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FOR JOINT COMMISSION COMPLIANCE STRATEGIES

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Spotlight on Success

NORTHPORT VETERANS AFFAIRS MEDICAL CENTER IMPROVES PREPAREDNESS FOR HIGH-CONSEQUENCE INFECTION

By Lisa C. Bailey, MS, RN, BSN, CIC; Nancy R. Barrett, MS, RN, CIC; Cheryl F. Cohen, MS, RN; Florence M. Ford, MSN, RN, BSN; and Monique Thorne, EdD, MS, RN-BC

High-consequence infections (HCIs) pose a significant risk to patients, health care workers, and society at large. HCIs are infections including, but not limited to, Ebola virus disease (EVD), severe acute respiratory syndrome (SARS), Middle East respiratory syndrome coronavirus (MERS-CoV), and pandemic flu, which typically, and for the purpose of this article, meet the following criteria:

- Are caused by pathogens with the potential to cause a high mortality rate among otherwise healthy people
- Pose a generalized risk from direct contact with clinical specimens to laboratory staff
- Are moderately to highly contagious (by whatever route) during some stage of the disease
- Are moderately to highly lethal
- Are not easily controllable by medical countermeasures or nonpharmaceutical interventions, or for which no known vaccine exists
- Are of concern to public safety

Joint Commission Leadership (LD) Standard **LD.03.09.01**, Element of Performance (EP) 7, requires accredited hospitals and nursing care centers to select one high-risk process and conduct a proactive assessment at least every 18 months. Northport Veterans Affairs Medical Center (VAMC) in Northport, New York, conducted such an assessment after identifying vulnerabilities in early recognition of HCIs. The assessment led to improved processes for identifying and isolating the hospital's patient population and for informing proper authorities of potential HCI outbreaks.

Northport VAMC provides health services to veterans in Long Island, New York, and is accredited under The Joint Commission's Hospital, Behavioral Health Care, and Home Care programs. An interdisciplinary team at Northport of key internal and external stakeholders, including infectious disease and prevention services; occupational health services; and occupational safety, emergency, and quality management staff, embarked on an improvement project to accomplish the following goals:

- Improve the HCI process by establishing policies, protocols, and procedures for preparedness.
- Integrate activities of internal and external stakeholders.

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- Implement facilitywide education on HCIs.
- Ensure compliance with key Joint Commission standards (*see* Table 1 on page 5 for related Joint Commission standards).
- Promote the health and safety of veterans, health care workers, volunteers, and visitors and meet the VA's customer requirements for the patient population served.

Using a Healthcare Failure Mode and Effect Analysis (HFMEA) process tool, the team convened weekly for three months in early 2019 to conduct a hazards analysis. Failure modes, causes, and effects were identified. Interventions were then applied to a decision tree to drive actions for improvement. Later, HFMEA team leaders met with key stakeholders to present proposed actions for improvements, and in August 2019 the team presented the improvement project to senior leadership, and buy-in was granted.

Improvement team members attended a Frontline Facility Special Pathogens course at NYC Health + Hospitals in New York. Materials supplied were reviewed and adopted for use, including an algorithm that gave Northport a standardized screening process to identify, isolate, and inform appropriate authorities of possible HCIs.

Recognizing the Risk for HCI

Failure to identify the risk for HCI was the first failure mode addressed by the hazard analysis. The cause of this failure was staff not asking two questions: The first related to sickness, the second related to travel in the past 30 days. After the team recognized challenges with implementing the two questions in the electronic medical record (EMR), it developed two health/travel questions that were placed in a new domain of the EMR titled *Check-in Screening.* Patients were asked: "In the past week have you had a fever, cough, or rash?" If the answer was "no," the screening process for HCI stopped. A "yes" answer triggered staff to ask a question about travel outside the country. If patients who had fever, cough, or rash had also traveled outside the country in the past 30 days (or come in contact with someone who had traveled outside the country), then staff was not only prompted to use standard precautions, but also to notify proper authorities of the patient's travel and symptoms.

Following the Frontline Facility course, all key staff were educated on modifications to the check-in screening process that affected clinics, emergency department triage, and admissions to all medical, long term care, and mental health units. This process starts when frontline staff ask all veterans entering a health care facility the health and travel questions. The decision to ask these questions to all patients leads to quick identification of possible exposure to infectious diseases, such as influenza or measles, and prompts staff to take other precautions, including asking the patient to wear a mask while in a waiting area and to use alcohol-based hand rub, for example, to reduce the spread of infection.

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Isolating the HCI

As a result of the hazard analysis, the team also recognized that when HCIs are identified, the next critical step to minimizing spread of infection is appropriate isolation. Affirmative answers to health and travel questions warrant isolating the patient from the waiting area and identifying any active illnesses in the region where the patient visited or had contact with. This is accomplished by having staff visit the Centers for Disease Control and Prevention (CDC) travel notices real-time information page, a link to which is now available on Northport's intranet. Prior to the improvement project, the challenge was getting the link on the intranet for quick, easy access for personnel. Working with the operations and information technology department, the team was able to get quick access to this link.

