, dressing change, wound vacuum dressing change, catheter, pleural catheter)?	PC.01.03.01 EP 5, 10, PC.02.01.03 EP 1 484.60(a)(2)(x)	
Are visit frequency orders complete, including duration? Do <i>prn</i> visits include <i>prn</i> visit reasons?	PC.01.02.03 EP 10 484.60(a)(2)(iv)	
Do goals meet the following requirements: ☐ Match all planned patient care? ☐ Are patient-centered goals? ☐ Are measurable goals? ☐ Include individualized time frames?	PC.01.03.01 EP 5 484.60(a)(2)(ix)	
Is cognitive and psychosocial information included on the certification (485) plan of care form?	PC.01.03.01 EP 10 484.60(a)(2)(ii)	
Is advance directive information accurate, and does it include the following, as applicable? ☐ Health care proxy ☐ Power of attorney ☐ Living will ☐ Do not resuscitate (DNR) information	PC.01.03.01 EP 10 484.60(a)(2)(xv)	
Are risks for emergency department visits and hospital readmission included on the certification (485) plan of care form?	PC.01.03.01 EP 10 484.60(a)(2)(xii)	
Is the plan of care updated when the following occurs? ☐ There are changes in the patient's assessed needs. ☐ There are changes in the patient's status. ☐ There are changes with progress toward the patient's goals.	PC.01.03.01 EP 5, 23 484.60(c)(2)	
Is the plan of care followed, regarding frequency of any medication or treatment orders?	PC.02.01.01 EP 1, PC.02.01.03 EP 7, 8 484.60(b)	

HOSPICE – Written Interdisciplinary Plan of Care	Joint Commission Standard / Medicare COP	Met / Not Met
Does each problem statement include related interventions and a measurable outcome/goal and time frame to meet the goal?	PC.01.03.01 EP 5, EP 18 418.56(c)(1-3)	
Are all interventions current and complete, including treatment orders, services, medications, and equipment?	PC.01.03.01 EP 18 418.56(c)(1,4,5)	
Are staff (discipline) responsible for intervention implementation identified?	PC.01.03.01 EP 18 418.56(c)(2)	
Is a time frame for the outcome/goal attainment readily identified and varied according to the type problem (that is, short term and long term)?	PC.01.03.01 EP 5, EP 18 418.56(c)(3)	
Does the plan of care include a method for the evaluation of intervention effectiveness, such as measurable outcome/goal met or not met? (for example, “acceptable pain level of less than 4”)	PC.01.03.01 EP 18 418.56(c)(3)	
When the patient resides in a skilled nursing facility, a nursing facility, an intermediate facility, or an intermediate care facility for individuals with intellectual disability, is there evidence that the plan is coordinated with the facility and the patient and/or the patient’s family? Is there evidence that the plan identifies which provider (hospice or facility) is responsible for performing a specific service?	PC.01.03.01 EP 13, 40, 42 418.112(d)(1-3)	
Does the plan of care include each discipline providing care with related problems, interventions, and measurable outcomes (for example, skilled nurse, social worker, chaplain, aide, volunteer, and any other direct, volunteer, or contracted staff, such as massage therapists, music therapist, physical therapists, occupational therapist, speech therapist, or registered dietitian)?	PC.01.03.01 EP 18 418.56(c)(2)	
Does the plan of care include the frequency of visits for each discipline providing care (aide, volunteer, all therapists)? Is the frequency of visits individualized and specific to meet patient needs?	PC.01.03.01 EP 18 418.56(c)(2)	
Do <i>prn</i> , or as needed, visits included in the plan identify specific indications/reasons for the visits?	PC.01.03.01 EP 18 418.56(c)(2)	
Is the plan of care updated when changes in the patient’s status occur (for example, when new or changed medications or treatments are ordered, frequency of visits change, or new symptoms develop), and at least every 15 days?	PC.01.03.01 EP 5, EP 24 418.56(d)	
Is the plan of care updated when problems are resolved (for example, a wound is healed)?	PC.01.03.01 EP 5, EP 24 418.56(d)	
Does the interdisciplinary group document its review of the plan of care at least once every 15 days?	RC.02.01.01 EP 6 PC.01.03.01 EP 24 418.56(d)	
Is the plan of care followed regarding frequency of medication and treatment orders?	PC.02.01.01 EP 1 418.56(e)(2)	

Top News

A Digest of Accreditation and Health Care News

Coronavirus (COVID-19) Resources

The Joint Commission continues to offer free [COVID-19 resources](#) to support health care organizations and workers on the front lines of the pandemic. Resources are updated frequently and are applicable to most Joint Commission accreditation settings.

