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The Source™

FOR JOINT COMMISSION COMPLIANCE STRATEGIES

Addressing the Rise in US Maternal Mortality Rates

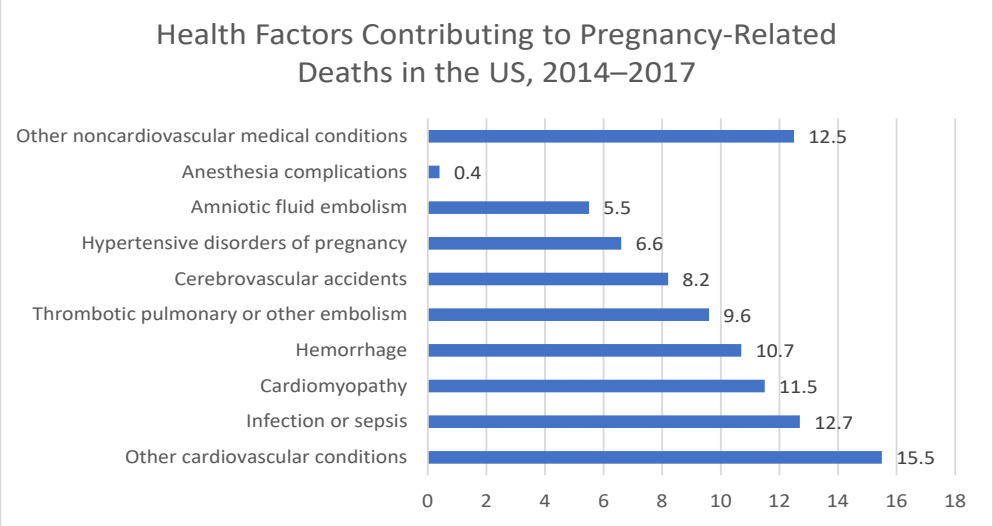
WHAT HEALTH CARE LEADERS CAN DO TO HELP REVERSE THIS TREND

For several years, the United States has held the dubious distinction of having the highest maternal mortality rate among developed countries. According to a recent report from the National Center for Health Statistics, that rate increased by 18% in 2020. The report reveals that in 2020, 861 pregnant or postpartum patients died from pregnancy-related causes in the US compared to 754 in 2019, pushing the already high maternal mortality rate from 20.1 maternal deaths per 100,000 live births in 2019 to 23.8 in 2020.

There is little doubt the COVID-19 pandemic has contributed to this rise. A large cohort study conducted in US medical centers and community affiliates found that pregnant patients giving birth with COVID-19 had higher rates of mortality, intubation, ICU admission, and preterm birth than pregnant patients without COVID-19. The question remains: What accounts for the rates of maternal mortality in the US, and what can health care leaders do about it?

Reasons for This Trend

According to the Centers for Disease Control and Prevention (CDC), certain medical conditions are on the rise in the US that put patients at higher risk of complications during pregnancy or postpartum. These include such chronic health conditions as hypertension, diabetes, and heart disease. Health factors that contributed to pregnancy-related deaths in the US from 2014 to 2017 are shown in the figure.



Source: Centers for Disease Control and Prevention, Division of Reproductive Health. Pregnancy Mortality Surveillance System. Nov 25, 2020. Accessed Apr 6, 2022. https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm.

But there may be other contributing factors. A 2020 report from The Commonwealth Fund compared obstetric care in the US to 10 other developed countries and identified the following[1]:

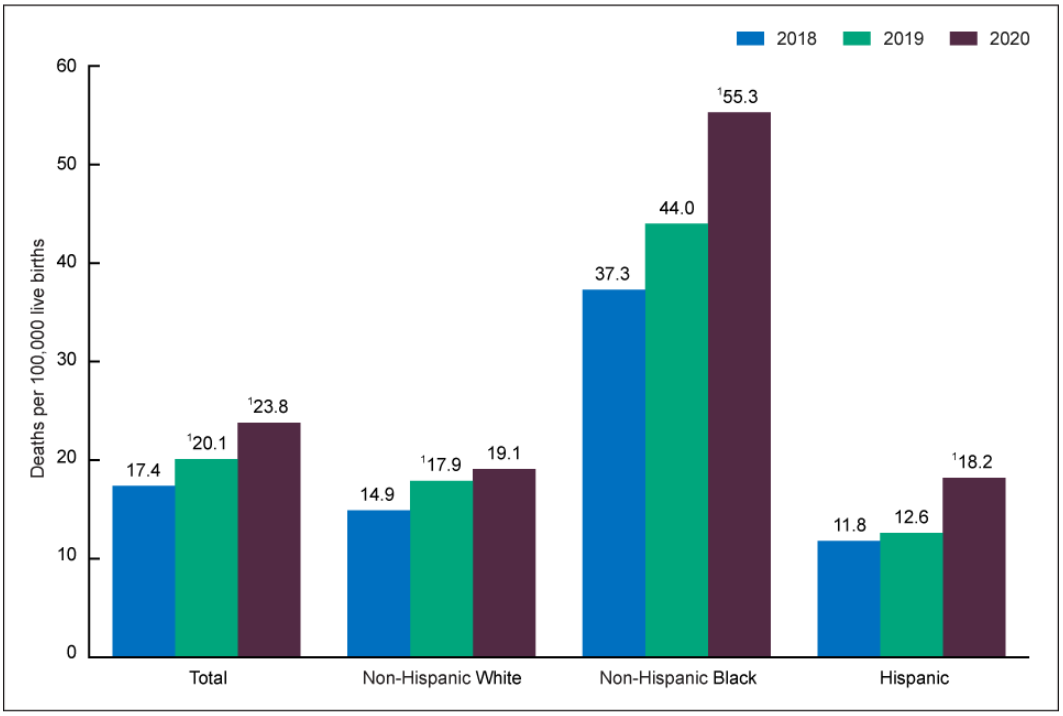
- **An overall shortage of obstetric care providers in the US, particularly midwives, relative to the number of births.**
- **Lack of postpartum care.** In the US, recommended follow-up care is, on average, six weeks postpartum. All other developed countries included in the report guarantee at least one visit from a nurse or midwife within one week postpartum.
- **Lack of guaranteed paid maternity leave.** Although a few states have recently introduced paid maternity leave, the US is the only high-income country that does not guarantee all postpartum patients paid maternity leave.
- **Racial and ethnic disparities in health.** Certain demographics face higher rates of pregnancy-related mortality than others. According to the CDC, between 2014 and 2017, the pregnancy-related mortality rates per 100,000 live births by ethnicity were as follows:
  - 41.7 deaths for non-Hispanic Black pregnant or postpartum patients
  - 28.3 deaths for non-Hispanic American Indian or Alaska Native pregnant or postpartum patients
  - 13.8 deaths for non-Hispanic Asian or Pacific Islander pregnant or postpartum patients
  - 13.4 deaths for non-Hispanic white pregnant or postpartum patients
  - 11.6 deaths for Hispanic or Latinx pregnant or postpartum patients