The team also identified causes for isolation failures such as not having appropriate isolation carts or special pathogen personal protective equipment (PPE) stocked, not having an appropriate spill kit, not having an appropriate isolation room, and insufficient masks, alcohol-based rubs, and hand sanitizers at check-in.

Informing Staff and Authorities

The last step in the improved HCI process is to inform appropriate personnel, which includes internal staff as well as external authorities. The most critical causes for failure to inform proper authorities of a possible HCI involve education and training. The team found that when staff were not properly trained and educated to conduct a travel history, isolate patients, obtain an isolation cart, and evaluate for special pathogens, they were not likely to inform key personnel of potential HCI risk.

Likewise, when staff were not sufficiently trained and proficient in donning/doffing PPE and disposing and handling special pathogen PPE and supplies, isolation becomes a challenge, and the risk for spread of infection increases.

Northport VAMC now specifies that in cases when a veteran has visited an HCI region, as identified on the CDC travel notices site, proper protocol is to isolate the veteran in a negative pressure room, notify infection control/infectious disease departments, and follow appropriate Department of Health guidance.

Key outcomes of this improvement project include the following:

- VAMC obtained a special pathogens isolation cart, stocked with HCI isolation equipment and supplies.
- Staff attended special education and training in HCI PPE donning and doffing techniques.
- Northport developed special pathogen books and implemented new HCI checklists for PPE donning and doffing, body fluid spill, and MERS specimen collection.
- Northport identified rooms for conversion to negative pressure rooms and anterooms for observation.

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- Northport identified and validated the proper process for transporting waste and cleaning special pathogen rooms with the federal Veterans Integrated Services Network (VISN).

Infectious diseases can have a profound impact on veterans, their families, staff, facility processes and procedures, and the general public. HCIs can result in mass casualties from spread of communicable disease long after an initial infection and, subsequently, require specialized mitigation, planning, and response to prevent and control the spread of disease. Because of the nature of their jobs, veterans can show up anywhere in the world and at any stage of illness. This new process gives the Northport staff standardized steps to help ensure staff and patient safety. By completing a timely triage, evaluation, and clinical management, Northport VAMC will now be equipped to quickly identify, isolate, and inform appropriate authorities of any potential HCI.

Organizations seeking support in their efforts to comply with The Joint Commission's infection prevention and control requirements related to health care worker exposure to pathogens may refer to the "Consistent Interpretation" column of the August 2019 issue of *Perspectives* for guidance on assessing, selecting, training, and appropriate use of PPE. TS

Table 1. Key Joint Commission Standards Related to High-Consequence Infection (HCI) Preparedness for the Hospital Setting

IC.01.03.01 The hospital identifies risks for acquiring and transmitting infections.	
EP 1	The hospital identifies risks for acquiring and transmitting infections based on: – Its geographic location, community, and population served – The care, treatment, and services it provides – The analysis of surveillance activities and other infection control data
EP 3	The hospital prioritizes the identified risks for acquiring and transmitting infections. These prioritized risks are documented.
IC.01.06.01 The hospital prepares to respond to an influx of potentially infectious patients.	
EP 2	The hospital obtains current clinical and epidemiological information from its resources regarding new infections that could cause an influx of potentially infectious patients.
EP 3	The hospital has a method for communicating critical information to licensed independent practitioners and staff about emerging infections that could cause an influx of potentially infectious patients.
EP 4	The hospital describes, in writing, how it will respond to an influx of potentially infectious patients. (*See also* EM.01.01.01, EP 2) **Note:** One acceptable response is to decide not to accept patients.
IC.02.01.01 The hospital implements its infection prevention and control plan.	
EP 6	The hospital minimizes the risk of infection when storing and disposing of infectious waste. (*See also* EC.02.02.01, EPs 1 and 12)
EM.02.01.01 The hospital has an Emergency Operations Plan.	
EP 7	The Emergency Operations Plan identifies alternative sites for care, treatment, and services that meet the needs of the hospital's patients during emergencies.

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EM.02.02.05 As part of its Emergency Operations Plan, the hospital prepares for how it will manage security and safety during an emergency.	
EP 4	The Emergency Operations Plan describes the following: How the hospital will manage hazardous materials and waste.
EM.02.02.11 As part of its Emergency Operations Plan, the hospital prepares for how it will manage patients during emergencies.	
EP 2	The Emergency Operations Plan describes the following: How the hospital will manage the activities required as part of patient scheduling, triage, assessment, treatment, admission, transfer, and discharge.
EP 5	The Emergency Operations Plan describes the following: How the hospital will manage the personal hygiene and sanitation needs of its patients.

