The Joint Commission

January 2024 | Volume 44 | Number 1

Joint Commission Perspectives®

THE OFFICIAL NEWSLETTER OF THE JOINT COMMISSION

Contents

2 **APPROVED: "Infection Prevention and Control" (IC) Chapter Fully Revised for Critical Access Hospitals and Hospitals**

Effective July 1, 2024, The Joint Commission fully revised its "Infection Prevention and Control" (IC) chapter to help critical access hospitals and hospitals to develop a strong framework for their IC programs.

3 **APPROVED: New and Revised Workplace Violence Prevention Requirements for BHC Organizations**

New and revised workplace violence prevention requirements have been approved for behavioral health care and human services (BHC) organizations effective July 1, 2024.

5 **NEW: Acute Care Hospitals Will Be Required to Join the Joint Commission NHSN Group**

Beginning July 1, 2024, acute care hospitals must join the Joint Commission–specific National Healthcare Safety Network (NHSN) group.

7 **APPROVED: "Emergency Management" (EM) Chapter Fully Revised for Ambulatory Care and Office-Based Surgery Programs**

The Joint Commission fully revised its "Emergency Management" (EM) chapter, effective July 1, 2024, to help ambulatory care organizations and office-based surgery practices develop a more comprehensive EM program and to apply lessons learn from the COVID-19 pandemic.

9 **UPDATED: Post–Acute Care Certification Requirements for Nursing Care Centers**

Effective July 1, 2024, new and revised requirements have been updated to improve the safety and quality of care for patients and residents receiving post–acute care in Joint Commission–accredited nursing care centers.

10 **APPROVED: Revised Requirements for Certified Community Behavioral Health Clinics**

Effective July 1, 2024, The Joint Commission approved new and revised requirements for behavioral health care and human services organizations that select the Certified Community Behavioral Health Clinic service on their electronic application.

11 **APPROVED: Revised Requirements for Total Hip and Total Knee Replacement**

The Joint Commission revised requirements for its advanced disease-specific care certification for total hip and total knee replacement to align with updated clinical practice guidelines effective July 1, 2024.

12 **Consistent Interpretation**

Joint Commission surveyors' observations related to presedation or preanesthesia assessment.

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

Table of Contents—December 2023

20 **In Sight**

Copyright 2024 The Joint Commission

APPROVED: "Infection Prevention and Control" (IC) Chapter Fully Revised for Critical Access Hospitals and Hospitals

Effective July 1, 2024, a fully revised "Infection Prevention and Control" (IC) chapter, including new and revised requirements, has been approved for all Joint Commission–accredited **critical access hospitals** and **hospitals**. The goal of the IC chapter rewrite was to help organizations develop a strong framework for their IC programs, while aligning requirements more closely to law and regulation and the US Centers for Medicare & Medicaid Services (CMS) Conditions of Participation (CoPs).

In keeping with the ongoing initiative to simplify standards content and structure, The Joint Commission eliminated requirements that do not add value to accreditation surveys so that organizations can focus on the structures that support IC quality and safety. Elements of performance (EPs) related to waste management and responding to an influx of potentially infectious patients also were removed from the IC chapter because they were redundant to existing Environment of Care (EC) and Emergency Management (EM) requirements.

The rewrite resulted in a 70% reduction of EPs in the chapter. The Joint Commission also introduced new Standard IC.07.01.01 with its two new EPs to enhance critical access hospitals' and hospitals' preparedness for high-consequence infectious diseases or special pathogens. These new requirements are based on scientific literature, government resources, and recommendations from The Joint Commission's technical advisory panel on emerging infectious disease preparedness. Additional information about the revisions is available in the project's *R³ Report*.

The Joint Commission also created a new IC Assessment Tool that details the IC practices and structures needed to meet the IC requirements. The tool was developed using regulations, CMS survey procedures, the CMS Hospital Infection Control Worksheet, the US Centers for Disease Control and Prevention (CDC) Core IC Practices, and Category IA recommendations from CDC guidelines. The new tool will be posted to Joint Commission–accredited critical access hospitals' and hospitals' *Joint Commission Connect*® extranet site by January 1, 2024, and added to the *Critical Access Hospital* and *Hospital Organization Survey Activity Guide*s in spring 2024.

