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Special Report: Suicide Prevention in Health Care Settings

Recommendations Regarding Environmental Hazards for Providers and Surveyors

The Joint Commission has assembled an expert panel to provide guidance to customers and surveyors on safeguards to prevent suicide. Following are recommendations from the panel's ongoing discussion of issues related to prevention of suicide in health care settings.

Suicide is now the 10th leading cause of death in the United States. Although the vast majority of suicides occur outside of health care facilities, many suicides occur every year within health care facilities, including psychiatric hospitals, psychiatric units within general hospitals, general medical/surgical wards, and emergency departments. Most experts think that far more suicides occur shortly after hospital discharge, although conclusive national data are not available.

Since publishing *Sentinel Event Alert* Issue 7, "Inpatient Suicides: Recommendations for Prevention" in 1998, The Joint Commission has worked with health care organizations on conducting rigorous risk assessments to help make their health care environment safer and prevent suicides. National Patient Safety Goal NPSG.15.01.01 was introduced in 2007 to further focus preventive efforts. However, suicides continue to occur within health care settings. Over the last five years, approximately 85 suicides per year were reported as sentinel events to The Joint Commission, leading to calls to redouble preventive efforts.

As health care organizations and accrediting bodies intensify efforts to make the health care environment safer, it is critical to use available data and expert opinion to have clear guidelines on what constitutes serious environmental hazards that must be corrected and what mitigation strategies are acceptable in those situations when all potential hazards

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The Joint Commission

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In Sight

This column lists developments and potential revisions that can affect accreditation and certification and tracks proposed changes before they are implemented. Items may drop off this list before the approval stage if they are rejected at some point in the process.

APPROVED

STANDARDS

- Revisions to requirements for **critical access hospitals** to maintain alignment with Centers for Medicare & Medicaid Services (CMS) requirements (*see* article on page 8 of this issue)
- Revisions to certification requirements for **patient blood management** to maintain alignment with AABB standards (*see* article on page 8 of this issue)
- Revisions to swing bed requirements for **hospitals** and **critical access hospitals** to maintain alignment with CMS requirements (*see* article on page 10 of this issue)

CURRENTLY IN DEVELOPMENT

STANDARDS

- Proposed further revisions to Environment of Care (EC) and Life Safety (LS) standards for **all accreditation programs** to maintain alignment with CMS requirements
- Proposed new and revised requirements for **deemed home health** organizations to align with new CMS requirements
- Proposed new requirements for documentation of maternal status for HIV, hepatitis B, group B strep disease, and syphilis for the **hospital** and **critical access hospital** programs
- Proposed new requirements for newborn naming conventions (program applicability to be determined by research)
- Proposed new requirement for weighing pediatric patients in kilograms (program applicability to be determined by research)
- Proposed new requirement for antibiotic stewardship for the **ambulatory care** and **office-based surgery practice** programs
- Proposed new pain management and assessment requirement for the **ambulatory care**, **behavioral health care**, **critical access hospital**, **home care**, **laboratory**, **nursing care center**, and **office-based surgery practice** programs

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cannot be removed. Over the last year there have been several specific situations where surveyors for The Joint Commission and/or state agencies have disagreed on what constitutes a ligature risk and what mitigation strategies are acceptable. There needs to be consensus on these issues so that health care organizations will know what changes they need to make to keep patients safe and so surveyors can reliably assess organizations' compliance with standards.

To provide guidance to customers and surveyors on what constitutes adequate safeguards to prevent suicide, The Joint Commission assembled an expert panel with representatives from provider organizations, experts in suicide prevention and design of behavioral health care facilities, Joint Commission surveyors and staff, and representatives from the Centers for Medicare & Medicaid Services (CMS). Two meetings were held at The Joint Commission on June 9 and August 18, 2017. The participants are listed in Appendix A. Health care organizations were asked to provide data on suicides that had occurred within their facilities, where possible, to help inform the panel's decisions on the risk posed by specific potential ligature risk points. A formal consensus process was used to develop the recommendations, which are presented on the following pages. These recommendations address only the most debated and contentious issues related to environmental hazards; excellent articles and books are available about the design of behavioral health care facilities and how to conduct full environmental risk assessments. In addition, although it was not a focus of discussion, the expert panelists all emphasized the critical importance of well-trained, vigilant, compassionate staff who rigorously follow procedures for protecting patients. Health care organizations should focus as much on staff training and monitoring compliance with protocols as they do on detecting and correcting specific environmental hazards.

The expert panel will continue to meet to discuss issues related to prevention of suicide in health care settings and the period immediately after discharge from inpatient care. The Joint Commission convened a third Suicide Expert Panel on October 11, 2017, to discuss other behavioral health care settings, such as residential treatment, partial hospitalization, and outpatient settings. The recommendations from that panel will be added to the recommendations in this document as soon as they are finalized. The Joint Commission is also organizing a fourth meeting to discuss mitigation plans, including recommendations for monitoring patients with serious suicidal ideation in settings that are not ligature-resistant. The Joint Commission believes the ongoing work of the panel will be an important resource for our country in trying to reach national consensus on the many challenging issues involved in caring for suicidal patients.