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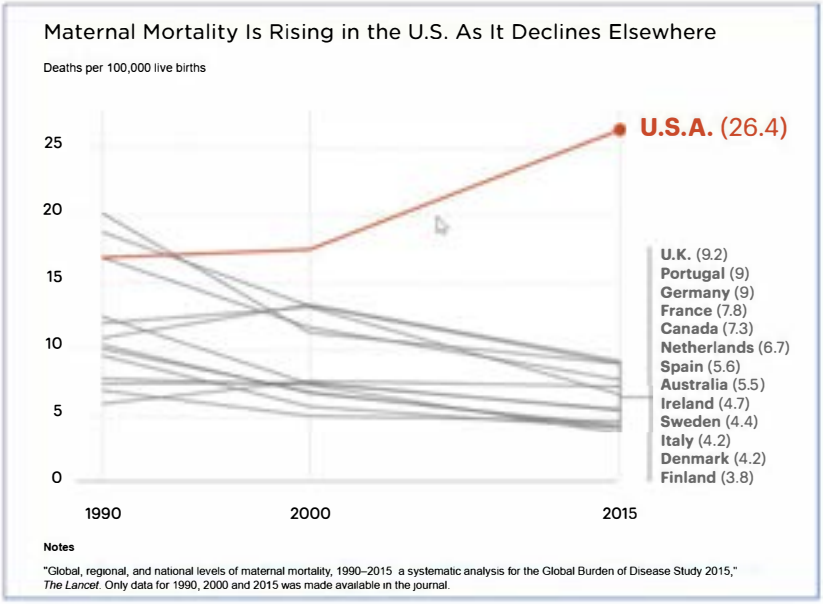
New Standards Address Rising Maternal Mortality

Maternal mortality is increasing in the United States.[1] In fact, the US maternal mortality rate (MMR) is one of the worst among developed countries.[2] In 2015 the US MMR was 26.4 women per 100,000 live births.[2] (By comparison, the second highest MMR among developed countries was in the United Kingdom—9.2 deaths per 100,000 live births, approximately one-third the rate in the US.[2]) This trend is particularly troubling when compared to the rest of the world. Between 2000 and 2015, global MMR decreased by 2.6%, while it increased by 2.7% in the US (see Figure 1, below)[2].



To address this crisis, The Joint Commission has developed new standards for maternal safety that go into effect July 1, 2020. These two standards in the "Provision of Care, Treatment, and Services" (PC) chapter apply to Joint Commission–accredited hospitals. This article summarizes existing Joint Commission standards related to maternal safety, outlines the new requirements, and provides compliance strategies for hospitals.

Overview of the Existing Standards

In January 2018 The Joint Commission introduced three requirements to identify mothers at risk for transmitting infectious diseases to newborns around the time of delivery. Standard PC.01.02.01, Elements of Performance (EPs) 14, 15, and 16, require hospitals that provide obstetric services to assess and document each mother's status related to the following infections:

- Human immunodeficiency virus (HIV)
- Hepatitis B

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- Group B *Streptococcus* (GBS)
- Syphilis

Hospitals must also document any positive maternal test results for these infections in the newborn's medical record.

In addition, The Joint Commission currently requires hospitals with more than 300 live births per year to collect and report data on several perinatal measures including, but not limited, to the following:

- PC-01: Elective Delivery (early elective delivery)
- PC-02: Cesarean Birth (nulliparous, term, singleton, vertex (NTSV) cesarean section rate)

Accredited hospitals must comply with these standards and measures as part of their overall maternal safety efforts.

Overview of New Standards

Although the existing requirements help hospitals improve perinatal outcomes, the increasing US MMR indicates that risks still need to be addressed. The Joint Commission evaluated evidence-based literature to determine areas with the most potential to significantly improve outcomes. Based on the literature, and on input from key obstetric stakeholders, The Joint Commission developed two new standards that address the care of women who experience maternal hemorrhage and severe hypertension/preeclampsia.

Maternal hemorrhage and severe hypertension/preeclampsia were selected for several reasons. Both are common causes of maternal morbidity and mortality in the US. They are also preventable and amenable to survey. Finally, evidence shows that when organizations mitigate these two risks, they can better recognize and treat an emergency in a timely manner and prevent further morbidity or even mortality.

"These two areas are known to show great improvement in response to relatively simple interventions, such as documented assessments, staff training, and necessary tools readily available," says Maura Naddy, MSN, RNC-OB, associate director, Standards Interpretation Group, The Joint Commission.

The new standards and EPs are outlined below. (The full text is on the The Joint Commission's website.)

Maternal Hemorrhage

Standard PC.06.01.01 will require hospitals to reduce the likelihood of harm related to maternal hemorrhage. This is to be accomplished through patient assessment, response and management procedures, provision of appropriate supplies, staff education and training, drills and performance improvement activities, and patient education.

