Top Standards Compliance Issues for First Half of 2012

The Joint Commission has aggregated standards compliance data for accredited organizations and certified programs surveyed or reviewed during the first half of 2012. These data help The Joint Commission recognize trends and tailor education around challenging standards; National Patient Safety Goals (NPSGs); the Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery™; and Accreditation or Certification Participation Requirements (APRs or CPRs). These data also help The Joint Commission identify risk areas to highlight in the Focused Standards Assessment process (see the article on page 10 of this issue).

The bar graphs on pages 14 to 19 identify, for each accreditation and certification program, the standards, NPSG and Universal Protocol requirements, and APRs or CPRs identified most frequently as “not compliant” during surveys and reviews from January 1, 2012, through June 30, 2012. While the text of the requirement also appears in the bar graph, the full text of each (including elements of performance and scoring information) is published in the applicable accreditation or certification manual.

The graphs display the 10 most frequently cited requirements in decreasing frequency for each program. The percentage shown at the beginning of each row represents the percentage (rounded to the nearest whole point) of organizations that received Requirements for Improvement (RFIs) for that particular requirement. More than 10 standards may be cited if two or more standards in a program were tied in their percentage of RFIs.

Perspectives publishes these compliance data to allow accredited organizations and certified programs to evaluate their own performance against that of others. Organizations may also find

Continued on page 13
InSight

This column informs you of developments and potential revisions that can affect your accreditation and certification and tracks proposed changes before they are implemented. Items may drop off this list before the approval stage if they are rejected at some point in the process.

APPROVED
- Intracycle Monitoring process, including the Focused Standards Assessment and customer TouchPoints, for all accreditation programs (see article on page 10)
- Deletion of two redundant requirements and modification to one “Care, Treatment, and Services” (CTS) requirement for behavioral health care (see article on page 8)
- Revisions to eligibility requirements in “Performance Measurement” (DSPM) Standard DSPM.1, Element of Performance (EP) 2, for comprehensive stroke center advanced certification in the disease-specific care program (article to be included in an upcoming issue of Perspectives®)
- Revisions to the Review and Appeal Procedures for all programs (article to be included in an upcoming issue of Perspectives)
- Revision to the Sentinel Event Policy for all programs (article to be included in an upcoming issue of Perspectives)
- Suspension of ORYX® non-core measure reporting requirements for long term acute care hospitals and inpatient rehabilitation hospitals (article to be included in an upcoming issue of Perspectives)

ACCEPTED
- Revisions to requirements in the critical access hospital and hospital programs to align with Centers for Medicare & Medicaid Services (CMS) requirements (see article on page 4)
- Revisions to ambulatory surgical center requirements in the ambulatory care program to align with CMS requirements (see article on page 3)
- Revisions for the ambulatory care, critical access hospital, and hospital programs to align standards with California legislative requirements for organizations in California that perform CT scans (see article on page 4)

CURRENTLY IN BOARD OR COMMITTEE REVIEW
- Expansion of ORYX measurement requirements for general medical/surgical hospitals

CURRENTLY IN DEVELOPMENT

STANDARDS AND GOALS
- Proposed revisions to core standards for the disease-specific care program
- Proposed revisions to primary stroke center certification for the disease-specific care program
- Proposed new and revised requirements for the long term care program
- Optional certification requirements for post-acute care for the long term care program
- Proposed new and revised requirements for the laboratory program
- Proposed requirements for a primary care medical home certification option for the critical access hospital and hospital programs
- Proposed new and revised requirements for the ambulatory care program
- Proposed new and revised requirements for emergency management oversight for the critical access hospital and hospital programs
- Proposed revisions to the primary care medical home option for the ambulatory care program
- Proposed requirements for a behavioral health home certification option for the behavioral health care program
On May 16, 2012, the Centers for Medicare & Medicaid Services (CMS) issued the final rule “Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction” (see July 2012 Perspectives, page 6). This rule, which represents part of recent efforts by CMS to remove unnecessary, obsolete, or excessively burdensome requirements, includes changes to Conditions for Coverage (CfCs) for ambulatory surgical centers (ASCs).

To align its standards with these revisions, The Joint Commission made several changes affecting the ambulatory care program. The revisions, which became effective July 16, 2012, include the deletion of an element of performance (EP) that required ASCs to have a detailed list of specific types of emergency equipment available in each operating room. In its place, The Joint Commission added four EPs that require an ASC to have emergency equipment that is appropriate for its patient population as well as the types of procedures performed there.

The revisions have been published in the recently mailed 2012 Update 2 to the Comprehensive Accreditation Manual for Ambulatory Care and will appear in the E-dition® this fall. The box below displays the revisions; new text is underlined and deleted text is shown in strikethrough. For more information, contact Joyce Webb, RN, BSN, MBA, CMPE, project director, Department of Standards and Survey Methods, at jwebb@jointcommission.org or 630-792-5277.
**ACCEPTED: New and Revised Requirements to Align with CMS CoPs**

The Centers for Medicare & Medicaid Services (CMS) final rule “Reform of Hospital and Critical Access Hospital Conditions of Participation [CoPs],” issued in May, resulted in CoP changes that became effective July 16, 2012 (see July 2012 Perspectives, page 6, for an article highlighting the changes). After reviewing these changes, The Joint Commission developed some new and revised elements of performance (EPs) for—and deleted others from—the hospital and critical access hospital programs. However, because many of the CoP revisions support The Joint Commission’s existing standards and survey process, changes to Joint Commission requirements were not necessary in all cases and resulted in the elimination of requirements in other cases.

These revisions address the following issues:

- Deletion of the requirement regarding qualifications of staff administering blood transfusions and intravenous medications (HR.01.02.01)
- Hospital-wide quality assessment (LD.01.02.01; MM.07.01.03)
- The inclusion of a doctor of podiatric medicine to be responsible for the organization and conduct of the medical staff (LD.01.05.01)
- Responsibility for outpatient services (LD.04.01.05)
- Pre-printed and electronic standing orders, order sets, and protocols for medication orders (MM.04.01.01)
- Verbal or written medication or other orders of a practitioner other than a licensed independent practitioner (MM.05.01.07; PC.02.01.03)
- Reporting requirements regarding death of a patient in restraints (PC.03.05.19)
- Authentication of a verbal or written order by the ordering practitioner or another practitioner who is responsible for the care of the patient (RC.01.02.01)
- Elimination of the requirement for authentication of a verbal order within 48 hours (RC.02.03.07)

**ACCEPTED: Changes to Requirements for CA Organizations Performing CT Scans**

In October 2010, California enacted a law regarding organizations that perform computed tomography (CT) scans in California. As announced in the January 2012 issue of Perspectives (pages 10–11), The Joint Commission responded by adding elements of performance (EPs) to “Environment of Care” (EC) Standard EC.02.04.03 and “Provision of Care, Treatment, and Services” (PC) Standard PC.01.02.15 for the ambulatory care, critical access hospital, and hospital programs. The four EPs became effective July 1, 2012—at the same time as parts of the California law.

