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Record of Care, Treatment, and Services (CAMH / Hospitals)

Texting Orders New | April 22, 2015

Is it acceptable for physicians and licensed independent practitioners (and other practitioners allowed to write orders) to text orders for patients to the hospital or other healthcare setting?

No it is not acceptable for physicians or licensed independent practitioners to text orders for patients to the hospital or other healthcare setting. This method provides no ability to verify the identity of the person sending the text and there is no way to keep the original message as validation of what is entered into the medical record.

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Record of Care, Treatment, and Services (CAMH / Hospitals)

Authentication of Documentation

Current | April 22, 2015

Q. Do the standards specify the time frame for authentication of documentation?

A: The Joint Commission standards do not specify the time frame for authentication of documentation. The organization is free to determine the time frame for completion of authentication. The timeframe must comply with any applicable laws or regulations. If the organization is silent on the issue for specific types of documentation, the time frame defaults to the time frame that the organization adheres to for completion of the medical record. For example, the standard RC.01.02.01.in the AMCAH, CAMH, CAMLTC, and CAMBHC while requiring the organization to establish a time frame for completion of the medical record, specifically limits the time frame to no more than 30 days. For example, the standard RC.01.02.01. in the AMCAH, CAMH, and CAMLTC, CAMBHC while requiring the organization to establish a time frame for completion of the medical record, specifically limits the time frame to no more than 30 days.

Q: Must signatures and dates on documentation such as verbal orders, histories and physicals, consultations, and discharged summaries, also include the time of the signature and dating?

A: If the required timeframe defined by the organization specifies a signature within a specified number of hours, then the signature and date must include the time of the signature and dating to ensure compliance.

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NPSG (CAMH / Hospitals)

Monitoring of Hand Hygiene - NPSG - Goal 7 - 07.01.01

Current | April 22, 2015

Q: Given the January 2010 changes to NPSG.07.01.01, what is now required in terms of hand hygiene monitoring?

A: It is a good idea to think of EPs 2 and 3 as a basic outline for a required performance improvement project. EP 2 requires each accredited organization formulate a goal for hand hygiene, and EP 3 requires organizations to improve compliance based on the goal set in EP 2. Each organization should customize its goals and improvement efforts to meet its unique needs. Please note that there is no specific requirement as to how measurement must occur other than it must occur according to CDC or WHO guidelines.

Measurement: Organizations must perform an accurate baseline assessment of hand hygiene in order to identify opportunities for improvement. Please note that participants in the Center for Transforming Healthcare Hand Hygiene Project found that their actual hand hygiene rates were significantly lower than they had previously estimated. For more information, visit Center for Transforming Healthcare Web site. In particular, please view page four of the storyboard presentation.

The Joint Commission recognizes that hand hygiene measurement is a challenge. In an effort to provide assistance, we have co-authored a monograph on this topic along with several other infection prevention leadership organizations. To access a free copy of "Measuring Hand Hygiene Adherence: Overcoming the Challenges", please visit http://www.jointcommission.org/PatientSafety/InfectionControl/hh_monograph.htm

Goal Formation: After establishing an accurate baseline, each accredited organization must formulate a goal for improvement. The Joint Commission previously required that each organization have a hand hygiene goal of at least 90%; that requirement is no longer in place. Rather, each organization must formulate a goal to improve over past performance.

Improving compliance: After measurement and goal formation, interventions to achieve improvement must be implemented. Per EP 1, these interventions must be designed utilizing either CDC or WHO guidelines. If the goal is not met, interventions should be redesigned based on an analysis of causitive factors. If the goal is met, it should be adjusted to foster higher levels of compliance.

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Medical Staff (CAMH / Hospitals)

Querying the National Practitoner DatabankUsing the "Proactive Disclosure Service" (PDS)? Current | April 22, 2015

Q. Can organizations use the National Practitioner Data Bank's (NPDB) "Proactive Disclosure Service" (PDS)for reprivileging?

A. Use of National Practitioner Data Bank's "Proactive Disclosure Service" (PDS) by an organization is acceptable for the ongoing NPDB information after the organization obtains an initial NPDB query for each practitioner.

