The Joint Commission

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Joint Commission Perspectives®

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Contents

Video Message from Dr. Chassin on COVID-19 Pandemic

The Joint Commission recognizes the incredible challenge that health care organizations and front-line workers are facing with the COVID-19 crisis. But while we have never seen anything like this, health care workers in the hardest hit areas are heroically working to save patients despite challenging conditions and shortages of personal protective equipment (PPE).

The situation is changing rapidly, and recommendations have been changing with similar speed. We also understand that health care personnel are wading through a deluge of information. Therefore, we have created a resource page for health care professionals and organizations that provides only the information that best meets the needs of health care workers and leaders. We also will continue to update this library of internal and external resources for our customers and the public.

If you have other questions, need other resources, or have leading practices you would like to share, please contact us.

Our President & CEO, Dr. Mark Chassin, wants you to know that we are here for you. However long it takes, you will have The Joint Commission's full support.

See this short video for more information. [2:10]

Full-Year 2019 Top Noncompliance Data

New Format Focuses on High-Risk Requirements

The Joint Commission regularly aggregates standards compliance data to identify areas that result in the highest number of Requirements for Improvement (RFIs) in accredited and certified programs. These data help The Joint Commission recognize trends and tailor education around challenging standards and National Patient Safety Goals (NPSGs). *Perspectives* annually publishes the "top 10" Joint Commission requirements scored most frequently as "not compliant" during accreditation surveys performed in the previous year (for each program); in addition, it publishes these data on the first six months of the current year in a late summer issue.

In its efforts to provide organizations with the most relevant data to help them achieve zero harm, this year's lists have been revised to report on the top elements of performance (EPs) scored on the *Survey Analysis for Evaluating Risk*® (*SAFER*™) Matrix in 2019 in the higher-risk categories. Click this link to review the top 10 standards scored in 2019.

SAFER Placement

In January 2017 The Joint Commission introduced the *SAFER* approach to cite deficiencies found and observed during on-site surveys. The implementation of the *SAFER* Matrix was driven by The Joint Commission's desire to provide its accredited and certified organizations with an on-site and post-survey experience that helps them focus on areas of noncompliance that are more likely to cause harm to patients, residents, and individuals served, staff, or visitors, or are more widespread in scope.

The 2019 standards noncompliance data will reflect only those RFIs placed in the moderate–pattern through high–widespread risk (and Immediate Threat to Health or Safety) categories. Because the *SAFER* Matrix is now familiar to most accredited and certified health care organizations, depicting scoring patterns in these areas can help organizations focus resources and corrective action plans in areas that are most in need of compliance activities and interventions. In addition, these data are provided at the EP level, which allows health care organizations to see the specific components driving scoring at any particular standard.

Included Data

The following bar charts show the top frequently scored standard/EP from January 1, 2019, through December 31, 2019, for each of the eight accreditation programs (certification information will be listed in a forthcoming issue of *Perspectives*). The colors in the bar charts depict where on the *SAFER* Matrix EPs were placed, and the numbers in the chart reflect the total number of surveys in 2019 with findings at that standard/EP and in that risk category. After each chart is a table with the standard and EP text for easy reference (this table does not include notes, footnotes, references, or rationales). In addition, this table includes the topic, key words, and in some cases common observations. For a comprehensive look at each standard, please refer to E-dition® or the program-specific *Comprehensive Accreditation Manual*.

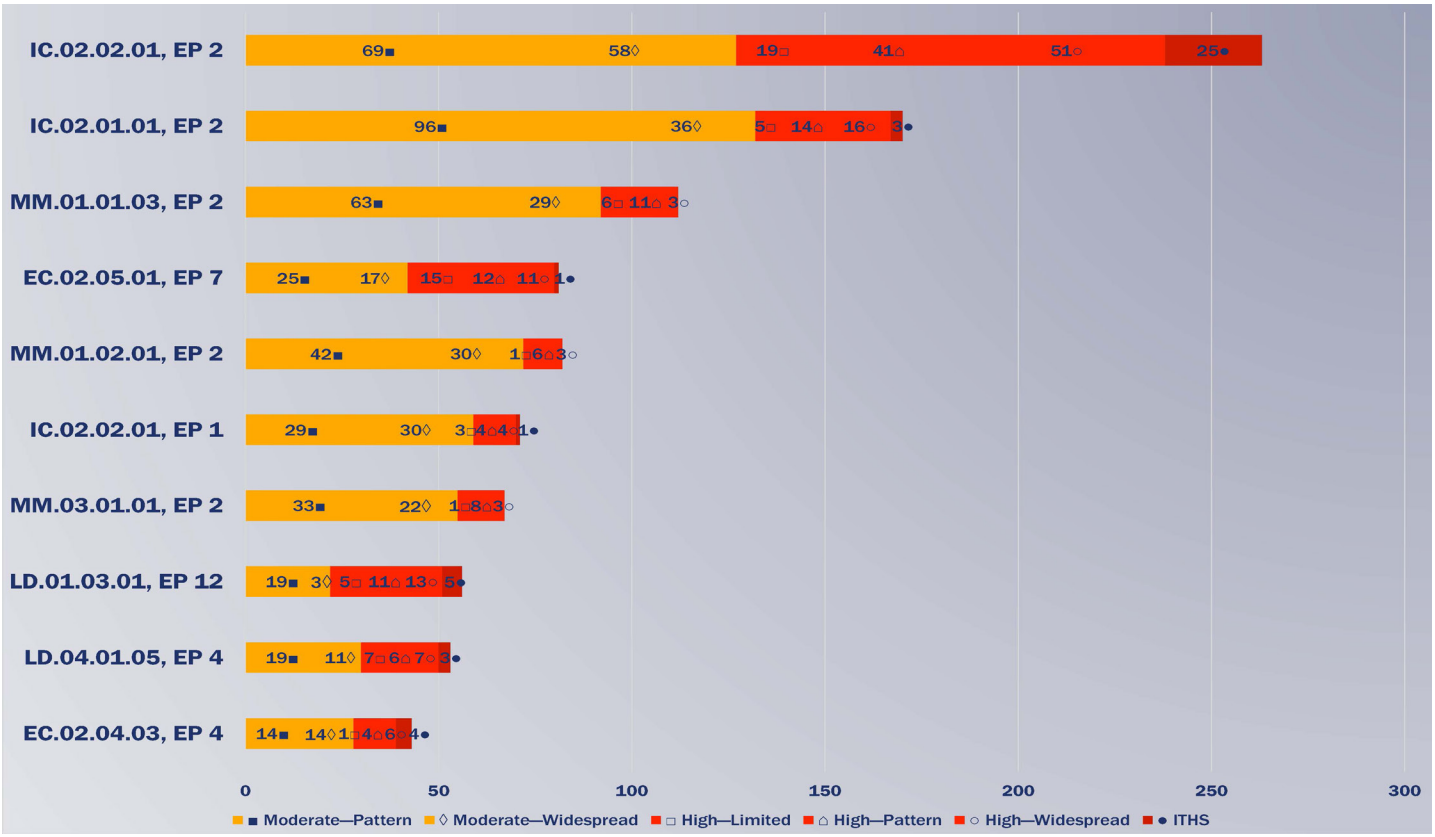
Note that surveyors evaluate compliance with *all* standards in the accreditation manuals. These data are provided only to help organizations recognize and address potential trouble spots. Health care organizations also can view the most frequently scored standards, as they have been depicted previously at the standard (not EP) level.

Visit the Joint Commission Standards FAQs page for questions and answers regarding Joint Commission requirements; questions not addressed in the FAQs may be directed to the Standards Interpretation Group via the Standards Online Submission Form. P

2019 Most Frequently Scored Higher-Risk* Accreditation Requirements†

Scored from January 1 through December 31, 2019

Ambulatory Health Care



Standard	EP	Keywords/Topics
IC.02.02.01: The organization reduces the risk of infections associated with medical equipment, devices, and supplies.	**EP 2:** The organization implements infection prevention and control activities when doing the following: Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies.	• Intermediate and high-level disinfection and sterilization • Disinfection, infection prevention • Instrument processing • Following manufacturers' instructions for use • Enzymatic cleaner
IC.02.01.01: The organizations implements infection prevention and control activities.	**EP 2:** The organization uses standard precautions, including the use of personal protective equipment, to reduce the risk of infection.	• Personal protective equipment • Standard precautions • Hand hygiene • Infection prevention and control plan • Reducing infection risk
MM.01.01.03: The organization safely manages high-alert and hazardous medications.‡	**EP 2:** The organization follows a process for managing high-alert and hazardous medications.	• Medication management • High-alert medications • Hazardous medication • Labeling • Medication safety

* Standards and EPs listed reflect those findings scored in the moderate/pattern through high/widespread categories and Immediate Threat to Health or Safety (ITHS).
† Some lists include more than 10 entries due to several standards having the same amount of EP–level RFIs.
‡ See Q4 2019 Heads-Up Report titled *Safe Management and Use of Look-Alike/Sound-Alike and High-Alert Medications* on your organization's *Joint Commission Connect*® extranet site.

