Joint Commission Requirements for Health Care Volunteers

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Session Objectives

- Describe how Joint Commission designated volunteers in hospitals
- Describe Joint Commission standards applicable to healthcare volunteers

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Understanding Joint Commission Requirements

Standard Label	Standard Text	Actions
HR.01.01.01	The hospital defines and verifies staff qualifications.	

Standard

Standard Introduction and Rationale

Nbr	Elements of Performance (EPs)	CMS	New	FSA	DOC	ESP
1	The hospital defines staff qualifications specific to their job responsibilities. Note 1: Qualifications for infection control may be met through ongoing education, training, experience, and/or certification (such as that offered by the Certification Board for Infection Control). Note 2: Qualifications for laboratory personnel are described in the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88), under Subpart M: "Personnel for Nonwaived Testing" §493.1351-§493.1495. A complete description of the requirement is located at https://www.ecfr.gov/cgi-bin/text-idx?SID=0854acca5427c69e771e5beb52b0b986&mc=true&node=sp42.5.493.m&rgn=div Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: Qualified physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, speech-language pathologists, or audiologists (as defined in 42 CFR 484.4) provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are provided by the hospital. The provision of care and staff qualifications are in accordance with national acceptable standards of practice and also meet the requirements of 409.17. See Appendix A for 409.17 requirements. Note 4: Qualifications for language interpreters and translators may be met through	§482.23(b)(5) §482.24(a) §482.26...			D	ESP-1

Element of Performance

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How are volunteers listed in requirements

Joint Commission Glossary: Staff

As appropriate to their roles and responsibilities, all people who provide care, treatment, or services in the organization, including those receiving pay (for example, permanent, temporary, part-time personnel, as well as contract employees), volunteers and health profession students.

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Environment of Care

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Ensuring a Safe Environment

The hospital establishes and maintains a safe, functional environment.

- To preserve quality and safety
- Major elements:
  - Quality of natural and artificial light
  - Privacy
  - Size and configuration of space
  - Security for patients and their belongings
  - Clear access to internal and external doors
  - Level of noise
  - Space that allows staff to work efficiently

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Safety and Security

The hospital identifies individuals entering its facilities.

Note: The hospital determines which of those individuals require identification and how to do so.

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Emergency Management

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Overall Emergency Management Requirements

- All accredited organizations must have a plan
- Plan is based on hazards vulnerability requirement completed by the organization
- Plan must be “tested” twice a year

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EM.12.01.01 EP 1

The hospital has a written all-hazards emergency operations plan (EOP) with supporting policies and procedures that provides guidance to staff, volunteers, physicians, and other licensed practitioners on actions to take during emergency or disaster incidents. The EOP and policies and procedures include, but are not limited to, the following:

- Mobilizing incident command
- Communications plan
- Maintaining, expanding, curtailing, or closing operations
- Protecting critical systems and infrastructure
- Conserving and/or supplementing resources
- Surge plans (such as flu or pandemic plans)
- Identifying alternate treatment areas or locations
- Sheltering in place
- Evacuating (partial or complete) or relocating services
- Safety and security
- Securing information and records

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EM.12.01.01 EP 3

The hospital's emergency operations plan includes written procedures for when and how it will shelter in place or evacuate (partial or complete) its staff, patients, and volunteers.

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EM.12.02.01 EP 1

The hospital maintains a contact list of individuals and entities that are to be notified in response to an emergency. The list of contacts includes the following:

- Staff
- Physicians and other licensed practitioners
- Volunteers
- Other health care organizations
- Entities providing services under arrangement, including suppliers of essential services, equipment, and supplies
- Relevant community partners (such as fire, police, local incident command, public health departments)
- Relevant authorities (federal, state, tribal, regional, and local emergency preparedness staff)
- Other sources of assistance (such as health care coalitions)

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EM.12.02.01 EP 2

The hospital's communications plan describes how it will establish and maintain communications in order to deliver coordinated messages and information during an emergency or disaster incident to the following individuals:

- Staff, licensed practitioners, and volunteers (including individuals providing care at alternate sites)
- Patients and family members, including people with disabilities and other access and functional needs
- Community partners (such as fire department, emergency medical services, police, public health department)
- Relevant authorities (federal, state, tribal, regional, and local emergency preparedness staff)
- Media and other stakeholders

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EM.12.02.03 EP 1

The hospital develops a staffing plan for managing all staff and volunteers to meet patient care needs during the duration of an emergency or disaster incident or during a patient surge. The plan includes the following:

- Methods for contacting off-duty staff, physicians, and other licensed practitioners
- Acquiring staff, physicians, and other licensed practitioners from its other health care facilities
- Use of volunteer staffing, such as staffing agencies, health care coalition support, and those deployed as part of the disaster medical assistance teams

Note: If the hospital determines that it will never use volunteers during disasters, this is documented in its plan.

