The Joint Commission

March 2024 | Volume 44 | Number 3

Joint Commission Perspectives®

THE OFFICIAL NEWSLETTER OF THE JOINT COMMISSION

Contents

2 **REVISED: Assisted Living Community Add-On Memory Care Certification Requirements**

The Joint Commission revised requirements to its add-on Memory Care Certification for assisted living communities to improve safety and quality of care.

3 **APPROVED: Critical Access Hospital and Hospital Requirements Revised**

The Joint Commission approved revisions to several elements of performance related to patient rights and complaint resolution.

4 **APPROVED: Revised Definition of *Designated Equivalent Source***

Effective July 1, 2024, The Joint Commission revised its definition of *designated equivalent source* for five accreditation programs.

5 **NEW: Product Categories Added to E-App to Align with Recent DMEPOS CMS Final Rule**

The Joint Commission added two product categories related to durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) to align with a recent US Centers for Medicare & Medicaid Services (CMS) final rule.

6 **Consistent Interpretation**

Joint Commission surveyors' observations related to timely completion of inpatient histories and physicals.

9 ***The Joint Commission Journal on Quality and Patient Safety***

Table of Contents—February 2024

12 **In Sight**

Copyright 2024 The Joint Commission

REVISED: Assisted Living Community Add-On Memory Care Certification Requirements

The Joint Commission has approved revisions to its Memory Care Certification for **assisted living communities**. **Effective July 1, 2024**, eight elements of performance (EPs) will be revised, and one EP deleted from the following chapters:

- "Leadership" (LD)
- "Medication Management" (MM)
- "Provision of Care, Treatment, and Services" (PC)

The revised requirements aim to improve safety and quality of care by addressing medical oversight for the care provided to assisted living community residents receiving memory care services and by removing barriers as to whom organizations can designate to provide medical oversight and care. Joint Commission–accredited assisted living communities certified in memory care will no longer be required to have a physician responsible for directing the program or providing medical services. The standards now will allow for other providers, including nurse practitioners and clinical nurse specialists, to provide oversight and medical care.

These revisions reflect current practices in assisted living communities, state regulations and provider scope of practice requirements, feedback from Joint Commission–accredited assisted living communities, and recommendations from assisted living and memory care subject matter experts, including the AMDA – The Society for Post–Acute Care and Long-Term Care Medicine and the Alzheimer's Association.

The revised requirements will be posted on the Prepublication Standards page of The Joint Commission's website and will publish online in the spring 2024 E-dition® update to the *Comprehensive Accreditation Manual for Assisted Living Communities (CAMALC)*.

For more information, please contact the Department of Standards and Survey Methods.

Copyright 2024 The Joint Commission

APPROVED: Critical Access Hospital and Hospital Requirements Revised

Effective July 1, 2024, The Joint Commission has approved revisions to several elements of performance (EPs) for **critical access hospitals** and **hospitals**. These revisions maintain consistency between the Critical Access Hospital and Hospital accreditation programs and align the requirements more closely to the US Centers for Medicare & Medicaid Services (CMS) Conditions of Participation. The revised requirements address issues related to patient rights and complaint resolution.

In addition, Environment of Care (EC) Standard EC.02.02.01, EP 19, has been revised for both critical access hospitals and hospitals to clarify that organizations need to account for the disposal of regulated medical waste in their procedures. Issues related to disposal of regulated medical waste will be scored at revised EP 19.

The revised requirements will be posted on the Prepublication Standards page of The Joint Commission's website and will publish online in the spring 2024 E-dition® update to the *Comprehensive Accreditation Manual for Critical Access Hospitals (CAMCAH)* and *Comprehensive Accreditation Manual for Hospitals (CAMH)*. For those customers who purchase it, the *CAMH* spring update service will include these revised requirements.

For more information, please contact the Department of Standards and Survey Methods.