Recommendations for Inpatient Psychiatric Units

1. ***Inpatient psychiatric units, in both psychiatric hospitals and general/acute care settings, must be ligature-resistant in the following areas:***
   - ***Patient rooms***
   - ***Patient bathrooms***
   - ***Corridors****
   - ***Common patient care areas****

   Nursing stations with an unobstructed view (so that a patient attempt at self-harm at the nursing station would be easily seen and interrupted) and areas behind self-closing/self-locking doors do not need to be ligature-resistant and will not be cited for ligature risks.

   **Note that patient rooms and bathrooms (recommendation 5) differ from corridors and common patient care areas (recommendation 6) in the type of ceiling required to be considered ligature-resistant.*

The panel recommended the term "ligature-resistant" rather than the term "ligature-free" because they did not think it possible to remove all the potential ligature risk points that have even a remote chance of being successfully used in a suicide attempt. With respect to elements in the physical environment, the panel adopted this definition of ligature resistant: "Without points where a cord, rope, bedsheet, or other fabric/material can be looped or tied to create a sustainable point of attachment that may result in self-harm or loss of life."

2. ***In inpatient psychiatric units, in both psychiatric hospitals and general/acute care settings, the doors between patient rooms and hallways must contain ligature-resistant hardware which includes, but may not be limited to, hinges, handles, and locking mechanisms.***

3. ***In inpatient psychiatric units, in both psychiatric hospitals and general/acute care settings, health care organizations should not be required to have risk-mitigation devices installed to decrease the chance that the top of a corridor door will be used as a ligature attachment point.***

Although exact rates are not available, several panelists reported that they were aware of cases in which a patient slipped a ligature between the corridor door and the door frame and/or hinges and committed suicide. Please see Appendix B for supporting data related to suicides by corridor doors. There are several mechanical devices available to decrease the risk of the top of a door being used to fix a ligature, including

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laser beams, pressure-sensing plates, and monitoring cameras. However, all of these have limitations, including false alarms that could distract staff and increase the risk that a patient will attempt suicide. Moreover, there is little data available on the real-world effectiveness of these devices. Instead of mandatory use of these unproven devices, organizations should note such doors on their environmental risk assessments and describe their mitigation strategies, such as appropriate rounding and monitoring by staff, requiring that doors be left open during certain hours, and so on.

4. ***In inpatient psychiatric units, in both psychiatric hospitals and general/acute care settings, the transition zone between patient rooms and patient bathrooms must be ligature-free or ligature-resistant.***

This may be accomplished with mechanical or behavioral solutions. Examples of mechanical solutions include removing the bathroom door, placing an alarm on the door to prevent inappropriate use, and using a special door designed to prevent using the top to support a ligature (for example, an angled upper edge or breakaway magnetic hinges). The most common behavioral solution is denying access to the bathroom unless staff is present; this still requires having the profile of the door be ligature-resistant in the closed arrangement. Note that some states do not allow modifications or removal of doors due to privacy concerns, including the state of Virginia's Human Rights Office, the Agency for Health-Care Administration in Florida, and the Department of Mental Health in Massachusetts. In such instances, surveyors must survey to state regulations.

5. ***In inpatient psychiatric units, in both psychiatric hospitals and general/acute care settings, patient rooms and bathrooms must have a solid ceiling.***

In these areas, a drop ceiling is not an acceptable alternative. Please see Appendix B for supporting data related to suicides by drop ceiling.

6. ***In inpatient psychiatric units, in both psychiatric hospitals and general/acute care settings, drop ceilings can be used in hallways and common patient care areas as long as all aspects of the hallway are fully visible to staff and there are no objects that patients could easily use to climb up to the drop ceiling, remove a panel, and gain access to ligature risk points in the space above the drop ceiling.***

Drop ceilings in areas that are not fully visible to staff (for example, a right-angle curve of a corridor) or for which it is possible that patients could easily move objects to access the area above the drop ceiling should be noted on the risk assessment and have an appropriate mitigation plan. Mitigation strategies for existing drop ceilings in these areas may include gluing the tiles in place, using tile retention clips, installing motion sensors above the ceiling to sense tampering, or using another comparable harm-resistive arrangement. The acceptability of these strategies depends upon the physical capabilities of the patient population.

Data from panelists on the risks posed from drop ceilings are shown in Appendix B.

7. ***In inpatient psychiatric units, in both psychiatric hospitals and general/acute care settings, medical needs and the patients' risk for suicide should be carefully assessed and balanced to determine the optimal type of patient bed utilized to meet both medical and psychiatric needs. For patients who require medical beds with ligature points, there must be appropriate mitigation plans and safety precautions in place.***

8. ***Standard toilet seats with a hinged seat and lid are not a significant risk for suicide attempts or self-harm; they should not be cited during surveys and do not need to be noted on a risk assessment.***

There needs to be consensus on these issues so that health care organizations will know what changes they need to make to keep patients safe and so surveyors can reliably assess organizations' compliance with standards.

No panelist was able to recall a suicide in which a patient used or attempted to use a toilet seat as a ligature attachment point. After the meeting, several panelists examined data from their own health care organizations (*see* Appendix B). In the large number of patients included in these analyses, there was only one case where a patient attempted suicide by using a toilet seat as a ligature attachment point. No harm occurred in this incident. Therefore, the panel concluded that traditional toilet seats are as safe as toilets without movable seats and covers (that is, the type used in prisons), offer patients more comfort, and are less stigmatizing.

Recommendations for General Acute Inpatient Settings

9. ***The general medical/surgical inpatient setting does not need to meet the same standards as an inpatient psychiatric unit to be a ligature-resistant environment. Fixed ligature risks, including bathroom fixtures and doors, will not be cited on survey in these areas.***

Patients with serious suicidal ideation who are admitted to medical/surgical inpatient settings often require equipment to monitor and treat their medical conditions, so it is impossible to make their environment truly ligature-resistant. (*See* Recommendation 10 for essential actions to protect patients with serious suicidal ideation).

10. If a patient requiring admission to a general acute inpatient setting has serious suicidal ideation, all objects that pose a risk for self-harm that can be removed without adversely affecting the ability to deliver medical care should be removed. In addition, mitigating strategies must be put into place and documented, including one-to-one (1:1) monitoring, careful assessment of objects brought into the room by visitors, and protocols for transporting patients to other parts of the hospital (such as radiology). Organizations should have policies, procedures, training, and monitoring systems in place to ensure these are done reliably.

The Joint Commission will cite ligature risk in a general/acute care inpatient setting if the organization cannot demonstrate that all of the following are routinely and rigorously done:

- Training staff and testing them for competency on how they would address the situation of a patient with serious suicidal ideation
- 1:1 monitoring of patients with serious suicidal ideation
- Conducting risk assessments for objects that pose a risk for self-harm and identifying those objects that should be routinely removed from the immediate vicinity of patients with suicidal ideation who are cared for in the main area of the emergency department
- Removing any items that a suicidal patient could use for self-harm
- Monitoring of visitors
- Monitoring of bathroom use for a patient with serious suicidal ideation
- Implementing protocols to have qualified staff accompany patients with serious suicidal ideation from one area of the hospital to another

Recommendations for Emergency Departments

11. Emergency departments do not need to meet the same standards as an inpatient psychiatric unit to be a ligature-resistant environment. Fixed ligature risks, including bathroom fixtures and doors, will not be cited on survey in these areas.

Patients cared for in emergency departments often require equipment to monitor and treat their medical conditions, so it is impossible to make their environment truly ligature-resistant. (*See* Recommendation 12 for essential actions to protect patients with serious suicidal ideation).

12. There are two main strategies to keep patients with serious suicide ideation safe in emergency departments: 1) Place the patient in a "safe room" that is ligature-resistant or that can be made ligature-resistant by having a system that allows fixed equipment that could serve as a ligature point to be excluded from the patient care area (for example, a locking cabinet), and 2) keep the suicidal patient in the main area of the emergency department, initiate continuous 1:1 monitoring, and remove all objects that pose a risk for self-harm that can be easily removed without adversely affecting the ability to deliver medical care. Organizations should have policies, procedures, training, and monitoring systems in place to ensure these are done reliably.

The Joint Commission does not mandate the use of "safe rooms" within the emergency department. Organizations should do all of the following to protect patients:

- Screen all patients presenting with psychiatric disorders for suicidal ideation (NPSG 15.01.01).
- Formally assess the risk of a suicide attempt among patients with suicidal ideation ("secondary screening").
- Conduct a risk assessment for objects that pose a risk for self-harm and identify those objects that should be routinely removed from the immediate vicinity of patients with suicidal ideation who are cared for in the main area of the emergency department.
- Have a protocol for removing all movable items that could be used for self-harm from within reach of a patient with suicidal ideation.
- Have protocols for monitoring patients with suicidal ideation, including the use of the bathroom, and how to ensure that visitors do not bring objects that the patient could use for self-harm.
- Have a protocol to have qualified staff accompany a patient with serious suicidal ideation from one area of the hospital to another.
- Train staff and test them for competency on how they would address a situation with a patient with serious suicidal ideation.

13. Patients with serious suicidal ideation must be placed under demonstrably reliable monitoring (1:1 continuous monitoring, observations allowing for 360-degree viewing, continuously monitored video). The monitoring must be linked to the provision of immediate intervention by a qualified staff member when called for. The organization has a defined policy that includes this detail.

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Appendix A: Suicide Expert Panel Participants

Expert Panel Members: June 9, 2017, Expert Panel

Brian Ahmedani, PhD, LMSW (Henry Ford Health System)
Kristen Baumann, PhD (NYC Health + Hospitals)
Pat Chmielewski, RN, MS (Centers for Medicare & Medicaid Services)
Mike Hogan, PhD (Hogan Health Solutions)
Jim Hunt, AIA (Behavioral Health Facility Consulting, LLC)
Stephanie Hursey, RN, MSN, MHA, CCM (Centers for Medicare & Medicaid Services)
Karen Johnson, MSW (Universal Health Services)
Ira Katz, MD, PhD (Department of Veterans Affairs)
Anne Kelly, MA, BSN (Acadia Healthcare)
Mary Jane Krebs, APRN, BC, FACHE (Spring Harbor Hospital)
Richard McKeon, PhD (Substance Abuse and Mental Health Administration [SAMHSA])
Peter Mills, PhD, MS (VA National Center for Patient Safety Field Office)
Mary Ellen Palowitch, MHA, RN (Centers for Medicare & Medicaid Services)
Robert Roca, MD, MPH, MBA (Sheppard Pratt Health System)
Michael Sherbun, PhD, RN, MHA (Signature Healthcare Services)
David Sine, DrBE, CSP, ARM, CPHRM (Veterans Health Administration)
Marie Vasbinder, JD, MBA, RN, CHC, NEA-BC (Centers for Medicare & Medicaid Services)
Kim Walton, Community Health Network
DD White, RN, MSN (HCA Healthcare)

Joint Commission panel members:

David Baker, MD, MPH, FACP (Executive Vice President, Division of Healthcare Quality Evaluation)
Ana McKee, MD (Executive Vice President & Chief Medical Officer)
Mark Pelletier, RN, MS (Chief Operating Officer)
Lisa Vandecaveye, JD, MBA, FACHE (General Counsel)
Sue Boylan-Murray, MBA (Senior Director of Field Operations)
Stephen Kramer, MD (Physician Surveyor)
Tim Markijohn, MBA, MHA, CHFM, CHE (Life Safety Code Field Director)
Kathryn Petrovic, MSN, RN-BC (Senior Associate Director, Standards Interpretation SIG)
Sandy Rahe, MBA, RN (Nurse Surveyor)
Nina Smith, RN (Hospital Field Director)
Peter Vance, LPCC, CPHQ (Behavioral Health Care Field Director)
James Woodson, PE, CHRM (Engineer, Standards Interpretation SIG)

Expert Panel Members: August 18, 2017, Expert Panel

Kristen Baumann, PhD (NYC Health + Hospitals)
Wade Ebersole, MHA (Denver Health)
Nancy Foster, MA (American Hospital Association)
Kate Gagliardi, MSN, RN (Office of Quality, Safety, and Value, VACO)
Jim Hunt, AIA (Behavioral Health Facility Consulting, LLC)
Karen Johnson, MSW (Universal Health Services)
Anne Kelly, MA, BSN (Acadia Healthcare)
Mary Jane Krebs, APRN, BC, FACHE (Spring Harbor Hospital)
Peter Mills, PhD, MS (VA National Center for Patient Safety Field Office)
Rebecca Parker, MD, FACEP (President, American College of Emergency Physicians)
Robert Roca, MD, MPH, MBA (Sheppard Pratt Health System)
Michael Sherbun, PhD, MHA, RN (Signature Healthcare Services)
David Sine, DrBE, CSP, ARM, CPHRM (Veterans Health Administration)
Joseph Weinstein, (Steward Group)
DD White, RN, MSN (HCA Healthcare)

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Paul Ziaya, MD (Senior Director of Field Operations)

Appendix B: Data on Specific Potential Ligature Risk Points

Data collection was initiated after both expert panels to inform potential ligature-related risks within health care organizations. Data collection centered on the use of toilet seats, drop ceilings, and corridor doors as ligature points.

Data on use of corridor doors as a ligature point:

- Several provider panel members provided numerator and denominator data for attempts or successful suicides in calendar year 2016 related to ligature via corridor doors. The denominators were reported in different terms:
  - 934,533 acute inpatient days
  - 2 million inpatients
  - 838,972 bed days of care
  - 11 acute care hospitals representing 1,413 beds
  - 44,337 patient days
  - 4,347 census days for adolescents and 13,321 for adults
- The total numerator was ***13 suicide attempts***.

Data on use of drop ceilings as a ligature point:

- Several provider panel members provided numerator and denominator data for attempts or successful suicides in calendar year 2016 related to ligature via drop ceilings. The denominators were reported in different terms:
  - 934,533 acute inpatient days
  - 2 million inpatients
  - 838,972 bed days of care
  - 11 acute care hospitals representing 1,413 beds
  - 44,337 patient days
  - 4,347 census days for adolescents and 13,321 for adults
- The total numerator was ***2 suicide attempts***. Both incidents involved locking ceiling tiles in bedrooms. No cases were reported of suicide attempts involving drop ceilings in corridors or common areas.

Data on use of toilet seats as a ligature point:

- We received responses from 4 health care provider systems that were represented on the June 9th panel. The denominators were reported in different terms:
  - 934,533 acute inpatient days
  - 2 million inpatients
  - 838,972 bed days of care
  - 11 acute care hospitals representing 1,413 beds
- The total numerator was ***1 attempt*** *(no harm reported as it was not useable as a ligature point)*.

EXCITING NEWS!

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Approved: Revisions to Requirements for Critical Access Hospitals

Effective November 12, 2017, The Joint Commission has revised Human Resources (HR) Standard HR.01.01.01, Element of Performance (EP) 15 and Leadership (LD) Standard LD.04.01.01, EP 6 for **critical access hospitals**. In addition, Standard LD.04.02.03 includes new EP 23 regarding the disclosure of information. These EP changes are intended to more clearly address the Centers for Medicare & Medicaid Services (CMS) Conditions of Participation (CoPs) for critical access hospitals.

Also **effective November 12, 2017**, are revisions to Standard LD.01.03.01, EP 21 and Provision of Care, Treatment, and Services (PC) Standard PC.02.01.03, EP 1 for **psychiatric and rehabilitation distinct part units in critical access hospitals**. The Joint Commission also has deleted all standards requirements related to distinct part units in a critical access hospital's use of a unified and integrated medical staff (Medical Staff [MS] Standard MS.01.01.05, EPs 1–4 and MS.01.01.01, EP 37). Per clarification from CMS, critical access hospitals are not permitted to have a unified and integrated medical staff.

These revisions, which are available on The Joint Commission website at https://www.jointcommission.org/standards_information/prepublication_standards.aspx, will be posted in the November 12, 2017, E-dition® update and published in the 2018 *Comprehensive Accreditation Manual for Critical Access Hospitals* print manual.

For more information, please contact Laura Smith, MA, project director, Department of Standards and Survey Methods, The Joint Commission, at lsmith@jointcommission.org.

Approved: Revisions to Patient Blood Management Certification Requirements

Effective January 1, 2018, The Joint Commission has updated several requirements in its certification program for **Patient Blood Management**. An evidence-based approach to optimizing the care of patients who might need transfusion, this Joint Commission certification program is based on the *AABB Standards for a Patient Blood Management Program* and encompasses all aspects of patient evaluation and clinical management surrounding the transfusion decision-making process.

To maintain alignment with the AABB Standards, The Joint Commission has updated the following areas of its Patient Blood Management certification program:

- Requirements for each activity level and program members
- Educational requirements for individuals who order and/or transfuse blood
- Defined guidelines on transfusion orders
- Procedures for emergent/urgent patients including massive blood loss
- Intraoperative methods for patient blood management
- Annual reporting of program performance

New requirements also have been added to address the following:

- Caring for patients who decline use of blood or blood-derived products
- Policies and procedures that minimize blood loss during phlebotomy
- Specific elements of preventive actions required when responding to nonconformances

The updated standards, which are available on The Joint Commission website at http://www.jointcommission.org/standards_information/prepublication_standards.aspx, will be included in the fall 2017 E-dition® update of requirements for the P*atient Blood Management Certification Manual*. As a reminder, Patient Blood Management certification is an option available to Joint Commission–accredited hospitals that have at least a four-month track record of compliance with all Patient Blood Management requirements included in this manual.

For more information, please contact Ron S. Quicho, MS, associate project director, Department of Standards and Survey Methods, at rquicho@jointcommission.org.

Summary of Upcoming E-dition® and Print Releases

<table>
<tr><th>E-dition Releases
(All accreditation and certification programs)</th><th>Print Release
(Ambulatory care, behavioral health care, critical access hospitals, disease-specific care, home care, hospitals, laboratory, and nursing care centers)</th></tr>
<tr><td>November 12, 2017
This release updates Emergency Management (EM) requirements for the ambulatory care, critical access hospital, hospital, and home care programs to align with changes resulting from the Centers for Medicare & Medicaid Services (CMS) final rule on emergency preparedness (see October Perspectives). Also updated in this release are various requirements for deemed-status critical access hospitals (see article on page 8 of this issue).</td><td rowspan="3">January 1, 2018
Revisions from the November 12 and January 1 E-dition release dates will be included in <u>one</u> print release date for the ambulatory care, behavioral health care, critical access hospital, hospital, laboratory, and nursing care center accreditation programs as well as for the disease-specific care certification program. This includes 2017 Update 2 for the ambulatory care, behavioral health care, and hospital programs as well as the print 2018 manuals for all of the listed programs. (Revisions for office-based surgery practices and other certification programs will be released only via E-dition).

Changes from the January 13 release related to swing beds and life safety will not be included in the ambulatory care, behavioral health care, critical access hospital, hospital, and nursing care center print releases. (These changes will appear in print in the 2018 spring update for the ambulatory care, behavioral health care, and hospital programs and the 2018 fall update for the critical access hospital and nursing care center programs.)

The publication date of the home care print release, including 2017 Update 2 and the print 2018 manual, has been delayed to allow for inclusion of the revisions from all three electronic E-dition release dates. Purchasers should receive the print home care releases in January 2018.</td></tr>
<tr><td>January 1, 2018
This release is the regularly scheduled update for all accreditation and certification programs for revisions to requirements effective January 1.</td></tr>
<tr><td>January 13, 2018
This release updates requirements related to swing beds for hospitals and critical access hospitals resulting from changes to CMS Conditions of Participation (CoPs) (see article on page 10 of this issue). Also updated in this release are several home care requirements to maintain alignment with a CMS final rule applicable for home health agencies (article to be included in upcoming issue of Perspectives). Some additional life safety-related changes will be included for ambulatory care, behavioral health care, critical access hospital, hospital, nursing care center, and office-based surgery practices.</td></tr>
<tr><td colspan="2">Questions about these upcoming releases may be directed to your Joint Commission account executive.</td></tr>
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Swing Bed Requirements Updated to Maintain Alignment with CMS

In response to revisions to Centers for Medicare & Medicaid (CMS) Conditions of Participation (CoPs), The Joint Commission will begin surveying deemed-status **hospitals** and **critical access hospitals** to updated swing bed regulatory requirements as of **November 28, 2017**.

Background

On October 4, 2016, CMS published the final rule "Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities."[1] This final rule revised CoPs for swing beds in hospitals and critical access hospitals at §482.58 and 485.645, respectively, and was effective November 28, 2016. As several technical errors were identified in this final rule, a corrected final rule was published in the *Federal Register* on July 13, 2017 (effective immediately).[2] Hospitals and critical access hospitals may access the corrected final rule to determine the applicability of regulations beginning with §483.

The Joint Commission will begin implementing the several changes it has made to its swing bed requirements based on this corrected final rule early in 2018, once CMS has accepted them (see table below for significant changes). Any swing-bed related findings on surveys conducted from November 28, 2017, through January 12, 2018, will be cited at Leadership (LD) Standard LD.04.01.01, Element of Performance (EP) 2: "The hospital provides care, treatment, and services in accordance with licensure requirements, laws, and rules and regulations." Effective January 13, 2018, surveyors will use the CMS-accepted EPs to survey swing beds.

The revised CoPs will appear in the hospital and critical access hospital crosswalks in a winter E-dition® update. The final standards changes will be posted on The Joint Commission's website at https://www.jointcommission.org/standards_information/prepublication_standards.aspx once acceptance from CMS is received. In the meantime, organizations can view partial crosswalks featuring the new and revised regulations on their *Joint Commission Connect*™ extranet sites.

For more information, please contact Laura Smith, MA, project director, Department of Standards and Survey Methods, The Joint Commission, at lsmith@jointcommission.org.

References

1. Federal Register. Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities. Accessed Oct 24, 2017. https://www.federalregister.gov/documents/2016/10/04/2016-23503/medicare-and-medicaid-programs-reform-of-requirements-for-long-term-care-facilities
2. Federal Register. Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities. Accessed Oct 24, 2017. https://www.federalregister.gov/documents/2017/07/13/2017-14646/medicare-and-medicaid-programs-reform-of-requirements-for-long-term-care-facilities

Changes to Swing Bed Requirements	Applicability	
	Hospital	Critical Access Hospital
Coordination of assessments with the preadmission screening and resident review (PASARR)	X	
Incorporation of any specialized rehabilitation services into the treatment plan as a result of PASARR recommendations		X
Dental services policy addressing when it is the organization's responsibility for lost or damaged dentures	X	X
Referral of residents with lost or damaged dentures for dental services within three days	X	X
Focus on patient-centered care and involvement of resident in care planning		X
Organization provides written notification of closure to required agencies and residents prior to impending closure		X
Reporting of alleged violations related to abuse and neglect within 2 hours or 24 hours after the allegation depending on the type of allegation	X	X

Clarifications and Expectations

Understanding Key Changes to the Life Safety Standards

The Joint Commission has identified the need to increase the field's awareness and understanding of the National Fire Protection Association's (NFPA's) Life Safety Code®* *(NFPA 101-2012). To address this need,* Perspectives *has been publishing the column* ***Clarifications & Expectations****, authored by George Mills, MBA, FASHE, CEM, CHFM, CHSP, director, Department of Engineering, The Joint Commission.† This column clarifies standards expectations and provides strategies for challenging compliance issues, primarily in life safety and the environment of care but also in the vital area of emergency management. You may wish to share the ideas and strategies in this column with your organization's facilities leadership.*

The Joint Commission has rewritten the "Life Safety" (LS) chapter to align with the 2012 edition of the Life Safety Code® *(NFPA 101-2012) and* Health Care Facilities Code *(NFPA 99-2012), and it has made changes to the "Environment of Care" (EC) chapter as well. In September 2016, the US Centers for Medicare & Medicaid Services (CMS) issued K-Tags; in response, The Joint Commission created a second iteration of elements of performance (EPs), which it expects to publish in late 2017 or early 2018.*

This 11th and final installment in a series of columns about the updated standards focuses on LS.02.01.34, addressing both the 2017 elements of performance (EPs) and proposed forthcoming EPs for 2018. These proposed EPs are still in draft form, pending edits and review, and may differ from their final language.

To distinguish the January 2017 EPs from the proposed EPs, ***the draft language for proposed forthcoming requirements will appear in italics****. Note that EP language currently in effect does not appear in italics, except for explanatory notes.*

Fire Alarm System Maintenance

The Joint Commission's Life Safety (LS) standards on fire alarm system maintenance pertain to installation and location requirements for the fire alarm system. This chapter also provides the requirements for complying with specific NFPA codes and lists specific editions of those codes. For requirements pertaining to ongoing maintenance of fire alarm systems, see the Environment of Care (EC) standards.

Standards Connection

Standard LS.02.01.34

The hospital provides and maintains fire alarm systems.

Revised EP 1, Proposed 2018

A fire alarm system is installed with systems and components to provide effective warning of fire in any part of the building in accordance with NFPA 70-2012, National Electric Code and NFPA 72-2010, National Fire Alarm Code.

The *National Electric Code* and *National Fire Alarm Code* are on equal footing with the *Life Safety Code.* As such, health care organizations must comply with all three, as defined in the "Application" chapter of each code. LS.02.01.34, EP 1 ensures compliance with the specific editions in effect for each code.

Standards Connection

LS.02.01.34, Revised EP 2, Proposed 2018

The master fire alarm control panel is located in an area with a smoke detector or in an area that is continuously occupied and protected, which is an area enclosed with one-hour–fire-rated walls and ¾-hour–fire-rated doors. In areas not continuously occupied and protected, a smoke detector is installed at each fire alarm control unit. In a newly designated occupancy, detection is also installed at notification appliance circuit power extenders and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity.
(For full text, refer to NFPA 101-2012: 18/19.3.4.1; 9.6)

This EP contains the following two components:

1. The organization protects the master fire alarm control panel by one of the following two options:
   - Locating it in an area with smoke detection OR
   - Locating it in an area that is:

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* Life Safety Code® *is a registered trademark of the National Fire Protection Association, Quincy, MA.*
† Please note that George Mills left The Joint Commission in early October 2017. This column was written before Mills's departure.