In the 2012 legislative session, California introduced a new bill to clarify a few of the original expectations. To maintain alignment between Joint Commission standards and California law, The Joint Commission recently accepted revisions that do the following:

- Clarify that the requirements apply only to CT exams performed for diagnostic purposes
- Specify the radiation dose for standard adult brain, adult abdomen, and pediatric brain protocols displayed on the system must be within 20% of the dose actually delivered
- Require that the radiation dose for each CT exam be documented in the patient’s record
- Update the reference to the new California law

The revisions have been published in the recently mailed 2012 Update 2 to the Comprehensive Accreditation Manual for the ambulatory care, critical access hospital, and hospital programs and will appear in the E-dition® versions of each of these manuals this fall.

In addition, The Joint Commission developed a new EP to address the section of the California law that becomes effective July 1, 2013. “Information Management” (IM) Standard IM.02.02.03, EP 13, addresses the detailed reporting requirements for specific radiation exposures and events that exceed specified radiation dose parameters. This EP is scheduled for publication in the 2013 Update 1 to the accreditation manuals.

The box on the next page displays the revisions to the EPs effective July 1, 2012, as well as the new EP effective July 1, 2013. New text is underlined, and deleted text is shown in strikethrough. For more information, contact Joyce Webb, RN, BSN, MBA, CMPE, project director, Department of Standards and Survey Methods, at jwebb@jointcommission.org or 630-792-5277.
APPLICABLE TO AMBULATORY CARE, CRITICAL ACCESS HOSPITALS, AND HOSPITALS

Effective July 1, 2012

Environment of Care (EC)

Standard EC.02.04.03
The [organization] inspects, tests, and maintains medical equipment.

Element of Performance for EC.02.04.03
A 17. For [organizations] in California that provide computerized computed tomography (CT) services: A qualified medical physicist measures the actual radiation dose* produced by each diagnostic CT imaging system at least annually and verifies that the radiation dose displayed on the system for standard adult brain, adult abdomen, and pediatric brain protocols is within 20 percent of the actual amount of radiation dose measured delivered. The dates of these verifications are documented. ⚠️

Note: This element of performance is applicable only for systems capable of calculating and displaying radiation doses.

C 5. For [organizations] in California that provide computerized computed tomography (CT) services: The [organization] documents in the patient’s record the radiation dose* on every study produced during a CT examination. ⚠️

Note 1: This element of performance is applicable only for systems capable of calculating and displaying radiation doses.

Note 2: This element of performance does not apply to systems used for therapeutic radiation treatment planning or delivery, or for calculating attenuation coefficients for nuclear medicine studies.

C 6. For [organizations] in California that provide computerized computed tomography (CT) services: The radiology interpretive report of a diagnostic CT study includes the radiation dose.* The dose is either recorded in the patient’s radiology interpretive report or included on the protocol page, which is then attached to the radiology interpretive report. ⚠️

Note: This element of performance is applicable only for systems capable of calculating and displaying radiation doses.

C 7. For [organizations] in California that provide computerized computed tomography (CT) services: The [organization] electronically sends each CT study and protocol page that lists the radiation dose* and related technical factors to the [organization]’s electronic picture archiving and communications system. ⚠️

Note: This element of performance is applicable only for systems capable of calculating and displaying radiation doses.

*For the definition of “radiation dose” according to California Senate Bill 1237, refer to http://www.leginfo.ca.gov/pub/09-10/bill/sen/sb_1201-1250/sb_1237_bill_20100929_chaptered.html section 115111(f) of the California Health and Safety Code.

Provision of Care, Treatment, and Services (PC)

Standard PC.01.02.15
The [organization] provides for diagnostic testing.

Elements of Performance for PC.01.02.15
C 5. For [organizations] in California that provide computerized computed tomography (CT) services: The [organization] documents in the patient’s record the radiation dose* on every study produced during a CT examination. ⚠️

Note: This element of performance is applicable only for systems capable of calculating and displaying radiation doses.

Note 2: This element of performance does not apply to systems used for therapeutic radiation treatment planning or delivery, or for calculating attenuation coefficients for nuclear medicine studies.

C 6. For [organizations] in California that provide computerized computed tomography (CT) services: The radiology interpretive report of a diagnostic CT study includes the radiation dose.* The dose is either recorded in the patient’s radiology interpretive report or included on the protocol page, which is then attached to the radiology interpretive report. ⚠️

Note: This element of performance is applicable only for systems capable of calculating and displaying radiation doses.

C 7. For [organizations] in California that provide computerized computed tomography (CT) services: The [organization] electronically sends each CT study and protocol page that lists the radiation dose* and related technical factors to the [organization]’s electronic picture archiving and communications system. ⚠️

Note: This element of performance is applicable only for systems capable of calculating and displaying radiation doses.

*For the definition of “radiation dose” according to California Senate Bill 1237, refer to http://www.leginfo.ca.gov/pub/09-10/bill/sen/sb_1201-1250/sb_1237_bill_20100929_chaptered.html section 115111(f) of the California Health and Safety Code.
Elimination of the requirement for critical access hospitals to directly provide diagnostic and therapeutic services, laboratory services, radiology services, and emergency procedures (LD.04.03.01). These services can now be provided directly or through arrangement.

For psychiatric and rehabilitation distinct part units in critical access hospitals to meet the hospital CoPs, the addition of two EPs related to self-administration of medication that are currently in the hospital accreditation manual but not in the critical access hospital accreditation requirements (MM.06.03.01)

The new and revised requirements became effective September 1, 2012, and have been published in the recently mailed 2012 Update 2 to the Comprehensive Accreditation Manual for Hospitals and the Comprehensive Accreditation Manual for Critical Access Hospitals. They will also appear in the E-dition® for both manuals this fall. To view the new and revised requirements, visit http://www.jointcommission.org/assets/1/18/PREPUB-08-27-2012-HAP-deeming.pdf for hospitals and http://www.jointcommission.org/assets/1/18/PREPUB-08-27-2012-CAH-deeming.pdf for critical access hospitals.

Please note that any additional changes based on CMS final review and approval will be communicated in future issues of Perspectives and Joint Commission Online. For more information, contact Laura Smith, associate project director, Department of Standards and Survey Methods, at lsmith@jointcommission.org or 630-792-5098.

The Joint Commission Launches New Comprehensive Stroke Certification Program

**Eligibility Criteria and Standards Available on DSC Organizations’ Extranet Sites**

Stroke is a leading cause of death and disability worldwide that requires varying degrees of care and intervention because it affects individuals in different ways. To improve the quality and safety of care for patients with complex strokes—who require more specialized diagnostic testing, interventions, and care than those receiving care at Primary Stroke Centers (PSCs)—The Joint Commission developed a new Disease-Specific Care Advanced Certification program for Comprehensive Stroke Centers (CSCs) in collaboration with the American Heart Association and the American Stroke Association. The CSC requirements were derived from the Brain Attack Coalition’s “Recommendations for Comprehensive Stroke Centers”* and from the recommendations of a multidisciplinary advisory panel of experts in complex stroke care.

**CSC Certification Requirements**

The goal of The Joint Commission’s CSC advanced certification is to recognize hospitals equipped to provide evidence-based comprehensive stroke care. The CSC requirements focus on these concepts:

- Complex care needs, such as advanced diagnostic techniques, surgical/interventional therapies, and post-ICU care and transitional care
- Education and training of licensed independent practitioners and staff
- Required practitioners, qualifications, and timing of care
- Outcomes of care and data collection processes
- Research and peer review

**Eligibility Requirements**

Organizations seeking CSC certification must meet all the general eligibility requirements in the “The Joint Commission Certification Process” (CERT) chapter of the 2012 Disease-Specific Care Certification Manual (pages CERT-1–CERT-2) and shown in the box on the next page. These programs also need to meet six additional eligibility criteria (also shown on the next page) at the time of application. Organizations seeking CSC certification must provide data demonstrating that the CSC eligibility criteria have been met. Joint Commission reviewers will validate compliance with all eligibility criteria at the on-site certification review.