Copyright 2024 The Joint Commission

APPROVED: Revised Definition of *Designated Equivalent Source*

Effective July 1, 2024, The Joint Commission has approved a revised definition for the term *designated equivalent source* in the "Glossary" (GL) chapter of the *Comprehensive Accreditation Manual (CAM)*. The revised term applies to **ambulatory care** organizations, **behavioral health care and human services** organizations, **critical access hospitals**, **hospitals**, and **office-based surgery practices**. The revisions help clarify the intent of the term and are shown in the following box with underline for additions and ~~strikethrough~~ for deletions.

The revised term will publish online in the spring 2024 E-dition® update to the *Comprehensive Accreditation Manual for Ambulatory Care (CAMAC)*, *Comprehensive Accreditation Manual for Behavioral Health Care and Human Services (CAMBHC)*, *Comprehensive Accreditation Manual for Critical Access Hospitals (CAMCAH)*, *Comprehensive Accreditation Manual for Hospitals (CAMH)*, and *Comprehensive Accreditation Manual for Office-Based Surgery Practices (CAMOBS)*. For those customers who purchase it, the *CAMBHC* and *CAMH* spring update service will include this revised term.

For questions regarding the revised definition, please contact the Department of Standards and Survey Methods. P

Joint Commission Requirement

Official Publication of Joint Commission Requirements

Revised Term Clarifies Intent

APPLICABLE TO AMBULATORY CARE ORGANIZATIONS, BEHAVIORAL HEALTH CARE AND HUMAN SERVICES ORGANIZATIONS, CRITICAL ACCESS HOSPITALS, HOSPITALS, AND OFFICE-BASED SURGERY PRACTICES

Effective July 1, 2024

Glossary (GL)

designated equivalent source Selected agencies that have been determined to maintain a specific item(s) of credential(s) information that is identical (that is, equivalent) to the information at the primary source. Examples of designated equivalent sources are listed below. ~~Some of the agencies may provide credential(s) information and services beyond what is identified below.~~ Listing the names of these agencies does not constitute an endorsement. In addition, the use of the word equivalent only refers to an organization's ability to provide information that is identical to the primary source. "Equivalent" does not imply that any two organizations on the list have verification processes that are of equal rigor or quality.

~~Designated equivalent sources~~ Examples include, but are not limited to, the following:

- The American Medical Association (AMA) Physician ~~Masterfile~~ Professional Data for verification of a physician's United States and Puerto Rican medical school graduation and postgraduate education completion
- The American Board of Medical Specialties (ABMS) for verification of a physician's board certification by an ABMS member board
- The Educational Commission for Foreign Medical Graduates (ECFMG) for verification of a physician's graduation from a foreign medical school
- The American Osteopathic Association (AOA) Physician Database for pre-doctoral education accredited by the AOA Bureau of Professional Education; postdoctoral education approved by the AOA Council on Postdoctoral Training; postdoctoral education approved by the Accreditation Council for Graduate Medical Education (ACGME); and Osteopathic Specialty Board Certification
- The Federation of State Medical Boards (FSMB) for all actions against a physician's medical license
- The American Academy of Physician Assistants (AAPA) Profile for physician assistant education, provided through the AMA Physician Profile Service (https://profiles.ama-assn.org/amaprofiles/)
- National Commission on Certification of Physician Assistants (NCCPA) certification
- The National Board of Physicians and Surgeons (NBPAS) for verification of a physician's NBPAS board certification

Some of the agencies may provide credential(s) information and services beyond what is identified above.

Copyright 2024 The Joint Commission

NEW: Product Categories Added to E-App to Align with Recent DMEPOS CMS Final Rule

In the November 13, 2023, *Federal Register*, the US Centers for Medicare & Medicaid Services (CMS) finalized regulations related to custom-fitted garments and other compression garments for the treatment of lymphedema. In response, The Joint Commission added the following two product categories to its electronic application (E-App) for organizations that have identified they provide **home care** services—more specifically that supply durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS):

- Lymphedema Compression Treatment Items – Custom, S04
- Lymphedema Compression Treatment Items – Non-Custom, S04