The COVID-19 pandemic only exacerbated existing racial disparities in pregnancy-related outcomes. During the pandemic, the rate of death for Black and Hispanic pregnant or postpartum patients rose significantly, while the rates for their white counterparts rose only slightly, as shown in the figure below. This racial and ethnic disparity in maternal mortality rates may be due to several factors, including access to care, quality of care, prevalence of chronic diseases, structural racism, and implicit biases.[2–4]

Patient Safety Efforts to Reverse This Trend

Health care delivery systems continue to look for ways to reverse the rising rates of maternal mortality. The Joint Commission evaluated the literature to determine which areas of intervention show the greatest potential for improving the quality and safety of care to patients at all stages of pregnancy and postpartum care. As a result, it introduced new standards that became effective January 2021 designed to address two of the identified contributors to maternal mortality and morbidity: hemorrhage and severe hypertension/preeclampsia. An *R³ Report* describes in detail 13 standards and elements of performance that apply to Joint Commission–accredited hospitals. The report includes the rationale for these requirements as well as supporting references. According to Joint Commission data, the

Maternal Mortality Rates by Race/Ethnicity in the US, 2018–2020



[1]Statistically significant increase in rate from previous years ($p < 0.05$).
Note: Race groups are single race.
Source: Hoyert DL. Maternal Mortality Rates in the United States, 2020. NCHS Health E-Stats. Feb 23, 2022. Accessed Apr 6, 2022. https://dx.doi.org/10.15620/cdc:113967.

satisfactory compliance rate for these new requirements was between 96.84% and 100% on hospital surveys conducted in 2021, indicating that health care organizations are making great strides in efforts to improve care for this patient population. Many organizations were fully prepared to implement interventions to address hemorrhage and severe hypertension/preeclampsia.

To proactively prevent death from postpartum hemorrhage (defined by the American College of Obstetrics and Gynecologists (ACOG) as a cumulative blood loss of greater than or equal to 1,000 mL, or blood loss accompanied by signs or symptoms of hypovolemia, within 24 hours after the birth process), The Joint Commission requires each obstetric unit to have a standardized, secured, dedicated hemorrhage supply kit that must be stocked per the organization's defined process. At a minimum, the kit should contain emergency hemorrhage supplies as determined by the organization and the organization's approved procedures for severe hemorrhage response. In its obstetric hemorrhage patient safety bundle, the Council on Patient Safety in Women's Health Care lists some recommendations for improved outcomes:

- **Readiness in every obstetric unit:** Establish a response team and supply kit that provides immediate access to hemorrhage medications, along with role-specific education, policies, protocols, drills, and debriefs on hemorrhage response procedures.

- **Recognition and prevention for every patient:** Assess hemorrhage risk at prenatal, on admission, and at all other appropriate times and educate patient and family on signs and symptoms of postpartum hemorrhage in the hospital and at home after discharge.
- **Response to every hemorrhage:** Develop an obstetric hemorrhage management plan that provides guidance on how to communicate with patients and families.
- **Reporting/systems learning in every unit:** Implement a system for huddles and post-event debriefs and monitor outcomes and processes to identify successes and opportunities for improvement.

To address safety concerns related to hypertension and preeclampsia, The Joint Commission added staff, patient, and family education requirements to help patients understand their hypertension/preeclampsia diagnosis. The rationale is to encourage patients to inform health care providers of their pregnancy history when they seek care to ensure correct diagnosis and comprehensive care.

Although it is up to each organization to identify the necessary supplies and processes that best serve their patients, a study published in the February 2022 issue of *The Joint Commission Journal on Quality and Patient Safety (JQPS)* suggests that keeping a postpartum hemorrhage cart and medication kit conveniently placed in labor and delivery (L&D) units significantly reduces the time needed to obtain essential materials to treat obstetric hemorrhage, enabling health care teams to initiate treatment sooner, which can save lives (*see* the infographic on pages 8–9).

Another way The Joint Commission is helping organizations combat maternal mortality and morbidity is through its Maternal Levels of Care Verification program, developed in collaboration with ACOG.

Maternal Levels of Care Verification Program

Through Maternal Levels of Care Verification, Joint Commission experts provide an objective assessment of a facility's capabilities. By verifying that a hospital treats only the patients it has the expertise, equipment, and resources to care for, this program facilitates safe, successful births and more positive pregnancy-related outcomes.

The program was developed using ACOG's Levels of Maternal Care Obstetric Care Consensus (OCC) document, which includes comprehensive uniform definitions, a standardized description of maternity facility capabilities and personnel, and a framework for integrated systems that address pregnant or postpartum patients' health needs. The program aims to reduce pregnancy-related morbidity and mortality by encouraging systems that help standardize risk-appropriate care from the most basic maternal care to the most complex.

Examining the Key Differences in US Perinatal Care

The Commonwealth Fund issue brief describes some key differences in perinatal care that set the US apart from other developed countries. First, in many

developed countries, midwives play a key role managing pregnancies, assisting with childbirth, and providing care during the postpartum visit. However, the US and Canada have the lowest overall supply of obstetrician-gynecologists (ob-gyns) and midwives—12 to 15 providers per 1,000 live births. Most developed countries have between two and six times that many, and often midwives outnumber ob-gyns. This is key, as the World Health Organization (WHO) recommends midwives as an evidence-based approach to reducing maternal mortality.[5]

In the US, private insurance companies rarely cover postpartum care, although some states do provide it for Medicaid beneficiaries.[6–7] Postpartum care visits in the home address not only medical conditions but also mental health and social determinants of health, such as access to food, safe housing, substance use, and domestic violence. All countries included in the brief, except the US, guarantee at least one home visit by a nurse or midwife within one week postpartum.

