The Joint Commission

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Joint Commission Perspectives®

THE OFFICIAL NEWSLETTER OF THE JOINT COMMISSION

Contents

2 **APPROVED: New and Revised Requirements for Disease-Specific Care Certification Programs**
The Joint Commission has approved new and revised standards and elements of performance for most disease-specific care programs effective January 1, 2025.

4 **CMS Renews The Joint Commission's Deeming Approval for Ambulatory Surgical Centers**
The US Centers for Medicare & Medicaid Services (CMS) renewed The Joint Commission's deeming approval for ambulatory surgical centers for a full six-year term effective September 1, 2024.

5 **APPROVED: "Emergency Management" (EM) Chapter Fully Revised for Nursing Care Centers**
Effective January 1, 2025, The Joint Commission fully revised its "Emergency Management" (EM) chapter to help nursing care centers develop a more comprehensive EM program and to apply lessons learned from the COVID-19 pandemic.

6 **REMINDER: Automatic Data Transfer Process Available for Advanced Stroke Programs**
The Joint Commission reminds organizations certified under its advanced disease-specific care stroke programs that an automatic data transfer process is available.

7 **Consistent Interpretation**
Joint Commission surveyors' observations related to a patient's informed consent rights.

12 ***The Joint Commission Journal on Quality and Patient Safety***
Table of Contents—August 2024

15 **In Sight**

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APPROVED: New and Revised Requirements for Disease-Specific Care Certification Programs

Effective January 1, 2025, The Joint Commission has approved new and revised standards and elements of performance (EPs) for most **disease-specific care** (DSC) certification programs.

The DSC certification standards and EPs were significantly revised, including eliminating or revising requirements that do not add value to the certification and review process. These requirements were evaluated for the following:

- How often the requirement was scored
- Whether the requirement was clear
- Whether the requirement was redundant to another
- Whether the requirement supported patient safety and quality of care

As illustrated in the following table, many requirements were revised or completely removed from each of the five chapters (DSPR, DSDF, DSSE, DSCT, and DSPM). In addition, new concepts were added to the certification requirements, such as providing community outreach/education based on services provided and incorporating patient perception of care to inform program improvement initiatives. EPs rarely or never scored were eliminated if they did not add value to the certification process. As a result, the DSC certification program requirements were reduced by 57%.

Chapter	Current EPs	Deleted EPs	New/Revised EPs
Program Management (DSPR)	38	17	21
Delivering or Facilitating Clinical Care (DSDF)	31	19	12
Supporting Self-Management (DSSE)	16	7	9
Clinical Information Management (DSCT)	22	17	5
Performance Measurement (DSPM)	31	18	13
Totals	**138**	**78**	**60**

Aligning Addenda for Select Advanced DSC Certification Programs

The addenda specific to most advanced DSC certification programs will move under new EPs; however, addenda content will not change. In the future, these addenda will be revised to cohesively align with the new and revised EPs. These revised requirements do not affect the intent of the advanced DSC certification programs or their program-specific requirements.

The advanced certifications for Lung Volume Reduction Surgery (LVRS) and Ventricular Assist Device (VAD) **are not** part of these revisions. The standards and EPs for these programs remain unchanged.

Health care organizations can access an overview or a complete copy of the new and revised requirements as follows:

- **Overview**—A high-level overview of the new and revised requirements will be posted on the Prepublication Standards page of The Joint Commission's website.

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- **Comprehensive Copy**—A complete comprehensive copy of the new and revised requirements for basic and/or advanced DSC programs is available on an organization's *Joint Commission Connect*® extranet site under the "Important Updates" section.

The new and revised requirements will publish online in the fall 2024 E-dition® update to the *Comprehensive Certification Manual for Disease-Specific Care (DSC)*. For those customers who purchase them, the PDF version of the *2025 DSC* manual, and the hard-copy and PDF versions of the *2025 Orthopedic Certification Standards Manual* and *2025 Stroke Certification Standards Manual* will include these new and revised requirements.

For more information, please contact your account executive.

