The Joint Commission

July 2021 | Volume 41 | Number 7

Joint Commission Perspectives®

THE OFFICIAL NEWSLETTER OF THE JOINT COMMISSION

Contents

3 **The Joint Commission and NQF Honor 2020 Eisenberg Award Recipients**
The Joint Commission and the National Quality Forum (NQF) recently announced the 2020 recipients of the John M. Eisenberg Patient Safety and Quality Awards.

6 **Potential Patient Safety Events Analysis Reveals Trends During the COVID-19 Pandemic**
The Joint Commission's Office of Quality and Patient Safety analyzed thousands of reported potential patient safety events related to COVID-19 and identified trends across health care organizations.

10 **New: The Joint Commission Collaborates with ACOG to Address Maternal Health Issues**
The Joint Commission recently announced a new collaboration with the American College of Obstetricians and Gynecologists (ACOG) to further address maternal health issues.

11 **Approved: New and Revised Requirements for Resuscitation**
The Joint Commission approved new and revised resuscitation requirements for critical access hospitals and hospitals effective January 1, 2022.

13 **Approved: New and Revised Workplace Violence Prevention Requirements**
The steady increase of workplace violence in health care organizations prompted The Joint Commission to revised and include new standards to support workplace violence prevention in critical access hospitals and hospitals.

15 **Updated: New and Revised Requirements for Sprinkler Heads**
Effective immediately, Life Safety (LS) Standard LS.02.01.35, Element of Performance 7, has been revised to clarify the number of spare sprinkler heads required by organizations that are classified as health care occupancies.

16 **Approved: Performance Improvement–Related Accreditation Participation Requirements Revised**
The Joint Commission approved revisions to its Accreditation Participation Requirements for assisted living communities, critical access hospitals, and hospitals.

17 **Approved: New and Revised Leadership and Performance Improvement Requirements**
New and revised Leadership (LD) and Performance Improvement (PI) requirements will be applicable to all accreditation programs except the Assisted Living Community program.

Continued on next page

18 **Sentinel Event Definition and Chapter Revised**
The Joint Commission's Office of Quality and Patient Safety has revised its definition of *sentinel event* as well as other revisions to the Sentinel Event Policy.

20 **Multiple Changes Effective January 2022 for Health Care Staffing Services Certification**
The Health Care Staffing Services Certification Program will convert to an off-site (virtual) review process in 2022.

24 **APPROVED: Revisions to the Ventricular Assist Device Program**
Revisions to the advanced certification program for ventricular assist devices will be effective January 1, 2022.

27 **UPDATED: Data Registry Requirements Revised for Select Advanced DSC Certification Programs**
The Joint Commission modified the data collection requirement and added a glossary term for organizations certified under select disease-specific care (DSC) advanced programs.

28 **UPDATED: Accelerate PI™ Dashboard Report Data Refreshed for 2021 Second Quarter**
Joint Commission–accredited home care settings, inpatient psychiatric facilities, and hospitals are among the multiple settings that can access second quarter dashboard reports.

29 **Call for Papers on Telehealth**
The Joint Commission Journal on Quality and Patient Safety is seeking manuscript submissions on telehealth.

30 **Consistent Interpretation**
Joint Commission surveyors' observations related to reprocessing ultrasound transducers.

33 ***The Joint Commission Journal on Quality and Patient Safety***
Table of Contents—June 2021

35 **In Sight**

The Joint Commission and NQF Honor 2020 Eisenberg Award Recipients

On June 8, 2021, The Joint Commission and the National Quality Forum (NQF) announced the recipients of the 2020 John M. Eisenberg Patient Safety and Quality Awards. Launched in 2002 by NQF and The Joint Commission, the patient safety awards program honors the late John M. Eisenberg, MD, MBA, former Administrator of the Agency for Healthcare Research and Quality (AHRQ), a founding member of NQF's board of directors, and advocate for health care quality improvement. On July 20, 2021, the recipients and their achievements will be honored during a virtual award ceremony that leads off the NQF 2021 Annual Conference.

> *"This year's Eisenberg Award recipients represent the best of the best in health care quality and safety improvement. Their visionary thinking, dedication, and bold initiatives have significantly improved patient care and saved lives."*
> **David W. Baker, MD, MPH, FACP, Executive Vice President, Division of Health Care Quality Evaluation, The Joint Commission, and Editor-in-Chief, *The Joint Commission Journal on Quality and Patient Safety***

The 2020 Eisenberg honorees received awards in the three categories—Individual Achievement, Innovation in Patient Safety and Quality at a National Level, and Innovation in Patient Safety and Quality at the Local Level. The achievements of each honoree will be featured in a special issue of *The Joint Commission Journal on Quality and Patient Safety* later this summer.

Individual Achievement

David M. Gaba, MD, Staff Anesthesiologist and Director of the Patient Simulation Center of Innovation, US Department of Veterans Affairs (VA) Palo Alto Health Care System, California; and Professor, Anesthesiology, Perioperative, and Pain Medicine; and Associate Dean for Immersive and Simulation-based Learning, Stanford University School of Medicine, Standford, California

Gaba was honored for his expansive career and seminal contributions in patient safety research, innovation, and dissemination. His work and experience include safety experimentation; developing and advancing theory, teaching, and editing; and being a scholar and institutional leader. He has authored more than 125 peer-reviewed publications in organizational safety theory, human factors, and safety culture. His contributions are innovative and lead the field in three areas:

1. Invention, use, and commercialization of modern mannequin-based simulation
2. Adaptation of crew resource management (CRM) from aviation to use within anesthesiology
3. Creation and promulgation of multi-event "cognitive aids" for real-time use in time-critical life-threatening situations

Innovation in Patient Safety and Quality at the National Level

Veterans Health Administration (VHA) Rapid Naloxone Initiative, Washington, DC

The VHA Rapid Naloxone Initiative reduced opioid overdose deaths by increasing the rapid availability of naloxone, using the following three elements:

1. Providing opioid overdose education and naloxone distribution (OEND) to VHA patients at risk for opioid overdose
2. Providing naloxone to VA police
3. Including naloxone in automated external defibrillator (AED) cabinets

The VHA Rapid Naloxone Initiative has equipped more than 255,000 veterans with naloxone, and 82% of VHA facilities have equipped 2,785 of their police officers with naloxone. In addition, 92 VHA facilities have deployed naloxone in 639 AED cabinets. As a result of these efforts, the OEND program has reported more than 1,500 overdose reversals with naloxone, while VA Police have reported 132 overdose reversals. There have also been six reported overdose reversals with the AED cabinet naloxone.

Innovation in Patient Safety and Quality at the Local Level

Northwestern Medicine Academy for Quality and Safety Improvement, Chicago

The Northwestern Medicine Academy for Quality and Safety Improvement was developed to prepare individuals, across multiple departments and professions in their health system, to lead quality improvement (QI). The seven-month program teaches QI methods and asks participants to complete a QI project during the program. It also prepares participants to engage in QI efforts and lead QI projects after completing the program. Over the past eight years, the program achieved the following results:

- 80 teams consisting of 441 individuals have participated, representing a range of specialties, settings, and professional backgrounds
- Overall, 66% of teams have improved performance across a wide range of improvement projects
- Participants surveyed 18 months post-program completion show that a majority (74%) have engaged in subsequent quality improvement efforts, many (43%) have led other QI projects, and (42%) provided QI mentorship.

