

# The Joint Commission Perspectives<sup>®</sup>

THE OFFICIAL NEWSLETTER OF THE JOINT COMMISSION

## FAQs: Suicide Risk Recommendations

The Joint Commission has received questions related to the Suicide Risk Recommendations published in various *Perspectives* articles over recent months.<sup>1-4</sup> The following set of Frequently Asked Questions (FAQs) is intended to address these questions and provide clarification to the field.

*For questions related to the FAQs or the suicide risk recommendations, please contact the Standards and Interpretation Group (SIG) via the [Standards Online Submission Form](#).*

### Inpatient Psychiatric Units

**QUESTION:** Can you please clarify the first recommendation as it relates to the nurses station?

**ANSWER:** *The recommendation states: “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.”<sup>1</sup> This refers to what can be seen within the nurses station, not what is being seen from the nurses station. If there is an unobstructed view of everything within a nurses station, then patients should not be able to attempt self-harm at the nurses station since this would be easily seen and interrupted.*

**QUESTION:** How many ligature-resistant medical beds does my unit have to have?

## Contents

- 1 FAQs: Suicide Risk Recommendations
- 6 Consistent Interpretation
- 9  **NEW:** Requirement for Distinct Identification for Newborns
- 10  **UPDATE:** EP Review Project, Phase IV
- 12  **CHANGES:** Changes to Requirements for Organizations Providing Fluoroscopy Services
- 13 FSA Tool Temporarily Offline for July 2018 Standards Update
- 14 New Direct Data Submission Platform Announced for Performance Measures
- 15  **APPROVED:** New Performance Measures for Primary Stroke Centers
- 17  **APPROVED:** New and Revised Pain Assessment and Management Standards
- 19 Enhancements Announced for Speak Up™ Program
- 20 June JQPS Table of Contents
- 22 In Sight

**ANSWER:** *The Joint Commission has not specified a requirement for the number of ligature-resistant beds on any given unit. This will depend on the needs of the patient population. The type of medical bed should be balanced based on the medical needs and the patients' risk for suicide. For patients who require medical beds that have ligature points, there must be appropriate mitigation plans and safety precautions in place. This information should be documented within the patient's medical record. In addition, The Joint Commission will not advise on the type of medical beds or ligature-resistant bed that should be purchased for patients. These decisions should be balanced based on patient needs.*

**If these medical beds are being used within an inpatient psychiatric unit, safety provisions must be considered for all patients who could be at risk for suicide. Provisions may include locking the patient room door where a medical bed is being used when unoccupied, removing a medical bed from the unit if not in use, and/or any intervention that restricts access to the medical bed by other patients.**

**QUESTION:** **Can drop ceilings be used in hallways and common patient care areas?**

**ANSWER:** *Yes. 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 at all times and there are no objects that patients could easily use to climb up to the drop ceiling.*

**QUESTION:** **Are over-the-door alarms required to be used on patient bedroom doors from the corridor?**

**ANSWER:** *We neither discourage nor promote the use of these devices.*

**QUESTION:** **If patients are transported to another location (such as another building for programming), does that building/space need to be ligature resistant?**

**ANSWER:** *Patients who are currently at high risk for suicide should remain in a ligature-resistant environment. Monitoring of patients leaving the unit for a period of time must protect patients from self-harm.*

**QUESTION:** **Is there a height requirement in order to consider something a “ligature risk”?**

**ANSWER:** *There is no height requirement for a ligature risk. Information from various sources notes that suicides as a result of asphyxiation can occur at any height. Specifically, we have had multiple reports of suicides or suicide attempts during which patients fixed a ligature to a low pipe and around their neck and then spun their body (“alligator roll”) to twist the ligature until it asphyxiated them. Thus, low-to-the-ground exposed piping (such as piping near toilets or under the sink, for example) or any other apparatus protruding from the wall or another structure is still considered a ligature risk if the patient is able to create a sustainable point of attachment with another material in order to inflict self-harm or cause loss of life.*

**QUESTION:** What type of shower curtains are allowable in an inpatient psychiatric unit?

**ANSWER:** *The Joint Commission will not advise or recommend any particular type of shower curtain, but shower curtains are considered a risk. The expectation is that shower curtains should be noted on an environmental risk assessment and the organization must have a mitigation plan for monitoring any high-risk patients near the curtain or area where this risk is present.*

**QUESTION:** Can curtains be used in place of a bathroom door in an inpatient psychiatric unit?

**ANSWER:** *If curtains are used in place of a bathroom door, analysis of this risk should be noted on the environmental risk assessment, and the organization must have a mitigation plan for monitoring any high-risk patients near the curtain or area where the risk is present.*

## Emergency Departments

**QUESTION:** Do emergency departments need to be ligature resistant?

**ANSWER:** *No. Emergency departments do not need to meet the same standards as an inpatient psychiatric unit to be a ligature-resistant environment. Patients in emergency departments often require equipment to monitor and treat their medical conditions, so it is impossible to make their environment truly ligature resistant. However, organizations must implement safeguards to keep patients with active suicidality safe during the course of treatment in that setting (see Recommendation #12<sup>1</sup>). In designing the emergency department environment, the organization must first consider state rules and regulations (typically the state health department).*

**QUESTION:** Does every emergency department need to have a “safe room”?

**ANSWER:** *No, The Joint Commission does not mandate “safe rooms” in emergency departments. Please see Recommendation #12 to understand how patients can be protected during treatment in the emergency department.<sup>1</sup>*

**QUESTION:** Do we have to have 1:1 monitoring for every psychiatric patient who comes in through the emergency department?