Of all the countries in the world classified by the World Bank as high-income, the US is the only one with no national policy guaranteeing paid leave to employed patients who give birth. Yet, according to an article in *Maternal and Child Health Journal*, patients who took paid maternity leave experienced a 51% decrease in the odds of being rehospitalized at 21 months postpartum compared to patients taking unpaid or no leave. These data support much-needed policy changes aimed at access to paid maternity and family leave in the US, which may help reverse the rising maternal mortality and morbidity trends.

Finally, social determinants of health, including racial disparities, account for a dramatic variance in maternal mortality rates in the US. Health care organizations can address social determinants of health and help change policies for care in several ways.

Health Care Leaders Can Drive Policy Efforts

The reasons for rising maternal mortality rates in the US are multifaceted. In addition to addressing chronic health issues that may contribute to maternal mortality rates, health care leaders must also address access to care and social determinants of health. A report from the National Academies of Sciences, Engineering, and Medicine addresses some strategies health care organizations can use to address social determinants of health, including the following:

- **Awareness:** Identify the social risks and assets of the patients and patient populations served.
- **Adjustment:** Pursue a strategy that focuses on adjusting the care provided to consider social determinates of health, such as providing or expanding telehealth to increase access to care, particularly in rural areas.
- **Assistance:** Connect patients with social needs to government and community resources.
- **Alignment:** Pursue a strategy that evaluates social care resources that exist in the community and organize those resources to promote teamwork across organizations.

- **Advocacy:** Form alliances with social care organizations to advocate for policies that create and distribute resources where needed. Health care organizations can leverage their political, social, and economic capital within a community to call for policy changes that improve transportation services, for example.

Disparities in health care are not unique to the US. Achieving equity in care is a global challenge, but efforts to close the gaps in health care will invariably help to reduce the overall maternal mortality rates in the US. Improving outcomes related to pregnancy should be a priority for all health care organizations and policy makers alike. As pregnancy-related outcomes continue to remain poor in the US—relative to the rest of the developed world—health care leaders should look to international perinatal care models for improvements and to advocate for change in US health policies. TS

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Journal on Quality and Patient Safety®

Postpartum Hemorrhage Cart and Medication Kit Improves Response Time

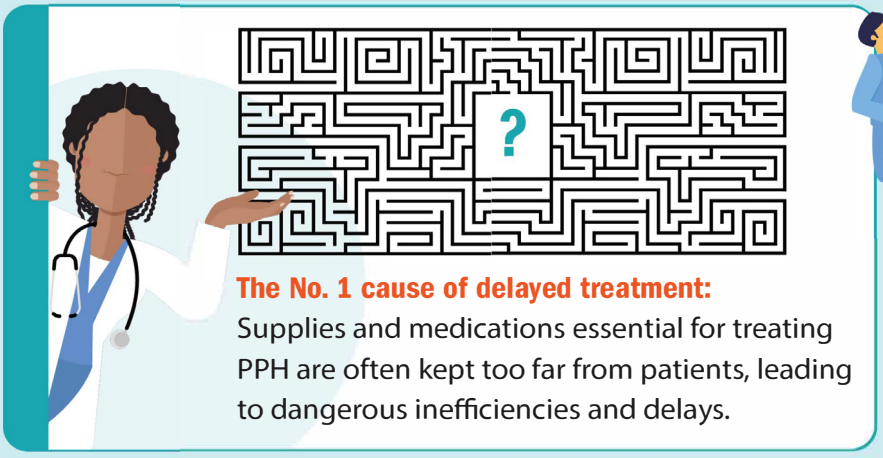
High maternal mortality rates continue to be a problem. And postpartum hemorrhage (PPH) is the leading cause of maternal morbidity in the United States. Because delayed treatment of PPH contributes to morbidity and mortality, timely treatment is imperative.

A study from the February 2022 issue of *The Joint Commission Journal on Quality and Patient Safety (JQPS)* suggests that keeping a PPH cart and medication kit conveniently placed in labor and delivery (L&D) units significantly reduces the time needed to obtain essential materials to treat obstetric hemorrhage, enabling health care teams to initiate treatment sooner, which should improve outcomes.

Maternal mortality rates in the U.S. have risen since the 1980s.

PPH is the leading cause of maternal morbidity and leading contributor to maternal mortality in the U.S. Globally, PPH leads to ~140,000 deaths annually.

Hemorrhage affects 3–5% of deliveries



The No. 1 cause of delayed treatment: Supplies and medications essential for treating PPH are often kept too far from patients, leading to dangerous inefficiencies and delays.

Timely treatment of PPH is imperative. Every second of delay can lead to significant blood loss, increasing morbidity and mortality.

L&D units should maximize PPH response efficiency by reducing time spent and distance traveled to accumulate materials necessary for PPH treatment.

Using Lean Six Sigma tools, the study team constructed a process map to chart the time and distance needed to collect items.

INTERVENTION 1:

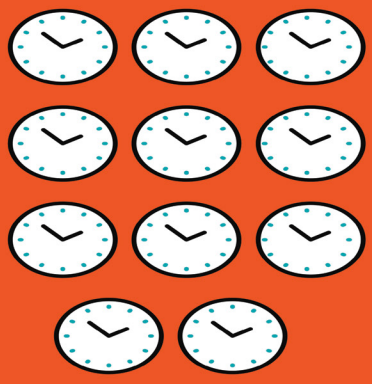
A five-drawer, moveable cart was created containing the supplies most used in response to PPH and positioned in a central, easily accessible location.

INTERVENTION 2:

A medication kit was added to the cart with a refrigerated box of all medications typically administered during a PPH.