"Improving the safety and quality of health care delivery through the rigorous application of measurement science has been a priority for NQF since its very inception. The Eisenberg Awards serve as an annual celebration of Dr. John Eisenberg's legacy by inspiring others in the health care ecosystem to continue making significant and lasting contributions in pursuit of this goal. I'm delighted to congratulate this year's award recipients on their tireless efforts to ensure every person in our country experiences care that is safe, high quality, and high value."
Chris Queram, Interim President and Chief Executive Officer, National Quality Forum

Additional information about the award ceremony is available on The Joint Commission's John M. Eisenberg Patient Safety and Quality Award page. Registration is open now, and there is no cost to attend the virtual event. The 2021 Eisenberg Award submission period is expected to open this August.

Potential Patient Safety Events Analysis Reveals Trends During the COVID-19 Pandemic

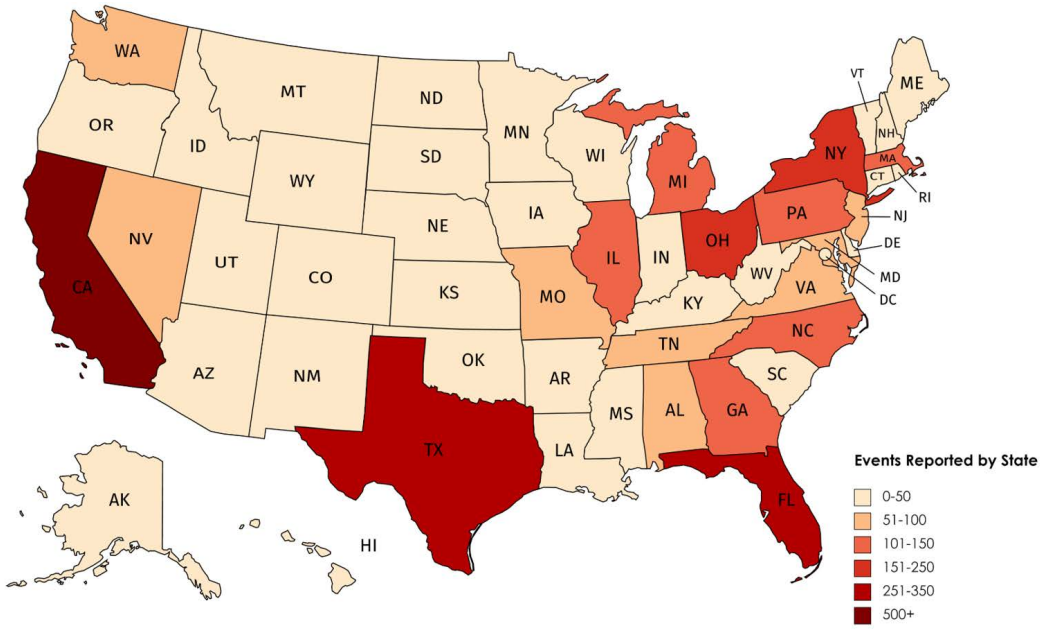
Dashboard Illustrates the Focus Areas That Challenged Health Care Organizations During the Pandemic

As health care organizations begin to see some relief from the effects of COVID-19, The Joint Commission's Office of Quality and Patient Safety (OQPS) began an in-depth analysis of the numerous patient safety event reports received related to the pandemic.

In 2020 OQPS received approximately 16,000 reports of potential patient safety events. Of those reports, more than 3,500 were related to the COVID-19 pandemic that came from a variety of sources, including, but not limited to, the following top five:

1. Anonymous sources (806)
2. Family members (744)
3. Organizational self-reporting/health care staff (571)
4. Patients/residents/individuals served (485)
5. Media (229)

The following graphic illustrates the concentration of these reported incidents by state.



For the first time, OQPS staff aggregated the data to identify any potential trends or themes to better understand the impact the pandemic had on health care organizations and to identify potential areas for improvement. Initial review of the reports identified that many concerns were safety events that fell in the following three distinct focus areas:

1. Assessment and care services
2. Infection prevention and control
3. Organizational structure

However, 48 incidents did meet The Joint Commission's sentinel event criteria. Of the confirmed sentinel events reported, the following three focus areas were identified:

1. Care management (that is, delays in care, falls)
2. Protection events (that is, suicide)
3. Surgical/invasive issues (that is, complications)

Making Sense of the Data

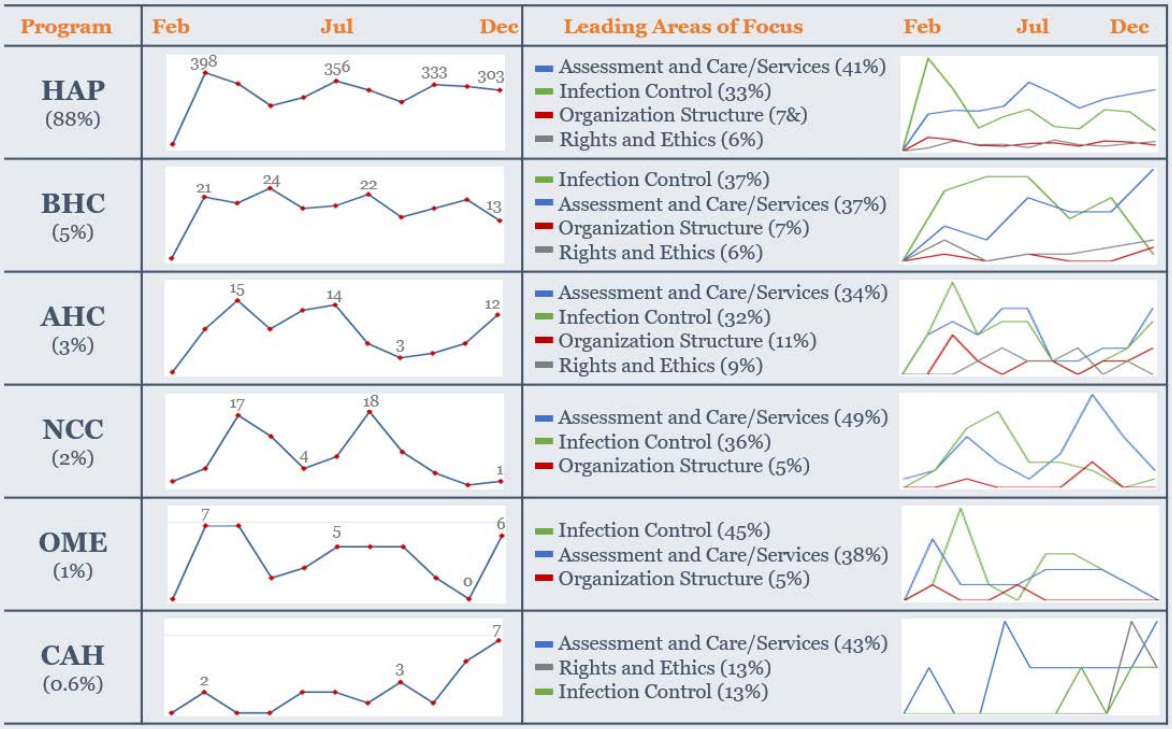
To ensure that the research shared with Joint Commission–accredited organizations was meaningful, OQPS began by separating the data by care settings. This initial categorization led staff to find interesting differences between trends.

