The Joint Commission

July 2025 | Volume 45 | Number 7

Joint Commission Perspectives®

THE OFFICIAL NEWSLETTER OF THE JOINT COMMISSION

Contents

Continued on next page

APPROVED: Critical Access Hospital and Hospital Requirements Streamlined to Reduce Burden

As part of its continued efforts to improve the accreditation process, The Joint Commission has revised its **critical access hospital** and **hospital** standards and elements of performance (EPs) to reduce burden on accredited organizations. These revisions provide a streamlined approach that more directly identifies the US Centers for Medicare & Medicaid Services (CMS) Conditions of Participation (CoPs). Consequently, the updates also differentiate which Joint Commission requirements rise above the regulatory requirements. Although these revisions, intended to provide greater clarity for organizations seeking accreditation and **effective January 1, 2026**, are substantial, no new concepts have been introduced.

Streamlined Requirements

The Joint Commission conducted a thorough review of each CoP requirement and revised and streamlined the aligned EPs to use language taken directly from the regulations. This effort reduced the number of EPs required to meet the intent of the CoPs:

- 46% of EPs were eliminated for critical access hospitals
- 48% of EPs were eliminated for hospitals

Accreditation manuals will display the regulation number in a new section below the text of each EP associated with a CoP (previously available only on E-dition®). This will help accredited organizations clearly identify the requirements based on regulation.

National Performance Goals

The Joint Commission consolidated the remaining requirements throughout the manual, excluding the "Medical Staff" (MS) chapter, that rise above regulation into a new "National Performance Goals" (NPG) chapter, which supersedes the National Patient Safety Goals. This new chapter organizes the requirements into salient, measurable topics with defined goals. In summary, the changes include replacing the "National Patient Safety Goals" (NPSG) chapter with the "National Performance Goals" chapter, which contains the requirements associated with CoPs on reducing the risk for suicide and staffing. These are critical topics for providing safe, high-quality care, treatment, and services that merit elevation to the level of an NPG.

Other Chapter Changes

The "Environment of Care" (EC) and "Life Safety" (LS) chapters have been replaced with a new "Physical Environment" (PE) chapter to match the structure of the CoPs.

Survey Process Guides

New *Survey Process Guide*s (*SPG*s) will replace the existing *Survey Activity Guide*s for critical access hospitals and hospitals. The SPGs closely follow CMS's interpretive guidelines and survey procedures, providing a direct correlation between the survey process and the associated EPs and CoPs. Accredited organizations will receive the same detailed SPG used by surveyors, promoting greater transparency and consistency throughout the survey process.

Free Webinars

To prepare critical access hospitals and hospitals for the revised requirements, a series of free, on-demand webinars will delve into the standards and EPs by chapter, offer examples on how they will be applied, and highlight resources to help organizations understand the revised requirements. The webinars are expected to launch starting in mid-August through December 2025.

More information about these free, on-demand webinars, including registration, will be available on the Pioneers in Quality General Sessions webinars page and announced in *Joint Commission Online*, *Perspectives*, and organizations' *Joint Commission Connect*® extranet.

The revised requirements and *SPG*s will be available on the Prepublication Standards page of The Joint Commission's website. They also will publish online in the fall 2025 E-dition update to the *Comprehensive Accreditation Manual for Critical Access Hospitals (CAMCAH)* and *Comprehensive Accreditation Manual for Hospitals (CAMH)*. For those who purchase them, the 2025 *CAMH* fall update service and the 2026 *CAMCAH* and *CAMH* manual products will include these revisions.

For more information, contact The Joint Commission's Standards and Survey Methods.

The Joint Commission and CHAI Partner to Promote Responsible Use of AI

The Joint Commission has entered a new strategic partnership with the Coalition for Health AI (CHAI), a nonprofit organization established by clinicians to promote responsible use of artificial intelligence (AI) in health care, to accelerate the development and adoption of AI best practices and guidance across the US health care system.

