New Palliative Care Certification Program Available for Hospitals

The Joint Commission’s new Advanced Certification for Palliative Care program for hospitals launches September 1, 2011. “Palliative care is a key component for improving the lives of patients who face serious illness, and The Joint Commission is very pleased to offer this certification that will help organizations improve the quality of care they provide to these patients,” says Michele Sacco, M.S., executive director of the Palliative Care Certification Program at The Joint Commission. “As people increasingly become aware of the benefits of palliative care, we are prepared to help organizations meet the needs and expectations of these patients and their families.”

Eligibility and Requirements

To be eligible for Advanced Certification for Palliative Care, a palliative care program must:

- Be located in the United States, operated by the U.S. government, or operated under a charter of the U.S. Congress
- Be provided within a Joint Commission–accredited hospital. All types of hospitals are eligible, including children’s hospitals and long-term acute care hospitals. A dedicated unit or dedicated beds are not required.

Continued on page 15
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 were rejected at some point in the process.

**ACCEPTED**

- Revisions to align with the Centers for Medicare & Medicaid Services’ (CMS) critical access hospital Conditions of Participation for the critical access hospital program (see article on page 6 of this issue)

**CURRENTLY IN FIELD REVIEW**

- Proposed new standards for a comprehensive stroke center certification program in the disease-specific care program
- Proposed new requirements and revisions to the emergency management drills for the home care program

**CURRENTLY IN DEVELOPMENT**

**STANDARDS AND GOALS**

- Proposed new and revised standards for influenza vaccination of health care workers in all accreditation programs
- Proposed new standards for children's hospitals in the hospital program
- Proposed new standards for a comprehensive stroke center certification program in the disease-specific care program
- Proposed revision to the emergency management drill requirement for the home care program
- Proposed new National Patient Safety Goal on alarm management for the ambulatory care, critical access hospital, hospital, long term care, and Medicare/Medicaid Certification-based long term care programs
- Proposed new National Patient Safety Goal on minimizing overuse in health care for the ambulatory care, critical access hospital, and hospital programs
- Proposed revisions to the patient flow requirements for the hospital program

**POLICIES AND PROCEDURES**

- Proposed revisions to the Sentinel Event Policy for all programs
The Joint Commission’s Accreditation Committee recently approved a new Accreditation Participation Requirement (APR) and Certification Participation Requirement (CPR) for all accreditation and certification programs so surveyors or reviewers can record an Immediate Threat to Health or Safety Situation during an on-site survey or review beginning January 1, 2012. Until now, there was no single requirement or element of performance (EP) in which an immediate threat to health or safety could be consistently recorded, and no requirement triggering a Preliminary Denial of Accreditation (PDA) or Preliminary Denial of Certification (PDC) decision for such a threat. The establishment of this APR or CPR does not change The Joint Commission policy for responding to immediate threat to health or safety situations.

The Joint Commission defines Immediate Threat to Health or Safety as “a threat that represents the most immediate risk and has or may potentially have serious adverse effects on the health or safety of the patient, resident, or individual served.” Such a situation can occur anywhere in an organization. When a surveyor or reviewer identifies an immediate threat to health or safety situation, the surveyor or reviewer consults with Joint Commission central office staff to confirm the surveyor’s or reviewer’s findings and to identify which standards are noncompliant as a result of the immediate threat to health or safety situation. The APR and CPR will be used by the surveyor or reviewer to identify in the survey report that an immediate threat to health or safety situation exists at the organization. When an immediate threat to health or safety situation is declared, the other related Requirements for Improvement (RFIs) will provide more detail regarding the specific issues that resulted in the declaration of the situation.

New APR.09.04.01 and CPR 15 are shown in the box below. The APR and CPR will appear in the 2011 Update 2 to the comprehensive accreditation manuals and 2012 certification manuals publishing in late September and the E-dition® update to be released in fall 2011.

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**New Immediate Threat to Health or Safety Situation Requirement**

**APPLICABLE TO ALL ACCREDITATION AND CERTIFICATION PROGRAMS**

**Effective January 1, 2012**

**APR.09.04.01 and CPR 15**

The organization provides care, treatment, services, and an environment that pose no risk of an “Immediate Threat to Health or Safety,” also known as “Immediate Threat to Life” or ITL situation.
Health care professionals agree that surgery on the wrong patient, with the wrong procedure, or at the wrong site or wrong side is a serious, preventable adverse event that should never happen. Although most states do not mandate reporting of wrong site surgery, some estimates put the national incidence rate as high as 40 incidents per week. Recognizing this is a critical patient safety issue, the Joint Commission Center for Transforming Healthcare recently released field-tested and field-validated solutions to help health care organizations reduce the risk of wrong site surgery. Those solutions will be available, along with robust, significant, and health care–setting specific implementation guidance within the Center’s Targeted Solutions Tool™ (TST) this fall.