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EM.12.02.03 EP 2

The hospital's staffing plan addresses the management of all staff and volunteers as follows:

- Reporting processes
- Roles and responsibilities for essential functions
- Integrating staffing agencies, volunteer staffing, or deployed medical assistance teams into assigned roles and responsibilities

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EM.15.01.01 EP 2

The hospital provides initial education and training in emergency management to all new and existing staff, individuals providing services under arrangement, volunteers, physicians, and other licensed practitioners that is consistent with their roles and responsibilities in an emergency. The initial education and training include the following:

- Activation and deactivation of the emergency operations plan
- Communications plan
- Emergency response policies and procedures
- Evacuation, shelter-in-place, lockdown, and surge procedures
- Where and how to obtain resources and supplies for emergencies (such as procedures manuals or equipment)

Documentation is required.

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EM.15.01.01 EP 3

The hospital provides ongoing education and training to all staff, volunteers, physicians, and other licensed practitioners that is consistent with their roles and responsibilities in an emergency:

- At least every two years
- When roles or responsibilities change
- When there are significant revisions to the emergency operations plan, policies, and/or procedures
- When procedural changes are made during an emergency or disaster incident requiring just-in-time education and training

Documentation is required.

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HR.01.01.01 EP 1

The hospital defines staff qualifications specific to their job responsibilities.

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HR.01.01.01 EP 4

The hospital obtains a criminal background check on the applicant **as required by law and regulation or hospital policy**. Criminal background checks are documented.

Is it required by law/reg or policy??

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HR.01.01.01 EP 5

Staff comply with applicable health screening as required by law and regulation or hospital policy. Health screening compliance is documented.

Is it required by law/reg or policy??

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HR.01.04.01 EP 1 and 3

1. The hospital orients its staff to the key safety content it identifies before staff provides care, treatment, and services. Completion of this orientation is documented.

Note: Key safety content may include specific processes and procedures related to the provision of care, treatment, or services; the environment of care; and infection control.

3. The hospital orients staff on the following:

- Relevant hospital-wide and unit-specific policies and procedures
- Their specific job duties, including those related to infection prevention and control and assessing and managing pain
- Sensitivity to cultural diversity based on their job duties and responsibilities
- Patient rights, including ethical aspects of care, treatment, or services and the process used to address ethical issues based on their job duties and responsibilities

Completion of this orientation is documented.

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HR.01.05.03 EP 29

As part of its workplace violence prevention program, the hospital provides training, education, and resources (at time of hire, annually, and whenever changes occur regarding the workplace violence prevention program) to leadership, staff, and licensed practitioners. The hospital determines what aspects of training are appropriate for individuals based on their roles and responsibilities. The training, education, and resources address prevention, recognition, response, and reporting of workplace violence as follows:

- What constitutes workplace violence
- Education on the roles and responsibilities of leadership, clinical staff, security personnel, and external law enforcement
- Training in de-escalation, nonphysical intervention skills, physical intervention techniques, and response to emergency incidents
- The reporting process for workplace violence incidents (See also LD.03.01.01, EP 9)

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Infection Prevention and Control

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Infection Control

- Understanding importance of handwashing
  - When to use alcohol-based hand rubs versus soap and water
- How to identify and treat isolation rooms and areas

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IM.01.01.03 EP 2

The hospital's plan for managing interruptions to information processes addresses the following:

- Scheduled and unscheduled interruptions of electronic information systems
- Training for staff and licensed independent practitioners on alternative procedures to follow when electronic information systems are unavailable
- Backup of electronic information systems

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National Patient Safety Goals

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Patient Identification

NPSG.01.01.01

Use at least two patient identifiers when administering medications, blood, or blood components; when collecting blood samples and other specimens for clinical testing; and when providing treatments or procedures. The patient's room number or physical location is not used as an identifier.

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Utilization of Volunteers as sitters

2 major utilizations

- Falls prevention
- Suicide risk reduction

- Volunteers should understand:
  - Organization's policy
  - Expectations while sitting
  - Any documentation requirements
  - When to contact a clinician

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Safety Event Reporting

- The leaders implement a hospitalwide patient safety program as follows:
  - One or more qualified individuals or an interdisciplinary group manage the safety program.
  - All departments, programs, and services within the hospital participate in the safety program.
  - The scope of the safety program includes the full range of safety issues, from potential or no-harm errors (sometimes referred to as close calls [“near misses”] or good catches) to hazardous conditions and sentinel events.

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Safety Event Reporting

- The leaders provide and encourage the use of systems for blame-free internal reporting of a system or process failure, or the results of a proactive risk assessment.

- Note: This is intended to minimize staff reluctance to report errors in order to help an organization understand the source and results of system and process failures. The EP does not conflict with holding individuals accountable for their blameworthy errors.