Beginning January 1, 2024, CMS began covering the following lymphedema treatments for Medicare Part B patients:

- Custom (uniquely sized and shaped to fit the exact dimensions of the affected extremity of a person from measurements) and non-custom compression garments, including those for daytime and nighttime use, which offer different levels of compression
- Compression bandaging systems and supplies provided during the initial decongestive phase and maintenance phases of treatment
- Gradient compression wraps with adjustable straps
- Necessary accessories for gradient compression garments and wraps include the following:
  - Aids for donning and doffing items for different body parts
  - Fillers
  - Lining
  - Padding
  - Zippers

Note that organizations that revise their E-App to comply with these new product categories may require an unannounced on-site survey prior to the next triennial accreditation survey.

Please contact your account executive with any questions.

Copyright 2024 The Joint Commission

Consistent Interpretation

Joint Commission Surveyors' Observations Related to Timely Completion of Inpatient History and Physicals

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

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

This month, **Consistent Interpretation** focuses on the medical history and physical examination process.

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

Noncompliance Implications	Obtaining a medical history and conducting a physical examination when providing care, treatment, and services establishes a patient's overall state of health and informs a plan of care. The history and physical process should identify any underlying conditions and/or comorbidities that may affect the planned course of care, treatment, and services. When completed no more than 30 days prior to inpatient admission or registration (for example, outpatient services), an updated history and physical are required within 24 hours after admission to determine any changes in the patient's condition and to ensure that the most current information is available to the patient care team. If surgery or other procedure requiring anesthesia services is planned, the history and physical and/or update must be completed prior to such procedures. To comply with accreditation and regulatory requirements, the history and physical and/or update must meet the following required elements: ● Include the elements as defined by the medical staff, law, and regulation ● Entered into the medical record ● Available to patient care team members For more information, *see* the following Joint Commission Frequently Asked Questions (FAQ)—History and Physical: ● Understanding the Requirements ● Update Requirements ● Update Requirements When Procedures Are Performed During Inpatient Stay ● Prenatal Record ● Dictated Not Transcribed

Provision of Care, Treatment, and Services (PC) Standard PC.01.02.03: The hospital assess and reassesses the patient and the patient's condition according to defined time frames.	
EP 4: The patient receives a medical history and physical examination no more than 30 days prior to, or within 24 hours after, registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. R **Note 1:** ***For hospitals that use Joint Commission accreditation for deemed status purposes:*** *Medical histories and physical examinations are performed as required in this element of performance, except any specific outpatient surgical or procedural services for which an assessment is performed instead.* **Note 2:** *For law and regulation guidance pertaining to the medical history and physical examination, refer to 42 CFR 482.22(c)(5)(iii) and 482.51(b)(1)(iii). Refer to "Appendix A: Medicare Requirements for Hospitals" (AXA) for full text.* (*See also* MS.01.01.01, EP 38; MS.03.01.01, EPs 6, 19; RC.02.01.03, EP 3)	
Compliance Rate	In 2022, the noncompliance percentage for this EP was **10.25%**—that is, **155** of **1,512** hospitals surveyed did not comply with this requirement.

Copyright 2024 The Joint Commission

Surveyor Observations	Guidance/Interpretation
• A history and physical were completed more than 30 days prior to admission or registration. • A history and physical were not completed within 24 hours of admission or registration. • A new history and physical were not performed for a patient whose electroconvulsive therapy (ECT) treatments exceeded 30 days.	• For obstetrical patients, the prenatal record may be used as the history and physical if it is updated to reflect the patient's condition at admission or prior to a high-risk or operative procedure. *See* the Prenatal Record FAQ for more information. • Organizations that permit an assessment in lieu of a history and physical for outpatient procedures also must demonstrate compliance with Medical Staff (MS) Standard MS.01.01.01, EP 38,* and MS.03.01.01, EP 19.† • Cite at MS.03.01.01, EP 19, if the organization does not have a policy identifying specific patients for whom an assessment may be used in lieu of a history and physical for an outpatient procedure. • Cite at MS.01.01.01, EP 38, for medical staff bylaws that do not specify that a patient assessment is completed and documented after registration—but prior to surgery or a procedure requiring anesthesia services—when the patient is receiving specific outpatient surgical or procedural services. • Cite at PC.01.02.03, EP 7,‡ for failure to complete and document the patient's assessment after registration/arrival. • A new history and physical are required for patients receiving ECT treatments for more than 30 days. • Cite at MS.01.01.01, EP 5,§ when the history and physical on the medical record are missing required elements as defined by the medical staff bylaws and law and regulation. • Cite at Record of Care, Treatment, and Services (RC) Standard RC.01.03.01, EP 3,¶ when a history and physical are performed within 24 hours of a patient's admission but are not in the medical record.