Wrong site surgery includes invasive procedures on the wrong patient as well as wrong procedure, wrong site, and wrong side surgeries. The Center teamed up with eight U.S. hospitals and ambulatory surgical centers using Robust Process Improvement™ (RPI) methods, including Lean Six Sigma and change management, to significantly reduce the risk of these preventable breakdowns in patient care. The Wrong Site Surgery Project began in July 2009 and grew to include the following eight participating organizations:

1. AnMed Health, Anderson, South Carolina
2. Center for Health Ambulatory Surgery Center, Peoria, Illinois
3. Holy Spirit Hospital, Camp Hill, Pennsylvania
4. La Veta Surgical Center, Orange, California
5. Lifespan—Rhode Island Hospital, Providence, Rhode Island
6. The Mount Sinai Medical Center, New York City
7. Seven Hills Surgery Center, Henderson, Nevada
8. Thomas Jefferson University Hospitals, Philadelphia

“While wrong site surgery is not an everyday occurrence, all facilities and physicians who perform invasive procedures are at some degree of risk,” says Mark R. Chassin, M.D., FACP, M.P.P., M.P.H., president, The Joint Commission. “The magnitude of this risk is often unknown or undefined. Providers who ignore this fact, or rely on the absence of such events in the past as a guarantee of future safety, do so at their peril. Unless an organization has taken a systematic approach to studying its own processes, it is flying blind. These eight organizations are leading the way in finding specific solutions to the complex problem of wrong site surgery.”

**Understanding the Scope of the Issue**

Using RPI, the project teams defined the specific risks that increase the likelihood of wrong site surgery and then systematically measured their frequency throughout the workflow of each invasive patient procedure. They then pinpointed the contributing factors for the most frequently occurring risks and developed specific solutions to mitigate each contributing factor. Finally, they thoroughly tested the solutions in real health care settings to determine if the frequency of these risks was reduced. Although invasive surgical procedures occur in many settings, the scope of this project included all procedures performed in the operating room and regional blocks performed by anesthesia either in the preoperative area or operating room. Participants in the project defined the scope to begin at the time a procedure is scheduled for surgery and to end with incision.

The participating hospitals and ambulatory surgical centers discovered that the following factors contributed to increasing the risk of wrong site surgery:

- Problems with scheduling and pre-operation/holding processes
- Ineffective communication
- Distractions in the operating room
- Conducting a time-out without full participation by all of the key people in the operating room

They also discovered that the contributing factors vary by organization and by event. This concept underscores the importance of identifying in each organization the specific contributing factors that increase risk so that the organization can target appropriate solutions to reduce the specific risks in its processes.

The Center and the participating organizations found that opportunities for errors or defects could be reduced by taking the following actions:

- Reinforcing quality and measurement
- Emphasizing a culture of safety
- Strengthening knowledge about wrong site surgery
- Improving consistency in surgical processes

For example, addressing documentation and verification
issues in the pre-operation/holding areas decreased defective cases (that is, cases with a cause of or risk for wrong site surgery) from a baseline of 52% to 19%. In turn, the incidence of cases containing more than one defect decreased 72%. The focus on eliminating defects is important because a single operative case has multiple opportunities for defects. When there are multiple defects in a single case, it can further increase the risk of an error reaching the patient. In addition, project participants determined that defective cases occurred more frequently when more than one procedure was performed.

A summary list of wrong site surgery causes and solutions is listed below. For a complete list, go to http://www.centerfortransforminghealthcare.org/UserFiles/file/CTH_Wrong_Site_Surgery_Project_6_24_11.pdf.

### Summary List of Wrong Site Surgery Causes and Solutions

<table>
<thead>
<tr>
<th>Contributing Factors</th>
<th>CAUSES</th>
<th>SOLUTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scheduling</td>
<td>Booking documents not verified by office schedulers</td>
<td>Confirm the accuracy of the operating room schedule</td>
</tr>
<tr>
<td></td>
<td>Schedulers accept verbal requests for surgical bookings instead of written documents</td>
<td>Limit entry points for primary documentation (consent, history and physical, physician orders, booking/scheduling form) to a single fax number</td>
</tr>
<tr>
<td></td>
<td>Unapproved abbreviations, cross-outs, and illegible handwriting used on booking form</td>
<td>Build on relationships with physician offices to improve the accuracy of information received and methods used to confirm the accuracy of the operating room schedule.</td>
</tr>
<tr>
<td>Pre-operation Holding</td>
<td>Primary documents (consent, history and physical, surgeon’s booking orders, operating room schedule) missing, inconsistent, or incorrect</td>
<td>Share the data and allow the team to ask questions</td>
</tr>
<tr>
<td></td>
<td>Inconsistent use of site marking protocol</td>
<td>Examine processes for site marking and seek to understand the causes of variation</td>
</tr>
<tr>
<td>Operation Room</td>
<td>Lack of intra-operative site verification when multiple procedures performed by the same provider</td>
<td>Perform a pause between each procedure that occurs within a single case to ensure that each procedure is performed accurately and according to the procedure, site and laterality identified within the signed surgical consent</td>
</tr>
<tr>
<td></td>
<td>Primary documentation not used to verify patient, procedure, site, and side</td>
<td>Monitor compliance of standardized work processes, tools, and methods in all steps of the process (scheduling/booking, pre-op/holding, operating/procedure room)</td>
</tr>
<tr>
<td></td>
<td>Time-out process occurs before all staff are ready or before prep and drape occurs</td>
<td>Empower all team members to participate in processes designed to reduce the risk of wrong site surgery; everyone is expected to speak up</td>
</tr>
<tr>
<td>Organization Culture</td>
<td>Senior leadership is not actively engaged</td>
<td>Hold all caregivers and staff accountable for their role in risk reduction; organization should define roles</td>
</tr>
<tr>
<td></td>
<td>Staff is passive or not empowered to speak up</td>
<td>Share the data and allow the team to ask questions</td>
</tr>
</tbody>
</table>