The Joint Commission Launches New Comprehensive Stroke Certification Program (continued)
Continued from page 6

CSC Certification Program
Reassessment

The Joint Commission recognizes that the science underlying comprehensive stroke care continues to evolve; as such, the CSC requirements and eligibility criteria may require revisions. To that end, The Joint Commission plans to evaluate all the CSC requirements in January 2013.

The current CSC requirements are accessible to all accredited organizations through their Joint Commission Connect™ extranet site and will appear in the 2013 Disease-Specific Care Certification Manual, scheduled for publication in March 2013.

For more information, please contact Jean Range, Executive Director, Certification, at dscinfo@jointcommission.org.

The Joint Commission Launches New Comprehensive Stroke Certification Program (continued)
Continued from page 6

APPLICABLE TO COMPREHENSIVE STROKE CENTERS

Effective September 1, 2012

Organizations seeking certification as a Comprehensive Stroke Center must meet all of the general eligibility requirements for Disease-Specific Care certification:

- The program is in the United States, operated by the US government, or operated under a charter of the US Congress.
- The program is provided within a Joint Commission-accredited organization.
- The program fits the description of types of services certified.
- The program must have served a designated minimum number of patients [see below for CSC volume requirements] at the time of its Joint Commission on-site review.
- The program uses a standardized method of delivering clinical care based on clinical practice guidelines and/or evidence-based practice.
- The program uses performance measurement to improve its performance over time.

In addition, eligibility for Comprehensive Stroke Center Advanced Certification includes all of the following requirements:

1. Volume
   - The Comprehensive Stroke Center:
     - Demonstrates that care is provided to 20 or more patients per year with a diagnosis of subarachnoid hemorrhage.
     - Demonstrates that 15 or more endovascular coiling or surgical clipping procedures for aneurysm are performed per year.
     - Administers IV tissue plasminogen activator (tPA) to 25 eligible patients per year.

   Note 1: Providing IV tPA to an average of 25 eligible patients over a two-year period is acceptable.

   Note 2: Administering IV tPA in the following situations can be counted in the requirement of 25 administrations per year:
     - IV tPA ordered and monitored by the CSC via telemedicine with administration occurring at another hospital.
     - IV tPA administered by another hospital, which then transferred the patient to the comprehensive stroke center.

2. Advanced imaging capabilities
   - The organization will be able to provide:
     - Carotid duplex ultrasound
     - Catheter angiography available on site 24 hours a day, 7 days a week
     - Computed tomography angiography available on site 24 hours a day, 7 days a week
     - Extracranial ultrasonography
     - Magnetic resonance angiography (MRA) available on site 24 hours a day, 7 days a week
     - Magnetic resonance imaging (MRI), including diffusion weighted MRI, available on site 24 hours a day, 7 days a week
     - Transcranial Doppler
     - Transesophageal echocardiography
     - Transthoracic echocardiography

3. Post-hospital care coordination for patients

4. Dedicated neuro-intensive care unit (neuro-ICU) beds for complex stroke patients
   - The hospital has dedicated neuro-ICU beds for complex stroke patients and staff and licensed independent practitioners with the expertise and experience to provide neuro–critical care 24 hours day, 7 days a week.

5. Peer review process
   - The hospital has a peer review process to review and monitor the care provided to patients with ischemic stroke, subarachnoid hemorrhage, and administered tPA.

6. Participation in stroke research
   - The CSC participates in Institutional Review Board–approved, patient-centered stroke research.
The Joint Commission, as a result of its ongoing review of its accreditation standards, has identified redundant elements of performance (EPs) in the “Care, Treatment, and Services” (CTS) chapter of the Comprehensive Accreditation Manual for Behavioral Health Care. This has resulted in the following deletions and modifications for the behavioral health care accreditation program:

- **CTS.04.01.01, EP 7**, has been deleted because it is redundant to CTS.03.01.07, EP 1, which has been retained and edited for clarity. CTS.04.01.01 has been edited to cross-reference CTS.03.01.07.
- **CTS.02.02.09** has been modified to apply only to opioid treatment programs. In addition, CTS.02.02.09, EP 1, has been deleted because it is superseded by Leadership (LD) Standard LD.04.03.09 addressing contracted services. If physical health assessments or diagnostic and laboratory tests are necessary or relevant to the care, treatment, or services provided to the individual served, then the organization must contract for these services and not merely make a referral. The deletion of CTS.02.02.09, EP 1, supports the expectation that all care, treatment, or services be of the same quality whether provided directly by the organization or through a contracted service.

The revisions, which became **effective August 27, 2012**, have been published in the recently mailed 2012 Update 2 to the Comprehensive Accreditation Manual for Behavioral Health Care and will appear in the E-dition® this fall. The box below displays the revisions; new text is underlined and deleted text is shown in strikethrough.

Questions about these changes may be directed to Lynn Berry, project director, Department of Standards and Survey Methods, at lberry@jointcommission.org.

---

**APPROVED: Revised Behavioral Health Care Requirements to Eliminate Redundancy**

The Joint Commission, as a result of its ongoing review of its accreditation standards, has identified redundant elements of performance (EPs) in the “Care, Treatment, and Services” (CTS) chapter of the Comprehensive Accreditation Manual for Behavioral Health Care. This has resulted in the following deletions and modifications for the **behavioral health care** accreditation program:

- **CTS.04.01.01, EP 7**, has been deleted because it is redundant to CTS.03.01.07, EP 1, which has been retained and edited for clarity. CTS.04.01.01 has been edited to cross-reference CTS.03.01.07.
- **CTS.02.02.09** has been modified to apply only to opioid treatment programs. In addition, CTS.02.02.09, EP 1, has been deleted because it is superseded by Leadership (LD) Standard LD.04.03.09 addressing contracted services. If physical health assessments or diagnostic and laboratory tests are necessary or relevant to the care, treatment, or services provided to the individual served, then the organization must contract for these services and not merely make a referral. The deletion of CTS.02.02.09, EP 1, supports the expectation that all care, treatment, or services be of the same quality whether provided directly by the organization or through a contracted service.

The revisions, which became **effective August 27, 2012**, have been published in the recently mailed 2012 Update 2 to the Comprehensive Accreditation Manual for Behavioral Health Care and will appear in the E-dition® this fall. The box below displays the revisions; new text is underlined and deleted text is shown in strikethrough.

Questions about these changes may be directed to Lynn Berry, project director, Department of Standards and Survey Methods, at lberry@jointcommission.org.

---

**Revisions to the “Care, Treatment, and Services” (CTS) Chapter**

**APPLICABLE TO BEHAVIORAL HEALTH CARE**

**Effective August 27, 2012**

**Care, Treatment, and Services (CTS)**

**Standard CTS.02.02.09**

For opioid treatment programs: When necessary or relevant to the care, treatment, or services provided. The organization has a process to provide medical histories, physical examinations, and diagnostic and laboratory tests results not directly provided by the organization.