* Standard **MS.01.01.01, EP 38**: **For hospitals that use Joint Commission accreditation for deemed status purposes:** When the medical staff has chosen to allow an assessment, in lieu of a comprehensive medical history and physical examination, for patients receiving specific outpatient surgical or procedural services, the medical staff bylaws specify that an assessment of the patient is completed and documented after registration, but prior to surgery or a procedure requiring anesthesia services, when the patient is receiving specific outpatient surgical or procedural services.

Note: *For law and regulation guidance pertaining to the medical history and physical examination, refer to 42 CFR 482.22(c)(5)(i), (ii), (iii), and (v). Refer to "Appendix A: Medicare Requirements for Hospitals" (AXA) for full text.*

(*See also* PC.01.02.03, EP 4)

† Standard **MS.03.01.01, EP 19**: **For hospitals that use Joint Commission accreditation for deemed status purposes:** If the medical staff chooses to develop and maintain a policy for the identification of specific patients to whom the assessment requirements would apply, in lieu of a comprehensive medical history and physical examination, the policy is based on the following:

- Patient age, diagnoses, the type and number of surgeries and procedures scheduled to be performed, comorbidities, and the level of anesthesia required for the surgery or procedure
- Nationally recognized guidelines and standards of practice for assessment of particular types of patients prior to specific outpatient surgeries and procedures
- Applicable state and local health and safety laws

Note: *For law and regulation guidance pertaining to the medical history and physical examination, refer to 42 CFR 482.22(c)(5)(iii). Refer to "Appendix A: Medicare Requirements for Hospitals" (AXA) for full text.*

(*See also* PC.01.02.03, EPs 4, 5)

‡ Standard **PC.01.02.03, EP 7**: **For hospitals that use Joint Commission accreditation for deemed status purposes:** When the medical staff has chosen to allow an assessment (in lieu of a comprehensive medical history and physical examination) for patients receiving specific outpatient surgical or procedural services, the assessment of the patient is completed and documented after registration but prior to surgery or a procedure requiring anesthesia services when the patient is receiving specific outpatient surgical or procedural services. (For more information, refer to Standard MS.03.01.01)

Note: *For further regulatory guidance, refer to 42 CFR 482.24(c)(4)(i)(A) and (B), 482.51(b)(1)(i) and (ii), and 482.22(c)(5)(v). Refer to "Appendix A: Medicare Requirements for Hospitals" (AXA) for full text.*

§ Standard **MS.01.01.01, EP 5**: The medical staff complies with the medical staff bylaws, rules and regulations, and policies.

¶ Standard **RC.01.03.01, EP 3**: **For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital records the patient's medical history and physical examination, including updates, in the medical record within 24 hours after registration or inpatient admission but prior to surgery or a procedure requiring anesthesia services.

