Joint Commission Enhances Pain Assessment and Management Requirements for Accredited Hospitals

The Joint Commission announces the implementation of new and revised pain assessment and management standards, effective January 1, 2018, for its accredited hospitals. These new and revised requirements were developed through a rigorous research, evaluation, and review process.

In early 2016, The Joint Commission began conducting an extensive literature review on contemporary clinical guidelines and best practices for pain assessment and management, including safe opioid prescribing, in order to identify disparities between its current accreditation requirements and contemporary guidance. Following the literature review, staff convened a technical advisory panel of experts to discuss developments in the field of pain assessment and management. Staff’s next step was to conduct learning visits to research leading practices in pain assessment and management and the safe use of opioids.

The Joint Commission then convened a standards review panel to review draft pain assessment and management standards. (Standards review panel members, who are nominated from Joint Commission–accredited organizations or professional associations, are individuals who can provide a “boots-on-the-ground” point of view and give insights into the practical application of proposed standards.) Finally, the draft pain assessment and management standards were released for public comment in January 2017.

The enhanced pain assessment and management standards include the following new requirements:

- Identifying a leader or leadership team that is responsible for pain management and safe opioid prescribing
- Involving patients in developing their treatment plans and setting realistic expectations and measurable goals
- Promoting safe opioid use by identifying high-risk patients

Continued on page 3
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 STANDARDS
- New and revised pain assessment and management requirements for hospitals (see article on pages 1, 3, and 4 of this issue)
- Deletion of six EPs from the critical access hospital program (see article on page 5 of this issue)
- Revisions to requirements to advanced disease-specific care certification programs for acute stroke ready hospitals, primary stroke centers, and comprehensive stroke centers (see article on pages 11 and 14 of this issue)
- Revisions to clarify language of several behavioral health care requirements as part of program maintenance (see article on pages 12–14 of this issue)
- New “Medication Compounding” (MC) chapter for the home care program (see article on page 15 of this issue)
- Revisions to Environment of Care (EC) and Life Safety (LS) standards for the behavioral health care, laboratory, nursing care center, and office-based surgery practice programs to maintain alignment with Centers for Medicare & Medicaid Services (CMS) requirements (see article on page 15 of this issue)

CURRENTLY IN DEVELOPMENT STANDARDS
- Proposed further revisions to EC and LS standards for all accreditation programs to maintain alignment with CMS requirements
- Proposed new and revised requirements for all accreditation programs in response to the CMS Emergency Management Final Rule
- Proposed consolidations to requirements for the ambulatory care, behavioral health care, critical access hospital, home care, laboratory, nursing care center, and office-based surgery programs as Phase IV of the EP Review component of Project REFRESH
- Proposed revisions to the Medication Management standards for the ambulatory care, critical access hospital, hospital, and home care programs
- Proposed revisions to National Patient Safety Goal NPSG.15.01.01 on suicide prevention for the hospital and behavioral health care programs and proposed addition of NPSG.15.01.01 to the critical access hospital program
- Proposed revisions for deemed critical access hospitals to maintain alignment with CMS requirements
- Proposed revisions to requirements regarding swing beds for hospitals and critical access hospitals
- Proposed new and revised requirements for deemed home health organizations to meet new CMS requirements
- Proposed requirements for a new Thrombectomy-Capable Stroke Center Certification program
Joint Commission Enhances Pain Assessment and Management Requirements for Accredited Hospitals (continued)
Continued from page 1

- Monitoring high-risk patients
- Facilitating clinician access to prescription drug monitoring program databases
- Conducting performance improvement activities focusing on pain assessment and management to increase safety and quality for patients

The new and revised requirements shown below (new text is underlined and deleted text has strikethrough) will also be posted by the end of June on The Joint Commission website at https://www.jointcommission.org/standards_information/prepublication_standards.aspx. These revisions will be reflected in the fall 2017 E-dition® release for the Comprehensive Accreditation Manual for Hospitals (as well as the hard copy publications for 2018).

Questions may be directed to Trina Crow, RN, MJ, associate project director, Department of Standards and Survey Methods, The Joint Commission, at tcrow@jointcommission.org.

Joint Commission Enhances Pain Assessment and Management Requirements for Accredited Hospitals (continued)

Official Publication of Joint Commission Requirements

New and Revised Standards Related to Pain Assessment and Management

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Effective January 1, 2018

Leadership (LD)

Standard LD.04.03.13
Pain assessment and pain management, including safe opioid prescribing, is identified as an organizational priority for the hospital.

Elements of Performance for LD.04.03.13

1. The hospital has a leader or leadership team that is responsible for pain management and safe opioid prescribing and develops and monitors performance improvement activities. (See also PI.02.01.01, EP 19)

2. The hospital provides nonpharmacologic pain treatment modalities.

3. The hospital provides staff and licensed independent practitioners with educational resources and programs to improve pain assessment, pain management, and the safe use of opioid medications based on the identified needs of its patient population. (See also RI.01.01.01, EP 8)

4. The hospital provides information to staff and licensed independent practitioners on available services for consultation and referral of patients with complex pain management needs.

5. The hospital identifies opioid treatment programs that can be used for patient referrals.

6. The hospital facilitates practitioner and pharmacist access to the Prescription Drug Monitoring Program databases.

Note: This element of performance is applicable in any state that has a Prescription Drug Monitoring Program.

Medical Staff (MS)

Standard MS.03.01.03

The management and coordination of each patient’s care, treatment, and services is the responsibility of a practitioner with appropriate privileges.

Element of Performance for MS.03.01.03

2. The hospital educates all licensed independent practitioners on assessing and managing pain. (See also RI.01.01.01, EP 8)

Standard MS.05.01.01

The organized medical staff has a leadership role in organization performance improvement activities to improve quality of care, treatment, and services and patient safety.

Element of Performance for MS.05.01.01

18. The medical staff is actively involved in pain assessment, pain management, and safe opioid prescribing through the following:

- Participating in the establishment of protocols and quality metrics
- Reviewing performance improvement data

Continued on page 4
New and Revised Standards Related to Pain Assessment and Management (continued)

Provision of Care, Treatment, and Services (PC)

Standard PC.01.02.07
The hospital assesses and manages the patient's pain and minimizes the risks associated with treatment.