Most patient safety event reports were attributed to hospitals. Other Joint Commission–accredited settings included the following:

- Ambulatory care
- Behavioral health care and human services
- Critical access hospitals
- Home care
- Nursing care centers

See the following graphic for the frequency of incidents reported by program.

Frequency of Reported Incidents (% of Total) by Program, Time, and Area of Focus



HAP, hospitals; BHC, behavioral health care and human services organizations; AHC, ambulatory care organizations; NCC, nursing care centers; OME, home care organizations; CAH, critical access hospitals.

Overall, the data identified seven focus areas. These areas are listed on the following graphic, with additional area-specific concerns that were reported.

Themes Associated with Leading Areas of Focus for All Programs

(Leading Areas of Focus represent 80% or more of reported COVID-19 related incidents)

Assessment and Care/Services (40%)	• COVID restrictions affecting care or access to care • Lack of COVID testing • Inadequate COVID screening	• Services interrupted, altered, or not available • Rapidly changing COVID care and services criteria
Infection Control (33%)	• Inadequate disinfection/ cleaning • Lack of mask/PPE availability • Inconsistent hand hygiene	• COVID outbreaks within organization • Lack of adherence to CDC guidelines
Organizational Structure (7%)	• Infection control/emergency management plans not initiated • COVID policy lacking/ unavailable • Lack of training for COVID	• Lack of precautions taken by leadership to protect patients and staff • Exposed/ill staff required to work
Rights & Ethics (6%)	• Coordination of care affected • Inconsistent visitor policy • Request for relocation denied due to COVID	• Medical decisions made without power of attorney • Lack of compassionate care
Staffing (3%)	• Critically short staffed (across disciplines) • Inadequate resource allocation • Unsafe nurse-to-patient ratios	• Mandated overtime • Inadequate staff competency and training
Communication (3%)	• Patients not informed of potential exposure • Lack of communication with family • Miscommunication over phone	• Difficulty reaching staff on phone • Interpreter/translator not available
Physical Environment (3%)	• Building at capacity/ overcrowded • Building design affecting patient placement/resources such as O_2 access	• Group sessions held in small/crowded rooms • Lack of air flow in small space • Lack of social distancing

PPE, personal protective equipment; CDC, US Centers for Disease Control and Prevention; O_2, oxygen.

The Joint Commission encourages its accredited health care organizations to study the results of the reoccurring themes of the leading focus areas to identify vulnerabilities in their own systems and processes. Organizations may consider the following questions as they review these data and determine next steps:

- What lessons learned can we identify from these data?
- What can we do to strengthen our systems and processes as a result of our lessons learned?
- What other lessons have been learned that are not reflected by these data?

Health care organizations also may consider the following actions as they review and revise their emergency management activities to ensure that lessons learned are not forgotten:

- Reevaluating staff training
- Assessing the critical resources central to how staff responds when emergency operations plans are deployed
- Continuing drills to evaluate staff responses

Although The Joint Commission hopes another global pandemic doesn't cripple health care organizations, it believes this data analysis will spotlight key areas to examine internally, which will help health care organizations prepare for any future pandemic and/or other emergency. P

NEW: The Joint Commission Collaborates with ACOG to Address Maternal Health Issues

New Maternal Levels of Care Verification Program and Advanced Certification Expected in 2022

The Joint Commission and the American College of Obstetricians and Gynecologists (ACOG) recently announced a new collaboration to address maternal health issues through the development of a new **Maternal Levels of Care** (MLC) **Verification Program**, available **January 1, 2022**. The United States is the only developed country with a rising maternal mortality rate and experiences large disparities in maternal morbidity and mortality.

The Levels of Maternal Care (LoMC) Obstetric Care Consensus, first published in 2015 by ACOG and the Society for Maternal-Fetal Medicine, defines the required minimal capabilities, physical facilities, and medical and support personnel for each level of care, which includes the following:

- Level I (basic care)
- Level II (specialty care)
- Level III (subspecialty care)
- Level IV (regional perinatal health care centers)

Conducted by The Joint Commission, the verification process will involve an on-site comprehensive review of the maternal services available in critical access hospitals and hospitals and a level of maternal care determination.

The MLC Verification Program launches as several state legislative and licensing authorities, health care systems, and hospitals explore levels of care verification to improve the quality and safety of maternal care.

The Joint Commission and ACOG are also considering a certification in obstetric care for health care organizations that meets advanced criteria beyond the level requirements. Through this initiative, the two organizations will combine efforts to improve the quality and safety of obstetric care within communities.

The new programs come after The Joint Commission implemented 13 new elements of performance (EPs) to improve the quality and safety of care provided to women during all stages of pregnancy and post-partum. The new maternal safety requirements were effective January 1, 2021. The Joint Commission also began publicly reporting hospital performance on two perinatal care measures for cesarean birth rates and unexpected complications in term newborns earlier this year.

In addition, ACOG has led and participated in long-standing, continued efforts to eliminate preventable maternal mortality, particularly for advocacy and clinical practice. ACOG is dedicated to working with health care professionals, legislators, community organizations, and other stakeholders to address the multiple, complex causes leading to the untimely deaths of mothers in the United States.

Further details about the MLC Verification Program and advanced certification, including standards and requirements, will be available in later issues of *Perspectives*.

For more information, please contact Jennifer Hurlburt, DNP, APRN, CNS, Associate Director, Department of Standards and Survey Methods.

APPROVED: New and Revised Requirements for Resuscitation

Effective January 1, 2022, The Joint Commission approved new and revised requirements for resuscitation that are applicable to **critical access hospitals** and **hospitals**. In 2020, The Joint Commission reviewed its resuscitation accreditation standards to begin aligning them with contemporary guidelines, evidence, and recommendations. The development team held discussions with a technical advisory panel of resuscitation experts and conducted an extensive literature review to identify several interlinked factors that contribute to better organizational performance in resuscitation and improved patient outcomes after cardiac arrest. The proposed draft requirements subsequently underwent two public comment periods and a review by a standards review panel of practicing clinicians and administrators to arrive at the final set of requirements.

The new and revised requirements will strengthen resuscitation and post-resuscitation care processes by reducing unnecessary variations in practice. In addition, the requirements will require critical access hospitals and hospitals to adopt a more proactive internal review of data to seek continuous learning and improvement opportunities to maximize patient survival with the best possible neurological outcomes. Additional progress is still required in the following areas:

- Determining reliable measurement
- Capturing intra-arrest resuscitation quality data
- Leveraging emerging resuscitation technologies
- Implementing optimal training strategies

The Joint Commission continues to monitor the literature and trends on these topics and will address them in future updates if necessary.