To demonstrate compliance in this area the organization would need to have record of a baseline query and then share with the surveyors that no updates have been received from the NPDB. There does not need to be documentation in the record that no further communication has been received.

As with any NPDB information, the orgnaization would review the PDS information received or confirm that no new information had been recieved, whenever they are granting a new privilege or renewing existing privileges.

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Medical Staff (CAMH / Hospitals)

Credentialing and Privileging in Hospital-Based* Behavioral Health Care settings surveyed under the Comprehensive Accreditation Manual for Behavioral Health Care

Current | April 21, 2015

Q. Can Hospital-Based Behavioral Health settings surveyed under the Comprehensive Accreditation Manual for Behavioral Health Care have a separate verification of competence/approval of clinical responsibilities process or must they be integrated with the hospital's medical staff and credentialing and privileging process?

A. The organizations are free to decide whether to have a separate process or whether to integrate with the hospital's medical staff and processes. Whichever approach is selected the approach must meet the intent for the standards in the manual under which the organization is being surveyed and when the practitioner is receiving privileges/authorization/clinical responsibilities in multiple settings using a single credentialing and privileging process, it must be clear as to what the practitioner is allowed to do in each setting.

*The term "hospital-based" means that the services are under the auspices of the hospital, meet the Joint Commission rules for functional and organization integration and are tailored with the hospital's accreditation survey, regardless of where the services are physically housed.

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Leadership (CAMH / Hospitals)

Contracted Services Current | April 22, 2015

Q: Do the standards for contracted services apply if the contracted organization is Joint Commission accredited or certified?

A: Yes. Organizations are expected to demonstrate compliance with all accreditation or certification requirements for their respective program.

Q: What are our responsibilities related to services provided by our contracted organization?
A. Leaders must oversee contracted services to make sure that they are provided safely and effectively. The only contractual agreements subject to the requirements at Standard LD.04.03.09 are those for the provision of care, treatment, and services provided to the hospital's (organization's) patients. This standard does not apply to contracted services that are not directly related to patient care. The EPs do not prescribe the methods for evaluating contracted services; leaders are expected to select the best methods for their hospital (organization) to oversee the quality and safety of services provided through contractual agreement.

Examples of sources of information that may be used for evaluating contracted services include the following:

- Review of information about the contractor's Joint Commission accreditation or certification status
- Direct observation of the provision of care
- Audit of documentation, including medical records
- Review of incident reports
- Review of periodic reports submitted by the individual or hospital providing services under contractual agreement
- Collection of data that address the efficacy of the contracted service
- Review of performance reports based on indicators required in the contractual agreement
- Input from staff and patients
- Review of patient satisfaction studies
- Review of results of risk management activities

In the event that contracted services do not meet expectations, leaders take steps to improve care, treatment, and services. In some cases, it may be best to work with the contractor to make improvements, whereas in other cases it may be best to renegotiate or terminate the contractual relationship. When the leaders anticipate the renegotiation or termination of a contractual agreement, planning needs to occur so that the continuity of care, treatment, and services is not disrupted.

Q: During a Joint Commission survey of a hospital (organization), is the surveyor required to manually verify human resource files/documents for employees, or independent contractors, of a Joint Commission accredited or certified contracted service?

A: The Joint Commission does not require hospitals (organizations) to request the entire set of personnel files from its accredited or certified contracted organizations so that surveyors can manually verify compliance with Joint Commission requirements. It should be noted that the contracted organization will undergo its own accreditation or certification survey or review by The Joint Commission and they will have to demonstrate compliance with all requirements their personnel records.

There may be instances, e.g., during tracer activities, where the surveyor requests to review the personnel file of a contracted staff or an independent contractor. Under these circumstances, the surveyor should review the hospital's process for monitoring the contracted services. If a concern is not sufficiently addressed, then the surveyor may request the personnel record of the contracted staff or independent contractor. The requested personnel record, from the contracted service or staffing firm, must be provided to the hospital in a timeframe sufficient for surveyor review during the survey.