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Workplace Violence

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Workplace Violence Prevention

Programs: **Hospitals & Critical Access Hospitals**

- NEXT STEPS: New/revised requirements for ALL Accreditation Programs

Why Important?

- Literature: Increased Prevalence
- VOC: Nurse Advisory Council

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– Workplace Violence Definition

- "An **act or threat** occurring at the workplace that can include any of the following: **verbal, nonverbal, written, or physical aggression**; threatening, intimidating, harassing, or humiliating words or actions; bullying; sabotage; sexual harassment; physical assaults; or other behaviors of concern **involving staff, licensed practitioners, patients, or visitors**"

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FAQs HR.01.05.03 EP29 (new)

Training & Education: Who and What?

- Leadership, staff, and licensed practitioners
- WPV definition
- Roles/responsibilities during/after event
- Reporting system
  - Per WPV definition
  - Ease of access

* Need to be able to speak to education plan with completion date of year-end 2022

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Compendium of Resources

https://www.jointcommission.org/resources/patient-safety-topics/workplace-violence-prevention/compendium-of-resources/

Purpose

- Free + accessible tools/resources
- Provide guidance/assist with compliance

Layout

- Introduction, including the new or revised requirements
- Resource table
- Reference list
- Index organized by associated topic

ON-DEMAND WEBINAR

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Workplace Violence Prevention Compendium of Resources to Support Joint Commission Accredited Hospitals in Implementation of New and Revised Standards

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Questions? workplaceviolence@jointcommission.org

COVID Vaccine Mandate Update

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Topics for Discussion

- Required facility documentation
- Compliance Timelines based on State
- Required policies and procedures
- External Communication

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Who does the requirement apply to?

The Joint Commission will only be evaluating compliance in the following programs that use our accreditation for deemed status purposes:

- Ambulatory Surgery Centers
- Critical Access Hospitals
- Home Health Agencies
- Home Infusion Therapy Suppliers
- Hospices
- Hospitals

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Required Documents

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Required Documents

1. Overall COVID vaccination rate of eligible staff
2. A list of all staff, including positions/titles, including COVID Vaccination status
3. All policies regarding health care staff COVID vaccinations
   - Policies for COVID Vaccination exemptions
   - Policies for COVID Vaccination Requirements
   - Policies for mitigation of unvaccinated staff
4. List of newly hired staff in last 60 days

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Required Policies and Procedures

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Policy Requirements must include:

- A process for **tracking** and securely **documenting** the COVID-19 **vaccination status** of all staff
- A process for **tracking** and securely **documenting** the COVID-19 vaccination status of any staff who have obtained any **booster doses** as recommended by the CDC.
- A **process** by which staff may **request an exemption** from the staff COVID-19 vaccination requirements based on an applicable federal law.
- A process for **tracking** and securely **documenting** information provided by those staff who have **requested**, and for whom the organization **has granted**, an **exemption** from the staff COVID-19 vaccination requirements based on recognized clinical contraindications or applicable federal laws.
  - *Surveyors will not assess the appropriateness of clinical contraindications or religious exemptions.*

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Policy Requirements must include (cont):

A process for **ensuring** that **all documentation** that confirms recognized clinical contraindications to COVID-19 vaccines and supports staff requests for **medical exemptions** from vaccination has **been signed and dated by a licensed practitioner** who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all applicable state and local laws. Such documentation contains:

- All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive
- The recognized clinical reasons for the contraindications
- A statement by the authenticating practitioner recommending that the staff member be exempted from the organization's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications. *NOTE: Surveyors only evaluate that the documentation is complete; they do not assess the appropriateness of clinical contraindications or religious exemptions.*

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Policy Requirements must include (cont):

- A **process** for ensuring **the implementation of additional precautions**, intended to mitigate the transmission, and spread of COVID-19, for all staff who are **not fully vaccinated** for COVID-19.
- A process for ensuring the **tracking** and securing **documentation** of the vaccination status of staff for whom COVID-19 **vaccination must be temporarily delayed**, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19 and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment.
- **Contingency plans** for staff who are **not fully vaccinated** for COVID-19.

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Vaccination Rate Calculation

SURVEYOR ARE NOT EXPECTED TO CONDUCT CALCULATIONS. THIS IS INFORMATION TO UNDERSTAND HOW THE CALCULATIONS SHOULD BE DONE

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For purposes of calculating compliance

- Staff who have received at least one dose of a vaccine should be placed in the numerator of the calculation during first 30 days.
- Organizations must ensure that any additional required doses are administered in multi-shot vaccination series

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For purposes of calculating compliance

- Numerator includes
  - Pending religious or medical exemption*
  - Approved religious or medical exemption
  - Persons having an approved CDC temporary delay for vaccination
  - Persons with clinical contraindication to receiving COVID Vaccine

* During first 30 days of implementation based on QSO Memo

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Example 1

The Provider employs 100 staff.