Copyright 2024 The Joint Commission

EP 5: For a medical history and physical examination that was completed within 30 days prior to registration or inpatient admission, an update documenting any changes in the patient's condition is completed within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services. **R**

Note 1: ***For hospitals that use Joint Commission accreditation for deemed status purposes:*** *Medical histories and physical examinations are performed as required in this element of performance, except any specific outpatient surgical or procedural services for which an assessment is performed instead.*

Note 2: *For law and regulation guidance pertaining to the medical history and physical examination, refer to 42 CFR 482.22(c)(5)(iii) and 482.51(b)(1)(iii). Refer to "Appendix A: Medicare Requirements for Hospitals" (AXA) for full text.*

(*See also* MS.03.01.01, EP 19; RC.02.01.03, EP 3)

Compliance Rate	In 2022, the noncompliance percentage for this EP was **6.08%**—that is, **92** of **1,512** hospitals surveyed did not comply with this requirement.

Surveyor Observations	**Guidance/Interpretation**
● There was no evidence that the history and physical completed prior to admission had been updated within 24 hours of admission. ● There was no evidence that a surgical patient's history and physical completed prior to admission were updated prior to surgery.	● An updated patient examination, including any changes in the patient's condition, must be completed and documented in the medical record when a history and physical are completed prior to admission or registration. ● Cite here, at Standard PC.01.02.03, EP 5, if there is no evidence that an updated examination was completed and entered into the medical record within the required time frame. ● The organization determines the required elements of an updated examination and where this information is documented; for example, a progress note, an addendum to the history and physical, a separate document, and so on. ● For inpatients with extended stays, the daily progress notes serve as the update to the history and physical. A separate update is not required in these cases. For example, a patient has a colon resection on day 4 of the admission.
● Anesthesia providers are not granted permission to conduct the history and physical update prior to surgery according to the organization's medical staff bylaws or rules and regulations. However, prior to surgery, an anesthesia provider completed the update of the history and physical that were performed prior to admission.	● Anesthesia providers may be permitted to perform a history and physical update if the following applies: ❍ The anesthesia provider is privileged to perform histories and physicals (*see* MS.01.01.01, EP 16,* and MS.03.01.01, EPs 2,† and 8‡). ❍ The anesthesia provider documents the minimum required elements as defined by the organization (*see* MS.03.01.01, EP 6,§ and the US Centers for Medicare & Medicaid Services Conditions of Participation beginning with 482.22(c)(5)). ❍ Completing a history and physical/update is within the scope of practice for the anesthesia provider as defined by state law and regulation. ❍ The organization recognizes the anesthesia provider and their documentation as the practitioner eligible to conduct the update.

* Standard **MS.01.01.01, EP 16**: **For hospitals that use Joint Commission accreditation for deemed status purposes:** The medical staff bylaws include the following requirements: The requirements for completing and documenting medical histories and physical examinations. The medical history and physical examination are completed and documented by a physician (as defined in section 1861(r) of the Social Security Act), an oral and maxillofacial surgeon, or other qualified licensed practitioner in accordance with state law and hospital policy.

Note: *For more information on performing the medical history and physical examination, refer to MS.03.01.01, EPs 6–11. For more information on completion time of the history and physical examination, refer to Standard PC.01.02.03, EPs 4 and 5.*

† Standard **MS.03.01.01, EP 2**: Physicians and other licensed practitioners practice only within the scope of their privileges as determined through mechanisms defined by the organized medical staff.

‡ Standard **MS.03.01.01, EP 8**: The medical staff requires that a physician or other licensed practitioner who has been granted privileges by the hospital to do so performs a patient's medical history and physical examination and required updates.

§ Standard **MS.03.01.01, EP 6**: Ⓓ The organized medical staff specifies the minimal content of medical histories and physical examinations, which may vary by setting or level of care, treatment, and services.

(*See also* PC.01.02.03, EP 4)

Copyright 2024 The Joint Commission

The Joint Commission Journal on Quality and Patient Safety®

IMPROVEMENT FROM FRONT OFFICE TO FRONT LINE

This issue of *Perspectives* presents the **February 2024** 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.

Tell your performance improvement story! Consider submitting an article to *The Joint Commission Journal on Quality and Patient Safety*. See website for author guidelines.

Did you know? Select *JQPS* articles are available free for you to read. Look for the "Open Access" sunburst and link to the article.