Elements of Performance for PC.01.02.07
1. The hospital conducts a comprehensive pain assessment that is consistent with its scope of care, treatment, and services and the patient’s condition. (See also PC.01.02.01, EP 2; RI.01.01.01, EP 8)
2. The hospital uses methods has defined criteria to screen, assess, and reassess pain that are consistent with the patient’s age, condition, and ability to understand.
3. The hospital reassesses and responds to the patient’s pain, based on its reassessment criteria screens patients for pain during emergency department visits and at the time of admission.
4. The hospital either treats the patient’s pain or refers the patient for treatment.

Note: Treatment strategies for pain may include pharmacologic and nonpharmacologic pain that are consistent with the patient’s age, condition, and ability to understand.

Performance Improvement

Standard PI.01.01.01
The hospital collects data to monitor its performance.

Element of Performance for PI.01.01.01
The hospital collects data on pain assessment and pain management including types of interventions and effectiveness.

Standard PI.02.01.01
The hospital compiles and analyzes data.

Elements of Performance for PI.02.01.01
18. The hospital analyzes data collected on pain assessment and pain management to identify areas that need change to increase safety and quality for patients.
19. The hospital monitors the use of opioids to determine if they are being used safely (for example, the tracking of adverse events such as respiratory depression, naloxone use, and the duration and dose of opioid prescriptions). (See also LD.04.03.13, EP 1)
Deletions for Distinct Part Units in Critical Access Hospitals

Effective September 24, 2017, The Joint Commission is deleting six elements of performance (EPs) from the Distinct Part Unit (DPU) standards for critical access hospitals. The deletions are designed to streamline the program so that it addresses only those requirements that crosswalk to the Centers for Medicare & Medicaid Services Hospital Conditions of Participation.

These six EPs will be deleted from the Leadership (LD), Medical Staff (MS), and Rights and Responsibilities of the Individual (RI) chapters. For reference, the text of each EP follows:

**Standard LD.04.01.05, EP 4**
For rehabilitation and psychiatric distinct part units in critical access hospitals: Staff are held accountable for their responsibilities.

**Standard LD.04.03.11, EP 5**
For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital measures the following components of the patient flow process:
- The available supply of patient beds
- The efficiency of areas where patients receive care, treatment, and services
- The safety of areas where patients receive care, treatment and services
- Access to support services

**Standard MS.01.01.01, EP 4**
For rehabilitation and psychiatric distinct part units in critical access hospitals: The medical staff bylaws, rules and regulations, and policies, the governing body bylaws, and the hospital policies are compatible with each other and are compliant with law and regulation.

**Standard RI.01.04.01, EP 1**
For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital informs the patient of the name of the physician, clinical psychologist, or other practitioner who has primary responsibility for his or her care, treatment, or services.

Note: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

**Standard RI.01.04.01, EP 2**
For rehabilitation and psychiatric distinct part units in critical access hospitals: The critical access hospital informs the patient of the name of the physician(s), clinical psychologist(s), or other practitioner(s) who will provide his or her care, treatment, and services.

Note: The definition of "physician" is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

This list of deletions will be posted by the end of June on The Joint Commission website at [https://www.jointcommission.org/standards_information/prepublication_standards.aspx](https://www.jointcommission.org/standards_information/prepublication_standards.aspx); they will no longer be part of the Comprehensive Accreditation Manual for Critical Access Hospitals as of the fall 2017 E-dition update and 2018 hard copy publications.

Questions may be directed to Laura Smith, MA, project director, Department of Standards and Survey Methods, The Joint Commission, at lsmith@jointcommission.org.

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**FSA Tool Temporarily Offline for July 2017 Standards Update**

Starting June 30, 2017, at 5:00 p.m. central time (CT), the Focused Standards Assessment (FSA) tool on the Intracycle Monitoring (ICM) Profile will be offline for the July 2017 standards update. The tool will resume July 10, 2017, at 9:00 p.m. CT. An extension date will be applied for accredited organizations with a scheduled ICM submission due date between July 1st and July 10th to allow additional time to review any changes made to standards displayed in the open FSA tool. The extension due date will be set to Monday, July 24, 2017.

Questions may be directed to your organization’s designated Account Executive at 630-792-3007.
Protecting Security and Confidentiality on Survey

The Joint Commission has the utmost concern for the security and safety of both surveyors and health care organizations. Security and confidentiality-related issues have increasingly been raised during survey—sometimes even before surveyors are permitted to begin the survey. The following practices are designed to protect the security and safety of organizations and surveyors during accreditation surveys and certification reviews.

- **Security Sign-In**—If signing in is a normal part of an organization’s security process for permitting visitors to enter the facility, surveyors will sign in as requested. For surveyor information beyond this requested sign-in step, however, organizations should refer to surveyors’ pictures and biographies—which are posted on the Joint Commission Connect™ secure extranet site—rather than asking to copy a surveyor’s driver’s license, Joint Commission badge, or any other form of identification.

- **Confidentiality Agreements**—Organizations that want surveyors to sign a confidentiality agreement must send the agreement to the Joint Commission Central Office for review in advance of the survey, as required by the accreditation and certification contract. Please note that asking an individual surveyor or reviewer to sign an agreement delays the survey and is unnecessary. The accreditation and certification contracts, along with the Business Associate Agreement between The Joint Commission and its customer organizations, bind individual surveyors and reviewers to confidentiality.

- **Access to Computer Systems**—If an organization requires a signed security agreement in order for surveyors to receive a user ID and password to access a computer system (for example, in order to review policies and medical records), surveyors will sign the agreement.

- **Videotaping Survey Activities**—The Joint Commission prohibits the recording or videotaping of any portion of a survey or review, including the exit conference.

Compliance with these practices is designed to foster a meaningful survey while ensuring the security and safety of surveyed organizations as well as surveyors and reviewers. Questions may be directed to your organization’s assigned Account Executive.

Consistent Interpretation

**Joint Commission Surveyors’ Observations on Standard MM.04.01.01, EPs 1 and 15**

The bimonthly Consistent Interpretation column is designed to support organizations in their efforts to comply with Joint Commission requirements. Each column draws from a de-identified database containing surveyors’ observations—as well as guidance from the Standards Interpretation Group on how to interpret the observations—on an element(s) of performance (EP) in the Comprehensive Accreditation Manual for Hospitals. This installation (the tenth in the series; the box at right lists the requirements previously featured in the column) highlights Medication Management (MM) Standard MM.04.01.01, EPs 1 and 15. **Note:** Interpretations are subject to change to allow for unique and/or unforeseen circumstances.