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CMS Renews The Joint Commission's Deeming Approval for Ambulatory Surgical Centers

The US Centers for Medicare & Medicaid Services (CMS) recently announced that it renewed The Joint Commission's deeming approval for **ambulatory surgical centers** accredited under the Ambulatory Care Accreditation program. The deeming approval is effective for the maximum six-year term from September 1, 2024, through September 1, 2030; the full notice published July 18, 2024, in the *Federal Register*.

In renewing The Joint Commission's deeming approval, CMS determined that The Joint Commission's standards and survey process meet or exceed those established by CMS. Accreditation is voluntary and seeking deemed status through accreditation is an option—not a requirement. Organizations seeking Medicare approval may choose to be surveyed either by an accrediting body, such as The Joint Commission, or by state surveyors on behalf of CMS.

All deemed status surveys are unannounced. Any ambulatory surgical center deemed to meet the CMS requirements is subject to validation and complaint investigation surveys performed by CMS or its agent(s).

"With renewed deeming approval from CMS, The Joint Commission can continue to help health care organizations across the nation provide the safest and highest-quality ambulatory care," says Ken Grubbs, DNP, MBA, RN, Executive Vice President of Accreditation and Certification Operations and Chief Nursing Officer, The Joint Commission. "Through participation in our Ambulatory Care Accreditation Program, ambulatory surgical centers will receive a framework for enhancing their performance reliability and minimizing risks associated with ambulatory care."

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APPROVED: "Emergency Management" (EM) Chapter Fully Revised for Nursing Care Centers

Effective January 1, 2025, a fully revised "Emergency Management" (EM) chapter, including new and revised EM standards, has been approved for all Joint Commission–accredited **nursing care centers**. The Joint Commission thoroughly analyzed and rewrote the EM chapter, which resulted in the following:

- Reorganized requirements
- Renumbered standards
- Reduced elements of performance (EPs) by more than 28% for nursing care centers

The goal of the EM chapter rewrite was to help health care organizations to develop more comprehensive EM programs and to better prepare for the health, safety, and security needs of their facilities, staff, patient and resident populations, and communities during emergencies or disasters (such as a natural disaster, cybersecurity attack, high-consequence infectious disease, or special pathogen). The new and revised EM requirements clarify and emphasize the following:

- Assessment, applicability, and incorporation of the hazard vulnerability analysis throughout the EM chapter
- Leadership involvement and oversight in all aspects of the EM program
- Staff education and training, with specific guidance for initial and ongoing EM training

The project's program-specific *R^3 Report* provides rationales for the requirements as well as references to the research articles and reports used to develop them. In addition to an extensive literature review, the new and revised requirements were developed based on voice-of-customer feedback resulting from the pandemic, public field review, expert guidance from a standards review panel, and an internal Joint Commission EM workgroup.

The new and revised requirements will be posted on the Prepublication Standards page of The Joint Commission's website and will publish online in the fall 2024 E-dition® update to the *Comprehensive Accreditation Manual for Nursing Care Centers (CAMNCC)*. For those customers who purchase it, the PDF version of the *2025 CAMNCC* will include these new and revised requirements.

For more information, please contact the Joint Commission's Standards and Survey Methods.

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REMINDER: Automatic Data Transfer Process Available for Advanced Stroke Programs

The Joint Commission is reminding certified organizations or those seeking certification under its advanced disease-specific care stroke programs that there is a process to automatically transfer data from the American Heart Association's (AHA) Get With The Guidelines® (GWTG)—Stroke registry into The Joint Commission's Certification Measure Information Process (CMIP). Since this process became available to stroke centers certified under the following advanced disease-specific care programs (*see* the April 2024 issue of *Perspectives*), more than 25% have selected this option:

- **Acute Stroke Ready Hospital** (ASRH)
- **Comprehensive Stroke Center** (CSC)
- **Primary Stroke Center** (PSC)
- **Thrombectomy-Capable Stroke Center** (TSC)

Organizations interested in automating their process for the 2024 Q2 data transfer must complete a GWTG—Stroke permission form and questionnaire. Contact your organization's AHA quality improvement consultant for more information about granting permissions for data sharing, completing the necessary forms, and receiving access to AHA's "How To Guide" for enrolling. Data should be finalized by 11:59 P.M. eastern standard time the night before the scheduled transfer date (*see* the following table for the data transfer schedule). It may take 2–3 business days after the data transfer date for data to populate in CMIP.

