

The Joint Commission Perspectives®

THE OFFICIAL NEWSLETTER OF THE JOINT COMMISSION



APPROVED: Revisions to National Patient Safety Goal Regarding Suicide Prevention

The Joint Commission has approved revisions to its National Patient Safety Goal® (NPSG), Standard **NPSG.15.01.01**, related to suicide prevention in **hospitals** and **behavioral health care** organizations. Because there has been no improvement in suicide rates in the United States since the Goal was introduced in 2007, and suicide is the 10th leading cause of death in the country, The Joint Commission concluded that it was time to reevaluate the Goal in response current best practices relative to suicide prevention. Moreover, many suicide deaths are among individuals who were recently seen by or currently under the care of a health care provider. These revisions will be **effective July 1, 2019**.

Reevaluating NPSG.15.01.01

In the March 2018 issue of *Perspectives*, The Joint Commission announced that it would revise NPSG 15.01.01 based on recommendations from its Technical Expert Panel and current evidence-based research. Previously, The Joint Commission held five technical expert panel meetings between June 2017 and March 2018. The results of the meetings were published in the November 2017, January 2018, February 2018, and March 2018 issues of *Perspectives*—including the article announcing the intention to revise the existing Goal.

Contents


-  **APPROVED:** Revisions to National Patient Safety Goal Regarding Suicide Prevention
-  **APPROVED:** Revisions to National Patient Safety Goal Addressing Anticoagulant Therapy
-  The Joint Commission Will Begin Publicly Reporting Cesarean Section Rates by July 2020
-  **ERRATA:** “Standards Applicability Process” Chapter for Ambulatory Health Care
-  FSA Tool Temporarily Offline for January 2019 Standards Update
-  **REMINDER:** Gift Policy
-  **REMINDER:** *Joint Commission Connect* Extranet Site Security
-  **REMINDER:** New Performance Measures for Primary Stroke Centers Effective January 1, 2019
-  **POSTED:** 2018 Fall Update to E-dition for Accreditation and Certification Manuals
- Consistent Interpretation
- November *JQPS* Table of Contents
- In Sight

The current Goal took a high-level approach to suicide prevention in health care organizations and, as such, has been limited in its objective of helping organizations improve their processes and environments for individuals at risk for suicide. The revised Goal, which now is more specific and instructional, aligns with current research and the expert panel recommendations.

Specific revisions include the following:

- Behavioral health care organizations, psychiatric hospitals, and psychiatric units in general hospitals should conduct environmental risk assessments to be ligature resistant.
- Non-psychiatric units in general hospitals are not expected to be ligature resistant; however, the units should minimize risks in the environment for patients identified at risk for suicide.
- Individuals being treated or evaluated for behavioral health conditions as their primary reason for care need to be screened for suicide risk using a validated tool. (The Goal does not require universal screening.)
- Organizations must develop a plan to mitigate suicide based on an individual's overall level of risk.
- Organizations must follow written policies and procedures for counseling and follow-up care for individuals identified as at risk for suicide.

These revisions will be posted on the [Prepublication Standards](#) page of The Joint Commission website and will be published online in the spring 2019 E-dition® update to the *Comprehensive Accreditation Manual for Behavioral Health Care (CAMBHC)* and *Comprehensive Accreditation Manual for Hospitals (CAMH)*; for customers who purchase it, the spring 2019 print update for *CAMBHC* and *CAMH* will include these revisions.

Visit the Joint Commission website for access to a [compendium of resources](#) that can be used to meet the requirements of the revised standards. For more information, please contact [Stacey Paul](#), RN, MSN, APN, PMHNP-BC, clinical project director, Department of Standards and Survey Methods. 



APPROVED: Revisions to National Patient Safety Goal Addressing Anticoagulant Therapy

Effective July 1, 2019, The Joint Commission will implement approved revisions to its National Patient Safety Goal® (NPSG) related to anticoagulant therapy, Standard **NPSG.03.05.01**, for medical centers accredited under the **ambulatory health care** (medical centers only), **critical access hospital**, **hospital**, and **nursing care center** programs.

Anticoagulation medications are high-risk medications that may cause severe bleeding when not administered or monitored appropriately. The new and revised elements of performance (EPs) address the following concepts:

- Using approved protocols and evidenced-based guidelines
- Ongoing patient monitoring
- Patient and family education
- Evaluating organizational safety practices and then taking actions to improve those practices

Further information on the research, including rationales for the revised requirements and research articles used to develop them will be posted in the project's [R³ Report](#).

Focusing Applicability

This Goal applies to organizations that initiate, manage, and adjust dosage for anticoagulation medications; it does not apply to organizations limited to the mechanical treatment of bleeding. After careful evaluation, The Joint Commission determined that the applicability of this Goal will be removed from the Episodic Care and Occupational/Worksite Health Services within the ambulatory health care program.