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  - – Continuously occupied
  - – Protected with 1-hour–fire-rated walls
  - – Protected with 45-minute–fire-rated doors

2. The organization monitors the integrity of conductors and other signaling channels in the following two ways:
   - In newly installed detection at the notification appliance circuit power extenders and supervising station transmitting equipment (in newly designated occupancies)
     - – Monitor circuit integrity is discussed in NFPA 72-1010, 10.17.
   - Monitoring the integrity of fire alarm system wiring (or other transmission paths)
     - – Monitoring occurs for interconnecting of equipment, devices, and appliances and wiring connections, unless otherwise permitted or required by NFPA 72-2010 10.17.1.3–10.17.1.14. Ensure the occurrence of a single open or single ground-fault condition in the installation conductors or other signaling channels is automatically indicated within 200 seconds (*see* NFPA 72-2010, 10.17.1.1).

Standards Connection

LS.02.01.34, Revised EP 3, Proposed 2018

Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas are not required at exits if manual alarm boxes are located at all nurse's stations or other continuously attended staff location, provided alarm boxes are visible, continuously accessible, and 200 feet of travel distance is not exceeded. (For full text, refer to NFPA 101-2012: 18/19.3.4.2.1; 18/19.3.4.2.2; 9.6.2.5)

Manual Fire Alarm Boxes

Manual alarm boxes throughout the facility allow for staff (or anyone else) to manually initiate the fire alarm system. Typically, these are located near an exit to allow building occupants to sound the alarm while also exiting the building as quickly as possible. Limiting access to manual fire alarm boxes is appropriate in some patient care areas. In these instances, fire alarm boxes are positioned in a nursing station or other continuously attended staff location, in a spot in which the manual pull station is visible and accessible. (Note that the distance from an exit may not exceed 200 feet.)

Standards Connection

LS.02.01.34, Revised EP 4, Proposed for 2018

In new buildings, occupant notification is provided automatically in accordance with NFPA 101-2012: 9.6.3 by audible and visual signals. Positive alarm sequence in accordance with 9.6.3.4 is permitted in buildings protected throughout by a sprinkler system. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of a fire. Annunciation zoning for the fire alarm and sprinklers is provided by audible and visual indicators; zones are not larger than 22,500 square feet per zone. (For full text, refer to NFPA 101-2012: 18.3.4.3; 18.3.4.4.3; 9.6.4)

Revised EP 5, Proposed 2018

In existing buildings, occupant notification is provided automatically in accordance with NFPA 101-2012: 9.6.3 by audible and visual signals. Positive alarm sequence in accordance with 9.6.3.4 is permitted in buildings protected throughout by a sprinkler system. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of a fire. (For full text refer to NFPA 101-2012: 19.3.4.3; 9.6.4; 9.7.1.1(1))

Occupant Notification

Occupant notification protects building occupants. Seconds matter in a fire condition, and occupant notification, including automatic audible and visual alerts, has saved lives. Staff must understand these alerts so they can react as expected by the organization. The fire alarm system also automatically transmits an alarm to first responders.

NFPA 72-2010 23.8.1.3 lists requirements for a positive alarm sequence. If an organization meets each of the six components listed, the organization could have an initial 15 seconds to acknowledge the signal from an automatic fire detection device. Then trained personnel would have as much as 180 seconds to evaluate the fire condition and possibly reset the system. If the system is not reset during the investigation phase, notification signals in accordance with the building evacuation or relocation plan (and remote signals) will activate automatically.

Standards Connection

LS.02.04.34, Revised EP 6, Proposed 2018

Activation of the required fire alarm control functions occurs automatically and is provided with an alternative power supply in accordance with NFPA 72-2010. (For full text refer to NFPA 101-2012: 18/19.3.4.4; 9.6.1; 9.6.5)

In critical care areas, such as the intensive care unit, the audible portion of the occupant notification alarm may be silenced. This is an option, not a requirement. If the building system is unable to manage this, the alarm will still sound.

In new buildings, annunciation zoning (that is, creating zones that will clearly indicate what area of the building is alarming) for the fire alarm and sprinklers is provided by audible and visual indicators. These zones are not larger than 22,500 square feet. Annunciation zoning allows staff and responders to manage notification by affected areas, which supports the defend-in-place practice in health care occupancies.

Standards Connection

Standard LS.02.01.34, Revised EP 7, Proposed 2018

The fire alarm signal automatically transmits using one of the provisions of NFPA 101-2012: 9.6.4. (For full text, refer to NFPA 101-2012: 18/19.3.4)

Activation of Control Functions

Activation of the fire alarm control functions means that the devices in the fire alarm system, when activated, initiate the expected response. The reference to *Life Safety Code* Section 9.6.5 provides an example in which a smoke detector senses smoke and in turn activates the fire alarm control, and the associated smoke barrier doors close.

