


Consistent Interpretation

Joint Commission Surveyors’ Observations Related to Post–Cardiac Arrest Care

The **Consistent Interpretation** column helps organizations to comply with specific Joint Commission requirements. Each installment of the column draws from a database of surveyors’ de-identified observations (left column) on an element of performance (EP)—as well as guidance from the Standards Interpretation Group on interpreting the observations (right column).

The requirements in this column are not necessarily those with high rates of noncompliance. Rather, they have the potential to negatively affect care or create risk if out of compliance. That is, they may appear in the upper right corner of a *Survey Analysis for Evaluating Risk*® (SAFER®) Matrix if cited on survey. Featured EPs apply to hospitals; however, the guidance may be extrapolated to apply to other accreditation programs with similar services and populations served.

This month, **Consistent Interpretation** focuses on developing and implementing policies and procedures related to post–cardiac arrest care.

Note: *Interpretations are subject to change to allow for unique and/or unforeseen circumstances.* 

Provision of Care, Treatment, and Services (PC) Standard PC.02.01.20: The hospital implements processes for post-resuscitation care.	
Noncompliance Implications	Comprehensive post–cardiac arrest care is necessary to address the systemic effects of the ischemia-reperfusion injury following cardiac arrest. Growing evidence suggests that it is critical for both patient survival and optimal neurological outcome. However, significant variations in implementation have been observed across hospitals. Because clinical sequelae following cardiac arrest are many and complex, The Joint Commission technical advisory panel* on resuscitation and the 2020 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care strongly recommend implementing comprehensive, structured, and multidisciplinary protocols of care to optimize survival and neurological outcome.
<p>EP 1: © The hospital develops and follows policies, procedures, or protocols based on current scientific literature for interdisciplinary post–cardiac arrest care.</p> <p>Note 1: <i>Post–cardiac arrest care is aimed at identifying, treating, and mitigating acute pathophysiological processes after cardiac arrest and includes evaluation for targeted temperature management and other aspects of critical care management.</i></p> <p>Note 2: <i>This requirement does not apply to hospitals that do not provide post–cardiac arrest care.</i> (See also PI.03.01.01, EP 22)</p>	
Compliance Rate	In 2022, the noncompliance percentage for this EP was 0.32% —that is, 4 of 1,245 hospitals surveyed did not comply with this requirement.

* See the [R³ Report](#) that includes the prepublication resuscitation standards that became effective January 1, 2022.

Surveyor Observations	Guidance/Interpretation
<ul style="list-style-type: none"> ● The organization did not provide evidence that it had adopted policies, procedures, and/or protocols. ● The organization did not review its policies, procedures, and/or protocols as required by organization policy. 	<ul style="list-style-type: none"> ● The Joint Commission does not mandate the use of specific therapies. For example, there is no mandate to treat all comatose patients with targeted temperature management (TTM). ● The organization can decide whether it develops a policy, procedure, and/or protocol. ● Processes for post–cardiac arrest care can be formalized as a single policy, several policies or procedures or protocols, and/or a combination of several types of documents. ● Standard PC.02.01.20, EPs 1 and 2, do not apply if the facility does not provide critical care management beyond initial stabilization and transfers cardiac arrest patients. ● A TTM policy, procedure, and/or protocol must be in place if the facility evaluates patients for TTM and initiates TTM before patients are transferred to another facility.

EP 2: © The hospital develops and follows policies, procedures, or protocols based on current scientific literature to determine the neurological prognosis for patients who remain comatose after cardiac arrest.