The new and revised requirements cover the following key concepts:

- Provision of Care, Treatment, and Services (PC) Standard PC.02.01.11, Element of Performance (EP) 4* (revised)—Educating and training periodically to promote resuscitation event preparedness
- Standard PC.02.01.20, EP 1 (new)—Developing and implementing policies, procedures, and protocols for interdisciplinary post–cardiac arrest care
- Standard PC.02.01.20, EP 2 (new)—Developing and implementing policies, procedures, and protocols on neurological prognostication for patients who remain comatose after cardiac arrest
- Standard PC.02.01.20, EP 3 (new)—Establishing processes for interfacility transfers of patients for post–cardiac arrest care
- Performance Improvement (PI) Standard PI.01.01.01, EP 10 (revised)—Collecting resuscitation data
- Standard PI.03.01.01,† EP 22 (new)—Reviewing data and cases by an internal interdisciplinary committee to identify and suggest practice and system improvements

* During the public comment period, The Joint Commission received inquiries about the revised requirement, Provision of Care, Treatment, and Services (PC) Standard PC.02.01.11, Element of Performance (EP) 4, on resuscitation education and training and its impact on current practices for biannual certification in basic life support (BLS), advanced cardiovascular life support (ACLS), pediatric advanced life support (PALS), and other life support certifications. Hospitals define staff qualifications and competencies specific to their job responsibilities, including any required certifications. The intent of PC.02.01.11, EP 4, is that hospitals provide education and training in addition to any such certifications. While certifications provide the necessary foundational knowledge in resuscitation, PC.02.01.11, EP 4, stresses institution-specific education and training to promote staff preparedness that massed certification courses may not provide (for example, training grounded in local policies, procedures, or protocols; equipment; and the staff's specific roles and expectations during a code event).

† Performance Improvement (PI) Standard PI.03.01.01 was formerly Standard PI.02.01.01. This standard was moved as a result of revisions to the PI standards. *See* page 17 for more information about the PI standards revisions.

The new and revised requirements have been posted on the Prepublication Standards page of The Joint Commission's website and will publish online in the fall 2022 E-dition® update for the *Comprehensive Accreditation Manual for Critical Access Hospitals (CAMCAH)* and *Comprehensive Accreditation Manual for Hospitals (CAMH)*. For those customers who purchase them, the fall hard-copy accreditation products, including the 2021 *CAMH* fall update service; 2022 *CAMCAH* and 2022 *CAMH*; and *2022 Hospital Accreditation Standards Manual*, will include these new and revised requirements. Additional information about the revised standards is available in the project's *R³ Report*.

For more information, please contact Natalya Rosenberg, PhD, RN, Project Director, Department of Standards and Survey Methods. P

APPROVED: New and Revised Workplace Violence Prevention Requirements

The Joint Commission approved new and revised workplace violence prevention requirements for all Joint Commission–accredited **critical access hospitals** and **hospitals**. These requirements will be **effective January 1, 2022**.

According to US Bureau of Labor Statistics data,* the incidence of violence-related health care worker injuries has steadily increased over, at least, the last decade. Incidence data reveal that in 2018 health care and social service workers† were five times more likely to experience workplace violence than all other workers, comprising 73% of all nonfatal workplace injuries and illnesses requiring days away from work. However, workplace violence is underreported, indicating that the actual rates may be much higher. Exposure to workplace violence can impair effective patient care and lead to psychological distress, job dissatisfaction, absenteeism, high turnover, and higher costs.

The Joint Commission's Response

The high incidence of workplace violence directly affecting patient and staff safety prompted The Joint Commission to develop accreditation requirements on workplace violence prevention. To develop the new requirements, The Joint Commission conducted an extensive literature review and public field review. In addition, it sought expert guidance from a technical advisory panel of practicing clinicians representing various organizations, both public and private, who provided knowledge and expertise related to workplace violence issues. Representatives from hospitals and professional associations comprised a standards review panel that provided insight into the practical application of the proposed standards.

The result—new and revised requirements that provide a framework to guide critical access hospitals and hospitals to develop effective workplace violence prevention systems and address the following concepts:

- Defining *workplace violence*, including a formal definition added to the Glossary
- Outlining leadership oversight
- Developing work site analysis
- Developing policies and procedures for the prevention of workplace violence
- Reporting systems, data collection, and analysis
- Implementing post-incident strategies
- Providing training and education to decrease workplace violence

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* US Bureau of Labor Statistics. Injuries, Illnesses, and Fatalities: Fact Sheet: Workplace Violence in Healthcare, 2018. (Updated Apr 8, 2020.) Accessed Jun 22, 2021.

† *Health care and social services workers* are defined by the North American Industry Classification System as the "Health Care and Social Assistance sector [that] comprises establishments providing health care and social assistance for individuals. The sector includes both health care and social assistance because it is sometimes difficult to distinguish between the boundaries of these two activities. The industries in this sector are arranged on a continuum starting with those establishments providing medical care exclusively, continuing with those providing health care and social assistance, and finally finishing with those providing only social assistance. The services provided by establishments in this sector are delivered by trained professionals. All industries in the sector share this commonality of process, namely, labor inputs of health practitioners or social workers with the requisite expertise. Many of the industries in the sector are defined based on the educational degree held by the practitioners included in the industry."

The Joint Commission developed a compendium of resources from key stakeholders, including, but not limited to, the following:

- Federal and state agencies (for example, the US Occupational Safety and Health Administration [OSHA])
- Professional associations (for example, the American Hospital Association [AHA])
- Peer-reviewed publications (for example, the *Journal of Occupational and Environmental Medicine*)
- Private entities (for example, the Healthy Workforce Institute)

This compendium provides guidance to organizations as they develop, implement, and evaluate their workplace violence prevention program and assists organizations in complying with the new and revised standards. The abbreviated version of the compendium is available on The Joint Commission's website, with an expanded version available in late summer or early fall of 2021.

The new and revised requirements have been posted on the Prepublication Standards page of The Joint Commission's website and will publish online in the fall 2021 E-dition® update for the *Comprehensive Accreditation Manual for Critical Access Hospitals (CAMCAH)* and *Comprehensive Accreditation Manual for Hospitals (CAMH)*. For those customers who purchase them, the fall hard-copy accreditation products, including the 2021 *CAMH* fall update service; 2022 *CAMCAH* and 2022 *CAMH*; and *2022 Hospital Accreditation Standards Manual*, will include these new and revised requirements. Additional information about the revised standards is available in the project's *R^3 Report*.

For more information, contact, Antigone E. Kokalias, MBA, MSN, RN, Project Director, Department of Standards and Survey Methods. P

UPDATED: New and Revised Requirements for Sprinkler Heads

Effective immediately, The Joint Commission revised Life Safety (LS) Standard LS.02.01.35, Element of Performance (EP) 7, to clarify the number of spare sprinkler heads required by **behavioral health care and human service** organizations, **critical access hospitals**, and **hospitals**. This clarification better aligns the EP with the National Fire Protection Association (NFPA) *Life Safety Code*®.* This requirement will also be added for **inpatient hospice** facilities, **effective January 1, 2022**, because these facilities are also defined as health care occupancies according to the *Life Safety Code*.