Source: Joint Commission Center for Transforming Healthcare
As part of the ongoing process to ensure equivalency with Medicare Conditions of Participation (CoPs), The Joint Commission Board of Commissioners recently accepted a revision to “Environment of Care” (EC) Standard EC.02.03.05 under existing element of performance (EP) 2 and added new EP 25 for critical access hospitals that use Joint Commission accreditation for deemed status purposes. These revisions become effective January 1, 2012. The Joint Commission must demonstrate equivalency of its standards and EPs with CoPs to maintain Centers for Medicare & Medicaid Services (CMS) deeming authority for the critical access hospital accreditation program.

EP 2 was changed to require quarterly (as opposed to semi-annual) testing of water-flow devices. The valve tamper switch testing interval has not changed and will remain semi-annual. New EP 25 was added to address a request by CMS to specifically delineate the actual documentation requirements previously implied under Standard EC.02.03.05. The revision to EP 2 and new EP 25 are shown in underline in the box below. These changes will appear in the 2011 Update 2 to the Comprehensive Accreditation Manual for Critical Access Hospitals (CAMCAH) publishing in late September and the E-dition® update that will be released in fall 2011.

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**Official Publication of Revised Standard**

**Changes to Fire Protection System Requirements**

**Applicable to Critical Access Hospitals**

**Effective January 1, 2012**

**Standard EC.02.03.05**

The critical access hospital maintains fire safety equipment and fire safety building features.

**Note:** This standard does not require critical access hospitals to have the types of fire safety equipment and building features described below. However, if these types of equipment or features exist within the building, then the following maintenance, testing, and inspection requirements apply.

**Elements of Performance for EC.02.03.05**

A 2. At least quarterly, the critical access hospital tests water-flow devices. Every 6 months, the critical access hospital tests valve tamper switches. The completion date of the tests is documented.

C 25. Documentation of maintenance, testing, and inspection activities for fire alarm and water-based fire protection systems includes the following:

- Name of the activity
- Date of the activity
- Required frequency of the activity
- Name and contact information, including affiliation, of the person who performed the activity
- NFPA standard(s) referenced for the activity
- Results of the activity

**Note:** For additional guidance on performing tests, see NFPA 25, 1998 edition (Sections 2-3.3 and 3-3.3) and NFPA 72, 1999 edition (Table 7-3.2).

**Note:** For additional guidance on documenting activities, see NFPA 25, 1998 edition (Section 2-1.3) and NFPA 72, 1999 edition (Section 7-5.2).
**REMINDER: E-App Improvements Planned for October**

In October 2011 The Joint Commission will launch its enhanced Electronic Application for Accreditation (E-App) for all accreditation programs, except the laboratory and certification programs. The current E-App will be locked down for a period of time while the new E-App is being implemented. Notification will be sent when that timeframe has been determined.

Any updates that organizations have made to the current E-App must be saved and submitted before September 26. In addition, organizations with due dates for submitting updates to the E-App between August 29 and November 1, 2011, will receive an extension to December 1, 2011. The Joint Commission will send an official e-mail message to the organization's CEO and primary accreditation contact in October announcing the date that organizations can access the new E-App. Before the launch, organizations will be provided with a video tutorial and answers to frequently asked questions about the enhanced E-App.

The E-App underwent extensive customer usability testing, and staff made improvements based on this feedback. The length of the E-App will be driven by the complexity of the organization and the care, treatment, and services it provides. The new E-App will include the following:

- New look and feel
- Easy to use, more intuitive, and user friendly
- Increased specificity by accreditation program and care setting
- Straightforward language with clear instructions
- New read-only option
- Improved printing functionality

Questions about the enhanced E-App can be directed to e-app@jointcommission.org. After the launch in October, your Joint Commission Account Executive will be able to answer questions and provide assistance related to the improved E-App process.

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**APPROVED: 2012 Accreditation and Certification Decision Rules**

The Joint Commission’s Accreditation Committee approved the 2012 accreditation and certification decision rules for all accreditation and certification programs. These decision rules are effective for surveys or reviews beginning January 1, 2012, and can be seen in the boxes on pages 8—14. Additions are underlined, while deletions are noted in strikethrough.

