

What's New in the 2004 Joint Commission Home Care and Hospice Standards? *Part 2*

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The greatly anticipated 2004-2005 Joint Commission on Accreditation of Healthcare Organizations' (Joint Commission) home care and hospice standards have been released after years of revision. The standards have been consolidated with a focused attempt by the Joint Commission's standards review project team to retain the most relevant and patient-focused standards.

This article, the second of a two-part series, reviews seven of the more significant standards' changes by chapter from the *2004-2005 Comprehensive Accreditation Manual for Home Care (CAMHC)*. Part one (*HHN*, January 2004) covered the Ethics, Rights, and Responsibilities, and the Provision of Care chapters as well as the new scoring methodology.

Medication Management Chapter

With the continued emphasis and focus on patient safety, the standards that address safe medication management are now located in their own chapter to emphasize the importance of this function and contain four new standards. **Standard MM.3.10** is a new standard that addresses ordering and transcribing to assure that only medications needed to treat the patient's condition are ordered. This means that when the nurse is reviewing the patient's medication on admission and ongoing that there is a med-

ical condition, diagnosis or some other indication for its use.

Standard MM.4.50 is a new standard, but only applies when a hospice provides care in a facility that has an on-site pharmacy and patients present in the organization, that there is a system in place to obtain medications that are needed when the pharmacy is closed.

Standard MM.4.60 is a new standard and applies to organizations that routinely administer medication, but do not operate a pharmacy. This is a new standard but has no new requirement that would impact home care or hospice operations. For example, the two elements of performance require that the home care or hospice organization have a process in place for obtaining medications during regular business hours, and when the pharmacy is closed.

Standard MM.5.20 is a new standard that addresses medications that are self administered by the patient or caregiver when the patient is receiving facility-based hospice care. This is to assure medications are administered safely and accurately. Teaching patients and caregivers to safely and accurately self-administer medications is nothing new to home care and hospice staff. Instead of the 14 bulleted items noted in the 2003 CAMHC as previously discussed, standard MM.5.20, EP2 requires that patient education be provided about the na-

ture of the medication, how to administer the medication, expected actions and side effects, and how to monitor the effects of the medication. These items are all routinely addressed with patients self-administering medication and as such are not new actions that need to be taken by staff.

One additional component in **MM.5.20 (EP3)** is that the person (non-staff member) who is going to be responsible for administering medication to the patient be deemed competent before being allowed to self administer medication. Again, this is a new standard and EP, but not a new requirement for home care providers. Assessing the patient's or caregiver's competence is routinely performed, especially as it relates to the self-administration of intravenous medication. Documentation is required for patient education and scored at MM.6.20, but there is no Joint Commission requirement for documenting the patient or caregiver's competence in medication administration.

Standard MM.7.10 is a new standard that addresses the home care or hospice organization's processes for managing high-risk or high-alert medications. These medications are those that involve a higher risk for abuse, errors, or other adverse outcome. In home care and hospice these medications may include, but are not limited to antineoplastic agents, anticoagulants, narcotics, medications

with a narrow therapeutic range, etc. To meet the intent of this standard, each home care and hospice organization will need to consider what medications they will and will not administer or monitor in the home and which of these medications the organization would consider high risk. When high-risk medication will be administered and/or monitored in the home, it is expected that processes be established and implemented that incorporate the characteristics of good process design, as previously discussed.

The last standard is **MM.8.10** that requires home care and hospice organizations specifically focus on its medication management system by evaluating its processes. Common processes within a home care and hospice medication management system would include, as applicable: ordering, transcribing, preparing, dispensing, administering, and monitoring. In the applicable medication management process, risk points are to be evaluated, as well as other areas to improve patient safety. Other activities need to include routinely evaluating the literature for new technologies or successful practices that have been demonstrated to improve safety and improve medication management systems.

Lastly, reports generated by the home care or hospice organization that include information addressing its own medication management processes need to be reviewed for trends or issues within its system. These reports may include, but are not limited to incident reports for medication errors or adverse drug reactions, patient complaints, and satisfaction

surveys. This evaluation activity is closely linked with ongoing performance improvement data that is collected on an ongoing basis. Once the data is collected, it needs to be aggregated and analyzed to determine whether current performance is acceptable or if there are "opportunities for improvement" identified which require follow-up actions to be taken.

Improving Organizational Performance

Like the Provision of Care chapter, the standards in the Improving Organizational Performance chapter have been consolidated to six standards.

events. It is not mandated that this data be collected, but that the organization *consider* collecting data in these areas to improve patient safety. If the organization does not collect data on these items, during the survey, home care and hospice leaders should be able to discuss their rationale as to why these data had not been collected.

Also in **Standard PI.1.10 (EP3)** there are new data collection requirements related to the patient's perception of care. One of the new requirements for home care and hospice organizations is to collect data on the patient/caregiver's perception of how they can improve patient safety, and when applicable, the


Assessing the patient's or caregiver's competence is routinely performed, especially as it relates to the self-administration of intravenous medication.