**ANSWER:** *No. Only patients with serious suicidal ideation (that is, those with a plan and intent) must be placed under demonstrably reliable monitoring. Most importantly, the monitoring must be linked to immediate intervention by a qualified staff member when called for.*

**QUESTION:** Do we have to assess every patient for suicide risk who comes into the emergency department?

**ANSWER:** *No. Only patients being evaluated or treated for behavioral health conditions as their primary reason for care must be screened for suicide risk. Please reference National*

Patient Safety Goal NPSG 15.01.01.01 for additional detail in addition to Joint Commission standards and requirements regarding screening protocols.

**QUESTION:** What if all objects posing a ligature risk cannot be removed from the area where high-risk patients are being treated or triaged?

**ANSWER:** Please refer to the [second Emergency Department FAQ above](#) and Recommendation #12.<sup>1</sup> The organization should remove all items that can be removed from the room and provide an appropriate level of monitoring based upon patient's suicide risk and the ligature/self-harm items that remain in the environment to ensure patient care is provided in a safe environment. The organization is expected to develop and implement a policy/procedure to direct staff, provide education to staff as to the procedure, and ensure demonstrated competence and compliance.

**If the organization has a designated "safe room," The Joint Commission expects this room to be ligature resistant.**

## Miscellaneous Questions

**QUESTION:** What are the requirements for an inpatient substance abuse detox unit?

**ANSWER:** Organizations providing inpatient substance abuse detox treatment (as the primary focus of treatment) should follow the recommendations applicable to general acute care inpatient settings, given the complexity of physical health care required to care for these patients. These units do not need to meet the same recommendations as psychiatric inpatient units.<sup>1</sup>

**As with any patient receiving treatment for mental health, screening, assessment, and reassessment are critical when determining the appropriate level of care.**

**QUESTION:** What does "serious" risk for suicide mean?

**ANSWER:** Organizations should use an evidence-based process to conduct a suicide assessment of patients who exhibit suicidal behavior or who have screened positive for suicidal ideation. The assessment should directly ask about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors. After this assessment, patients should be classified as high, medium, or low risk of suicide. The Joint Commission considers "serious" as equivalent to "high risk." (Please refer to NPSG 15.01.01 for information relevant to screening and assessment of patients at risk for suicide).

**QUESTION:** Are the recommendations the same for open and/or unlocked psychiatric units?

**ANSWER:** The recommendations for a ligature-resistant environment<sup>1</sup> for inpatient psychiatric units (in both a psychiatric hospital and a general acute care hospital) apply to closed or secure/locked psychiatric units in which entrance to and exit from the unit are controlled by unit staff and a patient could not independently leave the unit without supervision. The recommendations would not apply to an open or unlocked psychiatric unit in which patients are able to enter and exit of their own accord.

**QUESTION:** Do emergency departments in Joint Commission–accredited ambulatory care organizations need to comply with the “Recommendations for Emergency Departments” in the November 2017 *Perspectives* article?

**ANSWER:** Yes. These freestanding emergency departments accredited under the Ambulatory Care Accreditation Program must comply with the emergency department recommendations.<sup>1</sup> 

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## References

1. Joint Commission Resources. Special report: Suicide prevention in health care settings. *Jt Comm Perspect.* 2017 Nov;37(11):1 and 3–7.
2. Joint Commission Resources. Special report: Suicide prevention in health care settings. *Jt Comm Perspect.* 2018 Jan;38(1):1–3.
3. Joint Commission Resources. Notes on suicide prevention panel recommendations published in November. *Jt Comm Perspect.* 2018 Feb;38(2):12.
4. Joint Commission Resources. Update: Recommendations from fourth meeting of suicide expert panel. *Jt Comm Perspect.* 2018 Mar;38(3):1 and 2.

# Consistent Interpretation

## Joint Commission Surveyors' Observations on IC Requirements and Medication Compounding

The bimonthly **Consistent Interpretation** column is designed to support organizations in their efforts to comply with Joint Commission requirements. Each installment of the 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) from the hospital standards.

**Consistent Interpretation** is currently focusing on Joint Commission requirements that may be cited for observations related to medication compounding, a topic of growing concern for organizations that perform this service. This column highlights three Infection Prevention and Control (IC) requirements that surveyors have cited for medication compounding-related issues. **Note:** *Interpretations are subject to change to allow for unique and/or unforeseen circumstances.* 

<p><b>Infection Prevention and Control (IC) Standard IC.01.05.01:</b> The hospital has an infection prevention and control plan.</p>	
<p><b>EP 1*:</b> When developing infection prevention and control activities, the hospital uses evidence-based national guidelines or, in the absence of such guidelines, expert consensus.</p> <p>*In 2017 the noncompliance percentage for this EP was 3.81%—that is, 55 of 1,443 hospitals surveyed were out of compliance with this requirement.</p>	
Surveyor Observations	Guidance/Interpretation
<p>The organization failed to utilize standard of practice regarding personal protective equipment (PPE) requirements for sterile compounding. For example, the organization did not include hair coverings on the list of required PPE.</p>	<p>The organization's policy for PPE must include all of the following items:</p> <ul style="list-style-type: none"> <li>• Shoe covers</li> <li>• Head and facial hair covers</li> <li>• Face mask</li> <li>• Non-shedding gown</li> </ul> <p>If the organization's policy is correct but staff are not wearing the required PPE, this observation should be scored at Standard IC.02.01.01, EP 2.</p>
<p><b>Infection Prevention and Control (IC) Standard IC.02.01.01:</b> The hospital implements its infection prevention and control plan.</p>	
<p><b>EP 1*:</b> The hospital implements its infection prevention and control activities, including surveillance, to minimize, reduce, or eliminate the risk of infection. (See <i>also</i> MM.09.01.01, EP 5).</p> <p>*In 2017 the noncompliance percentage for this EP was 44.98%—that is, 649 of 1,443 hospitals surveyed were out of compliance with this requirement.</p>	