Element of Performance for CTS.02.02.09

A-1. When necessary or relevant to the care, treatment, or services provided, organizations that do not provide physical health assessments or diagnostic and laboratory tests arrange for such services to be provided by an outside source that is a recognized health care organization, laboratory, or qualified and competent licensed independent practitioner.

**Standard CTS.03.01.07**

When individuals served need additional care, treatment, or services not offered by the organization, referrals are made and documented in the clinical/case record. (*For more information, refer to Standard CTS.04.01.01*)

Element of Performance for CTS.03.01.07

C 1. **The When the organization refers individuals served to an outside source when does not directly provide care, treatment, or services needed are not directly provided by the organization, by the individual served, it refers the individual to an outside source.**

**Standard CTS.04.01.01**

The organization coordinates the care, treatment, or services provided to an individual served as part of the plan for care, treatment, or services and in a manner consistent with the organization’s scope of care, treatment, or services. (*For more information, refer to Standard CTS.03.01.07*)

Element of Performance for CTS.04.01.01

C 7. **When needs are identified for which the organization does not directly provide care, treatment, or services, the organization refers individuals served to an outside source.**
Mailed: Accreditation Manual Updates

The 2012 Update 2 to the following comprehensive accreditation manuals mailed at the end of September to accredited organizations:

- Comprehensive Accreditation Manual for Ambulatory Care
- Comprehensive Accreditation Manual for Behavioral Health Care
- Comprehensive Accreditation Manual for Critical Access Hospitals
- Comprehensive Accreditation Manual for Home Care
- Comprehensive Accreditation Manual for Hospitals
- Comprehensive Accreditation Manual for Laboratory and Point-of-Care Testing
- Comprehensive Accreditation Manual for Long Term Care
- Comprehensive Accreditation Manual for Office-Based Surgery Practices

The updates include the following changes:

- Revised several requirements in the “Human Resources” (HR); “Leadership” (LD); “Medication Management” (MM); “Provision of Care, Treatment, and Services” (PC); and “Record of Care, Treatment, and Services” (RC) chapters for hospitals and critical access hospitals that use Joint Commission accreditation for deemed status purposes. The revisions, effective September 1, 2012, are a result of a Centers for Medicare & Medicaid Services (CMS) final rule (see article on pages 4, 6).

- Added and revised elements of performance (EPs) in the LD and PC chapters for hospitals to address patient flow through the emergency department, effective January 1, 2013 (see the July issue of Perspectives, pages 1, 3–5).

- Revised requirements in the “Environment of Care” (EC) and PC chapters that align with California legislative requirements for organizations that perform computed tomography (CT) scans for the ambulatory care, critical access hospital, and hospital programs. Revisions became effective July 1, 2012 (see article on pages 4–5).

- Revised requirements in the EC, LD, and PC chapters for ambulatory care to reflect changes to CMS Conditions for Coverage (CCHCs) regarding emergency equipment in ambulatory surgical centers (ASCs), effective July 16, 2012 (see article on page 3).

- Added new Prevention and Wellness Promotion requirements to the “Care, Treatment, and Services” (CTS) chapter for the behavioral health care program, effective January 1, 2013 (see the July issue of Perspectives, pages 14–15).

- Updated requirements for “Emergency Management” (EM) Standard EM.03.01.03 for home care. Revisions address activation and testing of an organization’s Emergency Operations Plan and are effective January 1, 2013 (see the July issue of Perspectives, pages 10–12).

- Modified requirement for daily quality control checks of instruments used for waived testing for all accreditation programs except critical access hospitals, effective May 23, 2012 (see the July issue of Perspectives, page 13).

- Added one new and one revised EP to the “Quality System Assessment for Nonwaived Testing” (QSA) chapter for the laboratory program to align with the CMS Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88), effective August 27, 2012 (see the September 2012 issue of Perspectives, page 3).

- Replaced the Periodic Performance Review (PPR) with the Focused Standards Assessment (FSA), resulting in revised or new text in “The Accreditation Process” (ACC) and “Accreditation Participation Requirements” (APR) chapters for all accreditation programs and new risk icons (appearing in all updates except long term care) to denote EPs assessed through the FSA process (see article on pages 10–11).

- Updated the accreditation decision rules for 2013 in the ACC chapter, effective January 1, 2013, for all programs (see the September 2012 issue of Perspectives, pages 1, 9–15).

- Updated the Glossary for all programs.

Accredited organizations will receive one complimentary update for their respective manual that is addressed to the chief executive officer. If your organization does not receive its 2012 Update 2 by October 20 (or its certification manual by November 20), contact Customer Service at jrcustomer service@pdb.com or 877-223-6866 and have the following information available: your organization name, organization ID, and the accreditation or certification program(s) that are missing updates or manuals.

A new E-dition® release (including standards effective January 2013) for each accreditation manual will be accessible on the “Accreditation Home” page of The Joint Commission Connect™ in November. The E-dition for the accreditation programs will include filters to sort EPs by risk area as well as other EPs applicable to the FSA.

2013 Certification Manuals
The 2013 Health Care Staffing Services Certification Manual
Continued on page 10
and the 2013 Palliative Care Certification Manual are scheduled for publication at the end of October. The two manuals include the updated certification decision rules for 2013 in the “Certification Process” (CERT) chapter, effective January 1, 2013, (see the September 2012 issue of Perspectives, pages 1, 9–15).

The 2013 Disease-Specific Care Certification Manual is scheduled for publication in March 2013 to allow for the inclusion of revised core standards going into effect July 1, 2013. Until the refreshed core standards take effect, the standards in the 2012 Disease-Specific Care Certification Manual will remain largely in effect, with the exception of any changes published in Perspectives.

Certified organizations will receive one complimentary manual that is addressed to the chief executive officer. A new E-dition® release for the manuals will be accessible on The Joint Commission Connect home page in November.

E-dition and other accreditation and certification resources are also available for purchase at http://store.jcrinc.com.

On November 12, 2012, The Joint Commission will launch a new workspace for all accredited organizations on their secure Joint Commission Connect™ extranet site: the Intracycle Monitoring (ICM) Profile. The ICM Profile is part of the larger ICM process pilot tested in spring 2012 (see January 2012 Perspectives, page 1) and scheduled to launch in January 2013. The Joint Commission encourages organizations to participate in the ICM process by using the ICM Profile and having an annual “TouchPoint Conference Call” with the Joint Commission Standards Interpretation Group (SIG) to review performance. The ICM Profile itself provides an online area that an organization’s quality team can use to locate information, resources, and tools that support continuous compliance activities during the intracycle period between full survey events.

### Focused Standards Assessment vs. Periodic Performance Review

A major tool of the ICM Profile, the new Focused Standards Assessment (FSA) will replace the Periodic Performance Review (PPR). A description of the FSA appears in the 2012 Update 2 to the Comprehensive Accreditation Manuals (see article on page 9). As with the PPR, The Joint Commission will require FSA submission at approximately 12 and 24 months after the organization’s triennial survey (12 months after the biennial survey for the laboratory accreditation program). FSA submission will not be required at the 36th month of the accreditation cycle (nor the 24th month of the laboratory accreditation cycle). Options 1, 2, and 3 will continue to remain available.