**EPs Previously Featured in “Consistent Interpretation” Column**

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<td>January 2017</td>
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<td>March 2017</td>
<td>LS.02.01.20, EP 1</td>
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<tr>
<td>May 2017</td>
<td>RI.01.03.01, EP 13</td>
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Understanding Key Changes to the Life Safety Standards

The Joint Commission has identified the need to increase the field’s awareness and understanding of the National Fire Protection Association’s (NFPA’s) Life Safety Code® *(NFPA 101-2012)*. To address this need, Perspectives publishes the column Clarifications & Expectations, authored by George Mills, MBA, FASHE, CEM, CHFM, CHSP, director, Department of Engineering, The Joint Commission. This column clarifies standards expectations and provides strategies for challenging compliance issues, primarily in life safety and the environment of care but also in the vital area of emergency management. You may wish to share the ideas and strategies in this column with your organization’s facilities leadership.

The Joint Commission has rewritten the “Life Safety” (LS) chapter to align with the 2012 edition of the Life Safety Code® (NFPA 101-2012) and Health Care Facilities Code (NFPA 99-2012), and it has made changes to the “Environment of Care” (EC) chapter as well. In September 2016, the US Centers for Medicare & Medicaid Services (CMS) issued K-Tags; in response, The Joint Commission created a second iteration of elements of performance (EPs) that it expects to publish in late 2017 or early 2018.

This column, the eighth installment in a series addressing the updated standards, focuses on protection at LS.02.01.30, EPs 1–7. This and all subsequent columns will address both the January 2017 EPs and proposed forthcoming EPs. These proposed EPs are still in draft form, pending edits and review, and may differ from their final language.

To distinguish the January 2017 EPs from the proposed EPs, the draft language for proposed forthcoming requirements appears in italics. EP language currently in effect does not appear in italics, except for explanatory notes.

**Understanding LS.02.01.30**

Standard LS.02.01.30 requires hospitals to provide and maintain building features to protect individuals from the hazards of fire and smoke. Fire and smoke are specific concerns to health care organizations, in which patients are often “incapable of self-preservation.” To provide protection for occupants, the *Life Safety Code®* requires methods to restrict movement of fire and smoke, often using compartmentation. Openings that are necessary, such as exit stairs; elevator shafts; heating, ventilating, and air conditioning (HVAC) systems; and trash or linen chutes require appropriate separation from occupied spaces.

Vertical Openings

If a building has more than one floor, it will have vertical openings. Some vertical openings—such as exit stairs (exit enclosures)—serve the means of egress (see Standard LS.02.01.20) to ensure safe patient movement. Other vertical openings may not contribute to the means of egress, but if properly designed, installed, and maintained, they serve utilities (such as pipe chases) or other needs (such as trash or linen chutes). Regardless of the benefits of a vertical opening, it must be separated from the occupied areas. Ensuring the integrity of fire-rated barriers and openings (see Standard LS.02.01.10) is critical in providing appropriate protection.

In an existing health care building, the fire-rating requirement for vertical openings is 1 hour. (See the sidebar on page 8 for examples of vertical openings.) The doors in these vertical openings must be rated for 1 hour. For new construction, rated barriers must be 1-hour fire rated when connecting three or fewer stories and 1½-hour fire rated when connecting four or more stories.

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*Life Safety Code®* is a registered trademark of the National Fire Protection Association, Quincy, MA.
CLARIFICATIONS AND EXPECTATIONS: Understanding Key Changes to the Life Safety Standards (continued)
Continued from page 7

**Vertical Openings**

Vertical openings include the following:
- Shafts, which includes elevator, light, and ventilation shafts
- Communicating stairs, which are stairs that connect one floor to another, are not part of an exit enclosure, and are separated from corridors
- Ramps, which are vertical openings without steps that connect one floor to another (Ramps must be enclosed with fire-rated barriers and protected as appropriate for the fire-resistance rating.)
- Trash and linen chutes, which terminate in a room that is separated from the rest of the building with the same fire-resistance rating as the chute
- Utility chases, which run utility systems vertically in the building

**Hazardous Areas**

Any area that is considered more hazardous than a general occupancy should be separated from the occupants. These areas are identified as hazardous areas. In both new and existing buildings, many spaces are considered hazardous. These spaces must have doors that are self-closing or that close automatically and latch. In existing buildings, doors in unsprinklered spaces must be rated for 45 minutes in a 1-hour enclosure. If the area is sprinkler protected, unrated doors and walls are acceptable. However, new construction requires the walls to be 1-hour construction.

The following are identified as hazardous areas for both new and existing buildings:

- Boiler and fuel-fired heater rooms
- Central/bulk laundries larger than 100 square feet
- Paint shops
- Soiled-linen rooms
- Trash collection rooms with containers exceeding 64 gallons
- Laboratories that use flammable or combustible materials that are deemed less than a severe hazard

The *Life Safety Code* uses different terminology for repair and maintenance areas in new buildings than in existing buildings. For new buildings, it uses the term “physical plant maintenance shop.” For existing buildings, it uses the term “repair shop.” These are also considered hazardous areas.

Storage rooms for both new and existing buildings that are greater than 50 square feet are considered hazardous. The required level of protection increases when a storage room is greater than 100 square feet; for these, doors must be rated for ¾ hour (including latching and self-closing devices), and walls must be 1-hour fire rated. Also, in new construction, laboratories are considered hazardous areas.

**Standards Connection**

**LS.02.01.30, EP TBD: Proposed for 2018**

Laboratories using quantities of flammable, combustible, or hazardous materials that are considered a severe hazard are in accordance with NFPA 101-2012: 8.7 and NFPA 99 requirements applicable to administration, maintenance, and testing. (For full text refer to NFPA 101-2012: 18/19.3.2.2; NFPA 99-2012: 15.4.)

**LS.02.01.30, EP 2**

All new hazardous areas have doors that are self-closing or automatic-closing, except for laboratories using flammable or combustible materials deemed less than a severe hazard and storage rooms greater than 50 square feet but less than 100 square feet that are used for storage of combustible material. Hazardous areas have a fire barrier with a 1-hour fire-resistant rating. These areas include, but are not limited to, boiler and fuel-fired heater rooms, central/bulk laundries larger than 100 square feet, paint shops, repair shops, soiled-linen rooms, trash collection rooms with containers exceeding 64 gallons, laboratories considered a severe hazard, and storage rooms larger than 100 square feet that contain combustible material. (For full text, refer to NFPA 101-2012: 18.3.2.1; 18.3.2.2; 18.3.2.3; 18.3.2.4; Table 18.3.2.1.)