Surveyor Observations	Guidance/Interpretation
The hospital did not have documentation of the required hood and room cleaning for the IV compounding area in the pharmacy.	<ul style="list-style-type: none"> <li>• The following components of secondary engineering controls must be checked every six months:               <ul style="list-style-type: none"> <li>✓ Total air particulate count (ISO level)</li> <li>✓ HEPA filter leak test</li> <li>✓ Air exchanges in room</li> <li>✓ Room pressurization</li> <li>✓ Surface microbial sampling (must occur within each ISO classification environment)</li> <li>✓ Air microbial sampling</li> </ul> </li> <li>• Shift duties, daily duties, and monthly cleaning duties are required. Completion must be documented.</li> <li>• Handwashing must occur to elbows for a minimum of 30 seconds.</li> <li>• Staff must wash hands prior to donning gloves.</li> <li>• Gloves should be cleaned with sterile alcohol anytime they are removed from the ISO Class 5 environment or come into contact with a nonsterile surface.</li> <li>• A fingernail-cleaning device must be available for use to (and be used by) compounding staff.</li> <li>• Regular isopropyl alcohol cannot be used to clean the buffer area/ante area or the ISO Class 5 environment. Sterile alcohol must be used.</li> <li>• Detergent must be diluted per instructions for use for quantities of products.</li> <li>• Compounders are prohibited from wearing external wear (such as jackets, scarves), visible jewelry, and makeup.</li> <li>• Staff with upper respiratory infections or skin conditions that cause sloughing of skin (such as sunburn, dandruff, eczema) cannot work in the IV room.</li> </ul>
Rust was noted on the IV compounding cabinet.	
A staff member compounding a sterile product was noted to be wearing makeup.	
The mop utilized to clean the ISO Class 7 environment was also used to clean the pharmacy area.	
It was noted that the pharmacy compounding room had fabric chairs that cannot be properly cleaned as the environment requires.	
<p><b>EP 2<sup>‡</sup>:</b> The hospital uses standard precautions [footnote: For further information regarding standard precautions, refer to the website of the Centers for Disease Control and Prevention (CDC) at <a href="http://www.cdc.gov/hai/">http://www.cdc.gov/hai/</a> (Infection Control in Healthcare Settings)], including the use of personal protective equipment, to reduce the risk of infection. (See also EC.02.02.01, EP 4)</p> <p><b>Note:</b> <i>Standard precautions are infection prevention and control measures to protect against possible exposure to infectious agents. These precautions are general and applicable to all patients.</i></p> <p><sup>‡</sup> In 2017 the noncompliance percentage for this EP was 18.43%—that is, 266 of 1,443 hospitals surveyed were out of compliance with this requirement.</p>	
Surveyor Observations	Guidance/Interpretation
The compounding staff member used the same alcohol swab to clean more than one critical site.	Use one alcohol swab per critical site. Note that swabs—not spray bottles—must be used for critical sites.
A staff member was observed putting on shoe covers as the last step in donning PPE for the compounding room.	Because items must be donned from dirtiest to cleanest, PPE must be donned in order of the dirtiest activity to the cleanest activity: shoe cover → hair cover → face mask → hand wash → gown → gloves.

The neck of the compounder's gown was not snug around the neck.

Critical sites are equipment and locations that include any component or fluid pathway surfaces:

- Openings
- Vial tops
- Ampule necks
- Needle hubs, shafts, and tips
- Syringe tips and plungers
- Tubing and dispensing pin spikes
- Injection ports of IV solutions



# New: Requirement for Distinct Identification for Newborns

The Joint Commission recently approved one new requirement for **hospitals** and **critical access hospitals** that provide labor and delivery services. This new element of performance (EP)—**effective January 1, 2019**—is at National Patient Safety Goal NPSG.01.01.01, EP 3. The EP is designed to improve the naming convention of newborns after delivery to prevent medical errors—such as wrong tests, wrong procedures, or administering the wrong expressed breastmilk to an infant—due to conventional, nondistinct naming methods. These requirements were finalized using responses from a public field review, which included review from professional organizations. The project’s [R<sup>3</sup> Report](#) provides the rationales for the new requirements as well as references to the research articles used to develop them.

The new requirement requires hospitals and critical access hospitals to use distinct naming methods for their newborn patients; the EP also provides examples of how organizations may meet the new requirement based on their current practices and areas of self-perceived risk. Hospitals and critical access hospitals are asked to evaluate their current naming methods of newborn identification and determine how they can take that naming convention one step further for the safety of their newborn patients.

The new, underlined requirement shown below will be posted on the [Prepublication Standards](#) page of The Joint Commission website. The changes also will be reflected in the fall 2018 E-dition® and the 2019 hard copy publications of the *Comprehensive Accreditation Manuals* for the hospital and critical access programs.

For more information, please contact [Jennifer Hurlburt](#), MSN, RN, APN/CNS, associate director, Department of Standards and Survey Methods, The Joint Commission.

	<p><b>Official Publication of Joint Commission Requirements</b></p> <h2 style="margin: 0;">New Requirement for Newborn Naming Convention</h2>
<p>APPLICABLE TO HOSPITALS AND CRITICAL ACCESS HOSPITALS</p> <p><b>Effective January 1, 2019</b></p> <p><b>National Patient Safety Goals (NPSG)</b></p> <hr style="border: 0.5px solid #004a99;"/> <p><b>National Patient Safety Goal 01.01.01:</b> Use at least two patient identifiers when providing care, treatment, and services.</p> <p><b>Element of Performance for NPSG.01.01.01</b></p> <p>3. <u>For newborn patients:</u> Use distinct methods of identification for newborn patients.</p>	<p><b>Note:</b> <i>Examples of methods to prevent misidentification may include the following:</i></p> <ul style="list-style-type: none"> <li>● <i>Distinct naming systems could include using the mother’s first and last names and the newborn’s gender (for example: “Smith, Judy Girl” or “Smith, Judy Girl A” and “Smith, Judy Girl B” for multiples).</i></li> <li>● <i>Standardized practices for identification banding (for example, two body-site identification and barcoding).</i></li> <li>● <i>Establish communication tools among staff (for example, visually alerting staff with signage noting newborns with similar names).</i></li> </ul>



# UPDATE: EP Review Project, Phase IV

## Joint Commission Continues Streamlining of Accreditation Standards

The Joint Commission is continuing its efforts to streamline and consolidate its existing elements of performance (EPs) for **all accreditation programs** as part of the EP (Element of Performance) Review Project. The next group of revisions, which are part of Phase IV of the project, become **effective January 1, 2019**.