Organizations accredited under the critical access hospital and office-based surgery programs may access the ICM and FSA for self-assessment purposes; however, they will not be required—nor will they have the capability—to submit an FSA. In addition, all organizations accredited under the long term care program will be exempt from submitting an FSA during 2013.*

The FSA, like the PPR, enables organizations to access all applicable standards—those customized to an organization based upon accreditation program as well as service selections within the electronic application for survey (E-App).

Beginning in 2013, organizations that submit a Full FSA will have the option to focus their self-assessment on a minimum subset of risk-related standards (which encompasses about 45% to 60% of total applicable standards) rather than all standards as required by the current PPR.

### What Are Risk-Related Standards?

Over the past two years, Joint Commission process improvement teams developed a list of major risk areas applicable to each accreditation program. These risk areas were then linked to a selection of standards that address high-risk areas—that is, standards designed to proactively

---

* The long term care program is undergoing major changes that are scheduled for implementation in mid-2013.
Joint Commission to Launch New Intracycle Monitoring Process (continued)

Continued from page 10

manage risk and save lives by intentionally focusing on the “critical few” elements of performance (EPs). Risk-related standards (the minimum subset required for a Full FSA submission) appear with the risk icon in the FSA tool for all programs. The risk icon also appears with standards in the 2012 Update 2 to the accreditation manuals, E-dition®, and Accreditation Manager Plus® for all programs (except long term care).

Program-specific lists of the 2013 standards are now available on the extranet. Organizations may use these lists immediately to help prioritize current standards self-assessment activity. The risk-related standards for each accreditation program include the following:

- All National Patient Safety Goals (NPSGs)
- Standards related to accreditation program–specific risk areas identified by The Joint Commission
- Select direct and indirect impact standards
- Standards listed as requirements for improvement from an organization’s survey events conducted during the current triennial or biennial accreditation cycle

Organizations will have the option of reviewing either all or just the risk-related standards in the FSA tool.

A Note About Timing

On November 11, 2012, the PPR view on the extranet will change to the FSA view. Organizations with 2012 PPR submission due dates between November 12, 2012, and December 31, 2012, will receive a 2012 PPR submission extension to February 11, 2013. This submission extension allows organizations to become familiar with the FSA tool and submit the Full FSA—again, this will include a minimum subset of risk-icon standards instead of the current Full PPR requirement that must address all standards.

Organizations with 2013 FSA submission due dates between January 1, 2013, and February 10, 2013, will also receive a submission extension to February 11, 2013. The extension gives organizations time to review any changes to the FSA tool that are a result of the revised standards effective January 1, 2013, appearing in the 2012 Update 2 to the accreditation manuals.

Questions about the new ICM process may be directed to intracycle@jointcommission.org. Information about ongoing developments to intracycle monitoring will be communicated through Perspectives, Joint Commission Online, and the organization’s extranet site.

Clariﬁcations and Expectations

Super Suites

Special Space Designation Presents Fire Safety Advantages for Health Care Organizations

The Joint Commission has identiﬁed the need to increase the ﬁeld’s awareness and understanding of the Life Safety Code®.* To address this need, The Joint Commission Perspectives publishes the column Clarifications and Expectations, authored by George Mills, MBA, FASHE, CEM, CHFM, CHSP, director, Department of Engineering, The Joint Commission. This column clarifies standards expectations and provides strategies for challenging compliance issues, primarily in life safety and the environment of care. You may wish to share the ideas and strategies in this column with your facilities’ leadership.

Fire safety codes and standards for a typical nursing unit restrict corridor storage and require patient room doors to latch and resist the passage of smoke. They also require that the corridors be kept clear and unobstructed. However, certain clinical functions need open areas that do not restrict movement or storage but instead permit easy access to

* Life Safety Code® is a registered trademark of the National Fire Protection Association, Quincy, MA.
patients, equipment, and supplies. The Life Safety Code does allow for certain areas to have a group of rooms function as one large room. These areas are referred to as suites and can be designated as either sleeping suites (as in intensive care units) or non-sleeping suites (as in emergency departments). The area in a suite is treated as a single space. Therefore, there is no corridor to keep clear, there are no corridor door requirements, and some items can be stored outside the patient care room. The boundaries of the suite separate the function of the suite from other occupied spaces. These differing requirements can present distinct advantages.

**Non-Sprinklered vs. Sprinklered Suites**

If a suite is part of a smoke compartment that is not protected with an approved automatic sprinkler system, the barrier separation of the suite must meet the same requirements as a corridor wall in a non-sprinklered compartment. That is, the barrier separation must meet the following requirements:

- Be 30-minute fire rated
- Extend from the floor slab to the underside of the floor or roof deck above and from one outside wall to the other
- Limit the transfer of smoke

In addition, the doors must be fire rated for 20 minutes. They should be substantial (for instance, at least 1¾ inch thick), with door undercuts that do not exceed 1 inch. If a door is a corridor door, it must latch and resist the passage of smoke.

Alternatively, in a fully sprinkler-protected smoke compartment, the boundaries providing separation between a suite and other occupied space must meet the same requirements as a corridor wall. The suite separation wall can be a nonrated partition and may terminate at a lay-in ceiling when the ceiling is constructed to limit the transfer of smoke. An alternative to terminating at the lay-in ceiling is to have partitions terminating at monolithic ceilings that resist the passage of smoke—if there is a smoke-tight joint between the top of the partition and the bottom of the ceiling.

The door in this barrier is a corridor door, so it must be substantial (for instance, at least 1¾ inch thick) if there are no sprinklers. If sprinklers are present, the door must only resist the passage of smoke. The space between the bottom of the door and the floor must not exceed 1 inch, and the door must latch, although it does not need to have an automatic or self-closing device.

**Sleeping Suites**

In a typical nursing unit (in other words, a unit that is not a suite), a patient sleeping room must have an exit access door leading directly to an exit access corridor. However, this direct access is not required for a suite. Instead, there can be one room intervening between the exit access door in a sleeping suite patient room and the exit access corridor. However, the travel distance from anywhere in the sleeping suite to the exit access door within that suite must be no greater than 100 feet. The total travel distance from any point in the suite cannot exceed the overall 150-foot travel distance to a required exit (200 feet if the suite is fully sprinkler protected or is new construction).

A suite must have at least two exits. These exits must be remote from one another so that if one becomes compromised, a second egress is available. One of these two must exit onto an exit corridor. The second exit may exit into an exit enclosure, such as a stairwell.
Super Suites (continued)

According to the 2000 edition of the Life Safety Code, sleeping suites must not exceed 5,000 square feet in size. Later editions of the Life Safety Code allow them to be up to 7,500 square feet, provided that the area is protected by an approved automatic sprinkler system and meets the requirements for separation between the suite and the corridor. The 2012 edition of the Life Safety Code allows a size of up to 10,000 square feet for sleeping suites, with certain provisions. If the building complies with the requirements of later editions of the Life Safety Code, the suite may be eligible for a traditional equivalency (pending approval, including field verification from either a registered architect, a fire protection professional, or the local fire marshal responsible for the building’s fire safety).**

More Suite Advantages

Many believe that the greatest advantage of suites is that the 8-foot-wide space typically designated as an exit corridor is instead designated as an intervening room. This intervening room does not have the restrictions of a corridor. The doors in this space are not corridor doors, because the space is not a corridor. Those areas designated as hazardous, such as clean or soiled utility rooms, must have doors with self-closing and self-latching devices. Also, nonrated doors within the suite are not required to have positive latches or be smoke resistant. The intervening room can be treated as circulating space, which means that items can be placed in it as long as they do not block egress or create a hazard if there are too many combustibles in the defined space.

