The Joint Commission

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The Joint Commission Perspectives®

THE OFFICIAL NEWSLETTER OF THE JOINT COMMISSION

Contents

SPECIAL REPORT: Suicide Prevention in Health Care Settings

Recommendations from Third Expert Panel

The Joint Commission has assembled expert panels to provide guidance to customers and surveyors on safeguards to prevent suicide. The November 2017 *Perspectives* (pages 1 and 3–7) contained thirteen recommendations from the first two panels specific to inpatient units in both psychiatric and general acute care hospitals in addition to the emergency room settings. This article presents three recommendations from the third expert panel held on October 11, 2017, which focused on the prevention of suicide in other behavioral health care settings, such as residential treatment, partial hospitalization, intensive outpatient, and outpatient treatment programs. The Joint Commission convened a fourth expert panel on December 8, 2017, to develop recommendations for suicide risk assessment and key components for safe monitoring of high-risk patients. The recommendations from that meeting are under development and will be added to the current list as soon as they are available.

Recommendations for Residential, Partial Hospitalization, Day Treatment, and Intensive Outpatient Programming Facilities

14. These settings are not required to be ligature resistant.*

* *With respect to elements in the physical environment, the panel adopted this definition of* ligature resistant*: "Without points where a cord, rope, bedsheet, or other fabric/material can be looped or tied to create a sustainable point of attachment that may result in self-harm or loss of life."*

These levels of care are less restrictive than locked units. Creating a ligature-resistant environment may not prevent patients from attempting suicide because patients are able to exit the facility. Moreover, patients have been assessed and determined to be at low risk in the near term for self-harm and therefore appropriate for placement in a less restrictive level of care than that of inpatient psychiatric care.

15. These organizations should conduct a risk assessment to identify elements in the environment that residents could use to harm themselves, visitors, and/or staff. Those items that have high potential to be used to harm oneself or others should be removed and placed in a secure location (for example, putting sharp cooking utensils in a locked drawer) when possible. Staff should be trained to be aware of the elements of the environment that may pose a serious risk to a resident who could develop serious suicidal ideation. Staff should be aware of how to keep a resident safe from these hazards until the resident is stabilized and/or able to be transferred to a higher level of care.

The panel recognizes that a patient placed in this level of care may have a change in mental state based on some trigger within the environment or in his or her treatment, and staff should be prepared for this.

16. These organizations should have policies and procedures implemented to address how to manage a patient in these levels of care who may experience an increase in symptoms that could result in self-harm or suicidality.

Appendix: Suicide Expert Panel Participants

Expert Panel Members: October 11, 2017

Tracy Griffin Collander, LCSW (Northwest Community Hospital)

Wade Ebersole, MHA (Denver Health)

Nancy Foster, MA (American Hospital Association)

Kate Gagliardi, MSN, RN (Office of Quality, Safety and Value, VACO)

Jim Hunt, AIA (Behavioral Health Facility Consulting, LLC)

Karen Johnson, MSW (Universal Health Services)

Anne Kelly, MA, BSN (Acadia Healthcare)

Susan Knapik (Bureau of Inspection and Certification Office of Mental Health)

Mary Jane Krebs, APRN, BC, FACHE (Spring Harbor Hospital)

Peter Mills, PhD, MS (VA National Center for Patient Safety Field Office)

Robert Roca, MD, MPH, MBA (Sheppard Pratt Health System)

Michael Sherbun, PhD, RN, MHA (Signature Healthcare Services)

David Sine, DrBE, CSP, ARM, CPHRM (Veterans Health Administration)

Joseph Weinstein, MD (Steward Group)

DD White, RN, MSN (HCA Healthcare)

Joint Commission panel members:

David Baker, MD, MPH, FACP (Executive Vice President, Division of Healthcare Quality Evaluation)

Ana McKee, MD (Executive Vice President & Chief Medical Officer)

Mark Pelletier, RN, MS (Chief Operating Officer)

Lisa Vandecaveye, JD, MBA, FACHE (General Counsel)

Anne Bauer, MD (Physician Surveyor)

Sue Boylan-Murray, MBA (Senior Director of Field Operations)

Stephen Kramer, MD (Physician Surveyor)

Tim Markijohn, MBA, MHA, CHFM, CHE (Life Safety Code Field Director)

Kathryn Petrovic, MSN, RN-BC (Senior Associate Director, Standards Interpretation Group)

Sandy Rahe, MBA, RN (Nurse Surveyor)

Nina Smith, RN (Hospital Field Director)

Peter Vance, LPCC, CPHQ (Behavioral Health Care Field Director)

James Woodson, PE, CHRM (Engineer, Standards Interpretation Group)

Paul Ziaya, MD (Senior Director of Field Operations)

Kathy Tolomeo, CHEM, CHSP (Engineer, Standards Interpretation Group)

Merlin Wessels, LCSW (Associate Director, Standards Interpretation Group)

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You're Reading the First Digital-Only Issue of Perspectives!