Quarter (Q)	Data Transfer Date
Q1	June 15
Q2	September 15
Q3	December 15
Q4	March 15

This process also is available for the following advanced disease-specific care certification programs that transfer data from AHA's GWTG—Coronary Artery Disease (GWTG—CAD) registry into The Joint Commission's CMIP:

- Acute Heart Attack Ready (AHAR)
- Comprehensive Heart Attack Center (CHAC)
- Primary Heart Attack Center (PHAC)

Organizations that use GWTG—CAD for heart attack measure data sharing still must complete the stroke enrollment process to allow GWTG—Stroke automatic data transfer to CMIP. Data transfer is limited to aggregate counts of data captured in GWTG—Stroke for Joint Commission stroke measures. It does not capture patient-level data.

Note that organizations should continue to enter data manually until they receive confirmation of when the automatic data transfer will begin. In addition, organizations that allow the automatic data transfer from the registry into CMIP should check their CMIP data quarterly to ensure data accuracy.

Contact your Joint Commission account executive with any questions about this process.

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Consistent Interpretation

Joint Commission Surveyors' Observations Related to a Patient's Informed Consent Rights

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 requirements related to informed consent for patients and a recent memo addressing concerns from the US Centers for Medicare & Medicaid Services (CMS).

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

Noncompliance Implications	Patients have the right to make informed decisions regarding their care, including the right to give or withhold consent when important care, treatment, or services related to surgery, or an intimate/sensitive examination or an invasive procedure may be performed by another physician or a health profession student as part of their educational and training experience. Performing such examinations is necessary to teach medical and other students critical clinical examination skills. Thus, obtaining a patient's permission is an essential part of the informed consent process. The following is an excerpt from the CMS memo, QSO-24-10-Hospitals, published on April 1, 2024. Based on increasing concerns about the absence of informed patient consent prior to allowing practitioners or supervised medical, advanced practice provider, or other applicable students to perform training- and education-related examinations outside the medically necessary procedure (such as breast, pelvic, prostate, and rectal examinations), particularly on anesthetized patients, we are reinforcing hospitals' informed consent obligations. In response to this memo, The Joint Commission's survey process related to informed consent has been updated to align with CMS. *See* the August 2024 issue of *Perspectives* for information related to the updated survey process.

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Rights and Responsibilities of the Individual (RI) Standard RI.01.03.01: The hospital honors the patient's right to give or withhold informed consent.	
EP 1: Ⓓ The hospital follows a written policy on informed consent that describes the following: ● The specific care, treatment, and services that require informed consent ● Circumstances that would allow for exceptions to obtaining informed consent ● The process used to obtain informed consent ● The physician or other licensed practitioner permitted to conduct the informed consent discussion in accordance with law and regulation ● How informed consent is documented in the patient record **Note:** *Documentation may be recorded in a form, in progress notes, or elsewhere in the record.* ● When a surrogate decision-maker may give informed consent (*See also* RI.01.02.01, EP 2)	
Compliance Rate	In 2023, the noncompliance percentage for this EP was **29.65%**—that is, **411** of **1,386** hospitals surveyed did not comply with this requirement.

Surveyor Observations	**Guidance/Interpretation**
● The organization's informed consent policy did not require patients to be informed when another physician, an advanced practice provider, or a health profession student would participate in and/or perform an intimate/sensitive examination or invasive procedure for educational or training purposes; this includes situations in which the patient is sedated or anesthetized. ● The organization's informed consent policy did not require practitioners to document in the patient record when informed consent discussions related to an intimate/sensitive examination or invasive procedure included another practitioner, an advanced practice provider, and/or a health profession student in an outpatient clinic setting where sedation or anesthesia was not used. ● The organization's informed consent form did not include information that another physician, an advanced practice provider, or a health profession student may conduct portions of a surgical procedure or perform an intimate/sensitive examination or invasive procedure for educational or training purposes. ● The section of the informed consent form pertaining to another physician, an advanced practice provider, or a health profession student performing an intimate/sensitive examination or invasive procedure during surgery for educational or training purposes was not completed as required by the organization's policy.	● An organization's informed consent policy must address the informed consent discussion with a patient about another physician, an advanced practice provider, or a health profession student who is permitted to perform parts of and/or participate in surgery, or intimate/sensitive examinations or invasive procedures that involve sedation or anesthesia for educational or training purposes. A signed informed consent document that addresses this information must be obtained. ● An organization's informed consent policy must address the informed consent discussion with a patient about another physician, an advanced practice provider, or a health profession student who is permitted to perform parts of and/or participate in surgery, or intimate/sensitive examinations or invasive procedures that do not involve sedation or anesthesia for educational or training purposes.

