Health care–associated infections (HAIs) pose a tremendous risk to patient safety. Infection prevention and control activities in the home care setting are made all the more complex because the health care organization is operating in the patient’s home. The Joint Commission’s Infection Prevention and Control (IC) standards provide a framework on which organizations can base their efforts to protect patients from HAIs.

Standard IC.01.05.01 requires home care organizations to plan for preventing and controlling infections. All elements of performance (EPs) for that standard apply to hospice organizations. EP 9 of that standard—applicable to hospice organizations that elect to use The Joint Commission deemed status option—requires organizations to have a written infection prevention and control program for surveillance, identification, prevention, control, and investigation of infections. EP 10 requires that the infection prevention and control program be made a part of the hospice’s quality assessment and improvement program. (See “Related Requirements on page 13 for the complete standard.)

Because hospice care settings can vary widely—for example, care may be provided in the patient’s home, an inpatient setting (freestanding hospice or hospital), or a nursing home—overseeing such a program can be particularly difficult.

Following are some strategies that deemed status hospice organizations can use to ensure compliance with this standard.

**Strategy** Ensure that policies and procedures are comprehensive and in writing. Deemed status hospices should first look to the Joint Commission standards on infection prevention and control, which in some cases are more detailed than the Centers for Medicare & Medicaid Services (CMS) Conditions of Participation. “If you’re meeting Joint Commission standards, then you’re meeting the requirements for deemed status,” says Susan Ambrosy, RN, MSN, surveyor for The Joint Commission.

According to Ambrosy, the organization’s infection control program should be part of the hospice’s overall quality assessment and improvement efforts, and should include the following:

- Infection prevention and control risk assessment
- Policies for hand hygiene
- Policies for standard precautions
- Policies for cleaning and disinfection of equipment and supplies
- Patient and staff education about infection control

The program should also include any additional elements identified as specific to the organization’s patient population. At Family Hospice & Palliative Care in Pittsburgh, an infection prevention and control committee conducts an
annual assessment of the patient population and community served to ensure that specific infection prevention and control needs are being met.

“We serve a nine-county area, with patients in their homes, long term care facilities, one of our two inpatient units, and local hospitals,” says Debra Sauro, RN, BSN, CIC, vice president, Organizational Excellence, for the organization. “There are also a variety of complex diagnoses, such as cancer, cardiac disease, and renal disease, which need to be addressed in our infection prevention and control procedures.”

Strategy Base policies on evidence-based guidelines, expert consensus, and/or a review of current literature. Much of the infection prevention and control data available in the literature is related to inpatient care rather than home health and hospice care, which can make it difficult for hospice organizations to find appropriate guidelines. However, guidelines are available from the Association for Professionals in Infection Control and Epidemiology (APIC) as well as the Centers for Disease Control and Prevention (CDC). Visit http://www.apic.org/Professional-Practice/Scientific-guidelines or http://www.cdc.gov/NHPP/index.htm for more information.

Sauro also notes that organizations should review their state and local public health regulations to ensure that those are being met as well.

At Family Hospice & Palliative Care, the multidisciplinary infection control committee, which includes a dedicated infection prevention and control nurse who reports to the Organizational Excellence department, has been valuable in obtaining expert consensus when literature has not been available.

“The committee includes representatives from environmental services, dietary, pharmacy, employee health, and palliative care, as well as the infection control nurse and the chief medical officer,” Sauro says. “With this group, our organization is able to look at infection control issues from a wide range of perspectives and make sure all the risk factors are being addressed. For example, it might seem unusual to include the dietary department on the committee, but they can help prevent food-borne illnesses and transmission of infection, as well as nutritional support for patients who are more susceptible to infection.”

(continued on page 14)
**Strategy Measure and review infection control rates and policy compliance.** Joint Commission surveyors often find that organizations have established goals regarding infection control and prevention but have not implemented methods for tracking progress toward those goals.

“Organizations might say they’re going to improve hand hygiene or reduce the rate of bloodstream infections, for example, but they don’t have any specific numbers to work toward,” Ambrosy says. “When we ask, ‘How are you going to measure that?’ they don’t have answers. If you have a specific goal, then you can start taking action toward that goal.”

This means that deemed status hospices should have a reporting system for staff to report infections, such as Family Hospice’s electronic system that sends the reports directly to the infection control nurse for analysis.

The organizations should also have a system in place for educating staff and observing them to ensure their compliance with policies. This can be a particular challenge when staff are seeing patients in their homes.

“It’s one thing to use proper hand hygiene when you’re in the health care facility, and the proper supplies are all right there for you,” Ambrosy says. “But it’s another when you’re in the patient’s home, faced with using their sink, the bar soap, and a used hand towel. A trained observer who is well versed in organization policies and the CDC guidelines can find out whether staff are able to follow the procedures appropriately: Do they understand the procedures? Do they have all the supplies they need to follow them correctly?”

Sauro says that at her organization, when a noncompliance issue is discovered, the supervisor works with the infection prevention and control nurse to identify an action plan to be reviewed by the infection control committee.

**Strategy Make patient, family, and staff education an integral part of the infection prevention and control program.** Staff should receive infection prevention and control training at least annually, as well as any time the policies change and any time an incident occurs that leadership believes warrants reeducation.