While Phases I, II, and III of the EP Review Project (a component of the Project REFRESH process improvement initiatives) resulted in the deletion of hundreds of EPs across accreditation programs, Phase IV is the evaluation of EPs across all accreditation programs in order to streamline and consolidate them. Chapters reviewed in the first two parts of Phase IV were summarized by chapter and accreditation program in the October 2017 and February 2018 issues of *Perspectives*.

The recently completed third part of Phase IV reviewed the “Care, Treatment, and Services” (CTS) chapter (behavioral health care program), the “Medication Management” (MM) chapter (all programs except laboratory), the “Nursing” (NR) chapter (hospital and critical access hospital programs), and the “Provision of Care, Treatment, and Services” (PC) chapter (all programs except behavioral health care and laboratory). As with the first two parts of Phase IV, consolidating requirements has reduced the number of EPs in these chapters. The results are summarized by chapter and accreditation program in Table 1.

Table 1. Numbers of EPs Before and After Third Phase IV Consolidations			
Program	Chapter	Number of EPs Before Consolidation	Number of EPs After Consolidation
Ambulatory Care	MM	115	76
	PC	157	155
Behavioral Health Care	CTS	789	648
	MM	163	124
Critical Access Hospital	MM	137	95
	NR	22	15
	PC	191	190
Hospital	MM	143	94
	NR	21	14
	PC	210	199
Home Care	MM	146	106
	PC	267	259
Laboratory	N/A	N/A	N/A
Nursing Care Centers	MM	113	76
	PC	187	177
Office-Based Surgery Practices	MM	57	38
	PC	48	47

The consolidated requirements, which will be posted on the [Prepublication Standards](#) page of The Joint Commission website, will be reflected in the fall 2018 E-dition® update and the 2019 hard copy publications of the *Comprehensive Accreditation Manuals*.

## What's Next

The fourth and last part of Phase IV includes the review of the “Leadership” (LD) chapter (all programs) and the “Equipment Management” (EQ) chapter (home care program). The “Environment of Care” (EC) and “Emergency Management” (EM) chapters (all programs) and the “Life Safety” (LS) chapter (all programs except office-based surgery practice) are not part of the project because they have recently undergone significant revisions. The “Medical Staff” (MS) chapter (hospital and critical access hospital programs), the “Quality System Assessment for Nonwaived Testing” (QSA) chapter (laboratory program), and the “National Patient Safety Goals” (NPSG) chapter (all programs) may be reviewed at a later date.

Table 2 provides a recap of which chapters have been and are being reviewed during the different parts of Phase IV of the EP Review Project. Questions may be directed to [Laura Smith, MA](#), project director, Department of Standards and Survey Methods, The Joint Commission. 

Table 2. EP Review Project: Phase IV									
Part	Chapters Reviewed	Applicable Programs							
		AHC	BHC	CAH	HAP	OME	LAB	NCC	OBS
Part 1	“Human Resources” (HR)	✓		✓	✓	✓	✓	✓	✓
	“Human Resources Management” (HRM)		✓						
	“Infection Prevention and Control” (IC)	✓	✓	✓	✓	✓	✓	✓	✓
	“Rights and Responsibilities of the Individual” (RI)	✓	✓	✓	✓	✓	✓	✓	✓
Part 2	“Document and Process Control” (DC)						✓		
	“Information Management” (IM)	✓	✓	✓	✓	✓	✓	✓	✓
	“Performance Improvement” (PI)	✓	✓	✓	✓	✓	✓	✓	✓
	“Record of Care, Treatment, and Services” (RC)	✓	✓	✓	✓	✓		✓	✓
Part 3	“Care, Treatment, and Services” (CTS)		✓						
	“Medication Management” (MM)	✓	✓	✓	✓	✓		✓	✓
	“Nursing” (NR)			✓	✓				
	“Provision of Care, Treatment, and Services” (PC)	✓	✓	✓	✓	✓		✓	✓
Part 4	“Equipment Management” (EQ)					✓			
	“Leadership” (LD)	✓	✓	✓	✓	✓	✓	✓	✓

**Key**

AHC = ambulatory care	OME = home care
BHC = behavioral health care	LAB = laboratory
CAH = critical access hospital	NCC = nursing care center
HAP = hospital	OBS = office-based surgery practice



# Changes to Requirements for Organizations Providing Fluoroscopy Services

**Effective January 1, 2019**, The Joint Commission will implement several standards changes designed to enhance the provision of safe, high-quality imaging services for **ambulatory care organizations, critical access hospitals, hospitals, and office-based surgery practices**. Most of these standards changes focus on fluoroscopy; however, one of them revises required tests for computed tomography units, and another establishes a radiation safety officer. The changes were made to clarify expectations and address areas of risk associated with imaging.

The standards changes will be displayed on the [Prepublication Standards](#) page of The Joint Commission website and will be published online in the fall 2018 E-dition® update. The revisions will also be included in the 2019 hard copy publications of the *Comprehensive Accreditation Manuals* for the ambulatory care, critical access hospital, and hospital programs.

For more information, please contact [Joyce Webb](#), RN, BSN, MBA, project director, Department of Standards and Survey Methods, The Joint Commission. 