COVID-19 Vaccine Resources for Consumers

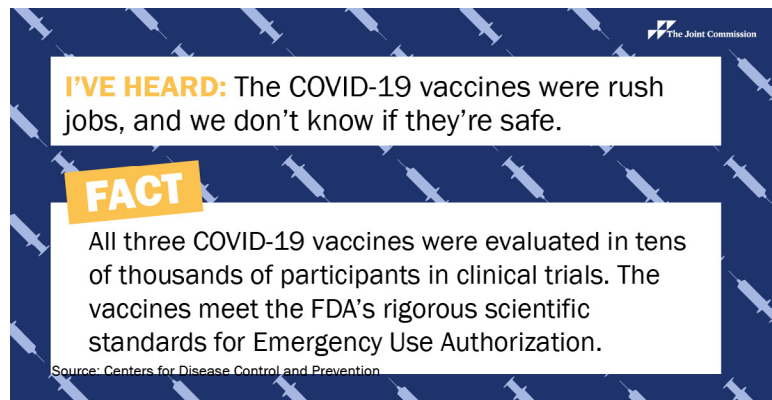
In addition to resources to support health care organizations and health care workers on the front lines, The Joint Commission has developed a webpage for consumers that provides information about [COVID-19 vaccines](#). Although access to at least one of the three US Food and Drug Administration (FDA)–approved vaccines is improving throughout the United States, many eligible Americans remain hesitant to get vaccinated for a variety of reasons. The Joint Commission encourages eligible individuals to be vaccinated as soon as one is available in their area.

The webpage offers insight from Joint Commission experts about the safety and efficacy of the COVID-19 vaccines and includes resources from the [Centers for Disease Control and Prevention \(CDC\)](#). Included among the COVID-19–related vaccine information are the following:

- [COVID-19 vaccine basics: What you need know](#)
- [Health equity and the COVID-19 vaccines](#)
- [Myths and Facts About COVID-19 Vaccines](#)
- [What to Expect After Getting a COVID-19 Vaccine](#)

Assisted Living Community Accreditation Program Launches

Beginning July 1, 2021, The Joint Commission will accept applications for its new Assisted Living Community (ALC) Accreditation Program. The program is designed to promote consistent quality of care across the industry and help organizations provide a safe living environment for its residents.



To improve the quality of life for residents, accredited communities will need to track the care provided to their residents and improve that care, when needed. Performance measures for the ALC program are listed in the table below.

Assisted Living Community Standardized Performance Measures	
ALC-01	Off-label antipsychotic drug use
ALC-02	Resident falls
ALC-03	Resident preferences and goals of care
ALC-04	Advanced care plan/surrogate decision-maker
ALC-05	Staff stability

Additional details regarding education for abstracting performance measures are forthcoming. For questions regarding performance measures, visit the [Performance Measurement Network Q&A Forum](#) on The Joint Commission's website. For updates on ALC Accreditation, visit the [ALC program page](#).

New Podcast Provides Overview of SAFER® Dashboard

In April 2021 The Joint Commission launched a new business intelligence tool aimed at helping accredited health care organizations access key performance data, with a goal to make data-informed decisions and prioritize potential improvements. A new [Take 5: SAFER® Dashboard](#) podcast provides an overview of this unique data analytic tool, which is available exclusively to Joint Commission–accredited organizations via their Joint Commission Connect portal.

The SAFER Dashboard provides organizations with a quick and complete picture of their post-survey results and presents historical trends and patterns in a visual way. The podcast highlights some of the unique features of this tool, including the following:

- **Patterns and trends:** Ability to view aggregate survey findings at the corporate, multiorganization, and program level
- **Performance metrics:** Access to current and historical data to help track performance
- **Data visualization:** Visual representations such as charts, graphs, and the SAFER Matrix can help users consume data more easily
- **Reporting:** Ability to share data with stakeholders so that they can draw conclusions and make timely decisions
- **Comparison data:** Joint Commission national accreditation comparison data

Accredited organizations can access the Dashboard on their Joint Commission Connect extranet site under the Resources and Tools tab. For more information, visit the [SAFER Dashboard webpage](#).

Announcement on Aisle Width Requirement

The Joint Commission announced recently that effective immediately its *Life Safety Code*® surveyors will cite noncompliance in hospital suites that have less than 36 inches of clearance from side to side. To facilitate egress, the requirement adheres to the National Fire Protection Association's (NFPA) *Life Safety Code* NFPA 101-2012, Section 7.3.4.1(2) in the core chapter on egress.