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Specifically, hospitals must do the following:

- EP 1—Assess risk of maternal hemorrhage upon admission to labor and delivery, and upon admission to postpartum. This assessment must use an evidence-based tool.
- EP 2—Develop written procedures for stage-based management of pregnant and postpartum patients who experience maternal hemorrhage. These procedures should describe how hemorrhage is identified and treated; use of emergency response medication(s); composition of the response team, their roles, and how the team is activated; management of blood products; guidance for when to elevate the level of care; how to communicate with patients and families; and criteria for a team debrief afterward.
- EP 3—Ensure that a standardized, secured, dedicated hemorrhage supply kit is in each obstetric unit. This kit must contain, at a minimum, the organization-specific emergency hemorrhage supplies and approved response procedures.
- EP 4—Educate and train appropriate staff about the organization's hemorrhage procedures. At a minimum, this education should happen at orientation, whenever changes to the procedures occur, or every two years.
- EP 5—Conduct drills at least annually to practice the hemorrhage response process and identify any opportunities for improvement. The drills should include representatives from each discipline the organization identifies in its hemorrhage response procedure. Debrief the team after the drill.
- EP 6—Review hemorrhage cases to evaluate the effectiveness of the care, treatment, and services provided by the hemorrhage response team during the event.
- EP 7—Educate patients (and, when possible, their families and designated support person) about signs and symptoms of postpartum hemorrhage that indicate a need to seek immediate care.

Severe Hypertension/Preeclampsia

Standard PC.06.03.01 will require hospitals to reduce the likelihood of harm related to maternal severe hypertension/preeclampsia. This is to be accomplished through identifying at-risk patients by measuring and monitoring blood pressure, developing and using response and management procedures, providing appropriate supplies, educating and training staff, doing drills and performance improvement activities, and educating patients. Specifically, hospitals must do the following:

- EP 1—Develop written procedures for measuring and remeasuring patients' blood pressure. Define criteria for identifying patients with severely elevated blood pressure.
- EP 2—Develop written procedures for managing pregnant and postpartum patients with severe hypertension/preeclampsia. These should include use of emergency medications, use of seizure prophylaxis, guidance for when

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to elevate the level of care, guidance on use of continuous fetal monitoring, guidance on when to consider emergent delivery, and criteria for a team debrief.

- EP 3—Educate and train appropriate staff about the organization's severe hypertension/preeclampsia procedures. This should happen, at a minimum, at orientation, whenever changes to the procedures occur, or every two years.
- EP 4—Conduct drills at least annually to identify any opportunities for improvement. Debrief the team after the drill.
- EP 5—Review severe hypertension/preeclampsia cases to evaluate the effectiveness of the care, treatment, and services provided during the event.
- EP 6—Educate patients (and, when possible, their families and designated support person) about signs and symptoms of severe hypertension/preeclampsia that indicate a need to seek immediate care, both during hospitalization and at discharge, and when to schedule a follow-up appointment after discharge.

Strategies to Prepare for Compliance

The first step is to become familiar with what is expected. This goes beyond simply reading the prepublication standards. The Joint Commission's *R*^{3} *Report* (Issue 24, August 21, 2019) helps organizations understand the who, what, when, and why of the requirements. This document provides the content of the new standards and EPs, in-depth rationales, and references with evidence for each requirement. The *R*^{3} *Report*, "Provision of Care, Treatment, and Services Standards for Maternal Safety," can be viewed online here.

Next, organizations should review their existing policies, procedures, and processes related to maternal hemorrhage and severe hypertension/preeclampsia. Compare with the new expectations. An organization may already comply with one or more of the new requirements. For example, a hospital may have an established maternal hemorrhage response team, or it may include signs and symptoms of preeclampsia in its patient education at discharge.

Be sure that existing policies, procedures, and documentation meet the minimum requirements in the standard. For example, are maternal hemorrhage response drills performed at least annually? Does the policy addressing severe hypertension/preeclampsia provide guidance on when continuous fetal monitoring is needed? Also, be sure that all policies, processes, and procedures are evidence-based and appropriately documented.

Identify any compliance gaps. Determine the interventions necessary to close those gaps, **using external resources** available to hospitals.

Safety Bundles and Resources

"There are a lot of resources out there—easily accessible online—that can assist organizations in preparing for the release of new standards," says Naddy. She suggests the American College of Obstetricians and Gynecologists (ACOG) and the Association of Women's Health, Obstetric and Neonatal Nurses (AWHONN).

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Naddy also encourages organizations to reach out to their state's perinatal quality collaboratives. These groups provide guidance, tools, and other support. Another resource to consider is the Alliance for Innovation on Maternal Health (AIM), a program of the Council on Patient Safety in Women's Health Care. AIM has developed maternal safety bundles for obstetric hemorrhage, severe hypertension/preeclampsia, and other maternal safety issues. The bundles, representing best practices for maternity care, describe actions hospitals can take to mitigate the risks.

