The Joint Commission
Perspectives®

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Joint Commission Requirement

Joint Commission Deletes Numerous EPs from Nonhospital Accreditation Programs

The Joint Commission recently completed the third phase of its EP Review Project, resulting in the deletion of many elements of performance (EPs) from the accreditation programs for **ambulatory care**, **behavioral health care**, **critical access hospitals**, **home care**, **laboratories**, **nursing care centers**, and **office-based surgery practices**. The box at right shows the number of EPs deleted for each program. These deletions are **effective July 1, 2017**.

Number of EPs Deleted Per Program

- Ambulatory Care (AHC): 85
- Behavioral Health Care (BHC): 63
- Critical Access Hospitals (CAH): 143
- Home Care (OME): 65
- Laboratory (LAB): 50
- Nursing Care Centers (NCC): 59
- Office-Based Surgery Practices (OBS): 50

The EP Review Project is a multiphased component of **Project REFRESH**, a series of interrelated process improvement initiatives The Joint Commission has been conducting throughout 2016 and 2017. Phases I and II of the EP Review Project (*see* May 2016 *Perspectives*, pages 5–14, and July 2016 *Perspectives*, page 5) resulted in the deletion of 225 hospital EPs. A majority of these deletions—131—became effective July 1, 2016; the deletion of the remaining 94 EPs became effective January 1, 2017.

Phase III of the EP Review Project evaluated the deleted hospital EPs that also exist in nonhospital programs and considered them for deletion. Deleted hospital EPs *not* considered for deletion from other programs included these exceptions:

- Some EPs deleted from the hospital program had to be retained for other program(s) because they align with Centers for Medicare & Medicaid Services (CMS) requirement(s). CMS requirements are not the same across programs.

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The Joint Commission

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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

- Deleted numerous requirements from the **ambulatory care**, **behavioral health care**, **critical access hospital**, **home care**, **laboratory**, **nursing care center,** and **office-based surgery** programs as a result of Phase III of the EP Review component of Project REFRESH (*see* article on beginning on page 1 of this issue)

CURRENTLY IN FIELD REVIEW

- Proposed requirements for a new **Thrombectomy-Capable Stroke Center Certification** program (field review ends May 29, 2017)

Note: *Please visit The Joint Commission website at http://www.jointcommission.org/standards_information/field_reviews.aspx for more information. Field review dates are subject to change.*

CURRENTLY IN DEVELOPMENT

- 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 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 EP Review Phase IV (Project REFRESH)
- Proposed new Human Resources requirement for **ambulatory care** organizations that provide sleep study services
- Proposed revisions for **behavioral health care** EPs as part of program maintenance
- Proposed revisions for **applicable programs** to NPSG.07.01.01, NPSG.07.03.01, NPSG.07.04.01, NPSG.07.05.01, and NPSG.07.06.01 on health care–associated infections
- Proposed new and revised requirements for deemed **home health** organizations to meet new Centers for Medicare & Medicaid Services (CMS) requirements
- Proposed new and revised requirements for **all accreditation programs** in response to CMS's Emergency Management Final Rule
- Proposed revisions to Medication Management requirements for the **ambulatory care**, **critical access hospital**, **hospital,** and **home care** programs
- Proposed new and revised pain assessment and management requirements for **hospitals**

Heart Failure Certification No Longer Offered in Collaboration with AHA

Effective April 2, 2017, The Joint Commission's Advanced Certification in Heart Failure (ACHF) is no longer affiliated with the American Heart Association® (AHA).

The ACHF program is designed in and of itself to help ensure quality outcomes for patients, and participation in the AHA's "Get with the Guidelines" quality improvement program is no longer a requirement for eligibility. Certified organizations may continue to use the combined AHA seal and Joint Commission Gold Seal of Approval® logo through their current certification cycle, after which a new Gold Seal may be downloaded from The Joint Commission website at https://www.jointcommission.org/certification/goldseal_downloads.aspx.

Partnerships are still in effect between The Joint Commission and the American Heart Association/American Stroke Association for the Acute Stroke Ready Hospital, Primary Stroke Center, and Comprehensive Stroke Center advanced disease-specific care certifications. For more information, please contact Business Development at 630-792-5291 or certification@jointcommission.org.

Joint Commission Deletes Numerous EPs from Nonhospital Accreditation Programs (continued)

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- Several hospital EPs were deleted because they were duplicative of another EP. In cases where the duplicative EP does not appear across program accreditation manuals, the EP that was duplicative for hospitals had to be retained by other accreditation program(s).
- Issues unique to some programs required retention of an EP that was deleted for hospitals.

For the most part, the deletions fall into one or more of the categories established during Phase I:

- Are similar to, implicit in, or duplicative of other existing EPs
- Address issues that, having been covered by standards for many years and are now a routine part of operations or clinical care processes, no longer need to be addressed in standards. Some of them no longer address contemporary quality and safety concerns, and how they are managed can be left to the discretion of the organization.
- Are adequately addressed by law and regulation or other external requirements, so separate Joint Commission requirements are not needed

The deleted requirements (and reasons for each deletion) are listed in the table beginning on page 13. The first column lists EPs that were deleted from the hospital program in Phases I and II of the EP Review Project. The rest of the columns show the disposition of the same EPs across other programs and whether they were deleted or retained. A blank cell indicates that the former hospital EP does not exist in that particular accreditation program. The deleted requirements will also be posted on The Joint Commission website at https://www.jointcommission.org/standards_information/prepublication_standards.aspx; they are no longer part of their respective program manuals as of the spring E-dition® and *2017 Update 1*.

Phase IV of the EP Review Project will involve consolidations of existing requirements across accreditation programs. In the meantime, questions may be directed to Maureen Carr, MBA, project director, Department of Standards and Survey Methods, The Joint Commission, at mcarr@jointcommission.org.

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The Joint Commission and NQF Honor 2016 Eisenberg Award Recipients

The Joint Commission and the National Quality Forum (NQF) presented the 2016 John M. Eisenberg Patient Safety and Quality Awards on April 4, 2017, at NQF's Annual Conference held this year in Pentagon City, VA. Launched in 2002 by NQF and The Joint Commission, the patient safety awards program honors John M. Eisenberg, MD, MBA, former administrator of the Agency for Healthcare Research and Quality (AHRQ) and member of NQF's founding board of directors.

As described below, the three 2016 Eisenberg honorees received awards in three annual categories for their achievements in the field of patient safety and quality.

1. **Individual Achievement—Carolyn Clancy, MD, deputy under secretary, US Department of Veterans Affairs, Washington, DC.** This award honors Clancy for her passion and impact on patient safety and quality of care. Throughout her career, Clancy has empowered patients and their families to make informed decisions about their own health care. As Eisenberg's immediate successor as director of AHRQ, Clancy led dramatic changes in quality improvement efforts, including the development and publication of AHRQ's annual National Healthcare Quality and Disparities reports to Congress. She also has significantly impacted the development and dissemination of practical patient safety and quality improvement tools used across the nation. In her current role, Clancy leads the Veterans Health Administration's Office of Organizational Excellence, which is charged with assuring quality, safety, and integrity as well as improving veterans' experience with VA care.

2. **Innovation in Patient Safety and Quality at the National Level—I-PASS Study Group**. Representing more than 150 individuals from across North America, the I-PASS Study Group is recognized for its national work to improve patient safety by standardizing provider communication and handoffs of care. The group's initial research study found that across nine hospitals, harmful medical errors (preventable adverse events) decreased by 30% following implementation of the I-PASS handoff bundle. From this

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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 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 is creating a second iteration of EPs that it expects to publish in late 2017 or early 2018.*

This column, the sixth installment in a series addressing the updated standards, focuses on means of egress (LS.02.01.20). This series addresses the January 2017 elements of performance (EPs) as well as 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.

Understanding LS.02.01.20: Means of Egress

The earliest edition of the *Life Safety Code* was titled "Building Exits Code," which reflects one of the main themes addressed in the code—ensuring that enough exits are provided to allow occupants to leave a building safely during a fire or similar emergency. This exit strategy is referred to as the ***means of egress***, and it has three components:

1. The exit access
2. The exit
3. The exit discharge

Life Safety Code Chapter 7, "Means of Egress," is often referenced in the chapters that address health care occupancies (NFPA 101-2012, 18/19.2). Health care occupancies differ from most other occupancies in that many of the occupants are unable to self-rescue and are dependent on rescue or the building for protection. This special need led to the development of the defend-in-place model for protecting patients in their rooms rather than defaulting to evacuation. When patient movement is necessary, the means of egress must be kept clear.

Standards Connection

LS.02.01.20, EP 1: MODIFIED for 2018

Doors in a means of egress are not equipped with a latch or lock that requires the use of a tool or key from the egress side, unless a compliant locking configuration is used, such as a delayed-egress locking system as defined in NFPA 101-2012: 7.2.1.6.1 or access-controlled egress door assemblies as defined in NFPA 101-2012: 7.2.1.6.2. *Elevator lobby exit access door locking is allowed if compliant with 7.2.1.6.3.* (For full text, refer to NFPA 101-2012: 18/19.2.2.2.4; 18/19.2.2.2.5; 18/19.2.2.2.6)

Editor's Note: *Italicized* text is proposed language for 2018.