These revisions will be posted on the [Prepublication Standards](#) page of The Joint Commission website and will be published online in the spring 2019 E-dition® update to the *Comprehensive Accreditation Manual for Ambulatory Care (CAMAC)*, *Comprehensive Accreditation Manual for Critical Access Hospitals (CAMCAH)*, *Comprehensive Accreditation Manual for Hospitals (CAMH)*, and *Comprehensive Accreditation Manual for Nursing Care Centers (CAMNCC)*; they also will be printed in the hard-copy spring 2019 update for CAMAC and CAMH and the 2020 CAMCAH and CAMNCC.

For more information, please contact [Helen Larios](#), MBA, MSN, RN, clinical project director, Department of Standards and Survey Methods. 

NEXT ▼



The Joint Commission Will Begin Publicly Reporting Cesarean Section Rates by July 2020

The Joint Commission will begin publicly reporting hospitals with consistently high cesarean birth rates on Quality Check® by July 1, 2020, using data reported by hospitals during the calendar years 2018 and 2019. This designation will be based on hospitals' rates on the perinatal care (PC) Cesarean Birth measure PC-02, which measure the rates of cesarean births among a subset of the general obstetric population of low-risk women having their first birth with a term, singleton baby in a vertex position (NTSV).

About the Cesarean Birth Measure

The Joint Commission began to require accredited hospitals to collect and submit data on PC-02 in 2010. However, The Joint Commission deferred publicly reported hospitals' rates on Quality Check for several reasons, including the following:

- Optimal rate of cesarean section was not clear
- Questions remained about whether the measure needed risk-adjustment methodology beyond limiting to low-risk NTSV deliveries
- Relatively few reports of how hospitals had been able to reduce their cesarean section rates safely without increasing neonatal complications

Since 2010, PC-02 rates among all reporting hospitals have remained around 26% without evidence of trends toward improvement. Moreover, in 2017, 25% of the hospitals reporting had rates greater than 30%. This led The Joint Commission to reexamine its position on public reporting.

What Has Changed

Data from the [California Maternal Quality Care Collaborative](#) (CMQCC) and the Joint Commission's internal analyses suggest that further risk adjustment beyond stratifying for NTSV deliveries has limited effect on hospitals' comparative rates. In addition, a Joint Commission Technical Advisory Panel supported reporting the NTSV cesarean section rate without further risk adjustment.

There is now more evidence that hospitals can safely reduce their cesarean section rates without an increase in neonatal complications.¹ The American College of Obstetrics and Gynecology also has released guidance on reducing cesarean section rates.²

Effective January 1, 2019, The Joint Commission will add measure PC-06, Unexpected Complications in Term Newborns.³ This measure gauges adverse outcomes resulting in severe or moderate morbidity in otherwise healthy term infants. Importantly, this metric will serve as a balancing measure to alert hospitals to any unanticipated or unintended consequences of quality improvement activities to reduce unnecessary cesarean births.

Rating PC-02 Performance

The Joint Commission will use the following three criteria to determine a hospital's PC-02 rating:

1. ≥30 cases reported in both years
2. PC-02 rate >30% for the current year
3. Overall two-year average PC-02 rate >30%

Hospitals will be identified on Quality Check with either a plus (+) or minus (-) symbol for the PC-02 measure.

- The plus (+) symbol will signify the hospital has an acceptable rate.
- A minus (-) symbol will signify the hospital's rate is consistently high and has a large enough sample size to make this determination.


Approximately 20% of hospitals met these three criteria using 2016–2017 data. For those hospitals identified as having high rates (-), The Joint Commission also will show those hospitals' actual 2019 PC-02 rate.

Note: 2018 and 2019 data will be used for the initial release.

Avoiding Unhealthy Consequences

Although The Joint Commission believes all hospitals should work to reduce unnecessary cesarean births, it does not want to differentiate between groups of hospitals whose rates are in the acceptable range. For this reason, The Joint Commission will not show the rates for hospitals with acceptable rates (+). The Joint Commission is concerned that doing so might inappropriately encourage hospitals to achieve lower cesarean section rates than may be safe for their patient populations. For this measure, lower is not always better.

Performance Measure Reports (PMR)—posted to a hospital's secure *Joint Commission Connect*[®] extranet site—will provide monthly and quarterly measure rates. Hospitals are encouraged to look to existing tools to assist with improving performance on the measures, successful examples can be found in [Alliance for Innovation on Material Health \(AIM\)](#) bundles^{1,2} or state collaboratives such as [CMQCC](#).⁴

Questions regarding this reporting initiative may be directed to the [Performance Measurement Network Q&A Forum](#) on the Joint Commission website. 

References

1. Vadnais, MA, et al. Quality improvement initiatives lead to reduction in nulliparous term singleton vertex cesarean delivery rate. *Jt Comm J Qual Patient Saf.* 2017 Feb; 43(2):53–61.
2. Council on Patient Safety in Women's Health Care. [Safe Reduction of Primary Cesarean Birth \(+AIM\)](#). Accessed Nov 9, 2018.
3. The Joint Commission. [Approved: New perinatal care performance measure](#). *Jt Comm Perspect.* 2018 Aug; 38(8):7–8. Accessed Nov 9, 2018.
4. California Maternal Quality Care Collaborative. [Toolkit to Support Vaginal Birth and Reduce Primary Cesareans](#). Accessed Nov 9, 2018.



ERRATA: “Standards Applicability Process” Chapter for Ambulatory Health Care

The Ambulatory Care Services Applicability Grid in the “Standards Applicability Process” (SAP) chapter of the **ambulatory health care** manual contains incorrect applicability information for three standards. This error was published incorrectly online in the fall 2018 E-dition® update and the 2018 Update 2 to the *Comprehensive Accreditation Manual for Ambulatory Care (CAMAC)* and the *2019 CAMAC*, which mailed recently.

Revisions to the applicability grid will be updated in E-dition after December 6, 2018. For customers who purchase it, the spring 2019 print update for *CAMAC* will include the corrected applicability grid.

The following grid provides a visual look at the revisions. All shaded boxes indicate an EP and applicable service change effective **January 1, 2019**; added applicability is shown with an underlined “X” and deleted applicability is shown with a strikethrough “~~X~~.”

We regret the error and apologize for any inconvenience. 

Standard/ Requirement Number	EP #	Ambulatory Surgery Centers	Endoscopy	Medical Centers	Dental Centers	Diagnostic/Therapeutic	Diagnostic Imaging Services	Diagnostic Sleep Centers	Kidney Care/Dialysis	Telehealth/Nonsurgical	Telehealth/Surgical	Episodic Care	Occupational/Worksite Health	Urgent/Immediate Care	Convenient Care
LD.04.03.13	1	X		X	X				X			X	X	X	
	3	X		X	X				X			X	X	X	
	4	X		X	X				X			X	X	X	
	6			X	X				X			X	X	X	
PC.01.02.07	1	X	X	X	X	X			X			X	X	X	X
	3	X	X	X	X	X			X			X	X	X	X
	4	X		X					X				X		
	5	X		X					X				X		
	7	X		X					X			X	X	X	
	8	X		X	X				X			X	X	X	
PI.02.01.01	4	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	6	X	X	X		X	X					X		X	
	8	X	X	X	X	X	X	X	X	X	X	X	X	X	X
	11	X	X												
	19	X		X	X				X			X	X	X	
	20	X	X	X	X	X	X		X			X		X	

FSA Tool Temporarily Offline for January 2019 Standards Update

Starting December 28, 2018, at 7:00 P.M. central standard time (CST), the Focused Standards Assessment (FSA) tool in the Intracycle Monitoring (ICM) Profile on the *Joint Commission Connect*® extranet site will be offline for the January 2019 standards update. The tool will come back online January 10, 2019, at 9:00 P.M. CST. The Joint Commission will apply an extension date for scheduled ICM submission due date between December 29, 2018, and January 10, 2019, to allow accredited organizations additional time to review any changes made to standards displayed in the open FSA tool. The due date will be Monday, January 28, 2019, for such organizations.

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

REMINDER: Gift Policy

Occasionally, and especially during the holiday season, staff at accredited and certified health care organizations want to provide Joint Commission surveyors and reviewers with gifts. Although appreciative of these kind thoughts, The Joint Commission has a gift policy that prohibits the acceptance of any gifts related to accreditation. This policy is designed to ensure the integrity of The Joint Commission's accreditation and certification decision process as well as to ensure independence in business judgment. The Joint Commission's official policy regarding what can be accepted from health care organizations seeking accreditation with respect to gifts* is summarized as follows:

- Joint Commission employees involved with the accreditation and certification decision process (specifically, surveyors and reviewers) **cannot** accept any gift of value from a surveyed/ reviewed or accredited/certified organization. A modest on-site meal **is acceptable** for efficiency purposes and is not considered a gift.
- Very few exceptions are allowable for accepting gifts. In order to avoid any potential conflicts of interest, it is in the best interest of organizations—as well as surveyors and reviewers—if no gifts are offered.
- Cash, cash equivalents, or entertainment **cannot** be accepted.
- If an organization feels it necessary to provide something, then promotional mementos and souvenirs of nominal value[†] are not considered gifts and can be accepted if given after the survey or review and when there is no apparent attempt to influence a business decision. Good judgment and caution are necessary in these situations.

Questions may be directed to [Fran Carroll](#), corporate compliance and privacy officer and senior assistant general counsel, The Joint Commission. 

* Gifts can include anything of value given to or by Joint Commission employees, including cash; gratuities; meals; gift certificates; tickets to sporting events, cultural or community events, or invitations to performances or other events; favors (specially arranged for the recipient and not commonly offered to everyone); discounts; free services; space; equipment; loans; education; lodging; or transportation. Gifts do **not** include emergency health care, security, or safety provisions to protect staff while on site for consultation or survey/review.

[†] A gift of "nominal value" is an item of little value, such as a promotional item (for example, a pen, coffee mug, cap, T-shirt) that carries an organization name or logo.

REMINDER: *Joint Commission Connect* Extranet Site Security

The *Joint Commission Connect*[®] extranet site is a secure, safeguarded portal for the direct and confidential exchange of information between The Joint Commission and its accredited and/or certified health care organizations. It provides a platform for the exchange of sensitive information, including Accreditation Reports, notifications, and other correspondence with The Joint Commission. Each health care organization designates a primary accreditation/certification contact and additional security administrator(s) to receive unlimited access to the extranet site. The primary accreditation/certification contact and designated security administrator(s) in turn are responsible for registering and deactivating any other users of the site.

Ensuring *Joint Commission Connect* Security


Giving *Joint Commission Connect* access to designated, exclusive staff—and immediately removing access for those who no longer need or require it—is the best way to protect the reliability and confidentiality of private information and prevent its inadvertent disclosure. To fully protect the integrity of the site’s information, each user must be provided with his or her own unique user ID, password, and specific site permission. *Joint Commission Connect* users should never share the same user name and password.

Role of the Consultant

The appropriately designated primary accreditation/certification contact must be an individual that is employed by the accredited and/or certified health care organization and is the primary point of on-site contact between the health care organization and The Joint Commission.

However, The Joint Commission has become aware that some health care organizations are designating contracted consultants as the primary accreditation/certification contact. The Joint Commission is reminding organizations to ensure that the designated “Contact Type” is aligned with the appropriate staff names for the contacts within the organization. While some job titles have overlapping responsibilities, The Joint Commission stresses the importance of identifying more than one user with accurate contact information as it relates to their job title.

The Joint Commission also would like to remind organizations, as noted in the March 2016 *Perspectives* article,¹ the goal of the survey/review process is to evaluate each health care organization’s ability to meet the intent of the standards and engage with employees to discover areas for performance improvement. While consultants may be present during a survey, their role is as an observer only. Consultants are not permitted to interact with surveyors/reviewers or respond to questions during the on-site survey/review process on behalf of the organizations. This practice will ensure a quality assessment of an organization’s ability to provide safe, quality care on an ongoing basis.

Questions may be directed to [Fran Carroll](#), corporate compliance and privacy officer and senior assistant general counsel, or [Michael Martino](#), director of accreditation and certification operations service teams and business operations, The Joint Commission. 

Reference


1. The Joint Commission. [Consultants' participation during survey restricted to observation only](#). *Jt Comm Perspect*. 2016 Mar; 36(3): 4. Accessed Nov X, 2018.



REMINDER: New Performance Measures for Primary Stroke Centers Effective January 1, 2019

The July 2018 issue of *Perspectives* announced that The Joint Commission will require data collection for two new performance measures for Advanced Certification for **Primary Stroke Center** (PSC), one a stroke outpatient (STK-OP) measure and the other a comprehensive stroke (CSTK) measure. The following measures are **effective January 1, 2019**:

- STK-OP-1—Door to Transfer to Another Hospital—will be used to monitor “door in–door out” times for stroke patients transferred from the emergency department of a PSC to a higher-level acute stroke center
- CSTK-01—National Institutes of Health Stroke Scale (NIHSS) Score Performed for Ischemic Stroke Patients—captures the proportion of ischemic stroke patients for whom an NIHSS score is performed prior to any acute recanalization therapy in patients undergoing recanalization therapy and documented in the medical record or documented within 12 hours of hospital arrival for patients who do not undergo recanalization therapy

Questions regarding this change may be directed to the [Performance Measurement Network Q&A Forum](#) on the Joint Commission website. 

The screenshot shows the website interface for The Joint Commission's Performance Measurement Network Q&A Forum. At the top right, there is a 'Log in' button. Below the header, there are navigation tabs for 'Home' and 'Performance Measurement FAQs'. The main content area is titled 'Measure Specifications Manuals' and is divided into two columns: 'Joint Commission Only Measures' and 'CMS and Joint Commission Aligned Measures'. A 'MANUAL' sidebar on the right contains three buttons: 'Ask a core measure question', 'BHC Instrument List', and 'Accreditation Literature'. A blue arrow points to the 'Ask a core measure question' button.

Click on “Ask a core measure question” if you do not see your question in the forum.