These actions are divided into several categories:

- Readiness—Preparing for maternal safety events, such as maintaining accessible supplies, establishing response teams, conducting drills, and educating and training staff
- Recognition and Prevention—Assessing patients' risk level and taking steps to manage that risk to avoid a maternal patient safety event
- Response—Performing standardized care processes in a timely manner to minimize harm when a maternal patient safety event occurs
- Reporting/Systems Learning—Measuring, analyzing, and improving performance of readiness, recognition and prevention, and response processes, as well as tracking outcomes and monitoring compliance

The AIM bundles link users with resources, tools, and guidance from organizations such as ACOG, AWHONN, the World Health Organization (WHO), and the Agency for Healthcare Research and Quality (AHRQ). TS

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Nutrition Care: The Impact of Food on Quality Care

Food, particularly what food is best for patients, is an important topic in health care practices. There is a great deal of evidence-based knowledge about supporting patients' nutritional needs as part of their health and well-being. Nutrition care, which may be any practice done by a health care professional to improve nutrition behavior and subsequent health of patients, has direct relevance for patient recovery and outcome. Although food and dietetic needs may not be the first thought a patient has when admitted to a hospital, food is an integral component of the hospital stay experience. How a hospital or health care organization manages and delivers food to patients can affect not only the quality of patient care but also the safe delivery of care.

For Joint Commission–accredited behavioral health care organizations, standards related to the preparation of food and to dietary planning—particularly for treatment of eating disorders—fall within the "Care, Treatment, and Services" (CTS) chapter of the *Comprehensive Accreditation Manual for Behavioral Health Care (CAMBHC)* (or its E-dition®, which is accessible through the program's *Joint Commission Connect*® extranet site).

For Joint Commission–accredited hospitals, nursing care centers, home care organizations, ambulatory health care organizations, and office-based surgery practices, food and nutritional services are surveyed under Provision of Care, Treatment, and Services (PC) Standard PC.02.02.03, which states that the "[organization] makes food and nutrition products available to its patients" and includes elements of performance (EPs) that cover the following, depending on the setting:

- The safe preparation and handling of food (EP 6)
- The use of food that is consistent with the patient's care, treatment, and services (EP 7)
- Accommodation of a patient's cultural, religious, or ethnic food and nutrition preferences, as appropriate, unless contraindicated (EP 9)
- The safe and appropriate storage of food, including food brought in by patients and their families (EP 11)
- The use of an approved and current therapeutic diet manual, available to all medical, nursing, and food staff (EP 22; for hospitals that use Joint Commission accreditation for deemed status purposes)

For hospitals, EPs 7 and 22 correspond to the Centers for Medicare & Medicaid Services (CMS) Conditions of Participation (CoPs) for food and dietetic services (CoP §482.28), which states: "The hospital must have organized dietary services that are directed and staffed by adequate qualified personnel." The table below provides a crosswalk between relevant EPs for Joint Commission Standard PC.02.02.03 and corresponding CoPs for the hospital setting.

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Assessing Food Services

Food services will be assessed during tracer activity—following a patient's care through the setting—or as part of a systems tracer (when food and dietetic services may emerge during survey of other systems, such as environment of care, medication management, or data use). As an integral part of the patient's experience through the hospital setting, food and dietetic needs—particularly for patients who have clinically driven dietary support needs, such as for diabetes—will often emerge and be evaluated by the surveyor to ensure that all systems that support a patient are working well.

Areas of review may include, but are not limited to, whether a nutrition risk assessment was done on admission, whether a diet order and dietitian consultation were completed based on organizational policy, and whether calorie counts or other intake were documented, as appropriate. As part of patient observation, a surveyor may evaluate whether the patient needs assistance at meal times, whether the patient received a visit from the dietitian and understands his or her diet, and how the dietary staff monitors patient selections in cases where cafeteria-style service is offered. An interview with the dietitian may determine how special diet orders are received and what protocols are in place to ensure that patients receive the appropriate diet, for example. In addition, a surveyor will typically interview the food service director and tour the kitchen; discuss director and staff qualifications, trainings, and orientations; and, in nursing care centers, evaluate what is being measured for the organization's Quality Assurance Performance Improvement (QAPI) plan (for example, food temperatures, patient satisfaction, and so on).

Compliance Challenges

Hospitals and health care providers in all settings that deliver food services should assess the effectiveness of their food and dietetic services by addressing the following potential challenges:

- Inconsistent handling and implementation of policies and procedures
- Not ensuring that the therapeutic diet manual has been approved by the dietitian and medical staff (EP 22)
- Insufficient training for dietetic staff
- Poor safety practices for handling food
- Failure of set menus to meet patients' nutritional, cultural, or clinical needs

Organizations might assess their compliance by creating a checklist of the requirements and assessing staff understanding of those requirements. An organization might also consider the following:

- The reporting structure ensures that all staff, including dieticians and food service workers, are appropriately qualified and competent.
- The nature of interactions between food and dietary services staff with clinical staff

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- The engagement of patients and their families in the food delivery process
- The involvement of food and dietary services staff in infection prevention and control, the environment of care, and performance improvement
- The requirements that should be included in written policies and the level of leadership input and oversight in the documentation process TS

