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FOR JOINT COMMISSION COMPLIANCE STRATEGIES



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New Patient Safety Measures to Reduce Adverse Drug Events from Anticoagulants

To reduce adverse drug events (ADEs) related to anticoagulant therapy, The Joint Commission revised National Patient Safety Goal® (NPSG) NPSG.03.05.01, effective July 1, 2019.

The revised NPSG (“Reduce the likelihood of patient harm associated with the use of anticoagulant therapy.”) applies to ambulatory health care (applicable to medical centers only), hospitals, and nursing care center accreditation programs that initiate, manage, and adjust dosage for anticoagulation medications. It does not apply to organizations limited to the mechanical treatment of bleeding.

Why Revisions Were Needed

An ADE is an injury to a patient that results from the use of a drug. Such injuries can occur due to accidental overdose, the patient receiving the wrong medication, or allergic reactions, for example. According to the Office of Disease Prevention and Health Promotion (ODPHP), each year, ADEs in ambulatory settings account for more than 3.5 million physician office visits, an estimated 1 million emergency department visits, and approximately 125,000 hospital admissions.¹

In its [National Action Plan for ADE Prevention](#), the [ODPHP](#) identified anticoagulants as one of the most common causes of ADEs (the others are diabetes agents and opioids).

“Anticoagulation medications are high-risk medications that may cause severe bleeding when not administered or monitored appropriately. For years, this NPSG has played an important role in improving the safety of patients receiving anticoagulation therapy,” says Helen Larios, MBA, MSN, RN, project director-clinical, Department of Standards and Survey Methods, Division of Healthcare Quality Evaluation, The Joint Commission. “However, in recent years, there has been a rise in ADEs associated with direct oral anticoagulants [DOACs]. The Joint Commission believes that relevant updates to this NPSG to address DOACs may help reverse that trend.” As part of efforts to address risks associated with DOACs, The Joint Commission released [Sentinel Event Alert 61: Managing the Risks of Direct Oral Anticoagulants](#).

Impact of Direct Oral Anticoagulants

DOACs are becoming popular because they require less monitoring, have fewer drug–drug and drug–food interactions, and offer faster onset. They are commonly prescribed in ambulatory health care settings to treat atrial fibrillation, venous thromboembolism, and low-risk pulmonary embolism.

Available DOACs have quickly increased, and with each new drug comes different concerns. (Some common DOACs are listed in the table below.) These concerns include limited accessibility and high-cost lab testing resources, blood products, and reversal drugs. Reversal agents for DOACs are extremely expensive and therefore not found on every formulary. So while some organizations may have DOACs on their formularies, they may not have a method for reversing life-threatening bleeding if it occurs.

Drug	Brand Name
Apixaban	Eliquis®
Betrixaban	Bevyxxa®
Dabigatran	Pradaxa®
Edoxaban	Savaysa®
Rivaroxaban	Xarelto®

Although DOACs offer ease of use to patients, stopping bleeding events may be more complicated, requiring different strategies than those used for warfarin and heparin. Unlike the more widely available reversal agents for warfarin and heparin, reversal agents for some DOACs are lesser known, may not be available in all health care settings, and may not have US Food and Drug Administration (FDA) approval at this time, and as a result, bleeding complications can be severe if patients are not properly assessed according to guidelines for managing DOACs.^{2,3}

Prescribing, monitoring, and treating complications of DOAC therapy are similar in theory to warfarin and heparin therapy but different in the types of agents and monitoring used. According to Larios, “Treatment of DOAC–induced severe bleeding requires a different approach from heparin and warfarin.”

In addition, The Joint Commission wants to further emphasize the use of approved protocols and evidence-based practices related to anticoagulants. The first two elements of performance (EPs) for this goal now read:

EP 1: The organization uses approved protocols and evidence-based practice guidelines for the initiation and maintenance of anticoagulant therapy that address medication selection; dosing, including adjustments for age and renal or liver function; drug–drug and drug–food interactions; and other risk factors as applicable.

EP 2: The organization uses approved protocols and evidence-based practice guidelines for reversal of anticoagulation and management of bleeding events related to each anticoagulant medication.

Strategies for Reducing Risk in High-Risk Settings

The first step to reduce ADEs is a comprehensive risk assessment. The organization should review past anticoagulant-related ADEs and look for causal patterns. A multidisciplinary team of physicians who often prescribe anticoagulants, nurses who administer the medications, and a nursing manager can help to understand the processes involved.

Unlike the more widely available reversal agents for warfarin and heparin, reversal agents for some DOACs are lesser known, may not be available in all health care settings, and may not have FDA approval, and as a result, bleeding complications can be severe if patients are not properly assessed.

In addition, all processes should be reviewed to determine where errors have occurred and where they are most likely to occur. This will give organizations a starting point to prevent ADEs. Some suggested tools to conduct these types of risk assessments are available from the [Institute for Healthcare Improvement](#) and the [Hospital Quality Institute](#).

When reviewing organizational processes and procedures for compliance, it is also important to consider the EPs for this NPSG and pay attention to those related to the most commonly used drugs. For example, the EP related to warfarin has been revised as follows:

EP 4: The organization has a written policy addressing the need for baseline and ongoing laboratory tests to monitor and adjust anticoagulant therapy.

Note: For all patients receiving warfarin therapy, use a current international normalized ratio (INR) to monitor and adjust dosage. For patients on a direct oral anticoagulant (DOAC), follow evidence-based practice guidelines regarding the need for laboratory testing.

Similarly, for hospital and nursing care center settings, EP 8 specifically addresses heparin:

EP 8: When heparin is administered intravenously and continuously, the organization uses programmable pumps in order to provide consistent and accurate dosing.

What to Know Moving Forward

Accredited organizations should carefully review the [revisions to NPSG.03.05.01](#) for their setting to determine what (if any) procedural changes need to be made to ensure compliance. Importantly, organizations should review current processes for using anticoagulants as well as treating anticoagulant-related ADEs and ensure that processes all are evidence-based. It is also important to ensure that

process-related decisions are documented and can be easily retrieved if and when needed.

To protect patients taking DOACs from adverse events related to bleeding, The Joint Commission recommends organizations take the following actions:

- Create name awareness for various types of DOACs, particularly among pharmacists, emergency department clinicians, and providers who may be called upon to reverse life-threatening bleeding.
- For each type of anticoagulant, use evidence-based protocols and practice guidelines for drug initiation and maintenance as well as reversal and management of bleeding events.
- Have a written policy on the need for baseline and ongoing laboratory tests to monitor and manage anticoagulant therapy.
- Include the DOACs' indications for use on the patient's prescription, in instructions to the patient, and in the electronic medical record (EMR).
- Address anticoagulant safety practices.
- To reduce the risks for bleeding or clotting, educate patients and their families about the anticoagulant prescribed.

For more information, including resources and recommendations for complying with the new NPSG requirements, download [Sentinel Event Alert 61: Managing the Risks of Direct Oral Anticoagulants](#).

[Click here](#) to review the *R³ Report*, which provides the rationale and references for the development of this requirement. 

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10 ways to be prepared to treat patients on direct oral anticoagulants (DOACs)



Anticoagulants are the **No. 2 top medications** involved in error incidents causing death or serious harm.




Risks for patients on DOACs can be avoided with **appropriate and timely treatment**.

- 1 **Learn the names of DOACs.**
- 2 You **CANNOT** stop bleeding in patients on DOACs the same way you can for patients on warfarin (Coumadin®) and heparin.
- 3 **Reversal agents** for DOACs are not as well-known as those for warfarin and heparin — and they may not be available in all care settings.
- 4 Some DOACs have **NO** FDA-approved reversal agent at this time, so patients on these DOACs need to be assessed according to guidelines on the management of DOACs.
- 5 **Avoid therapeutic duplication.** Because not all providers are familiar with all DOACs, they may accidentally prescribe a second anticoagulant. Also, patients may not recognize these drugs as anticoagulants and may not be able to identify them when questioned.
- 6 **Assess bleeding risk** before surgery and outpatient procedures.
- 7 Communicate the specifics of a patient's DOAC at **transitions of care**.
- 8 Follow **evidence-based practice guidelines** for baseline and ongoing laboratory tests to ensure that patients on a DOAC are monitored and dosed appropriately.
- 9 Include the DOAC's **indications for use** on the patient's prescription, in the instructions for the patient, and in the electronic medical record (EMR).








DOACs include:

- Apixaban (Eliquis®)
- Betrixaban (Bevyxxa®)
- Dabigatran (Pradaxa®)
- Edoxaban (Savaysa®)
- Rivaroxaban (Xarelto®)



- 10 **Educate patients and families about DOACs.** Patients may not fully understand the risks of the specific DOAC prescribed for them. Patients on DOACs should know:
 - Their medication dose and schedule.
 - Importance of follow-up appointments and laboratory testing, if needed.
 - Potential drug-drug, drug-herb/supplement and drug-food interactions.
 - Potential for adverse drug reactions and how adverse reactions present.
 - When to contact the doctor or visit the emergency department.

For more information, see Sentinel Event Alert Issue 61, "Managing the risks of direct oral anticoagulants."
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US Antibiotic Awareness Week Is November 18–24



**BE
ANTIBIOTICS
AWARE**
SMART USE, BEST CARE

A collaboration among the Centers for Disease Control and Prevention (CDC), state-based programs, and for-profit and nonprofit partners, [US Antibiotic Awareness Week \(USAAW\)](#) is an annual observance to raise awareness of the threat of antibiotic resistance and highlights steps that can be taken to improve antibiotic prescribing and use, also known as antibiotic stewardship.

According to the CDC's education campaign—[Be Antibiotics Aware: Smart Use, Best Care](#)—in US physician's offices and emergency departments, at least 47 million antibiotic prescriptions each year are unnecessary, making antibiotic resistance one of the most urgent threats to public health.¹ Be Antibiotics Aware stresses that while antibiotics save lives, they are not always necessary.

The Be Antibiotics Aware campaign offers tools and resources to combat antibiotic resistance and side effects in the following areas:

- Antibiotic prescribing and use in physician's offices, clinics, and other outpatient settings, focusing on appropriate prescribing for common illnesses in children and adults
- Antibiotic prescribing and use in hospitals and long term care, focusing on prescribing the right drug for the right patient at the right dose and time
- Core elements of antibiotic stewardships, focusing on key principles and guidelines to improve antibiotic use and therefore advance patient safety and improve patient outcomes

USAAW offers a Be Antibiotics Aware [Partner Toolkit](#) equipped with key messages for health care professionals in outpatient, hospital, and long term care settings. It includes resources such as articles, infographics, newsletters, blogs, and social media posts targeting health care professionals, patients, and families.

The CDC continues its work to improve antibiotic stewardship through data for action, implementation, innovation, and education and highlights its progress in its [Antibiotic Use in the United States: Progress and Opportunities, 2018 Update](#).

For more on the topic of antibiotic stewardship, the [September 2019](#) issue of *The Joint Commission Journal on Quality and Patient Safety (JQPS)* offers several scholarly articles. See below for a summary of these articles.

Editorial: *Antimicrobial Stewardship: It Takes a Village*, V. Fabre and S. Cosgrove

Abstract: Studies addressing implementation of antimicrobial stewardship (AS) in large or heterogeneous health care systems are limited, as are studies evaluating the role of nonphysician, nonpharmacist providers. In this editorial, Fabre and Cosgrove look at a study by Ha and colleagues that examined incorporating bedside nurses into AS and infection prevention and a study by Logan and colleagues describing the expansion of AS in a diverse health care system, both in this issue of the *Journal*, and comment on the importance of training and reinforcement of AS principles for all health care workers involved in prescribing, dispensing, and administering antibiotics.

Article: *Establishing an Antimicrobial Stewardship Collaborative Across a Large, Diverse Health Care System*, A.Y. Logan; J.E. Williamson; E.K. Reinke; S.W. Jarrett; M.S. Boger; L.E. Davidson

Abstract: Seeking to establish an antibiotic stewardship program collaborative across a diverse network by uniting local resources with a central advisory team, a system of 28 acute care facilities set out to implement the US Centers for Disease Control and Prevention's core elements for antibiotic stewardship. Logan and colleagues describe the details of this initiative and report on the progress made in its first year.

Article: *A Multidisciplinary Approach to Incorporate Bedside Nurses into Antimicrobial Stewardship and Infection Prevention*, D.R. Ha; M.B. Forte; R.D. Olans; K. OYong; R.N. Olans; D.P. Gluckstein; R. Kullar; M. Desai; N. Catipon; V. Ancheta; D. Lira; Y. Khattak; J. Legge; K.B. Nguyen; S. Chan; J. Mourani; J.A. McKinnell

Abstract: A multidisciplinary, interprofessional approach in antimicrobial stewardship programs has been espoused by the US Centers for Disease Control and Prevention and advocated for in several studies. In this retrospective evaluation, Ha and colleagues report on the implementation of bedside nurse-driven antimicrobial stewardship and infection prevention rounds in a 31-bed telemetry unit of a community regional medical center.