This requirement applies to Joint Commission–accredited hospitals and critical access hospitals that use the suite provisions of the code and, depending on building occupancy classification, may also apply to accredited behavioral health care and human services organizations, facility-based hospices, and nursing care centers. Findings will be scored under Life Safety (LS) Standard LS.02.01.20, Element of Performance (EP) 42, which requires organizations to maintain the integrity of the means of egress in accordance with the *Life Safety Code*. 

Other Learning Opportunities from The Joint Commission and Joint Commission Resources

JCR Webinars and On-Demand Events



The [Ambulatory Care Accreditation Essentials: Live Virtual Seminar](#) is July 19–22, 2021. This program explores challenging ambulatory health care standards and offers ideas and solutions to address them. A variety of topics will be covered, including infection prevention and control, safe medication expectations for both primary and specialty care settings, and the benefits of the new *SAFER*® Dashboard to ambulatory health care organizations. In

addition, the seminar will include an update on challenges facing outpatient hospital-based sleep labs.



Registration is open for the [Environment of Care and Life Safety Chapter for Ambulatory Care: Live Virtual Seminar](#). This event, held July 27–28, 2021, addresses the unique needs of ambulatory health care professionals who are responsible for Joint Commission accreditation survey compliance related to the “Environment of Care” (EC) chapter, the “Life Safety” (LS) chapter, and the *Life Safety Code*.®

The [Environment of Care Base Camp](#) is all new and completely updated to include Joint Commission Environment of Care (EC) standards released July 1, 2021. This live, virtual event will be held August 17–20, 2021. Joint Commission engineers will discuss current challenges, compliance tips, and strategies to help ensure survey readiness. Also scheduled for August 24–27, 2021 is the [Exploring the Life Safety Chapter](#) live virtual event, which offers practical compliance information and safety strategies to minimize risk and maximize safety in your facility.

Now is the time to register for the [2021 Hospital Executive Briefing: Live Virtual Conference](#), which will be held September 14–16, 2021. This year’s conference will feature the most current updates from Joint Commission officers and subject matter experts related to the environment of care, emergency management, life safety, medication management, infection control, and COVID-19 recovery.

Joint Commission Webinars

To connect with Joint Commission experts and get the targeted accreditation and certification information you need, check out the free [Webinar Replays & Upcoming Webinars](#) page on The Joint Commission’s website to attend live webinars or access replays at your convenience.

Publications from JCR

Free Download Offers Tips for Emergency Readiness

To help health care organizations better prepare for the next health crisis or public health emergency, Joint Commission Resources has released [*Emergency Readiness and Crisis Response: 7 Critical Steps*](#). This document addresses the uncertainty and unpredictability of events such as the COVID-19 pandemic and offers seven preparedness strategies for addressing needs associated with future pandemics and potential hazards in advance.

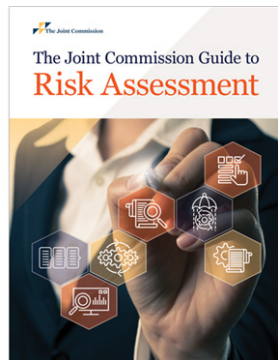


And for continuous and current content on the latest and best practices in emergency management subscribe to *EC News*.

[*Environment of Care® News*](#)

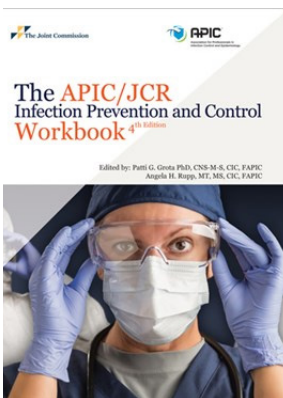
Your gateway to Environment of Care (EC), Life Safety (LS), and Emergency Management (EM) topics, this monthly newsletter keeps you current with best practices, the latest research, and practical advice.

Coming Soon!



The first-ever comprehensive guide to Joint Commission risk assessment includes a list of all Joint Commission standards across all health care settings that require a risk assessment. The book offers sample risk assessments, tools, mock tracers, checklists, and more for help with Joint Commission compliance.

[*The Joint Commission Guide to Risk Assessment*](#)



This updated Doody's Core Title, co-published by JCR and the Association for Professionals in Infection Control and Epidemiology (APIC), features authoritative guidance, best practices, and expertise from infection preventionists in all health care settings.

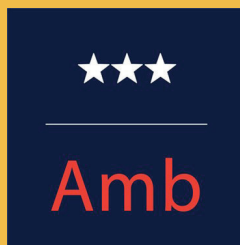
[*The APIC/JCR Infection Prevention and Control Workbook, 4th edition*](#)



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