ORIGINAL

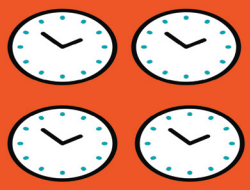
11 minutes 5 seconds



4,092 feet traveled

AFTER INTERVENTION 1

4 minutes



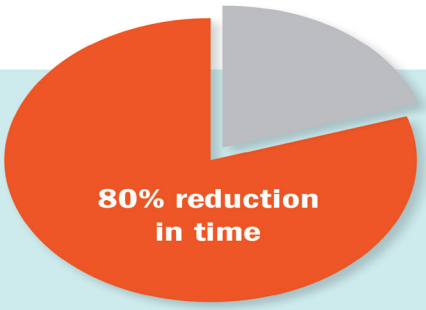
918 feet traveled

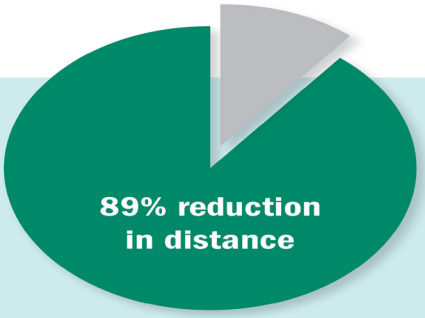
AFTER INTERVENTION 2

2 minutes and 14 seconds

462 feet traveled

Together, the interventions reduced the time to acquire a list of PPH response materials from **11 minutes 5 seconds to 2 minutes 14 seconds** and **reduced distance traveled by 3,630 feet**.





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A PPH cart and medication kit can significantly reduce the time and distance traveled to obtain materials necessary to treat hemorrhage, thus optimizing a team's ability to efficiently treat PPH.

To learn more about this study, visit:
https://www.jointcommissionjournal.com/article/S1553-7250(21)00240-3/fulltext

Navigating Joint Commission Post-Survey Decisions

By Andrea Coffaro, MBA, Senior Associate Director, Accreditation and Certification Operations, Joint Commission; and Lisa DiBlasi Moorehead, EdD, MSN, RN, CENP, CPPS, CJCP, Associate Nurse Executive, Accreditation and Certification Operations, Joint Commission

Health care organizations invest a great deal of time and resources into preparing for a Joint Commission accreditation survey. This is because during a survey, an organization must be prepared to *provide evidence* of compliance with applicable standards and *demonstrate compliance* with corresponding elements of performance (EPs). In conjunction with standards and EPs, organizations are evaluated on other Joint Commission requirements, including accreditation participation requirements, performance measurement data requirements (when applicable), and Joint Commission National Patient Safety Goals (NPSGs). For all accreditation programs, information on the policies that govern processes before and during surveys is in "The Accreditation Process" (ACC) chapter of *Comprehensive Accreditation Manual*s and corresponding E-ditions.® But what happens after the survey? What types of accreditation decisions might health care organizations expect? What are the reasons for various scoring decisions?

There are many reasons that an organization may not achieve full compliance and/or accreditation. This article answers those questions and provides organizations with a road map for managing expectations and navigating next steps following a Joint Commission survey. Summarized are key processes for accreditation surveys with the following post-survey decisions:

- Requirements for Improvement (RFIs)
- Medicare Condition-Level Deficiencies
- Immediate Threat to Health or Safety (ITHS)
- Preliminary Denial of Accreditation (PDA)
- Accreditation with Follow-up Survey

The important thing to remember is The Joint Commission's post-survey process is designed to guide organizations to full compliance with all requirements and to help them sustain compliance over time.

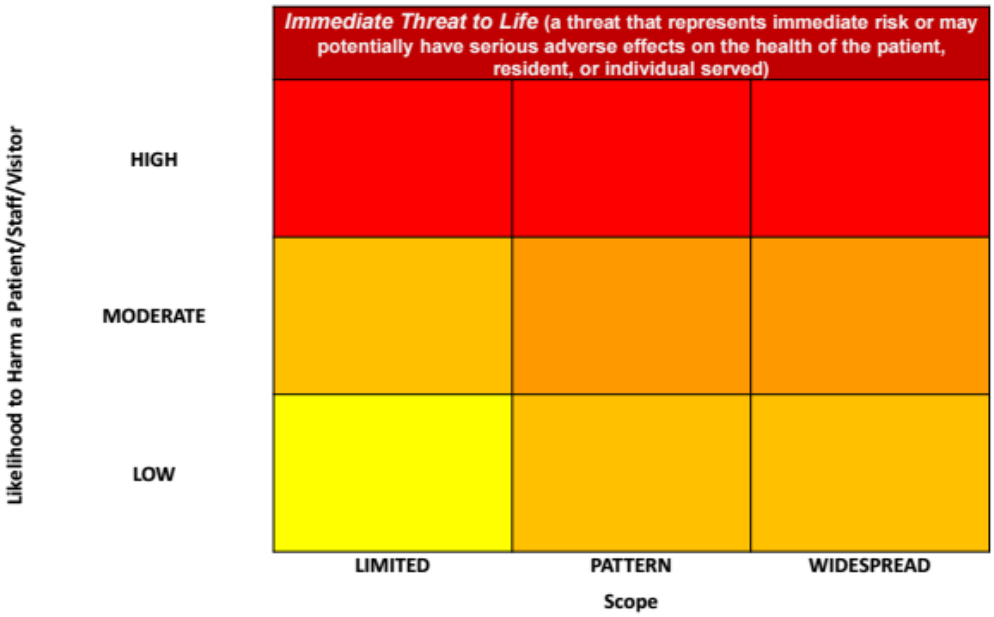
Requirements for Improvement

When a surveyor identifies Requirements for Improvement (RFIs), the organization must submit an Evidence of Standards Compliance (ESC) document within 60 days of the final accreditation report posting. Final reports are posted to an organization's secure extranet site (*Joint Commission Connect*®) within 10 business days following the survey. Organizations have the option to attempt to clarify or remove RFIs from the accreditation report (details on how to clarify an RFI are included in the accreditation manual).

The purpose of an ESC report is to allow the organization to provide detailed evidence of the action(s) taken to comply with a requirement that was scored out of compliance during the survey. An acceptable ESC report must include the following:

- Compliance at the EP level
- Action(s), along with the final date of such action(s), that the organization took to bring itself into compliance with a requirement
- Title of the staff member ultimately responsible for implementing the corrective action(s) and sustaining compliance
- The plan for sustaining compliance
- Leadership involvement in the corrective action and sustained compliance plan (for RFIs considered higher risk*)
- Preventive analysis (for those RFIs considered higher risk*)

*Note: Higher risk RFIs are those placed on the *Survey Analysis for Evaluating Risk®* (*SAFER®)* Matrix in the categories of Moderate Risk and Pattern Scope and Moderate Risk and Widespread Scope and in the High-Risk categories. This tool, shown below, helps organizations understand the risk of compliance deficiencies identified during the accreditation survey.