"In the decade ahead, nothing has the capacity to change health care more than AI in terms of innovation, transformation and disruption," says Jonathan B. Perlin, MD, PhD, President and CEO, The Joint Commission and Joint Commission International. "By working with CHAI, we are creating a road map and offering guidance for health care organizations so they can harness this technology in ways that not only support safety but engender trust among stakeholders."

By leveraging The Joint Commission's experience as the accrediting organization for more than 80% of US health care organizations and programs, in conjunction with CHAI's expertise and broad-based membership, the two organizations will partner to develop a suite of AI playbooks, tools, and a new certification program.

The first guidance will be available in fall 2025 with AI certification to follow.

Life Safety Code® Surveyor Role Expanded During Hospital Deemed Status Surveys

Effective June 30, 2025, Joint Commission *Life Safety Code*®* (*LSC*) surveyors will begin visiting general outpatient locations as part of **hospital** deemed status surveys. This update aligns with the US Centers for Medicare & Medicaid Services (CMS) guidance outlined in Chapters 2 and 4 of the State Operations Manual.

All locations under a hospital's CMS Certification Number (CCN) that use the deemed status option may be visited during an on-site survey. Historically, *LSC* surveyors have visited all inpatient-specific locations, including hospital-based ambulatory surgical locations, and freestanding emergency departments. Adding general outpatient locations to deemed status surveys will enhance quality and safety across care settings. The Joint Commission will assess your organization's type and number of outpatient locations, as well as your annual outpatient volume, to determine whether additional days are assigned to the *LSC* surveyor.

Clinical surveyors will continue to visit general outpatient locations and evaluate the quality of care, treatment, and services provided. The clinical surveyor(s) assigned to visit off-site outpatient locations will communicate to *LSC* surveyors which locations are being visited. Because their survey activity schedules often differ, the clinical and *LSC* surveyors may or may not evaluate a location at the same time.

If there are any changes to your organization's current survey complement, your account executive will contact your organization directly. For any questions, please contact your account executive.

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

APPROVED: Risk Areas and Risk Icon Removed for All Accreditation Programs

Effective January 1, 2026, The Joint Commission is removing risk areas and the risk icon (R) that appears with associated elements of performance (EPs) for **all accreditation programs**. Risk areas were introduced in 2013 to identify major risk areas in the health care settings The Joint Commission accredits. They were also used in the Focused Standards Assessment (FSA) tool to bring attention to critical EPs.

Since introducing risk areas, The Joint Commission has changed how it evaluates risk. The *Survey Analysis for Evaluating Risk*® (*SAFER*®) Matrix, introduced in 2017, is currently used to evaluate risk for survey findings based on scope and likelihood to cause harm to patients, staff, and/or visitors, and the unique circumstances of the required improvement identified within each organization during survey activity. The level of risk for each requirement is driven by various factors and can differ drastically among organizations. In addition, organizations are no longer required to submit an FSA as part of Intracycle Monitoring. Therefore, using the risk icon is no longer the most appropriate method to determine actual risk. Joint Commission–accredited organizations are advised to use the *SAFER* Accreditation Dashboard accessible on their *Joint Commission Connect*® extranet site to monitor areas that present the highest and most widespread risks based on recent survey data.

The risk icon will be removed in the fall 2025 E-dition® update to the *Comprehensive Accreditation Manual*s. The risk areas and risk icon will be removed from FSA beginning January 1, 2026. For those customers who purchase them, the risk icon will be removed from the 2025 fall update services and all 2026 accreditation products.

For more information, contact The Joint Commission's Standards and Survey Methods. P

APPROVED: Rural Health Clinic Leadership Requirements Revised to Align with CMS Final Rule

Effective immediately, The Joint Commission has developed one new element of performance (EP) and revised one EP to align with the US Centers for Medicare & Medicaid Services (CMS) final rule for **rural health clinics** published in the *Federal Register* on December 9, 2024.

Changes to the CMS regulations became effective January 1, 2025. They include a new Condition for Certification addressing the provision of primary care services and updates to basic laboratory services requirements. The following box includes the new and revised EPs; underlined text indicates new text and ~~strikethrough~~ text indicates deletions.

The new and revised requirements will be posted on the Prepublication Standards page of The Joint Commission's website and will publish online in the fall 2025 E-dition® update to the *Comprehensive Accreditation Manual for Rural Health Clinics (CAMRHC)*.

For more information, please contact The Joint Commission's Standards and Survey Methods. P

Joint Commission Requirement

Official Publication of Joint Commission Requirements

Leadership Requirements Revised to Align with CMS Final Rule

APPLICABLE TO RURAL HEALTH CLINICS

Effective Immediately

Leadership (LD)

Standard LD.04.03.01: The rural health clinic provides services that meet patient needs.

Elements of Performance for LD.04.03.01

8 The rural health clinic must provide primary care services.

9 The rural health clinic provides basic laboratory services essential to the immediate diagnosis and treatment of the patient, which include the following:

- Chemical examinations of urine by stick or tablet method or both (including urine ketones)
- ~~Hemoglobin or hematocrit blood tests~~
- Blood glucose tests
- ~~Examination of stool specimens for occult blood~~
- Pregnancy tests
- ~~Primary culturing for transmittal to a certified laboratory~~
- Collection of patient specimens for transmittal to a certified laboratory for culturing

REVISED: Advanced Total Hip and Total Knee Replacement Certification Performance Measures

The Joint Commission has revised some of its performance measures for its advanced **Total Hip and Total Knee Replacement** (THKR) certification program **effective January 1, 2026**, to align more closely with the US Centers for Medicare & Medicaid Services (CMS) Total Hip Arthroplasty/Total Knee Arthroplasty Patient-Reported Outcome-Based Performance Measure (THA/TKA PRO-PM). The following revisions aim to streamline the reporting process, reduce burden on health care providers, and ensure that the measures are clinically appropriate and closely aligned with similar measures:

- **Proximal Tibial and Fibular Fracture Codes:** These new codes align with the cohort exclusions of the CMS THA/TKA PRO-PM measures and exclude proximal tibial and fibular fractures from the Postoperative Ambulation on Day of Surgery (THKR-2) and Discharged to Home (THKR-3) measures. The Regional Anesthesia (THKR-1) measure remains unaffected, as fractures are not excluded for this measure.
- **New Data Element:** The Postoperative Functional/Health Status Assessment (THKR-5) measure includes a new data element, "Precollection Mortality," to exclude patients who die after the principal procedure and before the data collection period ends.

See the Specifications Manual for Joint Commission National Quality Measures 2026A release notes available in early August for further details. P

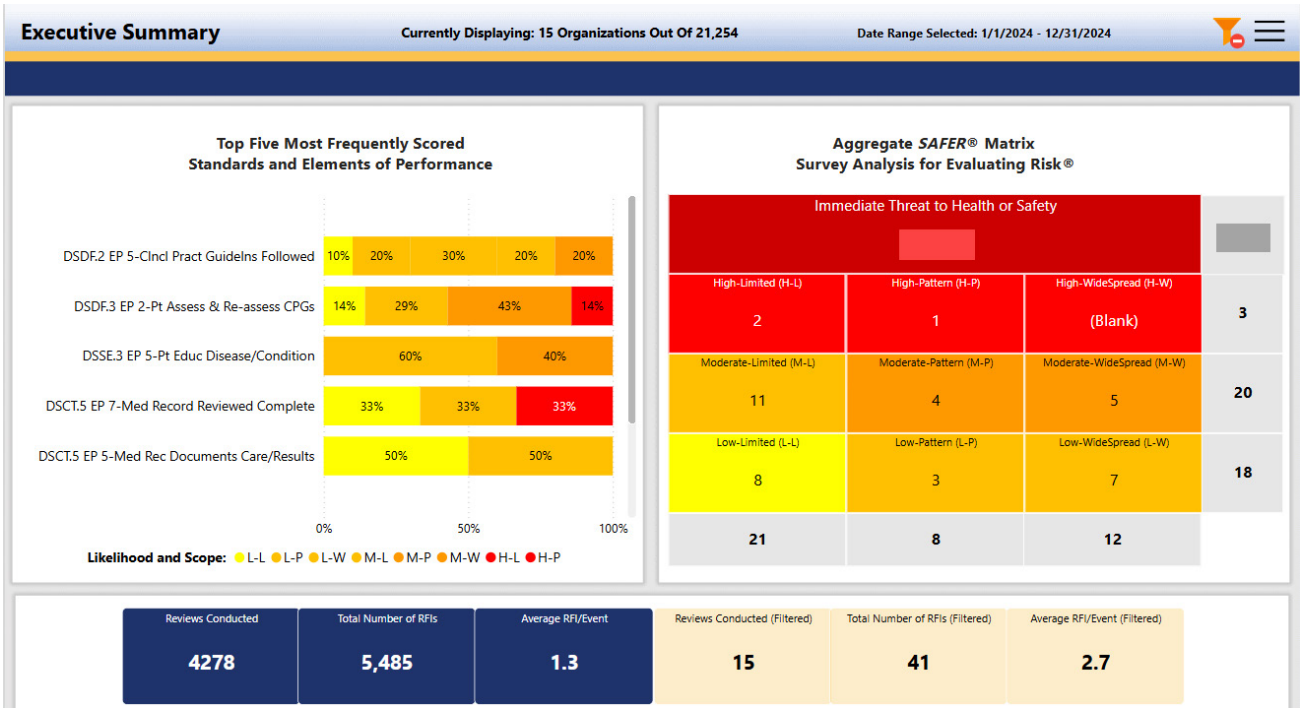
NEW: *SAFER*® Certification Dashboard

Based on feedback from its accredited and certified health care organizations, The Joint Commission has developed the *SAFER*®* Certification Dashboard, a self-serve data analytic tool. The new dashboard that will launch in mid-July is for **all Joint Commission–certified health care organizations** and comparable to the *SAFER* Accreditation Dashboard that launched in April 2021.

Certified organizations can use the dashboard to leverage data from their review to advance safety, quality, and ongoing performance improvements. Dashboard features include the following:

- Using simple, short names to describe standards and elements of performance
- Consolidated data from the Final Certification Report
- Centralized view of key metrics, such as the total number of Requirements for Improvement (RFIs) and the most frequently scored standards and elements of performance
- Historical and current findings to help organizations identify high-risk patterns and trends and support data-driven improvements

Organizations can access the dashboard in mid-July on their secure *Joint Commission Connect*® extranet site. Please contact your organization's Joint Commission account executive with questions.



* *SAFER*®, *Survey Analysis for Evaluating Risk*®.

CMS Renews The Joint Commission's Deeming Approval for Hospice Agencies

The US Centers for Medicare & Medicaid Services (CMS) recently announced that it renewed The Joint Commission's deeming approval for **hospice** agencies accredited under the Home Care Accreditation program. The deeming approval is effective June 18, 2025, through June 18, 2030; the full notice published June 2, 2025, in the *Federal Register*.

In renewing The Joint Commission's deeming approval, CMS determined that The Joint Commission's standards and survey process meet or exceed those established by CMS. Accreditation is voluntary, and seeking deemed status through accreditation is an option—not a requirement. Organizations seeking Medicare approval may choose to be surveyed by either an accrediting body, such as The Joint Commission, or state surveyors on behalf of CMS.

All deemed status surveys are unannounced. Any hospice agency deemed to meet the CMS requirements is subject to validation and complaint investigation surveys performed by CMS or its agent(s).

Now Available: Suicide Risk Reduction Resource Center

The Joint Commission recently launched a new Suicide Risk Reduction Resource Center.

The resource center offers curated resources with actionable strategies and tools to support organizational efforts in complying with The Joint Commission National Patient Safety Goal of reducing the risk of suicide. Resources include the following:

- Learning modules, toolkits, and guides
- Answers to frequently asked questions

Suicide is a major public health concern that can affect anyone, regardless of age, gender, ethnicity, or background. Often, health care settings are the first point of contact for people who are suicidal or have attempted suicide. Identifying individuals at risk for suicide while under the care of or following discharge from a health care organization is critical to protecting at-risk individuals. In addition, it is essential that health care professionals are trained and equipped to identify, assess, and intervene when an individual is considered at risk of suicide.

This resource center is designed to help organizations provide safe and high-quality care for individuals at risk of suicide, both during their time in a health care facility and at discharge. Providing compassionate and evidence-based care enables health care organizations to better prevent suicide deaths and promote recovery and resilience for individuals and their families. P

Consistent Interpretation

Joint Commission Surveyors' Observations Related to Staff Receiving Applicable Education and/or Training

The **Consistent Interpretation** column helps organizations to comply with specific Joint Commission requirements. Each installment of the column draws from a database of surveyors' de-identified observations (left column) on an element of performance (EP)—as well as guidance from the Standards Interpretation Group on interpreting the observations (right column).

The requirements in this column are not necessarily those with high rates of noncompliance. Rather, they have the potential to negatively affect care or create risk if out of compliance. That is, they may appear in the upper right corner of a *Survey Analysis for Evaluating Risk*® (*SAFER*®) Matrix if cited on survey. Featured EPs apply to hospitals; however, the guidance may be extrapolated to apply to other accreditation programs with similar services and populations served.

This month, **Consistent Interpretation** focuses on ensuring that staff receive the appropriate education and/or training to successfully comply with organizational policies, procedures, and processes.

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

Human Resources (HR) Standard HR.01.05.03: Staff participate in ongoing education and training	
EP 1: Ⓓ Staff participate in ongoing education and training to maintain or increase their competency and, as needed, when staff responsibilities change. Staff participation is documented. (*See also* PC.02.01.11, EP 4)	
Compliance Rate	In 2023, the noncompliance percentage for this EP was **1.66%**—that is, **23** of **1,386** hospitals surveyed did not comply with this requirement.
Noncompliance Implications	Education and training are essential for developing competent, accountable staff who can successfully implement policies, procedures, and processes. When process defects are identified, a common contributing factor is insufficient or lack of staff education and/or training. Failing to provide adequate education and/or training may result in unforeseen complications and increases the risk of adverse outcomes for both patients and staff. Education involves systematic instruction that imparts theoretical knowledge, whereas training focuses on acquiring specific technical skills, often performed manually. Both education and training can include the practical application of general organizational policies, processes, and procedures, or be tailored to specific job roles and responsibilities. For example, environmental services staff must be trained in surface disinfection methods and procedures. Monitoring compliance with policies, procedures, and processes allows organizations to determine whether ongoing education and training are needed. When surveyors identify defects in processes, they may review staff records or documentation to verify that the staff member has completed the required education and training mandated by the organization. Staff not completing required education and training and not understanding how to comply with policies, procedures, and processes are common findings during surveys.

Surveyor Observations	Guidance/Interpretation
• Staff were not receiving ongoing education and/or training for specific processes necessary to perform their job. • Environmental services staff were not educated and/or trained to use environmental cleaning and disinfection products. • Sleep lab staff were not educated and/or trained to reprocess the reusable components of continuous positive airway pressure (CPAP) equipment.	• This standard and EP relate specifically to ongoing education and/or training to increase competency. • Score at Standard HR.01.06.01,* for organization-defined competency assessments.
• A nuclear medicine technician was not educated and/or trained to properly clean up spills. • Staff handling hazardous chemicals chose inappropriate personal protective equipment (PPE) to protect them from hazardous chemical exposure. Staff were not educated and/or trained to select PPE appropriate to the chemicals being handled. • Staff chose goggles appropriate for a Class 3 laser when a Class 4 laser was used. Staff were not educated and/or trained to differentiate the available laser eye protection. There was no evidence that staff were educated and/or trained.	• In accordance with Environment of Care (EC) Standard EC.02.02.01, EPs 3–5, 8,† organizations must define and implement appropriate safety precautions for handling hazardous materials and waste spills or exposures. • Score at Standard EC.02.02.01, EPs 3–5, 8, if staff do not use PPE to protect themselves from hazardous chemical exposure. • If an organization does not have a policy for handling hazardous materials and waste spills or exposures, score at Standard EC.02.02.01, EP 3. • If an organization does not comply with its policy regarding spills or exposures while handling hazardous materials, score at Standard EC.02.02.01, EP 4.

* Standard **HR.01.06.01**: Staff are competent to perform their responsibilities.

† Standard **EC.02.02.01, EP 3**: Ⓓ The hospital has written procedures, including the use of precautions and personal protective equipment, to follow in response to hazardous material and waste spills or exposures. R

Standard **EC.02.02.01, EP 4**: The hospital implements its procedures in response to hazardous material and waste spills or exposures.

Standard **EC.02.02.01, EP 5**: The hospital minimizes risks associated with selecting, handling, storing, transporting, using, and disposing of hazardous chemicals. R

Standard **EC.02.02.01, EP 8**: The hospital minimizes risks associated with disposing of hazardous medications. (*See also* MM.01.01.03, EP 2)

• The organization did not sufficiently train or assess staff competency to ensure that they knew which PPE to don or how to don and/or doff PPE safely. • Staff entering the room of a patient with projectile vomiting did not don fluid-resistant barrier gowns as required by the organization. Staff were not trained to select appropriate PPE. • Staff entering a contact isolation room did not wear gowns and gloves. Staff were not trained to use the PPE; this statement was confirmed during a human resources record review. • Staff wore cloth lab coats while cleaning instruments in the decontamination room. However, the organization's policy requires staff to wear fluid-resistant barrier gowns while cleaning surgical instruments and endoscopes. Staff were not trained to select appropriate PPE for decontamination procedures. • Staff removed their respirator mask prior to exiting a patient's airborne isolation room. However, the organization's transmission-based precautions policy requires staff to remove their mask only after leaving the room. Staff were not trained on masking protocols.	• If PPE is not appropriately used, score at Infection Prevention and Control (IC) Standard IC.06.01.01, EP 3.* • Score at Standard HR.01.06.01, if the organization identified appropriately using PPE as a specific staff competency.
• Staff were not educated and/or trained on the organization's requirements to care for a patient who was self-managing their personal insulin pump.	• The organization determines any staff competency requirements. • If staff fail to meet any organization-required competencies, score at Standard HR.01.06.01. • The organization determines the staff training content about patients with individual pumps and other medical devices. Education should focus on devices' general care, assessments, and so on.
• A nurse caring for a premature neonate on oxygen had not been educated and/or trained to safely administer oxygen to a premature newborn. • A registered nurse/respiratory therapist was not educated and/or trained to safely use the oxygen delivery system for a neonate. However, the organization's policy or evidence-based guidelines require the education and training.	• When developing staff education and/or training, focus on safety and risk reduction strategies. Use subject matter experts in the organization to provide education and/or training. • Provide unit-based education for more detailed, disease-specific education and/or training.

* Standard **IC.06.01.01, EP 3**: The hospital implements activities for the surveillance, prevention, and control of health care–associated infections and other infectious diseases, including maintaining a clean and sanitary environment to avoid sources and transmission of infection, and addresses any infection control issues identified by public health authorities that could impact the hospital.
(*See also* NPSG.07.01.01, EP 1)

The Joint Commission Journal on Quality and Patient Safety®

IMPROVEMENT FROM FRONT OFFICE TO FRONT LINE

This issue of *Perspectives* presents the **June 2025** Table of Contents for *The Joint Commission Journal on Quality and Patient Safety* (*JQPS*). The Joint Commission works closely with *JQPS* (published by Elsevier) to make it a key component in helping health care organizations improve patient safety and quality of care.

To purchase a subscription or site license to *JQPS*, please visit *The Joint Commission Journal on Quality and Patient Safety* website.

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Adverse Events

Review Article

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Subscription Information:
Individual online license—$419
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Perspectives (ISSN 1044-4017) is published monthly by Joint Commission Resources, One Renaissance Boulevard, Suite 401, Oakbrook Terrace, IL 60181.