Nonsleeping Suites

Nonsleeping suites might be found in the surgical department, laboratory, emergency department, and radiology department. The boundaries are calculated the same for sleeping and nonsleeping suites. Both types of suites must have at least two separate and remote means of egress when they exceed 2,500 square feet. The size of a nonsleeping suite is limited to 10,000 square feet. In the suite, if travel distance to an exit access door is 100 feet or less, one intervening room is allowed. If the travel distance within the suite is less than 50 feet to the exit access door, a second intervening room is allowed.

The “Life Safety” Chapter and Suites

The Joint Commission’s “Life Safety” (LS) chapter requires all organizations to keep their electronic Statement of Conditions™ (E-SOC) current, including required Life Safety Code drawings. In 2011, 52% of all Joint Commission–accredited hospitals did not comply with Standard LS.01.01.01, Element of Performance 2, because of inaccurate Life Safety Code drawings, including the boundaries and suite sizes. The Life Safety Code drawings must clearly display certain information, as shown in “What to Include in Life Safety Code Drawings” on the preceding page.

The Joint Commission does not specify where Life Safety Code drawings should be kept; however, the Basic Building Information (BBI) in the E-SOC does require this information in the Additional Comments text field. Converting Life Safety Code drawings to a Web-based system can provide significant support in maintaining current drawings as well as size restrictions of suites.

This month’s column discusses the role of suites in fire safety. Next month’s column will continue to focus on the importance of maintaining various life safety features by discussing the documentation of compliance with important requirements.**

Top Standards Compliance Issues for First Half of 2012 (continued)

this information helpful in assessing their own compliance in these areas and planning any necessary improvement efforts. Remember: Surveyors review compliance with all standards in an accreditation or certification manual. This list is provided only to help organizations pinpoint potential trouble spots.

If you have questions about these requirements, please review the Standards Frequently Asked Questions at http://www.jointcommission.org/Standards/FAQs. Questions not addressed on this site may be directed to the Standards Interpretation Group through its online question form (http://www.jointcommission.org/Standards/OnlineQuestionForm) or by calling 630-792-5900.**
### Top Standards Compliance Issues for First Half of 2012

#### Ambulatory Care

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Standard Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>50%</td>
<td>HR.02.01.03</td>
<td>The organization grants initial, renewed, or revised clinical privileges to individuals who are permitted by law and the organization to practice independently.</td>
</tr>
<tr>
<td>39%</td>
<td>MM.03.01.01</td>
<td>The organization safely stores medications.</td>
</tr>
<tr>
<td>34%</td>
<td>IC.02.02.01</td>
<td>The organization reduces the risk of infections associated with medical equipment, devices, and supplies.</td>
</tr>
<tr>
<td>21%</td>
<td>IC.01.03.01</td>
<td>The organization identifies risks for acquiring and transmitting infections.</td>
</tr>
<tr>
<td>21%</td>
<td>EC.02.02.01</td>
<td>The organization manages risks related to hazardous materials and waste.</td>
</tr>
<tr>
<td>18%</td>
<td>MM.01.02.01</td>
<td>The organization addresses the safe use of look-alike/sound-alike medications.</td>
</tr>
<tr>
<td>17%</td>
<td>MM.01.01.03</td>
<td>The organization safely manages high-alert and hazardous medications.</td>
</tr>
<tr>
<td>16%</td>
<td>NPSG.07.01.01</td>
<td>Comply with either the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines or the current World Health Organization (WHO) hand hygiene guidelines.</td>
</tr>
<tr>
<td>16%</td>
<td>EC.04.01.01</td>
<td>The organization collects information to monitor conditions in the environment.</td>
</tr>
<tr>
<td>15%</td>
<td>UP.01.03.01</td>
<td>A time-out is performed before the procedure.</td>
</tr>
</tbody>
</table>

#### Behavioral Health Care

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Standard Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>34%</td>
<td>CTS.03.01.03</td>
<td>The organization has a plan for care, treatment, or services that reflect the assessed needs, strengths, preferences, and goals of the individual served.</td>
</tr>
<tr>
<td>20%</td>
<td>HR.02.01.03</td>
<td>The organization assigns initial, renewed, or revised clinical responsibilities to staff who are permitted by law and the organization to practice independently.</td>
</tr>
<tr>
<td>15%</td>
<td>HR.01.02.05</td>
<td>The organization verifies staff qualifications.</td>
</tr>
<tr>
<td>15%</td>
<td>EC.02.06.01</td>
<td>The organization establishes and maintains a safe, functional environment.</td>
</tr>
<tr>
<td>14%</td>
<td>CTS.04.03.33</td>
<td>For organizations providing food services: The organization has a process for preparing and/or distributing food and nutrition products.</td>
</tr>
<tr>
<td>14%</td>
<td>HR.01.06.01</td>
<td>Staff are competent to perform their responsibilities.</td>
</tr>
<tr>
<td>13%</td>
<td>CTS.02.01.05</td>
<td>The organization implements a written process requiring a physical health screening to determine the individual's need for a medical history and physical examination in [non–24-hour settings].</td>
</tr>
<tr>
<td>13%</td>
<td>NPSG.15.01.01</td>
<td>Identify individuals at risk for suicide.</td>
</tr>
<tr>
<td>13%</td>
<td>MM.03.01.01</td>
<td>The organization safely stores medications.</td>
</tr>
<tr>
<td>13%</td>
<td>EC.02.01.05</td>
<td>For foster care: The agency places individuals in foster care in physically safe environments.</td>
</tr>
</tbody>
</table>
Top Standards Compliance Issues for First Half of 2012

Critical Access Hospitals

50% EC.02.03.05 The critical access hospital maintains fire safety equipment and fire safety building features.

45% LS.02.01.10 Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.

38% EC.02.05.01 The critical access hospital manages risks associated with its utility systems.

36% LS.02.01.20 The critical access hospital maintains the integrity of the means of egress.

31% EC.02.06.01 The critical access hospital establishes and maintains a safe, functional environment.

31% IC.02.02.01 The critical access hospital reduces the risk of infections associated with medical equipment, devices, and supplies.

31% LS.02.01.35 The critical access hospital provides and maintains systems for extinguishing fires.

29% EC.02.05.07 The critical access hospital inspects, tests, and maintains emergency power systems.

29% LS.02.01.30 The critical access hospital provides and maintains building features to protect individuals from the hazards of fire and smoke.

29% RC.01.01.01 The critical access hospital maintains complete and accurate medical records for each individual patient.

Disease-Specific Care Certification

21% 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.

13% DSDF.3 The program is designed to meet the participant’s needs.

13% DSCT.5 The program initiates, maintains, and makes accessible a health or medical record for every participant.

9% DSSE.3 The program addresses participants’ education needs.

5% DSDF.1 Practitioners are qualified and competent.

5% DSPM.6 The program evaluates participant perception of the quality of care.

3% DSPR.1 The program defines its leadership roles.

2% DSCT.4 The program shares information with any relevant practitioner or setting about the participant’s disease or condition across the continuum of care.

2% DSPM.3 The program maintains data quality and integrity.