**LS.02.01.30, EP 3**

All existing hazardous areas have doors that are self-closing or automatic-closing. These areas are protected by either a fire barrier with one-hour fire-resistant rating or an approved electrically supervised automatic sprinkler system. Hazardous areas include, but are not limited to, boiler and fuel-fired heater rooms, central/bulk laundries larger than 100 square feet, paint shops, repair shops, soiled linen rooms, trash collection rooms with containers exceeding 64 gallons, laboratories employing flammable or combustible materials deemed less than a severe hazard, and storage rooms greater than 50 square feet used for storage of equipment and combustible supplies. (For full text, refer to NFPA 101-2012: 19.3.2.1; 19.3.2.2; 19.3.2.3; 19.3.2.4.)
The current EP 2 (new construction) calls out laboratories that are considered severe hazards, whereas EP 3 (existing) is silent. To correct this issue, a new EP was created with reference to NFPA 99-2012 15.4 that requires compliance with NFPA 45-2011, Standard on Fire Protection for Laboratories Using Chemicals.

Cooking Areas

The Joint Commission rarely cites an NFPA reference in the body of an EP, but it happens in this EP because the requirements are many. Suppression, deactivation of fuel sources, smoke detection, and sprinkler protection are a few of these requirements. This EP allows cooking to occur in the corridor, with certain restrictions. Only one cooking station is allowed open to the corridor per smoke compartment, and solid fuels (such as charcoal) and deep-fat frying are prohibited.

Alcohol-Based Hand Rub Dispensers

For this requirement, The Joint Commission decided to restate information included in the Life Safety Code. Organizations should refer to the sections of the Life Safety Code that are referenced in EP 5 and accompanying notes. A proposed EP (see the box at the top of the next column) provides more detail on how alcohol-based hand rub (ABHR) dispensers should be stored and handled.

Dispensers must not be positioned or stored within 1 inch of an ignition source. The space is measured 1 inch to the left and right of the dispenser and from the floor to the ceiling in that restricted space. Examples of noncompliance would be if an electrical receptacle were directly below the dispenser or if another possible ignition source were directly above.

ABHR dispensers must be protected against inappropriate access. For example, in a behavioral health care unit, the patients may try to ingest the solution, so restricted access might be appropriate.

Interior Finishes

Interior finishes must not contribute to the spread of fire, the development of fire, and associated gases (such as smoke). Controlling these surface treatments minimizes the effects of smoke and gases. Polypropylene or high-density

Standards Connection

**LS.02.01.30, EP 4**
Where residential or commercial cooking equipment is used to prepare meals for less than 31 people in a smoke compartment, one cooking facility is permitted to be open to the corridor provided all criteria in NFPA 101-2012: 18/19.3.2.5.3 are met.

**LS.02.01.30, EP 5**
Installation and use of alcohol-based hand rub (ABHR) dispensers that are 95% or less alcohol content by volume are allowed in each smoke compartment as per NFPA 101-2012: 18/19.3.2.6.

**Note 1:** See The Joint Commission’s website (https://www.jointcommission.org/life_safety_code_information_resources/) for alcohol-based hand rub (ABHR) requirements.

**Note 2:** This element of performance reflects NFPA 101-2012: 18/19.3.2.6. For alternative guidelines on ABHR dispensers, see NFPA 101-2012: 8.7.3.1.

**LS.02.01.30, EP 6**
Existing wall and ceiling interior finishes are rated Class A or B for limiting smoke development and the spread of flames. Newly installed wall and ceiling interior finishes are rated Class A. (For full text, refer to NFPA 101-2012: 18/19.3.3; 10.2)
Consistent Interpretation (Continued)
Continued from page 6

Medication Management (MM) Standard MM.04.01.01: Medication orders are clear and accurate.
EP 1*: The hospital has a written policy that identifies the specific types of medication orders that it deems acceptable for use.

Note: There are several different types of medication orders. Medication orders commonly used include the following:

- As needed (PRN) orders: Orders acted on based on the occurrence of a specific indication or symptom
- Standing orders: A prewritten medication order and specific instructions from the licensed independent practitioner to administer a medication to a person in clearly defined circumstances
- Automatic stop orders: Orders that include a date or time to discontinue a medication
- Titrating orders: Orders in which the dose is either progressively increased or decreased in response to the patient's status
- Taper orders: Orders in which the dose is decreased by a particular amount with each dosing interval
- Range orders: Orders in which the dose or dosing interval varies over a prescribed range, depending on the situation or patient's status
- Orders for compounded drugs or drug mixtures not commercially available
- Orders for medication-related devices (for example, nebulizers, catheters)
- Orders for investigational medications
- Orders for herbal products
- Orders for medications at discharge or transfer

* In 2016 the noncompliance percentage for this requirement was 3.26% (that is, 47 hospitals out of 1,441 hospitals surveyed were out of compliance with this requirement).

<table>
<thead>
<tr>
<th>Surveyor Observations</th>
<th>Guidance/Interpretation</th>
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<tbody>
<tr>
<td>Range and double-range orders were observed in medical records, but the health care organization's medication order policy did not specifically address range orders.</td>
<td>There are no Joint Commission standards that prohibit a health care organization from including range or double-range orders in its policies (for example, “Morphine 2 mg to 4 mg every 4 to 6 hours pm pain”). Therefore, do not write Requirements for Improvement for such orders as long as they are permitted by the organization’s policy.</td>
</tr>
<tr>
<td>The health care organization’s medication order policies were not comprehensive in that they did not define the necessary elements for a complete titration medication order.</td>
<td>Cite here only if the written policy for medication orders is not comprehensive. If the policy is comprehensive but not followed, cite at Standard MM.04.01.01, EP 13 on implementing policies for medication orders. See also “Ordering and Implementing Medication Titration Orders Safely,” May 2017 Perspectives, page 26.</td>
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</table>
EP 15†: For hospitals that use Joint Commission accreditation for deemed status purposes: Processes for the use of pre-printed and electronic standing orders, order sets, and protocols for medication orders include the following:

- Review and approval of standing orders and protocols by the medical staff and the hospital’s nursing and pharmacy leadership
- Evaluation of established standing orders and protocols for consistency with nationally recognized and evidence-based guidelines
- Regular review of such standing orders and protocols by the medical staff and the hospital’s nursing and pharmacy leadership to determine the continuing usefulness and safety of the standing orders and protocols
- Dating, timing, and authenticating of standing orders and protocols by the ordering practitioner or another practitioner responsible for the patient’s care in accordance with professional standards of practice; law and regulation; hospital policies; and medical staff bylaws, rules, and regulations.