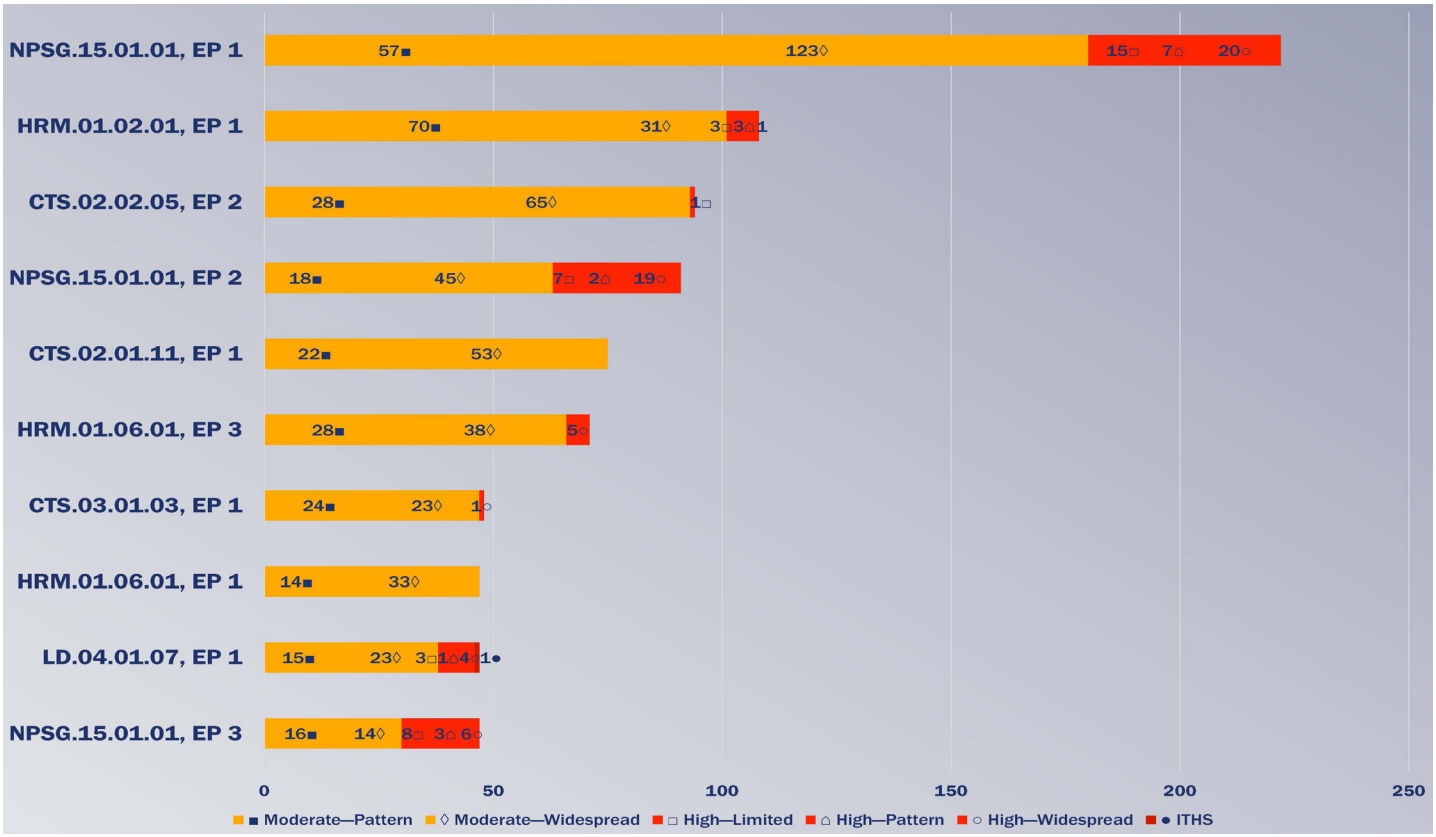
EC.02.05.01: The organization manages risks associated with its utility systems.	**EP 7:** In areas assigned to control airborne contaminants (such as biological agents, gases, fumes, dust), the ventilation system provides appropriate pressure relationships, air-exchange rates, filtration efficiencies, relative humidity, and temperature.	• Utility systems • Ventilation system • Temperature • Humidity • Airborne contaminants • Gases • Fumes • Dust • Air-exchange rates • Pressure relationships
MM.01.02.01: The organization addresses the safe use of look-alike/sound-alike medications.‡	**EP 2:** The organization takes action to avoid errors involving the interchange of medications on its list of look-alike/sound-alike medications.	• Look-alike, sound-alike medications • Medication errors • Medication safety
IC.02.02.01: The organization reduces the risk of infections associated with medical equipment, devices, and supplies.	**EP 1:** The organization implements infection prevention and control activities when doing the following: Cleaning and performing low-level disinfection of medical equipment, devices, and supplies.	• Processes for cleaning equipment • Documentation logs • Soiled equipment • No evidence of cleaning • Glucometers • Manufacturers' instructions for use
MM.03.01.01: The organization safely stores medications.*	**EP 2:** The organization stores medications according to the manufacturers' instructions.	• Medication storage • Safe storage of medication • Manufacturers' instructions for use
LD.01.03.01: Governance is ultimately accountable for the safety and quality of care, treatment, and services.	**EP 12: For ambulatory surgical centers that use Joint Commission accreditation for deemed status purposes:** The ambulatory surgical center has a governing body that assumes full legal responsibility for the operation of the ambulatory surgical center.	• Leadership • Conditions of Participation deficiencies • Governance • Governing body • Accountability
LD.04.01.05: The organization effectively manages its programs, services, or sites.	**EP 4:** Staff are held accountable for their responsibilities.	• Leadership • Management • Staff accountability • Governance • Site and service management
EC.02.04.03: The organization inspects, tests, and maintains medical equipment.	**EP 4:** The organization conducts performance testing of and maintains all sterilizers. These activities are documented.	• Sterilizers • Periodic maintenance • Preventive maintenance • Testing

EP, element of performance; IC, Infection Prevention and Control; MM, Medication Management; RFI, Requirement for Improvement; Q, quarter; EC, Environment of Care; LD, Leadership.

Note: *Data for the ambulatory health care program were derived from 720 applicable surveys.*

* *See* Q1 2020 Heads-Up Report titled *Inspection, Testing, and Maintenance of High-Risk Equipment* on your organization's *Joint Commission Connect* extranet site.

Behavioral Health Care



Standard	EP	Keywords/Topics
(Prior to July 1, 2019) **NPSG.15.01.01:** Identify individuals at risk for suicide.	**(Prior to July 1, 2019)** **EP 1:** Conduct a risk assessment that identifies specific characteristics of the individual served and environmental features that may increase or decrease the risk for suicide.	• Ligature risks • Suicide risk • Identification of items of self-harm • Environmental risk assessment • Suicide prevention
(After July 1, 2019) **NPSG.15.01.01:** Reduce the risk for suicide.	**(After July 1, 2019)** **EP 1:** The organization conducts an environmental risk assessment that identifies features in the physical environment that could be used to attempt suicide and takes necessary action to minimize the risk(s) (for example, removal of anchor points, door hinges, and hooks that can be used for hanging).	
HRM.01.02.01: The organization verifies and evaluates staff qualification.	**EP 1:** The organization performs primary source verification of staff licensure, certification, or registration in accordance with law and regulation and organization policy at the time of hire and the time of renewal.	• Staff licensure • Staff credentials • Primary source verification

CTS.02.02.05: The organization identifies individuals served who may have experienced trauma, abuse, neglect, or exploitation.*	**EP 2:** The organization identifies individuals served who may have experienced trauma, abuse, neglect, or exploitation during initial screening and assessment and on an ongoing basis.	• Trauma • Abuse • Neglect • Exploitation • Screening • Assessment • Identification
(Prior to July 1, 2019) **NPSG.15.01.01:** Identify individuals at risk for suicide.	**(Prior to July 1, 2019)** **EP 2:** Address the immediate safety needs and most appropriate setting for treatment of the individual served.	• Suicidal ideation screening • Suicide risk reduction • Validated screening tools • Suicide risk assessment • Suicide risk reduction
(After July 1, 2019) **NPSG.15.01.01:** Reduce the risk for suicide.	**(After July 1, 2019)** **EP 2:** Screen all individuals served for suicidal ideation using a validated screening tool.	
CTS.02.01.11: The organization screens all individuals served for their nutritional status.†	**EP 1:** The organization screens all individuals served to identify those for whom a nutritional assessment is indicated. At a minimum, the screening includes questions about the following: • Food allergies • Weight loss or gain of 10 pounds or more in the last 3 months • Decrease in food intake and/or appetite • Dental problems • Eating habits or behaviors that may be indicators of an eating disorder, such as bingeing or inducing vomiting	• Nutritional screening and assessment • Identification of nutrition needs
HRM.01.06.01: Staff are competent to perform their job duties and responsibilities.	**EP 3:** The organization conducts an initial assessment of staff competence. This assessment is documented.	• Staff competency • Initial assessment • Documentation of staff competency
CTS.03.01.03: The organization has a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served.	**EP 1:** The organization develops a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served.	• Individual care, treatment, and services planning • Individual goals • Individual needs • Plan of care
HRM.01.06.01: Staff are competent to perform their job duties and responsibilities.	**EP 1:** For each of its programs or services, the organization defines the competencies it requires of staff members who provide care, treatment, or services.	• Staff competency • Required competencies • Documentation of competency requirements

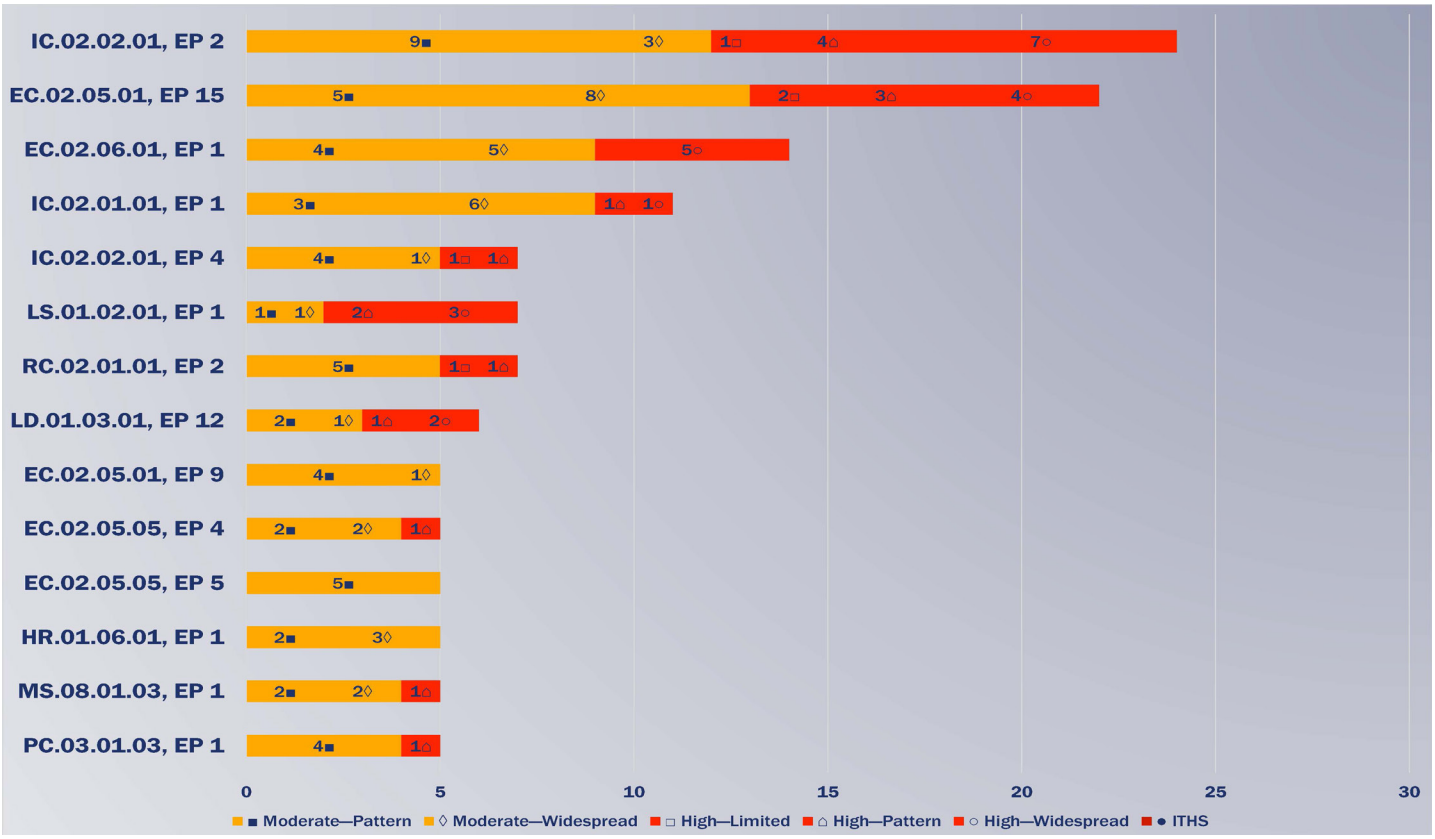
* *See* Q4 2019 Heads-Up Report titled *Identification of Individuals Who May Have Experienced Trauma, Abuse, Neglect, and Exploitation* on your organization's *Joint Commission Connect* extranet site.
† *See* Q1 2020 Heads-Up Report titled *Nutritional Screening* on your organization's *Joint Commission Connect* extranet site.