The new and revised requirements and a guide showing where concepts from the old EPs have moved in the new EPs 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* 2024 spring update service will include these new and revised requirements.

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

Copyright 2024 The Joint Commission

APPROVED: New and Revised Workplace Violence Prevention Requirements for BHC Organizations

Effective July 1, 2024, The Joint Commission approved new and revised workplace violence prevention requirements for all Joint Commission–accredited **behavioral health care and human services** (BHC) organizations.

According to US Bureau of Labor Statistics data,[1] violence–related health care worker injuries have steadily increased for at least a decade. Prevalence of workplace violence in behavioral health care settings—particularly in residential care facilities (for example, mental health, substance use disorder, and intellectual and developmentally disabled care, treatment, and services) is considerably greater compared with other industry segments. Among mental health care occupations, intentional injuries are higher for practitioner support technicians, nursing and psychiatric aides, and occupational and physical therapy assistants and aides.[2,3] Moreover, there is reason to believe that workplace violence is significantly underreported in BHC organizations than it is across the health care industry. The effects of exposure to workplace violence remain the same in terms of affecting accessibility to and impairing effective care, treatment, and services and causing staff psychological distress, job dissatisfaction, absenteeism, high turnover, and higher costs.

In response to workplace violence directly affecting the safety of patients and staff, The Joint Commission implemented accreditation requirements on workplace violence prevention in the critical access hospital and hospital programs in 2022 (*see* the July 2021 issue of *Perspectives*). A literature review and public field review were conducted to determine the applicability of similar requirements for BHC settings and services. A technical advisory panel of individuals representing various public and private organizations, as well as Joint Commission–accredited BHC programs, provided knowledge and expertise in examining the relevance of workplace violence prevention requirements to BHC providers.

The new and revised requirements provide a framework to guide BHC organizations in developing effective workplace violence prevention strategies. The requirements address the following:

- Defining *workplace violence*, including a formal definition added to the Glossary
- Outlining leadership oversight
- Developing worksite analysis processes
- Developing policies and procedures to prevent workplace violence
- Reporting systems, data collection, and analysis
- Implementing post-incident strategies
- Providing training and education to decrease workplace violence

A Resource Center is being developed, which will appear on The Joint Commission's website and will include resources focused on workplace violence prevention in BHC organizations. Additional information about the revised standards is available in the initial project *R³ Report*.

Copyright 2024 The Joint Commission

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 spring 2024 E-dition® update to the *Comprehensive Accreditation Manual for Behavioral Health Care and Human Services (CAMBHC)*. For those customers who purchase it, the *CAMBHC* 2024 spring update service will include these new and revised requirements.

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

References

1. US Bureau of Labor Statistics. Injuries, Illnesses, and Fatalities: Fact Sheet: Workplace Violence in Healthcare, 2018. (Updated: Apr 8, 2020.) Accessed Dec 14, 2023.
2. Hawkins D, Ghaziri ME. Violence in health care: Trends and disparities, Bureau of Labor Statistics survey data of occupational injuries and illnesses, 2011–2017. *Workplace Health Saf.* 2022 Mar;70(3):136–147. Accessed Dec 14, 2023.
3. Liu J, et al. Prevalence of workplace violence against healthcare workers: A systematic review and meta-analysis. *Occup Environ Med.* 2019 Dec;76(12):927–937.

Copyright 2024 The Joint Commission

NEW: Acute Care Hospitals Will Be Required to Join the Joint Commission NHSN Group

Despite being largely preventable, an estimated 633,300 patients contract health care–associated infections (HAIs) each year, resulting in approximately 72,000 annual in-hospital deaths, and an annual $28.4 billion estimated direct medical cost.

Because preventing HAIs remains a priority for The Joint Commission, **beginning July 1, 2024**, **acute care hospitals** with ORYX® performance measurement requirements and that are required through a US Centers for Medicare & Medicaid Services (CMS) program to participate in the US Centers for Disease Control and Prevention's (CDC) National Healthcare Safety Network (NHSN) system will be required to join the Joint Commission NHSN Group. Participation in the Joint Commission NHSN Group will be optional for critical access hospitals where participation in CMS programs is not required.

The Joint Commission identified the NHSN system as a data source to evaluate patient safety and clinical quality performance by Joint Commission–accredited hospitals—many of which already participate in NHSN as a CMS program requirement. The benefits of creating an NHSN Group include the following:

- Improve timeliness of facility-level performance data available to hospitals and surveyors.
- Provide Joint Commission facility-level performance data to design and evaluate improvement programs.
- Minimize time and effort required to report data to The Joint Commission.

Hospitals will grant The Joint Commission access to deidentified data on the following five CDC NHSN HAI measures from the NHSN application. Currently, all these measures in the CMS Hospital Value-Based Purchasing (VBP) Program and the Hospital-Acquired Condition (HAC) Reduction Program.

1. Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure
2. Facility-Wide Inpatient Hospital-Onset *Clostridium difficile* Infection (CDI) Outcome Measure
3. Central Line–Associated Bloodstream Infection (CLABSI) Outcome Measure
4. Colon and Abdominal Hysterectomy Surgical Site Infection (SSI) Outcome Measure
5. Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure

Hospitals will join the Joint Commission Group in the NHSN application by accepting the template of rights to share data. The time period parameter will be set to begin with events that occurred in Q1 2021. The Joint Commission selected a look-back period because historical data more accurately depict trends and hospital performance over time. The view options for patient-level data will be set for no patient identifiers. The Joint Commission will have access to facility-level data only. Hospital data will remain confidential and will not be shared with other Joint Commission–accredited hospitals. In accordance with NSHN Group rules, "A facility that joins a Group does not have access to any data from other facilities in the Group." The Joint Commission does not plan to publicly report NHSN data on Quality Check®.

Copyright 2024 The Joint Commission

As an NHSN Group user, The Joint Commission is custodian of the data to which they gain access and are responsible for establishing, using, and maintaining appropriate administrative, technical, and physical safeguards to prevent unauthorized access or use of the accessed NHSN data. The Joint Commission completed a rigorous evaluation process of technology components to ensure that privacy and security standards are met.

In April 2024 The Joint Commission will e-mail the primary accreditation contact on file for the organization to determine the appropriate contact person to correspond with regarding the Joint Commission NHSN Group. After the contact has been identified, detailed instructions for joining the Group will be provided, and onboarding will take place May through June 2024.

For previous communication regarding the Joint Commission NHSN requirement, please *see* the article in the November 2023 issue of *Perspectives* and the 2024 ORYX® Performance Measures Reporting Requirements document.

Additional information regarding the NHSN Group for The Joint Commission is available via the ORYX FAQs or the NHSN Group for The Joint Commission page.

Copyright 2024 The Joint Commission

APPROVED: "Emergency Management" (EM) Chapter Fully Revised for Ambulatory Care and Office-Based Surgery Programs

Effective July 1, 2024, a fully revised "Emergency Management" (EM) chapter, including new and revised EM standards, has been approved for all Joint Commission–accredited **ambulatory care** organizations and **office-based surgery practices**. 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 40% for ambulatory care organizations
- Eliminated redundant requirements for office-based surgery practices

The goal of the 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 populations, and communities during emergencies or disasters (such as the COVID-19 pandemic). 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

As a result of the EM revisions, the following changes also apply:

- Information Management (IM) Standard IM.01.01.03, EPs 5 and 6, will be deleted from the ambulatory care requirements.
- There will no longer be requirements specific to Federally Qualified Health Centers (FQHCs). Those organizations will follow the EM requirements on the applicability grid for either medical centers or dental centers, as applicable.
- Rural health clinics (RHCs) accredited under the ambulatory care program will follow the EM requirements identified by the lead-in for RHCs, beginning at Standard EM.02.01.01 and ending at Standard EM.04.01.01, until further notice.

The program-specific *R^3 Report* provides rationales for the requirements as well as references to the research 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, and expert guidance from the standards review panel and an internal Joint Commission EM workgroup.

Copyright 2024 The Joint Commission

The new and revised standards 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 Ambulatory Care (CAMAC)* and the *Comprehensive Accreditation Manual for Office-Based Surgery Practices (CAMOBS)*.

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

Copyright 2024 The Joint Commission

UPDATED: Post–Acute Care Certification Requirements for Nursing Care Centers

Effective July 1, 2024, The Joint Commission approved revisions to its requirements for Post–Acute Care add-on certification option for **nursing care centers** (NCCs). These revisions include the following:

- Five new elements of performance (EPs)
- Eleven revised EPs
- Six consolidated EPs
- Eighteen EPs with editorial changes
- Seven deleted EPs

The new and revised requirements are designed to improve the safety and quality of care for patients or residents receiving post–acute care in Joint Commission–accredited NCCs. The updates reflect the most recent clinical practice guidelines from the American Medical Directors Association's Society for Post-Acute and Long-Term Care Medicine; feedback from Joint Commission–accredited NCCs, including those with and without Post–Acute Care certification; and recommendations from subject matter experts in rehabilitation and long-term care. The revised requirements cover topics in the "Human Resources" (HR), "Leadership" (LD), "Provision of Care, Treatment, and Services" (PC), and "Performance Improvement" (PI) chapters.

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 Nursing Care Centers (CAMNCC)*.

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

Copyright 2024 The Joint Commission

APPROVED: Revised Requirements for Certified Community Behavioral Health Clinics

The Joint Commission approved new and revised requirements for Joint Commission–accredited **behavioral health care and human services** organizations that select the Certified Community Behavioral Health Clinic (CCBHC) service on their electronic application (E-App). These new and revised requirements are **effective July 1, 2024**.

The Joint Commission revised its requirements to reflect the updated CCBHC criteria released by the Substance Abuse and Mental Health Services Administration (SAMHSA) in March 2023. The revisions include the following and provide organizations additional flexibility with how they provide care, treatment, or services:

- Emphasizing trauma-informed crisis care
- Addressing substance use disorders
- Advancing health care equity

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 spring 2024 E-dition® update to the *Comprehensive Accreditation Manual for Behavioral Health Care and Human Services (CAMBHC)*. For those customers who purchase it, the *CAMBHC* spring update service will include these new and revised requirements.

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

Copyright 2024 The Joint Commission

APPROVED: Revised Requirements for Total Hip and Total Knee Replacement

The Joint Commission approved revised requirements for the advanced disease-specific care certification for **total hip and total knee replacement** (THKR) **effective July 1, 2024**.

In December 2022 the American Academy of Orthopaedic Surgeons (AAOS) released updated clinical practice guidelines for knee replacement. In response, The Joint Commission updated its THKR requirements to align with the updated AAOS clinical practice guidelines.

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 Certification Manual for Disease-Specific Care (DSC)*.

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

Copyright 2024 The Joint Commission

Consistent Interpretation

Joint Commission Surveyors' Observations Related to Presedation or Preanesthesia Assessment

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 safely and effectively conducting a preassessment before procedures that require sedation or anesthesia.

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

Copyright 2024 The Joint Commission

Noncompliance Implications	Conducting a credible presedation or preanesthesia assessment is critical to identify at-risk patients and allows the procedural team to anticipate—and potentially reduce—sedation- and anesthesia-related adverse events. To ensure consistency, medical staff should define the minimum required elements of the preassessment. The required elements should be determined based on accepted standards of practice, national guidelines, guidance from professional organizations, and applicable law and regulation. After the required elements have been defined, physicians and other licensed practitioners performing the assessment must be educated on the requirements and deemed qualified to perform such an assessment. The organization may determine who is qualified by education, training, law, and regulation to complete a presedation assessment. However, a preanesthesia assessment, including monitored anesthesia care (MAC), must be completed and documented by an individual qualified to administer anesthesia.* The assessment should be accurately and thoroughly documented immediately after its completion to communicate identified risks to the procedural team. Just prior to sedation or anesthesia induction, an immediate reevaluation is required to confirm that the patient's status has not changed since the initial assessment. This reevaluation occurs immediately prior to (meaning without delay) administering moderate or deep sedation or general anesthesia. The organization determines the process, required elements, and any documentation for this reevaluation. Not reassessing patients just prior to receiving sedation or anesthesia creates risk for adverse events that can negatively affect patient outcomes. When anesthesia services are provided, such services should be incorporated into the organizationwide Quality Assurance and Performance Improvement (QAPI) activities (*see* Leadership [LD] Standard LD.01.03.01, EP 21†). Therefore, organizations are required to collect data on adverse events related to moderate or deep sedation or anesthesia (*see* Performance Improvement [PI] Standard PI.01.01.01, EP 5, on page 15 of this issue). Leaders should use this data (*see* LD.03.07.01‡) to identify and prioritize performance improvement activities related to anesthesia services.

* **US Centers for Medicare & Medicaid Services Condition of Participation §482.52(b)(1):** A preanesthesia evaluation completed and documented by an individual qualified to administer anesthesia, as specified in paragraph (a) of this section, performed within 48 hours prior to surgery or a procedure requiring anesthesia services.

† Standard **LD.01.03.01, EP 21**: **For hospitals that use Joint Commission accreditation for deemed status purposes:** The governing body is responsible for making sure that performance improvement activities reflect the complexity of the hospital's organization and services, involve all departments and services, and include services provided under contract. (For more information on contracted services, *see* Standard LD.04.03.09)

Note: ***For hospitals that use Joint Commission accreditation for deemed status purposes:*** *The hospital is not required to participate in a quality improvement organization (QIO) cooperative project, but its own projects are required to be of comparable effort.*

‡ Standard **LD.03.07.01**: Leaders establish priorities for performance improvement. (Refer to the "Performance Improvement" [PI] chapter.)

Copyright 2024 The Joint Commission

Provision of Care, Treatment, and Services) Standard PC.03.01.03: The hospital provides the patient with care before initiating operative or other high-risk procedures, including those that require the administration of moderate or deep sedation or anesthesia.	
EP 1: Before operative or other high-risk procedures are initiated, or before moderate or deep sedation or anesthesia is administered: The hospital conducts a presedation or preanesthesia patient assessment. R (*See also* RC.02.01.01, EP 2)	
Compliance Rate	In 2022, the noncompliance percentage for this EP was **20.44%**—that is, **309** of **1,512** hospitals surveyed did not comply with this requirement.

Surveyor Observations	**Guidance/Interpretation**
• A preanesthesia assessment was not performed. • There was no evidence that an airway assessment was performed as part of preanesthesia or presedation assessment as required by organization policy. • There was no documented American Society of Anesthesiologists (ASA) Classification as required by organization policy. • A preanesthesia assessment was not performed prior to an electroconvulsive therapy (ECT) procedure. • Preanesthesia assessment/evaluation did not contain the required elements as defined by organization policy or medical staff.	• Cite here, at Standard PC.03.01.03, EP 1, for all moderate/deep sedation or anesthesia cases that do not have a preassessment. • For deemed organizations: Cite at Standard PC.03.01.03, EP 18, if a preanesthesia assessment was performed, but not within 48 hours of the procedure. • A preanesthesia assessment for an ECT procedure is required because moderate/deep sedation is used. An airway assessment and ASA Classification are also considered standard practice. • Cite here for all moderate/deep sedation or anesthesia cases that lack evidence that a preassessment was completed. • A preanesthesia assessment is needed for an ECT due to the use of moderate/deep sedation. • An airway assessment and ASA Classification are considered standard practice. • Cite at Standard PC.01.02.01, EP 1,* for failure to define the minimum required elements of the preanesthesia assessment.

* Standard **PC.01.02.01, EP 1**: Ⓓ The hospital defines, in writing, the scope and content of screening, assessment, and reassessment. Patient information is collected according to these requirements. R

Note 1: *In defining the scope and content of the information it collects, the organization may want to consider information that it can obtain, with the patient's consent, from the patient's family and the patient's other care providers, as well as information conveyed on any medical jewelry.*

Note 2: *Assessment and reassessment information includes the patient's perception of the effectiveness of, and any side effects related to, their medication(s).*

(*See also* RC.02.01.01, EP 2)

Copyright 2024 The Joint Commission

EP 8: The hospital reevaluates the patient immediately before administering moderate or deep sedation or anesthesia. R (*See also* RC.02.01.01, EP 2)	
Compliance Rate	In 2022, the noncompliance percentage for this EP was **2.31%**—that is, **35** of **1,512** hospitals surveyed did not comply with this requirement.

Surveyor Observations	**Guidance/Interpretation**
• There was no evidence that the patient was reevaluated immediately prior to administering sedation or anesthesia.	• This assessment generally occurs after the patient is on the procedure table and just before initiating the sedation or anesthetic. • The organization determines the required elements of the reevaluation. • The organization determines who is qualified to perform the reevaluation in accordance with law and regulation (scope of practice).

EP 18: For hospitals that use Joint Commission accreditation for deemed status purposes: A preanesthesia evaluation is completed and documented by an individual qualified to administer anesthesia within 48 hours prior to surgery or a procedure requirements anesthesia services. R	
Compliance Rate	In 2022, the noncompliance percentage for this EP was **0.64%**—that is, **9** of **1,414** hospitals surveyed did not comply with this requirement.

Surveyor Observations	**Guidance/Interpretation**
• Although a preanesthesia assessment was performed prior to a procedure, it was not performed within 48 hours of said procedure. • Because the preanesthesia assessment form was not timed by the practitioner, there was no way to determine when the assessment was completed. • The preanesthesia assessment was completed by a registered nurse who was not qualified to administer anesthesia.	• This requirement applies only to the administration of deep sedation (MAC) and general anesthesia. • Because moderate sedation is not considered "anesthesia," it is not subject to this requirement. • For failure to conduct a presedation assessment, *see* PC.03.01.03, EP 1.

Performance Improvement (PI) Standard PI.01.01.01: The hospital collects data to monitor its performance.	
EP 5: Ⓓ The hospital collects data on the following: Adverse events related to using moderate or deep sedation or anesthesia. (*See also* LD.03.07.01, EP 2)	
Compliance Rate	In 2022, all surveyed hospitals complied with this requirement

Copyright 2024 The Joint Commission

Surveyor Observations	Guidance/Interpretation
● The organization did not collect data related to adverse events related to moderate or deep sedation or anesthesia.	● A process exists for collecting data on all adverse events related to sedation or anesthesia. ● When procedures involving anesthesia services are performed at more than one location, the process captures data from all locations. ● The organization determines how data will be collected, documented, tracked, and reported. ● The following are examples of potential adverse events: ❍ Using too much of a reversal agent ❍ Performing an unplanned rescue of a patient ❍ Managing pain and/or level of sedation during a procedure ineffectively

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 **December 2023** 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.

From the Editors

655 *The Joint Commission Journal on Quality and Patient Safety* Adds New Editors to Team

D. Shearer; D.W. Baker

The *Journal* announces recent changes to our editorial team.

Editorials

657 No More Useless Band-Aids that Fail to Solve America's Emergency Department Boarding Crisis

R.J. Cooper; D.L. Schriger

Emergency department (ED) boarding results in poor-quality care and patient harm, not just for the admitted patients waiting for an inpatient bed but for all patients seeking care in the ED. In this editorial in response to an article by Loke and colleagues in this issue of the *Journal*, Cooper and Schriger discuss the solutions that have been proposed and the need to address ED boarding as a problem with the US health system rather than at an organizational level.

660 Screening for Suicide Risk Is Predicting the Future, Not Diagnosing the Present

R.C. Rossom; G.E. Simon

Primary care clinics could provide an important setting for suicide prevention, but recommendations on whether to screen for suicide risk in primary care settings are mixed. In this editorial in response to an article by Bryan and colleagues in this issue of the *Journal*, Rossom and Simon discuss the utility of screening for suicide in primary care and whether there are effective interventions in place in these settings to reduce suicide in at-risk populations.

Copyright 2024 The Joint Commission

Health Care Worker Well-Being

663 Clinicians' Insights on Emergency Department Boarding: An Explanatory Mixed Methods Study Evaluating Patient Care and Clinician Well-Being

D.E. Loke; K.A. Green; E.G. Wessling; E.T. Stulpin; A.L Fant

Emergency department (ED) boarding is a long-standing yet increasingly common national quality and safety issue. In this study, Loke and colleagues surveyed ED attending physicians, resident physicians, advanced practice providers, and nurses to describe clinicians' insights into the quality and safety of patient care delivered to ED boarding patients, as well as clinician safety and satisfaction related to ED boarding.



671 A Proposed Approach to Allegations of Sexual Boundary Violation in Health Care

W.O. Cooper; J.J. Foster; G.B. Hickson; A.J.R. Finlayson; K. Rice; S. Sanchez; J.C. Smith; I. Dees; J. Adler

Sexual boundary violations in the health care setting cause tremendous harm for victims, threaten an organization's culture of safety and respect, and create financial and reputational risk for organizations. Inconsistent organizational responses can implicitly endorse behaviors and allow them to continue unchecked. In this study, Cooper and colleagues reviewed 100 reports of alleged violations to identify the essential elements of an ideal initial triage and management approach.

Adverse Events

680 Does Suicide Risk Screening Improve the Identification of Primary Care Patients Who Will Attempt Suicide Versus Depression Screening Alone?

C.J. Bryan; M.H. Allen; A.O. Bryan; C.J. Thomsen; J.C. Baker; A.M. May

The effectiveness of suicide risk screening relative to depression screening alone among primary care patients has not been tested rigorously. However, people who die by suicide are more than twice as likely to visit primary care than a mental health clinic, suggesting primary care as an important setting for identifying patients at risk for suicide. In this study, Bryan and colleagues compared the performance of multiple depression screening methods and multiple suicide risk screening methods in a convenience sample of primary care patients.

Process Improvement

689 Long-Term Sustainability and Adaptation of I-PASS Handovers

S.L. Ryan; M. Logan; X. Liu; D.M. Shahian; E. Mort

Inadequate communication during transitions of care is a major health care quality and safety vulnerability. In 2013 Massachusetts General Hospital (MGH) implemented a standardized handover system (IPASS) that had been shown to reduce adverse events by 30% even when not completely executed on each patient. In this cross-sectional study, Ryan and colleagues used interviews and observation to characterize handover practices six years after the adoption of I-PASS.

698 Improving Diabetes Screening in the Primary Care Clinic

E. Tseng; Y.-J. Hsu; C. Nigrin; J.M. Clark; J.A. Marsteller; N.M. Maruthur

The US Preventive Services Task Force recommends that adults aged 35 to 70 years with overweight or obesity be screened for prediabetes and type 2 diabetes, but only half of US adults meeting these criteria report having been screened. In this article, Tseng and colleagues report a two-phase intervention to increase the rate of diabetes screening among eligible patients at a suburban primary care clinic.

706 Key Strategies to Publishing Your Quality Improvement Work

R. Suttle; G. Armstrong; L. Headrick; R. Miltner; G. Ogrinc

The publication of quality improvement (QI) work is vital to the growth of QI knowledge, as dissemination advances the field of improvement science, improves the quality and safety of clinical care, guides the design of future improvement endeavors by building on lessons learned, and helps others avoid ineffective strategies. In this article, Suttle and colleagues describe key components of scholarly improvement work and provide tips for successfully writing up the work for publication.

Copyright 2024 The Joint Commission

Improvement Brief

712 Improving the Format, Content, and Writing Process of Outpatient Clinic Letters Within a Musculoskeletal Therapy Department

C. Horler; E. Eve; R. Turner

Outpatient clinic letters are an important aspect of outpatient health care, facilitating good communication between patient and health professionals and supporting patient-centered care. Horler and colleagues performed this health care improvement project to coproduce clinic letters that have meaning and relevance for key stakeholders, including therapists, general practitioners, and patients, in a musculoskeletal therapy department in southern England.

Innovation Report

716 Learning from Latent Safety Threats Identified During Simulation to Improve Patient Safety

K. Congenie; L. Bartjen; D. Gutierrez; L. Knepper; K. McPartlin; A. Pack; K. Sava; L. Smith; H. Watts

Latent safety threats (LSTs) are often discovered during simulation-based training. No standardized method exists for collecting, analyzing, and classifying LSTs. Building on a large simulation program in one organization, Congenie and colleagues describe a project to collect LSTs systematically and develop a taxonomy to classify them.

Sentinel Event Alert

724 *Sentinel Event Alert* 67: Preserving Patient Safety After a Cyberattack

The number of cyberattacks and information system breaches in health care has grown steadily, escalating from isolated incidents to widespread targeted and malicious attacks. The Joint Commission issued this *Sentinel Event Alert* to guide health care organizations in identifying and implementing mitigation and preparedness actions to reduce the disruption of services and functions and ensure patient safety in the case of a cyberattack.

Letter to the Editor

730 Survey of Perioperative Nurses Regarding Their Experience with Operating Room Fires

E. Mlaver; J. Sharma

Despite improvement efforts and dissemination of best practices, operating room (OR) fires continue to contribute to preventable perioperative morbidity. In this letter, Mlaver and Sharma aim to shed light on the experience of OR nurses with surgical fires, and their perceptions about fire safety in their institutions.

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

- New and revised Infection Prevention and Control (IC) requirements for **critical access hospitals** and **hospitals** (*see* page 2 in this issue for the full article)
- New and revised workplace violence prevention requirements for **behavioral health care and human services** organizations (*see* page 3 in this issue for the full article)
- New requirement to join the Joint Commission National Healthcare Safety Network group for **critical access hospitals** and **hospitals** (*see* page 5 in this issue for the full article)
- New and revised Emergency Management (EM) requirements for **ambulatory care** organizations and **office-based surgery practices** (*see* page 7 in this issue for the full article)
- Updated Post–Acute Care certification requirements for **nursing care centers** (*see* page 9 in this issue for the full article)
- Revised **Certified Community Behavioral Health Clinic** requirements for **behavioral health care and human services** organizations (*see* page 10 in this issue for the full article)
- Revised requirements for advanced disease-specific care **Total Hip and Total Knee Replacement** certification program (*see* page 11 in this issue for the full article)

CURRENTLY IN FIELD REVIEW

- Safe staffing requirements for **critical access hospitals** and **hospitals** (field review expected in early January)
- Revised restraint and physical hold requirements for **behavioral health care and human services** organizations (field review expected in early January)
- New and revised Infection Prevention and Control (IC) requirements for **assisted living communities** (field review expected in early January)

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 **laboratories**
- Revised core requirements for **all disease-specific care programs**
- New workplace violence prevention requirements for **home care** organizations

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

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 PolicySource™ E-books

Ensure that your policies and procedures comply with Joint Commission standards



The 2024 *PolicySource* e-books offer a collection of downloadable sample P&Ps that are organized by and correlated to Joint Commission standards to help you comply with accreditation requirements.

Currently available for Hospital/Critical Access Hospital; Behavioral Health Care and Human Services; Home Care; Ambulatory Care/Office-Based Surgery; Laboratory; and Nursing Care Center/Assisted Living Community.

Learn more at https://store.jcrinc.com/2024-policysource-pandps-for-compliance-with-joint-commission-requirements/

JCR is an expert resource for health care organizations, providing advisory services, educational services, software 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



Emergency Management Standards Base Camp and Emergency Management Conference

June 18-20, 2024

The Emergency Management Conference showcases responses to real life disasters and threats. Hear from Joint Commission experts to help you understand the related accreditation standards with EM.

Call for abstracts! Deadline for submission is February 16, 2024.
Submit here

Register now - Emergency Standards Base Camp
Register now - Emergency Management Conference

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.

Copyright 2024 The Joint Commission