Most changes are editorial-related and are intended to clarify existing rules. These changes primarily support actual practice and provide a more accurate set of decision rules for Joint Commission customers. Specific changes to the accreditation or certification decision rules include the following:

- Added new Preliminary Denial of Accreditation (PDA) and Preliminary Denial of Certification (PDC) rule PDA03 or PDC02 to address organizations with serious or pervasive patterns and trends that require further monitoring and/or review
- Revised PDA06 and PDC06 to delete the mention of two opportunities to clear a not compliant standard
- Added new Contingent Accreditation and Certification (CONT) rule CONT01 to address an organization that has successfully abated Immediate Threat to Life
- Revised CONT02 to specify that an organization with a decision of Accreditation with Follow-Up Survey needs to resolve all requirements
- Revised Denial of Accreditation and Denial of Certification rules DA04 and DC04 to delete the specific number of days for submitting an Evidence of Standards Compliance (ESC) and/or Measure of Success (MOS)
- Added new rule PCMH01 regarding the decision process for the new Primary Care Medical Home (PCMH) option available to Joint Commission–accredited ambulatory care organizations. This rule became effective July 1, 2011, with the launch of the Primary Care Medical Home program.
- Revised Accreditation with Follow-Up Survey (AFS) and Certification with Follow-up Review (CFR) rules AFS04 and CFR03, deleting the specific number of

*Continued on page 8*
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The organization can address Requirements for Improvement within 91 days for
1. Revised AFS05 and CFR04, specifying an organization has at least two on-site ESCs to demonstrate the need for continued monitoring to assess whether the organization sustains improvement
2. Revised AFS10 to replace the term “corrective actions” with “Plan for Improvement” (PFI) and added language regarding Interim Life Safety Measures
3. Deleted accreditation and certification Administrative Rules (ADM) ADM01 and ADM02 because these rules do not render decisions
4. Deleted accreditation and certification Sentinel Event Rules (SE) SE01 and SE02 due to upcoming revisions to the “Sentinel Events” chapter

The 2011 Update 2 to the comprehensive accreditation manuals, the 2012 certification manuals, and the Edition® update release planned for the fall will include these new accreditation and certification decision rules. Questions about these 2012 rules should be directed to Keith Winfrey, associate director of survey technology, at kwinfrey@jointcommission.org or 630/792-5023.

Denial of Accreditation

Denial of Accreditation will be recommended when one or more of the following conditions are met

DA01 The organization does not permit the performance of any survey by The Joint Commission. (APR.02.01.01, EP 1)

DA02 The organization has failed to resolve Accreditation with Follow-up Survey or Contingent Accreditation status prior to withdrawing from the accreditation process.

DA03 The organization has failed to submit payment for survey fees or annual fees.

DA04 The organization has repeatedly failed to submit an ESC and/or MOS within 91 days of its due date.

Preliminary Denial of Accreditation

Preliminary Denial of Accreditation will be recommended when one or more of the following conditions are met:

PDA01 An Immediate Threat to Health or Safety exists for patients or the public within the organization.

PDA02 The organization’s patients have been placed at risk for a serious adverse outcome(s) due to significant and pervasive patterns, trends, and/or repeat findings.

PDA023 The organization’s patients have been placed at risk for a serious adverse outcome because either an individual who does not possess a license, registration, or certification is providing or has provided health care services in the organization that would, under applicable law or regulation, require such a license, registration, or certification; or an individual is practicing outside the scope of his or her license, registration, or certification.

Cross reference applies to critical access hospitals and hospitals only (HR.01.02.07, EPs 1 and 2; MS.06.01.05, EP 1)

Cross reference applies to ambulatory care and office-based surgery only (HR.01.02.07, EPs 1 and 2; HR.02.01.03, EP 4)

Cross reference applies to long term care only (HR.01.02.07, EPs 1 and 2; HR 02.01.04, EP 15)

Cross reference applies to behavioral health care, home care, and laboratory only
PDA04 The organization does not possess a license, certificate, and/or permit, as or when required by applicable law and regulation, to provide the health care services for which the organization is seeking accreditation. (LD.04.01.01, EP 1) Cross reference applies to all programs (LD.04.01.01, EP 2) Cross reference applies to office based surgery only

PDA05 The Joint Commission is reasonably persuaded that the organization submitted falsified documents or misrepresented information in seeking to achieve or retain accreditation. Information provided by an organization and used by The Joint Commission for accreditation purposes must be accurate and truthful and may be received in the following ways:
– Provided verbally, in writing, or electronically
– Obtained through direct observation by, or in an interview with, or any other type of communication with a Joint Commission employee
– Derived from documents supplied by the organization to The Joint Commission including, but not limited to, its application for accreditation or its RCA in response to a sentinel event
– Submitted electronically to The Joint Commission including, but not limited to, data or documents provided as part of the Periodic Performance Review (PPR) process or the electronic application process If accreditation is denied following implementation of this rule, the organization shall be prohibited from participating in the accreditation process for a period of one year unless the president of The Joint Commission, for good cause, waives all or a portion of this waiting period. (APR.01.02.01, EP 1)

PDA06 The result of a Contingent Accreditation follow-up survey continues to meet a rule for Contingent Accreditation.