The four provisions of the *Life Safety Code* at Section 9.6.4 are based on NFPA 72-2010:

1. An auxiliary fire alarm system is connected to a municipal fire alarm system for transmitting a fire alarm to the public fire service communication center.
2. A central station fire alarm system is a system (or a group of systems) in which the circuits and devices are operated automatically to a listed central station staffed by competent and experienced servers and operators. On receipt of a signal, staff take appropriate action.
3. A proprietary supervising station fire alarm system is a system that serves contiguous or noncontiguous properties under one ownership, from a proprietary supervising station located at the protected property, in which trained and competent staff are in constant attendance.
4. A remote supervising station fire alarm system is a system installed to transmit alarm, supervisory, and trouble signals from one or more protected premises to a remote supervising station, where appropriate actions are taken.

Each of these must be arranged to transmit the alarm automatically to the fire department (or another responding agency).

Standards Connection

LS.02.01.34, Revised EP 8, Proposed 2018

Smoke detection systems are provided in spaces open to corridors as required by NFPA 101-2012: Chapter 18/19. (For full text, refer to NFPA 101-2012: 18/19.3.4.5.2; 18/19.3.6.1)

Standards Connection

LS.02.01.34, Revised EP 9, Proposed 2018

The ceiling membrane is installed and maintained in a manner that permits activation of the smoke detection system. (For full text, refer to NFPA 101-2012: 18/19.3.4.1)

Smoke Detection Systems

This EP calls out smoke detection because of the importance of quick and appropriate actions when the fire alarm is activated. Throughout the sections covering corridor separation in NFPA 101-2012 18/19.3.6.1, the focus is on requirements for sprinkler protection, smoke detection, use of space (both allowed and not allowed use), access to an exit, and supervision by staff.

In a fire condition, the products of combustion (smoke, for example) rise and come into contact with a smoke detector, which then activates the fire alarm system. One property of heated air is to seek a cooler location, so as the smoke rises, it seeks a cooler space. If the ceiling tile were not in place, the smoke could enter the interstitial space and delay the activation of the smoke detector. This is why the entire ceiling membrane must be intact.

Standards Connection

LS.02.01.34, Revised EP 10, Proposed 2018

The hospital meets all other Life Safety Code fire alarm requirements related to NFPA 101-2012: 18/19.3.4.

"All Other" Requirements

The Joint Commission and CMS require organizations to comply with the entire *Life Safety Code* as well as associated codes and standards. LS.02.01.34 refers to fire alarm systems and requires compliance with Section 18/19.3.4 and portions of Chapters 7, 8, and 9 of the *Life Safety Code.*

This month's column also appears in the November issue of *Environment of Care®* News.

Consistent Interpretation

Joint Commission Surveyors' Observations on PC.01.03.01, EPs 25 and 26

The bimonthly ***Consistent Interpretation*** column is designed to support organizations in their efforts to comply with Joint Commission requirements. Each column draws from a de-identified database containing surveyors' observations—as well as guidance from the Standards Interpretation Group on how to interpret the observations—on an element(s) of performance (EP) in the *Comprehensive Accreditation Manual for Hospitals*. This installation (the 12th in the series) highlights Provision of Care, Treatment, and Services (PC) Standard PC.01.03.01, EPs 25 and 26. **Note:** *Interpretations are subject to change to allow for unique and/or unforeseen circumstances.*

Provision of Care, Treatment, and Services (PC) Standard PC.01.03.01: The hospital plans the patient's care.	
EP 25: The hospital establishes or adopts diagnostic computed tomography (CT) imaging protocols based on current standards of practice, which address key criteria including clinical indication, contrast administration, age (to indicate whether the patient is pediatric or an adult), patient size and body habitus, and the expected radiation dose index range. **Note:** *This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.*	
Surveyor Observations	**Guidance/Interpretation**
The health care organization was unable to produce evidence of adopting computed tomography (CT) protocols that included the required elements. There was no evidence that the imaging protocols contained contrast administration detail (type, dose, concentration, volume, etc.).	In accordance with current clinical practice, order detail for contrast administration (type, dose, concentration, volume, etc.) are addressed in approved imaging protocols. Do not look for separate orders for contrast detail. Contrast detail may reside in electronic retrievable systems and documented in the interpretive report. Examples of electronic retrievable systems may include a dose management system or a picture archiving and communication system; therefore, do not score if the imaging protocol is not contained within a patient chart in electronic health record systems.
EP 26: Diagnostic computed tomography (CT) imaging protocols are reviewed and kept current with input from an interpreting physician, medical physicist, and lead imaging technologist to make certain that they adhere to current standards of practice and account for changes in CT imaging equipment. These reviews are conducted at time frames identified by the hospital. (For hospitals that use Joint Commission accreditation for deemed status purposes, refer to MS.06.01.03, EP 9 for supervision of radiologic services) **Note:** *This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.*	
Surveyor Observations	**Guidance/Interpretation**
The health care organization was unable to demonstrate evidence that CT protocols had been reviewed since being initiated four years ago even though its policy required review every two years. There was no evidence that the review of imaging protocols included an interpreting radiologist, medical physicist, and lead imaging technologist.	If the organization is unable to retrieve imaging protocol information, see Standard RC.02.01.01 EP 2: "The medical record contains the following clinical information . . . Results of diagnostic and therapeutic tests and procedures." See Record of Care, Treatment, and Services (RC) Standard RC.01.05.01, EP 1 if the organization is not retaining imaging protocol information in accordance with record retention policy, law and regulation: "The retention time of the original or legally reproduced medical record is determined by its use and hospital policy, in accordance with law and regulation."

The Joint Commission Journal on Quality and Patient Safety®

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