It is important to note that *clarification* is not the same as *having the finding removed*. When clarifications are submitted, they are reviewed and, in some cases, may result in an RFI being removed if the clarification is considered acceptable by the review team. Examples of acceptable clarifications and suggestions for writing them were published in the February 2022 issue of *Perspectives*.

Medicare Condition-Level Deficiencies

For organizations that use The Joint Commission to evaluate Centers for Medicaid & Medicare Services (CMS) Conditions of Participation (CoPs), a Medicare deficiency survey is scheduled following a survey decision of noncompliance with CoPs at a more severe risk or widespread level—commonly called condition-level deficiencies.

After a condition-level deficiency is found, a follow-up Medicare deficiency survey must occur within 45 calendar days. These surveys evaluate whether the deficiency has been fixed. Corrective actions need to be in place for RFIs linked to condition-level deficiencies within 45 calendar days instead of the 60 days described above. A longer time frame for correction is given for RFIs having less severe risk and less widespread impact. Less severe risks and those with less widespread impact are commonly referred to as standard-level deficiencies.

The accreditation survey report includes a table indicating the time frame for completing ESCs. RFIs associated with condition-level deficiencies must be resolved and in full compliance at the 45-day survey. An example of a survey report is shown in the table below. In this example, the organization must demonstrate compliance with Environment of Care (EC) Standards EC.02.01.01, EP 5, and EC.02.02.01, EP 12 within 45 days to be compliant during the Medicare deficiency survey. The ESC report that describes corrective actions for these two RFIs may be submitted as part of the overall ESC report within 60 days.

Survey Report Follow-up Summary

Standard	EP	*SAFER*® Placement	CoP	Tag	Included in the Medicare Deficiency Survey (within 45 calendar days)	Included in the Evidence of Standards Compliance (within 60 calendar days)
EC.02.01.01	5	Moderate / Limited	§482.41(a)	A-0701	✓	✓
EC.02.02.01	12	Moderate / Limited	§482.41(a)	A-0701	✓	✓
	5	Low / Limited				✓
EC.02.03.01	9	Low / Limited	§482.15 (d)(1)(i)	E-0037		✓

Immediate Threat to Health or Safety

An Immediate Threat to Health or Safety (ITHS) is declared on a survey when an immediate risk with potential for serious adverse effects on the health or safety of a patient, resident, or individual served is identified. An organization must take immediate steps to mitigate or abate such risks prior to the survey team's departure. This could mean, for example, that the organization must stop performing a certain procedure or implement additional safety measures. Any RFIs that contribute to the ITHS decision cannot be clarified.

Organizations with an ITHS can expect another survey within 23 days from the last survey to validate that any RFIs linked to the ITHS have been corrected and patients

are no longer at risk for serious harm. In addition, a 45-day ESC—different from the typical 60-day ESC—is required to address all other RFIs identified by the surveyor during the initial survey.

Deemed organizations with an ITHS may also have condition-level deficiencies. In this case, additional follow-up activities outlined above in the Medicare condition-level deficiencies section would also apply. In addition, processes for an Accreditation with Follow-up Survey, discussed below, may also apply.

Preliminary Denial of Accreditation

A Preliminary Denial of Accreditation (PDA) decision is given when any of the following occur:

- An ITHS affecting patients, staff, or visitors exists (not all PDA decisions require an immediate threat).
- Significant noncompliance with Joint Commission standards (see explanation below)
- Failure to resolve the requirements of an Accreditation with Follow-up Survey after two opportunities to do so
- Submission of falsified documents or misrepresented information
- Lack of a required license or similar issue at the time of survey

A PDA decision that results from significant noncompliance with Joint Commission standards (commonly referred to as PDA02), requires organizations to submit a Plan of Correction within 10 business days from the day the final accreditation report is posted. A validation survey will occur within 60 calendar days from the final report posting. The surveyor will evaluate compliance with all RFIs found out of compliance during the originating survey. An Accreditation with Follow-up Survey will occur approximately 4 to 6 months after a successful validation survey to evaluate sustained compliance.

Accreditation with Follow-up Survey

The Accreditation with Follow-up Survey decision typically requires a follow-up survey to assess sustained compliance approximately 4 to 6 months after an acceptable ESC submission or a final decision is rendered.

Strategies for Sustaining Compliance

In addition to the ESC process, an Intracycle Monitoring (ICM) process helps organizations at various milestones in the accreditation cycle with continuous compliance efforts. An organization's ICM profile is available on the *Joint Commission Connect*® extranet site and identifies high-risk areas and related standards areas and displays them within a Focused Standards Assessment (FSA) tool. This tool helps organizations conduct a self-assessment of compliance and manage risks in their organizations.

Organizations may also schedule a Joint Commission surveyor to conduct this assessment. An ICM assessment is optional for organizations without a PDA02

accreditation decision and may be submitted to The Joint Commission at the 12th and 24th months following the accreditation survey.

Heads-Up Reports are accreditation program tools published by The Joint Commission and made available on the organization's extranet site (*Joint Commission Connect*, Continuous Compliance Resources Section). These reports highlight frequently scored, high-risk findings along with contributing factors and compliance improvement strategies.

Compliance resources are available through various Joint Commission portals, accessible at https://www.jointcommission.org/ under Resources, or Patient Safety Topics). Portals for high-risk areas, including workplace violence, suicide risk, pain management, infection prevention and control, and emergency management, offer ongoing tips for improving and sustaining compliance in these areas.

As patient safety issues are identified—in the literature, through sentinel events, via compliance data, or during survey activities—The Joint Commission publishes *Quick Safety* newsletters and *Sentinel Event Alert*s. Both publications define patient safety issues and provide additional resources to mitigate associated risks. Recent titles address health disparities, smart infusion pumps, and cybersecurity, to name a few.

The Joint Commission's Standards Interpretation Group (SIG) is available to answer questions related to standards requirements through the "Ask SIG" function on The Joint Commission's website. Frequently asked questions (FAQs) about standards interpretation are regularly published on the website.