Note 1: *Because any single method of neuroprognostication has an intrinsic error rate, current guidelines recommend that multiple testing modalities be incorporated into organizations' routine procedures and protocols to improve decision-making accuracy.*

Note 2: *This requirement does not apply to hospitals that do not provide post–cardiac arrest care.*

(See also PI.03.01.01, EP 22)

Compliance Rate	In 2022, the noncompliance percentage for this EP was 0.40% —that is, 5 of 1,245 hospitals surveyed did not comply with this requirement.
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Surveyor Observations	Guidance/Interpretation
<ul style="list-style-type: none"> ● The organization did not provide evidence that it had adopted policies, procedures, and/or protocols. ● The organization did not review its policies, procedures, and/or protocols as required by organization policy. 	<ul style="list-style-type: none"> ● Standard PC.02.01.20, EPs 1 and 2, do not apply if the organization does not provide critical care management beyond initial stabilization and transfers cardiac arrest patients.

EP 3: © The hospital follows written criteria or a protocol for inter-facility transfers of patients for post–cardiac arrest care, when indicated.

(See also PI.03.01.01, EP 22)

Compliance Rate	In 2022, the noncompliance percentage for this EP was 0.08% —that is, 1 of 1,245 hospitals surveyed did not comply with this requirement.
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Surveyor Observations	Guidance/Interpretation
<ul style="list-style-type: none"> ● The organization does not have written criteria or a protocol for inter-facility transfer. However, it accepts cardiac arrest patients, does not provide ongoing management of cardiac arrests patient survivors, and transfers these patients. 	<ul style="list-style-type: none"> ● <i>Inter-facility transfer</i> does not include transfers between different departments within the same organization or within the same organization complex.

Performance Improvement (PI) Standard PI.01.01.01: The hospital collects data to monitor its performance.	
<p>EP 10: The hospital collects data on the following:</p> <ul style="list-style-type: none"> ● The number and location of cardiac arrests (for example, ambulatory area, telemetry unit, critical care unit) ● The outcomes of resuscitation (for example, return of spontaneous circulation [ROSC], survival to discharge) <p>Note: ROSC is defined as return of spontaneous and sustained circulation for at least 20 consecutive minutes following resuscitation efforts.</p> <ul style="list-style-type: none"> ● Transfer to a higher level of care <p>(See also LD.03.07.01, EP 2; PI.03.01.01, EP 22)</p>	
Compliance Rate	In 2022, the noncompliance percentage for this EP was 0.93% —that is, 14 of 1,512 hospitals surveyed did not comply with this requirement.
Noncompliance Implications	There are many barriers to reliable data collection on resuscitation, such as the inadequacy of current diagnostic coding systems to reliably track the incidence of cardiac arrests. However, hospitals, at a minimum, must conduct regular surveillance of all cardiac arrest events and track data on cardiac arrest survival outcomes for the purposes of planning, training, and evaluation of current practices. Survival rates often vary depending on where cardiac arrests occur in the hospital, and it is important to have site-level data to target improvement interventions. Measuring survival after acute resuscitation (measured as the return of spontaneous circulation [ROSC]) provides information on the quality of intra-arrest resuscitative efforts. The metric of survival to discharge includes the quality of post-resuscitation care and is essential for internal quality measurement.
Surveyor Observations	Guidance/Interpretation
<ul style="list-style-type: none"> ● The organization was not collecting data on unexpected cardiac arrests or code blue events. 	<ul style="list-style-type: none"> ● A process exists to collect data on the results of resuscitation. ● It is up to the organization to define its “locations” for the purposes of data collection. ● Cardiac arrest in the emergency department would include only a cardiac arrest in this location and not include those who experience cardiac arrest elsewhere and arrive by emergency transport services. It is up to the organization to decide whether to capture out-of-hospital arrest data. ● <i>Transfer to a higher level of care</i> means transfer to another health care facility for continued treatment. Examples include hospital to hospital, ambulatory surgery center to hospital, and so on. It does not include transfers between different departments within the same organization if they are housed in the same building or within the same organization complex. ● If the organization transfers 100% of cardiac arrest survivors, <i>transfer to a higher level of care</i> and <i>survival to discharge</i> metrics do not apply. ● The organization determines how data will be collected, documented, tracked, and reported.