Standards that addressed performance-improvement planning and design activities have been moved to the leadership chapter and the standards remaining relate to improving performance through data collection, analysis, and action planning activities. In the *2004-2005 CAMHC*, the new requirements located in the elements of performance (EPs) and the one new standard primarily addresses patient safety.

In **Standard PI.1.10 (EP2)** there are two new bulleted items that pertain to collecting data on the staff's perceptions related to risks to individuals and suggestions for improving patient safety, as well as the staff's willingness to report unanticipated

effectiveness of the patient's pain management. Data are also required to be collected as they relate to the patient's specific needs and expectations and how the home care or hospice organization met these needs and expectations.

Another change is within **Standard PI.2.20** at **EP5** and **EP6**. Now the home care or hospice organization can develop their own definition of what is considered to be a serious adverse drug event (ADE) and significant medication error. A word of caution, in the glossary of the *2004-2005 CAMHC* there is still a Joint Commission definition of what would be considered an adverse drug reaction (ADR). Therefore, if the Joint



<p>2004-2005 CAMHC chapters addressed this month:</p> <ul style="list-style-type: none"> ■ Medication Management ■ Improving Organizational Performance ■ Leadership ■ Environmental Safety and Equipment Management ■ Management of Human Resources ■ Management of Information ■ Surveillance, Prevention, and Control of Infection ■ Accreditation Participation Requirements 	<p>2004-2005 CAMHC chapters addressed in the January 2004 issue of HHN:</p> <ul style="list-style-type: none"> ■ Changes in Scoring ■ Ethics, Rights, and Responsibilities ■ Provision of Care <p>One of the new requirements for home care and hospice organizations is to collect data on patients' or caregivers' perceptions of how they can improve patient safety and, when applicable, the effectiveness of the patient's pain management.</p>
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Commission's definition of an ADR is met, analysis will need to be conducted. Also make sure that the nursing staff are familiar with the organization's definition, so that if an ADE or medication error occurs, appropriate events and errors are reported and analyzed.

At **Standard PI.2.20 (EP9)** a new item requiring analysis is related to hazardous conditions. Hazardous conditions are circumstances that increase the chances of a serious adverse outcome as defined by the home care and hospice organization.

The new **Standard PI.3.20** requires that minimally on an annual basis by 12/31/04, the home care or hospice organization proactively identify a process, that if it were not planned or implemented correctly, it could jeopardize patient safety. This is also called conducting a failure, mode, and effects analysis (FMEA). This topic will be discussed further in a future issue of *HHN*.

Leadership

Standard LD.1.20 (EP7), which addresses the governance of an organization now requires that the governing body annually

evaluate the home care and hospice's organization's performance in relation to its vision, mission, and goals; whereas in the *2003 CAMHC*, an annual evaluation was not required.

Standard LD.3.50, which addresses contracted services, no longer requires that the written agreement contain a "laundry list" of Joint Commission-required items. Other than those items required by the Medicare Conditions of Participation for Home Health Agencies and Hospices, the nature and scope of services is the only specific content required by the Joint Commission.

Standard LD.4.20, which addresses the design of new and existing processes, has a new requirement in **EP3**; it requires that, when available, information about potential risks to patients be incorporated into the design activities.

Another new patient safety standard is **Standard LD.4.40**, which requires that leaders ensure that an integrated patient safety program is implemented throughout the home care and hospice organization. Development, implementation, and overseeing a patient safety program in home care and hospice

organizations will be discussed in a future issue of *HHN*.

Environmental Safety and Equipment Management

Standard EC.1.20 (EP3) requires that environmental tours to identify environmental deficiencies, hazards, and unsafe practices be conducted at least every 6 months in *all* areas, whereas in the *2003 CAMHC*, only patient care areas were toured every 6 months and all other areas were toured on an annual basis.

Standard EC.1.30, which applies to facility-based care only, has had its interpretation revised to permit smoking in the organization's building (by patients only) when the patient has met criteria established by the organization. This allows organizations to be more flexible in their no smoking policies for patients only and allow patients to smoke in certain controlled situations.

Standard EC.2.10 requires that hospices providing facility-based care develop and maintain a written management plan describing how it will manage the security of people, staff, and others visiting the facility.

Standard EC.4.10 addresses emergency management. Two *new* EPs address components required in the written emergency management plan. One of the changes is at **EP10**, second bulleted item, which includes making certain that plans are established for supporting staff during an emergency. Staff considerations may include housing, food, transportation, communicating with family members, child care arrangements, post-emergency debriefing activities, etc.

Another element (i.e., **EP12**) that has been expanded to include all home care services, and is no longer just required for hospices providing facility-based care, is the need for the emergency management plan to include processes for evacuating the entire office when necessary.