Finally, all organizations seeking accreditation are assigned an account executive. These individuals help guide organizations through each step of the accreditation process—before, during, and after—and they have experience and expertise in post-survey processes. TS

Compliance Improvement

MEDICATION RECONCILIATION IN HOME CARE

According to an article in *HomeCare* magazine, elderly patients in home care are particularly at risk for adverse effects from medication errors. These patients routinely take more than five prescription drugs for a variety of medical issues. Medications are frequently prescribed by different physicians and often include over-the-counter medications. Due to a less structured care environment, medication errors frequently occur in the home care setting.

Medication reconciliation—a comprehensive assessment of all the medications a patient is taking—is done to prevent common medication errors, such as omissions, duplications, dosing errors, or drug interactions. The process involves ensuring proper documentation of medication in all patient medical records, which is critical for safe care. Conflicting or missing information between the patient's medications and clinical documentation of those medications can lead to inappropriate care and serious adverse drug events.

Joint Commission data reveal that many home care agencies struggle to comply with Record of Care, Treatment, and Services (RC) Standard RC.02.01.01, Element of Performance (EP) 2, which requires the patient record to contain clinical information that ***[accurately]*** reflects the patient's care, treatment, or services. For the past two years, this requirement has been among the top 10 standards cited for noncompliance in the home care setting. In fact, 25.45% of home care organizations surveyed in 2021 were scored out of compliance with this requirement, and nearly 10% also failed to comply with National Patient Safety Goal (NPSG) Standard NPSG.03.06.01, EP 1 (see standards box below for relevant requirements).

NPSG.03.06.01 Maintain and communicate accurate patient medication information.

EP 1 Obtain and/or update information on the medications the patient is currently taking. This information is documented in a list or other format that is useful to those who manage medications.

Note 1: The organization obtains the patient's medication information during the first contact. The information is updated when the patient's medications change.

Note 2: Current medications include those taken at scheduled times and those taken on an as-needed basis. See the Glossary for a definition of medications.

Note 3: It is often difficult to obtain complete information on current medications from a patient. A good faith effort to obtain this information from the patient and/or other sources will be considered as meeting the intent of the EP.

RC.02.01.01 The patient record contains information that reflects the patient's care, treatment, or services.

EP 2 The patient record contains the following clinical information:

- Any medications administered, including dose
- Any activity restrictions
- Any changes in the patient's condition
- Any summaries of the patient's care, treatment, or services furnished to the patient's physician or allowed practitioner
- The patient's medical history
- Any allergies to medications
- Any adverse drug reactions
- The patient's functional status
- Any diet information or any dietary restrictions
- Diagnostic and therapeutic tests, procedures, and treatments, and their results
- Any specific notes on care, treatment, or services
- The patient's response to care, treatment, or services
- Any assessments relevant to care, treatment, or services
- Physician or allowed practitioner orders
- Any information required by organization policy, in accordance with law and regulation
- A list of medications, including dose, strength, frequency, route, date and time of administration for prescription and nonprescription medications, herbal products, and home remedies that relate to the patient's care, treatment, or services
- The plan(s) of care
- For DMEPOS [durable medical equipment, prosthetics, orthotics, and supplies] suppliers serving Medicare beneficiaries: The DMEPOS prescription, any certificates of medical necessity (CMN), and pertinent documentation from the beneficiary's prescribing physician or allowed practitioner.

Note 1: For organizations that provide personal care and support services: The plan of care may be a part of the service agreement or service contract, a list of duties to be carried out by the personal care or support service staff, or another separate document.

Note 2: For organizations that provide personal care and support services: The patient record contains the documentation on the list noted above that applies to the care, treatment, or services provided by the personal care and support staff. (*See also* PC.01.02.01, EP 1; PC.01.03.01, EP 23.)

Surveyor Observations

High-risk findings from Joint Commission surveyors reveal medication reconciliation errors in the home care setting, including the following:

- The agency's patient medication list did not correspond with the medications the patient was actually taking. For example, the list did not include PRN (*pro re nata*, which means "not scheduled or as needed") medications, such as over-the-counter pain relievers, including topical nonsteroidal anti-inflammatory drugs (NSAIDs), which can lead to gastrointestinal upset and bleeding.
- The patient medication record did not match what the patient reported or what was observed by the surveyor. For example, the record indicated ibuprofen every 8 hours, but the patient was taking it as needed.
- The clinical record was not current and failed to reflect the patient's current treatment. For example, the record indicated the patient was taking a blood thinner, when in fact the physician order to discontinue the blood thinner was not updated in the clinical record.

Factors that contribute to such reconciliation errors include failure to document verbal orders in the record of care; unclear or absent processes, policies, and procedures that ensure patient records accurately reflect care; and failure to identify the person(s) responsible for maintaining the medical record. These details should be included in the organization's written policies and procedures.

Understanding the Process

When properly done, the medication reconciliation process involves three steps:

1. Verification, or collecting an accurate medication history.
2. Clarification, or ensuring that medications and doses are appropriate for the patient.
3. Reconciliation, or documenting all changes to ensure that they reflect all medications the patient is currently taking.

Capture All Medications

Medication reconciliation begins with an accurate list of medications. Some organizations use a standardized form that facilitates capturing and verifying medications to create an accurate list of the patient's medications, which is accessible and visible to staff. When taking a medical history, staff should ask questions about the items listed in the table below.

Tips for Obtaining Medication Information	
Obtain or verify patients' medications by asking about all the following:	**Capture patients' full dosing information for all medications, including the following:**
• Prescription medications • Over-the-counter (OTC) drugs • Vitamins and nutraceuticals/health supplements • Herbal remedies • Respiratory therapy–related medications (inhalers)	• Name of medication • Strength • Formulation (extended release, controlled delivery, and so forth) • Dosage • Route • Frequency • Last dose taken

Incorporating probing questions into the patient interview, such as the following, can help trigger patients' memory about what medications they are taking and help staff capture an accurate medication list:

- Use both open-ended and closed-ended questions: "What do you take for your high cholesterol?" "Do you take medication for high cholesterol?"
- Ask patients about routes of medication administration: "Do you put any medications on your skin?" Patients often forget to mention topical ointments, skin patches, or inhalers, for example.
- When asking about OTC drugs, additional prompts may be useful, including the following:
  - What do you take when you get a headache?
  - What do you take for allergies?
  - Do you take anything for heartburn?