2% DSPM.2 The program uses measurement data to evaluate processes and outcomes.
Top Standards Compliance Issues for First Half of 2012

Health Care Staffing Services Certification

- **10% HSHR.1** The HCSS firm confirms that a person’s qualifications are consistent with his or her assignment(s).
- **7% HSHR.6** The HCSS firm evaluates the performance of clinical staff.
- **6% HSLD.5** The services contracted for by the HCSS firm are provided to customers.
- **4% HSHR.3** The HCSS firm provides orientation to clinical staff regarding initial job training and information.
- **4% HSPM.4** The HCSS firm analyzes its data.
- **3% HSHR.4** The HCSS firm assesses and reassesses the competence of clinical staff and clinical staff supervisors.
- **2% CPR 5** The staffing firm submits performance measurement data to The Joint Commission on a routine basis.
- **2% HSLD.9** The HCSS firm addresses emergency management.

**Note:** The remaining standards for the Health Care Staffing Services Certification program had a noncompliance rate of less than 1% or were fully compliant during the first half of 2012.

Top Standards Compliance Issues for First Half of 2012

Home Care

- **36% PC.02.01.03** The organization provides care, treatment, or services in accordance with orders or prescriptions, as required by law and regulation.
- **27% NPSG.07.01.01** Comply with either the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines or the current World Health Organization (WHO) hand hygiene guidelines.
- **24% EM.03.01.03** The organization evaluates the effectiveness of its Emergency Operations Plan.
- **24% HR.01.06.01** Staff are competent to perform their responsibilities.
- **23% HR.01.02.05** The organization verifies staff qualifications.
- **20% RC.02.01.01** The patient record contains information that reflects the patient’s care, treatment, or services.
- **19% PI.02.01.01** The organization compiles and analyzes data.
- **17% PI.01.01.01** The organization collects data to monitor its performance.
- **17% PC.01.03.01** The organization plans the patient’s care.
- **16% IC.01.03.01** The organization identifies risks for acquiring and spreading infections.
### Top Standards Compliance Issues for First Half of 2012

#### Hospitals

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Standard</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>61%</td>
<td>RC.01.01.01</td>
<td>The hospital maintains complete and accurate medical records for each individual patient.</td>
</tr>
<tr>
<td>52%</td>
<td>LS.02.01.20</td>
<td>The hospital maintains the integrity of the means of egress.</td>
</tr>
<tr>
<td>47%</td>
<td>LS.02.01.10</td>
<td>Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.</td>
</tr>
<tr>
<td>40%</td>
<td>EC.02.03.05</td>
<td>The hospital maintains fire safety equipment and fire safety building features.</td>
</tr>
<tr>
<td>39%</td>
<td>IC.02.02.01</td>
<td>The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.</td>
</tr>
<tr>
<td>37%</td>
<td>LS.02.01.30</td>
<td>The hospital provides and maintains building features to protect individuals from the hazards of fire and smoke.</td>
</tr>
<tr>
<td>36%</td>
<td>MM.03.01.01</td>
<td>The hospital safely stores medications.</td>
</tr>
<tr>
<td>34%</td>
<td>LS.02.01.35</td>
<td>The hospital provides and maintains systems for extinguishing fires.</td>
</tr>
<tr>
<td>33%</td>
<td>EC.02.06.01</td>
<td>The hospital establishes and maintains a safe, functional environment.</td>
</tr>
<tr>
<td>29%</td>
<td>EC.02.02.01</td>
<td>The hospital manages risks related to hazardous materials and waste.</td>
</tr>
<tr>
<td>26%</td>
<td>QSA.01.02.01</td>
<td>The laboratory maintains records of its participation in a proficiency testing program.</td>
</tr>
<tr>
<td>25%</td>
<td>QSA.02.04.01</td>
<td>The laboratory evaluates instrument-based testing with electronic or internal systems prior to using them for routine quality control.</td>
</tr>
<tr>
<td>24%</td>
<td>QSA.02.08.01</td>
<td>The laboratory performs correlations to evaluate the results of the same test performed with different methodologies or instruments or at different locations.</td>
</tr>
<tr>
<td>23%</td>
<td>TS.03.01.01</td>
<td>The organization uses standardized procedures for managing tissues.</td>
</tr>
<tr>
<td>20%</td>
<td>WT.05.01.01</td>
<td>The organization maintains records for waived testing.</td>
</tr>
<tr>
<td>20%</td>
<td>QSA.01.03.01</td>
<td>The laboratory has a process for handling and testing proficiency testing samples.</td>
</tr>
<tr>
<td>17%</td>
<td>QSA.01.03.02</td>
<td>The laboratory has a process for handling and testing proficiency testing samples.</td>
</tr>
</tbody>
</table>

### Top Standards Compliance Issues for First Half of 2012

#### Laboratory and Point-of-Care Testing

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Standard</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>67%</td>
<td>QSA.01.01.01</td>
<td>The laboratory participates in Centers for Medicare &amp; Medicaid Services (CMS)–approved proficiency testing programs for all regulated analytes.</td>
</tr>
<tr>
<td>38%</td>
<td>HR.01.06.01</td>
<td>Staff are competent to perform their responsibilities.</td>
</tr>
<tr>
<td>35%</td>
<td>QSA.02.03.01</td>
<td>The laboratory performs calibration verification.</td>
</tr>
<tr>
<td>35%</td>
<td>DC.02.03.01</td>
<td>The laboratory report is complete and is in the patient’s clinical record.</td>
</tr>
<tr>
<td>26%</td>
<td>QSA.01.02.01</td>
<td>The laboratory maintains records of its participation in a proficiency testing program.</td>
</tr>
<tr>
<td>25%</td>
<td>QSA.02.04.01</td>
<td>The laboratory evaluates instrument-based testing with electronic or internal systems prior to using them for routine quality control.</td>
</tr>
<tr>
<td>24%</td>
<td>QSA.02.08.01</td>
<td>The laboratory performs correlations to evaluate the results of the same test performed with different methodologies or instruments or at different locations.</td>
</tr>
<tr>
<td>23%</td>
<td>TS.03.01.01</td>
<td>The organization uses standardized procedures for managing tissues.</td>
</tr>
<tr>
<td>20%</td>
<td>WT.05.01.01</td>
<td>The organization maintains records for waived testing.</td>
</tr>
<tr>
<td>20%</td>
<td>QSA.01.03.01</td>
<td>The laboratory has a process for handling and testing proficiency testing samples.</td>
</tr>
</tbody>
</table>
### Top Standards Compliance Issues for First Half of 2012