In addition, this sprinkler head requirement has been added for organizations classified as ambulatory health care occupancies in accordance with the *Life Safety Code*. The new Standard LS.03.01.35, EP 7, applies to **ambulatory care** organizations, **critical access hospitals**, and **hospitals** and will be **effective January 1, 2022**.

The new and revised requirements have been posted on the Prepublication Standards page of The Joint Commission's website and will publish online in the fall 2021 E-dition® update for the *Comprehensive Accreditation Manual for Ambulatory Care (CAMAC)*, *Comprehensive Accreditation Manual for Behavioral Health Care and Human Services (CAMBHC)*, *Comprehensive Accreditation Manual for Critical Access Hospitals (CAMCAH)*, *Comprehensive Accreditation Manual for Home Care (CAMHC)*, and *Comprehensive Accreditation Manual for Hospitals (CAMH)*. For those customers who purchase them, the fall hard-copy accreditation products will include these revised requirements, including the 2021 fall update service for *CAMAC*, *CAMBHC*, *CAMHC*, and *CAMH*; *2022 Comprehensive Accreditation Manuals* for the listed programs; and 2022 standards manuals for ambulatory care, behavioral health care and human services, and hospitals.

For more information, please contact Herman McKenzie, MBA, CHSP, Director of Engineering, Standards Interpretation Group. P

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

APPROVED: Performance Improvement–Related Accreditation Participation Requirements Revised

The Joint Commission approved revisions to its "Accreditation Participation Requirements" (APR) chapter for **assisted living communities**, **critical access hospitals**, and **hospitals**. **Effective January 1, 2022**, these revisions at Standard APR.04.01.01 include the following:

- Updated to align with current ORYX® requirements
- Deleted an element of performance to reduce redundancy
- Improved language consistency across programs

The revisions have been posted on the Prepublication Standards page of The Joint Commission's website and will publish online in the fall 2021 E-dition® update for the *Comprehensive Accreditation Manual for Assisted Living Communities (CAMALC)*, *Comprehensive Accreditation Manual for Critical Access Hospitals (CAMCAH)*, and *Comprehensive Accreditation Manual for Hospitals (CAMH)*. For those customers who purchase them, the fall hard-copy accreditation products, including the 2021 *CAMH* fall update service; 2022 *CAMCAH* and 2022 *CAMH*; and 2022 *Hospital Accreditation Standards Manual*, will include these new and revised requirements.

For questions, please contact The Joint Commission's Performance Measurement team.

APPROVED: New and Revised Leadership and Performance Improvement Requirements

Effective January 1, 2022, The Joint Commission revised the following Leadership (LD) and Performance Improvement (PI) accreditation standards for **all accreditation programs** except the Assisted Living Community program:

- Moved Standard PI.01.01.01, Element of Performance (EP) 1, to LD.03.07.01, EP 2
- Added a new Standard PI.02.01.01 with two new EPs
- Added a new EP 3 to Standard PI.04.01.01
- **Renumbered standards and EPs to reflect new content** and revisions

During its research, The Joint Commission identified that health care organizations use a wide range of capabilities and execution strategies to monitor quality and improve performance. However, two common themes emerged among organizations with successful improvement programs:

1. They adopted an established improvement methodology and used the associated tools in their efforts.
2. They developed and maintained relevant and manageable plans for monitoring quality and prioritizing improvement initiatives.

The new and revised requirements incorporate these two aspects of successful programs, along with strengthening the link between leadership priorities and goal setting and planning organizational quality assessment and performance improvement efforts.

The new and revised requirements have been posted on the Prepublication Standards page of The Joint Commission's website and will publish online in the fall 2021 E-dition® update of all *Comprehensive Accreditation Manuals* (*CAMs*), except for the assisted living communities manual. For those customers who purchase them, the fall hard-copy accreditation products, including the 2021 fall update service, 2022 *CAMs*, and 2022 standards manuals, will include these new and revised requirements.

For more information, please contact Caroline Christensen, BS, Project Director, Department of Standards and Survey Methods. P

Sentinel Event Definition and Chapter Revised

The Joint Commission's Office of Quality and Patient Safety (OQPS) revised its definition of a *sentinel event* and clarified some of the event-specific examples in the Sentinel Event Policy. Additional revisions to the Sentinel Event Policy clarify expectations regarding a health care organization's partnership and collaboration with OQPS and include editorial revisions to improve the flow of the chapter. **Effective January 1, 2022**, these revisions apply to **all Joint Commission accreditation** and **certification programs**, except the Health Care Staffing Services and Integrated Care Certification programs.

Revised Terms

The current definition of *sentinel event* lists the outcomes of death, permanent harm, and severe temporary harm. Although the definition provided a footnote defining *severe temporary harm*, the definition can be confusing to consistently apply to such incidents. OQPS revised the definition to clarify the differences between severe harm (which may or may not be permanent) and permanent harm (regardless of severity). The revised definitions include the following:

> ***sentinel event*** *A patient safety event (not primarily related to the natural course of the [patient's] illness or underlying condition) that reaches a [patient] and results in death, severe harm (regardless of duration of harm), or permanent harm (regardless of severity of harm).*
>
> ***severe harm*** *An event or condition that reaches the individual, resulting in life-threatening bodily injury (including pain or disfigurement) that interferes with or results in loss of functional ability or quality of life that requires continuous physiological monitoring or a surgery, invasive procedure, or treatment to resolve the condition.*
>
> ***permanent harm*** *An event or condition that reaches the individual, resulting in any level of harm that permanently alters and/or affects an individual's baseline.*

Revised List of Specific Sentinel Events

As part of the chapter overhaul, OQPS reordered and revised the list of events considered sentinel events, including to reflect revisions related to the updated sentinel event definition and the clarification of severe and permanent harm. New footnotes and corresponding definitions (moved into a new sidebar titled "Defining Events That Are Sentinel") were created to help organizations better understand the revised list.

The following event-specific items have been added or revised, with additions or moves shown with underlined text and deletions shown with ~~strikethrough text~~.

