

What's New in the 2004 Joint Commission Home Care and Hospice Standards? PART 1

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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 month's Accreditation Strategies column, the first of a two-part series, reviews two chapters and the most significant standards' changes by chapter from the *2004-2005 Comprehensive Accreditation Manual for Home Care (CAMHC)* and addresses the new scoring methodology. Part two (February 2003 *HHN*) will cover additional significant standards' changes.

Changes in Scoring

Each standard now has one or more Element of Performance

(EP). Each EP is scored on a three-point scale: 0 = Insufficient Compliance; 1 = Partial Compliance; 2 = Satisfactory Compliance; and NA = Not Applicable. A score of 1 for partial compliance can also be obtained if full compliance with the track record for an initial or full survey was not met.

A standard is considered not compliant if:

- one or more of its EPs is scored 0; or
- if 35% or more of its EPs are scored 1.

The scoring of each individual EP determines whether the overall standard is judged to be compliant or noncompliant. The total number of noncompliant standards determines the organization's overall accreditation status of Accredited, Conditionally Accredited, or Preliminary Denial of Accreditation.

Element of Performance Categories

Each EP is classified into one of three scoring categories (i.e., A, B, or C). To determine an EP's scoring category, it can be found in the margin of the *2004-2005 CAMHC* just to the left of the scoring scale.

Category A (see Table 1): EPs relate to structural components of the home care or hospice organization that are either present or not present or met or not met.

Category B (see Table 2): EPs may also contain structural components, and have qualitative components in which the quality, adequacy, or comprehensiveness is judged.

If partial or insufficient compliance with an EP is identified during the survey process, the home care or hospice organization needs to demonstrate that good process design principles were considered in the structure or process design and implemented in process.

The principles of good process design are outlined in **Standard LD.4.20** (formerly standard PI.2) and include:

- The needs and expectations of patients, staff and others;
- the results of performance improvement, when available;
- information about potential risks to patients, when available;

Table 1. Category A Scoring

SCORE	ELEMENT OF PERFORMANCE COMPLIANCE	TRACK RECORD	
		Initial Survey	Full Survey
2	Met	4 months or more	12 months or more
		2-3 months	6-12 months
1		2-3 months	6-12 months
0	Not met	Fewer than 2 months	Fewer than 6 months

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Table 2. Category B Scoring

SCORE	GOOD PROCESS DESIGN PRINCIPLES CONSIDERED	TRACK RECORD	
		Initial Survey	Full Survey
2	All applicable principles considered	4 months or more	12 months or more
		Initial Survey	Full Survey
1	Some applicable principles considered	2-3 months	6-12 months
0	Not all applicable principles considered	Fewer than 2 months	Fewer than 6 months

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- current knowledge, when available and relevant (e.g., practice guidelines, successful practices, information from relevant literature and clinical standards);
- information about sentinel event, when available and relevant;
- testing and analysis to determine whether the proposed design or redesign is an improvement; and
- leaders' collaboration with staff and other stakeholders to design services" (JCAHO, 2003, LD-19).

Category C (see Table 3): EPs are considered rate-based or frequency-based observations as the EP is scored based on the number of observations in which the EP is not met. For example, home health aide supervision does not consistently occur every 14 days.

Ethics, Rights, and Responsibilities Chapter

One of the new home care standards is **Standard RI.2.50** which requires that the patient's consent be obtained when patient recording or filming is performed for purposes other than identification, diagnosis, or treatment (JCAHO,

2003). In home care, this commonly occurs when photographing a patient's wound to document the wound size, changes, etc., that may be used for staff education, clinical record documentation, and reimbursement purposes.

The simplest means to meet the intent of EP 1 is to add language to your organization's existing general consent form that gives the organization's staff permission to photograph, film, or audiotape the patient for internal organizational purposes only and have the patient or their legal representative sign the consent on admission prior to rendering care.

If a patient recording or film will be viewed by the general public, a separate written consent must be obtained prior to recording or filming that speci-

fies how it will be used. If a non-employee or contractor records or films the patient and they do not fall under the organization's confidentiality policy, they too must sign a confidentiality statement to protect the patient's identity and confidential information.

One of the *new* patient safety standards is **Standard RI.2.90** which requires that patients, and when appropriate their families, are informed about outcomes of care, treatment, and services, including unanticipated outcomes (JCAHO, 2003). Generally patients are kept informed about their outcomes and overall response to home care and hospice treatment. What makes this standard different is that the patient, or when appropriate, the patient's family must be told about "negative" outcomes of care, treatment, and services that have been provided by the home care or hospice organization. The patient must be aware of the outcome to participate in decisions affecting their care.

