July 2018 Volume 38 | Number 7

The Joint Commission Perspectives®

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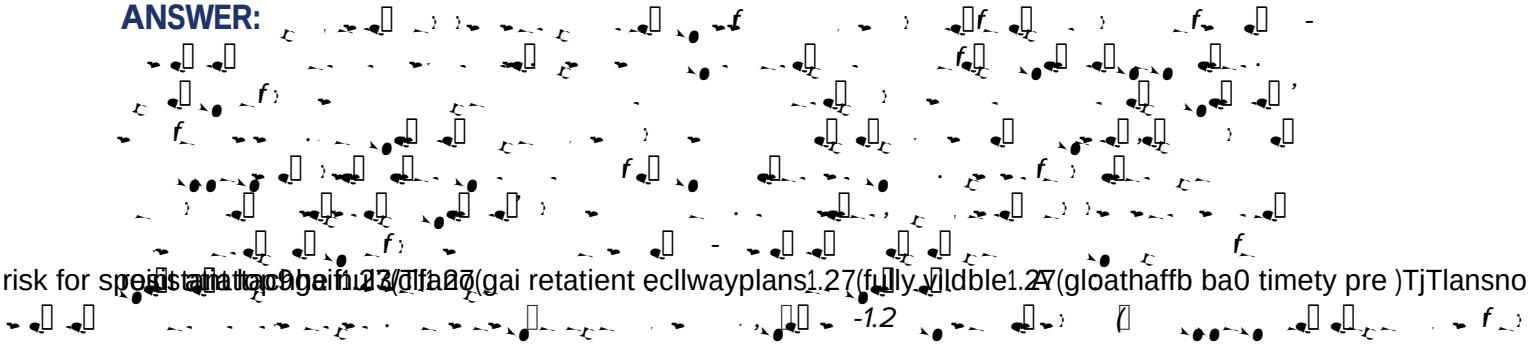
NEW:


UPDATE:

ANSWER:



QUESTION: **What type of shower curtains are allowable in an inpatient psychiatric unit?**

ANSWER:

QUESTION: **Can curtains be used in place of a bathroom door in an inpatient psychiatric unit?**

ANSWER:

Emergency Departments

QUESTION: **Do emergency departments need to be ligature resistant?**

ANSWER:

QUESTION: **Does every emergency department need to have a "safe room"?**

ANSWER:

QUESTION: **Do we have to have 1:1 monitoring for every psychiatric patient who comes in through the emergency department?**

ANSWER:

QUESTION: **Do we have to assess every patient for suicide risk who comes into the emergency department?**

ANSWER:

QUESTION: Do emergency departments in Joint Commission–accredited ambulatory care organizations need to comply with the "Recommendations for Emergency Departments" in the November 2017 *Perspectives* article?

ANSWER:

References

1. Joint Commission Resources. Special report: Suicide prevention in health care settings. 2017 Nov;37(11):1 and 3–7.
2. Joint Commission Resources. Special report: Suicide prevention in health care settings. 2018 Jan;38(1):1–3.
3. Joint Commission Resources. Notes on suicide prevention panel recommendations published in November. 2018 Feb;38(2):12.
4. Joint Commission Resources. Update: Recommendations from fourth meeting of suicide expert panel. 2018 Mar;38(3):1 and 2.

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Consistent Interpretation

Joint Commission Surveyors' Observations on IC Requirements and Mw8sTEmtatiot Copounw8sTEmnrg

Surveyor Observations	Guidance/Interpretation
The hospital did not have documentation of the	

The neck of the compounder's gown was not snug around the neck.	Critical sites are equipment and locations that include any component or fluid pathway surfaces: • Openings • Vial tops • Ampule necks • Needle hubs, shafts, and tips • Syringe tips and plungers • Tubing and dispensing pin spikes • Injection ports of IV solutions

NEW: Requirement for Distinct Identification for Newborns

The Joint Commission recently approved one new requirement for **hospitals** and **critical access hospitals** that provide labor and delivery services. This new element of performance (EP)—**effective January 1, 2019**—is at National Patient Safety Goal NPSG.01.01.01, EP 3. The EP is designed to improve the naming convention of newborns after delivery to prevent medical errors—such as wrong tests, wrong procedures, or administering the wrong expressed breastmilk to an infant—due to conventional, nondistinct naming methods. These requirements were finalized using responses from a public field review, which included review from professional organizations. The project's [illegible] provides the rationales for the new requirements as well as references to the research articles used to develop them.

The new requirement requires hospitals and critical access hospitals to use distinct naming methods for their newborn patients; the EP also provides examples of how organizations may meet the new requirement based on their current practices and areas of self-perceived risk. Hospitals and critical access hospitals are asked to evaluate their current naming methods of newborn identification and determine how they can take that naming convention one step further for the safety of their newborn patients.

The new, underlined requirement shown below will be posted on the Prepublication Standards page of The Joint Commission website. The changes also will be reflected in the fall 2018 E-dition® and the 2019 hard copy publications of the [illegible] for the hospital and critical access programs.

For more information, please contact Jennifer Hurlburt, MSN, RN, APN/CNS, associate director, Department of Standards and Survey Methods, The Joint Commission.

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UPDATE: EP Review Project, Phase IV

Joint Commission Continues Streamlining of Accreditation Standards

The Joint Commission is continuing its efforts to streamline and consolidate its existing elements of performance (EPs) for **all accreditation programs** as part of the EP (Element of Performance) Review Project. The next group of revisions, which are part of Phase IV of the project, become **effective January 1, 2019**.

While Phases I, II, and III of the EP Review Project (a component of the Project REFRESH process improvement initiatives) resulted in the deletion of hundreds of EPs across accreditation programs, Phase IV is the evaluation of EPs across all accreditation programs in order to streamline and consolidate them. Chapters reviewed in the first two parts of Phase IV were summarized by chapter and accreditation program in the October 2017 and February 2018 issues of .

The recently completed third part of Phase IV reviewed the "Care, Treatment, and Services" (CTS) chapter (behavioral health care program), the "Medication Management" (MM) chapter (all programs except laboratory), the "Nursing" (NR) chapter (hospital and critical access hospital programs), and the "Provision of Care, Treatment, and Services" (PC) chap-

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Changes to Requirements for Organizations Providing Fluoroscopy Services

Effective January 1, 2019, The Joint Commission will implement several standards changes designed to enhance the provision of safe, high-quality imaging services for **ambulatory care organizations**, **critical access hospitals**, **hospitals**, and **office-based surgery practices**. Most of these standards changes focus on fluoroscopy; however, one of them revises required tests for computed tomography units, and another establishes a radiation safety officer. The changes were made to clarify expectations and address areas of risk associated with imaging.

The standards changes will be displayed on the Prepublication Standards page of The Joint Commission website and will published online in the fall 2018 E-dition® update. The revisions will also be included in the 2019 hard copy publications of the [illegible] for the ambulatory care, critical access hospital, and hospital programs.

For more information, please contact Joyce Webb, RN, BSN, MBA, project director, Department of Standards and Survey Methods, The Joint Commission. P

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FSA Tool Temporarily Offline for July 2018 Standards Update

Starting June 29, 2018, at 7:00 P.M. central time (CT), the Focused Standards Assessment (FSA) tool on the Intracycle Monitoring (ICM) Profile will be offline for the July 2018 standards update. The tool will resume July 12, 2018, at 9:00 P.M. CT. An extension date will be applied for accredited organizations with a scheduled ICM submission due date between June 30th and July 12th 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 30, 2018.**

Questions may be directed to your organization's designated Account Executive at 630-792-3007.

New Direct Data Submission Platform Announced for Performance Measures

The Joint Commission recently launched a new direct data submission platform for reporting electronic clinical quality measure (eCQM) data. Quality and health informatics leaders at more than 600 Joint Commission–accredited hospitals representing independent and health system organizations across the country comprised the first wave of participating hospitals submitting data in 2018 for calendar year (CY) 2017.

The hospitals that have transitioned to the new platform reported that the new technology has streamlined their process—and reduced the time and resources required—for ORYX® performance measurement reporting. In addition, hospitals and systems are reporting realized or projected annual savings of $20,000 to $50,000 compared to their traditional process of contracting with a data vendor (with the technological capacity to manage the data) to submit to The Joint Commission on their behalf.

For more than 30 years, The Joint Commission has developed and incorporated performance measure data reporting into its accreditation and certification processes to support accredited and certified organizations in measuring their performance for quality improvement.

Historically, most hospitals manually abstracted data from patient charts to compile and submit their quality measures for patient care. Over the last several years, a number of hospitals began transitioning to eCQMs that rely on structured, encoded data present in the electronic health record. Meanwhile, The Joint Commission worked to identify the technology and a process to receive that eCQM data directly from hospitals without the need for a third-party vendor.

After the CY 2017 eCQM data submission is closed for 2018, The Joint Commission will invite all its accredited hospitals with CY 2018 ORYX® eCQM reporting requirements to transition to direct data submission through its new platform. (Additional information will be provided later this summer to hospitals with eCQM requirements.) While it will continue accepting hospitals' chart-based data submitted through ORYX® vendors through 2019, The Joint Commission encourages transition to the direct data submission platform for the CY 2018 eCQM reporting period.

Updated details will be provided on the Performance Measurement page of The Joint Commission website.

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APPROVED: New Performance Measures for Primary Stroke Centers

Effective January 1, 2019, The Joint Commission will require data collection for two new performance measures for **Primary Stroke Center (PSC) Certification** (an advanced disease-specific care certification program). Adding these two new measures means that there will be 10 stroke performance measures required to achieve and maintain this certification designation.

Stroke Outpatient (STK-OP) Measure

A stratified measure, STK-OP-1 Door to Transfer to Another Hospital, will be used to monitor "door in, door out" times for stroke patients transferred from the emergency department of a PSC to a higher-level acute stroke center. Median time in minutes will be reported monthly for hemorrhagic stroke patient transfers and four groupings of ischemic stroke patients. The ischemic stroke submeasures will differentiate between patients who receive IV alteplase (t-PA) therapy prior to transfer ("drip and ship") and those patients who have a large vessel occlusion and may be eligible for mechanical thrombectomy (table). STK-OP-1 Door to Transfer to Another Hospital will complement the door-to-transfer measure collected by Acute Stroke Ready Hospitals.

tabletable

2019 MEASURES FOR PSC CERTIFICATION

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- A **Primary Care Panel** of experts in chronic noncancer pain management in the primary care setting such as members of leading health care organizations with ongoing safe prescribing and provider education initiatives
- A **Standards Review Panel** of representatives from organizations or professional associations who provided a "boots on the ground" point of view and insights into the practical application of the proposed standards

The standards changes will be displayed on the Prepublication Standards page of The Joint Commission website. All requirements do not apply to all settings in the ambulatory care program. A standards applicability grid is forthcoming on the above website.

The revisions will also be included in the fall 2018 E-dition® update and the 2019 hard copy publications of the [illegible] for the ambulatory care and critical access hospital programs.

For more information, please contact Natalya Rosenberg, PhD, RN, project director–clinical, Department of Standards and Survey Methods, The Joint Commission.

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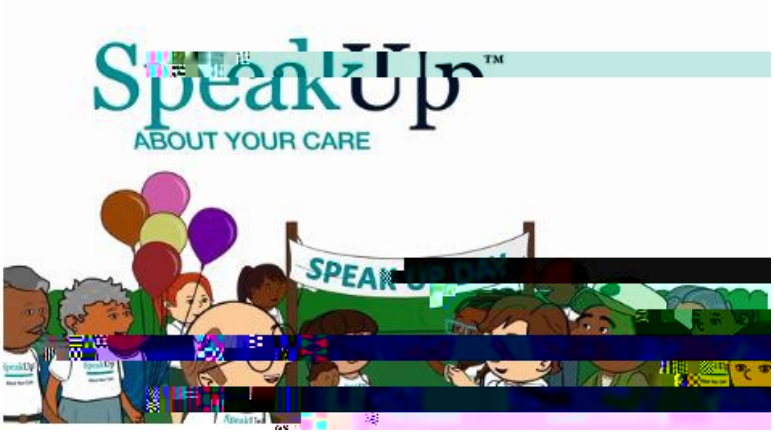
Enhancements Announced for Speak Up™ Program



The Joint Commission recently relaunched its Speak Up™ program, featuring Speak Up™ About Your Care as the first campaign in the refreshed program, to help educate and empower patients to play active roles in their care.

The revamped program includes an enhanced look and updated content for free, downloadable educational materials for the public. The new materials that will be included with each campaign are as follows:

- Infographic (available in three sizes) for patients and families
- Animated video (available in English and Spanish) to incorporate in hospital programming
- Podcast for health care professionals on the value of the program
- Distribution guide with recommendations on how health care organizations can use the materials

Launched in 2002, the Speak Up™ program encourages patients to be their own advocate and to take action in the following ways:

- **S**peak up
- **P**ay attention
- **E**ducate yourself
- **A**dvocates (family members and friends) can help
- **K**now about your new medicine
- **U**se a quality health care organization
- **P**articipate in all decisions about your care

The Speak Up™ program was refreshed after national market research conducted in 2017 that included feedback from a focus group of patients and their families. Additional Speak Up™ campaigns will be updated and debuted over the next several years. To stay up-to-date on refreshed Speak Up™ campaigns as they become available, sign up for e-mail alerts about the new campaigns or subscribe to the e-newsletter [redacted]. For more information about the Speak Up™ program, visit The Joint Commission website.

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334 Reducing Serious Safety Events and Priority Hospital-Acquired Conditions in a Pediatric Hospital with the Implementation of a Patient Safety Program—A.R. Phipps, M. Paradis, K.A. Peterson, J. Jensen, K. Nielsen, M. Hall, K. Simonsen, B.M. Norton

A freestanding children's hospital evaluated the impact of its No Harm Patient Safety Program on serious safety events (SSEs) and hospital-acquired conditions (HACs). The rate of SSEs decreased from 0.19 in 2014 to 0.09 in 2015 and 0.00 in 2016. The organization reached two years without an SSE in July 2017. For HACs, the central line–associated bloodstream infection rate declined from 2.8 per 1,000 line-days in 2015 to 1.6 in 2016 ($p = 0.036$), surgical site infection rates declined from 3.8 infections per 100 procedures in 2015 to 2.6 in 2016 ($p = 0.30$), and catheter-associated urinary tract infection rates declined from 2.7 per 1,000 catheter-days in 2015 to 1.4 in 2016 ($p = 0.28$).

341 What Is the Realistic Scope of Informed Consent?—J.T. Clapp, L.A. Fleisher

The success of a program to use training modules developed by the Agency for Healthcare Research and Quality to teach leaders and staff the principles of informed consent provides an example that other organizations can follow as a first step to ensure that a minimum standard of information is provided to patients in a clear and concise manner during the consent process.

343 Opportunities to Improve Informed Consent with AHRQ Training Modules—S.J. Shoemaker, C. Brach, A. Edwards, S.O. Chitavi, R. Thomas, M. Wasserman

In informed consent, patients often do not understand the risks and benefits associated with a specific intervention and alternatives, even after signing a consent form. In a mixed-methods pilot test of two Agency for Healthcare Research and Quality (AHRQ) informed consent training modules implemented in four

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