- Severe maternal morbidity ~~(not primarily related to the course of the patient's illness or underlying condition) when it reaches a patient and results in permanent harm or severe temporary harm~~
- Surgery or other invasive procedure performed at the wrong site, on the wrong patient, or that is the wrong (unintended) procedure for a patient regardless of the type of procedure or the magnitude of the outcome

- ~~Prolonged fluoroscopy with cumulative dose > 1,500 rads to a single field or any delivery of radiotherapy to the wrong body region or > 25% above the planned radiotherapy dose~~ Fluoroscopy resulting in permanent tissue injury when clinical and technical optimization were not implemented and/or recognized practice parameters were not followed
- Any delivery of radiotherapy to the wrong patient, wrong body region, unintended procedure or > 25% above the planned radiotherapy dose
- Fall in a staffed-around-the-clock care setting or fall in a care setting not staffed around the clock during a time when staff are present resulting in any of the following: any fracture; surgery, casting, or traction; required consult/management or comfort care for a neurological (for example, skull fracture, subdural or intracranial hemorrhage) or internal (for example, rib fracture, small liver laceration) injury; a patient with coagulopathy who receives blood products as a result of the fall; or death or permanent harm as a result of injuries sustained from the fall (not from physiologic events causing the fall)

Organization Guidance Clarified

The final substantive revisions clarify the expectations for health care organizations' collaboration with OQPS, which include the following:

- Removed redundant verbiage and duplicative content
- Clarified guidance on how to complete a comprehensive systematic analysis to align with current Joint Commission requirements
- Reorganized content to flow in a more logical order
- Clarified content to determine whether a patient safety incident meets criteria for sentinel event review

Since 1996 the Sentinel Event Policy has guided organizations that experience serious adverse events in their efforts to collaborate with The Joint Commission; protect the patient, resident, or individual served; improve systems; and prevent further harm. The last major revision of the entire policy occurred in 2014. These revisions will be included in the fall 2021 update to E-dition® and all hard-copy accreditation and certification products.

For the most current version of the Sentinel Event Policy, *see* the "Sentinel Event" (SE) chapter on E-dition or in your *Comprehensive Accreditation Manual*. Questions about the policy may be submitted via e-mail to The Joint Commission.

Multiple Changes Effective January 2022 for Health Care Staffing Services Certification

Effective January 1, 2022, The Joint Commission approved improvements and updates to the **Health Care Staffing Services** (HCSS) Certification Program. The following sections outline the three changes to the HCSS program:

1. Revised standards
2. Updated performance measure requirements
3. Converted review process

Revised Health Care Staffing Services Certification Standards

The Joint Commission will revise the following HCSS standards and elements of performance (EPs):

Human Resources Management (HSHR)

- **Standard HSHR.3**—will now clarify that this is the firm's new employee orientation and specifies that a new employee will complete it before his or her first assignment start date. An enhanced rationale statement and a revised glossary definition of the term *orientation* accompany the standard.
- **Standard HSHR.4**—will no longer include clinical staff supervisors, which means deleting EPs 5 and 6.
  - New EP 8 requires that staffing firms engage clinical professionals in competence assessment and reassessment activities when necessary. It also requires that these clinical professionals have knowledge and experience reflecting that of the firm's clinical staff.
  - New EP 9 requires staffing firms to identify in documented procedures the predefined circumstances in which they will engage qualified clinical professionals in their competence assessment and reassessment activities. Reviewers will expect to see evidence that a firm is implementing the procedure defined in this EP through documentation in personnel records, when applicable.

Leadership (HSLD)

- **Standard HSLD.9, EP 5**—will now specify that testing the emergency management plan includes the test date and any identified opportunities to improve the plan. If no improvement opportunities are identified through testing, documentation should state this fact.

The revised requirements will be posted on the Prepublication Standards page of The Joint Commission's website and will publish online in the fall 2021 E-dition® update of the *Health Care Staffing Services Certification Manual*.

For more information about the standards revisions, please contact Caroline Christensen, BS, Project Director, Department of Standards and Survey Methods.

Updated Performance Measure Requirements for HCSS Certification

Revised performance measure requirements for HCSS certification will apply to currently certified firms, as well as those seeking initial certification. The revisions update the three original standardized HCSS measures that have been used since 2008.

The following table outlines the original and revised measure sets. The revised measure sets now separate the "Do Not Return" and "Completeness of Personnel File" by per diem and travel staff.

Original Measure Set	Revised Measure Set
HCSS-1—Do Not Return – Clinical	HCSS-4—Do Not Return – Per Diem ● HCSS-4a: Firm Group 1 ● HCSS-4b: Firm Group 2 ● HCSS-4c: Firm Group 3 ● HCSS-4d: Firm Group 4
HCSS-2—Do Not Return – Professional	HCSS-5—Do Not Return – Travel ● HCSS-5a: Firm Group 1 ● HCSS-5b: Firm Group 2 ● HCSS-5c: Firm Group 3 ● HCSS-5d: Firm Group 4
HCSS-3—Completeness of the Personnel File	HCSS-6—Completeness of the Personnel File – Per Diem ● HCSS-6a: Firm Group 1 ● HCSS-6b: Firm Group 2 ● HCSS-6c: Firm Group 3 ● HCSS-6d: Firm Group 4
	HCSS-7—Completeness of the Personnel File – Travel ● HCSS-7a: Firm Group 1 ● HCSS-7b: Firm Group 2 ● HCSS-7c: Firm Group 3 ● HCSS-7d: Firm Group 4

Firms with only one staffing group (that is, per diem or travel staff) will collect two of the four measures specific for their staffing group. Firms with both per diem and travel clinical staff (that is, nursing professionals, allied health professionals, and licensed independent practitioners) will collect all four performance measures.

The size of the firm is defined as the total number of clinical placements (per diem or travel staff) placed in a 12-month period (*see* the following table) by each site listed in the HCSS certification application, including allied health professionals, nursing professionals, and licensed independent practitioners. If the firm requested that independent contractors be excluded from the scope of the certification review in its application, these individuals should not be included in the size of the firm. The electronic application (E-App)—also available on a firm's *Joint Commission Connect*® site—should be used as a reference to select the appropriate size category for reporting. Only one category may be selected for each review cycle.

Group 1	Group 2	Group 3	Group 4
< 40 clinical placements	40 to 99 clinical placements	100 to 349 clinical placements	≥ 350 clinical placements

Data will be reported in CMIP (Certification Measure Information Process)—available on a firm's *Joint Commission Connect* extranet site—based on the size of the staffing firm. Data submission is quarterly via CMIP and should be submitted no later than 45 days following the end of the calendar quarter.

Additional Performance Measure Improvements

The *Performance Measurement Implementation Guide* will be replaced with an electronic Health Care Staffing Services Measure Specifications Manual, Version 2022A. The manual provides detailed instructions for data collection. The Web-based version is user friendly and easy to navigate, and a printable version of the manual can be downloaded for users who prefer a hard copy.

In addition, new measures are in development to monitor staff turnover. HCSS input from a Joint Commission field review on this topic, conducted March 30 through May 5, 2021, will guide measure specification. Implementation of these new measures is anticipated mid-2022 or 2023 and will be published in a future issue of *Perspectives*.

Questions regarding these measures may be sent via the Performance Measurement Network Q&A Forum.

HCSS Program Shifts Permanently to an Off-Site Review Format

The ongoing pandemic-related contact and safety restrictions in 2020 prompted The Joint Commission to find alternative methods to conduct reviews. In August 2020 The Joint Commission began conducting off-site (virtual) reviews to ensure the safety of its customers and reviewers. Because of the positive response from HCSS customers and reviewers, The Joint Commission will adopt the off-site review process for the HCSS certification program beginning January 1, 2022.

HCSS firms will need to meet the following criteria to participate in an off-site review:

- The organization will be asked to sign a contract amendment titled "Amendment to Permit Virtual Surveys."
  - This contract can be found on the organization's *Joint Commission Connect* site under the "Review Process" tab in the "Contracts" section.
- The off-site review is conducted using Zoom as the meeting platform.
  - All organization representatives participating in the off-site review must be able to download the Zoom application to the device(s) they are using for the review.
  - All participants also must be able to share video through a built-in or external camera device.
- All documents required by the standards must be available electronically for viewing using the share screen capabilities of Zoom.
  - This includes items such as contracts and personnel files.
  - Any paper documents needed for the review must be scanned for viewing electronically, using the share screen capabilities of Zoom.

- Organizations will be given access to a secure SharePoint folder accessible only to the organization and the assigned Joint Commission reviewer.
  - Organizations will be provided with a list of documents required for the off-site review that must be uploaded no later than 72 hours prior to the first day of the review.
  - Organizations need to have a Microsoft e-mail account to access the SharePoint folder.
- Organizations will have a 30-minute dry run call with an account executive to test the technical capability for the off-site review.
  - During this call, the account executive will ensure that the organization can share screens, access the SharePoint folder, test video capabilities, and review the Zoom video functionality.

The option for an on-site review will not be available for HCSS customers as of January 1, 2022. In addition, organizations unable to meet the technology requirements for an off-site certification review will not be eligible to apply for or seek recertification. Organizations can reapply for certification when they have the technology required for the off-site review process.

The Joint Commission will continue to provide the Primary Certification Contact a courtesy seven business–day advance notice of the scheduled review date by e-mail for a recertification review. For an initial review, the Primary Certification Contact will receive a 30 business–day advance notice of the scheduled review date by e-mail. All notices are also posted under the "Notification of Scheduled Events" link on the organization's *Joint Commission Connect* site.

For any questions regarding these program changes, please contact your account executive.

APPROVED: Revisions to the Ventricular Assist Device Program

The Joint Commission approved revisions to its requirements in the advanced certification program for **ventricular assist devices** (VADs) that will be **effective January 1, 2022**. These revisions include changes based on the December 1, 2020, decision memo release by the US Centers for Medicare & Medicaid Services (CMS). In addition, The Joint Commission incorporated updates to the program based on best practices from organizations that provide VADs. Initial notification of these revisions was published in the April 2021 issue of *Perspectives*.

The following is an overview of the substantive revisions to the VAD program:

- **Renamed program**—CMS expanded the patient selection criteria to include all VAD procedures for short-term (bridge-to-recovery and bridge-to-transplant) or long-term (destination therapy) mechanical circulatory support. In response, The Joint Commission has renamed its advanced disease-specific care certification program to Ventricular Assist Device from its former Ventricular Assist Device Destination Therapy.
- **Expanded interdisciplinary team members**—The members of the interdisciplinary team have been expanded at Program Management (DSPR) Standard DSPR.1, Element of Performance (EP) 4a, to include anesthesiologist(s) or certified registered nurse anesthetist(s), advanced practice provider(s) (if utilized by the program), and nursing staff.
- **Revised DSPR requirement**—A documented heart transplant consultation for each patient is no longer required at DSPR.3, EP 4a. The requirement has been changed to "a referral process to a heart transplant center, if needed."
- **Moved Delivering or Facilitating Clinical Care (DSDF) requirement**—Standard DSDF.1, EP 1a, requiring the experience and expertise of the interdisciplinary team as well as additional requirements have moved to the Program Eligibility requirements. Including this as program eligibility versus a standard ensures that the interdisciplinary team's experience and expertise are verified at the time of the organization's initial application and reapplication to determine if the organization qualifies for VAD certification prior to scheduling a review. The following blue-shaded box is the revised Program Eligibility requirements (see the blue shaded content) with additions or moves shown with underlined text and deletions shown with ~~strikethrough text~~.

Program-Specific Eligibility ~~VAD Requirements Assessed at Application~~

In addition to the General Eligibility Requirements listed in "The Joint Commission Certification Process" (CERT) chapter of this manual, organizations applying for VAD certification must include ~~also do~~ the following:

- Provide ventricular assist device ~~destination therapy~~ to an adult population and establishes selection criteria and VAD eligibility as set forth by the Centers for Medicare & Medicaid Services (CMS) for the adult population
- Utilize [US Food and Drug Administration]-approved left ventricular devices for short-term or long-term mechanical support for heart failure patients

  Note: *The VAD certification program excludes temporary VADs or extracorporeal membrane oxygen (ECMO).*
- Have facilities with the infrastructure to support VAD ~~ventricular assist device~~ placements as evidenced by adequate staffing and spaces facilities to perform the cardiac surgery and to recover patients afterward ~~after cardiac surgery~~
- Participate in an ~~Be an active continuous member of a national,~~ audited registry for mechanically assisted circulatory support devices ~~that requires submission of health data on ventricular assist device destination therapy patients* from the date of implantation throughout the remainder of their lives~~
- The VAD program team must be based at the facility and must include the following individuals:
  - ~~Include~~ One or more cardiothoracic surgeons, each of whom is trained, experienced, and privileged to perform VAD procedures and has placed 10 ventricular assist devices in the past 36 months with current activity in the past 12 months ~~meets the following volume requirement~~

    ~~**Note:** *If a surgeon on the team has not placed 10 ventricular assist devices during the required time period, the volume requirements can be met by including artificial heart placements for no more than 50% of the total volume.*~~
  - One or more cardiologists, each of whom is trained and experienced to manage advanced heart failure patients and has recent experience managing patients before and after placement of a VAD
  - A social worker
  - A palliative care specialist

Note 1: *Additional cardiothoracic surgeons can perform VAD procedures as a primary or secondary surgeon providing there is documentation of supervision by a certified and experienced VAD surgeon.*

Note 2: *The cardiothoracic surgeon volume requirement is effective at the time the application is submitted to The Joint Commission.*

Note 3: *Temporary mechanical circulatory assist devices, including extracorporeal or paracorporeal VADs, do not count toward the total number of VAD implants for cardiothoracic surgeons.*

~~* Programs are highly encouraged to enter patients who have ventricular assist devices as bridges to transplant into national, audited registries. This will allow the program to easily track information for quality improvement purposes.~~

- **Added new DSDF requirement**—A new requirement at DSDF.2, EP 2a, requires that the program follows clinical practice guidelines such as those set forth by the American College of Cardiology (ACC), American Heart Association (AHA), Heart Failure Society of America (HFSA), and/or International Society for Heart and Lung Transplantation (ISHLT) for care, treatment, and services rendered to advanced heart failure and VAD patients.

The program revisions have been posted on the Prepublication Standards page of The Joint Commission's website and will publish online in the fall 2022 E-dition® update for the *Comprehensive Certification Manual for Disease-Specific Care (DSC)*.

For more information, please contact Angela Murray, MSN, RN, Project Director, Department of Standards and Survey Methods. 