Editorial

93 Realizing the Promise of Advance Care Planning Will Require Health System Accountability to Quality Standards

S.E. Hickman; E.K. Fromme

To accomplish their intended purpose, advance care planning processes and documentation tools must be used correctly. In this editorial responding to two articles in this issue of the *Journal* presenting innovative technology-based approaches to support high-quality utilization of advance care planning, Hickman and Fromme discuss possible steps to be taken to ensure that best practices are followed in the use of these tools.

Teamwork and Communication

95 The TeamSTEPPS® for Improving Diagnosis Team Assessment Tool: Scale Development and Psychometric Evaluation

K.J. Ali; C.A. Goeschel; M.M. Eckroade; K.N. Carlin; M. Haugstetter; M. Shofer; M.A. Rosen

One in three patients is affected by diagnosis-related communication failures, but there is no valid and reliable instrument that measures teamwork and communication with a focus on improving diagnosis. To fill this gap, Ali and colleagues developed, refined, and psychometrically evaluated the Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS®) for Improving Diagnosis Team Assessment Tool, which assesses diagnostic teamwork and communication in five critical teamwork domains and can be used to identify strengths and opportunities for improvement and monitor performance.

Copyright 2024 The Joint Commission

104 A Multifaceted Intervention to Improve Teamwork on an Inpatient Pediatric Neurosurgery Service

E. Levoy; A. Sperber; D. Poon; M. Casazza; J. Vargas; S. Yang; G. Grant; S. Singer; N. Srinivas

Effective teamwork is essential for patient safety, but there are multiple barriers to building interprofessional team identity in health care settings. In this article, Levoy and colleagues describe the implementation and outcomes of a quality improvement effort aimed at improving teamwork between pediatric neurosurgery team members at a quaternary children's hospital.

Patient Engagement

116 Hospital Testing of the Effectiveness of Co-Designed Educational Materials to Improve Patient and Visitor Knowledge and Confidence in Reporting Patient Deterioration

L. King; I. Belan; R.A. Clark; T. Young; H. Grantham; K. Thornton; M.R. Kidd

Patients and their visitors are in an ideal position to report deterioration if they possess the knowledge and confidence to do so. In this study, King and colleagues investigated patients' and visitors' knowledge and confidence in recognizing and reporting patient deterioration in hospitals before and after exposure to educational materials.

Process Improvement

127 Implementing and Evaluating a Discharge Before Noon Initiative in a Large Tertiary Care Urban Hospital

K. Kausar; E. Coffield; R. Tarkovsky; M.A. Alvarez; K.A. Hochman; R.A. Press

Discharging clinically ready patients before noon on their discharge day may influence overall discharge process quality, emergency department boarding times, and length of stay. Kausar and colleagues evaluated the effectiveness of a discharge before noon program using an accelerated failure time model to directly evaluate how discharge times changed after program implementation.

139 Perspectives on Perioperative Team-Based Morbidity and Mortality Conferences: A Mixed Methods Study

A. Samost-Williams; R. Rosen; E. Cummins; Y. Sonnay; G. Nash; A. Hannenberg; M. Brindle

Morbidity and mortality conferences (MMCs) are central to medical system functioning, but the extent to which MMCs affect outcomes remains unclear. Samost-Williams and colleagues performed this mixed methods study to understand the perspectives of perioperative clinicians and leaders toward MMCs generally and perioperative team-based morbidity and mortality conferences specifically, as well as to describe real and perceived barriers and facilitators to the implementation of perioperative team-based morbidity and mortality conferences.

Improvement Brief

149 A Quality Improvement Initiative to Increase Documentation of Preferences for Life-Sustaining Treatment in Hospitalized Adults

D. Harmon; B. De Lima; K. Littlefield; M. Brooks; K. Drago

After an internal review revealed that only 29.5% of adult internal medicine patients with an inpatient do-not-resuscitate (DNR) order and without a DNR Portable Order for Life-Sustaining Treatment (POLST) were discharged from their institution with a DNR POLST form on file during 2019, Harmon and colleagues sought to improve this rate through systems analysis and interventions targeting areas of need within the system.