† In 2016 the noncompliance percentage for this requirement was 5.89% (that is, 79 hospitals out of 1,341 hospitals surveyed were out of compliance with this requirement).

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<thead>
<tr>
<th>Surveyor Observations</th>
<th>Guidance/Interpretation</th>
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<tbody>
<tr>
<td>There was no evidence that the protocol implemented for sliding scale insulin had been approved by the required individuals.</td>
<td>This EP is specific to the process for reviewing, approving, and using protocols, order sets, preprinted orders, and so on.</td>
</tr>
<tr>
<td>There was no evidence that the protocol implemented for the administration of vasoactive medications had been approved by pharmacy leadership.</td>
<td>If the protocol is not part of the permanent patient record, cite Provision of Care, Treatment, and Services (PC) Standard PC.02.01.03, EP 1 on obtaining/renewing orders in accordance with professional standards of practice; law and regulation; hospital policies; and medical staff bylaws, rules, and regulations.</td>
</tr>
<tr>
<td>There was no evidence that the postoperative order set used for joint replacement procedures had been approved by the required individuals.</td>
<td>If the protocol is part of record but not authenticated by the provider within the health care organization’s defined time frame, cite Record of Care, Treatment, and Services (RC) Standard RC.01.02.01, EP 4 on authenticating entries in the medical record.</td>
</tr>
<tr>
<td>There was no defined process or frequency in place for the regular review of protocols, order sets, preprinted orders, and so on.</td>
<td>For failure to review/approve imaging protocols, cite Standard PC.01.03.01, EPs 25 and 26 on establishing, reviewing, and updating diagnostic computed tomography imaging protocols.</td>
</tr>
</tbody>
</table>

Revisions to Advanced Stroke Certification Programs Effective January 1, 2018

To provide clarity and consistency among its advanced stroke certification programs for accredited hospitals, The Joint Commission has identified requirements in the Acute Stroke Ready, Primary Stroke Center, and Comprehensive Stroke Center certification programs that require revisions. All revisions are editorial in nature and do not change the original intent of the requirements. Revisions were made in the following ways:

- Moved requirements that apply across stroke certification programs so that they are now located at the same standard and element of performance within each program
- Deleted redundant requirements
- Revised requirements or added notes for clarification

Revisions for these advanced disease-specific care certification program requirements become effective January 1, 2018, and will be posted by the end of June on The Joint Commission website at http://www.jointcommission.org/standards_information/prepublication_standards.aspx. The revisions will also be published in the fall 2017 E-dition®.
**APPROVED:** Phase II Revisions to Update Behavioral Health Care Requirements

The Joint Commission has completed its two-phase review of the Comprehensive Accreditation Manual for Behavioral Health Care (CAMBHC) and identified a number of standards requiring maintenance. This review project involved clarifying existing language, adding new elements of performance (EPs), and revising notes.

The previously announced Phase I revisions (see the January 2017 Perspectives, pages 8 and 9) are effective July 1, 2017. Phase II revisions, which are effective January 1, 2018, consist of the following:

- A new EP has been added to Care, Treatment, and Services (CTS) Standard CTS.02.01.03 that requires organizations to gather health information (as relevant to the individual’s current care, treatment, or services) from other providers.
- Standard CTS.02.01.11, EP 1 has been revised to include a component about eating disorders. In addition, the note has been removed from the standard.
- New Standard CTS.04.03.20 has been added to address the supervision of individuals served and applies to organizations providing an inpatient/24-hour crisis stabilization setting.
- Standard CTS.05.05.09, EP 1 has been revised for clarity.
- Standard CTS.05.05.09, EP 5 has been deleted. Because it was out of place in the CTS chapter, the requirement to document physical holding of a child/youth in the clinical/case record is now addressed in the “Record of Care, Treatment, and Services” (RC) chapter at Standard RC.02.01.05.
- The note at Standard CTS.05.05.11, EP 1 has been revised to include sensory modulation as an example.
- A new EP has been added to Standard CTS.05.05.21 that addresses written policies and procedures regarding initiation of physical holding of a child/youth by an authorized staff member. This change aligns the standard with the revision to Standard CTS.05.05.09, EP 1.
- The note at Standard CTS.05.06.09, EP 1 has been revised to include additional information regarding nonphysical techniques for managing behaviors of individuals served.
- A new EP has been added to Standard CTS.05.06.35 that requires organizations to add details about debriefing to their written policies and procedures regarding restraint or seclusion.
- Language referencing physical holding of a child/youth has been added to Standard RC.02.01.05, and new EPs 5 and 6 detail what should be included in the clinical/case record regarding the physical holding.

These revisions are shown below (new text is underlined and deleted text is shown with strikethrough) and will be posted by the end of June on The Joint Commission website at http://www.jointcommission.org/standards_information/prepublication_standards.aspx. The revisions will be published in the fall 2017 E-dition® release for the Comprehensive Accreditation Manual for Behavioral Health Care as well as the hard copy publications for 2018.

Questions may be directed to Lynn Berry, MLA, project director, Department of Standards and Survey Methods, The Joint Commission, at lberry@jointcommission.org.
Phase II Maintenance Revisions to Behavioral Health Care Requirements (continued)

5-6. For acute 24-hour settings: A qualified, licensed independent practitioner is responsible for determining the degree of assessment and care for each individual treated in an emergency care area.

Note: “Acute 24-hour settings” includes inpatient crisis stabilization or medical detoxification.

6-7. For opioid treatment programs: Patients receive a comprehensive evaluation that covers the following, based on the patient’s condition and needs: medical, psychosocial, vocational, educational, behavioral, family, financial, legal, health, and self-care needs.

Note: For patients receiving interim maintenance treatment, the program is not required to provide rehabilitative, education, and other counseling services to the patient.

7-8. For opioid treatment programs: The comprehensive evaluation is conducted by one or more disciplines within approximately 30 days of admission or earlier when necessary.

Standard CTS.02.01.11
The organization screens all individuals served for their nutritional status.