Door Openings

Doors in a means of egress are often cross-corridor doors, and they are required to open without the "use of a tool or key from the egress side." Nothing is to restrict occupant movement during an emergency. However, instances occur when locking of doors is required, either when the patient's clinical needs require specialized security measures or based on clinical and security needs to protect the patient from self-harm. This first component—the specialized security measures for the patient—is new to the elements of performance (EPs) for this standard for 2017, protecting infants, pediatric patients, and addressing other situations designed to protect the patients. When doors need to be locked, the locking configuration

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

must comply with the *Life Safety Code*. Chapters 18/19 and 7 discuss the following:

1. **Delayed egress** (18/19.2.2.2.5(2) and 7.2.1.6.1) is allowed on any door in the facility and is generally used where monitoring of the egress is required, such as a memory care unit. Delayed egress is allowed provided that the building is protected by an approved automatic sprinkler system. The delayed egress requires pushing on the hardware for 15 seconds to unlock the door (or 30 seconds, if approved by the authority having jurisdiction) and initiating an alarm signal. The door must unlock in the direction of egress if either the sprinkler system is activated, two or more smoke detectors activate, or at least one heat detector activates. Also, loss of power controlling the locking mechanism must unlock the door, appropriate signage must be on the door, and emergency lighting must be provided on the egress side of the door.
2. **Access-controlled egress door** (18/19.2.2.2.4(3) and 7.2.1.6.2) is generally used where automatic access is best served by a sensor, such as at an entry into an operating area. An access-controlled door is controlled by either a sensor or a manual release on the egress side, within 60 inches of the door opening, and with a sign reading "PUSH TO EXIT." Also, the door must unlock in the direction of egress with the activation of the fire-protective signaling system (but not the manual fire alarm boxes), the activation of either the sprinkler system or the fire alarm system, and loss of power controlling the locking mechanism. Emergency lighting on the egress side is also required.
3. **New for 2018:** ***Elevator lobby exit access door locking*** *Doors that separate an elevator lobby from exit access can be normally locked if compliant with 7.2.1.6.3. A normally locked elevator lobby door must be a UL 294 compliant lock, be within a building protected by a fire alarm system and fire sprinkler system, and there must be smoke detection within the elevator lobby. An elevator lobby exit access door must unlock under the following conditions: activation of the fire alarm system by fire sprinkler water-flow or by smoke detection within the elevator lobby (but not by manual pull stations), and loss of electrical power controlling the locking mechanism. There must be two-way communication between a locked elevator lobby and a central control point that is constantly staffed by personnel trained to provide emergency assistance. Once unlocked, remaining unlocked mechanical latching devices must properly release when activated, and the door must remain unlocked until manual fire alarm reset. Emergency lighting on the egress side is also required.*

Standards Connection

LS.02.01.20, EP TBD

Doors to patient sleeping rooms are not locked unless the clinical needs of a patient require specialized security or a patient poses a security threat and staff can readily unlock the door at any time. (For full text, refer to NFPA 101-2012: 18/19.2.2.2.2; 18/19.2.2.2.5.1; 18/19.2.2.2.5.2)

Standards Connection

LS.02.01.20, EP TBD

Horizontal sliding doors permitted by NFPA 101-2012: 7.2.1.14 that are not automatic closing are limited to a single leaf and have a latch or other mechanism to prevent the door from rebounding. (For full text, refer to NFPA 101-2012: 18/19.2.2.2.10.1)

Doors to the patient sleeping rooms are not to be locked unless locking a door is required either because of clinical needs to protect a patient from self-harm or for the safety and security of the patient. When the organization determines that doors need to be locked, staff must be able to readily unlock the doors at all times. For example, if the lock is unlocked by a key, all staff need to carry a key with them (It is **not** acceptable for staff to depend on the key being at the nursing station). Staff include those assigned to normally work in the affected area if a patient door is locked. Incidental staff who occasionally enter (such as a phlebotomist) would not normally be expected to be part of a door-unlocking strategy.

The requirements for this horizontal sliding door exceed those of Chapter 7, as a door in a health care occupancy must be a single leaf to avoid an opening at meeting edges of two doors. The requirements of 7.2.1.14 must be reviewed by the organization to ensure compliance.

Standards Connection

LS.02.01.20, EP TBD

Horizontal sliding doors serving an occupant load of fewer than 10 are permitted as long as they comply with NFPA 101-2012: 18/19.2.2.2.10.2 and meet the following criteria:

- *The area served by the door has no hazards.*
- *The door is operable from either side, without special knowledge or effort.*
- *The force required to operate the door in the direction of travel is less than or equal to 30 pounds-force (lbf) to set the door in motion and less than or equal to 15 lbf to close or open to the required width.*
- *The assembly is appropriately fire rated and is self- or automatic-closing by smoke detection, per 7.2.1.8; the assembly is installed per NFPA 80-2010.*
- *Where required to latch, the door has a latch or another mechanism to prevent the door from rebounding.*

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Clarifications and Expectations: Understanding Key Changes to the Life Safety Standards (continued)

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Standards Connection

LS.02.01.20, EP TBD

New stairs serving three or more stories and existing stairs serving five or more stories have signs on each floor landing in the stairwell that identify the story, the stairwell, the top and bottom, and the direction to and story of exit discharge. ~~Information is also presented in tactile lettering.~~ ***Floor level designation shall also be tactile, in accordance with ICC/ANSI A117.1.*** The signs are placed five feet above the floor landing, in a position that is easily visible when the door is open or closed. (For full text, refer to NFPA 101-2012: 18/19.2.2.3; 7.2.2.5.4)

Editor's Note: *Italicized* text is proposed language for 2018. ***Bold italic*** text represents corrections effective July 2017. ~~Strikethrough~~ text indicates deletions effective July 2017.

The requirements for this horizontal sliding door align with 7.2.1.4.1(4)(c). This horizontal door is an exemption from the requirement that all doors be of the swinging type (7.2.1.4.1). Doors complying with 18/19.2.2.2.10.2 are not required to have a break-away feature. Horizontal doors are often used in suites, such as intensive care units. (If located in a suite, the doors are not required to latch.) The latching requirement is for corridor doors, and the door must not rebound into a partially open position.

> *"Nothing is to restrict occupant movement during an emergency. However, instances occur when locking of doors is required, either when the patient's clinical needs require specialized security measures or based on clinical and security needs to protect the patient from self-harm."*

Standards Connection

LS.02.01.20, EP 9: MODIFIED FOR 2018

Exits discharge to the outside at grade level or through an approved exit passageway that is continuous and *provides a level walking surface. The exit discharge is a hard-packed, all-weather travel surface that is free from obstructions and* terminates at a public way or at an exterior exit discharge. (For full text, refer to NFPA 101-2012: 18/19.2.7; 7.1.7; 7.1.10.1; 7.2.6; 7.7.2)

The proposed revisions clarify that new construction requires stair signage for three or more stories, and existing construction requires signage for five or more stories. Also, a mistake is corrected, effective immediately: On the required signage, only the floor level designation **must** be tactile.

Exit Passageways

The third component of the means of egress, the exit discharge, must be at grade to the public way or an approved exit passageway that is continuous and leads to a public way or an exterior exit discharge. For example, as the occupant moves from the exit access through the exit, two alternatives may be provided. First, the exit discharges to the outdoors (at grade) and terminates at the public way. An alternative is to move through an approved exit into an exit passageway. The exit passageway maintains the integrity of the exit access and exit all the way to the public way. For example, if the exit access is a two-hour fire-rated corridor and then leads through an exit, the occupant either leaves into the outdoors or enters an equivalent exit passageway. At no time should the occupant enter an assembly that provides less protection. The exception to this is a horizontal exit (*see* LS.02.01.20, EPs 3–5, and *Life Safety Code* 18/19.2.2.5). The exit out of the exit passageway should be level and free of obstructions, have an all-weather surface, and terminate at the public way.

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

The Joint Commission and NQF Honor 2016 Eisenberg Award Recipients (continued)

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foundation, the group expanded its work to involve nurses and physicians from across specialties in more than 50 hospitals nationwide. Through the newly formed I-PASS Institute, the study group has developed a series of tools and processes to work with hospitals to achieve institution-wide implementations of the program.

3. **Innovation in Patient Safety and Quality at the Local Level—Christiana Care Health System, Wilmington, DE.** This award honors Christiana Care Health System for the development of Christiana Care Care Link, an innovative and technology-driven care coordination program that

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Consistent Interpretation

Joint Commission Surveyors' Observations on RI.01.03.01, EP 13

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 of performance (EP) in the *Comprehensive Accreditation Manual for Hospitals*. This installation (the ninth in the series; the box at right lists the requirements previously featured in the column) highlights Rights and Responsibilities of the Individual (RI) Standard RI.01.03.01, EP 13. **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, EP 1
	PC.02.01.03, EP 7
	PC.02.01.03, EP 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

Rights and Responsibilities of the Individual (RI) Standard RI.01.03.01: The hospital honors the patient's right to give or withhold informed consent.