# FSA Tool Temporarily Offline for July 2018 Standards Update

Starting June 29, 2018, at 7:00 P.M. central time (CT), the Focused Standards Assessment (FSA) tool on the Intracycle Monitoring (ICM) Profile will be offline for the July 2018 standards update. The tool will resume July 12, 2018, at 9:00 P.M. CT. An extension date will be applied for accredited organizations with a scheduled ICM submission due date between June 30th and July 12th to allow additional time to review any changes made to standards displayed in the open FSA tool. **The extension due date will be set to Monday, July 30, 2018.**

Questions may be directed to your organization's designated Account Executive at 630-792-3007. 

# New Direct Data Submission Platform Announced for Performance Measures

The Joint Commission recently launched a new direct data submission platform for reporting electronic clinical quality measure (eCQM) data. Quality and health informatics leaders at more than 600 Joint Commission–accredited hospitals representing independent and health system organizations across the country comprised the first wave of participating hospitals submitting data in 2018 for calendar year (CY) 2017.

The hospitals that have transitioned to the new platform reported that the new technology has streamlined their process—and reduced the time and resources required—for ORYX® performance measurement reporting. In addition, hospitals and systems are reporting realized or projected annual savings of \$20,000 to \$50,000 compared to their traditional process of contracting with a data vendor (with the technological capacity to manage the data) to submit to The Joint Commission on their behalf.

For more than 30 years, The Joint Commission has developed and incorporated performance measure data reporting into its accreditation and certification processes to support accredited and certified organizations in measuring their performance for quality improvement.

Historically, most hospitals manually abstracted data from patient charts to compile and submit their quality measures for patient care. Over the last several years, a number of hospitals began transitioning to eCQMs that rely on structured, encoded data present in the electronic health record. Meanwhile, The Joint Commission worked to identify the technology and a process to receive that eCQM data directly from hospitals without the need for a third-party vendor.

After the CY 2017 eCQM data submission is closed for 2018, The Joint Commission will invite all its accredited hospitals with CY 2018 ORYX® eCQM reporting requirements to transition to direct data submission through its new platform. (Additional information will be provided later this summer to hospitals with eCQM requirements.) While it will continue accepting hospitals' chart-based data submitted through ORYX® vendors through 2019, The Joint Commission encourages transition to the direct data submission platform for the CY 2018 eCQM reporting period.

Updated details will be provided on the [Performance Measurement page](#) of The Joint Commission website. 



# APPROVED: New Performance Measures for Primary Stroke Centers

**Effective January 1, 2019**, The Joint Commission will require data collection for two new performance measures for **Primary Stroke Center (PSC) Certification** (an advanced disease-specific care certification program). Adding these two new measures means that there will be 10 stroke performance measures required to achieve and maintain this certification designation.

## Stroke Outpatient (STK-OP) Measure

A stratified measure, STK-OP-1 Door to Transfer to Another Hospital, will be used to monitor “door in–door out” times for stroke patients transferred from the emergency department of a PSC to a higher-level acute stroke center. Median time in minutes will be reported monthly for hemorrhagic stroke patient transfers and four groupings of ischemic stroke patients. The ischemic stroke submeasures will differentiate between patients who receive IV alteplase (t-PA) therapy prior to transfer (“drip and ship”) and those patients who have a large vessel occlusion and may be eligible for mechanical thrombectomy (see [table](#)). STK-OP-1 Door to Transfer to Another Hospital will complement the door-to-transfer measure collected by Acute Stroke Ready Hospitals.

Stroke patients who are not admitted for inpatient care (that is, outpatients) currently are not included in the STK measure initial patient population. To operationalize the new STK-OP-1 transfer measure, a stroke outpatient (STK-OP) initial patient population algorithm will also be added to the specifications manual.

## Comprehensive Stroke (CSTK) Measure

The second new measure for primary stroke centers will be CSTK-01 National Institutes of Health Stroke Scale (NIHSS) Score Performed for Ischemic Stroke Patients. CSTK-01 captures the proportion of ischemic stroke patients for whom an NIHSS score is performed prior to any acute recanalization therapy in patients undergoing recanalization therapy and documented in the medical record, or documented within 12 hours of hospital arrival for patients who do not undergo recanalization therapy. This inpatient measure is currently collected by certified Thrombectomy-Capable Stroke Centers and Comprehensive Stroke Centers. Adding the measure for PSC data collection is designed to promote measure alignment across the stroke certification programs.

Specifications for the eight existing STK measures, as well as for the new STK-OP-1 and CSTK-01 measures, will be detailed in the [Specifications Manual for Joint Commission National Quality Measures](#), Version 2018B, available in early August. Questions about these measures may be sent via the [Performance Measurement Network Q&A Forum](#). 

## 2019 MEASURES FOR PSC CERTIFICATION

Stroke (STK) Measures	Stroke Outpatient (STK-OP) Measure	Comprehensive Stroke (CSTK) Measure
STK-1 Venous Thromboembolism (VTE) Prophylaxis	STK-OP-1 Door to Transfer to Another Hospital: <ul style="list-style-type: none"> <li>• Hemorrhagic Stroke</li> <li>• Ischemic Stroke; Drip and Ship</li> <li>• Ischemic Stroke; No IV t-PA Prior to Transfer; LVO and MER Eligible</li> <li>• Ischemic Stroke; No IV t-PA Prior to Transfer; LVO and Not MER Eligible</li> <li>• Ischemic Stroke; No IV t-PA Prior to Transfer; No LVO</li> </ul>	CSTK-01 NIHSS Score Performed for Ischemic Stroke Patients
STK-2 Discharged on Antithrombotic Therapy		
STK-3 Anticoagulation Therapy for Atrial Fibrillation/Flutter		
STK-4 Thrombolytic Therapy		
STK-5 Antithrombotic Therapy by End of Hospital Day Two		
STK-6 Discharged on Statin Medication		
STK-8 Stroke Education		
STK-10 Assessed for Rehabilitation		
<b>Key</b> tPA = tissue plasminogen activator                      LVO = large-vessel occlusion MER = mechanical endovascular reperfusion		



# APPROVED: New and Revised Pain Assessment and Management Standards

**Effective January 1, 2019**, new and revised pain assessment and management standards will be applicable to Joint Commission–accredited **ambulatory care organizations, critical access hospitals**, and **office-based surgery practices**. This project is a continuation of the initiative that resulted in new and revised pain assessment and management requirements for hospitals effective in January 2018 (see July 2017 *Perspectives*, pages 1, 3, and 4).