PDA07 The organization with a decision of Contingent Accreditation has failed to clear not compliant standards after two opportunities to do so as a result of the follow-up survey.

PDA07 The organization has knowingly used a Joint Commission employee to provide any accreditation-related consulting services (APR.06.01.01, EP 1)

PDA08 The Joint Commission is notified that the Skilled Nursing Facility/Nursing Facility has been terminated for cause or voluntarily withdraws from the Medicare/Medicaid program. (APR.10.01.01, EP 1)

Note: This rule applies to Medicare/Medicaid certification-based long-term care only.

Applicable to laboratory only:

PDA09 The laboratory has failed to comply with a cease testing order issued by The Joint Commission, one of its cooperative partners, or a regulatory agency.

Applicable to laboratory only:

PDA10 The organization’s laboratory personnel have referred proficiency testing samples to another laboratory for analysis or participated in inter-laboratory communication regarding proficiency testing results before the results have been reported to the program provider. (QSA.01.04.01, EPs 1 and 2)

Contingent Accreditation
Contingent Accreditation will be recommended when one or more of the following conditions are met:

CONT01 The organization with a decision of Accreditation with Follow-up Survey has failed to successfully address all requirements after two opportunities to do so. The Immediate Threat to Health and Safety has been successfully abated and verified through direct observation or other determining method.

CONT02 The organization with a decision of Accreditation with Follow-up Survey Contingent Accreditation has failed to resolve all requirements. One or more of the original RFIs from the previous on-site survey, may be scheduled for a second as a result of the Contingent Accreditation follow-up survey.

Accreditation with Follow-up Survey
Note: The Accreditation Follow-up Survey could occur within 30 days or up to six months after the decision is rendered.

Accreditation with Follow-up Survey will be recommended when one or more of the following conditions are met:

AFS01 The organization demonstrates systemic patterns, trends, and repeat findings primarily with direct impact standards.

AFS02 The organization demonstrates systemic patterns, trends, and repeat findings primarily with indirect impact standards.
2012 Accreditation Decision Rules (continued)

AFS032 There is credible evidence that the organization may have engaged in possible fraud or abuse. (LD.04.02.03, EP 3)

AFS043 The organization fails to successfully address all RFIs in an ESC or MOS within 45 or 60 days.

AFS054 At least two on-site ESC demonstrate the need for continued monitoring to assess whether the organization sustains improvements.

AFS065 The organization, which has failed to resolve one or more of its original RFIs, may be scheduled for a second Accreditation with Follow-up Survey.

AFS07 The organization consistently fails to meet requirements for the timely submission of data and information to The Joint Commission.

Not applicable to critical access hospital and office-based surgery:

AFS086 The organization fails to submit a Periodic Performance Review (PPR) and corrective action plan as appropriate.

Note: This rule applies to Medicare/Medicaid certification-based long term care only. Note applicable to long term care only

Applicable to laboratory only:

AFS097 The laboratory fails to submit a written plan of action for unsuccessful proficiency testing after two requests from The Joint Commission.

Applicable to ambulatory care, critical access hospital and hospitals only:

AFS108 The organization has one or more Condition of Participation scored as a Condition-level deficiency.

Note: This rule applies only to organizations that use accreditation for deemed status purposes.

AFS411 The organization fails to demonstrate continued compliance with all not compliant standards in an MOS submission within four to six months.

AFS1209 An individual who does not possess a license, registration, or certification is providing or has provided health care services in the organization that would, under applicable law or regulation, require such a license, registration, or certification; or an individual is practicing outside the scope of his or her license, registration, or certification. (HR.01.02.07, EPs 1 and 2; MS.06.01.05, EP 1)

Cross reference applies to critical access hospitals and hospitals

AFS130 Cross reference applies to ambulatory care and office-based surgery practices

Note: This rule applies to critical access hospitals and hospitals only

AFS140 Cross reference applies to home care and laboratories

Note: This rule applies to critical access hospitals and hospitals only

AFS150 Cross reference applies to behavioral health care

Note: Except as provided under rule PDA03.

AFS160 The organization has failed to implement or make sufficient progress toward the Plan for Improvement (PFI) corrective actions described in a Statement of Conditions™, Part 4, Plan for Improvement, which was previously accepted by The Joint Commission; or has failed to develop and implement or enforce applicable the interim life safety measures (ILSM) policy and its criteria, associated with evaluation and compensation for increased safety.

Note: Cross reference applies to critical access hospitals, home care, hospitals, long term care, and office-based surgery practices

Note: This rule applies to hospice inpatient facilities only. Note applies to home care only

AFS170 The organization has one or more Condition of Participation scored as a Condition-level deficiency.