Clarify Medications

Clearly understanding how to obtain a complete medication history is critical. This involves knowing what medications and doses are appropriate for the patient. Staff should receive ongoing training to maintain and improve competency in the reconciliation process. Staff should also understand how to monitor changes in a patient's medication or treatment regimen and how to document those changes in the patient's record. This includes regular review of charts at several points of care (initial, reassessment, discharge) as well as close attention to medications that may frequently change, such as insulins or anticoagulants. In addition, during home care visits, a patient's medication profile in the record of care should be compared to medications in the home. This helps monitor medication use and ensures that discontinued medications are removed.

Educate Patients and Family Caregivers

When patients understand their medication's purpose—and what results they can expect—they are more inclined to follow their medication regimen. During home visits, qualified staff should be able to evaluate the patient's (or caregiver's)

understanding of all medications taken. Methods for assessing patient/caregiver comprehension include the “show me” and the “teach back” methods, to name a few.

A resource from the Home Health Quality Improvement National Campaign describes the show-me method as effective for determining whether patients can demonstrate **how** to take their medication and whether they can open pill bottles or administer medications as prescribed. This method goes beyond a conversation to help determine whether patients can in fact do what they say they can do. After staff educate patients or caregivers, the teach-back approach can help staff assess comprehension of instructions. This approach asks patients to describe, in their own words, instructions that staff have explained to them. This technique captures the patient’s understanding and decision-making abilities. Both techniques invite opportunities for staff to educate and evaluate patient comprehension, particularly about high-risk medications, potential side effects, and possible drug interactions.

Identify Responsibility for the Process

Leadership should identify team roles and clarify who on the care team is responsible for the information in the medical record. Is it the registered nurse, the physical or occupational therapist, someone else, or several people? It may be helpful to identify a standard location for the medication history. It is also important to establish a time frame for resolving variances in the record of care as well as how to document medication changes. Such processes help eliminate omissions, duplication of efforts, and confusion and help mitigate inconsistency in clinical documentation.

Develop and Implement an Audit Process

Home care agencies should have a plan to audit both open and closed patient records to identify potential for, or actual, adverse drug events associated with failures in the medication reconciliation process. Routine review of patient records and observation of a medication reconciliation process during a home visit can help leaders ensure oversight of clinical documentation. Regular review of records of care (whether paper or electronic) allow home health agencies to verify that all relevant information is documented. Finally, audit processes help all health care providers identify areas for improvement, reduce errors, and improve patient safety. TS

Top News

A Digest of Accreditation and Health Care News

Nurse and Health Care Economist Addresses the US Nursing Shortage

The ongoing COVID-19 pandemic has had many negative effects on the health care industry, among them is the strain placed on frontline staff, including nurses. As hospitals have been overwhelmed by patients with COVID-19, many nurses have decided to leave hospital care, work in temporary positions, or have retired from the profession, prompting a critical nursing shortage across the United States.

In a recent interview with David Baker, MD, MPH, FACP, Editor-in-Chief of *The Joint Commission Journal on Quality and Patient Safety*, Peter Buerhaus, PhD, RN, FAAN, Professor, College of Nursing at Montana State University, and Director of the Center for Interdisciplinary Health Workforce Studies, offers a unique perspective on the current nursing shortage.

Buerhaus, who has studied nursing workforce trends as a health care economist, shares his personal experience as a nurse and offers suggestions for both short- and long-term solutions to this crisis. In the discussion, Buerhaus suggests health care organizations take a close look at lessons learned from the COVID-19 pandemic and consider resetting the relationship between nurses and hospitals in a way that benefits both parties as well as patients.

Click here to view the discussion.

Health Care Staffing Shortages Identified as a Global Concern

A recent report, *Clinician of the Future*, summarizes results from a quantitative global survey that revealed 31% of clinicians are considering leaving their positions by 2024. The survey consisted of qualitative interviews and roundtable discussions with nearly 3,000 physicians and nurses worldwide, nearly half of whom were US clinicians. A purpose of the report, published by Elsevier Health, is to help understand clinician challenges as drivers of change in health care for the coming decade. Some key themes revealed in the report include the following:

- Burnout: How clinician well-being can be prioritized to overcome workforce shortages.
- The impact of digital health and technology: How clinician education and training can keep pace with the rapid rate of technological advances.
- The evolving skill set for physicians and nurses: What skills clinicians will need to develop as traditional relationships between the patient and physician transitions to a health partnership.
- The focus on prevention. How clinicians can respond to a growing emphasis on managing public health amid a growing and aging population.

Effective Soon: New Nursing and Memory Care Program Requirements

Effective July 1, 2022, The Joint Commission will add 29 new and 55 revised requirements to its Nursing Care Center (NCC) Accreditation Program. In addition, 10 new and 4 revised requirements will be added to the NCC Memory Care Certification (MCC) Program.

These new and revised requirements span several standards chapters and address infection prevention and control, dementia care staff, recruitment, retention and wellness, pressure injuries, and medication safety. The rationale for these updates is to reflect current scientific and evidence-based practices in long term and memory care and to address many lessons learned from the COVID-19 pandemic. New and revised requirements include recommendations and practice guidelines from the Alzheimer's Association, Centers for Disease Control and Prevention, Centers for Medicare & Medicaid Services, National Coalition for Hospice and Palliative Care, and National Pressure Injury Advisory Panel. Learn more by downloading *R³ Report* Issue 33.

Infection Control Resources for Health Care Workers

The Centers for Disease Control and Prevention's (CDC)'s Project Firstline, recently released a new collection of infection control educational resources and training materials, designed by health care workers for health care workers.

These resources were created to help health care staff recognize the risk for germs to spread throughout their workday by focusing on where germs live in the health care environment. This recognition of where germs are is described as the first step in understanding how to stop the spread of germs to protect both patients and health care workers. Also addressed are strategies for actions to take to minimize risk for exposure. Educational materials include videos, social media content, posters and job aids, and training tool kits.

Coronavirus (COVID-19) Resources

The Joint Commission continues to offer free COVID-19 resources to support health care organizations and workers on the front lines of the pandemic. Resources are updated frequently and are applicable to most Joint Commission accreditation settings.