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

Reference

1. US Centers for Disease Control and Prevention, National Center for Emerging and Zoonotic Infectious Diseases. Aug 22, 2019. Accessed Oct 8, 2019. <https://www.cdc.gov/antibiotic-use/>.

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Focus on Certification

THE IMPORTANCE OF AN INPATIENT DIABETES PROGRAM

Diabetes is a complex, chronic illness that affects more than 30 million Americans. Nearly 1.25 million adults and children have type 1 diabetes, a condition in which the pancreas—the organ that lies deep inside the abdomen and is integral to the digestive and endocrine systems—does not produce insulin, the hormone responsible for regulating glucose levels in the blood.¹ Type 2 diabetes, which is far more common, affects about 90% of people with diabetes. Type 2 diabetes occurs when the pancreas produces insulin, but the body does not use it properly.²

For many, diabetes can be a manageable chronic condition—however, it can also be deadly if not properly managed. In 2015 diabetes was the seventh leading cause of death in the United States, killing nearly 80,000 Americans.¹ Worldwide, an estimated 1.6 million deaths were directly caused by diabetes in 2016. Over time, diabetes can damage the heart, blood vessels, eyes, and nerves and is among the leading causes of kidney failure.³ In some cases, these comorbidities can lead to hospital admission for people with diabetes.

Components of a Successful Program

Recognizing the widespread prevalence of diabetes, The Joint Commission launched its Advanced Disease-Specific Care Certification program for Inpatient Diabetes in 2006. The Certificate of Distinction for Inpatient Diabetes Care recognizes hospitals that aim to provide the best possible care for patients with diabetes and foster better outcomes across all inpatient settings. The certification program is based on the American Diabetes Association (ADA) Clinical Practice Recommendations and identifies six critical attributes of a successful inpatient diabetes program:

1. Specific staff education requirements
2. Written blood glucose monitoring protocols
3. Plans for the treatment of hypoglycemia and hyperglycemia
4. Data collection of incidences of hypoglycemia
5. Patient education on self-management of diabetes
6. An identified program champion or program champion team

According to Beth Melvin, RD, RN, CDE, reviewer for The Joint Commission's Inpatient Diabetes Certification Program, a successful hospital diabetes program is unique in its scope. Melvin explains that an inpatient diabetes program must account not only for patients who may or may not have been admitted for a primary diagnosis of diabetes but also those patients admitted for any reason who also have diabetes as a secondary condition. Melvin says that because a successful inpatient diabetes program “encompasses the entire hospital, leadership buy-in, from the top down, must support the program throughout the

entire facility—from the emergency department to inpatient units, to any area caring for a patient with diabetes.”

Equally important, Melvin says, is a strong diabetes leadership team. A successful program requires a program champion with “a strong passion for taking a regular admission and identifying that diabetes is present.” Melvin stresses that the program champion should create and monitor processes that allow the organization to create a “culture” of diabetes care. The actual work of the program is then woven into the fabric of what the organization and the staff at a patient’s bedside do every day. “The goal is everyone identifies diabetes, everyone monitors, and everyone educates,” says Melvin.

Improving Patient Outcomes

When patients with diabetes are admitted to the hospital, they are at greater risk of several health factors that can lead to poor outcomes, such as infection, heart attack, and stroke, particularly when hyperglycemia (very high blood glucose levels) and hypoglycemia (low blood glucose levels) are not addressed, managed, and controlled.

Melvin says that the end goal of a robust inpatient diabetes program is to reduce the risk of adverse outcomes. According to Melvin, “If you control the diabetes, you reduce the risk of a heart attack or stroke, and the risk of a poor outcome from infection.” She adds, “You may also reduce the length of hospital stay and the likelihood of readmission.”

Melvin’s comments are supported not only by Joint Commission requirements but also by recommendations by the ADA, which releases updates and revisions to its standards and clinical guidelines on a regular basis. In its current [Standards of Medical Care in Diabetes—2019](#), the ADA stresses that for patients with diabetes, hospitals should promote the shortest hospital stay possible, provide effective transition from the hospital that prevents acute complications and readmission, and prevent hyperglycemia and hypoglycemia, which are both associated with adverse outcomes.

Achievement in The Joint Commission’s Advanced Disease-Specific Care Certification in Inpatient Diabetes signals that the hospital is committed to providing high-quality care and effectively meeting the needs of its diabetic patient population. For more information on this program, visit The Joint Commission’s [Certification in Inpatient Diabetes home page](#). 