Note: This rule applies only to organizations that use accreditation for deemed status purposes.

AFS180 Cross reference applies to ambulatory care and behavioral health care

Applicable to ambulatory care, critical access hospital, hospital, laboratory, and office-based surgery only:

One-Month Survey
A one-month survey will be scheduled when the following condition is met:

FOC01 A full laboratory survey will be conducted when an organization providing laboratory services cannot demonstrate to The Joint Commission that their
2012 Accreditation Decision Rules (continued)

Applicable to laboratory only:

Proficiency Testing Monitoring Survey
A proficiency testing monitoring survey will be scheduled when one or more of the following conditions are met:

PTM01 The laboratory has either initial or subsequent unsuccessful proficiency test performance and a determination is made that an on-site evaluation is required to assess either the plan of action or the plan for reinstatement when applicable, following cessation of testing (voluntary or involuntary).

Evidence of Standards Compliance (ESC)
An ESC will be required when the following condition is met:

ESC01 An organization has one or more standards scored not compliant at the time of a survey event.

On-site ESC Survey
An on-site ESC survey will be scheduled when the following condition is met:

ESC02 An on-site evaluation may be scheduled to validate compliance with the relevant standards in a written ESC.

Measure of Success (MOS)
An MOS for all applicable EP corrections will be required when the following condition is met:

MOS01 The organization has submitted a successful ESC for an EP that requires an MOS submission.

On-site MOS Survey
A four-month on-site MOS survey may be scheduled when the following condition is met:

MOS02 An on-site MOS evaluation rather than an MOS submission may be required to validate compliance with the relevant standards.

Preliminary Accreditation
Preliminary Accreditation will be recommended when the following condition is met:

PA01 The organization has demonstrated compliance with the selected standards used in the first survey conducted under the Early Survey Policy.

Accredited
Accreditation will be recommended when one or more of the following conditions are met:

A01 The organization is in compliance with all standards at the time of the on-site survey or has successfully addressed all RFIs in its first ESC submission and does not meet any rules for other accreditation decisions.

A02 The organization, as a result of an on-site follow-up survey, meets all of the original RFIs.

Applicable to ambulatory care organizations only:

Primary Care Medical Home Option
For Joint-Commission accredited ambulatory care organizations that choose to achieve the Primary Care Medical Home Option:

PCMH01 A Joint Commission-accredited ambulatory care organization that demonstrates systematic patterns and/or trends regarding non-compliant Primary Care Medical Home standards/EPs will not be designated as a Primary Care Medical Home until they have successfully addressed all RFIs in its ESC submission. (Effective July 1, 2011)

Administrative Rules
Administrative rules will be used when one or more of the following conditions are met:

ADM01 Depending on the severity of the issue, The Joint Commission may shorten follow-up time frames or change the nature of follow-up activity from what is stated in these decision rules.

ADM02 Survey findings that meet program-specific screening criteria based on the number of not compliant direct impact standards will be subject to a more intensive review by Joint Commission Central Office staff.

Note: The first survey is conducted using a defined subset of applicable standards. The second survey is a full announced survey (except for deemed status purposes). A Preliminary Accreditation decision remains in effect until the organization completes the second full survey.

Continued on page 12
### 2012 Accreditation Decision Rules (continued)

#### Sentinel Event Rules
Sentinel event rules will be used when one or more of the following conditions are met:

<table>
<thead>
<tr>
<th>SE01</th>
<th>The organization experienced a sentinel event subject to review under the Sentinel Event Policy.</th>
</tr>
</thead>
<tbody>
<tr>
<td>SE02</td>
<td>The organization experienced a sentinel event subject to review under the Sentinel Event Policy, and The Joint Commission has determined that the organization completed a thorough and credible root cause analysis and action plan.</td>
</tr>
</tbody>
</table>

**Note:** The follow-up activity will assess the implementation and effectiveness of the organization’s action plan.

### APPLICABLE TO ALL CERTIFICATION PROGRAMS (DISEASE-SPECIFIC CARE, HEALTH CARE STAFFING SERVICES, AND PALLIATIVE CARE PROGRAMS)

#### Effective January 1, 2012

#### Denial of Certification
Denial of Certification will be recommended when one or more of the following conditions are met:

<table>
<thead>
<tr>
<th>DC01</th>
<th>The program/staffing firm does not permit the performance of any review by the Joint Commission. (CPR 3, EP 1)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DC02</td>
<td>The program/staffing firm has failed to resolve a Certification with Follow-up Review or Contingent Certification status prior to withdrawing from the certification process.</td>
</tr>
<tr>
<td>DC03</td>
<td>The program/staffing firm has failed to submit payment for review fees or annual fees.</td>
</tr>
<tr>
<td>DC04</td>
<td>The program/staffing firm has repeatedly failed to submit an ESC or MOS within 91 days of its due date or has failed to comply with elements of the intra-cycle evaluation.</td>
</tr>
</tbody>
</table>