Other Learning Opportunities

JOINT COMMISSION RESOURCES AND THE JOINT COMMISSION CENTER FOR TRANSFORMING HEALTHCARE

JCR Live Events

Hospital Accreditation Essentials with Tracers & Data Analysis (June 7–9, 2022). This three-day, in-person seminar offers practical solutions and tips for a successful Joint Commission accreditation survey. New this year, an add-on session covers tips for conducting tracers in your organization to ensure survey readiness. Note: At this time, for this in-person event, attendees are required to show proof of COVID-19 vaccination as per Centers for Disease Control and Prevention (CDC) guidelines. Attendees may also be asked to exercise social distancing and wear a CDC–recommended face mask in all building areas unless they are eating and drinking. These guidelines are subject to change.

Environment of Care Base Camp (August 9–10, 2022). Perfect for health care professionals preparing for a Joint Commission survey and those working to build a safe environment of care for staff and patients, this in-depth seminar will include a survey accreditation overview; focus on hazardous materials, medical equipment, and utilities management; and environment of care updates and trends to help prepare you for your next survey.

Exploring the Life Safety Chapter (August 11–12). This comprehensive seminar will focus on the complex requirements found in the "Life Safety" (LS) chapter of the Comprehensive Accreditation Manuals and is designed for anyone responsible for compliance with the challenging Life Safety Code®*Real-life examples and interactive exercises led by Joint Commission experts, will address the latest updates and changes and what they mean for your organization.

Both the Environment of Care Base Camp and Exploring the Life Safety Chapter seminars are currently scheduled as in-person events. Note that the event team continues to monitor the COVID-19 pandemic. Visit the Health & Safety tab for guidelines and updates.

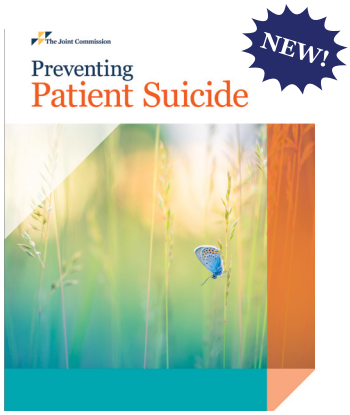
*Life Safety Code® is a registered trademark of the National Fire Protection Association, Quincy, MA.

Digital Learning Center

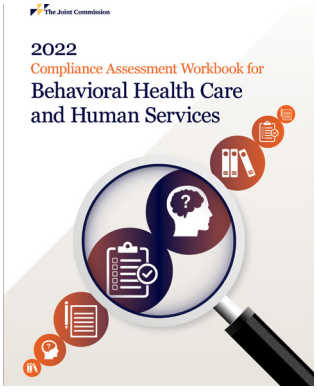
Be sure to check out JCR's Digital Learning Center (DLC) for top webinars, videos, select eBooks, *PolicySource*,™ digital newsletters—including *The Source*—and other resources. This subscription-based virtual learning service provides self-paced education and allows staff to customize their learning experience. Content is developed, curated, and regularly updated by JCR subject matter experts.

Must-Have JCR Books

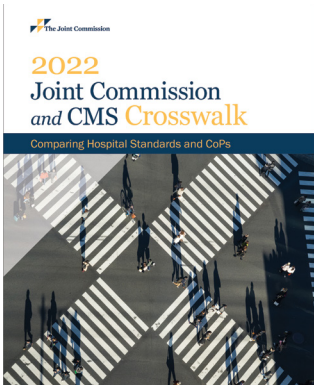
Treatment Planning in Behavioral Health Care and Human Services delivers practical strategies on the #1 topic requested by Joint Commission BHC organizations. Developed to help BHC organizations tackle compliance challenges related to planning, developing, monitoring, and revising individualized treatment plans, this brand-new book takes a deep dive into key requirements in the "Care, Treatment, and Services" (CTS) chapter of the *Comprehensive Accreditation Manual for Behavioral Health Care and Human Services* (*CAMBHC*) and its corresponding E-dition®.



Preventing Patient Suicide is a new resource for professionals working in hospitals, behavioral health care, and psychiatric hospitals aimed at addressing strategies to identify, mitigate, and prevent suicide risk for their patients. This book offers insights and clarifications for meeting The Joint Commission's National Patient Safety Goal® (NPSG) Standard NPSG.15.01.01—reducing the risk of suicide among patients. It contains information vital to anyone who needs to understand Joint Commission requirements related to patient suicide, including not only assessing individuals at risk of suicide but also assessing for potential risks in the environment of care.



The *2022 Compliance Assessment Workbook for Behavioral Health Care and Human Services* includes all behavioral health care and human services (BHC) standards, including those applicable to the behavioral health home certification option.



The *2022 Joint Commission and CMS Crosswalk: Comparing Hospital Standards and CoPs* provides easy access to full and current (as of January 1, 2022) Medicare hospital Conditions of Participation (CoPs) requirements and equivalent Joint Commission hospital standards. This resource is essential for hospitals and psychiatric hospitals preparing for a deemed status survey from The Joint Commission.

The Joint Commission Center for Transforming Healthcare

The Joint Commission Center for Transforming Healthcare offers several virtual workshops and training opportunities for today's health care leaders.

Online Yellow Belt Certification program offers effective process improvement tools and methods to move health care organizations out of their current state toward zero harm. This online program is the foundation of Robust Process Improvement® (RPI®), which blends Lean, Six Sigma, and formal change management. Organizations will learn from a certified team of instructors how to do the following:

- Optimize quality and performance improvement efforts
- Increase the spread of improvements in clinical and nonclinical processes
- Increase alignment and staff engagement in improvement initiatives with common language and methodology.

Leaders *Facilitating Change®* Workshop provides health care leaders formal training in change management processes to help them address ongoing challenges in their organizations, such as staff limitations, reduced resources, burnout, and others. This two-day virtual workshop equips attendees with tools to manage change effectively and achieve strategic and operational goals. New sessions are scheduled for June and October. Click here to register.

Green Belt Certification Training is an engaging three-part training course designed to align with your organization's project to ensure that staff enrich their knowledge with applicable skill. As with the Yellow Belt program, Green Belt certification applies the systematic approach of RPI. Health care organizations will learn how to apply RPI methodology to address the following:

- Complex high-impact patient safety and quality care issues
- Root causes of your organization's most pressing quality and safety issues
- Solutions to issues tailored to your organization's processes, norms, and culture

Green Belt Training kickoff is June 6, 2022. A second kickoff session begins August 29, 2022. The time to register is now.

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