Research Letter

154 Clinician Review of Advance Care Planning for Older Surgical Patients Requiring Intensive Care

J.A. Lin; A. Colley; L. Pierce; E. Finlayson; R.L. Sudore; E. Wick

For existing advance care planning to be helpful during the surgical episode, it must be accessible by clinicians in the electronic health record. In this study, Lin and colleagues reviewed electronic health record data to determine patterns of clinician advance care planning review.

Copyright 2024 The Joint Commission

Sentinel Event Alert

157 *Sentinel Event Alert* 68: Updated Surgical Fire Prevention for the 21st Century

Surgical fires continue to occur and represent a significant risk to patients and health care professionals. The Joint Commission issues this *Alert* to help health care organizations recommit to surgical fire prevention.

The *Journal* is celebrating its 50th anniversary in 2024! Select previously published *Journal* articles will be available via open access on the 50th Anniversary Open Access Article Collections page. The March article collection will focus on preventing workplace violence.

Copyright 2024 The Joint Commission

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

- Revised Memory Care Certification for **assisted living communities** (*see* page 2 in this issue for the full article)
- Revised requirements for **critical access hospitals** and **hospitals** (*see* page 3 in this issue for the full article)
- Revised the definition of *designated equivalent source* for **ambulatory care** organizations, **behavioral health care and human services** organizations, **critical access hospitals**, **hospitals**, and **office-based surgery practices** (*see* page 4 in this issue for the full article)

CURRENTLY IN FIELD REVIEW

- Revised restraint and physical hold requirements for **behavioral health care and human services** organizations (field review expected to begin in early March)
- New workplace violence prevention requirements for **home care** organizations (focused engagement with current customers ends March 7)
- New and revised Emergency Management (EM) requirements for **laboratories** (field review ends March 15)

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

CURRENTLY BEING RESEARCHED OR IN DEVELOPMENT

- New and revised Infection Prevention and Control (IC) requirements for **assisted living communities**, **home care** organizations, and **nursing care centers**
- Safe staffing requirements for **critical access hospitals** and **hospitals**
- Revised core requirements for **all disease-specific care programs**
- New and revised Emergency Management (EM) requirements for **nursing care centers**

Joint Commission Perspectives®

Executive Editor
Kathy DeMase

Senior Content Systems Specialist
Chris Zwirek

Associate Director, Editorial, Accreditation Content
Mary Beth Curran

Associate Director, Production
Johanna Harris

Executive Director, Global Publishing
Catherine Chopp Hinckley, MA, PhD

Joint Commission Editorial Advisory Group

Department of Corporate Communications

Katie Bronk, Associate Director, Communications

Hannah Miller, Communications Specialist

Caron Wong, MPS, Associate Director, Publications & Multimedia

Division of Accreditation and Certification Operations

Ashley Krueger, MPH, PMP, Director, Strategic Initiatives and Business Operations

Division of Healthcare Quality Evaluation and Improvement

Allison Reese, Senior Writer and Regulatory Specialist, Standards and Survey Methods

John Wallin, MS, RN, Associate Director, Standards Interpretation Group

Susan Yendro, MSN, RN, Associate Director, Measurement Coordination and Outreach

Subscription Information:
Individual online license—$419
Online site license—$1113
Online system license—Contact jcrcustomerservice@jcrinc.com or 877-223-6866, option 1, for pricing.

Perspectives (ISSN 1044-4017) is published monthly by Joint Commission Resources, One Renaissance Boulevard, Suite 401, Oakbrook Terrace, IL 60181.

