The Joint Commission

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The Joint Commission Perspectives®

THE OFFICIAL NEWSLETTER OF THE JOINT COMMISSION

Contents

UPDATE: Recommendations from Fourth Meeting of Suicide Expert Panel

As previously announced, The Joint Commission recently conducted four meetings of an expert panel to provide guidance to customers and surveyors on safeguards to prevent suicide. The recommendations from the first two panel meetings (in June and August 2017) were published in the November 2017 issue of *Perspectives* ("SPECIAL REPORT: Suicide Prevention in Health Care Settings," pages 1 and 3–7) and focused on inpatient psychiatric units, general acute inpatient settings, and emergency departments. The intent of these thirteen recommendations was to clarify existing standards for maintaining a safe physical environment for patients with suicidal ideation. The January 2018 issue of *Perspectives* ("SPECIAL REPORT: Suicide Prevention in Health Care Settings," pages 1–3) published additional recommendations that resulted from the third panel meeting (in October 2017). These three recommendations focused on the prevention of suicide in other behavioral health care settings, including residential, partial hospitalization, day treatment, and intensive outpatient programming facilities.

The Joint Commission convened the fourth meeting of the expert panel in December 2017 to develop recommendations for issues that were not fully addressed in earlier panel discussions: 1) suicide risk assessment and 2) key components for safe monitoring of high-risk patients. After reviewing the discussion from this meeting, it became apparent that some of the recommendations went beyond clarification of current standards and were actually recommendations for

new accreditation standards. Therefore, instead of publishing the recommendations at this time, The Joint Commission and the panel are assessing the recommendations to see which of them are appropriate to include as new elements of performance in the revised National Patient Safety Goal on suicide prevention (NPSG 15.01.01). The updated version of the NPSG will then be sent for national field review, according to The Joint Commission's usual process for obtaining feedback on new requirements. P

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FDA's December 2017 Final Rule on Health Care Antiseptic Washes and Rubs: Hospitals Should See Minimal Changes

The US Food and Drug Administration (FDA) recently issued the final rule* on Safety and Effectiveness of Health Care Antiseptics. This rule applies to over-the counter (OTC) health care antiseptic products† intended for use by health care professionals in hospitals or other health care settings such as ambulatory surgery centers or clinics.

Over the last several years, the FDA requested and reviewed data to support the use of certain active ingredients in OTC health care antiseptics as part of an initiative to better understand antiseptic resistance and antibiotic cross-resistance. The final rule establishes that 24 active ingredients used in OTC antiseptic products intended for use by health care professionals in health care settings are not generally recognized as safe and effective (GRAS/GRASE). Thus, these ingredients need pre-market review by the FDA before they can be used. Of the 24 ingredients banned, tricolsan is the only ingredient currently being used in marketed health care antiseptic products. Because these ingredients are not used in the majority of currently marketed health care antiseptics products, there should be little change to the antiseptic products used in health care settings.

The FDA also deferred further rulemaking on six other active ingredients used in OTC health care antiseptics products until further studies could be completed. The deferred active ingredients are benzalkonium chloride, benzethonium chloride, chloroxylenol, alcohol (ethanol or ethyl alcohol), isopropyl alcohol, and povidone-iodine. While at this time it recommends no changes to the use of antiseptic products containing these six active ingredients, the FDA will provide additional information on these ingredients in future rulemaking.

It is important to note that this rule does not apply to active ingredients ineligible for evaluation under the FDA's OTC drug review program—these must be reviewed under a new drug application process, such as commonly used alcohol or chlorhexidine.

Lastly, the FDA emphasized the agency's support for the Centers for Disease Control and Prevention's recommendations: to use plain soap and water for handwashing and antiseptic hand washes/rubs when soap and water are unavailable. As a reminder, National Patient Safety Goal NPSG.07.01.01 requires health care organizations to have a hand hygiene program. The Joint Commission will cite organizations for observations of individual failure to perform hand hygiene in accordance with its standards.

Questions may be directed to Kathryn E. Spates, JD, ACNP-BC, director, Federal Relations, The Joint Commission.