In addition, staff must be prepared to provide infection prevention and control education to patients and their families. This education should include details on procedures when caring for the patient, and also information on preventing the spread of communicable illnesses, such as minor respiratory infections, that could become serious for patients in hospice care.

“After we educate them, we also provide them with written material,” Sauro says. “We also provide them with the supplies they may need to follow the procedures, such as latex gloves or hand sanitizer. It depends on the infection prevention and control needs of the particular patient.”

**Strategy Take a proactive approach to ongoing infection control and prevention.** Although health care workers often used to focus primarily on infection control, prevention has also become an important part of this care quality issue. To that end, deemed status hospice organizations can address potential infection concerns before they impact the patient.

For example, Family Hospice & Palliative Care’s infection control committee is currently analyzing the risk factors for bloodstream infections, drug-resistant organisms, and infection risks to employees.

“We’re always looking at infection risk factors to make sure we have the necessary controls in place,” Sauro says. “In the end, this isn’t a matter of finding mistakes; it’s about providing the safest possible care to all of our patients.”
The Joint Commission has compiled compliance data from 2012 surveys and reviews to identify the most problematic standards. These are the standards with which health care organizations seeking accreditation or certification struggled the most. The Joint Commission releases such data twice a year. In October 2012, data were released for the first six months of the year. These data represent compliance for the entire 2012 calendar year.1

These data help The Joint Commission recognize trends and tailor education around challenging standards and requirements. They also help organizations identify potential problem areas that need attention.

For the Disease-Specific Care (DSC) Certification Program, few of the identified problematic standards changed between the first six months of 2012 and the year’s end. The following problematic standards for January through June 2012 were removed from the “top ten” by the end of the year:
• Performance Measurement (DSPM) Standard DSPM.2: The program uses measurement data to evaluate processes and outcomes.
• Standard DSPM.3: The program maintains data quality and integrity
• Clinical Information Management (DSCT) Standard DSCT.4: The program shares information with any relevant practitioner or setting about the participant’s disease or condition across the continuum of care.

Replacing these standards on the year-end list are the following:
• Standard DSPM.1: The program has an organized, comprehensive approach to performance measurement.
• Program Management (DSPR) Standard DSPR.8: The program communicates to participants the scope and level of care, treatment, and services it provides.
• Supporting Self-Management (DSSE) Standard DSSE.2: The program addresses lifestyle changes that support self-management regimens.

Top 10 Standards Compliance Issues for 2012, Disease-Specific Care Certification

<table>
<thead>
<tr>
<th>Rank</th>
<th>Standard</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>21%</td>
<td>DSDF.2</td>
<td>The program develops a standardized process originating in clinical practice guidelines or evidence-based practice to deliver or facilitate the delivery of clinical care.</td>
</tr>
<tr>
<td>14%</td>
<td>DSDF.3</td>
<td>The program is designed to meet the participant’s needs.</td>
</tr>
<tr>
<td>13%</td>
<td>DSCT.5</td>
<td>The program initiates, maintains, and makes accessible a health or medical record for every participant.</td>
</tr>
<tr>
<td>12%</td>
<td>DSSE.3</td>
<td>The program addresses participants’ education needs.</td>
</tr>
<tr>
<td>8%</td>
<td>DSDF.1</td>
<td>Practitioners are qualified and competent.</td>
</tr>
<tr>
<td>6%</td>
<td>DSPM.6</td>
<td>The program evaluates participant perception of the quality of care.</td>
</tr>
<tr>
<td>4%</td>
<td>DSPR.1</td>
<td>The program defines its leadership roles.</td>
</tr>
<tr>
<td>4%</td>
<td>DSPR.8</td>
<td>The program communicates to participants the scope and level of care, treatment, and services it provides.</td>
</tr>
<tr>
<td>3%</td>
<td>DSSE.2</td>
<td>The program addresses lifestyle changes that support self-management regimens.</td>
</tr>
<tr>
<td>3%</td>
<td>DSPM.1</td>
<td>The program has an organized, comprehensive approach to performance improvement.</td>
</tr>
</tbody>
</table>

(continued on page 18)
The most problematic standard for both the first six months of 2012 and the year’s end was Delivering or Facilitating Clinical Care (DSDF) Standard DSDF2: “The program develops a standardized process originating in clinical practice guidelines (CPGs) or evidence-based practices to deliver or facilitate the delivery of clinical care;” 21% of DSC–certified organizations were found noncompliant with that standard during 2012.

To see strategies for improving compliance with this standard, see the article “Focus on Certification: Standardizing Processes Based on Clinical Practice Guidelines,” in the January 2012 issue of this newsletter. Key strategies discussed in that article include the following:

• Choosing credible clinical practice guidelines that are appropriate for your organization and patient population
• Educating staff about clinical practice guidelines
• Identifying strategic clinical champions—well-respected clinicians in each department to whom other staff look for guidance to help gain staff buy-in
• Including point-of-care reminders and easily accessible tools in patient care areas or in electronic medical records systems
• Informing and educating patients about the clinical practice guidelines

References: