The Joint Commission
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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 Joint Commission

Joint Commission Resources

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

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In Sight

This column lists developments and potential revisions that can affect accreditation and certification and tracks proposed changes before they are implemented. Items may drop off this list before the approval stage if they are rejected at some point in the process.

APPROVED

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. P

Joint Commission Requirement

Official Publication of Joint Commission Requirements

New and Revised Standards Related to Pain Assessment and Management

APPLICABLE TO HOSPITALS

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 database, whether querying is voluntary or is mandated by state regulations for all patients prescribed opioids.*
7. Hospital leadership works with its clinical staff to identify and acquire the equipment needed to monitor patients who are at high risk for adverse outcomes from opioid treatment. (*See also* PC.01.02.07, EP 6)

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).~~ R

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

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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)~~ R

~~2.~~ 1. Ⓓ 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. R

~~3.~~ 2. 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. R

~~4.~~ 3. The hospital ~~either~~ treats the patient's pain or refers the patient for treatment.

Note: *Treatment strategies for pain may include ~~pharmacologic and nonpharmacologic~~ nonpharmacologic, pharmacologic, or a combination of approaches. ~~Strategies should reflect a patient-centered approach and consider the patient's current presentation, the health care providers' clinical judgment, and the risks and benefits associated with the strategies, including potential risk of dependency, addiction, and abuse.~~*

4. Ⓓ The hospital develops a pain treatment plan based on evidence-based practices and the patient's clinical condition, past medical history, and pain management goals.

5. Ⓓ The hospital involves patients in the pain management treatment planning process through the following:

- Developing realistic expectations and measurable goals that are understood by the patient for the degree, duration, and reduction of pain
- Discussing the objectives used to evaluate treatment progress (for example, relief of pain and improved physical and psychosocial function)
- Providing education on pain management, treatment options, and safe use of opioid and non-opioid medications when prescribed (*See also* RI.01.02.01, EPs 6–8; RI.01.03.01, EP 6)

6. The hospital monitors patients identified as being high risk for adverse outcomes related to opioid treatment. (*See also* LD.04.03.13, EP 7)

7. Ⓓ The hospital reassesses and responds to the patient's pain through the following:

- Evaluation and documentation of response(s) to pain intervention(s) (*See also* RC.01.01.01, EP 7)
- Progress toward pain management goals including functional ability (for example, ability to take a deep breath, turn in bed, walk with improved pain control)
- Side effects of treatment
- Risk factors for adverse events caused by the treatment

8. Ⓓ The hospital educates the patient and family on discharge plans related to pain management including the following:

- Pain management plan of care
- Side effects of pain management treatment
- Activities of daily living, including the home environment, that might exacerbate pain or reduce effectiveness of the pain management plan of care, as well as strategies to address these issues
- Safe use, storage, and disposal of opioids when prescribed

Performance Improvement

Standard PI.01.01.01

The hospital collects data to monitor its performance.

Element of Performance for PI.01.01.01

56. 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 MS.03.01.01, EP 3
For rehabilitation and psychiatric distinct part units in critical access hospitals: Licensed independent practitioners are responsible for the oversight activities of the organized medical staff.

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; 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.

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.

Security and confidentiality-related issues have increasingly been raised during survey—sometimes even before surveyors are permitted to begin the survey.

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

Perspectives Issue	Featured EP(s)
January 2016	PC.02.01.11, EP 2
March 2016	EC.02.06.01, EP 1
May 2016	PC.02.01.03, EPs 1, 7, and 20
July 2016	MM.03.01.03, EPs 1–3
September 2016	PC.01.02.01, EP 1
November 2016	EC.02.05.01, EP 15
January 2017	RC.02.01.03, EP 7
March 2017	LS.02.01.20, EP 1
May 2017	RI.01.03.01, EP 13

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Clarifications and Expectations

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.

Standards Connection

LS.02.01.30, EP 1

In new construction, vertical openings, including exit stairs, are enclosed by one-hour fire-rated walls when connecting three or fewer floors and two-hour fire-rated walls when connecting four or more floors. Existing vertical openings, including exit stairs, are enclosed with a minimum of one-hour fire-rated construction.

Note: *These vertical openings include, but are not limited to, shafts (including elevator, light, and ventilation), communicating stairs, ramps, trash chutes, linen chutes, and utility chases. (For full text, refer to NFPA 101-2012: 8.6; 18/19.3.1; 7.1.3.2.1.)*

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.*

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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:

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.)

- 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 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-resistive 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-resistive 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*.

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.

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.

Standards Connection

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.*

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.

Standards Connection

LS.02.01.30, EP TBD: Proposed for 2018

Alcohol-based hand rubs (ABHR) are stored and handled in accordance with NFPA 101-2012: 8.7.3.1, unless all of the following conditions are met:

- *The corridor is at least 6 feet wide.*
- *The ABHR does not exceed 95% alcohol.*
- *The maximum individual dispenser capacity is 0.32 gallon of fluid (0.53 gallon in suites) or 18 ounces of NFPA Level 1–classified aerosols.*
- *There is a minimum of 4 feet of horizontal spacing between dispensers.*
- *Dispensers are not installed within 1 inch of an ignition source.*
- *If floor is carpeted, the building is fully sprinkler protected.*
- *Operation of the dispenser complies with NFPA 101-2012: 18/19.3.2.6(11).*
- *ABHR is protected against inappropriate access.*
- *Not more than an aggregate of 10 gallons of fluid or 135 ounces of aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room.*
- *Storing more than 5 gallons of fluid in a single smoke compartment complies with NFPA 30.*

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.

Standards Connection

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)

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

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CLARIFICATIONS AND EXPECTATIONS: Understanding Key Changes to the Life Safety Standards (continued)

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polyethylene (HDPE) that is now being used for lockers or bathroom partitions must be tested using NFPA 286-2011 (see NFPA 101-2012; 10.2.3.7).

Floor Finishes

There are no restrictions for floor finishes in existing buildings. New construction interior floor finishes must be Class I, as established using a critical radiant flux test procedure (see NFPA 101-2012 10.2.7). Carpet and other "unusual" materials (such as rubber) are finishes that may not comply with the Class I designation. New construction should have "cut sheets" (for example, specification sheets) available to provide this information.

Standards Connection

LS.02.01.30, EP 7

Newly installed interior floor finishes in corridors of smoke compartments with an approved automatic sprinkler system is at least Class II. Existing floor finishes are not restricted. (For full text, refer to NFPA 101-2012: 18/19.3.3; 10.2.7)

This month's column also appears in the July 2017 issue of *Environment of Care® News*.

Consistent Interpretation (Continued)

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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).

Surveyor Observations	Guidance/Interpretation
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.	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 prn pain"). Therefore, do not write Requirements for Improvement for such orders *as long as they are permitted by the organization's policy*.
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.	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.

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Consistent Interpretation (Continued)

Continued from page 10

EP 15[†]: For hospitals that use Joint Commission accreditation for deemed status purposes: Processes for the use of preprinted 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).

Surveyor Observations	Guidance/Interpretation
• There was no evidence that the protocol implemented for sliding scale insulin had been approved by the required individuals. • There was no evidence that the protocol implemented for the administration of vasoactive medications had been approved by pharmacy leadership. • There was no evidence that the postoperative order set used for joint replacement procedures had been approved by the required individuals. • There was no defined process or frequency in place for the regular review of protocols, order sets, preprinted orders, and so on.	This EP is specific to the *process* for reviewing, approving, and using protocols, order sets, preprinted orders, and so on. 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. 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. If the protocol was implemented based on a telephone or verbal order but not signed within the organization's defined time frame, cite Standard RC.02.03.07, EP 4 on authenticating verbal orders within a specified time frame. 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.

Joint Commission Requirement

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®

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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:

This review project involved clarifying existing language, adding new elements of performance (EPs), and revising notes.

- 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 or 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.