PC.02.02.03 The hospital makes food and nutrition products available to its patients				
Elements of Performance (EPs) with a Crosswalk to CMS Conditions of Participation (CoPs) §482.28 for the Hospital Settings				
EP	**EP Language**	**Related CoP**	**CoP**	**CoP Language**
EP 6	The hospital prepares food and nutrition products using proper sanitation, temperature, light, moisture, ventilation, and security.	No		
EP 7	Food and nutrition products are consistent with each patient's care, treatment, and services.	Yes	§482.28(b)(1) §482.28(b)	(b) Standard: Diets. Menus must meet the needs of the patients. (1) Individual patient nutritional needs must be met in accordance with recognized dietary practices.
EP 9	When possible, the hospital accommodates the patient's cultural, religious, or ethnic food and nutrition preferences, unless contraindicated.	No		
EP 11	The hospital stores food and nutrition products, including those brought in by patients or their families, using proper sanitation, temperature, light, moisture, ventilation, and security.	No		

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EP 22	**For hospitals that use Joint Commission accreditation for deemed status purposes:** A current therapeutic diet manual approved by the dietitian and medical staff is available to all medical, nursing, and food service staff. [Documentation required]	Yes	§482.28(b)(3) §482.28(b)(1)	(b)(3) A current therapeutic diet manual approved by the dietitian and medical staff must be readily available to all medical, nursing, and food service personnel. (b) (1) Individual patient nutritional needs must be met in accordance with recognized dietary practices.

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TRACER Methodology 101

Exploring Food Services During a Hospital Tracer

Scenario

This individual tracer explores the food and dietetic services in a mid-sized suburban hospital in the Southeast. The hospital is part of a large health care system that includes three additional hospitals, ambulatory health care, long term care, and home care organizations across one state. The surveyor selected the record of a patient admitted to the hospital having undergone coronary bypass surgery four days earlier. The patient was male, diabetic, aged 62, and had been undergoing physical therapy and nutritional support as part of his recovery plan. There was a notation in the patient's care plan, based on his preadmission assessment, that he should receive a diabetes-appropriate diet while admitted. To explore how the patient was being supported in recovery after surgery, the surveyor wanted to understand how the hospital handled provision of food and dietetic services within the setting. She wanted to review the dietary services for patients with special dietary needs as well as for the wider population. [1, 2] The surveyor met with the head of food services and the director of dietetic services at the hospital. She also spoke with one of the patient's nurses and the patient.

Exploring food and dietetic services. The surveyor wanted to learn how food and dietetic services were assessed within the setting, during preadmission processes (if appropriate), and on admission. [3] After learning about patient assessment processes, the surveyor wanted to explore how the patient's experience reflected these services. On reviewing the patient's record, the surveyor learned that the patient's diabetes status had not been recorded on his dietary services order, which was part of the electronic medical record (EMR), although it had been flagged on the preadmission documentation and in the related care plan. She was interested to learn the manner in which time-sensitive nutritional and dietary care-related information is passed on to the food services and dietary staff. [4] The food services manager explained that, typically, when the nutritional assessment and preadmission assessment are complete, the EMR triggers a report to the food services department so that appropriate menu planning can take place. He added that this was usually checked daily. However, recent staff and information technology (IT) changes (the food services manager was new in his role; the hospital's EMR was recently upgraded) may have contributed to the record being missed. The surveyor was interested in the training and support the staff received on the EMR and how it related to nutritional services. [5]

Patient engagement in the process. The surveyor then visited the patient at the bedside. His wife was with him. The patient was alert and able to speak with the surveyor about his experience related to food and nutritional care while in the hospital. [6] The patient was generally happy with the food, although he was surprised to be served a meal that he felt was inappropriate for his

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diabetes—namely, a high-sugar dessert and mashed potatoes. When he raised concern, the patient was told by food services staff that they had not been informed that he had diabetes. The patient's wife explained that after she mentioned this to the nursing staff, subsequent meals were more appropriate for the patient's dietary needs. She also noted that she had been allowed to bring in food for her husband and that the staff had shown her how to safely store it. [7] The surveyor reviewed the hospital's policy and documentation about the safe storage of food and found that it was consistent with the hospital's own practices and policy.

Going forward. The surveyor and staff discussed reviewing training and systems for food and dietary services to ensure that clinically relevant information is clearly communicated to proper staff and that documentation reflects that. In addition, the surveyor advised that staff be trained to act appropriately on such information and that patient and family education processes be reviewed. TS

Sample Questions

The following questions represent some that could be asked during a tracer. Use them as a starting point to plan your own tracers. Relevant standard: PC.02.02.03, EPs 6, 7, 9, 11, and 22.

1. Please describe how your food and dietetic services are structured at your organization.

2. Who is responsible for the services, and how are they monitored? How are food and dietetic services integrated into the wider patient care and services at the organization?

3. Describe the patient assessment process when patients arrive and are admitted to the facility, particularly the food and dietetic needs assessment. Who is responsible for the patient assessment processes?