The project's [R<sup>3</sup> Report](#) provides the rationales for the new requirements as well as references to the research articles and reports used to develop them. The program-tailored standards are designed to strengthen organizations' practices for pain assessment, treatment, education, and monitoring. The pain assessment and management requirements are now included in the "Leadership" (LD) chapter at Standard LD.04.03.13; the "Provision of Care, Treatment, and Services" chapter at Standard PC.01.02.07; the "Performance Improvement" chapter at Standards PI.01.01.01 and PI.02.01.01; and the "Medical Staff" chapter (applicable to critical access hospitals only) at Standard MS.05.01.01.

The enhanced elements of performance will require organizations to do the following:

- Provide staff and licensed independent practitioners with educational resources and programs to improve pain assessment, pain management, and the safe use of opioid medications based on the identified needs of their patient populations
- Involve patients in developing their treatment plans and setting realistic expectations and measurable goals
- Facilitate clinician access to prescription drug monitoring program databases
- Conduct performance improvement activities focusing on pain management and safe prescribing to increase safety and quality for patients
- Ensure that the critical access hospital organized medical staff take an active part in pain assessment, pain management, and safe opioid prescribing through participating in the establishment of protocols, quality metrics, and reviewing performance improvement activities
- Monitor high-risk patients in critical access hospitals

Because a substantial burden of pain exists throughout the United States, combined with gaps in the evidence on optimal pain management and a continuing opioid crisis, it is necessary to provide applicable accreditation programs with contemporary guidance for pain assessment and management, including safe opioid prescribing. In addition to an extensive literature review and public field review, The Joint Commission obtained expert guidance from the following groups:

- A **Technical Advisory Panel** of practicing clinicians from various health care and academic organizations, professional associations, and the payor and health technology sectors

- A **Primary Care Panel** of experts in chronic noncancer pain management in the primary care setting such as members of leading health care organizations with ongoing safe prescribing and provider education initiatives
- A **Standards Review Panel** of representatives from organizations or professional associations who provided a “boots on the ground” point of view and insights into the practical application of the proposed standards

The standards changes will be displayed on the [Prepublication Standards](#) page of The Joint Commission website. All requirements do not apply to all settings in the ambulatory care program. A standards applicability grid is forthcoming on the above website.

The revisions will also be included in the fall 2018 E-dition® update and the 2019 hard copy publications of the *Comprehensive Accreditation Manuals* for the ambulatory care and critical access hospital programs.

For more information, please contact [Natalya Rosenberg](#), PhD, RN, project director—clinical, Department of Standards and Survey Methods, The Joint Commission. 

# Enhancements Announced for Speak Up™ Program

The Joint Commission recently relaunched its [Speak Up™ program](#), featuring [Speak Up™ About Your Care](#) as the first campaign in the refreshed program, to help educate and empower patients to play active roles in their care.

The revamped program includes an enhanced look and updated content for free, downloadable educational materials

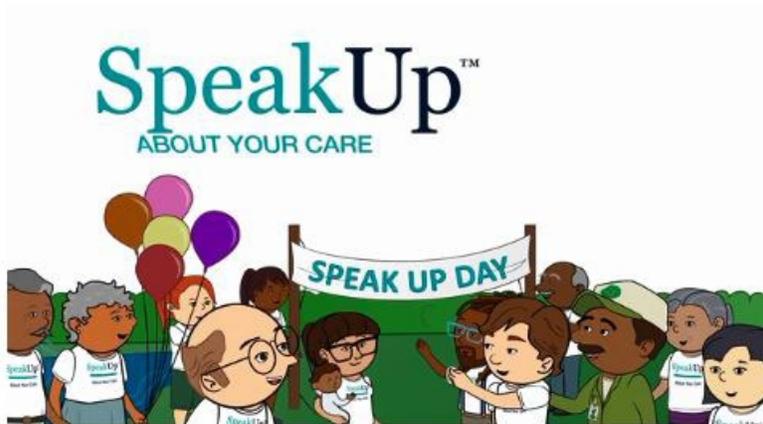
for the public. The new materials that will be included with each campaign are as follows:

- Infographic (available in three sizes) for patients and families
- Animated video (available in English and Spanish) to incorporate in hospital programming
- Podcast for health care professionals on the value of the program
- Distribution guide with recommendations on how health care organizations can use the materials

Launched in 2002, the Speak Up™ program encourages patients to be their own advocate and to take action in the following ways:

- **S**peak up
- **P**ay attention
- **E**ducate yourself
- **A**dvocates (family members and friends) can help
- **K**now about your new medicine
- **U**se a quality health care organization
- **P**articipate in all decisions about your care

The Speak Up™ program was refreshed after national market research conducted in 2017 that included feedback from a focus group of patients and their families. Additional Speak Up™ campaigns will be updated and debuted over the next several years. To stay up-to-date on refreshed Speak Up™ campaigns as they become available, [sign up](#) for e-mail alerts about the new campaigns or subscribe to the e-newsletter [Joint Commission Online](#). For more information about the Speak Up™ program, visit [The Joint Commission website](#). 