** Federal Register. Safety and Effectiveness of Health Care Antiseptics; Topical Antimicrobial Drug Products for Over-the-Counter Human Use. Dec 20, 2017. Accessed Feb 23, 2018.*

† Health care antiseptic products include health care personnel hand washes, health care personnel hand rubs, surgical hand scrubs, surgical hand rubs, and patient antiseptic skin preparations.

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Consistent Interpretation

Joint Commission Surveyors' Observations on LD.04.03.09, EPs 4–6

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 hospital standards. This column in the series highlights Leadership (LD) Standard LD.04.03.09, EPs 4–6. **Note:** *Interpretations are subject to change to allow for unique and/or unforeseen circumstances.* P

Leadership (LD) Standard LD.04.03.09: Care, treatment, and services provided through contractual agreement are provided safely and effectively.

EP 4*: Leaders monitor contracted services by establishing expectations for the performance of the contracted services. (*See also* MS.13.01.01, EP 1)

Note 1: *In most cases, each licensed independent practitioner providing services through a contractual agreement must be credentialed and privileged by the hospital using their services following the process described in the "Medical Staff" (MS) chapter.*

Note 2: ***For hospitals that do not use Joint Commission accreditation for deemed status purposes:*** *When the hospital contracts with another accredited organization for patient care, treatment, and services to be provided off site, it can do the following:*

- *Verify that all licensed independent practitioners who will be providing patient care, treatment, and services have appropriate privileges by obtaining, for example, a copy of the list of privileges.*
- *Specify in the written agreement that the contracted organization will ensure that all contracted services provided by licensed independent practitioners will be within the scope of their privileges.*

Note 3: ***For hospitals that use Joint Commission accreditation for deemed status purposes:*** *The leaders who monitor the contracted services are the governing body.*

* In 2017 the noncompliance percentage for this EP was 5.06% (that is, 73 of 1,443 hospitals surveyed were out of compliance with this requirement).

Surveyor Observations	Guidance/Interpretation
The organization failed to establish that the performance of the contracted service for compounded sterile products must comply with the requirements of United States Pharmacopeial Convention (USP®) General Chapter <797> Pharmaceutical Compounding—Sterile Preparations. This was evidenced by the fact that the organization neglected to include compliance with USP <797> (or equivalent standards) in the contract.	If the organization utilizes a 503B pharmacy, quality metrics should be established to ensure appropriate compliance with Sterile Compounding Practices. If the organization uses a 503A pharmacy, it should ensure compliance with USP <797> and have documentation of receiving qualitative data as proof and evidence that the 503A establishment is appropriately testing the engineering controls (including viable testing) and taking appropriate action when tested components do not meet minimum requirements.

EP 5[†]: Leaders monitor contracted services by communicating the expectations in writing to the provider of the contracted services.

Note: *A written description of the expectations can be provided either as part of the written agreement or in addition to it.*

[†] In 2017 the noncompliance percentage for this EP was 7.14% (that is, 103 of 1,443 hospitals surveyed were out of compliance with this requirement).

Surveyor Observations	Guidance/Interpretation
There was no evidence that the organization communicated, in writing, to the contracted service providing compounded sterile products regarding the requirement to comply with USP <797> or equivalent standards.	If the organization utilizes a 503B pharmacy, quality metrics should be submitted to the compounding pharmacy in writing to ensure appropriate compliance with Sterile Compounding Practices. If the organization uses a 503A pharmacy, it should ensure compliance by requesting in writing the receipt of ongoing testing and certification performed at the compounding pharmacy to include appropriately testing the engineering controls (including viable testing) and taking appropriate action when tested components do not meet minimum requirements.

EP 6[‡]: Leaders monitor contracted services by evaluating these services in relation to the hospital's expectations.

[‡] In 2017 the noncompliance percentage for this EP was 6.24% (that is, 90 of 1,443 hospitals surveyed were out of compliance with this requirement).