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2. US Centers for Disease Control and Prevention. Diabetes: Type 2 Diabetes. May 30, 2019. Accessed Oct 8, 2019. <https://www.cdc.gov/diabetes/basics/type2.html>.
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Top News

A Digest of Accreditation and Health Care News

US Pharmacopeia Releases Notice of “Intent to Revise” Compounding Standards

In a recent statement, the US Pharmacopeia (USP) issued an “Intent to Revise,” due to appeals from stakeholders on certain provisions in compounding standards. In accordance with USP’s formal appeals process, stakeholders who submitted appeals on the compounding chapters have requested further review by an appointed panel. As a result, USP is postponing the official dates of the revised <795> and <797>, and the new general chapter <825> until further notice.

The Joint Commission is aware of the USP statement, released on September 23, 2019, regarding the delay of implementation of the USP Chapters 795 and 797 revisions and delayed USP 800 enforcement. The Joint Commission will continue to survey compliance with sterile compounding against the principles within the USP chapters that are currently in effect and will continue to monitor the situation and provide information regarding changes to our survey process when additional information becomes available.

[Click here](#) to read the statements released by USP.

Health Care Organizations Recognized for Efforts to Reduce Clinician Burnout

The American Medical Association (AMA) recently honored 22 health care organizations for their efforts to address clinician burnout. Stemming from its [Practice Transformation Initiative](#), which provides resources to increase physician well-being, the AMA’s [Joy in Medicine™ Recognition Program](#) was designed to provide a road map to health care organizations engaged and committed to reducing burnout and improving job satisfaction among clinicians.

The program is based on three levels of organizational achievement—bronze, silver, and gold—among six areas of competency: commitment, assessment, leadership, efficiency of practice environment, teamwork, and peer support. This effort is just one of many designed to address the increased risk to patient safety from clinician burnout. [Click here](#) for the list of organizations recognized by the AMA in 2019.

Older Adults Express Concern About Virtual Health Care Visits

A 2019 University of Michigan [National Poll on Healthy Aging](#) asked a national sample of adults age 50–80 about their experiences with telehealth, which allows for remote patient visits with health care providers using video technology. The study revealed that despite a growing number of health care providers capable of conducting telehealth visits with patients, only 4% of older adults surveyed reported having a telehealth visit in the previous year.

For older adults who need frequent health care services, have mobility challenges, or live in rural areas where many hospitals are closing, telehealth visits can be particularly helpful; however, among this segment of the population, the study revealed the following concerns:

- Provider wouldn't be able to do a physical exam (71%)
- Quality of care not as good as face-to-face visit (68%)
- Privacy (49%)
- Not feeling personally connected to the clinician (49%)
- Difficulty using the technology (47%)
- Difficulty seeing or hearing the clinician (39%)

The good news is nearly half of the adults surveyed expressed interest in telehealth visits, particularly under specific circumstances, such as unexpected illness while traveling or for a one-time follow-up after a surgery or a procedure.

The results of this study underscore an opportunity for health care providers to better educate older adults about the benefits of telehealth services and as a result enhance their comfort level with and access to this convenient form of health care service. The study suggests that the concerns expressed by older adults must be addressed in order for the potential impact of telehealth services to be realized. For more information on this report, visit <https://www.healthyagingpoll.org/>.

November Accreditation & Certification Education Events

Environment of Care Base Camp is scheduled for November 5–6, 2019, in Lake Buena Vista, Florida. This two-day seminar is for anyone preparing for Joint Commission survey and those working to build the safest environment for staff and patients.

Exploring the “Life Safety” (LS) Chapter 2019 will take place November 7–8, 2019, in Lake Buena Vista, Florida. This comprehensive seminar will help you master the *Life Safety Code*® standards and reduce risk and maximize safety throughout your facility.

2020 Vision for the Laboratory—An Education Day with The Joint Commission will convene November 11–12, 2019, in Rosemont, Illinois. A preconference networking reception will take place on Monday, November 11, followed by a full day of information covering what's in store for the laboratory professional in 2020. [Click here](#) to register and view the agenda for this event.

Primary Care Medical Home Certification Conference, November 13, 2019, in Rosemont, Illinois. This one-day multifaculty event offers strategies and insights to help organizations achieve Primary Care Medical Home (PCMH) certification.

Ambulatory Care Conference, November 14–15, 2019, in Rosemont, Illinois. Offering a full two days of education, tips, tools, and strategies, this conference provides key updates related to ambulatory health care standards.

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For details on these events and to register, visit the [Events](#) page. 

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