POSTED: 2018 Fall Update to E-dition for Accreditation and Certification Manuals

2019 Print Accreditation and Certification Products in the Mail

The fall E-dition® updates for the accreditation and certification manuals posted to the *Joint Commission Connect*® extranet site in early November. E-dition updates follow the hard-copy publications for the 2018 Update 2 to the *Comprehensive Accreditation Manuals*, published at the end of October, which are available for purchase for the ambulatory health care, behavioral health care, home care, and hospital programs. The *2019 Comprehensive Accreditation Manuals* for accreditation and disease-specific care also have published. (See the November 2018 Perspectives for the [full list of accreditation and certification manuals](#).)

Key revisions that appear in E-dition and the print update and manuals include the following changes. Review the What's New section—included in your accreditation or certification resource—to identify specific changes for your program setting.

Requirements-Related Revisions

- Added new Element of Performance (EP) for National Patient Safety Goals® (NPSG) Standard NPSG.01.01.01, EP 3 requiring **critical access hospitals** and **hospitals** to [use distinct methods of identification for newborn patients](#) (July 2018 *Perspectives*)
- Completed Phase IV of the Elements of Performance (EPs) review component of Project REFRESH, resulting in the consolidation and movement of requirements in the following chapters (as described in [July](#), [August](#), [September](#), and [October](#) 2018 *Perspectives*):
 - “Care, Treatment, and Services” (CTS) (**behavioral health care** organizations)
 - “Equipment Management” (EQ) (**home care** organizations)
 - “Leadership” (LD) (**all accreditation programs**)
 - “Medication Management” (MM) (**ambulatory health care, behavioral health care, critical access hospital, home care, hospital, nursing care center, and office-based surgery** programs)
 - “Nursing” (NR) (**critical access hospitals** and **hospitals**)
 - “Provision of Care, Treatment, and Services” (PC) (**ambulatory health care, behavioral health care, critical access hospital, home care, hospital, nursing care center, and office-based surgery** programs)
- Revised [fluoroscopy-related requirements](#) for **ambulatory health care** organizations, **critical access hospitals, hospitals,** and **office-based surgery** practices (July 2018 *Perspectives*)
- Added new and revised [pain assessment and management standards](#) for **ambulatory health care** organizations, **critical access hospitals,** and **office-based surgery** practices (July 2018 *Perspectives*)
- Revised [medication compounding–related requirements](#) in the **medication compounding** certification program and the “Medication Compounding” (MC) chapter of the **home care** manual (September 2018 *Perspectives*)

- Revised [requirements to help improve outcomes and quality of life for patients](#) in the **Comprehensive Cardiac Center** certification program (October 2018 *Perspectives*)
- Deleted [Performance Improvement \(PI\) Standard PI.01.01.01, EP 21](#), which was applicable to **deemed-status ambulatory surgical centers** that were required to collect data on the medical necessity and appropriateness of procedures (October 2018 *Perspectives*)


Eligibility-Related Changes

- Added eligibility requirements for [minimum thrombectomy volumes](#) for **comprehensive stroke center** certification (May 2018 *Perspectives*)
- Added [registry requirement to eligibility](#) for advanced certification in **heart failure** (August 2018 *Perspectives*)
- Added and revised eligibility requirements for **ambulatory surgery centers, critical access hospitals, and hospitals** that are certified under the advanced certification for Total Hip and Total Knee Replacement ([August](#) and [November](#) 2018 *Perspectives*)
- Expanded [eligibility requirements to accommodate small homes](#) for **nursing care centers** (September 2018 *Perspectives*)
- Revised eligibility requirement allows all hospitals (with or without Joint Commission accreditation) to [pursue advanced certification](#) in **heart failure** and **comprehensive cardiac center** certification (October 2018 *Perspectives*)
- [Suspended previously approved training and volume requirements](#) for individual physicians for the **thrombectomy-capable stroke center** and **comprehensive stroke center** advanced certification programs* (October 2018 *Perspectives*)

Other Important Revisions to Note

- Added two [new performance measures](#) for **primary stroke centers** (July 2018 *Perspectives*)
- Approved new Perinatal Care (PC) performance measure, PC-06, [Unexpected Complications in Term Newborns](#) for accredited **hospitals** (August 2018 *Perspectives*)

Managing Your Manuals

Please contact [Customer Technical Support](#) for any challenges in accessing updated standards in the E-edition release from your *Joint Commission Connect* extranet site. If you are missing a purchased hard-copy accreditation manual product, please contact [Customer Service](#) or call 877-223-6866 with your order number and organization name. [Print](#) and [online](#) manuals, as well as other accreditation resources, are also available for purchase at on the [Joint Commission Resources](#) website. 


* Note that this item was effective immediately as reported in the October 2018 issue of *Perspectives* and does not affect the facility volume requirement of 15 mechanical thrombectomies per year for either certification program.