- **58 have received all doses of a multi-dose vaccine**
- **5 have been granted medical exemptions**
- **5 have pending religious exemptions**
- **10 have a temporary delay**
- **22 have not received any doses of COVID-19 vaccine and do not have a pending request for an exemption.**

58 + 5 + 5 + 10 = 78; 78 ÷ 100 = 0.78 x 100 = 78% of staff are vaccinated, or have a granted or pending exemption, or have a temporary delay.

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Example 2

The Provider employs 38 staff.

- **13 staff received all doses of a multi-dose vaccine**
- **17 received a single-dose vaccine**
- **5 have a temporary delay**
- **3 have not received any doses of COVID-19 vaccine and have not been granted an exemption.**

13 + 17 + 5 = 35; 35 ÷ 38 = 0.921 x 100 = 92.1 or 92% of staff are vaccinated, have a granted exemption, or a temporary delay.

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Who must be vaccinated?

The vaccination requirements apply to all eligible staff, both current and new, working at a facility regardless of clinical responsibility or patient contact, including:

- Facility Employees
- Licensed Practitioners
- Students
- Trainees
- **Volunteers**
- Contracted Staff
- Staff who perform duties offsite (e.g., home health, home infusion therapy, etc.) and to individuals who enter a CMS regulated facility (Example: A physician with privileges in a hospital who is admitting and/or treating patients onsite)

The regulation does not apply to full-time telehealth workers or remote employees

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What is considered "good faith"?

- If the organization has no or has limited access to vaccine, and the organization has documented attempts to obtain vaccine access (e.g., contact with health department and pharmacies).

AND/OR

- If the organization provides evidence that they have taken aggressive steps to have all staff vaccinated, such as advertising for new staff, hosting vaccine clinics, etc.

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External Communication

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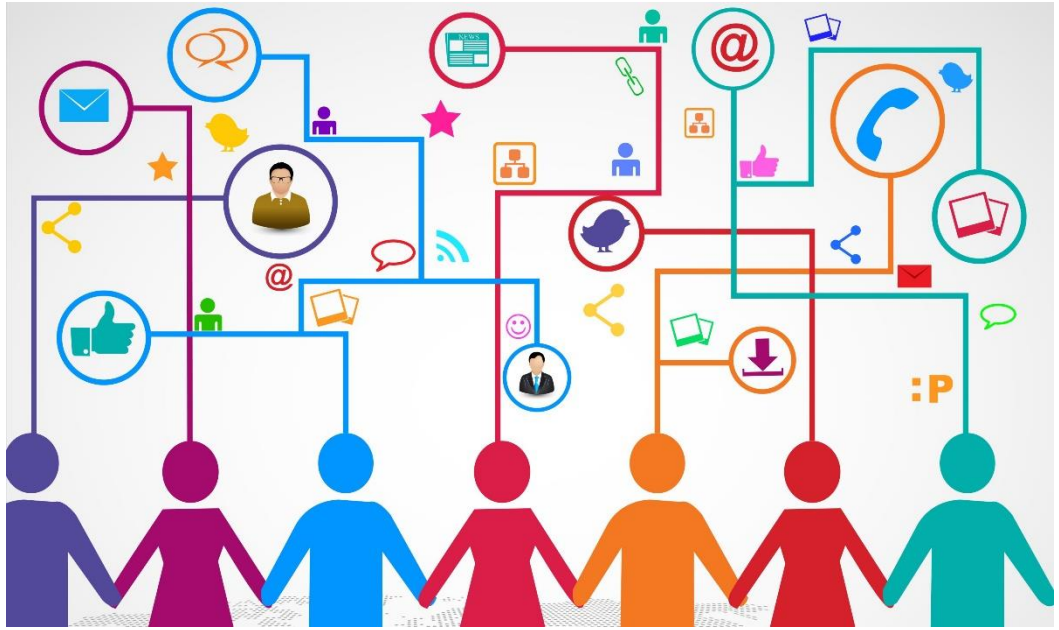
Communication to customers

JC Online Article

FAQ development

Extranet communication

Use of social media



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Current FAQ's

The following is a list of related FAQs:

COVID-19 CMS Vaccination Requirements - Applicable Entities

COVID-19 CMS Vaccination Requirements - Applicable Staff

COVID-19 CMS Vaccination Requirements - CMS Definition of 'Fully Vaccinated'

COVID-19 CMS Vaccination Requirements - Exemptions

COVID-19 CMS Vaccination Requirements - Good Faith Efforts

COVID-19 CMS Vaccination Requirements - Required Documents, Policies and Procedures

COVID-19 CMS Vaccination Requirements - Determination of Compliance

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