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• The organization's informed consent policy did not require patients be informed when another physician, an advanced practice provider, or a health profession student would participate in/perform part of a surgical procedure for educational or training purposes.	• A note must be entered into the medical record that the patient was informed during the informed consent discussion that another physician, an advanced practice provider, or a health profession student may perform parts of and/or participate in surgery, or intimate/sensitive examinations or invasive procedures that do not involve sedation or anesthesia for educational or training purposes. A signed informed consent form may be used in lieu of a note in the medical record, but it is not required unless required by organization policy.
	• Examples of health profession students include the following: ❍ Residents ❍ Medical students ❍ Advanced practice providers ❍ Anesthesia providers ❍ Surgical techs ❍ First assists ❍ Nurse practitioners ❍ Physician assistants • Examples of surgical tasks include the following: ❍ Opening and closing ❍ Dissecting tissue ❍ Removing tissue ❍ Harvesting grafts ❍ Transplanting tissue ❍ Administering anesthesia ❍ Implanting devices ❍ Placing invasive lines • Examples of intimate/sensitive examinations or invasive procedures include the following: ❍ Breast exams ❍ Pelvic exams ❍ Prostate exams ❍ Rectal exams

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EP 2: The informed consent process includes a discussion about the following:

- The patient's proposed care, treatment, and services.
- Potential benefits, risks, and side effects of the patient's proposed care, treatment, and services; the likelihood of the patient achieving their goals; and any potential problems that might occur during recuperation.
- Reasonable alternatives to the patient's proposed care, treatment, and services. The discussion encompasses risks, benefits, and side effects related to the alternatives and the risks related to not receiving the proposed care, treatment, and services.

Compliance Rate	In 2023, the noncompliance percentage for this EP was **4.40%**—that is, **61** of **1,386** hospitals surveyed did not comply with this requirement.

Surveyor Observations	**Guidance/Interpretation**
• A patient explained during an interview that a medical student performed an intimate/sensitive examination. However, it was not disclosed to the patient during the informed consent discussion that the examination was being performed by a medical student as part of their training. • A practitioner in an outpatient clinic was not aware that an informed consent discussion must include informing a patient that a medical student may perform an intimate/sensitive examination as part of their training. • A patient explained during an interview that during the informed consent discussion it was not disclosed that a registered nurse first assist student or physician assistant student would be suturing their incision as part of their training. • A practitioner was not aware that documenting the informed consent discussion included informing the patient that medical students may perform part of the operative procedure or an intimate/sensitive examination during the procedure as part of their training.	• An organization's informed consent policy must address the informed consent discussion with a patient about another physician, an advanced practice provider, or a health profession student who is permitted to perform parts of and/or participate in surgery, or intimate/sensitive examinations or invasive procedures that involve sedation or anesthesia for educational or training purposes. A signed informed consent document that addresses this information must be obtained. • An organization's informed consent policy must address the informed consent discussion with a patient about another physician, an advanced practice provider, or a health profession student who is permitted to perform parts of and/or participate in surgery, or intimate/sensitive examinations or invasive procedures that do not involve sedation or anesthesia for educational or training purposes.
• The medical record of a patient undergoing an intimate/sensitive examination being performed by another physician, an advanced practice provider, or a health profession student for educational or training purposes did not include documentation that an informed consent discussion occurred as required by organization policy.	• A note must be entered into the medical record that the patient was informed during the informed consent discussion that another physician, an advanced practice provider, or a health profession student may perform parts of and/or participate in surgery, or intimate/sensitive examinations or invasive procedures that do not involve sedation or anesthesia for educational or training purposes. A signed informed consent form may be used in lieu of a note in the medical record, but it is not required unless required by organization policy.