Consistent Interpretation

Joint Commission Surveyors' Observations of Leadership Requirements Related to Policies and Procedures

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 de-identified database containing surveyors' observations (in the column to the left) on an element of performance (EP)—as well as guidance from the Standards Interpretation Group on how to interpret the observations (in the column to the right). Featured EPs are from standards applicable to the hospital program; however, the guidance in this column may be extrapolated to apply to other accreditation programs that offer similar services and populations served.

This month, **Consistent Interpretation** focuses on Joint Commission requirements that may be cited for observations related to organization leadership's development of policies and procedures and its implementation of those policies and procedures. This month's column highlights two Leadership (LD) requirements that surveyors have cited for missing policies and procedures related to concurrent surgeries, as well as failure to implement established policies and procedures.

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

Standard LD.04.01.07: The hospital has policies and procedures that guide and support patient care, treatment, and services.	
EP 1: Leaders review and approve policies and procedures that guide and support patient care, treatment, and services. (See also NR.02.03.01, EP 1*; RI.01.07.01, EP 1*)	
Compliance Rate	In the first half of 2018, the noncompliance percentage for this EP was 5.60%—that is 38 of 679 hospitals surveyed were out of compliance with this requirement.
Surveyor Observations	Guidance/Interpretation
<ul style="list-style-type: none"> ● No evidence the health care organization had a policy on concurrent surgery that outlined the following: <ul style="list-style-type: none"> ○ Prohibiting concurrent surgery ○ Establishing a mechanism for monitoring whether concurrent surgery is occurring ○ Setting requirements for overlapping surgery 	<ul style="list-style-type: none"> ● This EP is specific to leadership's responsibility to review and approve policies and procedures. ● See Standard LD.04.01.07, EP 2, for failure to implement approved policies. ● The survey process/tracer should include a review of the surgical schedule to determine if there is more than one patient scheduled for the same procedure, at the same time, and by the same practitioner. ● If such a scenario is identified, determine if the health care organization has a policy regarding the scheduling of concurrent (overlapping) surgery and whether the policy is being followed.

EP 2: The hospital manages the implementation of policies and procedures. (See <i>also</i> NR.02.03.01, EP 2 [†])	
Compliance Rate	In the first half of 2018, the noncompliance percentage for this EP was 3.98%—that is 27 of 679 hospitals surveyed were out of compliance with this requirement.
Surveyor Observations	Guidance/Interpretation
<ul style="list-style-type: none"> ● Review of the surgical schedule revealed two patients scheduled for a right hip replacement procedure at the same time and by the same surgeon. ● Staff were unaware of the policy approved by leadership that prohibited concurrent surgical procedures. 	<ul style="list-style-type: none"> ● This EP is specific to the implementation of policies and procedures. ● The survey process/tracer should include a review of the surgical schedule to determine if there is more than one patient scheduled for the same procedure, at the same time, and by the same practitioner. ● If such a scenario is identified, determine if the hospital has a policy (see LD.04.01.07, EP 1) regarding the scheduling of concurrent (overlapping) surgery and whether the policy is being followed.

* Standard **NR.02.03.01, EP 1:** The nurse executive or designee approves nursing policies; nursing standards of patient care, treatment, and services; and standards of nursing practice for the hospital before implementation. (See *also* LD.04.01.07, EP 1)

† Standard **RI.01.07.01, EP 1:** The hospital establishes a complaint resolution process and informs the patient and his or her family about it. (See *also* LD.04.01.07, EP 1; MS.09.01.01, EP 1)

Note: *The governing body is responsible for the effective operation of the complaint resolution process unless it delegates this responsibility in writing to a complaint resolution committee.*

‡ Standard **NR.02.03.01, EP 2:** The nurse executive implements nursing policies, procedures, and standards that describe and guide how the staff provide nursing care, treatment, and services. (See *also* LD.04.01.07, EP 2)

The Joint Commission Journal on Quality and Patient Safety®

IMPROVEMENT FROM FRONT OFFICE TO FRONT LINE

This issue of *Perspectives* presents the **November 2018** Table of Contents for *The Joint Commission Journal on Quality and Patient Safety (JQPS)*. The Joint Commission works closely with *JQPS* (published by Elsevier) to make it a key component in helping health care organizations improve patient safety and quality of care.

To purchase a subscription or site license to *JQPS*, please visit [The Joint Commission Journal on Quality and Patient Safety](http://www.jointcommission.org/jqps) website.

Adverse Events

627 Anticoagulation Across Care Transitions: Identifying Minimum Data to Maximize Drug Safety

N. Shehab; J.L. Greenwald; D.S. Budnitz

Anticoagulants are the leading cause of acute, serious ADEs among hospitalized patients, long term care residents, and older outpatients. The final anticoagulation communication at discharge (the ACDC List) is a well-thought-out and needed approach to addressing the care transition gap for patients treated with anticoagulants. Its implementation will have challenges, but they are likely to be greatly outweighed by the potentially devastating clinical consequences of poorly coordinated anticoagulation management.