#### Long Term Care

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Standard Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>39%</td>
<td>HR.02.01.04</td>
<td>The organization permits licensed independent practitioners to provide care, treatment, and services.</td>
</tr>
<tr>
<td>26%</td>
<td>NPSG.07.01.01</td>
<td>Comply with either the current CDC hand hygiene guidelines or the current WHO hand hygiene guidelines.</td>
</tr>
<tr>
<td>24%</td>
<td>WT.04.01.01</td>
<td>The organization performs quality control checks for waived testing on each procedure.</td>
</tr>
<tr>
<td>21%</td>
<td>IM.02.02.01</td>
<td>The organization effectively manages the collection of health information.</td>
</tr>
<tr>
<td>18%</td>
<td>PC.01.02.03</td>
<td>The organization assesses and reassesses the resident and his or her condition according to defined time frames.</td>
</tr>
<tr>
<td>16%</td>
<td>PC.02.03.01</td>
<td>The organization provides resident education and training based on each resident’s needs and abilities.</td>
</tr>
<tr>
<td>15%</td>
<td>EC.04.01.01</td>
<td>The organization collects information to monitor conditions in the environment.</td>
</tr>
<tr>
<td>14%</td>
<td>MM.03.01.01</td>
<td>The organization safely stores medications.</td>
</tr>
<tr>
<td>14%</td>
<td>WT.03.01.01</td>
<td>Staff and licensed independent practitioners performing waived tests are competent.</td>
</tr>
<tr>
<td>13%</td>
<td>PC.01.02.07</td>
<td>The organization assesses and manages the resident’s pain.</td>
</tr>
<tr>
<td>13%</td>
<td>PC.01.03.01</td>
<td>The organization plans the resident’s care.</td>
</tr>
<tr>
<td>13%</td>
<td>RC.02.01.21</td>
<td>Clinical record documentation includes resident education.</td>
</tr>
</tbody>
</table>

### Top Standards Compliance Issues for First Half of 2012

#### Medicare/Medicaid Certification–Based Long Term Care

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Standard Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>44%</td>
<td>HR.02.01.04</td>
<td>The organization permits licensed independent practitioners to provide care, treatment, and services.</td>
</tr>
<tr>
<td>26%</td>
<td>WT.03.01.01</td>
<td>Staff and licensed independent practitioners performing waived tests are competent.</td>
</tr>
<tr>
<td>25%</td>
<td>RC.02.01.21</td>
<td>Clinical record documentation includes resident education.</td>
</tr>
<tr>
<td>22%</td>
<td>EM.03.01.01</td>
<td>The organization evaluates the effectiveness of its emergency management planning activities.</td>
</tr>
<tr>
<td>21%</td>
<td>EC.04.01.01</td>
<td>The organization collects information to monitor conditions in the environment.</td>
</tr>
<tr>
<td>21%</td>
<td>IM.02.02.01</td>
<td>The organization effectively manages the collection of health information.</td>
</tr>
<tr>
<td>16%</td>
<td>LD.04.04.05</td>
<td>The organization has an organization-wide, integrated resident safety program.</td>
</tr>
<tr>
<td>15%</td>
<td>NPSG.07.01.01</td>
<td>Comply with either the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines or the current World Health Organization (WHO) hand hygiene guidelines.</td>
</tr>
<tr>
<td>14%</td>
<td>HR.02.02.01</td>
<td>The organization provides orientation to licensed independent practitioners.</td>
</tr>
<tr>
<td>14%</td>
<td>PC.01.02.07</td>
<td>The organization assesses and manages the resident’s pain.</td>
</tr>
</tbody>
</table>
### Top Standards Compliance Issues for First Half of 2012

**Office-Based Surgery Practices**

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Standard</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>45%</td>
<td>HR.02.01.03</td>
<td>The practice grants initial, renewed, or revised clinical privileges to individuals who are permitted by law and the organization to practice independently.</td>
</tr>
<tr>
<td>31%</td>
<td>IC.02.02.01</td>
<td>The practice reduces the risk of infections associated with medical equipment, devices, and supplies.</td>
</tr>
<tr>
<td>24%</td>
<td>MM.03.01.01</td>
<td>The practice safely stores medications.</td>
</tr>
<tr>
<td>14%</td>
<td>IC.01.03.01</td>
<td>The practice identifies risks for acquiring and transmitting infections.</td>
</tr>
<tr>
<td>14%</td>
<td>NPSG.07.01.01</td>
<td>Comply with either the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines or the current World Health Organization (WHO) hand hygiene guidelines.</td>
</tr>
<tr>
<td>13%</td>
<td>PI.02.01.01</td>
<td>The practice compiles and analyzes data.</td>
</tr>
<tr>
<td>13%</td>
<td>WT.05.01.01</td>
<td>The practice maintains records for waived testing.</td>
</tr>
<tr>
<td>10%</td>
<td>HR.01.02.05</td>
<td>The practice verifies staff qualifications.</td>
</tr>
<tr>
<td>10%</td>
<td>HR.01.06.01</td>
<td>Staff are competent to perform their responsibilities.</td>
</tr>
<tr>
<td>10%</td>
<td>NPSG.03.04.01</td>
<td>Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings.</td>
</tr>
</tbody>
</table>

### Top Standards Compliance Issues for First Half of 2012

**Advanced Certification for Palliative Care**

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Standard</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>60%</td>
<td>PCPC.4</td>
<td>The interdisciplinary program team assesses and reassesses the patient’s needs.</td>
</tr>
<tr>
<td>13%</td>
<td>PCPC.5</td>
<td>The program provides care, treatment, and services according to the plan of care.</td>
</tr>
<tr>
<td>13%</td>
<td>PCPI.2</td>
<td>The program collects data to monitor its performance.</td>
</tr>
<tr>
<td>7%</td>
<td>PCPC.3</td>
<td>The program tailors care, treatment, and services to meet the patient’s lifestyle, needs, and values.</td>
</tr>
<tr>
<td>7%</td>
<td>PCPI.3</td>
<td>The program analyzes and uses its data.</td>
</tr>
<tr>
<td>7%</td>
<td>PCPM.6</td>
<td>Program leaders are responsible for selecting, orienting, educating, retaining, and providing incentives for staff.</td>
</tr>
<tr>
<td>7%</td>
<td>PCPM.7</td>
<td>The program has an interdisciplinary team which includes individuals with expertise in and/or knowledge about the program’s specialized care, treatment, and services.</td>
</tr>
</tbody>
</table>

**Note:** The remaining standards for the Advanced Certification for Palliative Care program were in full compliance during the first half of 2012.
Get your all-Access pass to drive CMS and Joint Commission compliance

**Accelerate your CoP compliance**

Introducing CMSAccess™

A convenient, all-in-one portal to the latest info about Medicare certification and requirements

At last, a fast and organized way to connect to CMS guidelines, Medicare Conditions of Participation (CoPs), transmittals, interactive forms, personal e-mail, alerts, publications, survey processes, and more. From completing form 2567 online to your 23 CoP survey readiness checklist, you’ll have easy access to useful tools, tips, timelines, and forms for maintaining continuous compliance with the CoPs.

CMSAccess delivers an integrated toolkit of resources to help you achieve peak regulatory performance.

So quick. So easy. So efficient.

Learn how CMSAccess will help you work faster and smarter at store.jcrinc.com/cmsaccess.

**Advance your accreditation preparation**

Introducing JCAccess™

An easy-to-use, multimedia portal to the most trusted and relevant Joint Commission hospital accreditation information, education, and tools

With one click, you’ll be connected to the most updated Joint Commission standards, as well as staff and patient education, optional CE and Joint Commission Certified Accreditation Professional™ (JCCAP™) credits, tools, Sentinel Event Alerts, case studies, tracers, model policies and procedures, the Perspectives newsletter, and hot topics. Focus on the topics you want and access the accreditation information you need in seconds.

JCAccess delivers an all-access pass to the accreditation resources you require, customizable to meet your hospital’s accreditation goals.


Learn how JCAccess will help you work faster and smarter at store.jcrinc.com/jcaccess.

CMSAccess and JCAccess are available late 2012!

Powered by the trusted Wolters Kluwer platform