Note: Triggers for a nutritional assessment may include a weight loss or weight gain of 10 pounds or more in the past three months, a change in appetite, dental problems, noncompliance with a special diet, and food allergies. (Refer to CTS.02.03.09, EP 1 for more information)

Element of Performance for CTS.02.01.11
1. The organization screens all individuals served to identify those for whom a nutritional assessment is indicated. At a minimum, the screening includes questions about the following:
   - Food allergies
   - Weight loss or gain of ten pounds or more in the last three months
   - Decrease in food intake and/or appetite
   - Dental problems
   - Eating habits or behaviors that may be indicators of an eating disorder, such as bingeing or inducing vomiting

Standard CTS.04.03.20
For inpatient crisis stabilization: The organization supervises individuals served as needed.

Elements of Performance for CTS.04.03.20
1. For inpatient crisis stabilization: The organization supervises the daily activities of individuals served as needed to prevent them from engaging in behavior that could be detrimental to their health.

2. For inpatient crisis stabilization: Supervision is conducted by staff; the organization prohibits one individual served from supervising another.

Standard CTS.05.05.09
For organizations that use physical holding on a child or youth: Physical holding of children and youth is used in a safe manner.

Elements of Performance for CTS.05.05.09
1. For organizations that use physical holding on a child or youth: The authorization to initiate physical holding is initiated by an authorized staff member in accordance with law and regulation and organization policy.

5. For organizations that use physical holding on a child or youth: The physical holding of the child or youth is documented in the clinical case record.

Standard CTS.05.5.11
For organizations that use physical holding on a child or youth: Nonphysical techniques are the preferred intervention in managing behaviors of children and youth.

Element of Performance for CTS.05.05.11
1. For organizations that use physical holding on a child or youth: Whenever possible, the organization uses nonphysical techniques in managing behaviors of children and youth.

Note: Such interventions techniques may include implementing a crisis response plan, redirecting the focus of the child or youth, employing verbal de-escalation and positive behavioral support, or using sensory modulation.

Standard CTS.05.05.21
For organizations that use physical holding on a child or youth: The organization’s policies and procedures address the prevention of the use of physical holding and, when employed, guide its use.

Elements of Performance for CTS.05.05.21
For organizations that use physical holding on a child or youth: The organization has written policies and procedures regarding physical holding that include details about the following:

7-10. Debriefing.

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Phase II Maintenance Revisions to Behavioral Health Care Requirements (continued)

40.11. Reporting injuries and deaths to the organization’s leadership and appropriate external agencies consistent with applicable law and regulation.

42.12. Documentation of physical holding.

42.13. Data collection and the integration of physical holding into performance improvement activities.

Standard CTS.05.06.09
For organizations that use restraint or seclusion: Non-physical techniques are the preferred intervention in managing behaviors of individuals served.

1. For organizations that use restraint or seclusion:
   Whenever possible, the organization uses nonphysical techniques in managing behaviors of individuals served.

   Note: Such interventions may include implementing a crisis response plan, redirecting the focus of the individual served, or employing verbal de-escalation and positive behavioral support, or using sensory modulation.

Standard CTS.05.06.35
For organizations that use restraint or seclusion: Organization policies and procedures address prevention of restraint and seclusion and, when employed, guide their use.

Element of Performance for CTS.05.06.35
18. For organizations that use restraint or seclusion:
   The organization has written policies and procedures regarding restraint or seclusion that include details about the following: Debriefing.

Record of Care, Treatment, and Services (RC)

Standard RC.02.01.05
The clinical/case record contains documentation of the use of restraint and/or seclusion and documentation of physical holding of a child or youth.

Elements of Performance for RC.02.01.05
5. The organization documents the use of physical holding of a child or youth for behavioral health purposes in the clinical/case record, including the following:
   - Each episode of physical holding
   - The circumstances that led to the use of physical holding
   - Attempt at or failure of nonphysical interventions
   - The rationale for the use of physical holding
   - Names of the staff members who participated in the use of physical holding, including who did the holding and who observed the child’s or youth’s physical well-being
   - Any preexisting medical conditions or any physical disabilities that would place the individual served at greater risk during physical holding
   - Any history of sexual or physical abuse or other trauma that would place the individual at greater psychological risk during physical holding
   - That the individual served and/or his or her family was informed of the organization’s policy on the use of physical holding
   - That the individual’s parent(s) or guardian was notified of the use of physical holding
   - Behavior criteria for discontinuing physical holding
   - That the individual served was informed of the behavior criteria he or she needed to meet in order for physical holding to be discontinued
   - Assistance provided to the individual served to help him or her meet the behavior criteria for discontinuing the use of physical holding
   - Debriefing the individual served with staff following an episode of physical holding
   - Any injuries the individual served sustained and the treatment for these injuries
   - The death of the individual served while in a physical hold

6. The method(s) used to document physical holding facilitates the collection and analysis of data for performance improvement activities.

Revisions to Advanced Stroke Certification Programs Effective January 1, 2018 (continued)
Continued from page 11

For more information, please contact Tabitha Vieweg, RN, MBA, associate project director, Department of Standards and Survey Methods, The Joint Commission, at tvieweg@jointcommission.org.
New “Medication Compounding” Chapter for Home Care Manual

Effective January 1, 2018, The Joint Commission will implement a new “Medication Compounding” (MC) standards chapter in the Comprehensive Accreditation Manual for Home Care. These requirements will apply to all compounding pharmacies seeking initial accreditation or triennial reaccreditation. These standards were adapted from The Joint Commission’s Medication Compounding Certification requirements and align with current United States Pharmacopeial Convention (USP®) requirements for sterile and nonsterile preparations.

These new standards will augment current Home Care–Pharmacy accreditation requirements and meet the needs ofJoint Commission–accredited customers for a more focused and specialized evaluation of pharmacy compounding practices. The chapter is divided into five sections:

1. General Responsibilities
2. Education, Training, and Evaluation
3. Compounding Sterile Preparations
4. Compounding Sterile and Nonsterile Preparations
5. Compounding Nonsterile Preparations

Because it is known that microbial contamination of compounded sterile preparations occurs through direct contact or exposure to moisture or particles in the air generated by personnel, objects, or other mechanisms, the standards focus on the following areas:

- **People**—Training, competency, proper use of personal protective equipment, aseptic technique
- **Product**—Sterility of base products, beyond-use dates, labeling
- **Environment**—Airflow, buffer areas, guidelines for cleaning and documentation, storage

The “Medication Compounding” chapter standards will be posted by the end of June on The Joint Commission website at https://www.jointcommission.org/standards_information/prepublication_standards.aspx. In addition, the chapter will be included in the fall 2017 E-dition® release for the Comprehensive Accreditation Manual for Home Care (as well as the hard copy publications for 2018).

Questions may be directed to Kathy Clark, MSN, RN, associate project director specialist, Department of Standards and Survey Methods, at kclark@jointcommission.org.

Revisions Continue for Life Safety and Environment of Care Chapters

Ongoing revisions—a result of the Centers for Medicare & Medicaid Services (CMS) adoption of the 2012 editions of the National Fire Protection Association’s NFPA 101: *Life Safety Code* and NFPA 99: *Health Care Facilities Code*—continue for the “Life Safety” (LS) and “Environment of Care” (EC) chapters. In addition to those revisions previously announced in *Perspectives* (see the November 2016 issue, page 7, and the April 2017 issue, page 18), The Joint Commission has revised a number of other EC and LS requirements for the behavioral health care, laboratory, nursing care center, and office-based surgery practice programs.

The additional revisions to the LS and EC chapters include new, revised, and relocated elements of performance (EPs) that address topics such as the following:

- Testing of emergency lighting systems
- Inspection and testing of piped medical gas and vacuum systems
- Updating pertinent NFPA code numbering in references
- Adding more specificity to existing EPs

These changes are effective January 1, 2018, and will be posted by the end of June on The Joint Commission website at http://www.jointcommission.org/standards_information/prepublication_standards.aspx. The revisions will also be reflected in the fall 2017 E-dition® release and the 2018 hard copy publications of the Comprehensive Accreditation Manuals for the respective programs.

Questions may be directed to Kenneth A. Monroe, PE, MBA, CHC, PMP, associate project director, Department of Standards and Survey Methods, The Joint Commission, at kmonroe@jointcommission.org.
Joint Commission Clarifies Four Life Safety Requirements

The Joint Commission is revising its Life Safety (LS) standards to align with the 2012 edition of the National Fire Protection Association’s *Life Safety Code™* (NFPA 101-2012). As part of that process, The Joint Commission has clarified the following four elements of performance (EPs), effective immediately:

1 **Emergency Department Occupancy Classification (LS.02.01.10, EP 1; LS.03.01.10, EP 1):**

   Emergency departments could be classified as health care occupancies or ambulatory health care occupancies.

   Pursuant to NFPA 101-2012 18/19.1.1.1.5 and 18/19.1.1.1.9, facilities that provide sleeping accommodations for persons who are mostly incapable of self-preservation or provide housing on a 24-hour basis for occupants are classified as health care occupancies.

   Per NFPA 101-2012, 3.3.188.1, an ambulatory health care occupancy is used to provide services or treatment simultaneously to four or more patients and provides, on an outpatient basis, one or more of the following:

   - Treatment for patients that renders the patients incapable of taking action for self-preservation under emergency conditions without the assistance of others
   - Anesthesia that renders patients incapable of taking action for self-preservation under emergency conditions without the assistance of others
   - Emergency or urgent care for patients who, due to the nature of their injury or illness, are incapable of taking action for self-preservation under emergency conditions without the assistance of others

2 **Annual Door Inspection (EC.02.03.05, EP 25):**

   The Joint Commission requires annual inspection and testing for fire doors and smoke door assemblies per NFPA 80-2010, *Standard for Fire Doors and Other Opening Protectives*, NFPA 105-2010, *Standard for Smoke Door Assemblies and Other Opening Protectives*, and NFPA 101-2012 Section 7.2.1.15. Annual inspection and testing must be completed by July 5, 2017, which is one year after the US Centers for Medicare & Medicaid Services (CMS) regulatory adoption of NFPA 101-2012. Although the health care and ambulatory chapters of NFPA 101-2012 do not specifically cite 7.2.1.15, Section 18/19.2.2.2.1 refers to 7.2.1. Also, both CMS and The Joint Commission believe that these door inspections are beneficial to the ongoing reliability of the organization’s fire protection program.

   Corridor doors that are not required to be fire doors or smoke door assemblies (for example, patient room doors) are not subject to the NFPA annual inspection and testing but should be routinely inspected as part of the organization’s facilities maintenance program.

   Doors to be included in the annual door inspection (based on 7.2.1.15) include the following:

   - Doors equipped with panic hardware or fire exit hardware in accordance with 7.2.1.7
   - Door assemblies in exit enclosures
   - Electrically controlled egress doors
   - Door assemblies with special locking arrangements subject to 7.2.1.6

   The Joint Commission does not require the following doors to be included in the annual door inspection:

   - Corridor doors (for example, patient room doors)
   - Office doors (provided that the room does not contain flammable or combustible materials)

3 **Rated Fire Door Assemblies Installed in Lesser-Rated or Nonrated Barriers (LS.01.01.01, EP 6; EC.02.03.05, EP 25):**

   If the organization has doors that are “superior quality, strength, fire resistance” (see NFPA 101-2012, Section 1.4), they are allowed in the assembly.

   Per NFPA 101-2012, Section 4.6.12.3, existing fire protection features obvious to the public, if not required by the code, shall be either maintained or removed. Therefore, doors shall be maintained as per the barrier assembly requirements, but in cases where a fire-rated door is used in a nonrated barrier assembly, the fire door must be maintained as a fire door unless the features that identify it as a fire door have been removed in a manner that maintains the opening protective requirements applicable to the barrier into which it is installed.

   - If a 90-minute fire-rated door were installed in an existing smoke barrier, the door would need to be annually inspected and tested as a fire door and the smoke barrier maintained as a smoke barrier.
   - If the 90-minute door were modified to remove all fire door hardware (such as the bottom rod and floor receiver) and labeling and repaired as a smoke barrier door (see NFPA
New Performance Measures for Advanced Certification in Total Hip and Total Knee Replacement

The Joint Commission recently finalized performance measures for Total Hip and Total Knee Replacement (THKR) Certification (an advanced disease-specific care certification available to Joint Commission–accredited hospitals, critical access hospitals, and ambulatory surgery centers). Data collection for the new measures will be mandatory effective January 1, 2018, for all currently THKR-certified programs as well as those seeking initial certification.

Nearly 700,000 total hip and total knee replacements are performed each year—with the demand expected to quadruple by 2030—placing these procedures among the most common surgeries performed in the United States. For the most part, these surgeries are highly successful; however, according to the Centers for Medicare & Medicaid Services, there is significant variance in the quality and cost of care for these surgeries.

