The Joint Commission

CHRISTUS Health

Joint Commission standards are the basis of an objective evaluation process that can help health care organizations measure, assess, and improve performance. The standards focus on important patient, individual, or resident care and organization functions that are essential to providing safe, high quality care.

The Joint Commission's state-of-the-art standards set expectations for organization performance that are reasonable, achievable, and survey-able.

https://www.jointcommission.org/standards/about-our-standards/

TJC related to Medical Staff

Timing and Dating of Entries

- All medical record entries must be timed, dated and signed.
- This includes orders, progress notes and immediate post-procedure notes.

History & Physical

- A medical H&P must be completed & documented no more than 30 days prior to or within 24 hours after inpatient admission
- For H&Ps competed within 30-days prior to inpatient admission, an ***UPDATE*** documenting any changes in the patients condition is completed within 24 hours after inpatient admission or prior to an operative or other high-risk procedure, whichever comes first.
- The H&P must be on the chart prior to any surgery or procedure.

TJC related to Medical Staff

TIMELY Authentication of Verbal Orders

- Verbal order are authenticated within the time frame defined by law and regulation *(within 48 hours).* Exception – DNR and restraint orders may not be given verbally.
- The verbal order may be authenticated, dated, and timed by any physician who is responsible for the care of the patient by virtue of being in a cross-coverage arrangement.
- Verbal orders are to be given ONLY in an emergent situation such as a code.
- Again, authentication must include date and time of signature!

TJC related to Medical Staff

Discharge Summaries

- The dictated or handwritten (must be legible) summary shall be completed as soon as possible but no longer than seventy-two (72) hours after a patient's discharge
  - *Paper documentation is discouraged and electronic/dictated summaries should be utilized whenever available.*
- All expired patients required a death summary regardless of the duration of the patient's stay (excluding emergency department and clinical outpatient visits). The death summary must be dictated to facilitate completion of the death certificate and must include the elements of a discharge summary and the patient's time of death.

TJC related to Medical Staff

Time Out

A time-out is performed immediately prior to starting procedures.

A time-out must address and document the following:

- ✓ Correct side and site are marked
- ✓ Correct patient identity
- ✓ Accurate procedure consent form
- ✓ Agreement on procedure to be done
- ✓ Correct patient position
- ✓ Correct implants (laterality and size) and equipment
- ✓ Relevant images & results properly labeled & appropriately displayed
- ✓ Need to administer antibiotics or fluids for irrigation purposes
- ✓ Safety precautions based on patient history or medication use

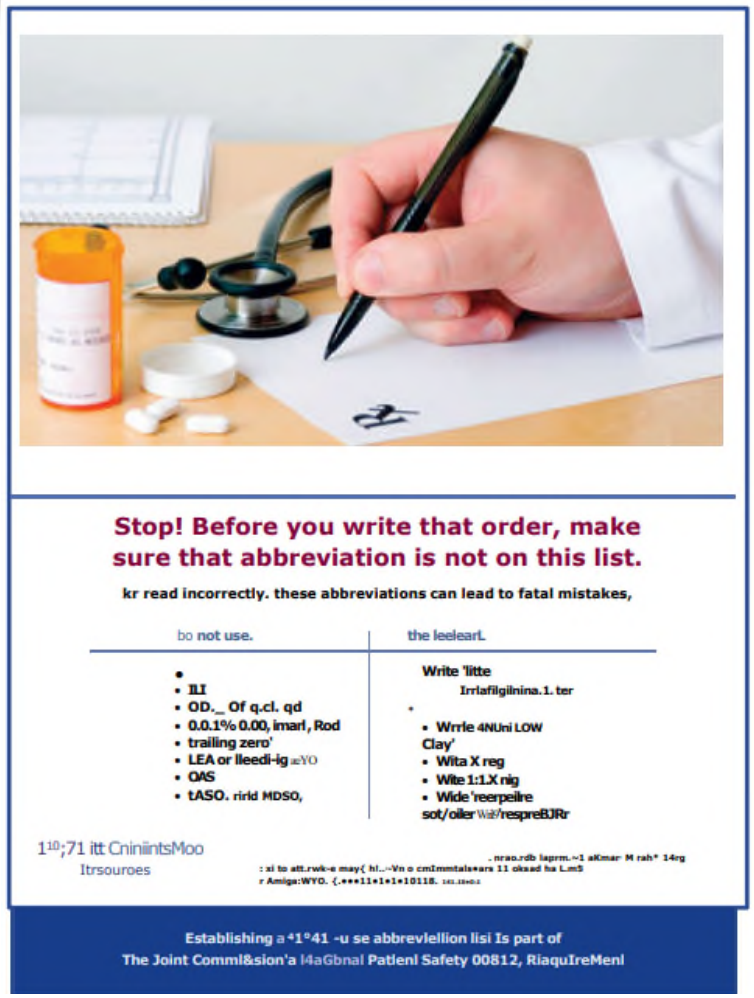
TJC related to Medical Staff

PRN Medications

- Always write the ***indications*** for "PRN" medications.

  Examples:

  - "Valium 2 mg po every 4 hours prn spasms."
  - "Neb treatment every 6 hours prn shortness of breath."
  - PRN <u>pain medication</u> orders must always contain a range, "...for pain scale of 1-4"



TJC related to Medical Staff

Official "Do Not Use" List[1]

Do Not Use	Potential Problem	Use Instead
U, u (unit)	Mistaken for "0" (zero), the number "4" (four) or "cc"	Write "unit"
IU (International Unit)	Mistaken for IV (intravenous) or the number 10 (ten)	Write "International Unit"
Q.D., QD, q.d., qd (daily)	Mistaken for each other	Write "daily"
Q.O.D., QOD, q.o.d, qod (every other day)	Period after the Q mistaken for "I" and the "O" mistaken for "I	Write "every other day"
Trailing zero (X.0 mg)* Lack of leading zero (.X mg)	Decimal point is missed	Write X mg Write 0.X mg
MS	Can mean morphine sulfate or magnesium sulfate	Write "morphine sulfate" Write "magnesium sulfate"
MSO_4 and $MgSO_4$	Confused for one another	

TJC related to Medical Staff

Medication Reconciliation

1. Obtain and/or update information on the medications that the patient is currently taking:
   - Applies to both the Inpatient and OP setting and is ultimately the provider's responsibility
   - Utilize a format useful to those who manage medications (eg. Meditech, Epic or Athena templates)
2. Define the types of medication information (for example, name, dose, route, frequency, purpose) to be collected in different settings.
3. Compare the medication information the patient brought to the organization with the medications ordered for the patient by the organization in order to identify and resolve discrepancies.
4. Provide the patient (or family as needed) with **written** information on the medications the patient should be taking at the end of the episode of care (for example, name, dose, route, frequency, purpose).
5. Explain the importance of managing medication information to the patient at the end of the episode of care (prior to inpatient discharge or at end of OP clinic visit) such as updating their PCP with any changes or carrying a list of current medications.

TJC related to Medical Staff

Bylaws, Rules & Regulations

- When there is CONFLICT

  (A) If conflict arises within the medical staff regarding bylaws, rules & regulations, etc., it implements its process for managing internal conflict.

  (B) If conflict arises between the Board and the Organized Medical Staff regarding bylaws, rules & regulations, etc., the hospital implements the hospital's conflict management process.