The Joint Commission

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UPDATE:

new accreditation standards. Therefore, instead of publishing the recommendations at this time, The Joint Commission and the panel are assessing the recommendations to see which of them are appropriate to include as new elements of performance in the revised National Patient Safety Goal on suicide prevention (NPSG 15.01.01). The updated version of the NPSG will then be sent for national field review, according to The Joint Commission's usual process for obtaining feedback on new requirements. P

FDA's December 2017 Final Rule on Health Care Antiseptic Washes and Rubsd

Consistent Interpretation

Joint Commission Surveyors' Observations on LD.04.03.09, EPs 4–6

The bimonthly **Consistent Interpretation** column is designed to support organizations in their efforts to comply with Joint Commission requirements. Each installment of the column draws from a de-identified database containing surveyors' observations—as well as guidance from the Standards Interpretation Group on how to interpret the observations—on an element(s) of performance (EP) in the hospital standards. This column in the series highlights Leadership (LD) Standard LD.04.03.09, EPs 4–6. **Note:** *Interpretations are subject to change to allow for unique and/or unforeseen circumstances.* P

Leadership (LD) Standard LD.04.03.09: Care, treatment, and services provided through contractual agreement are provided safely and effectively.

EP 4*: Leaders monitor contracted services by establishing expectations for the performance of the contracted services. (*See also* MS.13.01.01, EP 1)

Note 1: *In most cases, each licensed independent practitioner providing services through a contractual agreement must be credentialed and privileged by the hospital using their services following the process described in the "Medical Staff" (MS) chapter.*

Note 2: ***For hospitals that do not use Joint Commission accreditation for deemed status purposes:*** *When the hospital contracts with another accredited organization for patient care, treatment, and services to be provided off site, it can do the following:*

- *Verify that all licensed independent practitioners who will be providing patient care, treatment, and services have appropriate privileges by obtaining, for example, a copy of the list of privileges.*
- *Specify in the written agreement that the contracted organization will ensure that all contracted services provided by licensed independent practitioners will be within the scope of their privileges.*

Note 3: ***For hospitals that use Joint Commission accreditation for deemed status purposes:*** *The leaders who monitor the contracted services are the governing body.*

* In 2017 the noncompliance percentage for this EP was 5.06% (that is, 73 of 1,443 hospitals surveyed were out of compliance with this requirement).

Surveyor Observations	Guidance/Interpretation
The organization failed to establish that the performance of the contracted service for compounded sterile products must comply with the requirements of United States Pharmacopeial Convention (USP®) General Chapter <797> Pharmaceutical Compounding—Sterile Preparations. This was evidenced by the fact that the organization neglected to include compliance with USP <797> (or equivalent standards) in the contract.	If the organization utilizes a 503B pharmacy, quality metrics should be established to ensure appropriate compliance with Sterile Compounding Practices. If the organization uses a 503A pharmacy, it should ensure compliance with USP <797> and have documentation of receiving qualitative data as proof and evidence that the 503A establishment is appropriately testing the engineering controls (including viable testing) and taking appropriate action when tested components do not meet minimum requirements.

Center for Transforming Healthcare Offers Assistance Building Sustainable RPI® Programs

Since 2008 the Joint Commission Center for Transforming Healthcare has sought to transform health care into a high-reliability industry through the development of highly effective, durable solutions to health care's most critical quality and safety problems. These solutions, offered via the Targeted Solutions Tool® (TST®), were developed through a rigorous multi-year collaboration with Center-participating hospitals that had expertise in Robust Process Improvement® (RPI®)—a blended approach to process improvement based on Lean Six Sigma and formal Change Management. Joint Commission–accredited organizations can access a TST® at no additional cost directly through the Center's website.