630 Defining Minimum Necessary Anticoagulation-Related Communication at Discharge: Consensus of the Care Transitions Task Force of the New York State Anticoagulation Coalition

D. Triller; A. Myrka; J. Gassler; K. Rudd; P. Meek; P. Kouides; A.E. Burnett; A.C. Spyropoulos; J. Ansell

Anticoagulated patients are particularly vulnerable to ADEs when they experience changes in medical acuity, pharmacotherapy, or care setting, and resources guiding care transitions are lacking. A multidisciplinary task force convened by the New York State Anticoagulation Coalition developed a consensus list of 15 requisite data elements that should be communicated to downstream providers for all anticoagulated patients undergoing care transitions. Additional study is needed to objectively evaluate the ability of existing care systems to communicate the elements and to assess possible relationships between communication of the elements and clinical outcomes.

641 Suicide and Hospitals: New Data Suggest an Updated Approach

M. Hogan

The rate of death by suicide continues to rise in the United States, and the use of effective new interventions is not yet widespread. The first rigorous study to estimate national figures for the number and cause of inpatient suicides yields important findings: the rate of suicides within hospitals is low compared to previous estimates, and the great majority (about 70%) of inpatient suicides are by hanging. One important implication of these data is that there are almost certainly far more suicides in the days after discharge than during inpatient care. The burden of disease, trends, and emerging evidence of effective strategies call for increased focus on suicide prevention.

643 Incidence and Method of Suicide in Hospitals in the United States

S.C. Williams; S.P. Schmaltz; G.M. Castro; D.W. Baker

Understanding the rate of suicides in general and psychiatric hospitals and the methods used is important to guide prevention efforts. A cross-sectional analysis of data from 27 states reporting to the National Violent Death Reporting System for 2014–2015, and from hospitals reporting to The Joint Commission’s Sentinel Event Database from 2010 to 2017 used categorical variables and qualitative reviews of event narratives to identify and code suicide events occurring during hospital inpatient treatment. The estimated number of hospital inpatient suicides per year ranges from 48.5 to 64.9, which is far below the widely cited figure of 1,500 per year. Analysis of inpatient suicide methods suggests that hospital prevention efforts should be primarily focused on mitigating risks associated with hanging, and additional suicide prevention efforts may be best directed toward reducing the risk of suicide immediately following discharge.

651 Characteristics of Reported Adverse Events During Moderate Procedural Sedation: An Update

M.R. Jones; S. Karamnov; R.D. Urman

Many interventional procedures are performed under moderate procedural sedation (MPS), but little data exist examining reportable adverse events (AEs) during MPS across specialties. In a retrospective review in which 83 MPS cases were analyzed, type of AE and severity of harm were examined to uncover associations between events with provider, procedure, and patient characteristics. The most common AEs were oversedation/apnea (60.2%), hypoxemia (42.2%), and aspiration (24.1%). The most common unplanned interventions were the use of reversal agents (55.4%) and prolonged bag-mask ventilation (25.3%). Significant differences in rates of AEs were demonstrated according to age, sex, and other patient characteristics. Interventional procedures involving MPS outside the operating room require thorough patient evaluation, optimization, and risk assessment prior to start. Communication among sedation providers and consulting and primary team members is paramount.

Hospital Readmissions

663 Evaluating the Implementation of Project Re-Engineered Discharge (RED) in Five Veterans Health Administration (VHA) Hospitals

J.L. Sullivan; M.H. Shin; R.L. Engle; E. Yaksic; C. VanDeusen Lukas; M.K. Paasche-Orlow; L.M. Starr; J.D. Restuccia; S.K. Holmes; A.K. Rosen

A qualitative evaluation of five Veterans Health Administration hospitals’ implementation of Project Re-Engineered Discharge (RED) was conducted through semistructured telephone interviews with personnel involved in implementation. Qualitative data from these interviews were used to compare implementation activities across the five sites. Guided by the Practical, Robust Implementation and Sustainability Model (PRISM), cross-site analyses of the contextual factors were conducted using a consensus process. Progress and adherence to the implementation steps and intervention components varied across study sites. Although the sites were able to tailor and implement RED because of its adaptability, redesigning discharge processes and incorporating them into an organization’s existing practices requires additional support/resources. Lessons learned from the study should be useful to Veterans Health Administration and private-sector hospitals interested in implementing RED and undertaking a care transition intervention.

Teamwork and Communications

674 Understanding Test Results Follow-Up in the Ambulatory Setting: Analysis of Multiple Perspectives

A. Ai; S. Desai; A. Shellman; A. Wright

Delayed or incomplete test result follow-up, which can lead to missed and/or delayed diagnosis, is an important issue in the ambulatory setting. Five sources of data were used to compass multiple perspectives on safety culture—two national surveys, patient and family complaints, safety reports, and provider response times to test message results in the electronic health record. The following metrics were inspected: how patients and providers estimated the frequency for providing timely test results; how patients’ satisfaction with their provider correlated with their provider’s response time to test result messages; and qualitative themes in patient complaints and safety reports filed by clinic. The institution was compared to national benchmarks using surveys. As test result response time decreased, patient satisfaction increased ($p = 0.0073$). Use of these five sources of data led to an examination of multiple perspectives in follow-up culture and identification of possible explanations for inappropriate follow-up.