Copyright 2024 The Joint Commission

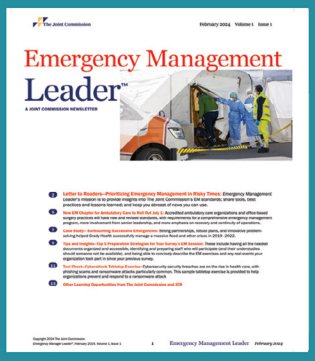
This publication may be posted in full or in part on Joint Commission–accredited and –certified organizations' secure intranet site or shared within the organization by other means without fee or permission from The Joint Commission. Outside of these parameters, no part of this publication may be reproduced or transmitted in any form or by any means without written permission. Contact permissions@jcrinc.com for inquiries.

Joint Commission Resources, Inc. (JCR), a not-for-profit affiliate of The Joint Commission, has been designated by The Joint Commission to publish publications and multimedia products. JCR reproduces and distributes the materials under license from The Joint Commission. The mission of The Joint Commission is to continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value.

Visit us on the Web at
https://www.jcrinc.com.

The Joint Commission | Joint Commission Resources

Are you ready to lead your health care organization through an emergency? Subscribe NOW to JCR'S new newsletter!



Emergency Management Leader™—a brand-new digital newsletter from JCR—provides practical strategies to help health care organizations comply with The Joint Commission's Emergency Management (EM) requirements. This newsletter features case studies explaining how health care organizations handle real emergencies; practical tips from Joint Commission subject matter experts and industry leaders to help maintain and support compliance; and useful tools such as tabletop exercises, drill scenarios, checklists, sample policies and plans, and after-action reports.

Intended for emergency management leaders, managers, and coordinators in all health care settings, *Emergency Management Leader*™ covers a wide range of topics, including mass casualty incident response, communication during disasters, infectious disease preparedness, EM training, EM program evaluation, and more.

Learn more/subscribe HERE!

Emergency Management Leader™ publishes bimonthly in 2024—February, April, June, August, October, and December.

The Joint Commission | Joint Commission Resources

2024 Conferences and Seminars



March 12-14, 2024
Ambulatory Care Accreditation Essentials - Live Webcast

March 19-20, 2024
Environment of Care and Life Safety for Ambulatory Care - Live Webcast

April 9-10, 2024
Environment of Care Base Camp - In-person or Live Webcast

April 11-12, 2024
Exploring the Life Safety Chapter - In-person or Live Webcast

April 16-18, 2024
Hospital Accreditation Essentials with Tracers & Data Analysis - In-person

May 7-9, 2023
Home Care Accreditation Essentials - Live Webcast

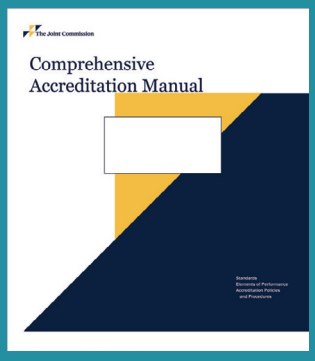
LEARN MORE

Joint Commission Resources, Inc. (JCR), a wholly controlled, not-for-profit affiliate of The Joint Commission, is the official publisher and educator of The Joint Commission. JCR is an expert resource for health care organizations, providing advisory services, educational services and publications to assist in improving quality and safety and to help in meeting the accreditation standards of The Joint Commission. JCR provides advisory services independently from The Joint Commission and in a fully confidential manner.

The Joint Commission | Joint Commission Resources

2024 Comprehensive Accreditation Manuals

Obtain the most accurate and up-to-date information your organization needs for continuous compliance!



Order a copy today so your organization gets the necessary accreditation processes, standards, and requirements for achieving *The Gold Seal of Approval®* . All standards and elements of performance are effective January 1, 2024.

Available for these health care settings: Ambulatory Health Care, Hospitals, Critical Access Hospitals, Home Care, Behavioral Health Care and Human Services, Laboratory, Assisted Living Community, and Nursing Care Center.

Order now at www.jcrinc.com

JCR is an expert resource for health care organizations, providing advisory services, educational services and publications to assist in improving quality and safety and to help in meeting the accreditation standards of The Joint Commission. JCR provides advisory services independently from The Joint Commission and in a fully confidential manner

Copyright 2024 The Joint Commission