In addition, the Center now offers technical assistance and training—based on the curriculum developed and used to train and certify Joint Commission staff and leadership—in how to build and launch a self-sustaining RPI® program. Customizable for hospitals, health systems, and other provider organizations seeking to build their process improvement capabilities and establish stronger improvement cultures, these training engagements typically consist of the following:

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New Provides Background on Revisions to Outcome Measure Standard

The Joint Commission's newest *R3 Report* provides in-depth rationale and evidence for revisions to Care, Treatment, and Services (CTS) Standard CTS.03.01.09. As previously announced (*see* the article from the January 2017 *Perspectives*), these revisions became effective for accredited behavioral health care organizations on January 1, 2018.

Standard CTS.03.01.09 requires the use of a standardized tool or instrument to assess outcomes of care, treatment, or services. A standardized instrument is a tool designed for use as a repeated measure and is sensitive to measuring change associated with the care, treat-

In addition to the revision to Life Safety (LS) Standard LS.02.01.30, Element of Performance (EP) 13 previously announced (*see* the February 2017 *Perspectives*, pages 6 and 7), The

This issue of *Perspectives* showcases the February 2018 Table of Contents for *The Joint Commission Journal on Quality and Patient Safety (JQPS)*. The Joint Commission works closely with *JQPS* (published by Elsevier) to make it a key component in helping health care organizations improve patient safety and quality of care. To purchase a subscription or site license to *JQPS*, please visit The Joint Commission Journal on Quality and Patient Safety website.

94 **A Novel Bedside-Focused Ward Surveillance and Response System**—F. Sebat, M.A. Vandegrift, S. Childers, G.K. Lighthall

Despite broad implementation, there is little evidence regarding the effective organizational elements of rapid response systems (RRSs) that are responsible for improved outcomes. Expanded administrative oversight of an existing RRS which focused on early recognition of patient deterioration by the bedside nurse was undertaken at a community regional medical center. A prospective five-year before-and-after comparison was conducted for 28,914 patients in the 24-month control period and 39,802 patients in the 33-month intervention period. Response team activations increased from 10.2 to 48.8/1,000 discharges ($p < 0.001$), ward cardiac arrest decreased from 3.1 to 2.4/1,000 discharges ($p = .04$), hospital mortality decreased from 3.8% to 3.2% ($p < 0.001$), and the observed-to-expected ratio, from 1.5 to 1.0 ($p < 0.001$).

101 **An Initiative to Change Inpatient Practice: Leveraging the Patient Medical Home for Postdischarge Follow-Up**—P. Marcus, K. Hautala, N. Allaudeen

The standard of care for hospital discharge planning includes arranging follow-up appointments, usually with a primary care provider. However, follow-up phone calls instead of face-to-face visits may be an appropriate alternative for some patients, which was explored within the framework of the Department of Veterans Affairs (VA) patient-centered medical home model of care, the Patient Aligned Care Team. After a pilot study (Phase 1) at one clinic and staff at the other eight clinic sites were trained (Phase 2), 76 (14.5%) of 447 eligible discharges were scheduled for phone follow-up (Phase 3). This initiative changed provider practices to use phone call follow-up for select patients instead of face-to-face provider visits after hospital discharge, without significantly increasing rates of 30-day ED utilization or rehospitalization.

107 **'Who's Covering This Patient?' Developing a First-Contact Provider (FCP) Designation in an Electronic Health Record**—A. Chandiramani, J. Gervasio, M. Johnson, J. Kolek, S. Zibrat, D. Edelson

Safe and efficient inpatient care depends on accurate identification of the licensed independent practitioner (LIP) primarily responsible for each admitted patient. At an 800-bed academic hospital, an Epic feature—First Contact Provider (FCP)—was developed to identify the responsible LIP for each inpatient. By the end of the nine-month study period, the weekly mean percent of patients with one FCP documented at noon reached 98.6%. The monthly mean percent of critical results reported directly to LIPs increased from a pre-FCP baseline of 18.0% to 87.8%. FCP largely solved the far-reaching problem of accurate LIP identification for hospitalized patients, which, in turn, significantly improved the ability to report inpatient critical lab values directly to LIPs.

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