(Prior to July 1, 2019) **NPSG.15.01.01:** Identify individuals at risk for suicide.	**(Prior to July 1, 2019)** **EP 3:** When an individual at risk for suicide leaves the care of the organization, provide suicide prevention information (such as a crisis hotline) to the individual and his or her family.	• Suicide screening • Evidence-based process • Suicide assessment • Validated screening tools • Suicidal ideation screening • Suicide reduction
(After July 1, 2019) **NPSG.15.01.01:** Reduce the risk for suicide.	**(After July 1, 2019)** **EP 3:** Use an evidence-based process to conduct a suicide assessment of individuals served who have screened positive for suicidal ideation. The assessment directly asks about suicidal ideation, plan, intent, suicidal or self-harm behaviors, risk factors, and protective factors.	
LD.04.01.07: The organization has policies and procedures that guide and support care, treatment or services.	**EP 1:** Leaders review, approve, and manage the implementation of policies and procedures that guide and support care, treatment or services.	• Leadership • Care, treatment, or service policies and procedures

EP, element of performance; NPSG, National Patient Safety Goals; HRM, Human Resources Management; CTS, Care, Treatment, and Services; Q, quarter; LD, Leadership.

Note: *Data for the behavioral health care program were derived from 1,164 applicable surveys.*

Critical Access Hospitals



Standard	EP	Keywords/Topics
IC.02.02.01: The critical access hospital reduces the risk of infections associated with medical equipment, devices, and supplies.	**EP 2:** The critical access hospital implements infection prevention and control activities when doing the following: Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies.	• Performing high-level disinfection and sterilization • Infection prevention • Following manufacturers' instructions for use
EC.02.05.01: The critical access hospital manages risks associated with its utility systems.*	**EP 15:** In critical care areas designed to control airborne contaminants (such as biological agents, gases, fumes, dust), the ventilation system provides appropriate pressure relationships, air-exchange rates, filtration efficiencies, temperature, and humidity. For new and existing health care facilities, or altered, renovated, or modernized portions of existing systems or individual components modernized portions of exisiting systems or individual components (constructed or plans approved on or after July 5, 2016), heating, cooling, and ventilation are in accordance with NFPA 99-2012, which includes 2008 ASHRAE 170, or state design requirements if more stringent.	• Temperature and humidity readings • Appropriate pressure relationships (negative/positive) • Risk assessments with humidity waivers
EC.02.06.01: The critical access hospital establishes and maintains a safe, functional environment.	**EP 1:** Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided.	• Safe and suitable internal environment • Ceiling tiles • Sterile and compounding areas

* *See* Q1 2020 Heads Up Report titled *Management of Utility Systems* on your organization's *Joint Commission Connect* extranet site.

IC.02.01.01: The critical access hospital implements its infection prevention and control plan.	**EP 1:** The critical access hospital implements its infection prevention and control activities, including surveillance, to minimize, reduce, or eliminate the risk of infection.	• Infection prevention surveillance • Monitoring • Processes for cleaning equipment • Following manufacturers' instructions for use • Documentation logs • Soiled equipment • Cross contamination
IC.02.02.01: The critical access hospital reduces the risk of infections associated with medical equipment, devices, and supplies.	**EP 4:** The critical access hospital implements infection prevention and control activities when doing the following: Storing medical equipment, devices, and supplies.	• Infection prevention • Equipment storage • Medical devices • Supply storage
LS.01.02.01: The critical access hospital protects occupants during periods when the *Life Safety Code* is not met or during periods of construction.	**EP 1:** The critical access hospital has a written interim life safety measure (ILSM) policy that covers situations when *Life Safety Code* deficiencies cannot be immediately corrected or during periods of construction. The policy includes criteria for evaluating when and to what extent the critical access hospital implements LS.01.02.01, EPs 2–15 to compensate for increased life safety risk. The criteria include the assessment process to determine when interim life safety measures are implemented.	• Interim life safety measures • Safety during construction projects • Life safety risks • Life safety deficiencies
RC.02.01.01: The medical record contains information that reflects the patient's care, treatment, or services.	**EP 2:** The medical record contains the following clinical information: • The reason(s) for admission for care, treatment, and services • The patient's initial diagnosis, diagnostic impression(s), or condition(s) • Any findings of assessments and reassessments • Any allergies to food • Any allergies to medications • Any conclusions or impressions drawn from the patient's medical history and physical examination • Any diagnoses or conditions established during the patient's course of care, treatment, and services (including complications and hospital-acquired infections). For psychiatric distinct part units in critical access hospitals: The diagnosis includes intercurrent diseases (diseases that occur during the course of another disease; for example, a patient with AIDS may develop an intercurrent bout of pneumonia) and the psychiatric diagnoses.	• Medical record • Documentation • Patient information • Electronic medical record • Missing orders

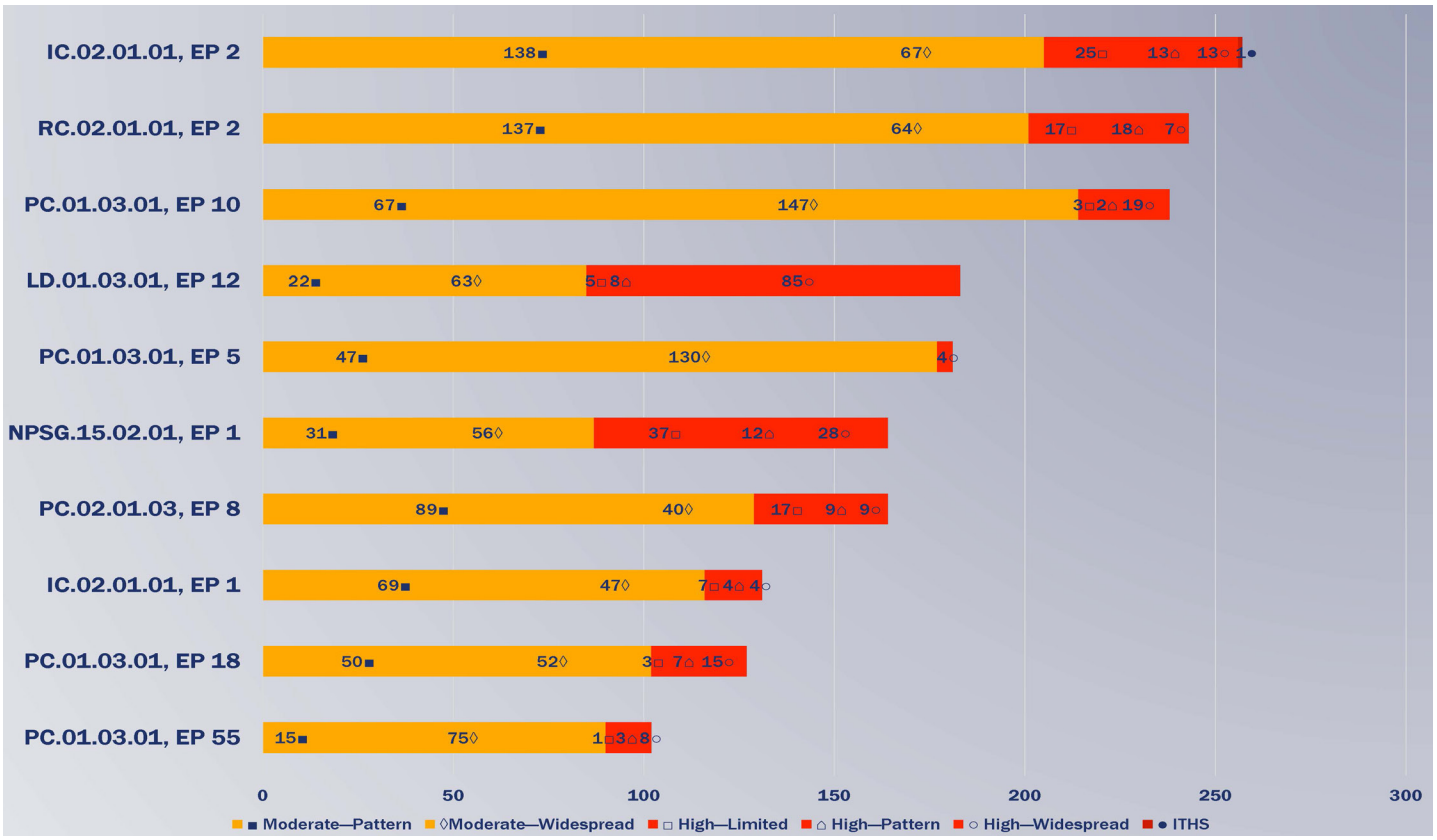
	• Any consultation reports • Any observations relevant to care, treatment, and services • The patient's response to care, treatment, and services • Any emergency care, treatment, and services provided to the patient before his or her arrival • Any progress notes • All orders • Any medications ordered or prescribed • Any medications administered, including the strength, dose, route, date and time of administration • Any access site for medication, administration devices used, and rate of administration • Any adverse drug reactions • Treatment goals, plan of care, and revisions to the plan of care • Results of diagnostic and therapeutic tests and procedures • Any medications dispensed or prescribed on discharge • Discharge diagnosis • Discharge plan and discharge planning evaluation	
LD.01.03.01: The governing body is ultimately accountable for the safety and quality of care, treatment, and services.	**EP 12:** The critical access hospital has a governing body that assumes full legal responsibility for the operation of the critical access hospital.	• Conditions of Participation deficiencies • Leadership • Governing body accountability
EC.02.05.01: The critical access hospital manages risks associated with its utility systems.	**EP 9:** The critical access hospital labels utility system controls to facilitate partial or complete emergency shutdowns.	• Utility systems • Labels • Emergency shutdowns • Main switches • Valves • Circuits • Fire alarm circuits
EC.02.05.05: The critical access hospital inspects, tests, and maintains utility systems.	**EP 4:** The critical access hospital inspects, tests, and maintains the following: High-risk utility system components on the inventory. The completion date and the results of the activities are documented.	• Maintenance • Testing • Inspection • Utility systems • High-risk systems
EC.02.05.05: The critical access hospital inspects, tests, and maintains utility systems.	**EP 5:** The critical access hospital inspects, tests, and maintains the following: Infection control utility system components on the inventory. The completion date and the results of the activities are documented.	• Utility system maintenance • Testing • Inspection • Infection control • Documentation
HR.01.06.01: Staff are competent to perform their responsibilities.	**EP 1:** The critical access hospital defines the competencies it requires of its staff who provide patient care, treatment, or services.	• Staff competence • Defined competencies • Provision of care, treatment, or services

MS.08.01.03: Ongoing professional practice evaluation information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), or to revoke an existing privilege prior to or at the time of renewal.	**EP 1:** The process for the ongoing professional practice evaluation includes the following: There is a clearly defined process in place that facilitates the evaluation of each practitioner's professional practice.	• Privileging • Renewal of privileges • Professional practice • Professional practice evaluation
PC.03.01.03: The critical access hospital provides the patient with care before initiating operative or other high-risk procedures, including those that require the administration of moderate or deep sedation or anesthesia.	**EP 1:** Before operative or other high-risk procedures are initiated, or before moderate or deep sedation or anesthesia is administered: The critical access hospital conducts a presedation or preanesthesia patient assessment.	• Administration of sedation • Moderate or deep sedation • Anesthesia • Incomplete presedation • Patient assessment

EP, element of performance; IC, Infection Prevention and Control; EC, Environment of Care; LS, Life Safety; RC, Record of Care, Treatment, and Services; LD, Leadership; HR, Human Resources; MS, Medical Staff; PC, Provision of Care, Treatment, and Services.

Note: *Data for the critical access hospital program were derived from 95 applicable surveys.*

Home Care



Standard	EP	Keywords/Topics
IC.02.01.01: The organization implements the infection prevention and control activities it has planned.	**EP 2:** The organization uses standard precautions, including the use of personal protective equipment, to reduce the risk of infection.	• Standard precautions • Personal protective equipment • Infection prevention and control plan • Hand hygiene • Reducing infection risk
RC.02.01.01: The patient record contains information that reflects the patient's care, treatment, or services.*	**EP 2:** The patient record contains the following clinical information: • Any medications administered, including dose • Any activity restrictions • Any changes in the patient's condition • Any summaries of the patient's care, treatment, or services furnished to the patient's physician or licensed independent practitioner(s) • The patient's medical history • Any allergies to medications • Any adverse drug reactions	• Medical record • Record of care • Patient information • Patient care • Medical history • Treatment and services • Documentation

* *See* Q1 2020 Heads-Up Report titled *Documentation and Record of Care* on your organization's *Joint Commission Connect* extranet site.

	• The patient's functional status • Any diet information or any dietary restrictions • Diagnostic and therapeutic tests, procedures, and treatments, and their results • Any specific notes on care, treatment, or services • The patient's response to care, treatment, or services • Any assessments relevant to care, treatment, or services • Physician orders • Any information required by organization policy, in accordance with law and regulation • A list of medications, including dose, strength, frequency, route, date and time of administration for prescription and nonprescription medications, herbal products, and home remedies that relate to the patient's care, treatment, or services • The plan(s) of care For DMEPOS suppliers serving Medicare beneficiaries: The DMEPOS prescription, any certificates of medical necessity (CMN), and pertinent documentation from the beneficiary's prescribing physician.	
PC.01.03.01: The organization plans the patient's care.	**EP 10: For home health agencies that elect to use The Joint Commission deemed status option:** The individualized plan of care specifies the care and services necessary to meet the needs identified in the comprehensive assessment and addresses the following: • All pertinent diagnoses • Mental, psychosocial, and cognitive status • Types of services, supplies, and equipment required • The frequency and duration of visits • The patient's prognosis • The patient's potential for rehabilitation • The patient's functional limitations • The patient's permitted activities • The patient's nutritional requirements • All medications and treatments • Safety measures to protect against injury • A description of the patient's risk for emergency department visits and hospital readmission, and all necessary interventions to address the underlying risk factors • Patient-specific interventions and education	• Care planning • Individual plans of care • Patient care plans • Measurable outcomes and goals

	• Measurable outcomes and goals identified by the organization and patient as a result of implementing and coordinating the plan of care • Patient and caregiver education and training to facilitate timely discharge • Information related to any advance directives • Identification of the disciplines involved in providing care • Any other relevant items, including additions, revisions and deletions	
LD.01.03.01: Governance is ultimately accountable for the safety and quality of care, treatment, or services.	**EP 12: For home health agencies and hospices that elect to use The Joint Commission deemed status option:** The organization has a governing body that assumes full legal authority and responsibility for the overall operation of the organization. **For home health agencies that elect to use The Joint Commission deemed status option:** Overall operation of the organization includes provision of services, fiscal operations, review of the agency's budget and operational plans, and its quality assessment and performance improvement (QAPI) program.	• Governance • Accountability • Governing body • Leadership responsibilities
PC.01.03.01: The organization plans the patient's care.	**EP 5:** The written plan of care is based on the patient's goals and the time frames, settings, and services required to meet those goals.	• Written plan of care • Documentation • Care planning • Patient goals
NPSG.15.02.01: Identify risks associated with home oxygen therapy such as home fires.*	**EP 1:** Conduct a home oxygen safety risk assessment before starting oxygen therapy in the home and when home care services are initiated that addresses at least the following: • Whether there are smoking materials in the home • Whether or not the home has functioning smoke detectors • Whether there are other fire safety risks in the home, such as the potential for open flames. Document the performance of the risk assessment.	• Home oxygen therapy • Home oxygen safety • Oxygen risk assessment • Home fires • Fire safety • Smoking materials
PC.02.01.03: The organization provides care, treatment, or services in accordance with orders or prescriptions, as required by law and regulation.	**EP 8: For home health agencies that elect to use The Joint Commission deemed status option:** The organization follows physician orders when administering medications or providing care, treatment, or services.	• Physicians' orders • Medication administration • Provision of care • Following orders • Adherence with prescriptions

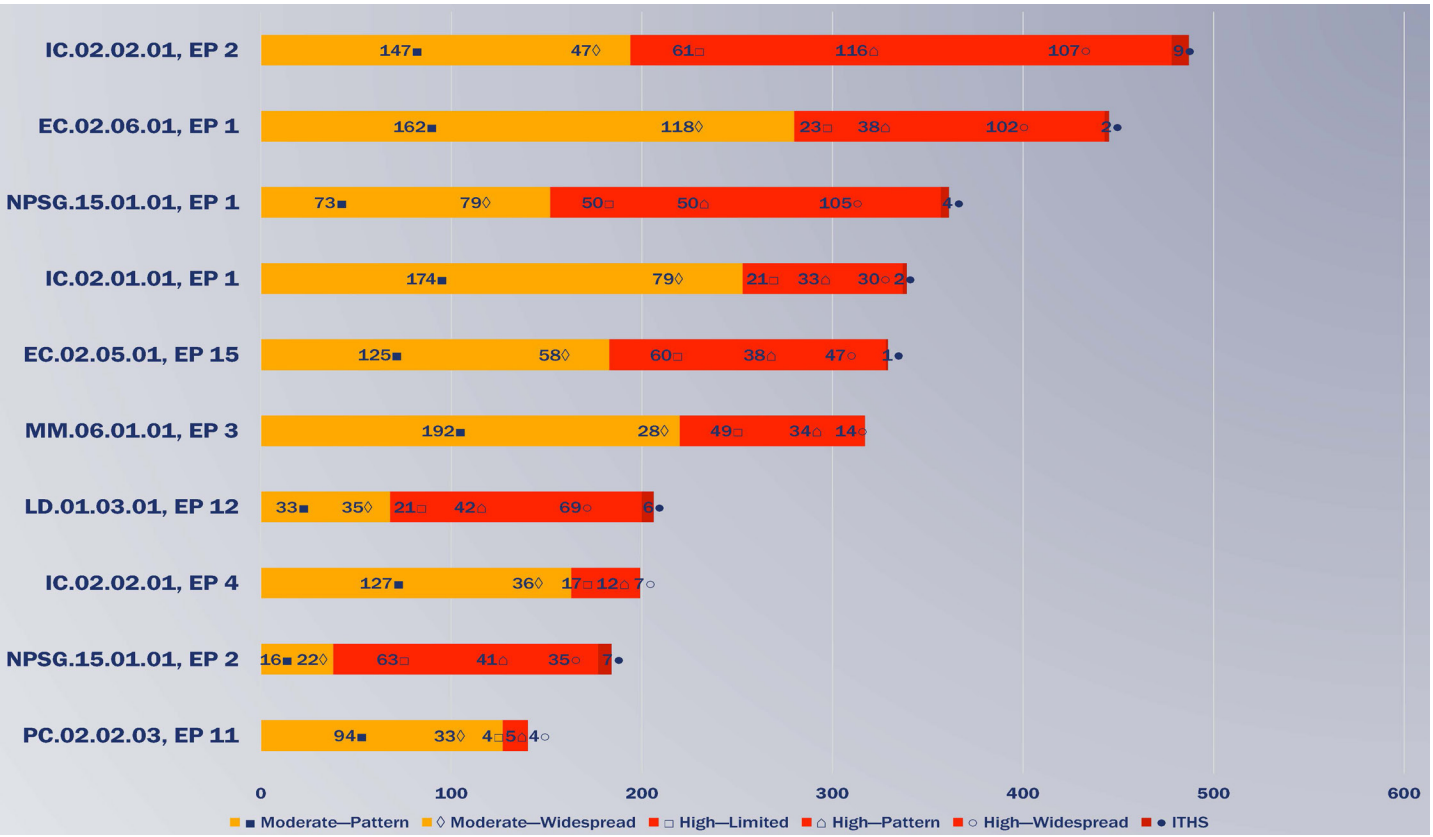
* *See* Q4 2019 Heads-Up Report titled *Identification of Risks Associated with Home Oxygen Therapy* on your organization's *Joint Commission Connect* extranet site.

IC.02.01.01: The organization implements the infection prevention and control activities it has planned.	**EP 1:** The organization implements its infection prevention and control activities, including surveillance, to minimize, reduce, or eliminate the risk of infection.	• Infection prevention • Infection control • Infection risk reduction • Surveillance • Infection prevention monitoring
PC.01.03.01: The organization plans the patient's care.	**EP 18: For hospices that elect to use The Joint Commission deemed status option:** The plan of care includes all services needed for the palliation and management of the terminal illness and related conditions, including the following: • Interventions to manage pain and symptoms • A statement of the scope and frequency of the services necessary to meet the patient's and family's needs • Measurable outcomes anticipated from implementing and coordinating the plan of care • Medications and treatment necessary to meet the patient's needs • Medical supplies and appliances necessary to meet the patient's needs	• Patient care planning • Plan of care • Hospice • Palliative care • Terminal illness • Care planning • End-of-life care
PC.01.03.01: The organization plans the patient's care.	**EP 55: For home health agencies that elect to use The Joint Commission deemed status option:** There is a plan for the patient that provides instructions if there is an emergency in the organization or the community that might disrupt the care, treatment, or service provided by the organization. This plan is based on the patient's assessed needs, including clinical, functional, and communication needs; reliance upon equipment or assistive devices; and available caregiver support.	• Care planning • Emergency management plan • Emergency plans • Instructions • Disruption in care, treatment, or services

EP, element of performance; IC, Infection Prevention and Control; RC, Record of Care, Treatment, and Services; Q, quarter; DMEPOS, durable medical equipment prosthetics, orthotics, and supplies; PC, Provision of Care, Treatment, and Services; LD, Leadership; NPSG, National Patient Safety Goals.

Note: *Data for the home care program were derived from 2,015 applicable surveys.*

Hospitals



Standard	EP	Keywords/Topics
IC.02.02.01: The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.	**EP 2:** The hospital implements infection prevention and control activities when doing the following: Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies.	• Intermediate and high-level disinfection and sterilization • Infection prevention • Following manufacturers' instructions for use
EC.02.06.01: The hospital establishes and maintains a safe, functional environment.	**EP 1:** Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided.	• Safe environment • Interior spaces • Sterile compounding area • Dirty ceiling tiles • Porous surfaces
(Prior to July 1, 2019) **NPSG.15.01.01:** Identify patients at risk for suicide.	**(Prior to July 1, 2019)** **EP 1:** Conduct a risk assessment that identifies specific patient characteristics and environmental features that may increase or decrease the risk for suicide.	• Ligature risks • Environmental risk assessment • Suicide risk reduction • Suicide prevention • Anchor points • Door hinges

(After July 1, 2019) **NPSG.15.01.01:** Reduce the risk for suicide.	**(After July 1, 2019)** **EP 1: For psychiatric hospitals and psychiatric units in general hospitals:** The hospital conducts an environmental risk assessment that identifies features in the physical environment that could be used to attempt suicide; the hospital takes necessary action to minimize the risk(s) (for example, removal of anchor points, door hinges, and hooks that can be used for hanging). **For nonpsychiatric units in general hospitals:** The organization implements procedures to mitigate the risk of suicide for patients at high risk for suicide, sucah as one-to-one monitoring, removing objects that pose a risk for self-harm if they can be removed without adversely affecting the patient's medical care, assessing objects brought into a room by visitors, and using safe transportation procedures when moving patients to other parts of the hospital.	
IC.02.01.01: The hospital implements its infection prevention and control plan.	**EP 1:** The hospital implements its infection prevention and control activities, including surveillance, to minimize, reduce, or eliminate the risk of infection.	• Processes for cleaning equipment • Minimizing infection risks • Infection prevention surveillance • Accurate documentation logs • Soiled equipment • No evidence of cleaning
EC.02.05.01: The hospital manages risks associated with its utility systems.	**EP 15:** In critical care areas designed to control airborne contaminants (such as biological agents, gases, fumes, dust), the ventilation system provides appropriate pressure relationships, air-exchange rates, filtration efficiencies, temperature, and humidity. For new and existing health care facilities, or altered, renovated, or modernized portions of existing systems or individual components (constructed or plans approved on or after July 5, 2016), heating, cooling, and ventilation are in accordance with NFPA 99-2012, which includes 2008 ASHRE 170, or state design requirements if more stringent.	• Utility systems • Temperature and humidity readings • Ventilation system • Appropriate pressure relationships (negative/positive) • Control of airborne contaminants • Risk assessments with humidity waivers

MM.06.01.01: The hospital safely administers medications.*	**EP 3:** Before administration, the individual administering the medication does the following: Verifies that the medication selected matches the medication order and product label. **(Added July 1, 2019)** Before administration, the individual administering the medication does the following: ● Verifies that the medication selected matches the medication order and product label ● Visually inspects the medication for particulates, discoloration, or other loss of integrity ● Verifies that the medication has not expired ● Verifies that no contraindications exist ● Verifies that the medication is being administered at the proper time, in the prescribed dose, and by the correct route ● Discusses any unresolved concerns about the medication with the patient's licensed independent practitioner, prescriber (if different from the licensed independent practitioner), and/or staff involved with the patients care, treatment, and services.	● Medication administration safety ● Verification of orders ● Verification of dosages ● Titration rates ● Expiration dates ● Verification or notification of licensed independent practitioners/providers with changes
LD.01.03.01: The governing body is ultimately accountable for the safety and quality of care, treatment, and services.	**EP 12: For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital has a governing body that assumes full legal responsibility for the operation of the hospital.	● Conditions of Participation deficiencies ● Leadership ● Governing body, accountability
IC.02.02.01: The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.	**EP 4:** The hospital implements infection prevention and control activities when doing the following: Storing medical equipment, devices, and supplies.	● Infection prevention ● Safe storage of medical devices ● Equipment ● Supplies ● Ultrasound probes

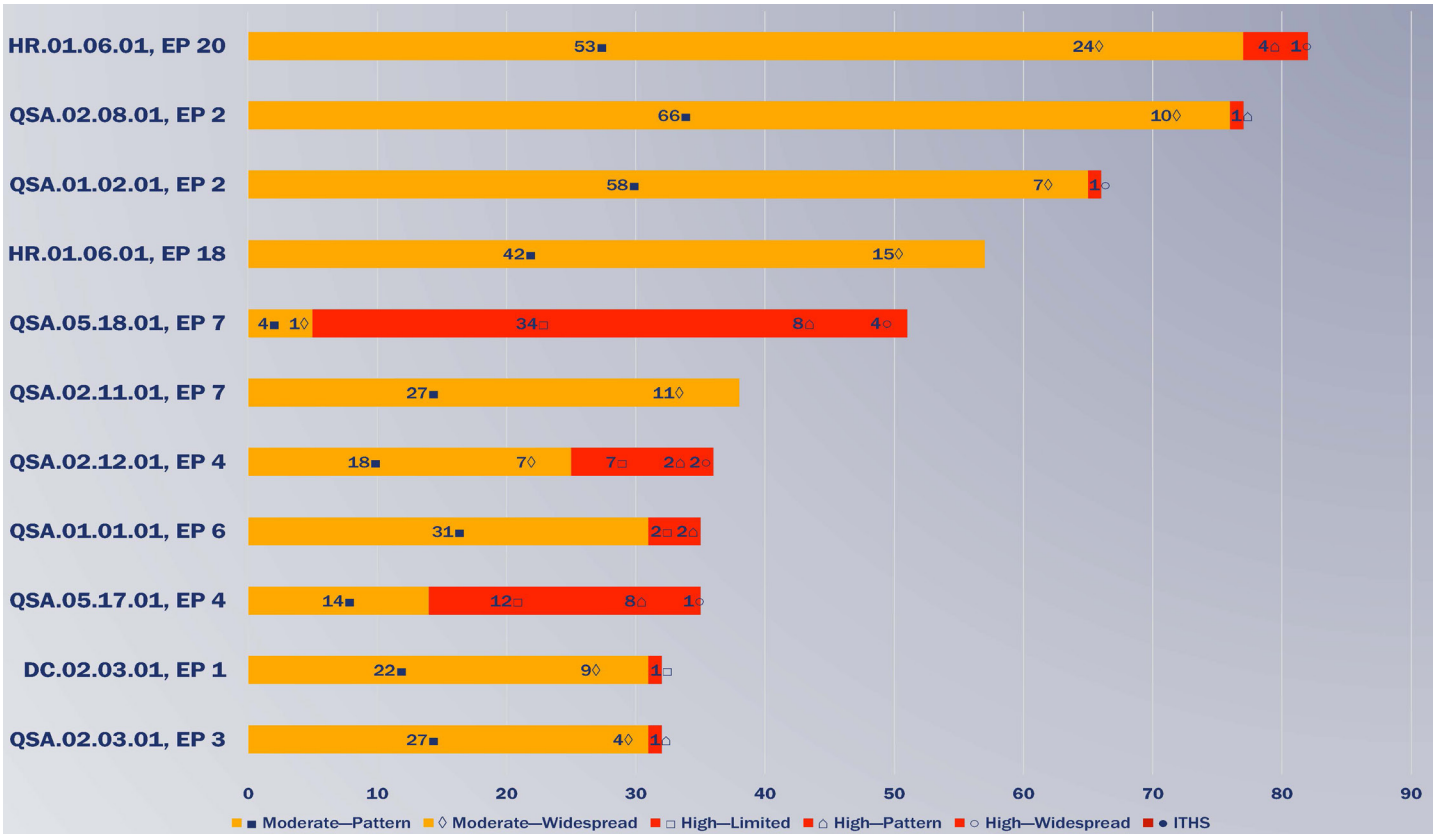
* *See* Q1 2020 Heads-Up Report titled *Safe Medication Administration* on your organization's *Joint Commission Connect* extranet site.

(Prior to July 1, 2019) **NPSG.15.01.01:** Identify patients at risk for suicide.	**(Prior to July 1, 2019)** **EP 2:** Address the patient's immediate safety needs and most appropriate setting for treatment.	• Suicide risk screening • Suicide risk assessment • Suicide validated screening tools • Suicidal ideation
(After July 1, 2019) **NPSG.15.01.01:** Reduce the risk for suicide.	**(After July 1, 2019)** **EP 2:** Screen all patients for suicidal ideation who are being evaluated or treated for behavioral health conditions as their primary reason for care using a validated screening tool.	
PC.02.02.03: The hospital makes food and nutrition products available to its patients.	**EP 11:** The hospital stores food and nutrition products, including those brought in by patients or their families, using proper sanitation, temperature, light, moisture, ventilation, and security.	• Food storage • Nutrition products • Food and nutrition safety • Sanitation • Refrigeration temperatures • Labeling/expiration dates

EP, element of performance; IC, Infection Prevention and Control; EC, Environment of Care; NPSG, National Patient Safety Goals; MM, Medication Management; Q, quarter; LD, Leadership; PC, Provision of Care, Treatment, and Services.

Note: *Data for the hospital program were derived from 1,417 applicable surveys.*

Laboratories and Point-of-Care Testing



Standard	EP	Keywords/Topics
HR.01.06.01: Staff are competent to perform their responsibilities.*	**EP 20:** After the first year of employment, each staff member's competence is assessed on an annual basis for all laboratory tests he or she performs. This assessment is documented.	• Competency • Assessment • Annual competency assessment • Human resources files • Laboratory procedures
QSA.02.08.01: The laboratory performs correlations to evaluate the results of the same test performed with different methodologies or instruments or at different locations.	**EP 2:** The laboratory performs correlations at least once every six months. The correlations are documented.	• Correlations • Documentation of testing correlations • Automated differentials
QSA.01.02.01: The laboratory maintains records of its participation in a proficiency testing program.	**EP 2:** The laboratory conducts an investigation of all potential causes, provides evidence of review, and performs corrective action for the following: • Individual unacceptable proficiency testing results • Late submission of proficiency testing results (score is zero) • Nonparticipation in the proficiency testing event (score is zero; see Note 2) • Lack of consensus among all laboratories participating in the proficiency testing event (score is ungradable) These actions are documented.	• Proficiency testing • Proficiency testing events • Recordkeeping • Investigating proficiency deficiencies

* *See* Q1 2020 Heads-Up Report titled *Staff Competency* on your organization's *Joint Commission Connect* extranet site.

HR.01.06.01: Staff are competent to perform their responsibilities.*	**EP 18:** The staff member's competency assessment includes the following: ● Direct observations of routine patient test performance, including patient preparation, if applicable, and specimen collection, handling, processing, and testing ● Monitoring, recording, and reporting of test results ● Review of intermediate test results or worksheets, quality control, proficiency testing, and preventive maintenance performance ● Direct observation of performance of instrument maintenance function checks and calibration ● Test performance as defined by laboratory policy (for example, testing previously analyzed specimens, internal blind testing samples, external proficiency, or testing samples) ● Problem-solving skills as appropriate to the job	● Competency requirements ● Proficiency testing ● Competency testing methods ● Direct observation ● Test performance ● Incomplete testing
QSA.05.18.01: The organization has policies and procedures to monitor and evaluate the patient and report suspected transfusion-related adverse events.	**EP 7:** The organization follows its policies and procedures that guide the monitoring of the patient and the reporting of suspected transfusion-related adverse events during blood and blood component administration.	● Transfusion safety ● Transfusion policies and procedures ● Transfusion-related adverse events ● Blood and blood component administration
QSA.02.11.01: The laboratory conducts surveillance of patient results and related records as part of its quality control program.	**EP 7:** The laboratory performs review of other records (for example, work records, equipment records, quality control summaries) at a frequency defined by the laboratory, but at least monthly. The review is documented.	● Surveillance of patient records ● Quality control program ● Record review and documentation
QSA.02.12.01: The laboratory investigates and takes corrective action for deficiencies identified through quality control surveillance.	**EP 4:** The laboratory performs corrective action when the following situations occur: ● Quality control results do not meet the laboratory's criteria for acceptability. ● An instrument does not meet function check or performance testing requirements. ● Incidents of incorrect test results are reported. ● Patient test results are reported outside of the laboratory's reportable range of test results. ● Criteria for proper storage of reagents and specimens are not met.	● Quality control surveillance ● Quality control deficiencies ● Quality control corrective action

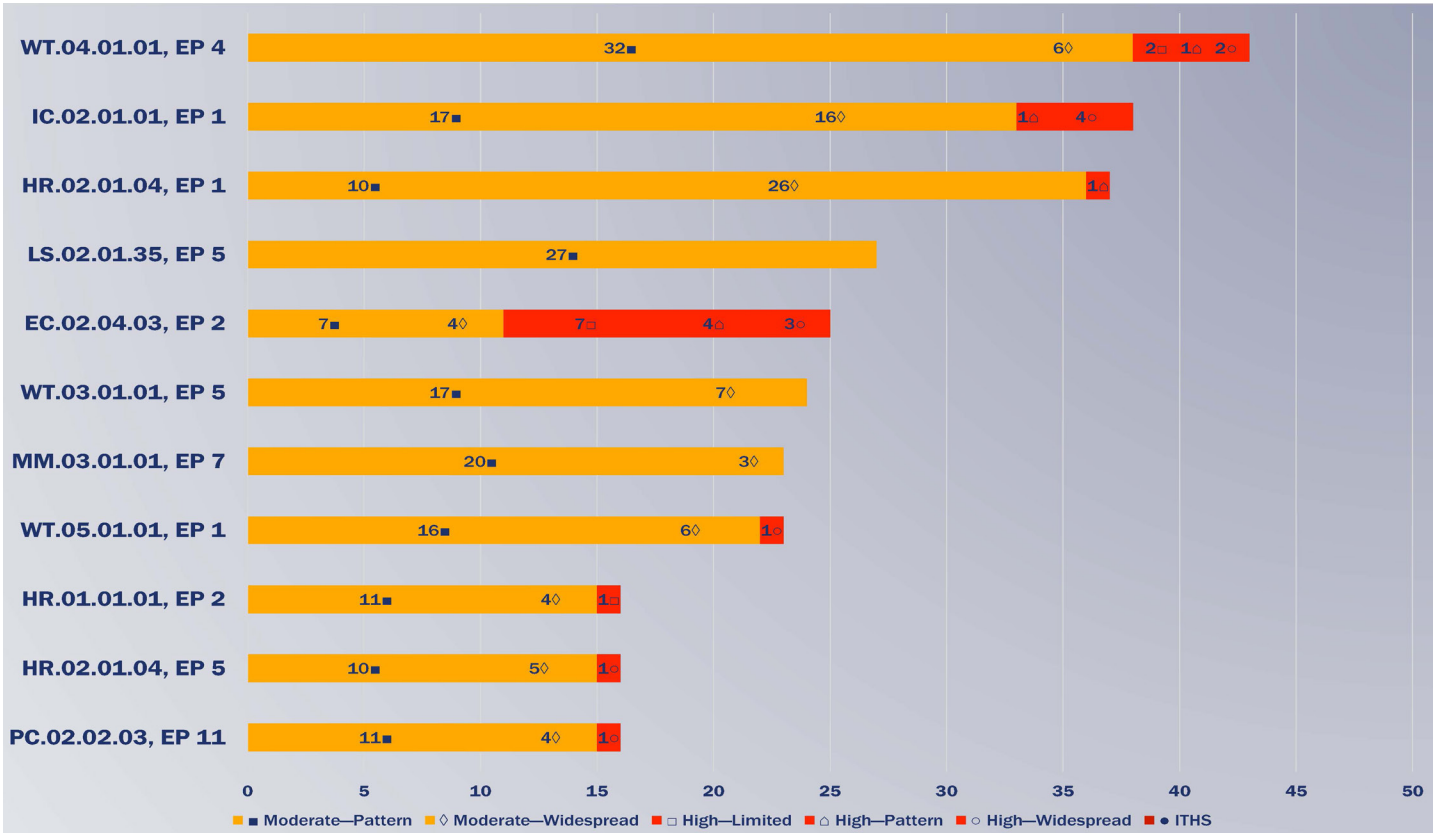
* *See* Q1 2020 Heads-Up Report titled *Staff Competency* on your organization's *Joint Commission Connect* extranet site.

	• Communication breaks down between the laboratory and an authorized person who orders or receives the test. • Other incidents of unsatisfactory specimen collection, testing, or reporting are identified. The corrective action is documented.	
QSA.01.01.01: The laboratory participates in Centers for Medicare & Medicaid Services (CMS)–approved proficiency testing programs for all regulated analytes.	**EP 6:** The laboratory's proficiency test performance is successful for each specialty, subspecialty, analyte, or test, as required by law and regulation.	• CMS proficiency testing • Analytes • Law and regulation
QSA.05.17.01: The laboratory has policies and procedures for transfusion-related activities.	**EP 4:** The laboratory follows its policies and procedures for transfusion-related activities.	• Transfusion policies and procedures
DC.02.03.01: The laboratory report is complete and is in the patient's clinical record.	**EP 1:** The laboratory report is maintained in the patient's clinical record.	• Laboratory reports • Missing documentation • Maintenance in clinical record
QSA.02.03.01: The laboratory performs calibration verification.	**EP 3:** Calibration verification is performed every six months.	• Calibration verification

EP, element of performance; HR, Human Resources; QSA, Quality System Assessment for Nonwaived Testing; Q, quarter; DC, Document and Process Control.

Note: *Data for the laboratory program were derived from 725 applicable surveys.*

Nursing Care Centers



Standard	EP	Keywords/Topics
WT.04.01.01: The organization performs quality control checks for waived testing on each procedure.*	**EP 4:** For instrument-based waived testing, quality control checks are performed on each instrument used for patient or resident testing per manufacturers' instructions.	• Waived testing • Quality control • Patient or resident testing devices • Following manufacturers' instructions for use
IC.02.01.01: The organization implements its infection prevention and control plan.	**EP 1:** The organization implements its infection prevention and control activities, including surveillance, to reduce and/or minimize the risk of infection.	• Infection prevention and control plan • Infection prevention activities • Surveillance • Infection risk reduction

* *See* Q4 2019 Heads-Up Report titled *Quality Control (QC) Practices for Waived Testing* on your organization's *Joint Commission Connect* extranet site.

HR.02.01.04: The organization permits licensed independent practitioners to provide care, treatment, and services.*	**EP 1:** Before permitting licensed independent practitioners new to the organization to provide care, treatment, and services, the organization does the following: ● Documents current licensure and any disciplinary actions against the license available through the primary source. ● Verifies the identity of the individual by viewing a valid state or federal government-issued picture identification (for example, a driver's license or passport). ● Obtains and documents information from the National Practitioner Data Bank (NPDB). The medical director evaluates this information. ● Determines and documents that the practitioner is currently privileged at a Joint Commission–accredited organization; this determination is verified through the accredited organization. If the organization cannot verify that the practitioner is currently privileged at a Joint Commission–accredited organization, the medical director oversees the monitoring of the practitioner's performance and reviews the results of the monitoring. This monitoring continues until it is determined that the practitioner is able to provide the care, treatment, and services that he or she is being permitted to provide.	● Licensing ● Privileging ● New licensed independent practitioners ● Verification of licensure ● Primary source verification ● Permission to provide care ● Documentation of licensing requirements ● National Practitioner Data Bank
LS.02.01.35: The organization provides and maintains systems for extinguishing fires.	**EP 5:** Sprinklers are not damaged. They are also free from corrosion, foreign materials, and paint and have necessary escutcheon plates installed.	● Fire safety ● *Life Safety Code* ● Extinguishing fires ● Sprinkler head maintenance
EC.02.04.03: The organization inspects, tests, and maintains medical equipment.	**EP 2:** The organization inspects, tests, and maintains all life-support equipment. These activities are documented.	● Inspection, testing, and maintenance of medical equipment ● Life-support equipment

* *See* Q1 2020 Heads-Up Report titled *Verification of Licensed Independent Practitioners (LIP)* on your organization's *Joint Commission Connect* extranet site.

WT.03.01.01: Staff and licensed independent practitioners performing waived tests are competent.*	**EP 5:** Competency for waived testing is assessed using at least two of the following methods per person per test: ● Performance of a test on a blind specimen ● Periodic observation of routine work by the supervisor or qualified designee ● Monitoring of each user's quality control performance ● Use of a written test specific to the test assessed	● Staff competency ● Licensed independent practitioner competency ● Waived testing competence, competency assessment methods
MM.03.01.01: The organization safely stores medications.	**EP 7:** All stored medications and the components used in their preparation are labeled with the contents, expiration date, and any applicable warnings.	● Safe medication storage ● Medication labeling ● Expiration dates ● Insulin vials and pens ● Medication carts
WT.05.01.01: The organization maintains records for waived testing.	**EP 1:** Quality control results, including internal and external controls for waived testing, are documented.	● Waived testing records ● Quality control results and documentation
HR.01.01.01: The organization defines and verifies staff qualifications.	**EP 2:** The organization verifies and documents the following: ● Credentials of care providers using the primary source when licensure, certification, or registration is required by law and regulation to practice their profession. This is done at the time of hire and at the time credentials are renewed. ● Credentials of care providers (primary source not required) when licensure, certification, or registration is not required by law and regulation. This is done at the time of hire and at the time credentials are renewed	● Staff qualifications ● Verification ● Documentation of staff credentials

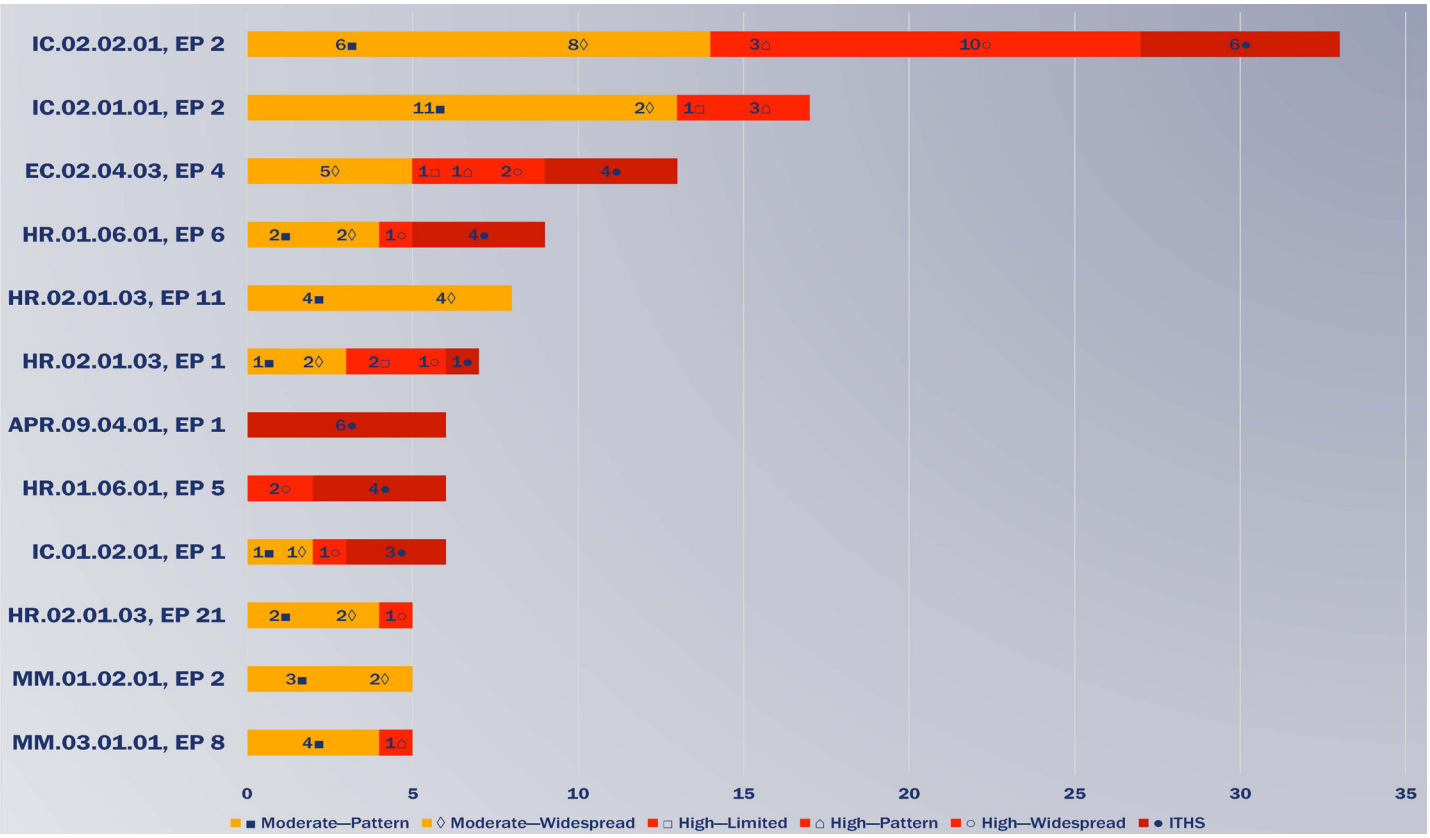
* *See* Q4 2019 Heads-Up Report titled *Quality Control (QC) Practices for Waived Testing* on your organization's *Joint Commission Connect* extranet site.

HR.02.01.04: The organization permits licensed independent practitioners to provide care, treatment, and services.	**EP 5:** At least every two years, before permitting licensed independent practitioners to continue to provide care, treatment, and services, the organization does the following: ● Documents current licensure and any disciplinary actions against the license available through the primary source. ● Obtains and documents information from the National Practitioner Data Bank (NPDB). The medical director evaluates this information. ● Reviews any clinical performance in the organization that is outside acceptable standards. The medical director evaluates this information. ● Reviews information from any of the organization's performance improvement activities pertaining to professional performance, judgment, and clinical or technical skills. The medical director evaluates this information. ● Confirms the licensed independent practitioner's adherence to organization policies, procedures, rules, and regulations.	● Renewal of licensed independent practitioner privileges
PC.02.02.03: The organization makes food and nutrition products available to its patients and residents.	**EP 11:** The organization stores food and nutrition products, including those brought in by patients and residents or their families, under proper conditions of sanitation, temperature, light, moisture, ventilation, and security.	● Food and nutrition availability ● Improper food storage ● Food and nutrition products ● Sanitary food storage practices

EP, element of performance; WT, Waived Testing; IC, Infection Prevention and Control; HR, Human Resources; Q, quarter; LS, Life Safety; EC, Environment of Care; MM, Medication Management; PC, Provision of Care, Treatment, and Services.

Note: *Data for the nursing care center program were derived from 339 applicable surveys*.

Office-Based Surgery Practices



Standard	EP	Keywords/Topics
IC.02.02.01: The practice reduces the risk of infections associated with medical equipment, devices, and supplies.	**EP 2:** The practice implements infection prevention and control activities when doing the following: Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies.	• Performing intermediate and high-level disinfection and sterilization • Infection prevention • Following manufacturers' instructions for use
IC.02.01.01: The practice implements infection prevention and control activities.	**EP 2:** The practice uses standard precautions, including the use of personal protective equipment, to reduce the risk of infection.	• Standard precautions • Personal protective equipment • Lack of hand hygiene • Infection prevention and control plan • Reducing infection risk
EC.02.04.03: The practice inspects, tests, and maintains medical equipment.	**EP 4:** The practice conducts performance testing of and maintains all sterilizers. These activities are documented.	• Medical equipment inspection • Testing • Maintenance • Sterilizers • Manufacturers' instructions for use • Equipment maintenance logs
HR.01.06.01: Staff are competent to perform their responsibilities.	**EP 6:** Staff competence is assessed and documented once every three years, or more frequently as required by practice policy or in accordance with law and regulation.	• Staff competency • Competence assessment • Competency policies and requirements

HR.02.01.03: The practice grants initial, renewed, or revised clinical privileges to individuals who are permitted by law and the organization to practice independently.*	**EP 11:** Before granting initial, renewed, or revised privileges to a licensed independent practitioner, practice leaders evaluate the following: ● The applicant's written statement that no health problems exist that could affect his or her ability to perform the requested privileges ● Any challenges to licensure or registration ● Any voluntary and involuntary relinquishment of license or registration ● Any voluntary and involuntary termination of medical staff membership at another organization ● Any voluntary or involuntary limitation, reduction, or loss of clinical privileges ● Any professional liability actions that resulted in a final judgment against the applicant ● Information from the National Practitioner Data Bank ● Whether the requested privileges are consistent with the population served by the organization ● Whether the requested privileges are consistent with the site-specific care, treatment, or services provided by the organization	● Clinical privileging ● Initial, renewal ● Revised privileges ● Privileging process
HR.02.01.03: The practice grants initial, renewed, or revised clinical privileges to individuals who are permitted by law and the organization to practice independently.*	**EP 1:** The practice follow a process, approved by its leaders, to grant initial, renewed, or revised privileges and to deny privileges.	● Clinical privileging process ● Initial, renewed, and revised privileges
APR.09.04.01: The practice provides care, treatment, services, and an environment that pose no risk of an "Immediate Threat to Health or Safety," also known as "Immediate Threat to Life" or ITL situation.	**EP 1:** The practice provides care, treatment, services, and an environment that pose no risk of an "Immediate Threat to Health or Safety," also known as "Immediate Threat to Life" or ITL situation.	● Immediate risks to health or safety ● Documentation in "Infection Prevention and Control" (IC), "Environment of Care" (EC), "Human Resources" (HR), and "Leadership" (LD) chapters
HR.01.06.01: Staff are competent to perform their responsibilities.	**EP 5:** Staff competence is initially assessed and documented as part of orientation.	● Staff competency not documented (for example, for performing sterilization)
IC.01.02.01: Practice leaders allocate needed resources for infection prevention and control activities.	**EP 1:** The practice provides access to information needed to support infection prevention and control activities.	● Lack of resources allocated for proper sterilization ● No manufacturers' instructions for use available
HR.02.01.03: The practice grants initial, renewed, or revised clinical privileges to individuals who are permitted by law and the organization to practice independently.*	**EP 21:** The practice grants initial, renewed, or revised privileges for no longer than a two-year period.	● Granting and renewal of clinical privileging ● Privileging time lines

* *See* Q1 2020 Heads-Up Report titled *Granting Initial, Renewed, or Revised Clinical Privileges* on your organization's *Joint Commission Connect* extranet site.

MM.01.02.01: The practice addresses the safe use of look-alike/sound-alike medications.	**EP 2:** The practice takes action to prevent errors involving the interchange of the medications on its list of look-alike/sound-alike medications.	• Look-alike/sound-alike medications • Medication errors • Medication safety
MM.03.01.01: The practice safely stores medications.*	**EP 8:** The practice removes all expired, damaged, and/or contaminated medications and stores them separately from medications available for administration.	• Medication storage • Safe storage of medication • Expiration date • Contaminated medication

EP, element of performance; IC, Infection Prevention and Control; EC, Environment of Care; HR, Human Resources; APR, Accreditation Participation Requirements; Q, quarter; MM, Medication Management.

Note: *Data for the office-based surgery program were derived from 82 applicable surveys.*

* *See* Q4 2019 Heads-Up Report titled *Management of High-Alert Medications and Medication Storage* on your organization's *Joint Commission Connect* extranet site.

Implementation of Perinatal Safety Standards Delayed

Delayed Requirements Related to Maternal Hemorrhage and Severe Hypertension/Preeclampsia

In the September 2019 issue of *Perspectives*, The Joint Commission announced the addition of two new standards that would be effective July 1, 2020, to improve the quality and safety of perinatal care in Joint Commission–accredited **hospitals** to address the rising maternal morbidity and mortality.

Due to the recent worldwide pandemic related to the COVID-19 virus, The Joint Commission is delaying the implementation of the new perinatal safety standards. The delayed implementation will allow hospitals to continue focusing on the COVID-19 outbreak. After the outbreak has receded, hospitals can give full attention to these new perinatal safety standards to ensure a successful implementation. The perinatal safety standards now will be **effective January 1, 2021**.

The new standards are posted on the Prepublication Standards page of The Joint Commission's website and will publish in the spring 2020 E-dition update to the *Comprehensive Accreditation Manual for Hospitals* (*CAMH*). For those customers who purchase it, the spring hard-copy 2020 update for *CAMH* will include these new requirements.

Note: *Although the standards will appear in the spring update for* CAMH *requirements effective July 1, 2020, hospitals will not be held to these perinatal safety requirements during survey until January 2021.*

For more information, please contact Jennifer Hurlburt, MSN, RN, APN/CNS, associate director, Department of Standards and Survey Methods. P

FAQ: Clarifying Expectations for Suicide Risk Reduction in Nonpsychiatric Areas

In July 2019 The Joint Commission implemented the revised National Patient Safety Goal (NPSG) NPSG.15.01.01 related to suicide risk reduction, which was applicable to behavioral health care organizations and hospitals only. Effective July 1, 2020, NPSG 15.01.01 also will be applicable to critical access hospitals. The following answer to a frequently asked question (FAQ) received from customers clarifies how to address Standard NPSG 15.01.01, Element of Performance (EP) 1. EP 1 requires an environmental risk assessment to identify features in the physical environment that could be used to attempt suicide in nonpsychiatric areas of critical access hospitals and hospitals.

Note: *For questions related to this FAQ or the suicide risk recommendation, please contact the Standards Interpretation Group via the* Standards Online Submission Form.

QUESTION: What is The Joint Commission's expectation for an environmental risk assessment in nonpsychiatric units/areas in general hospitals where patients at risk for suicide are housed (for example, nondesignated patient rooms within medical/surgical units or emergency departments)?

ANSWER: *The Joint Commission requires the following of an environmental risk assessment to evaluate potential suicide risks:*

- ***Thoughtful evaluation of the environment.*** *The evaluation is meant to be a proactive process to, at a minimum, identify self-harm issues before a patient is placed in the room.*
- ***A plan.*** *The plan needs to identify who is responsible for removing any objects identified to be of a self-harm nature.*
- ***Resources to guide staff.*** *When caring for individuals at risk for suicide in a patient room in a nondesignated space, staff can reference resources, such as the following:*
  - *Checklists identifying the self-harm objects to be removed*
  - *Electronic flags (for example, the patient being placed in a medical/surgical room is high risk; sweep the room for items not essential for patient care that may pose a self-harm risk)*
  - *Competency/training for all sitters who will be with high-risk patients to do the environmental assessments*
  - *Visual reminders (for example, posters) of the most common items that are significant risks on the unit*
  - *On-site psychiatric professional who is available to complete an environmental risk assessment in areas where staff do not have the training to do this independently* P

UPDATE: Spring 2020 Postings to E-dition® for Accreditation and Certification Manuals with March and July 2020 Requirements

2020 Update 1 Hard-Copy Products Mailing Soon

Following are the expected posting and mailing dates and applicability of upcoming spring accreditation and certification releases. Please note that these time frames are anticipated dates. For questions about these current and upcoming releases, contact your account executive or visit the Prepublication Standards page of The Joint Commission's website. P

MARCH INTERIM E-DITION® RELEASE

This interim release of Joint Commission requirements (reflecting changes from the US Centers for Medicare & Medicaid Services [CMS]) posted to E-dition is effective as of **March 15, 2020,** for the following accreditation and certification programs:

Note: *In this release for critical access hospitals and hospitals, two new elements of performance are effective March 30, 2020.*

- Ambulatory Health Care
- Comprehensive Cardiac Center
- Critical Access Hospitals
- Disease-Specific Care
- Home Care
- Hospitals

SPRING HARD-COPY RELEASE

This release is the regularly scheduled update of hard-copy products with requirements **effective July 1, 2020,** including requirements effective March 15 and 30, 2020, for the following **accreditation programs**:

- Ambulatory Health Care
- Behavioral Health Care
- Home Care
- Hospitals

Expected Time Frame to Mail
On or Around April 20, 2020

Scheduled Spring E-dition Release

This release is the regularly scheduled update of the online E-dition **effective July 1, 2020, for all accreditation and certification programs**.

Accreditation	Certification
• Ambulatory Health Care • Behavioral Health Care • Critical Access Hospitals • Home Care • Hospitals • Laboratories and Point-of-Care Testing • Nursing Care Centers • Office-Based Surgery Practices	• Comprehensive Cardiac Centers • Disease-Specific Care, including advanced programs • Health Care Staffing Services • Integrated Care • Medication Compounding • Palliative Care • Patient Blood Management • Perinatal Care

Expected Time Frame to Post
On or Around April 23, 2020

The Joint Commission Releases Next Round of Heads-Up Reports

Reports Now Available for Critical Access Hospitals, Hospitals, and Laboratories

On March 20, The Joint Commission released its most recent version of the Heads-Up Reports to all accreditation programs. This program-specific report identifies important topics and themes that surveyors are noting and citing during recent surveys. In addition, the Heads-Up Report clarifies not only on **what** standards are being cited, but **why** they are being cited.

Topics for the first quarter of 2020 for Joint Commission–accredited organizations include the following:

- **Ambulatory health care**—Inspection, testing, and maintenance of high-risk equipment
- **Behavioral health care**—Nutritional screening
- **Critical access hospitals**—Management of utility systems
- **Home care**—Documentation and record of care
- **Hospitals**—Safe medication administration
- **Laboratories**—Staff competency
- **Nursing care centers**—Verification of licensed independent practitioners
- **Office-based surgery practices**—Granting initial, renewed, or revised clinical privileges

Sharing Survey Trends and Observations

The Joint Commission developed the Heads-Up Report to give organizations a "heads up" or notice about ongoing survey trends. The report provides the following data that organizations can use to determine how these trends and observations affect them.

- The volume of surveys that identified the particular issue
- Relevant standards and elements of performance
- Relevant Conditions of Participation or Conditions for Coverage, as appropriate and applicable

The report also includes de-identified surveyor comments explaining why a standard was cited as noncompliant and contributing factors to the noncompliance. Clear recommendations of how to trace and uncover similar issues are provided so organizations can identify and resolve issues before their on-site survey or as part of their ongoing survey readiness activities. Additional references also are provided in this report.

Engaging with Health Care Organizations

The Joint Commission is providing a Heads-Up Report as part of its ongoing efforts to continuously engage customers. The downloadable report will be posted at least quarterly in the "Resources and Tools" section on an accredited organization's secure *Joint Commission Connect*® extranet site. Primary accreditation contacts are strongly encouraged to distribute each report to departments and individuals in their organizations who are involved in the identified processes and are empowered to mitigate any potential risks.

For additional information, contact your account executive. P

Consistent Interpretation

Joint Commission Surveyors' Observations Related to Life Safety Deficiencies

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

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

This month, **Consistent Interpretation** focuses on life safety and fire safety deficiencies.

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

Life Safety (LS) Standard LS.02.01.35: The hospital provides and maintains systems for extinguishing fires.	
LS.02.01.35, EP 14: The hospital meets all other Life Safety Code automatic extinguishing requirements related to NFPA 101 2012: 18/19.3.5.	
Compliance Rate	In 2019 the noncompliance percentage for this EP was **49.79%**—that is, **703** of **1,412** hospitals surveyed did not comply with this requirement.
Noncompliance Implication	Life safety deficiencies that are not specifically addressed by a specific EP are vital to maintaining a safe environment and, if not maintained, present a risk to occupants when systems do not operate as designed or built to the *Life Safety Code*®.*

Surveyor Observation	**Guidance/Interpretation**
• A significantly broken ceiling tile with a portion missing. • A blocked kitchen suppression pull station. • A missing ceiling tile in a room with sprinkler protection only. • The fire suppression system in the kitchen did not cover the deep fryer. • Gaps between the baffles in the kitchen exhaust hood. • A blocked fire extinguisher. • The exterior fire department connection was not identified.	• Location is essential. • Score here, at Standard LS.02.01.35, EP 14, if the space is protected only by automatic sprinklers. • Score at Standard LS.02.01.34, EP 9,† if the space has smoke detection • Do not score gaps within light fixtures, as they are part of the ceiling system. • NFPA 96–2011 requires the suppression system to cover the grease-producing equipment properly and baffles to be securely in place. • Fire extinguishers must always remain accessible. • NFPA 13–2010, 8.17.2.4.7, requires the fire department connection to be identified.

* *Life Safety Code*® is a registered trademark of the National Fire Protection Association, Quincy, MA.

† **LS.02.01.34, EP 9:** The ceiling membrane is installed and maintained in a manner that permits activation of the smoke detection system. (For full text, refer to NFPA 1012012: 18/19.3.4.1)

The Joint Commission Journal on Quality and Patient Safety®

IMPROVEMENT FROM FRONT OFFICE TO FRONT LINE

This issue of *Perspectives* presents the **March 2020** 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.

EDITORIAL

Adverse Events

Performance Improvement

Infection Prevention and Control

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

- Delayed implementation of perinatal safety standards for **hospitals** (*see* page 31 in this issue for the full article)

CURRENTLY IN FIELD REVIEW

- **Laboratory** program expansion related to embryology, pathology, and molecular diagnostics (field review ends April 6)

Note: *Please visit the Standards Field Reviews pages on The Joint Commission's website for more information. Field reviews usually span six weeks; dates are subject to change.*

CURRENTLY BEING RESEARCHED OR IN DEVELOPMENT

- Developing proposed new and revised requirements to incorporate updated American Heart Association/American Stroke Association Acute Ischemic Stroke Guidelines in all **disease-specific care** advanced stroke programs
- Developing proposed requirements for a new Assisted Living Community accreditation program; The Joint Commission intends to launch a field review sometime in April
- Researching quality and safety issues regarding electronic health records

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