# The Joint Commission Journal on Quality and Patient Safety®

IMPROVEMENT FROM FRONT OFFICE TO FRONT LINE

This issue of *Perspectives* presents the June 2018 Table of Contents for *The Joint Commission Journal on Quality and Patient Safety (JQPS)*. The Joint Commission works closely with JQPS (published by Elsevier) to make it a key component in helping health care organizations improve patient safety and quality of care. To purchase a subscription or site license to JQPS, please visit [The Joint Commission Journal on Quality and Patient Safety website](#).

**309 Management of Neonatal Abstinence Syndrome: The Importance of a Multifaceted Program Spanning Inpatient and Outpatient Care**—M. Balakrishnan, G. Suresh

Experience with the Managing Abstinence in Newborns (MAiN) program demonstrates that using a multidisciplinary, coordinated treatment program whose foundation is collaborative, community-based care may provide a safe, cost-effective, and sustainable alternative to neonatal abstinence syndrome management.

**312 Early Treatment Innovation for Opioid-Dependent Newborns: A Retrospective Comparison of Outcomes, Utilization, Quality, and Safety, 2006–2014**—J. Summey, L. Chen, R. Mayo, E. Charron, J.A. Hudson, W.W. Sherrill, L. Dickes

Fetal opioid exposure can result in neonatal abstinence syndrome (NAS), which can have serious consequences for newborns. The Managing Abstinence in Newborns (MAiN) program was designed to provide an alternative to traditional care models for NAS. Infants cared for in the MAiN program in South Carolina from 2006 through 2014 were less likely to be treated in a higher-level nursery or to have emergency department visits compared to those who received traditional care. Median per-birth charges were approximately \$8,204 lower for MAiN infants.

**321 Using Concentration Curves to Assess Organization-Specific Relationships Between Surgeon Volumes and Outcomes**—M.H. Kanter, Y.-C. Huang, Z. Kally, M.A. Gordon, C. Meltzer

A well-documented association exists between higher surgeon volumes and better outcomes for many procedures, but surgeons may be reluctant to change practice patterns without objective, credible, and near real-time data on their own performance. This study used concentration curve methodology to identify associations between surgeon procedure volumes and outcomes using their own organization's data for three procedures: uncomplicated hysterectomies, infant circumcisions, and total thyroidectomies. The concentration indices confirmed the higher prevalence of adverse outcomes among low-volume surgeons, which supported organizational discussions about surgical quality.

**328 Using an Inpatient Quality Improvement Curriculum for Internal Medicine Residents to Improve Pneumococcal Conjugate Vaccine Administration Rates**—J. Jolin, R. van Aalst, B. Volpp, T. Taylor, E. Cohen

The Advisory Committee on Immunization Practices recommends the use of the 13-valent pneumococcal conjugate vaccine (PCV13) to reduce complications from pneumococcal infections. At a Veterans Affairs Medical Center, 16 internal medicine inpatient residents participated in a resident-driven quality improvement (QI) project that entailed eight Plan-Do-Study-Act cycles. The percentage of Veterans discharged from the hospital medicine service with an up-to-date PCV13 vaccination increased from approximately 30% to 87%—an improvement sustained during the 12-month follow-up period. Continuous improvement can be achieved through a structured and iterative process while providing active learning of core QI concepts to residents.

**334 Reducing Serious Safety Events and Priority Hospital-Acquired Conditions in a Pediatric Hospital with the Implementation of a Patient Safety Program**—A.R. Phipps, M. Paradis, K.A. Peterson, J. Jensen, K. Nielsen, M. Hall, K. Simonsen, B.M. Norton

A freestanding children's hospital evaluated the impact of its No Harm Patient Safety Program on serious safety events (SSEs) and hospital-acquired conditions (HACs). The rate of SSEs decreased from 0.19 in 2014 to 0.09 in 2015 and 0.00 in 2016. The organization reached two years without an SSE in July 2017. For HACs, the central line–associated bloodstream infection rate declined from 2.8 per 1,000 line-days in 2015 to 1.6 in 2016 ( $p = 0.036$ ), surgical site infection rates declined from 3.8 infections per 100 procedures in 2015 to 2.6 in 2016 ( $p = 0.30$ ), and catheter-associated urinary tract infection rates declined from 2.7 per 1,000 catheter-days in 2015 to 1.4 in 2016 ( $p = 0.28$ ).

**341 What Is the Realistic Scope of Informed Consent?**—J.T. Clapp, L.A. Fleisher

The success of a program to use training modules developed by the Agency for Healthcare Research and Quality to teach leaders and staff the principles of informed consent provides an example that other organizations can follow as a first step to ensure that a minimum standard of information is provided to patients in a clear and concise manner during the consent process.

**343 Opportunities to Improve Informed Consent with AHRQ Training Modules**—S.J. Shoemaker, C. Brach, A. Edwards, S.O. Chitavi, R. Thomas, M. Wasserman

In informed consent, patients often do not understand the risks and benefits associated with a specific intervention and alternatives, even after signing a consent form. In a mixed-methods pilot test of two Agency for Healthcare Research and Quality (AHRQ) informed consent training modules implemented in four hospitals, knowledge increased for leaders ( $p < 0.05$ ) and staff ( $p < 0.001$ ) completing the training modules. The hospitals reported that piloting the modules helped them improve their informed consent practices.

**353 Implementation and Evaluation of a Novel Colorectal Cancer Decision Aid Using a Centralized Delivery Strategy**—C.E. Tate, D.D. Matlock, A.F. Dalton, L.M. Schilling, A. Marcus, T. Schommer, C. Lyon, C.L. Lewis

Patient decision aids (DAs) for colorectal cancer (CRC) screening can be unsuccessful because of provider preferences for colonoscopy and lack of effective DA implementation. In a hybrid implementation-effectiveness study, using a centralized preventive health screening outreach infrastructure was a feasible and efficient method for implementing DAs in a large academic health system. More than 90% of the primary care patients in the intervention group remembered receiving the DA, and 80% found it helpful in their decision-making process. However, overall CRC screening rates significantly decreased between the control and intervention periods (50.8% vs. 39.2%, respectively;  $p = 0.03$ ).