To select performance measures for development, The Joint Commission worked with a technical advisory panel that included experts in orthopedic surgery, anesthesia, rehabilitative medicine, internal medicine, physical therapy, perioperative nursing, social work, and joint program administration. These measures were then posted for public comment. The final four THKR measures address patients undergoing a total hip or a total knee replacement in the inpatient or outpatient setting and comprise the following:

- THKR-1 Regional Anesthesia
- THKR-2 Postoperative Ambulation on the Day of Surgery
- THKR-3 Discharged to Home
- THKR-4 Preoperative Functional/Health Status Assessment

Programs will be required to collect monthly data for the four standardized measures and report the data on a quarterly basis to The Joint Commission via the Certification Measure Information Process (CMIP) on the secure Joint Commission Connect™ extranet site.

Measure specifications for the four mandatory THKR measures are detailed in the Advanced Certification in Total Hip and Total Knee Replacement Performance Measurement Implementation Guide. This guide will be available in July on The Joint Commission website at https://www.jointcommission.org/certification/adv_cert_total_hip_total_knee_replacement.aspx.

Questions may be directed to Marilyn Parenzan, MBA, RHIA, CPHQ, associate project director, Department of Quality Measurement, The Joint Commission, at mparenzan@jointcommission.org.

Revisions Announced for Comprehensive Stroke Center Measures

Effective January 1, 2018, The Joint Commission will implement changes to the performance measure requirements for Comprehensive Stroke Center (CSTK) Certification. Changes include the suspension of CSTK-02 and the addition of CSTK-10, CSTK-11, and CSTK-12 (see sidebar in left column on page 18 for CSTK measures), resulting in 10 mandatory comprehensive stroke measures (in addition to the eight [STK] measures) for meeting performance measure requirements.

CSTK-02, CSTK-10, and Modified Rankin Score

The Joint Commission is converting CSTK-02—Modified Rankin Score (mRS) at 90 Days from a process to an outcome measure that captures the percentage of ischemic stroke patients treated with a reperfusion therapy (IV or IA thrombolytic [tPA] therapy or mechanical reperfusion [MER] therapy) and have a good outcome (mRS 0, 1, or 2) at 90 days. The mRS (see table in right column on page 18) is a commonly used scale for measuring the degree of disability or dependence in the daily activities of people who have suffered a stroke or other cause of neurological disability. It has become the most widely used clinical outcome measure for stroke clinical trials.

Originally intended as an outcome measure, the design of CSTK-02 was modified prior to its 2015 implementation to focus on the process of obtaining score data 90 days after the patient’s discharge from the hospital. Comprehensive Stroke Centers now have processes in place to collect 90-day mRS scores.

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Revisions Announced for Comprehensive Stroke Center Measures (continued)
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Comprehensive Stroke (CSTK) Measures

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</table>

These robust measures of mechanical reperfusion effectiveness are designed to bridge the performance gap between CSTK-07—Median Time to Revascularization and CSTK-09—Arrival Time to Skin Puncture.


The CSTK measures were developed for the management of both ischemic and hemorrhagic stroke patients in hospitals equipped with the clinical expertise, infrastructure, and specialized neurointerventional and imaging services needed to provide the next level of stroke care. Questions may be directed to https://manual.jointcommission.org.

CSTK-11, CSTK-12, and Timeliness of Reperfusion

Also effective January 1, 2018, the CSTK measures will include the new CSTK-11—Timeliness of Reperfusion: Arrival Time to TICI 2B or Higher and CSTK-12—Timeliness of Reperfusion: Skin Puncture to TICI 2B or Higher.

data with aggregate performance nearing 90%. Therefore, effective January 1, 2018, CSTK-10—Modified Rankin Score (mRS) at 90 days: Favorable Outcome will be added to the CSTK measures and the CSTK-02 process measure will be suspended.

Joint Commission Clarifies Four Life Safety Requirements (continued)
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105-2010, 5.1.4), the door could be annually inspected and tested as a smoke door.

4 Fire Drills (EC.02.03.03, EP 3):

Fire drills conducted no closer than one hour apart would be acceptable. However, drills must be performed under varying conditions, per 18/19.7.1.6, so there should not be a pattern of drills being conducted one hour apart.

This article also appears in the July 2017 issue of Environment of Care® News.
This issue of Perspectives showcases the June 2017 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 http://www.jointcommissionjournal.com/.

265 Knowing, and Doing: Closing the Gaps in Board Leadership for Improvement of Quality and Safety—J.L. Reinertsen

The gap between what boards (and CEOs) know and what they should know is substantial; the gap between what they do and what they should do is even greater.

267 Closing the Gap and Raising the Bar: Assessing Board Competency in Quality and Safety—P.A. McGaffigan, B.D. Ullem, T.K. Gandhi

In a survey on quality and safety practices, knowledge, and understanding, 80% and 84% of health care organization board members and CEOs, respectively, ranked patient safety and/or quality as their "number one" strategic priority. In contrast, a smaller percentage of each group reported that patient safety events or dashboard measures were discussed at all board meetings.


Lean principles were used to rapidly and sustainably transform clinical operations in a freestanding behavioral health facility providing crisis services and emergency psychiatric care to adults and children. Organizational changes such as the development of shift leads and daily huddles were implemented to sustain change and create an environment supportive of future improvements.

284 Introductions During Time-outs: Do Surgical Team Members Know One Another’s Names?—D.J. Birnbach, I.F. Rosen, M. Fitzpatrick, J.T. Paige, K.L. Arheart

Introductions are the first item of the time-out in the World Health Organization Surgical Safety Checklist (SSC). All operating room (OR) personnel at the three teaching hospitals of a large academic medical center were individually interviewed at the end of 25 surgical cases in which the SSC was used. For example, 147 (98%) of the 150 OR personnel named the surgery attending correctly, while the surgery attending named only 44% of other OR staff (p < 0.001).


To help determine how organizations monitor rapid response teams (RRTs), interviews were conducted with 27 nurse executives and key informants at 15 300-to-500-bed hospitals in the southcentral United States. All of the hospitals monitored patient outcomes in the context of the RRT and perceived positive influences of the RRT on the health care team.


The Michigan Anticoagulation Quality Improvement Initiative (MAQI²), a consortium of six anticoagulation management services, performs root cause analyses (RCAs) for patients with major bleeds or thromboembolic events. Most (55 [80%]) of the 69 RCA cases were due to patient-related issues, suggesting the need for more effective patient education.

308 An Organizational Framework to Reduce Professional Burnout and Bring Back Joy in Practice—S.J. Swensen, T. Shanafelt

To reduce professional burnout and bring back Joy in Practice, the authors explain how leaders can take six evidence-based actions.
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