Welcome to the first digital-only issue of *Perspectives*®! Although print issues of *Perspectives* have been discontinued, you'll receive the same trusted and authoritative content from Joint Commission Resources in this and subsequent issues. As time is of the essence, you now have digital access 24/7 at your fingertips to this issue of *Perspectives* as well as quick and easy access to digital archives going back 5 years on the JCR website at https://www.jcrinc.com/my-account/periodicals/. If you have any questions, or if you did not receive an e-mail notification alerting you to this issue's publication, please contact JCR Customer Service at jcrcustomerservice@pbd.com or 877-223-6866. Customers who read their complimentary *Perspectives* through their *Joint Commission Connect*™ extranet site will continue to access their subscription this way.

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Home Health Requirements Updated to Maintain Alignment with CMS

In response to revisions to Centers for Medicare & Medicaid Services (CMS) Conditions of Participation (CoPs) for home health, The Joint Commission will begin surveying deemed-status **home health agencies** to updated home health regulatory requirements **effective January 13, 2018**.

Background

On January 13, 2017, CMS published the final rule "Medicare and Medicaid Program: Conditions of Participation for Home Health Agencies."[1] This final rule revised CoPs for home health agencies and was to be effective July 13, 2017. On July 10, 2017, CMS published revisions to the final rule in the *Federal Register* and delayed implementation of the final rule to January 13, 2018.[2]

CMS has reviewed a majority of The Joint Commission's standards changes, which will be implemented on January 13, 2018. Any additional changes based on CMS's continued review of The Joint Commission's standards will be published at a future release.

The final standards changes will be posted on The Joint Commission's website at https://www.jointcommission.org/standards_information/prepublication_standards.aspx and in an E-dition® update scheduled for January 13, 2018 (the revised CoPs will appear in the home health crosswalk in this E-dition update as well). In addition, these revisions will be published in the 2018 *Comprehensive Accreditation Manual for Home Care*.

For more information, please contact Kathy Clark, associate project director specialist, Department of Standards and Survey Methods, The Joint Commission, at kclark@jointcommission.org.

References

1. Federal Register. Medicare and Medicaid Program: Conditions of Participation for Home Health Agencies. Accessed Dec. 11, 2017. https://www.federalregister.gov/documents/2017/01/13/2017-00283/medicare-and-medicaid-program-conditions-of-participation-for-home-health-agencies
2. Federal Register. Medicare and Medicaid Programs; Conditions of Participation for Home Health Agencies; Delay of Effective Date. Accessed Dec. 11, 2017. https://www.federalregister.gov/documents/2017/07/10/2017-14347/medicare-and-medicaid-programs-conditions-of-participation-for-home-health-agencies-delay-of

Credentialing and Privileging of Independent Pathologists

Effective immediately, The Joint Commission will no longer require **hospitals**, **critical access hospitals**, and **ambulatory care organizations** to credential and privilege pathologists who provide diagnostic services through a reference laboratory. A reference (contract) laboratory is a laboratory contracted for testing that is owned and operated by an organization other than the organization referring the testing.

Clinical Laboratory Improvement Amendments (CLIA) regulations 42 CFR 493.1351–493.1495 outline specific and rigorous competency requirements for laboratory personnel, including requirements for pathology services and its subspecialties. Because pathologists practicing in the United States are required to comply with these requirements, Joint Commission–accredited organizations that seek the services of pathologists within independent reference laboratories (that comply with CLIA regulations) can safely presume that the pathologists are qualified and competent to perform all diagnostic services within their pathology practice, making an additional credentialing and privileging process unnecessary.