Please note: This FAQ applies only to staff and independent contractors of accredited or certified organizations and not to licensed independent practitioners."

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Infection Prevention and Control (CAMH / Hospitals)

Influenza vaccination for licensed independent practitioners and staff Current | April 22, 2015

Where can I find more information about influenza vaccination for licensed independent practitioners and staff?

Read the R3 Report Issue 3 - Influenza vaccination for licensed independent practitioners and staff.

Published for Joint Commission accredited organizations and interested health care professionals, R3 Report provides the rationale and references that The Joint Commission employs in the development of new requirements. While the standards manuals also provide a rationale, the rationale provided in R3 Report goes into more depth. The references provide the evidence that supports the requirement. R3 Report may be reproduced only in its entirety and credited to The Joint Commission.

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Human Resources (CAMH / Hospitals)

Peer References

Current | April 22, 2015

Q. Who can provide a peer reference for independent or non-independent allied health practitioners such as nurse practitioners, physician assistants, and psychologists, midwives, and social workers when there is no other similar practitioner on staff?

A. The definition of a peer is someone from the same discipline with essentially equal qualifications. To be able to provide a reference the peer would need to be familiar with the individual's actual performance. For the nurse practitioner, physician assistant, and psychologist, or social worker ideally this should be another individual from the same discipline and the organization should attempt to obtain such references. This could be someone within the same organization or someone from outside the organization.

However, in situations where there is no nurse practitioner, physician's assistant, psychologist, or social worker who could provide a peer reference it is acceptable for a physician or D.O with essentially equal qualifications, who is familiar with the allied health practitioner's performance, to provide the reference. For example, an internist could provide a reference for a physician assistant, an anesthesiologist could provide a reference for a nurse anesthetist, and a psychiatrist could provide a reference for a psychologist and a psychologist with similar responsibilities could provide a reference for a social worker.

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Human Resources (CAMH / Hospitals)

Primary Source Verification

Current | April 27, 2015

Q. What is Primary Source Verification? Who does it apply to?

A. Primary Source verification applies only to licensure/certification or registration required to practice a profession. It is not required for organizational requirements such as cardiopulmonary resuscitation (CPR) advanced cardiac life support (ACLS) or pediatric advanced life support (PALS) or clinical certifications such as peripherally inserted central catheter (PICC) line certification. Current licensure/certification or registration is verified at the time of hire or renewal via a secure electronic communication or by telephone is acceptable, if verification is documented. Primary Source verification will be obtained from State licensing boards or a primary source of information to be verified may designate to an agency the role of communicating credentials information. The delegated agency then becomes acceptable to be used as a primary source.

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Human Resources (CAMH / Hospitals)

Requirements for Criminal Background Checks

Current | April 22, 2015

Q: What is the Joint Commission requirement for criminal background checks and for which type of individual must it be performed?

A: Staff, students and volunteers who work in the same capacity as staff who provide care, treatment, and services, would be expected to have criminal background checks verified when required by law and regulation and organization policy.

This means that if state law, regulation or organization policy requires background checks on all employees, volunteers and students, Joint Commission expects them to be done on all three categories.

If state law requires background checks on only specified types of health care providers (e.g. nursing assistants/child care workers), then Joint Commission would require background checks on only those specified in state law (unless organization policy goes beyond state law).

If state law requires background checks on all "employees", the organization should seek an opinion from the state on what categories of health care workers are considered "employees".

If the state clearly does not consider volunteers or students to be employees, then Joint Commission would not require background checks on them (unless organization policy goes beyond state law and requires it).

If state law is ambiguous as to the definition of employee, the organization can define the scope of background checks to fit its own definition. As such, they may include or exclude students and volunteers, and Joint Commission would survey to hospital policy.

In the absence of a state law on criminal background checks, each organization can develop its own expectations, e.g., and organization elects to screen employees and not students/volunteers. Joint Commission would evaluate compliance with the organization's internal policy only. There would be no Joint Commission expectation that an organization check categories of providers beyond what is required in their own policy, which must comply with law and regulation. All criminal background checks must be documented by the organization.

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