EP 13*: Informed consent is obtained in accordance with the hospital's policy and processes and, except in emergencies, prior to surgery. (*See also* RC.02.01.01, EP 4)

* In 2016 the noncompliance percentage for this requirement was 10.34% (that is, 149 hospitals out of 1441 hospitals surveyed were out of compliance with this requirement).

Surveyor Observations	Guidance/Interpretation
An informed consent form examined during survey, though signed by the patient, was not dated or timed—despite the hospital's own policy requiring that consent forms be dated and timed.	This requirement is not cited when a patient's signature is not dated or timed unless specifically required by a health care organization's policy. In general, the dating and timing of informed consent forms is documented by the individual witnessing the signature when the consent is signed. Any additional dating or timing requirements would be an organizational decision.
Some consent-to-treat forms were discovered to have been signed by someone other than the patient but, contrary to hospital policy, without identifying the person who signed them.	
Although required by hospital policy, a procedural, anesthesia, and/or surgical consent form did not include information such as the name of the procedure—in fact, the procedure line was blank.	
Surveyor Observations	**Guidance/Interpretation**
There was no evidence that a patient who received a blood transfusion had signed an informed consent form.	A finding of "lack of informed consent" is not cited for procedures or transfusions unless specifically mandated by hospital policy or by state law and/or regulation. Refer to Standard RI.01.03.01, EP 2 ("The hospital's written policy identifies the specific care, treatment, and services that require informed consent, in accordance with law and regulation") for policy issues.
An informed consent form for a Spanish-speaking patient was written in Spanish and signed by the patient. However, although required by hospital policy, the space on the form for an interpreter's signature was left blank.	

The Joint Commission and NQF Honor 2016 Eisenberg Award Recipients (continued)

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serves nearly 75,000 Medicare beneficiaries and health plan members in the greater Delaware region. Using real-time clinical information from the regional health information exchange as well as other health information and claims data, an interdisciplinary care coordination team works closely with primary care providers and patients to improve safety, quality of care, cost, and outcomes. Results showed

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Compliance Data for Deemed Psychiatric Hospitals Using SAFER Methodology

The April 2017 issue of *Perspectives* (*see* "Top Standards Compliance Data Announced for 2016," pages 1 and 3–8) identified the Joint Commission requirements scored most frequently as "not compliant" during accreditation surveys and certification reviews from January 1, 2016, through December 31, 2016. As a follow-up to that article, The Joint Commission has compiled compliance data for the first group of organizations surveyed using the Survey Analysis for Evaluating Risk™ (SAFER™) approach—psychiatric hospitals that use Joint Commission accreditation to meet the Centers for Medicare & Medicaid Services (CMS) deemed status requirements.

As one of the first components of **Project REFRESH**, surveyors began using the SAFER methodology for deemed psychiatric hospitals in the summer of 2016. The bar graph on page 9 illustrates the 10 most frequently cited requirements for deemed psychiatric hospitals surveyed between August 1, 2016, and February 17, 2017.* This data is displayed in a brand-new way: Instead of showing the percentage of organizations that were found to be out of compliance with each standard, the bar graph represents the distribution of Requirements for Improvement (RFIs) within the SAFER matrix for each most frequently scored standard. This means that the distribution of RFIs (or findings) in each bar totals 100%, as the distribution takes into account all findings under that particular standard.

As a reminder, the SAFER matrix represents a shift from the historical approach of "counting" observations to an evaluative approach of assessing the scope of patients impacted (or potentially impacted) by an issue of noncompliance. Surveyors place each RFI within the matrix according to the likelihood of the issue to cause harm to patients, staff, or visitors and according to the scope of a cited deficiency. Aggregating data on where RFIs occur within the SAFER matrix for the most frequently cited standards provides additional insight on the level of risk associated with a finding.

Going forward, The Joint Commission will continue to analyze the SAFER information surrounding risk for all programs. The goal of the analysis is to utilize the aggregate data gathered through the SAFER matrix to continuously improve consistency, identify potential elements of performance (EPs) for revision, and assist in identifying areas of high risk noted within each program. Questions may be submitted to safer@jointcommission.org.

** While the principal text of each standard appears in the graph, see the Comprehensive Accreditation Manual for Hospitals for each standard's full text.*

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Posting: Spring E-dition for Accreditation and Certification Manuals

The spring E-dition® updates to the comprehensive accreditation manuals and certification manuals are scheduled to post to the *Joint Commission Connect*™ extranet site in May. The box at right lists the programs that received updates in the E-dition.

The E-dition updates follow the hard copy publications for *2017 Update 1* to the *Comprehensive Accreditation Manuals* publishing at the end of April, which are available for purchase for the ambulatory care, behavioral health care, home care, and hospital programs.

Major revisions that appear in the print and/or E-dition updates include the changes in the following list. See the What's New section included in your accreditation or certification resource to identify specific changes for your setting.

- Revised definition of *designated equivalent source* in the Glossary for the **ambulatory care**, **behavioral health care**, **critical access hospitals**, **hospitals**, **nursing care center**, and **office-based surgery practice** programs, currently effective (*see* January 2017 *Perspectives*, page 4)

Programs with E-dition Updates Effective July 1	
ACCREDITATION	**CERTIFICATION**
• Ambulatory Care • Behavioral Health Care • Critical Access Hospitals • Home Care • Hospitals • Laboratory and Point-of-Care Testing • Nursing Care Centers • Office-Based Surgery Practices	• Comprehensive Cardiac Centers • Disease-Specific Care • Health Care Staffing Services • Integrated Care • Medication Compounding • Palliative Care • Patient Blood Management • Perinatal Care

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Compliance Data for Deemed Psychiatric Hospitals Using SAFER Methodology (continued)

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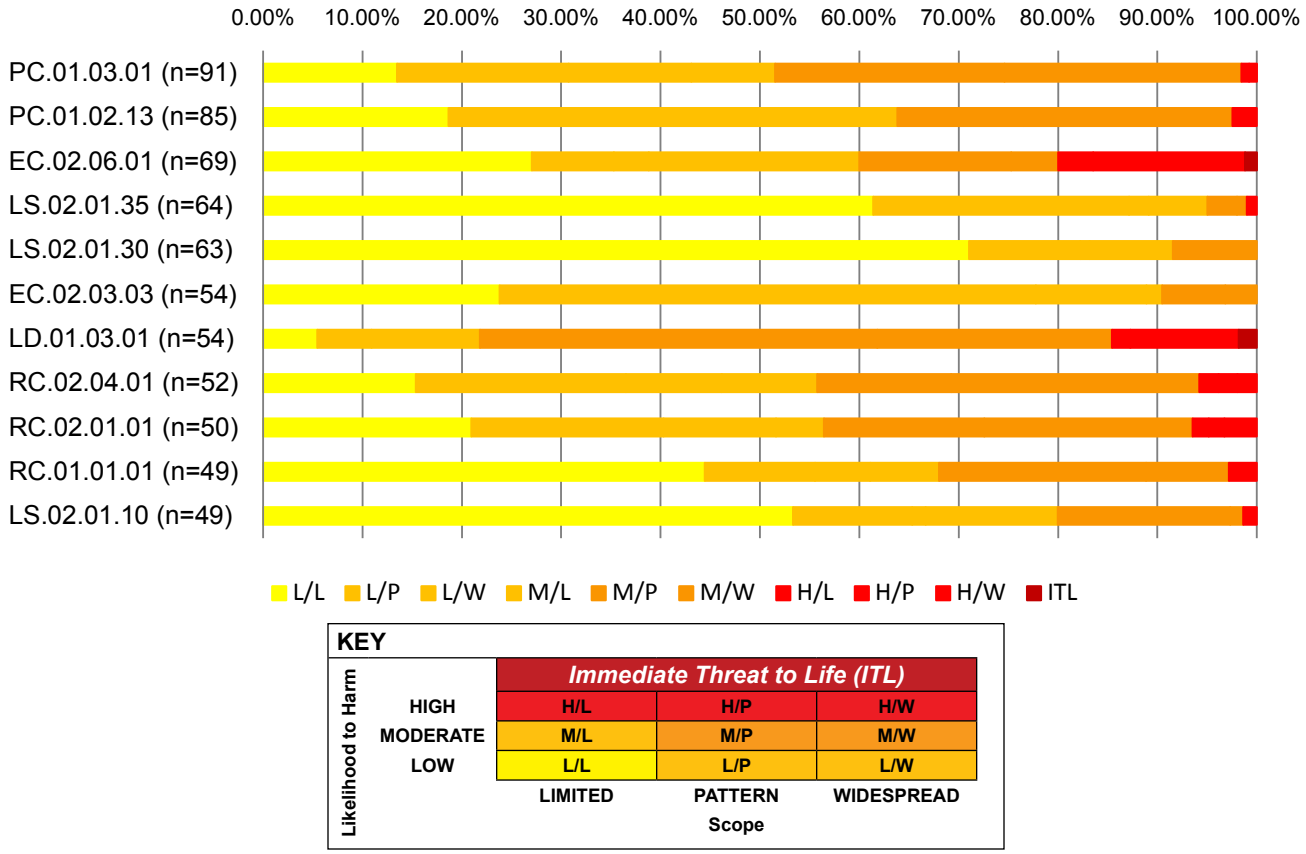
SAFER Matrix Placement for Top Standards Compliance Data in Deemed Psychiatric Hospital Surveys



KEY

Likelihood to Harm	Immediate Threat to Life (ITL)		
HIGH	H/L	H/P	H/W
MODERATE	M/L	M/P	M/W
LOW	L/L	L/P	L/W
	LIMITED	PATTERN	WIDESPREAD
	Scope		

PC.01.03.01	The hospital plans the patient's care.
PC.01.02.13	The hospital assesses the needs of patients who receive treatment for emotional and behavioral disorders.
EC.02.06.01	The hospital establishes and maintains a safe, functional environment.
LS.02.01.35	The hospital provides and maintains systems for extinguishing fires.
LS.02.01.30	The hospital provides and maintains building features to protect individuals from the hazards of fire and smoke.
EC.02.03.03	The hospital conducts fire drills.
LD.01.03.01	The governing body is ultimately accountable for the safety and quality of care, treatment, and services.
RC.02.04.01	The hospital documents the patient's discharge information.
RC.02.01.01	The medical record contains information that reflects the patient's care, treatment, and services.
RC.01.01.01	The hospital maintains complete and accurate medical records for each individual patient.
LS.02.01.10	Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.

The Joint Commission and NQF Honor 2016 Eisenberg Award Recipients (continued)

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a 30% increase in the number of patients discharged to their homes with self-care or with home health care after elective joint replacement surgery, a 62% reduction in the number of patients transferred to skilled nursing facilities after total joint replacement surgery, and a 30% reduction in readmissions after 90 days.

The achievements of each of the 2016 award recipients will be featured in the July 2017 issue of *The Joint Commission Journal on Quality and Patient Safety*.

Posting: Spring E-dition for Accreditation and Certification Manuals (continued)

Continued from page 8

- Revisions to several **behavioral health care** requirements as the first of two phases of a program maintenance review, effective July 1, 2017 (*see* January 2017 *Perspectives*, pages 8 and 9)
- Revisions to Care, Treatment, and Services (CTS) Standard CTS.03.01.09 on outcome measures for the **behavioral health care** program, effective January 1, 2018 (*see* January 2017 *Perspectives*, pages 10 and 11)
- New and revised requirements for the **laboratory** program on molecular and genetic testing, clinical chemistry and toxicology, and aligning with Clinical Laboratory Improvement Amendments Interpretive Guidelines, effective July 1, 2017 (*see* February 2017 *Perspectives*, pages 6 and 8–14)
- Revised Accreditation Participation Requirement APR.07.01.01 for **all accreditation programs** and Certification Participation Requirement CPR 10 for **all certification programs** to update the definition of a survey or review *observer*, effective July 1, 2017 (*see* February 2017 *Perspectives*, page 7)
- New Medication Compounding Certification program for **all compounding pharmacies**, effective January 1, 2017 (*see* March 2017 *Perspectives*, pages 1 and 3)
- Revisions to the policy on notifying organizations of upcoming Joint Commission survey/review events for **all accreditation and certification programs**, effective March 6, 2017 (*see* March 2017 *Perspectives*, pages 3 and 4)
- Revisions to EC and LS requirements for the **ambulatory care**, **critical access hospital**, **hospital**, **home care**, and **nursing care center programs** to maintain alignment with Centers for Medicare & Medicaid Services requirements, effective July 1, 2017 (*see* April 2017 *Perspectives*, page 18)
- Revisions to decision rules (including the elimination of the Contingent Accreditation decision category) and the post-survey process for **all accreditation programs**, effective January 1, 2017 (*see* April 2017 *Perspectives*, pages 8 and 12)
- Deletion of several requirements from the **ambulatory care**, **behavioral health care**, **critical access hospitals**, **home care**, **laboratories**, **nursing care center**, and **office-based surgery practices programs** as part of Phase III of the EP Review Project, effective July 1, 2017 (*see* article on pages 1, 3, and 13–26 of this issue)

Managing Your Manuals

If there are challenges with accessing updated standards in the E-dition release from your *Joint Commission Connect*™ site, please contact Customer Technical Support at support@jcrinc.com. If you are missing a purchased hard copy accreditation manual product, please e-mail jcrcustomerservice@pbd.com (or call 877-223-6866) with your order number and organization name. Print and online manuals, as well as other accreditation resources, are also available for purchase at http://www.jcrinc.com/software/landing and http://www.jcrinc.com/store/publications/manuals.

Pediatric Readiness in the Emergency Room

In an effort to reduce childhood mortality and morbidity resulting from illness or trauma, The Joint Commission (along with Emergency Medical Services for Children, American Academy of Pediatrics, American College of Emergency Physicians, and Emergency Nurses Association) has identified the need for all emergency rooms in the United States to have the proper pediatric equipment to treat children of any age and size in the case of a pediatric emergency.

Children account for approximately 20% of all visitors to hospital emergency departments. Most of these visits happen at a local general hospital rather than a specialized pediatric hospital. Being prepared to treat every type of pediatric emergency requires specific equipment that is readily available in all emergency rooms across the United States.

Beginning October 1, 2017, the list of pediatric equipment shown on page 12 will be required in all **hospital**, **critical access hospital**, and **ambulatory care** emergency rooms. Emergency rooms that do not have all of the listed equipment will be cited by Joint Commission surveyors at Provision of Care, Treatment, and Services (PC) Standard PC 02.01.11, Element of Performance 2: "Resuscitation equipment is available for use based on the needs of the population served. **Note:** *For example, if the hospital has a pediatric population, pediatric resuscitation equipment should be available.*"

Questions may be directed to your organization's Account Executive.

Continued on page 12

ESC Form Redesigned to Promote Successful Submission

As part of **Project REFRESH**, The Joint Commission has redesigned the Evidence of Standards Compliance (ESC) form to help organizations focus on describing the critical aspects of corrective actions they have taken to resolve Requirements for Improvement (RFIs). The redesigned form will be implemented in phases, beginning with surveys of **ambulatory care organizations** and **deemed psychiatric hospitals** occurring on and after **April 10, 2017**,* and extending to all accreditation and certification programs by the middle of the year.

The redesigned form is intended to help organizations successfully complete their ESC within the first submission and sustain compliance efforts. As part of the streamlined layout, required fields with lead-in statements enable organizations to provide targeted, relevant information that better aligns with proven performance improvement methodologies. In addition, the form allows organizations the flexibility to implement corrective actions within their unique environment while providing program-specific examples to highlight key elements of effective compliance. The table below is an at-a-glance comparison of the previous and redesigned ESC formats.

What's Not Changing?

As previously announced in *Perspectives*,† one change to the post-survey process resulting from Project REFRESH was that, effective January 2017, all cited deficiencies are assigned a single time frame of 60 days for corrective action—that is, the 45-day ESC submission time frame was eliminated. This 60-day submission time frame is still in effect as part of the ESC process. Organizations can also continue to access the ESC guidelines and submission process via their *Joint Commission Connect*™ secure extranet site.

Questions about the redesigned ESC form may be directed to your organization's assigned Account Executive.

PREVIOUS FORMAT	REDESIGNED FORMAT
WHO is ultimately responsible for the corrective action?	**Assigning Accountability:** • Who is ultimately responsible for corrective action and sustained compliance?
Not applicable prior to the rollout of the Survey Analysis for Evaluating Risk™ (SAFER™) scoring methodology	**Assigning Accountability—Leadership Involvement:** • Which member(s) of leadership are supporting future compliance? (This ESC field, which was implemented with the SAFER rollout, is required only for higher-risk RFIs—those placed within the dark orange and red areas of the matrix.)
Not applicable prior to the roll-out of SAFER	**Correcting the Noncompliance—Preventive Analysis:** • What analysis was completed to ensure not only that the noncompliant issue was corrected (surface/high-level resolution) but also that any underlying reasons for the failure were addressed? (This ESC field, which was implemented with the SAFER rollout, is required only for higher-risk RFIs—those placed within the dark orange and red areas of the matrix.)
WHAT actions were completed to correct each finding? **WHEN** were each of the actions completed?	**Correcting the Noncompliance:** • What actions were taken to correct each finding? • When were all actions completed? (This is indicated with one final date.)
HOW will compliance be sustained?	**Ensuring Sustained Compliance:** • What procedures/activities have been identified to monitor compliance? • What is the frequency of the monitoring activities? • What data will be collected from these activities? • How, and to whom, will this data be reported?

** During the first phase of implementation, surveys that include an ambulatory care organization and/or a deemed psychiatric hospital will also utilize the redesigned form for all other programs surveyed at that time.*

† *See May 2016* Perspectives, *"The SAFER Matrix: A New Scoring Methodology," pages 1 and 3; and October 2016* Perspectives, *"The SAFER Matrix and Changes to the Post-Survey Process," pages 1, 3, and 4.*

Continued from page 10

*Required Supplies for Treating Pediatric Emergencies**

General

- Patient warming device
- Intravenous blood/fluid warmer
- Weight scale in kilograms
- Tool/chart that incorporates weight in kilograms
- Age-appropriate pain scale assessment tools

Patient Monitoring

- Blood pressure cuffs (neonatal, infant, child, adult–arm, adult–thigh)
- Doppler ultrasonography devices
- Electrocardiography monitor/defibrillator (including pads/paddles) with pediatric and adult capabilities
- Hypothermia thermometer
- Pulse oximeter with pediatric and adult probes
- Continuous end-tidal CO_2 monitoring device

Fracture Management

- Extremity splints
- Femur splints–pediatric sizes
- Femur splints–adult sizes
- Age-appropriate spine-stabilization devices

Vascular Access

- Arm boards (infant, child, adult)
- Catheter-over-the needle devices (14-, 16-, 18-, 20-, 22-, and 24-gauge)
- Intraosseous needles/devices (pediatric and adult)
- Umbilical vein catheters (3.5 French [F], 5.0 F)
- Central venous catheters (4.0 F, 5.0 F, 6.0 F, 7.0 F)

Specialized Pediatric Trays/Kits

- Lumbar puncture tray (infant/pediatric 22-gauge and adult 18- to 21-gauge)
- Tube thoracostomy tray
- Newborn delivery kit
- Urinary catheterization kits/catheters (6 F–22 F)

Respiratory Supplies

- Endotracheal tubes
  - Uncuffed (2.5, 3.0, 3.5, 4.0, 4.5, 5.0, 5.5 mm)
  - Cuffed (3.5, 4.0, 4.5, 5.0, 5.5, 6.0, 6.5, 7.0, 7.5, 8.0 mm)
- Oropharyngeal airways (0, 1, 2, 3, 4, 5)
- Feeding tubes (5 F, 8 F)
- Stylets for ET tubes (pediatric and adult)
- Suction catheters (infant, child, adult)
- Laryngoscope blades
  - Straight (0, 1, 2, 3)
  - Curved (2, 3)
- Magill forceps (pediatric/adult)
- Tracheostomy tubes (2.5, 3.0, 3.5, 4.0, 4.5, 5.0, 5.5 mm)
- Bag-mask device
  - Infant (450 ml)
  - Adult (1000 ml)
- Mask to fit bag-mask device adaptor (neonatal, infant, child, adult)
- Oxygen mask (standard infant, standard child, standard adult, partial nonrebreather infant, nonrebreather child, nonrebreather adult)
- Nasal cannulas (infant, child, adult)
- Nasogastric tubes (8 F, 10 F, 14–18 F)
- Laryngeal mask airway (sizes 1, 1.5, 2, 2.5, 3, 4, 5)

** List compiled from recommendations of the American Academy of Pediatrics, American College of Emergency Physicians, Emergency Medical Services for Children, and Emergency Nurses Association. Additional resource: Guidelines for Care of Children in the Emergency Department at https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/children-and-disasters/documents/checklist_ed_aug2010.pdf.*

Assessing Usage of Glucometers and Fingerstick/Lancing Devices

According to the Centers for Disease Control (CDC), fingerstick devices should never be used for more than one person, and—whenever possible—blood glucose meters should not be shared. If a glucose meter *must* be shared, the device must be cleaned and disinfected after every use in a manner consistent with the manufacturer's instructions. In the absence of these instructions, the device should not be reused.

The Joint Commission reminds organizations that they can conduct a risk assessment on how they use glucometers and fingerstick/lancing devices by determining whether staff are using single-use devices on multiple patients—a practice that may put patients at risk of exposure to bloodborne pathogens. Identified breaches of this nature are to be reported to organizations' local and state Departments of Health.

For additional information, please visit the CDC website at https://www.cdc.gov/injectionsafety/blood-glucose-monitoring.html.

Joint Commission Deletes Numerous EPs from Nonhospital Accreditation Programs (continued)

Continued from page 3

Deleted Requirement	Topic	Reason for Deletion by Program					
		AHC	BHC	CAH	LAB	NCC	OBS	OME
EC.01.01.01, EP 2	Identifying who will intervene in threatening environmental conditions	EC.01.01.01, EP 1	EC.01.01.01, EP 1	EC.01.01.01, EP 1	EC.01.01.01, EP 1	EC.01.01.01, EP 1		
EC.02.01.03, EP 4	Designating physically separate smoking areas		EC.02.01.03, EP 1	EC.02.01.03, EP 1		EC.02.01.03, EP 1		
EC.02.03.01, EP 2	Minimizing fire risk if patients are permitted to smoke		EC.02.03.01, EP 1	EC.02.03.01, EP 1				
EC.02.04.01, EP 1	Selecting and acquiring medical equipment	◀		◀	◀		◀	
EC.02.04.01, EP 8	Monitoring and reporting harm caused by medical equipment			★				
EC.02.05.01, EP 12	Having procedures for obtaining emergency repair services			◀	◀	◀		
EC.02.05.07, EPs 11 and 12 (formerly EPs 9 and 10)	Implementing protective measures and performing a retest after a required emergency power system test fails	●	●	●	●	●	●	●
EC.02.06.01, EP 23	Providing emergency access to all locked and occupied spaces	◀				◀		
EC.03.01.01, EP 1	Having staff who can describe/ demonstrate how to eliminate/ minimize physical risks in environment of care	◀	◀	◀	◀		◀	
EC.03.01.01, EP 3	Having staff who can describe/ demonstrate how to report environment of care risks	◀	◀	◀	◀		◀	
EC.04.01.01, EP 12	Conducting environmental tours every six months in patient and resident care areas			◀		Retained		◀
EC.04.01.01, EP 13	Conducting annual environmental tours in areas where care is not provided			◀	◀	Retained		
EC.04.01.01, EP 14	Monitoring environmental deficiencies, hazards, unsafe practices	◀	Retained	◀	◀	◀	◀	

[EP]	=	Duplicative or implicit in EP shown	◀	=	Should be left to organization's discretion
●	=	Addresses routine part of operations or clinical care processes	Retained	=	EP applicable to, and retained in, program
★	=	Adequately addressed by external requirements	[Blank]	=	EP not applicable to program

Continued on page 14

Joint Commission Deletes Numerous EPs from Nonhospital Accreditation Programs (continued)

Continued from page 13

Deleted Requirement	Topic	Reason for Deletion by Program						
		AHC	BHC	CAH	LAB	NCC	OBS	OME
EC.04.01.03, EP 1	Analyzing environment of care data	▲	▲	▲	▲	▲		▲
EC.04.01.03, EP 3	Recommending priorities for environment of care improvements			Other EPs in this standard	Other EPs in this standard			
EC.04.01.05, EP 2	Determining whether changes resolved environmental safety issues	EC.04.01.05, EP 1	EC.04.01.05, EP 1	EC.04.01.05, EP 1	EC.04.01.05, EP 1	EC.04.01.05, EP 1		
EC.04.01.05, EP 3	Reporting performance improvement results for analysis			Other EPs in this standard				
HR.01.02.05, EP 6	Making decisions about staff job responsibilities	▲		▲	Retained	▲	▲	▲
HR.01.02.05, EP 17	Having a qualified social worker			Moved to Glossary				
HR.01.04.01, EP 7	Orienting external law enforcement and security personnel			▲				
HR.01.05.03, EP 5	Staff education and training specific to population served	HR.01.05.03, EPs 1 and 4		HR.01.05.03, EPs 1 and 4	Retained	Retained		Retained
HR.01.05.03, EP 6	Staff education and training on communication, collaboration, coordination			▲	▲			
HR.01.05.03, EP 7	Staff education and training on reporting unanticipated adverse events	HR.01.05.03, EPs 1 and 4; reporting requirements in LD chapter		HR.01.05.03, EPs 1 and 4; reporting requirements in LD chapter	HR.01.05.03, EPs 1 and 4; reporting requirements in LD chapter			HR.01.05.03, EPs 1 and 4; reporting requirements in LD chapter
HR.01.05.03, EP 8	Staff education and training on fall reduction activities			▲				
HR.01.05.03, EP 13	Staff education and training on early warning signs of change in patient's condition			PC.02.01.19				
HR.01.06.01, EP 2	Using assessment methods to determine competence			▲		▲		▲
HR.01.06.01, EP 15	Taking action when competence does not meet expectations	● ▲		● ▲	Retained	● ▲		● ▲