Joint Commission Requirement

Official Publication of Joint Commission Requirements

Phase II Maintenance Revisions to Behavioral Health Care Requirements

Effective January 1, 2018

Applicable to Behavioral Health Care

Care, Treatment, and Services (CTS)

Standard CTS.02.01.03

The organization performs screenings and assessments as defined by the organization's policy.

Elements of Performance for CTS.02.01.03

5. Ⓓ When relevant to the individual's current care, treatment, or services, as determined by the organization, the organization gathers behavioral and physical health information from both inpatient and outpatient providers who have treated the individual. When it is not possible to obtain this information, the organization documents the reason why it could not be obtained.

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 p~~Physical holding is initiated by an authorized staff member in accordance with law and regulation and organization policy. R
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, ~~or~~ 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. Ⓓ Initiation of physical holding by an authorized staff member.

~~7.~~ 8. Ⓓ Monitoring of the child or youth.

~~8.~~ 9. Ⓓ Discontinuation of the physical hold.

~~9.~~ 10. Ⓓ Debriefing.

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APPROVED: Phase II Revisions to Update Behavioral Health Care Requirements (continued)

Continued from page 13

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

~~10.~~11. Ⓓ Reporting injuries and deaths to the organization's leadership and appropriate external agencies consistent with applicable law and regulation.

~~11.~~12. Ⓓ Documentation of physical holding.

~~12.~~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: Nonphysical 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~~ techniques 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

update and the 2018 *Comprehensive Certification Manual for Disease-Specific Care*.

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 of Joint 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.

* Life Safety Code® *is a registered trademark of the National Fire Protection Association, Quincy, MA.*

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

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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

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Revisions Announced for Comprehensive Stroke Center Measures (continued)

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Comprehensive Stroke (CSTK) Measures

CSTK-01	National Institutes of Health Stroke Scale (NIHSS Score Performed for Ischemic Stroke Patients)
CSTK-02	Modified Rankin Score (mRS at 90 days)—**SUSPENDED 1/1/18**
CSTK-03	Severity Measurement Performed for Subarachnoid Hemorrhage (SAH) and Intracerebral Hemorrhage (ICH) Patients (Overall Rate)
CSTK-04	Procoagulant Reversal Agent Initiation for ICH
CSTK-05	Hemorrhagic Transformation (Overall Rate)
CSTK-06	Nimodipine Treatment Administered
CSTK-07	Median Time to Revascularization—**SUSPENDED 1/1/16**
CSTK-08	Thrombolysis in Cerebral Infarction (TICI) Post-Treatment Reperfusion Grade
CSTK-09	Arrival Time to Skin Puncture—**EFFECTIVE 1/1/17**
CSTK-10	Modified Rankin Score (mRS) at 90 Days: Favorable Outcome—**EFFECTIVE 1/1/18**
CSTK-11	Timeliness of Reperfusion: Arrival Time to TICI 2B or Higher**—EFFECTIVE 1/1/18**
CSTK-12	Timeliness of Reperfusion: Skin Puncture to TICI 2B or Higher**—EFFECTIVE 1/1/18**

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.

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. 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.

Details regarding the CSTK-10, CSTK-11, and CSTK-12 measure specifications will be available by early August in the *Specifications Manual for Joint Commission National Quality Measures*, future Version 2017A, on The Joint Commission website at https://manual.jointcommission.org/releases/TJC2017A/.

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.

MODIFIED RANKIN SCALE	DESCRIPTION
0	The patient has no residual symptoms.
1	The patient has no significant disability; able to carry out all pre-stroke activities.
2	The patient has slight disability; unable to carry out all pre-stroke activities but able to look after self without daily help.
3	The patient has moderate disability; requiring some external help but able to walk without the assistance of another individual.
4	The patient has moderately severe disability; unable to walk or attend to bodily functions without assistance of another individual.
5	The patient has severe disability; bedridden, incontinent, requires continuous care.
6	The patient has expired.

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*.

The Joint Commission Journal on Quality and Patient Safety®

IMPROVEMENT FROM FRONT OFFICE TO FRONT LINE

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/.

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