#### Preliminary Denial of Certification
Preliminary Denial of Certification will be recommended when one or more of the following conditions are met:

<table>
<thead>
<tr>
<th>PDC01</th>
<th>An Immediate Threat to Health or Safety exists for patients or the public within the program or served by the staffing firm’s employees.</th>
</tr>
</thead>
<tbody>
<tr>
<td>PDC02</td>
<td>The program’s patients/patients served by the staffing firm’s employees have been placed at risk for a serious adverse outcome(s) due to significant and pervasive patterns, trends, and/or repeat findings.</td>
</tr>
<tr>
<td>PDC03</td>
<td>The program’s patients or patients served by the staffing firm’s employees have been placed at risk for a serious adverse outcome because either an individual who does not possess a license, registration, or certification is providing or has provided health care services in the organization that would, under applicable law or regulation, require such a license, registration, or certification; or an individual is practicing outside the scope of his or her license, registration, or certification.</td>
</tr>
<tr>
<td>PDC04</td>
<td>The program/staffing firm does not possess a license, certificate, and/or permit, as or when required by applicable law and regulation, to provide health care services or health care staffing services for which the organization is seeking certification.</td>
</tr>
</tbody>
</table>
| PDC05 | The Joint Commission is reasonably persuaded that the program/staffing firm submitted falsified documents or misrepresented information in seeking to achieve or retain certification. Information provided by a staffing firm/program and used by The Joint Commission for certification purposes must be accurate and truthful and may be received in the following ways:  
  – Provided verbally, in writing, or electronically |
2012 Certification Decision Rules (continued)

- Obtained through direct observation by, or in interview with or any other type of communication with a Joint Commission employee
- Derived from documents supplied by the staffing firm/program to The Joint Commission including, but not limited to its application for certification or its root cause analysis in response to a sentinel event;
- Submitted electronically to The Joint Commission, including but not limited to data or documents provided as part of the intra-cycle evaluation process or the electronic application process. If certification is denied following implementation of this rule, the staffing firm/program shall be prohibited from participating in the certification process for a period of one year unless the president of The Joint Commission, for good cause, waives all or a portion of this waiting period. (CPR 7, EP 1)

PDC05  The result of a Contingent Certification Follow-up review continues to meet a rule to Contingent Certification.

PDC06  The program/staffing firm with a decision of Contingent Certification has failed to clear not compliant standards after two opportunities to do so as a result of the follow-up review.

PDC07  The program/staffing firm knowingly used a Joint Commission employee to provide any certification-related consulting services.

Contingent Certification
Contingent Certification will be recommended when one or more of the following are met:

CONT01  The organization with a decision of Certification with Follow-up, has failed to successfully address all requirements after two follow-up reviews. The Immediate Threat to Health and Safety has been successfully abated and verified through direct observation or other determining method.

CONT02  The organization with a decision of Certification with Follow-up Review Contingent Certification has failed to resolve all requirements, one or more of the original RFIs from the previous on-site survey, may be scheduled for a second as a result of the Contingent Certification follow-up review.

Certification with Follow-up Review
Certification with Follow-up Review will be recommended when one or more of the following are met:

CFR01  The program/staffing firm demonstrates systemic patterns, trends, and repeat findings primarily in the direct impact standards.

CFR02  The program/staffing firm demonstrates systemic patterns, trends and repeat findings primarily in the indirect impact standards.

CFR032  The program/staffing firm fails to successfully address all RFIs in an ESC or MOS within 45 or 60 days.

CFR043  At least two An onsite ESC demonstrate the need for continued monitoring to assess whether the program/staffing firm sustains improvements.

CFR052  The program/staffing firm, which has failed to resolve one or more of the original RFIs, may be scheduled for a second Certification with Follow-up Review.

CFR06  The program/staffing firm consistently fails to meet requirements for the timely submission of data and information to the Joint Commission

CFR07  The program/staffing firm fails to demonstrate continued compliance with all not complaint standards in an MOS within four to six months.

CFR085  An individual who does not possess a license, registration, or certification is providing or has provided health care services to the program’s patients/patients served by the staffing firm’s employees that would under applicable law or regulation, require such a license, registration, or certification; or an individual is practicing outside the scope of his or her license, registration, or certification.

Note: Except as provided under rule PDC023.

Evidence of Standards Compliance (ESC)
An ESC will be required when the following condition is met:

ESC01  A program/staffing firm has one or more standards scored not compliant at the time of a review event.

On-Site ESC Review
An on-site ESC review will be scheduled when the following condition is met:

Continued on page 14
2012 Certification Decision Rules (continued)

ESC02 An on-site evaluation may be scheduled to validate compliance with the relevant standards in a written ESC.

Measure of Success (MOS)
An MOS for all applicable EP corrections will be required when the following condition is met:

MOS01 The program/staffing firm has submitted a successful ESC for an EP that requires an MOS submission.

On-Site MOS Review
A four-month on-site MOS review may be scheduled when the following condition is met:

MOS02 An on-site MOS review rather than an MOS submission may be required to validate compliance with the relevant standards.