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Deleted Requirement	Topic	Reason for Deletion by Program						
		AHC	BHC	CAH	LAB	NCC	OBS	OME
IC.01.05.01, EP 3	Describing process for evaluating infection prevention and control plan	▲	Retained	▲	▲		▲	▲
IC.01.05.01, EP 7	Communicating responsibilities for preventing/ controlling infection	IC.02.01.01, EP 7	IC.02.01.01, EP 7	IC.02.01.01, EP 7	IC.02.01.01, EP 7		IC.02.01.01, EP 7	IC.02.01.01, EP 7
IC.01.05.01, EP 8	Reporting infection surveillance/ control information to external organizations	IC.02.01.01, EP 9	IC.02.01.01, EP 9	IC.02.01.01, EP 9	IC.02.01.01, EP 9		IC.02.01.01, EP 9	IC.02.01.01, EP 9
IC.01.06.01, EP 1	Identifying resources about infections that could cause influx of potentially infectious individuals	▲	▲	▲		▲		▲
IC.01.06.01, EP 5	Describing methods for managing influx of potentially infectious individuals	IC.01.06.01, EP 4	IC.01.06.01, EP 4	IC.01.06.01, EP 4	IC.01.06.01, EP 4			IC.01.06.01, EP 4
IC.01.06.01, EP 6	Activating response to influx of potentially infectious individuals	▲	▲	▲	▲	▲		▲
IM.01.01.01, EP 1	Identifying internal and external information needed to provide care	LD.03.02.01, EP 1	LD.03.02.01, EP 1	LD.03.02.01, EP 1	LD.03.02.01, EP 1	LD.03.02.01, EP 1		LD.03.02.01, EP 1
IM.01.01.01, EP 3	Developing processes for managing information	LD.03.02.01, EP 1	LD.03.02.01, EP 1	LD.03.02.01, EP 1	LD.03.02.01, EP 1			LD.03.02.01, EP 1
IM.01.01.01, EP 4	Assessing, selecting, integrating, and using information management systems	LD.03.02.01, EP 1	LD.03.02.01, EP 1	LD.03.02.01, EP 1	LD.03.02.01, EP 1			LD.03.02.01, EP 1
IM.01.01.03, EP 5	Testing plan for managing interruptions to information processes	EC utilities management and EM emergency management requirements	EC utilities management and EM emergency management requirements	EC utilities management and EM emergency management requirements	EC utilities management and EM emergency management requirements	EC utilities management and EM emergency management requirements		EC utilities management and EM emergency management requirements
IM.01.01.03, EP 6	Implementing plan for managing interruptions to information processes	EC utilities management and EM emergency management requirements	EC utilities management and EM emergency management requirements	EC utilities management and EM emergency management requirements	EC utilities management and EM emergency management requirements	EC utilities management and EM emergency management requirements		EC utilities management and EM emergency management requirements

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●	=	Addresses routine part of operations or clinical care processes	Retained	=	EP applicable to, and retained in, program
★	=	Adequately addressed by external requirements	[Blank]	=	EP not applicable to program

Continued on page 16

Joint Commission Deletes Numerous EPs from Nonhospital Accreditation Programs (continued)

Continued from page 15

Deleted Requirement	Topic	Reason for Deletion by Program						
		AHC	BHC	CAH	LAB	NCC	OBS	OME
IM.02.01.01, EP 5	Monitoring compliance with policy on health information privacy	IM.02.01.01, EP 3	IM.02.01.01, EP 3	IM.02.01.01, EP 3	IM.02.01.01, EP 3	IM.02.01.01, EP 3		IM.02.01.01, EP 3
IM.02.01.03, EP 8	Monitoring compliance with policies on health information security/integrity	● ▲	● ▲	● ▲	● ▲			● ▲
IM.02.02.01, EP 1	Using uniform data sets to standardize data collection	▲	▲	▲	▲	▲		▲
IM.02.02.03, EP 1	Having written policies addressing data capture, display, transmission, retention			▲	Retained			▲
IM.03.01.01, EP 2	Making cooperative or contractual arrangements for knowledge-based information resources			IM.03.01.01, EP 1				
IM.04.01.01, EP 1	Having processes to check accuracy of health information	RC.01.04.01, EP 1	RC.01.04.01, EP 1	RC.01.04.01, EP 1	Retained			RC.01.04.01, EP 1
LD.01.02.01, EP 2	Making decisions when a leadership group fails			▲				
LD.01.04.01, EP 2	Providing for recruitment and retention of staff by chief executive	LD.03.06.01, EP 3	LD.03.06.01, EP 3	LD.03.06.01, EP 3				LD.03.06.01, EP 3
LD.01.04.01, EP 11	Designating someone to perform duties of an absent chief executive	▲	▲	▲				Retained
LD.01.05.01, EP 5	Overseeing quality of care, treatment, services by medical staff			MS.03.01.01				
LD.01.07.01, EP 1	Identifying skills required of individual leaders			▲ all EPs in this standard				
LD.01.07.01, EP 2	Orienting leaders to organizational aspects such as mission, vision, operations, population served, applicable laws	Retained	Retained	▲ all EPs in this standard	▲ other EPs in this standard		▲ other EPs in this standard	▲ other EPs in this standard
LD.01.07.01, EP 3	Providing leaders with access to additional information and training	Retained	Retained	▲ all EPs in this standard	▲ other EPs in this standard		▲ other EPs in this standard	▲ other EPs in this standard

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★	=	Adequately addressed by external requirements	[Blank]	=	EP not applicable to program

Deleted Requirement	Topic	Reason for Deletion by Program						
		AHC	BHC	CAH	LAB	NCC	OBS	OME
LD.02.03.01, EP 1	Discussing issues affecting organization and population served	Retained	Retained	▲ other requirements such as LD.04.04.05	▲ other requirements such as LD.04.04.05	Retained	▲ other requirements such as LD.04.04.05	▲
LD.02.03.01, EP 2	Establishing time frames for discussing issues affecting organization and population served	Retained	▲	▲	▲		▲	▲
LD.02.04.01, EP 2	Approving process for managing conflict among leadership groups			▲				
LD.02.04.01, EP 4	Establishing conflict management process steps			▲				
LD.03.01.01, EP 3	Providing opportunities to participate in safety and quality initiatives	▲	▲	▲	▲	Retained	▲	▲
LD.03.01.01, EP 6	Providing education on safety and quality for all individuals	▲	▲	▲	▲	▲	▲	▲
LD.03.01.01, EP 7	Establishing team approach among staff at all levels	▲	▲	▲	▲	▲	▲	▲
LD.03.01.01, EP 8	Making sure all staff can openly discuss issues of safety and quality	▲	Retained	▲	▲	▲	▲	▲
LD.03.01.01, EP 9	Making patient safety literature and advisories available to all staff	▲	▲	▲	▲	▲	▲	▲
LD.03.01.01, EP 10	Defining how patients can help identify/manage safety/quality issues	▲	▲	▲	▲	▲	▲	▲
LD.04.01.03, EP 5	Monitoring implementation of budget and long-term capital expenditure plan	●	Retained	●		●		●
LD.04.01.05, EP 1	Overseeing operations	LD.04.01.05, EPs 2–5	LD.04.01.05, EPs 2–5	Retained		LD.04.01.05, EPs 2–5	LD.04.01.05, EPs 2–5	LD.04.01.05, EPs 2–5
LD.04.01.11, EP 2	Arranging and allocating space for care, treatment, and services	LD.04.01.11, EP 3	LD.04.01.11, EP 3	Retained			LD.04.01.11, EP 3	LD.04.01.11, EP 3

[EP]	=	Duplicative or implicit in EP shown	▲	=	Should be left to organization's discretion
●	=	Addresses routine part of operations or clinical care processes	Retained	=	EP applicable to, and retained in, program
★	=	Adequately addressed by external requirements	[Blank]	=	EP not applicable to program

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Joint Commission Deletes Numerous EPs from Nonhospital Accreditation Programs (continued)

Continued from page 17

Deleted Requirement	Topic	Reason for Deletion by Program						
		AHC	BHC	CAH	LAB	NCC	OBS	OME
LD.04.02.03, EP 3	Following ethical practices for marketing and billing	●	Retained	●	●	●		●
LD.04.02.03, EP 4	Representing care, treatment, and services accurately in marketing materials	●	Retained	●	●		●	Retained
LD.04.02.03, EP 6	Monitoring effective care, treatment, and services when staff are excused from responsibilities	▲	▲	▲		▲		▲
LD.04.02.03, EP 7	Informing patients about their charges	Retained	Retained	●				Retained
LD.04.02.05, EP 2	Providing safe, quality care regardless of patient's ability to pay		★	★				Retained
LD.04.03.07, EP 2	Maintaining care, treatment, and services consistent with mission, vision, and goals	▲	▲	▲	▲		▲	▲
LD.04.04.03, EP 6	Analyzing design of new/modified services/processes to determine whether design is improvement	▲	▲	▲		▲	▲	▲
LD.04.04.03, EP 7	Involving staff/patients in design of new/modified services/processes	Retained	▲	▲	▲	▲		▲
MM.03.01.05, EP 3	Informing prescriber and patient if medications brought in are not permitted	MM.03.01.05, EPs 1 and 2	MM.03.01.05, EPs 1 and 2	MM.03.01.05, EPs 1 and 2		MM.03.01.05, EPs 1 and 2		MM.03.01.05, EPs 1 and 2
MM.08.01.01, EP 4	Reviewing literature and other external sources for new technologies and best practices	▲		▲				▲
NR.01.01.01, EP 4	Including nurse executive in leadership meetings			NR.01.01.01, EP 5				
NR.01.02.01, EP 4	Considering education and experience when appointing nurse executive			▲ NR.01.02.01, EP 3				
NR.01.02.01, EP 5	Considering scope of services when appointing nurse executive			▲				

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Deleted Requirement	Topic	Reason for Deletion by Program						
		AHC	BHC	CAH	LAB	NCC	OBS	OME
NR.01.02.01, EP 6	Considering scope of nursing care needs of patient population when appointing nurse executive			▲				
NR.01.02.01, EP 7	Considering availability of staff and services needed when appointing nurse executive			▲				
NR.02.01.01, EP 1	Coordinating hospital's nursing care, treatment, services			NR.02.01.01, EP 4				
NR.02.02.01, EP 5	Writing standards to measure, assess, and improve patient outcomes			Other EPs in standard; PI duties of leaders in LD and PI chapters				
PC.01.02.01, EP 4	Including certain information in initial patient assessment	● ▲ PC.01.02.01, EPs 1 and 2		● ▲ PC.01.02.01, EPs 1 and 2				
PC.01.02.01, EP 23	Gathering required data and information during (re)assessment	● PC.01.02.01, EP 1		● PC.01.02.01, EP 1		● PC.01.02.01, EP 1	● PC.01.02.01, EP 1	● PC.01.02.01, EP 1
PC.01.02.03, EP 7	Completing a nutritional screening within 24 hours of admission			● ▲				
PC.01.02.03, EP 8	Completing a functional screening within 24 hours of admission			● ▲ PC.01.02.01, EPs 1 and 2				
PC.01.02.09, EP 5	Assessing or referring those who meet criteria for possible abuse or neglect	Other EPs in this standard		Other EPs in this standard		Other EPs in this standard	Other EPs in this standard	Other EPs in this standard
PC.01.02.15, EP 1	Performing testing and procedures as ordered	●		●		●	●	
PC.01.02.15, EP 3	Providing information to interpret results	●		●		●	●	

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●	=	Addresses routine part of operations or clinical care processes	Retained	=	EP applicable to, and retained in, program
★	=	Adequately addressed by external requirements	[Blank]	=	EP not applicable to program

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Joint Commission Deletes Numerous EPs from Nonhospital Accreditation Programs (continued)

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Deleted Requirement	Topic	Reason for Deletion by Program						
		AHC	BHC	CAH	LAB	NCC	OBS	OME
PC.02.01.11, EP 3	Locating resuscitation equipment			PC.02.01.11, EP 2				
PC.02.01.19, EP 3	Seeking additional assistance when staff have concerns about patient's condition			●		Retained		
PC.02.01.19, EP 4	Informing patient and family how to seek assistance when there are concerns about patient's condition			●		Retained		
PC.02.02.03, EP 1	Assigning responsibility for safe/accurate provision of food/nutrition products			●				
PC.02.02.03, EP 8	Accommodating special diets			PC.02.02.03, EP 7		Retained		
PC.02.02.03, EP 10	Offering substitutes to those who refuse food			PC.02.02.03, EP 7		Retained		
PC.02.02.07, EP 1	Arranging for academic education for children and youth					★		
PC.02.03.01, EP 4	Educating and training patients based on assessed needs	Retained				PC.02.03.01, EP 10	Retained	Retained
PC.03.01.01, EP 1	Administering moderate or deep sedation and anesthesia by qualified individuals	HR.01.02.01, HR.01.02.05, HR.01.02.07, HR.02.01.03		HR.01.02.01, EP 1; HR.01.02.05, EP 3; HR.01.02.07, EPs 1 and 2; HR.01.06.01, EP 1; LD.03.06.01, EP 3; MS.06.01.03, EP 6; PC.03.01.01, EP 9			HR.01.02.05, HR.01.02.07, HR.02.01.03	

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●	=	Addresses routine part of operations or clinical care processes	Retained	=	EP applicable to, and retained in, program
★	=	Adequately addressed by external requirements	[Blank]	=	EP not applicable to program

Deleted Requirement	Topic	Reason for Deletion by Program						
		AHC	BHC	CAH	LAB	NCC	OBS	OME
PC.03.01.01, EP 2	Conducting procedures with moderate or deep sedation and anesthesia with a sufficient number of qualified staff	Retained		HR.01.02.01, EP 1; HR.01.02.05, EP 3; HR.01.02.07, EPs 1 and 2; HR.01.06.01, EP 1; LD.03.06.01, EP 3; MS.06.01.03, EP 6; PC.03.01.01, EP 9			Retained	
PC.03.01.01, EP 8	Making sure resuscitation equipment is available during operative/high-risk procedures	PC.02.01.11, EP 2		PC.02.01.11, EP 2			PC.02.01.11, EP 2	
PC.03.01.03, EP 2	Anticipating care needed after operative/high-risk procedures or those with moderate or deep sedation and anesthesia	●		●			●	
PC.03.01.03, EP 3	Providing treatment/services before operative/high-risk procedures or those with moderate or deep sedation and anesthesia	●					●	
PC.03.01.03, EP 7	Making sure LIP plans/concurs with sedation or anesthesia plan	● PC.01.03.01, EP 1		● PC.01.03.01, EP 1			● PC.01.03.01, EP 1	
PC.03.02.01, EPs 1 and 2	Limiting use of restraint for nonbehavioral health purposes			PC.03.05.01, EPs 1–5; PC.03.05.03 EPs 1 and 2				
PC.03.03.01, EPs 1 and 2	Defining the hospital's approach to the use of restraint and seclusion for behavioral health purposes			PC.03.05.01, EPs 1–5; PC.03.05.03 EPs 1 and 2				

[EP]	=	Duplicative or implicit in EP shown	▲	=	Should be left to organization's discretion
●	=	Addresses routine part of operations or clinical care processes	Retained	=	EP applicable to, and retained in, program
★	=	Adequately addressed by external requirements	[Blank]	=	EP not applicable to program

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Joint Commission Deletes Numerous EPs from Nonhospital Accreditation Programs (continued)

Continued from page 21

Deleted Requirement	Topic	Reason for Deletion by Program						
		AHC	BHC	CAH	LAB	NCC	OBS	OME
PC.04.01.01, EP 3	Describing mechanisms for external transfer of patient	PC.04.01.01, EP 2		PC.04.01.01, EP 2			PC.04.01.01, EP 2	PC.04.01.01, EP 2
PC.04.01.01, EP 4	Agreeing on transferring and receiving organizations' roles to keep individuals safe during transfer	PC.04.01.01, EP 2		PC.04.01.01, EP 2		PC.04.01.01, EP 2	PC.04.01.01, EP 2	PC.04.01.01, EP 2
PC.04.01.05, EP 3	Giving the individual reasons for discharge or transfer			Other EPs in this standard		Other EPs in this standard		Other EPs in this standard
PC.04.01.05, EP 5	Informing individuals about any alternatives to transfer			Other EPs in this standard		Other EPs in this standard		
PC.04.01.05, EP 8	Providing written, understandable discharge instructions	RI.01.01.03, EP 1		RI.01.01.03, EP 1		Retained	Retained	RI.01.01.03, EP 1
PI.01.01.01, EP 12	Collecting data on behavior management and treatment					▲		
PI.01.01.01, EP 30	Considering collecting data on staff input	▲	▲	▲	▲	▲		▲
PI.01.01.01, EP 38	Evaluating effectiveness of fall reduction activities			▲				
PI.01.01.01, EP 39	Collecting data on efficacy of response to changes in patient's condition			▲				
PI.02.01.01, EP 1	Compiling data in usable formats	▲	▲	▲	▲		▲	▲
PI.02.01.01, EP 2	Identifying frequency for data analysis	▲	▲	▲	▲		▲	▲
PI.02.01.01, EP 5	Comparing data with available external sources	▲	▲	▲	Retained	▲	▲	▲
PI.03.01.01, EP 1	Prioritizing identified improvement opportunities	▲	▲	▲	▲		▲	Retained
PI.03.01.01, EP 3	Evaluating whether actions resulted in improvements	PI.03.01.01, EPs 2 and 4	PI.03.01.01, EPs 2 and 4	PI.03.01.01, EPs 2 and 4	PI.03.01.01, EPs 2 and 4	PI.03.01.01, EPs 2 and 4	▲	Retained
RC.01.01.01, EP 4	Making sure medical record contains unique individual information		RC.02.01.01, EPs 1 and 2	RC.02.01.01, EPs 1 and 2		RC.02.01.01, EPs 1 and 2		

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Deleted Requirement	Topic	Reason for Deletion by Program						
		AHC	BHC	CAH	LAB	NCC	OBS	OME
RC.01.01.01, EP 9	Using standardized formats to document care, treatment, and services	▲	Retained	▲		▲		▲
RC.01.01.01, EP 12	Tracking location of all components of medical record	▲	Retained	▲		▲	▲	▲
RC.01.01.01, EP 13	Making sure medical record has all information required to provide care, treatment, and services	●	●			●	●	●
RC.01.04.01, EP 3	Measuring medical record delinquency rate no less than every three months			●				
RC.01.04.01, EP 4	Making sure medical record delinquency rates are no greater than 50% of the average monthly discharge rate			● RC.01.03.01, EP 2				
RC.02.01.07, EP 1	Initiating summary list for patient by third visit	RC.01.01.01, EP 13		● all EPs in standard				
RC.02.01.07, EP 2	Maintaining a summary list that contains certain information	RC.02.01.01, EP 2; RC.02.01.03, EP 1		● all EPs in standard				
RC.02.01.07, EPs 3 and 4	Keeping summary list updated and available to practitioners	● all EPs in standard		● all EPs in standard				
RI.01.03.01, EP 12	Discussing when an individual's information must be disclosed/ reported	★	★	★		★		★
RI.01.03.03, EP 2	Obtaining/documenting informed consent for external use of recordings, films, or other images	▲	▲	▲		▲		▲

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Joint Commission Deletes Numerous EPs from Nonhospital Accreditation Programs (continued)

Continued from page 23

Deleted Requirement	Topic	Reason for Deletion by Program						
		AHC	BHC	CAH	LAB	NCC	OBS	OME
RI.01.03.03, EPs 3–5	Taking certain actions when an individual is unable to give informed consent for recordings, films, or other images			▲				
RI.01.03.03, EPs 6–8	Informing patient of right to request cessation of production, making sure confidentiality agreements are signed, and accommodating patient's right to rescind consent prior to use of recording, film, or image	▲	▲	▲				▲
RI.01.03.05, EP 1	Reviewing all research protocols and weighing risks/benefits to research participant	●▲ other EPs in this standard	●▲ other EPs in this standard	●▲ other EPs in this standard		●▲ other EPs in this standard	●▲ other EPs in this standard	●▲ other EPs in this standard
RI.01.03.05, EP 9	Keeping all information given to subjects in the medical record or research file			▲				
RI.01.06.05, EPs 15 and 16	Offering telephone (private access, if desired) and mail service		▲	Retained		▲		
RI.01.06.05, EP 19	Evaluating restrictions on communication for therapeutic effectiveness		▲					
RI.01.07.01, EP 10	Allowing individuals to voice complaints and recommend changes	Retained	★	★		★		Retained
RI.01.07.03, EPs 2 and 3	Maintaining (and providing to patients) list of patient advocacy groups		RI.01.07.03, EP 1	▲		RI.01.07.03, EP 1		
TS.01.01.01, EP 2	Identifying affiliated organ procurement organization in written policies and procedures			TS.01.01.01, EP 1				
TS.03.01.01, EP 4	Coordinating tissue acquisition, receipt, storage, issuance	▲		▲	▲		▲	

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Deleted Requirement	Topic	Reason for Deletion by Program						
		AHC	BHC	CAH	LAB	NCC	OBS	OME
TS.03.01.01, EP 11	Complying with state and/or federal regulations as a tissue supplier	★		★	Retained		★	
WT.01.01.01, EP 5	Making current/complete policies and procedures available to waived tester	▲	▲	▲	Retained	▲	▲	Retained
WT.01.01.01, EP 6	Following written policies, procedures, and manufacturer's instructions for waived testing	▲★ WT.01.01.01, EPs 1 and 2	▲★ WT.01.01.01, EPs 1 and 2	▲★ WT.01.01.01, EPs 1 and 2	Retained	▲	▲★ WT.01.01.01, EPs 1 and 2	Retained
WT.01.01.01, EP 7	Following specified criteria for confirmatory testing	▲	▲	▲	▲	▲	▲	▲
WT.01.01.01 , EP 8	Making sure clinical use of results is consistent with policies and manufacturer's recommendations	▲★	▲★	▲★	▲★	Retained	▲★	

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Ordering and Implementing Medication Titration Orders Safely

Titration orders are a common medication order type used in the treatment of critically ill patients. While useful in managing care, titration orders may create risk for the patient and the nurse caring for the patient if not properly ordered. Medication Management (MM) Standard MM.04.01.01, Elements of Performance (EPs) 1 and 2 require organizations to identify the specific types of orders they allow as well as the elements necessary for the order to be considered complete.

Defining the elements required for a complete titration order helps ensure that there are clear instructions for the provision of safe, consistent administration of titrated medications. Table 1 crosswalks the elements of a medication order required by the Centers for Medicare & Medicaid Services (CMS) Condition of Participation (CoP) §482.23(c), which coincide with National Standards of Practice, with the elements required by The Joint Commission. An additional precedence for these required elements ensures that different caregivers consistently provide the same care in a given situation.

Table 1. Crosswalk of Required Elements for Titration Orders

CoP §482.23(c) and National Standards of Practice	The Joint Commission
Drug name	Medication name
Dose	Starting dose Incremental dosage change Maximum dose
Route	Medication route
Frequency	Frequency of titration
Dose calculation requirements (if applicable)	Alternate for dose if order is expressed in dosing unit/weight unit/time (also could be utilized to support measurable end point)
Exact strength of concentration (if applicable)	Would only be necessary if order is written to infuse at a rate
Quantity/duration (if applicable)	Covered through hospital policy in Standard MM.04.01.01
Special instructions (if applicable)	Measurable end point

Ordering points that should be taken into account for titration orders include the need to ensure the nurse caring for the patient has a clearly written order with sufficient detail to direct the rate of infusion as well as the frequency in which a medication may be titrated. Ranges may be included in the order; however, these must also be clearly defined in the medication order policy. Another important element is inclusion of an objective, measurable endpoint—for example, a numeric target on an evidence-based assessment tool such as a RASS scale.

Assessing Compliance

Joint Commission surveyors will assess the organization's degree of compliance with standards related to the ordering and implementation process for titration orders as part of tracer activities. The evaluation will include reviewing the written policy/procedure for titration orders; the ordering and pharmacy review processes; documentation of any assessments, reassessments, and incremental dose changes according to the order; and staff competencies related to the administration of titrated medications. Table 2 provides guidance on which requirements will be cited for various surveyor findings.

Table 2. Surveyor Guidelines for Evaluating Compliance

Observed Scenario	Requirement Cited
Components listed in Table 1 not included in policy	MM.04.01.01, EP 1
Components listed in Table 1 included in policy but not in order written by LIP	MM.04.01.01, EP 13
Administration of medication not in accordance with order written by LIP	PC.02.01.03, EP 7
Components listed in Table 1 not included in order and order does not have items listed in Table 1	MM.04.01.01, EP 1 for the policy; MM.05.01.06, EP 1 for pharmacy not clarifying elements needed for order to be implemented
Requirements not defined for assessing and reassessing patients receiving a titrated medication	PC.01.02.01, EP 1
Competencies specific to safe administration of titrated medications not defined	Human Resources (HR) Standard HR.01.06.01, EP 1
Safe medication ordering and administration practices not incorporated into overall Quality Assessment/Performance Improvement (QAPI) activities	Leadership (LD) Standard LD.01.03.01, EP 21

As the process for assessment and reassessment is evaluated, organizations should review Provision of Care, Treatment, and Services (PC) Standard PC.01.02.01, EP 1, which requires hospitals to define, "in writing, the scope and content of screening, assessment, and reassessment." While hospitals have set a standard for assessing sedation levels for critical patients, they are often challenged as to how to assess patients on sedative drips who have different targeted responses or desired outcomes to the medication. Therefore, hospitals should determine and define whether the current assessment of sedation level adequately includes patients on a sedative drip and those who are not. In addition, the assessment tool used for the order should be the same tool used to assess sedation (for example, if the order is written based on a RASS assessment, then a GCS should not be used as the indicator for the infusion rate).

It is suggested that organizations consider other patient care areas (such as labor and delivery) that also could utilize titration orders. During this review, clinical endpoints should be clearly defined, and terms such as *adequate contractions* should be avoided (unless adequately defined).

For more information, please see the April 5, 2017, issue of *Joint Commission Online* at https://www.jointcommission.org/assets/1/23/JC_Online_April_5.pdf. Questions may be directed to the Standards Interpretation Group at https://web.jointcommission.org/sigsubmission/sigquestionform.aspx.

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