Surveyor Observations	Guidance/Interpretation
The organization did not have adequate oversight over the contracted service for compounded sterile products. This was evidenced by the organization's lack of documented review of qualitative performance indicators showing compliance with USP <797> or equivalent standards.	If the organization utilizes a 503B pharmacy, quality metrics should be monitored to ensure appropriate compliance with Sterile Compounding Practices. If the organization uses a 503A pharmacy, it should ensure compliance with USP <797> and have documentation of receiving qualitative data and evaluating the results to monitor the 503A establishment is appropriately testing the engineering controls (including viable testing) and taking appropriate action when tested components do not meet minimum requirements.

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Center for Transforming Healthcare Offers Assistance Building Sustainable RPI® Programs

Since 2008 the Joint Commission Center for Transforming Healthcare has sought to transform health care into a high-reliability industry through the development of highly effective, durable solutions to health care's most critical quality and safety problems. These solutions, offered via the Targeted Solutions Tool® (TST®), were developed through a rigorous multi-year collaboration with Center-participating hospitals that had expertise in Robust Process Improvement® (RPI®)—a blended approach to process improvement based on Lean Six Sigma and formal Change Management. Joint Commission–accredited organizations can access a TST® at no additional cost directly through the Center's website.

In addition, the Center now offers technical assistance and training—based on the curriculum developed and used to train and certify Joint Commission staff and leadership—in how to build and launch a self-sustaining RPI® program. Customizable for hospitals, health systems, and other provider organizations seeking to build their process improvement capabilities and establish stronger improvement cultures, these training engagements typically consist of the following:

1. Leadership training and mentoring in high reliability and change management
2. Training, mentoring, and certification of waves of RPI® Green Belts or Change Leaders (initially taught by Center Black Belts and Master Change Leaders, these responsibilities are ultimately transferred to the client organization's Black Belts and Master Change Leaders)
3. Training and support building the processes, structures, and roles necessary for a self-sustaining program

RPI® plays a key role in the high-reliability health care framework introduced in the seminal article "High-Reliability Health Care: Getting There from Here."* In that framework, the RPI® objectives of leadership commitment to zero harm, a fully functioning safety culture, and a common approach to process improvement together support an organization's transformation into an entity focused on continual improvement in order to approach zero levels of harm to patients, staff, and visitors—the ultimate goal of a high-reliability organization.

For information on Robust Process Improvement® training programs and the Center's other high-reliability tools, please contact David Grazman, PhD, MPP, business development director, Joint Commission Center for Transforming Healthcare.

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* *Chassin MR, Loeb JM. High-reliability health care: Getting there from here.* Milbank Q. *2013 Sep;91(3): 459–490.*

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Deletion of RI.01.01.01, EP 8

In 2017 The Joint Commission undertook an extensive project to update and revise the standards for assessing and managing pain. The result is a comprehensive set of requirements that address the role of leadership (LD.04.03.13) and medical staff (MS.05.01.01) in ensuring appropriate assessment and management of pain, screening patients for pain and involving patients in the pain management treatment planning process (PC.01.02.07), and collecting data and monitoring performance including interventions used and their effectiveness (PI.01.01.01). These requirements became effective January 1, 2018.

On a routine basis, The Joint Commission reviews its standards and elements of performance (EPs) to see if they are still relevant and necessary to ensure patient quality of care and safety. A recent review indicated that RI.01.01.01, EP 8 is no longer relevant.

> RI.01.01.01, EP 8: The hospital respects the patient's right to pain management. (*See also* HR.01.04.01, EP 4; PC.01.02.07, EP 1; MS.03.01.03, EP 2)

This conclusion is based on the fact that the new set of pain assessment and management requirements are comprehensive and require that the patient be included in the process of planning pain management treatment. The current requirement also references two EPs that no longer exist as of January 2018 (PC.01.02.07, EP 1 and MS.03.01.03, EP 2). Additionally, The Joint Commission reviewed standards that more generally address patients' rights and determined that there is an adequate focus on patients' rights without RI.01.01.01, EP 8. For example, RI.01.02.01, EP 1 requires that the hospital involve the patient in making decisions about his or her care, treatment, and services. Other RI standards also include promoting and respecting those rights, receiving information and the need for effective communication, participating in decisions about their care, being free from neglect, preserving dignity, and having a process to resolve complaints.

For these reasons, RI.01.01.01, EP 8 will be deleted effective immediately (the deletion will be reflected in the March E-dition® release). This requirement will still appear in the manual until it can be removed with the next manual update, but surveyors will not survey it as of the effective date.

Please contact Mary Brockway, MS, RN, director, Clinical Research and Standards and Survey Methods, Division of Healthcare Quality Evaluation, The Joint Commission, for any questions.

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New *R3 Report* Provides Background on Revisions to Outcome Measure Standard

The Joint Commission's newest *R3 Report* provides in-depth rationale and evidence for revisions to Care, Treatment, and Services (CTS) Standard CTS.03.01.09. As previously announced (*see* the article from the January 2017 *Perspectives*), these revisions became effective for accredited behavioral health care organizations on January 1, 2018.

Standard CTS.03.01.09 requires the use of a standardized tool or instrument to assess outcomes of care, treatment, or services. A standardized instrument is a tool designed for use as a repeated measure and is sensitive to measuring change associated with the care, treatment, or services being provided. These types of instruments are often referred to as "routine outcome measures," "measurement-based care instruments," or "outcome and feedback tools." The Joint Commission does not specify or endorse a specific tool.

Feedback derived through standardized instruments may be used to inform goals and objectives, monitor individual progress, and inform decisions related to individual plans of care, treatment, or services. Specifically, using standardized tools or instruments for measurement-based care can support organizations in the following tasks:

- Determining whether current care, treatment, or services are having a positive and significant impact on the individual served
- Detecting, as early as possible, those individuals served who are not improving
- Helping individuals served evaluate, in a quantifiable way, whether they are making progress
- Providing an objective view of what is happening to both the organization and the individual served
- Informing shared decisions about whether to stay the course or make changes in the plan of care, treatment or services

In addition, aggregate data from the standardized instruments may also be used for organizational performance improvement efforts and to evaluate outcomes of care, treatment, or services provided to the population(s) served.

The revisions to Standard CTS.03.01.09 were posted in the January 1 E-dition® release and published in the *2018 Comprehensive Accreditation Manual for Behavioral Health Care* (as well as *2017 Update 2*) and the *2018 Standards for Behavioral Health Care*. The *R3 Report* is freely available on The Joint Commission website and may be reproduced if credited to The Joint Commission.

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Two EC Revisions for March E-dition Release

In addition to the revision to Life Safety (LS) Standard LS.02.01.30, Element of Performance (EP) 13 previously announced (*see* the February 2017 *Perspectives*, pages 6 and 7), The Joint Commission has implemented two more changes related to maintaining alignment with the *Life Safety Code*®. * **Effective March 11, 2018**, these changes occur in the "Environment of Care" (EC) chapter and are summarized in the box that follows.

New and Revised EC Requirements Effective March 11, 2018

Change	Applicable Programs	Purpose
Revision to Standard EC.02.03.05, EP 25	ambulatory care, behavioral health care, critical access hospital, home care, hospital	To provide additional clarity on nonrated doors
Addition of Standard EC.02.05.01, EP 27	ambulatory care, critical access hospital, hospital, office-based surgery practice	To address environmental features of areas administering inhaled anesthetics

The program-specific EPs can be viewed at the Prepublication Standards webpage on The Joint Commission website and will be reflected in the March E-dition® release. Questions may be directed to Kenneth A. Monroe, PE, MBA, CHC, PMP, director—Engineering, Standards Interpretation Group, The Joint Commission.