**361 The Characteristics of Physicians Who Are Re-Disciplined by Medical Boards: A Retrospective Cohort Study**—T. Jeyalingam, J.J. Matelski, A.Q. Alam, J.J. Liu, H. Goldberg, J. Klemensberg, C.M. Bell

A study was conducted to compare the characteristics of re-disciplined to first-time disciplined physicians among Canadian physicians disciplined by medical boards between 2000 and 2015. There were 938 disciplinary events for 810 disciplined physicians, with 1 in 8 ( $n = 101$ , 12.5%) being re-disciplined (each with up to six disciplinary events). Re-disciplined physicians had more mental illness (1.7% vs. 0.1%,  $p = 0.01$ ) and unlicensed activity (19.2% vs. 7.2%,  $p < 0.01$ ), but they were less likely to have sexual misconduct (20.1% vs. 27.9%,  $p = 0.02$ ). License suspension and restriction occurred more frequently among those re-disciplined (56.8% vs. 48.0%,  $p = 0.02$ , and 38.4% vs. 26.7%,  $p < 0.01$ , respectively). Re-discipline is not uncommon and underscores the need for better identification of at-risk individuals and optimization of remediation penalties.

**366 Principles of Automation for Patient Safety in Intensive Care: Learning from Aviation**—J. Dominiczak, L. Khansa

The transition away from written documentation and analog methods has opened up the possibility of leveraging data science and analytic techniques to improve health care. The Principles of Automation for Patient Safety in Intensive Care (PASPIC) framework draws on Billings's principles of human-centered aviation automation and helps in identifying the advantages, pitfalls, and unintended consequences of automation in health care. Because it combines "smart" technology with the necessary controls to withstand unintended consequences, PAPSIC could help ensure more informed decision making and better patient care in the ICU.

# 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

- Consolidations to requirements for **all accreditation programs** as the third part of Phase IV of the EP Review Project, effective January 1, 2019 ([see article on page 10 of this issue](#))
- New and revised pain assessment and management requirements for the **ambulatory care, critical access hospital, and office-based surgery practice** programs effective January 1, 2019 ([see article on page 17 of this issue](#))
- A revision to a requirement related to computed tomography and new requirements related to fluoroscopy for the **ambulatory care, critical access hospital, hospital, and office-based surgery practice** programs, effective January 1, 2019 ([see article on page 12 of this issue](#))
- New National Patient Safety Goal NPSG.01.01.01 requirement regarding distinct identification for newborns for the **hospital and critical access hospital** programs, effective January 1, 2019 ([see article on page 9 of this issue](#))

## CURRENTLY IN FIELD REVIEW

- Proposed new and revised requirements for National Patient Safety Goal NPSG.03.05.01 on reducing harm from anticoagulant therapy for the **ambulatory care, critical access hospital, home care, hospital, nursing care center, and office-based surgery practice** programs (field review ends July 31, 2018)
- Proposed new and revised pain assessment and management requirements for the **home care** program (field review begins July 6, 2018, and ends August 17, 2018)
- Proposed new and revised pain assessment and management requirements for the **nursing care center** program (field review begins July 24, 2018, and ends September 4, 2018)

**Note:** Please visit the [Standards Field Reviews](#) page on The Joint Commission website for more information. Field reviews usually span six weeks; dates are subject to change.

## CURRENTLY BEING RESEARCHED OR IN DEVELOPMENT

- Proposed revision to Provision of Care, Treatment, and Services (PC) Standard PC.01.03.01, EP 10 for **deemed home health agencies** regarding the written plan of care
- Proposed new antimicrobial stewardship requirement for the **ambulatory care and office-based surgery practice** programs
- Proposed consolidations to requirements for **all accreditation programs** as the fourth part of Phase IV of the EP Review Project
- Proposed new and revised pain assessment and management requirements for the **behavioral health care, nursing care center, and home care** programs
- Proposed new and revised National Patient Safety Goal NPSG.15.01.01 requirements for the **behavioral health care and hospital** programs on identifying individuals at risk for suicide

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- Proposed revisions to credentialing and privileging requirements related to contracted services for the **ambulatory care, critical access hospital, and hospital** programs
- Proposed requirements regarding the use of oral care to prevent pneumonia for the **critical access hospital, hospital, and nursing care center** programs
- Proposed requirements to address Centers for Medicare & Medicaid Services (CMS) Conditions for Coverage (CfCs) for **ambulatory care** organizations that provide treatment for end-stage renal disease
- Proposed deletions to requirements in the **laboratory** program to reduce redundancies
- Proposed new and revised requirements for National Patient Safety Goal NPSG.02.03.01 on follow-up of all test results (program applicability to be determined by research)
- Proposed **behavioral health care** requirements related to telehealth use in medication-assisted treatment programs for opioid use disorder
- Proposed new and revised requirements to incorporate updated [American Heart Association/American Stroke Association Acute Ischemic Stroke Guidelines](#) in all advanced disease-specific care stroke programs
- Proposed new requirements for the **ambulatory care, critical access hospital, and hospital** programs regarding access to pediatric equipment and supplies listed in "[Guidelines for Care of Children in the Emergency Department](#)"
- Researching issues related to dental and vision care for the **behavioral health care** program
- Researching issues related to preparing security officers for interactions with behavioral health patients in non-behavioral health settings
- Researching issues related to ensuring the accuracy of electronic health records
- Researching issues related to ensuring health equity during survey



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