For home care and hospice organizations, this means that if an "unanticipated outcome" occurs that is minimally related to one of the sentinel events considered reviewable by the Joint Commission, the patient/

Table 3. Category C Scoring

SCORE	ELEMENT OF PERFORMANCE NONCOMPLIANCE	TRACK RECORD	
		Initial Survey	Full Survey
2	No or one instance of noncompliance	4 months or more	12 months or more
		Initial Survey	Full Survey
1	Two instances of noncompliance	2-3 months	6-12 months
0	Three or more instances of noncompliance	Fewer than 2 months	Fewer than 6 months

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family must be informed by an organizational leader that this “unanticipated outcome” occurred.

Sentinel events considered reviewable by the Joint Commission would include an occurrence that meets any of the following criteria:

- The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient’s illness or underlying condition, or
- The event is one of the following (even if the outcome was not death or major permanent loss of function unrelated to the natural course of the patient’s illness or underlying condition):

New Standard RI.2.90 requires that patients, and when appropriate their families, are informed about the positive and negative outcomes of care, treatment, and services, including unanticipated outcomes before participating in care decisions.

1. Suicide of a patient in a setting where the patient receives around-the-clock care.
2. Unanticipated death of a full-term infant (and the patient is an infant).
3. Infant abduction (and the patient is an infant).
4. Rape.
5. Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities.

Even though this is a new standard, it should not impact home care or hospice organization’s operations as staff are already keenly aware and astute to the possibility of patient abuse, neglect, and exploitation and refer these cases to the state’s protective service agencies.

Of the three new ethics, rights, and responsibilities standards discussed, the only one that is significantly different for home care and hospice organizations is that of informing the patient and families of “unanticipated outcomes” which hopefully won’t occur too often, if at all.

Additional qualifying information about the above criteria may be found on the Joint Commission’s Web site at: http://www.jcaho.org/accredited+organizations/home+care/sentinel+events/se_pp.htm#4.

The home care standards have always addressed the patient’s right to security (2003 standard RI.6) and required an assessment for alleged abuse or neglect. However, **Standard RI.2.150** now specifically includes the patient’s right to be free from mental, physical, sexual, and verbal abuse, neglect, and exploitation. To the best of the home care or hospice organization’s ability, the patient is to be protected from real or perceived abuse, neglect, or exploitation from anyone, including staff, students, volunteers, other patients, visitors, or family members.

Provision of Care Chapter

This *new* chapter title is a compilation of standards from the former Assessment; Care, Treatment and Services (except standards addressing medication), Education and Continuum of Care chapters, and does contain a few new requirements. One significant change is the standards and former bulleted items have been greatly condensed and consolidated.

For example, the *2003 CAMHC* contained 17 standards that addressed patient/family education; the *2004-2005 CAMHC* lists only two standards that address patient education. In the *2004-2005 CAMHC* **Standard PC.6.10 (EP 3)** has 14 bulleted items that previously were stand-alone education standards. In the *2003*



2004-2005 CAMHC Chapters addressed this month:

- Changes in Scoring
- Ethics, Rights, and Responsibilities
- Provision of Care

2004-2005 CAMHC Chapters to be addressed next issue:

- 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

CAMHC, an education standard may have contained numerous bulleted items that the surveyor would review for compliance. Another example, 2003 **Standard PF.3.1** required that as appropriate, the patient and family be educated on 14 aspects of safe and effective medication use.

Standard PC.6.10 still requires that the patient and family be educated on the safe and effective use of medications, but all of the specific components of this education are no longer listed out in the Provision of Care chapter. Some of the education requirements related to medication are now in the Medication Management Chapter at **Standard MM.5.20**. This same principle of stan-

dards' consolidation and simplification holds true for the other standards in the Provision of Care Chapter.

In the standards that address waived testing, new items that were not in the 2003 *CAMHC* are noted at **Standard PC.16.10** in **EP2** and **EP3**.

In standard PC.16.40 there are new requirements:

- in EP 1 that the policies and procedures address specimen identification and if there is any required labeling, and
- in EP 4, that the Director named on the waived testing certificate or designee approve waived testing policies and procedures at defined intervals.

In February's column eight more Chapters will be reviewed noting the changes and new standards from the 2004-2005 *CAMHC*. ■

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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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