4. How are special dietary needs of patients communicated to food services? How is this communication documented? How often are these special dietary needs reports sent to the food services department?

5. How are staff trained and supported to work with the communication systems that support nutritional and dietary services?

6. How do you engage patients and their families in the food and dietary services process? How do you accommodate their particular dietary needs and concerns? How is this documented?

7. How are patients and their family members informed about the organization's policy regarding bringing in and safely storing food?

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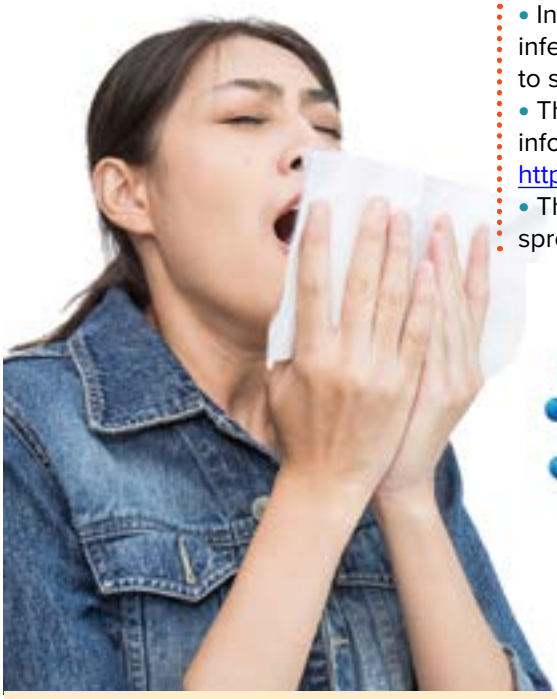
Seasonal Influenza Activity in the United States

It's Not Too Late to Get Vaccinated.



- Influenza (flu) is a contagious respiratory illness caused by viruses that infect the nose, throat, and sometimes the lungs and that can cause mild to severe illness or death.
- The Centers for Disease Control and Prevention (CDC) offers specific information and resources for health care professionals at https://www.cdc.gov/flu/professionals/index.htm.
- The best way to prevent flu, its potentially serious complications, and its spread of illness is by getting a flu vaccination each year.

influenza B Victoria virus

influenza A H1N1 virus

U.S. INFLUENZA STATS

The CDC estimates that so far this season (week ending January 4, 2020), there were:

9.7 MILLION FLU ILLNESSES

87,000 HOSPITALIZATIONS

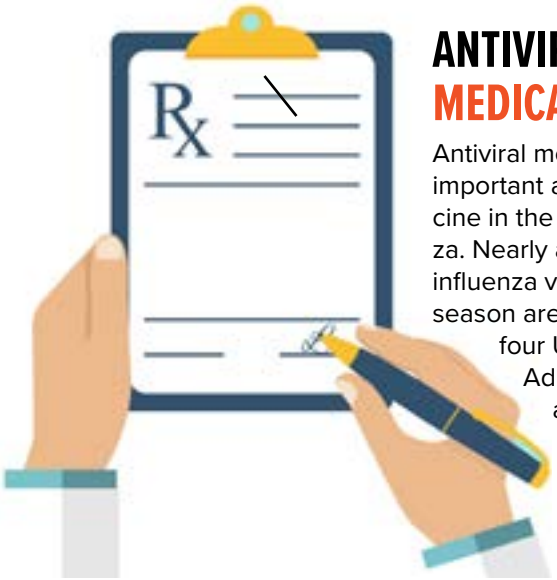
4,800 DEATHS FROM FLU

6.9%

HEALTH CARE VISITS

During the final week of 2019, outpatient visits to health care providers for influenza-like illnesses increased from 5.1% to 6.9%, marking a rise in illness baselines for all regions of the U.S.

Source of data: Centers for Disease Control and Prevention. Weekly U.S. Influenza Surveillance Report. Key Updates for Week ending January 4, 2020. Accessed January 14, 2020. https://www.cdc.gov/flu/weekly/index.htm



ANTIVIRIAL MEDICATIONS

Antiviral medications are an important adjunct to flu vaccine in the control of influenza. Nearly all (> 99%) of the influenza viruses tested this season are susceptible to the four US Food and Drug Administration (FDA)–approved medications recommended for use in the U.S. this season.

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Top News

A Digest of Accreditation and Health Care News

Enhancements to Substance-Use Disorder Treatment Standards Announced

The Joint Commission has announced enhancements to standards applicable to behavioral health care (BHC) organizations that provide substance-use disorder treatment services. Revisions to eight standards with 14 new and revised elements of performance become effective July 1, 2020, and are intended to incorporate best practices and decrease variation among these organizations to further improve safety and quality of care in this setting.