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	• Examples of nonphysician students include the following:
	  • Residents
	  • Medical students
	  • Advanced practice providers
	  • Anesthesia providers
	  • Surgical techs
	  • First assists
	  • Nurse practitioners
	  • Physician assistants
	• Examples of surgical tasks include the following:
	  • Opening and closing
	  • Dissecting tissue
	  • Removing tissue
	  • Harvesting grafts
	  • Transplanting tissue
	  • Administering anesthesia
	  • Implanting devices
	  • Placing invasive lines
	• Examples of intimate/sensitive examinations or invasive procedures include the following:
	  ❍ Breast exams
	  ❍ Pelvic exams
	  ❍ Prostate exams
	  ❍ Rectal exams

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The Joint Commission Journal on Quality and Patient Safety®

IMPROVEMENT FROM FRONT OFFICE TO FRONT LINE

This issue of *Perspectives* presents the **August 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.

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The 2023 John M. Eisenberg Patient Safety and Quality Awards

The Joint Commission and National Quality Forum (NQF) are pleased to recognize the recipients of the 22nd John M. Eisenberg Patient Safety and Quality Awards. The Eisenberg Awards recognize major achievements by individuals and organizations to improve patient safety and health care quality. Additional information about the Eisenberg Award program, including the awards announcement, is available on The Joint Commission's John M. Eisenberg Patient Safety and Quality Awards page.

Individual Achievement

549 An Interview with Eduardo Salas, PhD

Interviewed by E.J. Thomas

Dr. Salas is recognized for his body of work across 40 years, designing, developing, and evaluating evidence-based principles and tools to help health care organizations create a culture of teamwork and safety. Salas was instrumental in creating the pioneering and revolutionary TeamSTEPPS—Team Strategies and Tools to Enhance Performance and Patient Safety—which has now been adopted by 70% of US hospitals.

Healthcare Equity

552 Racial/Ethnic Disparities in Peripartum Pain Assessment and Management

N.H. Greene; S.J. Kilpatrick

Racial/ethnic disparities in pain management have been reported across the peripartum timeline, but results have been inconsistent. Greene and Kilpatrick conducted a retrospective cohort study of all births from January 2019 to December 2021 in a single urban, quaternary care hospital to determine if there were racial/ethnic disparities in pain assessment and management from labor throughout the postpartum period.

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Care Transitions

560 [Enhancing Implementation of the I-PASS Handoff Tool Using a Provider Handoff Task Force at a Comprehensive Cancer Center]

M.C.F. Vega; M.A. Aiss; M. George; L. Day; A. Mbadugha; K. Owens; C. Sweeney; S. Chau; C. Escalante; D.C. Bodurka

Communication failures are among the most common medical errors that cause harm, and more than half of communication failures occur during handoffs. In this article, Vega and colleagues describe the implementation of an organizationwide project to improve handoffs and implement an evidence-based handoff tool across all inpatient services at a comprehensive cancer center.

Workplace Violence

569 Screening and Intervention to Prevent Violence Against Health Professionals from Hospitalized Patients: A Pilot Study

K. Adams; L. Topper; I. Hashim; A. Rajwani; C. Montalvo

Health care providers, particularly nursing staff, are at risk of physical or emotional abuse from patients. This abuse is associated with increased use of patient restraints, poor patient outcomes, high staff turnover, and reduced job satisfaction. Adams and colleagues implemented the Brøset Violence Checklist (BVC), a screening tool administered by nurses to identify patients displaying agitated behavior, in an inpatient medical setting. Patients who scored high on the BVC were provided a psychiatric consultation. Health care providers received one-hour de-escalation training led by nursing and Public Safety.