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

94 **A Novel Bedside-Focused Ward Surveillance and Response System**—F. Sebat, M.A. Vandegrift, S. Childers, G.K. Lighthall

Despite broad implementation, there is little evidence regarding the effective organizational elements of rapid response systems (RRSs) that are responsible for improved outcomes. Expanded administrative oversight of an existing RRS which focused on early recognition of patient deterioration by the bedside nurse was undertaken at a community regional medical center. A prospective five-year before-and-after comparison was conducted for 28,914 patients in the 24-month control period and 39,802 patients in the 33-month intervention period. Response team activations increased from 10.2 to 48.8/1,000 discharges ($p < 0.001$), ward cardiac arrest decreased from 3.1 to 2.4/1,000 discharges ($p = .04$), hospital mortality decreased from 3.8% to 3.2% ($p < 0.001$), and the observed-to-expected ratio, from 1.5 to 1.0 ($p < 0.001$).

101 **An Initiative to Change Inpatient Practice: Leveraging the Patient Medical Home for Postdischarge Follow-Up**—P. Marcus, K. Hautala, N. Allaudeen

The standard of care for hospital discharge planning includes arranging follow-up appointments, usually with a primary care provider. However, follow-up phone calls instead of face-to-face visits may be an appropriate alternative for some patients, which was explored within the framework of the Department of Veterans Affairs (VA) patient-centered medical home model of care, the Patient Aligned Care Team. After a pilot study (Phase 1) at one clinic and staff at the other eight clinic sites were trained (Phase 2), 76 (14.5%) of 447 eligible discharges were scheduled for phone follow-up (Phase 3). This initiative changed provider practices to use phone call follow-up for select patients instead of face-to-face provider visits after hospital discharge, without significantly increasing rates of 30-day ED utilization or rehospitalization.

107 **'Who's Covering This Patient?' Developing a First-Contact Provider (FCP) Designation in an Electronic Health Record**—A. Chandiramani, J. Gervasio, M. Johnson, J. Kolek, S. Zibrat, D. Edelson

Safe and efficient inpatient care depends on accurate identification of the licensed independent practitioner (LIP) primarily responsible for each admitted patient. At an 800-bed academic hospital, an Epic feature—First Contact Provider (FCP)—was developed to identify the responsible LIP for each inpatient. By the end of the nine-month study period, the weekly mean percent of patients with one FCP documented at noon reached 98.6%. The monthly mean percent of critical results reported directly to LIPs increased from a pre-FCP baseline of 18.0% to 87.8%. FCP largely solved the far-reaching problem of accurate LIP identification for hospitalized patients, which, in turn, significantly improved the ability to report inpatient critical lab values directly to LIPs.

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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

- Deletion of Rights and Responsibilities of the Individual (RI) Standard RI.01.01.01, Element of Performance (EP 8) for the **ambulatory care**, **critical access hospital**, **home care**, **hospital**, and **nursing care center** programs, effective immediately (see article on page 7 of this issue)
- Revisions to two Environment of Care (EC) requirements to maintain alignment with the Life Safety Code® * (see article on page 9 of this issue)

CURRENTLY IN FIELD REVIEW

- Proposed revisions to credentialing and privileging requirements under Leadership (LD) standard on contract services for the **ambulatory care**, **behavioral health care**, **critical access hospital**, **hospital**, **nursing care center**, and **office-based surgery practice** programs (field review ends March 21, 2018)
- Proposed new and revised Provision of Care, Treatment, and Services (PC) requirements regarding pediatric emergency equipment and supplies for the **ambulatory care**, **critical access hospital**, and **hospital** programs (field review ends March 27, 2018)
- Proposed new requirements for distinct newborn identification for the **hospital** and **critical access hospital** programs (field review begins March 6, 2018, and ends April 17, 2018)

  Note: *Please visit the Standards Field Reviews page on The Joint Commission website for more information. Field review dates are subject to change.*

CURRENTLY BEING RESEARCHED OR IN DEVELOPMENT

- Proposed new requirement for weighing 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 Centers for Medicare & Medicaid Services (CMS) requirements
- Proposed revisions to National Patient Safety Goal NPSG.03.05.01 for anticoagulant therapy related to direct oral anticoagulants for the **ambulatory care**, **critical access hospital**, **home care**, **hospital**, and **nursing care center** programs
- Proposed revisions for **ambulatory care organizations**, **critical access hospitals**, and **hospitals** that provide fluoroscopy services

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