New and revised standards will focus on the following topics:

- Thorough assessments addressing key aspects of the individual's history
- Placing the individual in an appropriate level of care
- Treatment and discharge planning
- Collecting toxicological specimens
- Safety measures for those on medication-assisted therapy
- Disclosure of estimated costs for the program

After evaluating contemporary literature and national guidelines, and engaging stakeholders in the field, it was determined that improvements in these areas were needed to treat individuals at an appropriate level of care, for care transitions, for discharge expectations, and for proper uses of urine drug testing. *R³ Report* Issue 25 provides references and rationale for these changes. The revised standards will be posted on the Prepublications Standards page of The Joint Commission's website and will publish in the spring 2020 E-dition® update to the *Comprehensive Accreditation Manual for Behavioral Health Care (CAMBHC)*.

Toolkit Offers Framework for Improved Antibiotic Use in Acute Care Hospitals

The Agency for Healthcare Research and Quality (AHRQ) has developed a toolkit designed to improve antibiotic prescribing and reduce hospital-acquired infections in acute care hospitals. The toolkit includes training modules, tools, and resources that support the "Four Moments of Antibiotic Decision Making" framework for improving antibiotic use, which clinicians are encouraged to use whenever the need for antibiotics is being considered.

The framework suggests that clinicians ask the following questions before prescribing antibiotics:

Moment 1: Does my patient have an infection that requires antibiotics?

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Moment 2: Have I ordered appropriate cultures before starting antibiotics? What empiric therapy should I initiate?

Moment 3: A day or more has passed. Can I stop antibiotics? Can I narrow therapy or change from IV to oral therapy? These questions should be asked every day that a patient is on antibiotics.

Moment 4: What duration of antibiotic therapy is needed for my patient's diagnosis?

In addition to applying this framework, the Toolkit to Improve Antibiotic Use in Acute Care Hospitals emphasizes developing a culture of safety around antibiotic prescribing, developing or improving your antibiotic stewardship program, and learning best practices for diagnosing and treating infections.

Updated Guidelines for Infection Control Among Health Care Staff

Recently, the Centers for Disease Control and Prevention (CDC) issued updates to its *Guideline for Infection Control in Health Care Personnel, 1998*. The updates address four sections of Part 1 of the document that describe the infrastructure and routine practices of Occupational Health Services (OHS) for providing occupational infection prevention and control (IPC) services to health care personnel (HCP) as well as special considerations associated with emergency response personnel and provisions in the Americans with Disabilities Act (ADA) that are relevant to OHS.

The 2019 recommendations are aimed at leaders and staff in OHS as well as administrators and leaders in health care organizations. The recommendations address eight IPC elements of OHS as listed below:

1. Leadership and management
2. Communication and collaboration
3. Assessment and reduction of risks for infection among HCP populations
4. Medical evaluations
5. Occupational IPC education and training
6. Immunization programs
7. Management of potentially infectious exposures and illnesses
8. Management of HCP health records

The updated recommendations are informed by recent literature review in peer-reviewed journals and repositories of systematic reviews from January 2004 through December 2015 as well as a review of occupational IPC guidelines, regulations, and standards. The updated recommendations are classified as good practices and are based on expert opinions and the Healthcare Infection Control Practices Advisory Committee (HICPAC).

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The comprehensive update, including executive summary, introduction, background, references, and more, can be downloaded from the CDC website.

February Is American Heart Month

National Wear Red Day and Congenital Heart Defect Awareness Week are among the activities sponsored by the American Heart Association to kick off American Heart Month, an annual federally designated event created to remind all Americans to focus on their own heart health and to get friends, families, and communities to come together with the shared goal to eradicate heart disease and stroke.

According to healthfinder.gov, heart disease is the leading cause of death for men and women in the United States, responsible for 1 in 4 deaths. In an effort to improve the cardiovascular health of all Americans, the U.S. Department of Health and Human Services offers a toolkit to encourage health consumers and health care professionals to raise awareness. Health care providers are encouraged to take advantage of the following resources, videos, and recommendations and to spread the word about strategies to prevent heart disease and encourage patients to live heart healthy.

- A go-to guide for clinicians to talk to patients about self-measured blood pressure monitoring: https://millionhearts.hhs.gov/tools-protocols/smbp.html
- Six reasons why people don't take their blood pressure medicines as directed and how clinicians can help: https://www.cdc.gov/vitalsigns/blood-pressure/index.html
- What is heart age? This video offers a way to talk with patients about their risk for heart disease and stroke: https://www.youtube.com/watch?v=jvOU4Do4xZ8
- Tips for talking with patients about their blood pressure numbers and what they mean: https://www.cdc.gov/bloodpressure/measure.htm
- A checklist that includes important blood pressure questions to ask patients during their next visit: https://millionhearts.hhs.gov/files/TipSheet_HCP_Checklist.pdf

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Comprehensive Stroke Center Certification Webinar Series

Starts April 21, 2020

During this 7-part webinar series, faculty will review the on-site review process for Comprehensive Stroke Center (CSC) Certification. You will also hear about the standards and expectations set forth by The Joint Commission.

Learn More: https://store.jcrinc.com/2020-comprehensive-stroke-center-certification-webinar-series/

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