To reflect this change, the Introduction to Leadership (LD) Standard LD.04.03.09 now includes the following additional exception to the requirement that "each licensed independent practitioner providing services through a contractual agreement must be credentialed and privileged by the [organization] using his or her services":

- Services provided by a pathologist through a contracted reference laboratory compliant with CLIA (Clinical Laboratory Improvement Amendments) regulations.

Impact to Survey Process

Credentialing and privileging are no longer required when the contracted pathologist from a reference laboratory is performing tests and/or providing his or her professional services off site. For example, when a laboratory or an organization sends a specimen to a reference laboratory to be interpreted by an independent pathologist(s), the pathologist(s) who is providing the interpretation does not need to be credentialed and privileged by the hospital or ambulatory care organization.

Please note that anytime the pathologist provides his or her professional service, including consultation in the same laboratory or organization where the specimen was collected or prepared, credentialing and privileging would be required.

This change is reflected in the January 2018 E-dition® release as well as the 2018 print products for the *Comprehensive Accreditation Manuals* for ambulatory care, critical access hospitals, and hospitals (including 2017 Update 2 for ambulatory care and hospitals). For more information, please contact Ron S. Quicho, MS, associate project director, Department of Standards and Survey Methods, at rquicho@jointcommission.org.

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NEW: Requirements for Maternal Status Assessment and Documentation

The Joint Commission recently approved three new requirements for **hospitals** and **critical access hospitals** that offer obstetric services, specifically labor and delivery. These new elements of performance (EPs)—**effective July 1, 2018**—are at Provision of Care, Treatment, and Services (PC) Standard PC.01.02.01. The EPs are designed to improve the identification of mothers, upon admission to labor and delivery, who are at risk for transmitting infectious diseases, including human immunodeficiency virus (HIV), hepatitis B, Group B streptococcus (GBS), and syphilis, to their newborns. Timely identification will ensure that the mother and/or the newborn can be treated promptly to prevent harm.

These requirements were finalized using responses from public field review along with feedback from a standards review panel of experienced labor and delivery professionals (listed on The Joint Commission website at https://www.jointcommission.org/assets/1/18/2017_Maternal_status_assessment_and_documentation_standards_review_panel_not_tech.r3docx_(1).pdf. The project's *R3 Report*, at https://www.jointcommission.org/standards_information/r3_report.aspx, provides the rationales for the new requirements as well as references to the research articles used to develop them.

The new requirements are shown below and will be available online in early January at https://www.jointcommission.org/standards_information/prepublication_standards.aspx. They also will appear in the spring 2018 E-dition® release for hospitals and critical access hospitals and the 2018 Update 1 print publication for the *Comprehensive Accreditation Manual for Hospitals*.

For more information, please contact Kathy Clark, MSN, RN, associate project director specialist, Department of Standards and Survey Methods, The Joint Commission, at kclark@jointcommission.org.

Joint Commission Requirement

Official Publication of Joint Commission Requirements

EPs for Maternal Status Documentation Prior to Delivery

APPLICABLE TO HOSPITALS AND CRITICAL ACCESS HOSPITALS

Effective July 1, 2018

Provision of Care, Treatment, and Services (PC)

PC.01.02.01
The [organization] assesses and reassesses its patients.

Elements of Performance for PC.01.02.01

14. **For [organizations] that provide obstetric services:** Upon admission to labor and delivery, the mother's status of the following diseases (during the current pregnancy) is documented in the mother's medical record:
    - Human immunodeficiency virus (HIV)
    - Hepatitis B
    - Group B streptococcus (GBS)
    - Syphilis
15. **For [organizations] that provide obstetric services:** If the mother had no prenatal care or the disease status is unknown, testing for the following diseases are performed and the results documented in the mother's medical record:
    - Human immunodeficiency virus (HIV)

EPs for Maternal Status Documentation Prior to Delivery (continued)

- Hepatitis B
- Group B Streptococcus (GBS)
- Syphilis

Note: *Because GBS test results may not be available for 24–48 hours, organizations may elect not to perform this test but instead administer prophylactic antibiotics to the mother.*

16. **For [organizations] that provide obstetric services:** If the mother tests positive for human immunodeficiency virus (HIV), hepatitis B, group B streptococcus (GBS), or syphilis when tested in labor and delivery or during the current pregnancy, that information is also documented in the newborn's medical record after delivery.