Certification
Certification will be recommended when one or more of the following conditions are met:

CT01 The program/staffing firm is in compliance with all standards at the time of the on-site review or has successfully addressed all RFIs in its first ESC submission and does not meet any rules for other certification decisions.

CT02 The program/staffing firm as a result of a follow-up review meets all of the original RFIs.

Note: The program/staffing firm must provide ESC for new RFIs that were not the subject of the follow-up review and which were identified as not compliant at the time of the follow-up review.

CT03 The program/staffing firm shows sufficient evidence of continuing compliance with standards submitted at the time of the 12 month Intra-cycle Evaluation Report.

Administrative Rules
Administrative rules will be used when one or more of the following conditions are met:

ADM01 Depending on the severity of the issue, The Joint Commission may shorten follow-up time frames or change the nature of follow-up activity from what is stated in these decision rules.

ADM02 Review findings that meet program-specific screening criteria based on the number of not-compliant direct impact standards will be subject to a more intensive review by Joint Commission Central office staff.

Sentinel Event Rules
Sentinel event rules will be used when one or more of the following conditions are met:

SE01 The program experienced a sentinel event subject to review under the Sentinel Event Policy.

SE02 The program experienced a sentinel event subject to review under the Sentinel Event Policy and The Joint Commission has determined that the program has completed a thorough and credible root cause analysis and action plan.

Note: The follow-up activity will assess the implementation and effectiveness of the program’s/staffing firm’s action plan.

Reminder: Access Free JCR Articles
Joint Commission Resources (JCR) has made it easier for Joint Commission–accredited and –certified organizations to sample its periodicals and access valuable information.

JCR is offering complimentary articles from its five periodicals to accredited and certified organizations via their Joint Commission Connect™ extranet site. These periodicals include The Joint Commission Journal on Quality and Patient Safety, The Joint Commission Benchmark, The Source, Environment of Care® News, and Joint Commission Perspectives on Patient Safety.

Go to your Joint Commission Connect extranet site and click on the “Perspectives” link. This will take you to a page listing that month’s free articles and, if you’re interested, information on how to subscribe to JCR periodicals.

You also can find more information on JCR periodicals on the JCR Web site at http://www.jcrinc.com/Products-and-Services/Periodicals-Home/.
The Growth of Palliative Care

Currently, palliative care programs are found increasingly in hospitals, which are the main site of care for the seriously ill and the site of death for 50% of adults on average nationwide. As of 2009, 63% of U.S. hospitals overall and 85% of hospitals with more than 300 beds reported the presence of a palliative care program.

Palliative care focuses medical and support care on relief of pain and other sources of suffering for patients with advanced illness, along with providing support resources for their families. It is appropriate at any point in a serious illness, whether the patient is expected to fully recover, will live for years with chronic illness, or is subject to progressive decline up to the time of death. Unlike hospice, palliative care is not prognosis-driven; eligibility depends strictly on need and likelihood of benefit. Throughout the continuum of illness, palliative care involves addressing physical, intellectual, emotional, social, and spiritual needs and facilitating patient-centered treatment, autonomy, and access to information.

Essential structural elements of hospital palliative care programs include the following:

- An interdisciplinary team of clinical staff (doctors, nurses, pharmacists, and social workers)
- Appropriate staffing or staffing determined by hospital size and patient need
- Staff trained, credentialed, and/or certified in palliative care
- Staff who are accessible and responsive 24 hours a day, 7 days a week

The coordinated effort in palliative care programs can reduce hospital costs, readmissions, and emergency department visits.

Provision of Care: Access to the program's services, patient involvement in decision making pertaining to their care, and the coordination of care

Performance Improvement: Collection and analysis of data to improve care and services

Information Management: Maintenance of confidential, accurate patient information, and preservation of the quality and integrity of the information

The 2012 Palliative Care Certification Manual will publish this fall. To review the pre-publication standards for this new certification program, go to The Joint Commission Web site at http://www.jointcommission.org/palliative_care_advanced_certification_pre-publication_standards/.

If you have questions about the Advanced Certification for Palliative Care program, please call 630/792-5291 or e-mail palliative@jointcommission.org.
The Medical Staff Handbook


The Medical Staff Handbook has been completely updated and features an in-depth explanation of Joint Commission standards that address all medical staff issues, including the recently revised MS.01.01.01. This resource provides information on the credentialing, privileging, and appointment processes for hospital practitioners. The Medical Staff Handbook also includes the following:

- An appendix with all Joint Commission Medical Staff (MS) standards, rationales, elements of performance, and scoring information
- Complete coverage of medical staff bylaws and other areas affected by the revised Standard MS.01.01.01
- Thorough interpretation of all Joint Commission standards related to the medical staff
- Tips for developing new medical staff processes and improving existing processes for appointment and reappointment
- Sample documents, practical strategies, and detailed examples to help readers understand and comply with the Medical Staff standards

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