Process Improvement

579 [Evaluating Real-World Implementation of INFORM (Improving Nursing Home Care through Feedback on Performance Data): An Improvement Initiative in Canadian Nursing Homes]

S. Saeidzadeh; J.T. Minion; S. Bryan; P.G. Norton; C.A. Estabrooks

Nursing homes have struggled to improve quality of care for decades, but proposed strategies to address this need present their own challenges. INFORM (Improving Nursing Home Care through Feedback on Performance Data) equipped nursing home managers with skills to conduct local improvement projects and supported them in improving performance through modifiable elements in their units. In this article, Saeidzadeh and colleagues report findings from a formative service evaluation of INFORM as modified for use in real-world settings.

591 Improving Appropriate Use of Peripherally Inserted Central Catheters Through a Statewide Collaborative Hospital Initiative: A Cost-Effectiveness Analysis

M. Heath; S.J. Bernstein; D. Paje; E. McLaughlin; J.K. Horowitz; A. McKenzie; T. Leyden; S.A. Flanders; V. Chopra

The Michigan Hospital Medicine Safety Consortium (HMS) used a physician-led, performance-incentivized quality improvement intervention to improve the appropriateness of use of peripherally inserted central catheters (PICCs) and reduce device-related complications. Although this intervention has improved process measures, the return on investment and financial sustainability of the HMS model have yet to be shown. In this retrospective study, Heath and colleagues assessed the costs of implementing and sustaining the HMS PICC initiative and evaluated its impact.

Improvement Brief

601 [Standardizing the Dosage and Timing of Dexamethasone for Postoperative Nausea and Vomiting Prophylaxis at a Safety-Net Hospital System]

A.V. Yurkonis; L. Tollinche; J. Alter; S.E. Pope; P. Traxler; H.E. Hill; A. Torres

A single dose of dexamethasone is routinely given during general anesthesia for postoperative nausea and vomiting prophylaxis, although the exact dosage and timing may vary among practitioners. After identifying a lack of standardization in the administration of this medication, Yurkonis and colleagues aimed to standardize the dose to 8 to 10 mg and administration timing to induction of anesthesia or at least prior to first incision in adult patients.

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Innovation Report

606 A Systemwide Strategy to Embed Equity into Patient Safety Event Analysis

K. Chandra; M. Garcia; K. Bajaj; S. Tsega; J. Talledo; D. Alaiev; P.A. Manchego; M. Zaurova; H. Jalon; E. Wei; M. Krouss

Event analysis without an equity lens captures an incomplete picture, as health equity can affect any and every patient. In this article, Chandra and colleagues describe the development and evaluation of equity tools across acute care facilities at a large municipal health care system.

Article Collection

612 *The Joint Commission Journal on Quality and Patient Safety* 50th Anniversary Article Collections: John M. Eisenberg Patient Safety and Quality Awards

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 September article collection will focus on quality improvement in non-hospital settings.

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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

- New and revised requirements for most **disease-specific care** programs (*see* page 2 in this issue for the full article)
- New and revised Emergency Management (EM) requirements for **nursing care centers** (*see* page 5 in this issue for the full article)

CURRENTLY IN FIELD REVIEW

- No standards currently in field review

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 Emergency Management (EM) requirements for **assisted living communities**, **behavioral health care and human services** organizations, **laboratories**, and **office-based surgery practices**
- Safe staffing requirements for **critical access hospitals** and **hospitals**
- Revised requirements for **health care staffing services** certification
- New and revised Infection Prevention and Control (IC) requirements for **ambulatory care** organizations, **behavioral health care and human services** organizations, **laboratories**, and **office-based surgery practices**

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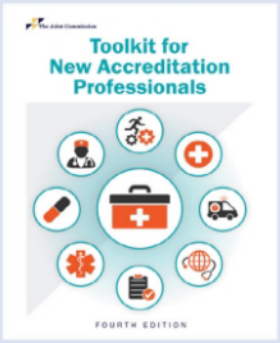
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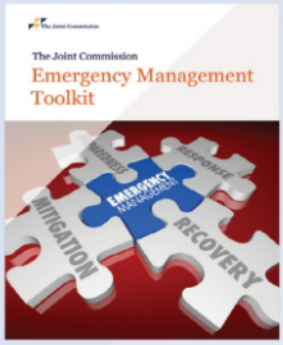
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