The last section of the chapter discusses measuring and improving activities. Within each of the standards, a new element has been added to **Standard EC.9.10 (EP9)** and **EC.9.20 (EP9)** to address patient safety.

- **Standard EC.9.10 (EP9)** requires that the environmental safety monitoring and response activities are integrated into the patient safety program at standard LD 4.40.
- **Standard EC.9.20 (EP9)** requires that environmental safety issues are communicated to the individual(s) or group responsible for the patient safety program and
- **Standard EC.9.30** requires that staff participate in implementing the recommendations and in the ongoing monitoring activities.

Management of Human Resources

Throughout the Management of Human Resources chapter, language that addresses the use of students has been added. There are no requirements addressing the use of students, but the term has been added to be consistent with the terminology used in other accreditation programs.

Standard HR.1.20 (EP18 and EP19) addresses nonlicensed staff providing care without re-

quired licensure, registration, or certification. These are not new requirements, but rather are criteria previously used to make accreditation decisions. For example, EP18 was formerly one of the criteria for conditional accreditation and EP19 was a condition for preliminary denial of accreditation.

Standard HR.2.10 addresses staff orientation. In the *2004-2005 CAMHC*, there is no longer an exhaustive list of items that are required to be addressed in staff orientation. The number of required items is now limited to six topics.

Standard HR.2.20 addresses staff's roles and responsibilities in safety. This is not a new patient safety standard, but rather a compilation of existing standards whereby the staff's knowledge and understanding is assessed and scored at this standard. To meet the intent of this standard, staff will need to be able to describe risks within the patient and organization's environment and demonstrate actions that should be taken to reduce or eliminate risks or if identified that they are properly reported, actions to take in the event of an incident, and how to report problems that commonly occur such as failures or user errors.

Standard HR.2.30 addresses ongoing staff education. **EPs 5 and 6** were added as a component of patient safety.

- **EP5** requires that ongoing education incorporates methods of team training, and
- **EP6** requires that ongoing staff education reinforces the need and way to report unanticipated adverse events.

Management of Information

New confidentiality requirements were added to **Standard IM.2.10** at **EP, 6, 7, and 8** to be consistent with the provisions in the Health Insurance Portability and Accountability Act (HIPAA)

Standards IM.2.20, IM.2.30, and IM.3.10 had elements of performance added to address electronic systems and will not result in new processes to be added. Although, most home care and hospice organizations will need to expand their existing policies and procedures to address **EP7** at **Standard IM.2.20**.

EP7 requires that policies and procedures include plans for implementation and for electronic information systems. The policies and procedures also need to address data integrity, authentication, nonrepudiation, encryption as warranted, and auditability, as appropriate to the system and types of information (JCAHO, 2003, pp. IM-14).

Surveillance, Prevention, and Control of Infection

There are no changes in the standards in the 2004 Surveillance, Prevention, and Control of Infection chapter. New standards will be released later this year to become effective in January 2005.

Accreditation Participation Requirements

Several changes have also been made in the Accreditation Participation Requirements (APR) requirements in 2004. The APRs addressing Performance Measurement (i.e., APR 4 and APR 7) have been revised to reflect recent policy changes in ORYX re-

quirements for home care and hospice organizations. For example, APR 7 is new and requires that organizations collect and analyze data internally for use in internal quality-improvement activities. APR 5, 6, and 15 are not applicable to home care.

APR 12 is new and prohibits accredited organizations or organizations seeking accreditation from using Joint Commission full-time, part-time, or intermittent surveyors to provide any accreditation-related consulting services.

APR 14 addresses the new Periodic Performance Review (PPR) requirements. Accredited home care and hospice organizations will be required to conduct a full PPR or participate in one of the PPR options mid-point in their accreditation cycle.

Previously, compliance with the six National Patient Safety

Goals (NPSG) was addressed in one APR (i.e., 2003 **APR 12**). In 2004, compliance with the NPSGs has been split into seven individual APRs (i.e., **APR 16** through **APR 22**) and addresses each of the seven NPSGs. APR 19 and NPSG #4 that addresses having a process to eliminate wrong-site, wrong-patient, wrong procedure-surgery is no longer applicable to home care in 2004. NPSG 1, 2, and 3 will be scored at the applicable standard's EP; whereas, NPSG 5, 6, and 7 will be scored at APR 20, 21, and 22, respectively. The results of compliance with each NPSG will be available for public viewing in the Joint Commission's new Quality Report available for surveys conducted beginning in 2004.

Summary

The changes in the 2004-2005 *CAMHC* are significant; some of

the standards' changes are less restrictive and make operational compliance easier and more focused on the organization's requirements, rather than those of the Joint Commission. The majority of new changes in this manual address patient safety and medication management with the focus on doing the right thing for our patients—which is what we want to do anyway. ■

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REFERENCE

Joint Commission on Accreditation on Healthcare Organizations. (2003). *2004-2005 Comprehensive Accreditation Manual for Home Care*. Oakbrook Terrace, IL: Author.

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