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Consistent Interpretation

Joint Commission Surveyors' Observations on LS.02.01.35, EPs 4, 5, and 14

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) in the *Comprehensive Accreditation Manual for Hospitals*. The 13th column in the series highlights Life Safety (LS) Standard LS.02.01.35, EPs 4, 5, and 14. **Note:** *Interpretations are subject to change to allow for unique and/or unforeseen circumstances.* P

Life Safety (LS) Standard LS.02.01.35: The hospital provides and maintains systems for extinguishing fires.	
EP 4*: Piping for approved automatic sprinkler systems is not used to support any other item. (For full text, refer to NFPA 25-2011: 5.2.2.2) * For the first six months of 2017, the noncompliance percentage for this EP was 58.04% (that is, 433 hospitals out of 746 hospitals surveyed were out of compliance with this requirement).	
Surveyor Observations	**Guidance/Interpretation**
Conduits, tubing, and wiring were supported by a sprinkler system; in some cases, cabling was wrapped around the sprinkler pipe.	The sprinkler piping cannot be used to support anything. This includes items that are touching the piping.
EP 5†: Sprinkler heads are not damaged. They are also free from corrosion, foreign materials, and paint and have necessary escutcheon plates installed. (For full text, refer to NFPA 101-2012: 18.3.5.1; 19.3.5.3; 9.7.5; NFPA 25-2011: 5.2.1.1.1; 5.2.1.1.2; NFPA 13-2010: 6.2.6.2.2; 6.2.7.1) † For the first six months of 2017, the noncompliance percentage for this EP was 39.41% (that is, 294 hospitals out of 746 hospitals surveyed were out of compliance with this requirement).	
Surveyor Observations	**Guidance/Interpretation**
The sprinkler heads in the clean storage room were coated with thick dust and mottled with rust and paint splashes. Escutcheon plates are missing from several sprinkler heads.	Escutcheon plates are parts of the approved installation of the sprinkler system and must be in place. The sprinkler heads must be free of debris.
EP 14‡: The hospital meets all other *Life Safety Code* automatic extinguishing requirements related to NFPA 101-2012: 18/19.3.5. ‡ For the first six months of 2017, the noncompliance percentage for this EP was 34.45% (that is, 257 hospitals out of 746 hospitals surveyed were out of compliance with this requirement).	

Surveyor Observations	Guidance/Interpretation
There were broken ceiling tiles (with pieces of tile missing) and missing ceiling tiles in the room with sprinkler protection only.	Location is essential. Cite here if the space is protected *only* by automatic sprinklers. If the space has smoke detection, cite Standard LS.02.01.34, EP 3 (moved to EP 9 as of January 1, 2018): "The ceiling membrane is installed and maintained in a manner that permits activation of the smoke detection system. (For full text, refer to NFPA 101-2012: 18/19.3.4.1)." Do *not* cite the gaps within light fixtures as they are part of the ceiling system.
In the kitchen, the Ansul fire suppression system did not cover the deep fryer and there were gaps between the baffles in the kitchen exhaust hood.	NPFA 96-2011 requires the suppression system to cover the grease-producing equipment properly and baffles to be securely in place.
It was noted that there was a blocked fire extinguisher that could not be readily accessed.	Fire extinguishers must remain accessible at all times.
The exterior fire department connection was not identified.	NFPA 13-2010, 8.17.2.4.7 requires the fire department connection to be identified.
The nurse on a behavioral health unit was unable to find the key to unlock the cabinet containing the fire extinguisher.	Fire extinguisher unavailability (locked, and no available keys) is considered a *safety* hazard, not a *fire* hazard. Cite Standard LS.02.01.35, EP 14 in a hospital. In a business occupancy, cite Environment of Care (EC) Standard EC.02.06.01, EP 1: "Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided."

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Redesigned Websites Launching This Spring

Easier navigation, more robust search functionality, and resources specifically tailored for health care organizations based on their accreditation and certification needs—customers can expect these improvements for the websites of The Joint Commission, Joint Commission Resources, Joint Commission International, and the Joint Commission Center for Transforming Healthcare in early 2018.