Human Factors Engineering

683 Reducing Treatment Errors Through Point-of-Care Glucometer Configuration

J.L. Estock; I.T. Pham; H.K. Curinga; B.J. Sprague; M.Y. Boudreaux-Kelly; J. Acevedo; K. Jacobs

Multiple adverse events reported to the Food and Drug Administration (FDA) revealed that treatment decisions may be affected by how information is displayed on a point-of-care (POC) glucometer's results screen. A randomized, crossover simulation study was conducted to compare two results screen configurations: a numeric blood glucose value ("32 mg/dL") and a range abbreviation ("RR LO"). When the glucometer displayed a range abbreviation, 10.6% of participants made a treatment error. None of the participants made a treatment error when the glucometer displayed a numeric reading. Displaying a numeric reading eliminated potentially life-threatening treatment errors caused by confusing range abbreviations. Manufacturers should consider these findings during future research and development of POC glucometers.

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

- Revised National Patient Safety Goal® (NPSG) Standard NPSG.15.01.01 requirements reduce the risk for suicide for the **behavioral health care** and **hospital** programs effective July 1, 2019 (see [page 1](#) in this issue for the full article)
- New and revised requirements for Standard NPSG.03.05.01 address the reduction of harm from anticoagulant therapy for the **ambulatory health care** (medical centers only), **critical access hospital**, **hospital**, and **nursing care center** programs effective July 1, 2019 (see [page 3](#) in this issue for the full article)
- Public reporting of **hospitals** with consistently high cesarean birth rates will begin by July 1, 2020 (see [page 4](#) in this issue for the full article)

CURRENTLY IN FIELD REVIEW

- Proposed new requirements for the **ambulatory health care**, **critical access hospital**, and **hospital** programs regarding access to pediatric equipment and supplies in the emergency department (this second field review began November 19 and ends on December 10)

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

CURRENTLY BEING RESEARCHED OR IN DEVELOPMENT

- Proposed new antimicrobial stewardship requirement for the **ambulatory health care** and **office-based surgery** practice programs
- Proposed new and revised pain assessment and management requirements for the **behavioral health care** program, **home care** (home health services), and **nursing care center** programs
- Proposed requirements to address Conditions for Coverage for **ambulatory health care** organizations that provide treatment for end-stage renal disease
- Proposed requirement deletion in the **laboratory** program to reduce redundancies between the hospital and laboratory survey processes
- Evaluating current National Patient Safety Goal NPSG.02.03.01 on follow-up of all test results (**program applicability to be determined**)
- Proposed **behavioral health care** requirements related to substance use disorders
- 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
- Researching issues related to dental and vision care for the **behavioral health care** program
- Researching potential perinatal care standards for the **critical access hospital** and **hospital** programs
- Researching issues related to management of biosafety threats (**program applicability to be determined**)
- Evaluating current requirements related to credentialing and privileging practitioners providing contract services for the **ambulatory health care**, **behavioral health care**, **critical access hospital**, **hospital**, **nursing care center**, and **office-based surgery** programs

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2019 WEBINARS

National Patient Safety Goals®

12:00pm-1:00pm CST

Wednesday, March 20, 2019
Wednesday, June 12, 2019
Wednesday, September 11, 2019
Wednesday, December 04, 2019

CMS Readiness Webinar Series

12:00pm-1:00pm CST

Wednesday, January 23, 2019
Wednesday, February 20, 2019
Wednesday, March 27, 2019
Wednesday, April 24, 2019
Wednesday, May 22, 2019
Wednesday, June 19, 2019

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Infection Control Webinar Series

12:00pm-1:00pm CST

Thursday, March 14, 2019
Thursday, June 13, 2019
Thursday, September 19, 2019
Thursday, December 12, 2019

Wednesday, July 24, 2019

Wednesday, August 21, 2019
Wednesday, September 25, 2019
Wednesday, October 23, 2019
Wednesday, November 20, 2019
Wednesday, December 18, 2019

Environment of Care and Exploring the Life Safety Webinar Series

12:00pm-1:00pm CST

Wednesday, March 13, 2019
Wednesday, June 26, 2019
Wednesday, September 18, 2019
Wednesday, December 11, 2019

Medication Management Webinar Series

12:00pm-1:00pm CST

Thursday, March 21, 2019
Thursday, June 20, 2019
Thursday, September 26, 2019
Thursday, November 07, 2019