The redesigned websites are expected to launch by April, replacing current sites that are nearly 10 years old. The new sites are being designed specifically to provide current and prospective customers and stakeholders with the following:

- A unified single sign-on for the multiple sites of The Joint Commission enterprise, including the *Joint Commission Connect*™ extranet, E-dition®, and the Joint Commission Resources webstore
- Content that is more effectively and dynamically organized for health care providers based on care setting, needs, and current stage in the accreditation and certification process as well as quality improvement tools and resources
- A faster, more comprehensive search experience providing results from across all Joint Commission, Joint Commission Resources, Joint Commission International, and Joint Commission Center for Transforming Healthcare websites
- Optimization for fast and easy mobile viewing and navigation
- Consistent presentation and experience of information that makes it easy to navigate across different pages, sections, portals, and sites of The Joint Commission enterprise

Over the next three months, watch for additional details to come in *Perspectives* as well as *Joint Commission Connect*.

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The Joint Commission Journal on Quality and Patient Safety®

IMPROVEMENT FROM FRONT OFFICE TO FRONT LINE

This issue of Perspectives showcases the December 2017 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 http://www.jointcommissionjournal.com/.

661 Pragmatic Insights on Patient Safety Priorities and Intervention Strategies in Ambulatory Settings—U. Sarkar, K. McDonald, A. Motala, P. Smith, L. Zipperer, R.M. Wachter, R. Shanman, P.G. Shekelle

Building from the findings in a Technical Brief commissioned by the Agency for Healthcare Research and Quality, the authors provide seven recommendations, along with specific research and policy activities, for advancing ambulatory safety.

671 Improving the Quality of Data for Inpatient Claims-Based Measures Used in Public Reporting and Pay-for-Performance Programs—H. Crews, P.J. Pronovost, P.R. Helft, J.M. Austin

Although claims-based measures are widely used, their validity and reliability and the data used to populate them can be poor or unknown, posing both a financial and reputational risk to hospitals. The authors review key challenges associated with the use of these measures and recommend ways to improve claims data fit for quality measurement, public reporting, and value-based programs.

676 User-Centered Collaborative Design and Development of an Inpatient Safety Dashboard—E. Mlaver, J.L. Schnipper, R.B. Boxer, D.J. Breuer, E.F. Gershanik, P.C. Dykes, A.F. Massaro, J. Benneyan, D.W. Bates, L.S. Lehmann

An electronic health record–embedded dashboard was developed for used by interdisciplinary rounding teams on inpatient medical services. It collects real-time data covering 13 safety domains and generates stratified alerts with an interactive check-box function. Integration of the dashboard into clinical care is intended to promote communication about patient safety and facilitate identification and management of safety concerns.

686 Advances in Rapid Response, Patient Monitoring, and Recognition of and Response to Clinical Deterioration—J.C. Rojas, C. Shappell, M. Huber

As discussed at the 13th International Conference on Rapid Response Systems and Medical Emergency Teams, held in May 2017, hospitals have largely moved beyond initiating new rapid response systems and are now focusing on how to continually evaluate and improve them.

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In Sight

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

APPROVED

STANDARDS

- Revisions to requirements for **deemed home health** organizations to align with Centers for Medicare & Medicaid Services (CMS) requirements, effective January 13, 2018 (*see* article on page 5 of this issue)
- Revision to the Introduction of "Leadership" (LD) Standard LD.04.03.09 for the **laboratory** program, effective immediately (*see* article on page 6 of this issue)
- New Provision of Care, Treatment, and Services (PC) requirements for documentation of maternal status for HIV, hepatitis B, group B strep disease, and syphilis for the **hospital** and **critical access hospital** programs, effective July 1, 2018 (*see* article on pages 7 and 8 of this issue)

CURRENTLY BEING RESEARCHED OR IN DEVELOPMENT

STANDARDS

- Proposed further revisions to Environment of Care (EC) and Life Safety (LS) standards for **all accreditation programs** to maintain alignment with CMS requirements
- Proposed new requirements for newborn naming conventions (program applicability to be determined by research)
- Proposed new requirement for weighing pediatric patients in kilograms (program applicability to be determined by research)
- Proposed new requirement for antibiotic stewardship for the **ambulatory care** and **office-based surgery practice** programs
- Proposed new pain management and assessment requirements for the **ambulatory care**, **behavioral health care**, **critical access hospital**, **home care**, **laboratory**, **nursing care center**, and **office-based surgery practice** programs (*see* related article in July 2017 *Perspectives* on revisions to pain assessment and management requirements effective January 1, 2018, for **hospitals**)
- Proposed revisions to **laboratory** requirements to align with new CMS requirements

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