UPDATED: Data Registry Requirements Revised for Select Advanced DSC Certification Programs

Effective January 1, 2022, The Joint Commission modified the data collection requirement for organizations certified in the following advanced disease-specific care (DSC) certification programs:

- **Acute Stroke Ready Hospital**
- **Comprehensive Cardiac Center**
- **Comprehensive Stroke Center**
- **Primary Stroke Center**
- **Thrombectomy-Capable Stroke Center**
- **Ventricular Assist Device**

The revised language clarifies that organizations can participate in audited registries that collect state, regional, or national data. In addition, The Joint Commission developed the following new definition for *audited registry*, which will be added to the Glossary in the *DSC* manual:

> *Audited registry—A state, regional, or national registry that collects patient data, including, but not limited to, patient demographics, comorbidities, treatments, and process and outcome measures. Audited registries perform data quality audits to confirm data validity and inter-rater reliability. In addition, participation in an audited registry allows for benchmarking, which provides organizations an opportunity to improve or validate clinical practice and monitor the effectiveness of a service or intervention.*

Participation in an audited registry facilitates an organized approach to performance measurement and improvement, including data collection and analysis. Registries that perform audits ensure data validity and inter-rater reliability. The Joint Commission requires that information obtained from an audited registry be used by its certified organizations to compare their performance to other organizations by state, region, or nationally.

The revised requirements have been posted on the Prepublication Standards page of The Joint Commission's website and will publish online in the fall 2021 E-dition® update for the *Comprehensive Certification Manual for Disease-Specific Care (DSC)*.

For more information, please contact Angela Murray, MSN, RN, Project Director, Department of Standards and Survey Methods.

UPDATED: Accelerate PI™ Dashboard Report Data Refreshed for 2021 Second Quarter

Dashboard Reports Available on *Joint Commission Connect*®

Joint Commission–accredited home care settings, inpatient psychiatric facilities, long term care hospitals, inpatient rehabilitation facilities, hospitals, and critical access hospitals can access refreshed Accelerate PI™ Dashboard Reports on their *Joint Commission Connect*® extranet site. These reports—posted for the second quarter of 2021—reflect the most recent and available external data from the US Centers for Medicare & Medicaid Services (CMS) Compare Website. In addition, chart-abstracted and electronic clinical quality measure (eCQM) quality measurement data reported by hospitals to The Joint Commission under the ORYX® program have been refreshed with the most recent quarter of data.

Posted in the "Resources and Tools" section of an organization's *Joint Commission Connect* extranet site, Accelerate PI Dashboard Reports represent an organization's relative performance on each of the selected measures. For each measure, the dashboard shows the organization's performance compared to various benchmarks. The dashboard is not scored during survey; rather, it's a tool to facilitate discussion about ongoing quality improvement work. For example, surveyors may ask how an organization addresses the subset of performance measures in the report and what action(s) it is taking to improve processes. P

Call for Papers on Telehealth

In early 2020 the COVID-19 pandemic necessitated the closure of many outpatient facilities and the cancellation or postponement of nonurgent appointments. To continue providing care to patients without unnecessarily increasing infection risk, health care providers turned to telehealth. Although telehealth is not a new concept, the rapid shift from in-person to virtual appointments over the past year put many health care organizations on a steep learning curve with little advance preparation. This challenging transition has given rise to many questions related to health care quality and patient safety, from the effect the shift toward telehealth has had on care disparities, to how to best provide virtual care to visually impaired and hearing impaired patients, to how telehealth visits can be optimally integrated with in-person appointments.

To begin answering these questions, *The Joint Commission Journal on Quality and Patient Safety* is seeking manuscript submissions on telehealth, including retrospective analyses of quality and safety issues and prospective studies of strategies to improve quality, safety, access to care, and utilization. Please *see* the Guide for Authors for complete submission guidelines and instructions for authors. P

Consistent Interpretation

Joint Commission Surveyors' Observations Related to Reprocessing Ultrasound Transducers

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 also can 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 two Infection Prevention and Control (IC) requirements as they relate to reprocessing ultrasound transducers.

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

<table>
<tr><td colspan="3">Infection Prevention and Control (IC) Standard IC.02.02.01: The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.</td></tr>
<tr><td rowspan="3">Noncompliance Implications</td><td colspan="2">The US Food and Drug Administration (FDA) uses the Spaulding Classification System to develop appropriate reprocessing instructions for medical devices. Surface ultrasound transducers are classified as noncritical, semicritical, or critical, based on their intended use, and require a minimum level of reprocessing based on the following classifications:</td></tr>
<tr><td>Device Classification
● Noncritical
● Semicritical
● Critical</td><td>Minimum Level of Required Reprocessing
● Low-Level Disinfection
● High-Level Disinfection
● Sterilization</td></tr>
<tr><td colspan="2">Guidance to manufacturers has been published, but manufacturer's may choose to require a higher level of reprocessing based on their knowledge and specifications for the device that they manufacture. Organizations must follow the minimum level of reprocessing based on intended use as well as the manufacturer's instructions for cleaning and reprocessing devices unless they do not meet the minimum reprocessing requirements.</td></tr>
<tr><td colspan="3">EP 1: The hospital implements infection prevention and control activities when doing the following: Cleaning and performing low-level disinfection of medical equipment, devices, and supplies.* R

Note: Low-level disinfection is used for items such as stethoscopes and blood glucose meters. Additional cleaning and disinfecting is required for medical equipment, devices, and supplies used by patients who are isolated as part of implementing transmission-based precautions.

* For further information regarding cleaning and performing low-level disinfection of medical equipment, devices, and supplies, refer to the website of the Centers for Disease Control and Prevention (CDC) at https://www.cdc.gov/infectioncontrol/guidelines/disinfection/#r3.</td></tr>
</table>

Compliance Rate	In 2020, the noncompliance percentage for this EP was **21.63%**—that is, **122** of **564** hospitals surveyed did not comply with this requirement.

Surveyor Observations	Guidance/Interpretation
● A surface ultrasound transducer used on intact skin was not reprocessed in accordance with the manufacturer's instructions for use, as evidenced by the following: ❍ The organization performed only low-/intermediate-level disinfection on a surface ultrasound transducer contaminated with blood and/or body fluid that requires high-level disinfection in accordance with the manufacturer's instructions for use. ❍ The low-/intermediate-level disinfection required by the manufacturer's instructions for use was not performed on a surface ultrasound transducer contaminated with blood and/or body fluid. ❍ There was no evidence that cleaning and/or disinfecting was performed in accordance with the manufacturer's instructions for use on a surface ultrasound transducer used on intact skin.	● The Requirement for Improvement (RFI) must include the type of transducer (for example, surface, rectal, vaginal, sterile body cavity) used that is out of compliance. ● Note that surface ultrasound transducers and endocavity probes are not the same device. ● Surface ultrasound transducers should be reprocessed according to their intended use, which is commonly low-/intermediate-level disinfection unless high-level disinfection is specifically required by the manufacturer's instructions for use. ● This EP does not require a policy. ● Score here, at Standard IC.02.02.01, EP 1, only if it is directly observed that the organization is not compliant with the manufacturer's instructions for use or does not meet minimum reprocessing requirements based on intended use.

EP 2: The hospital implements infection prevention and control activities when doing the following: Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies.* (*See also* EC.02.04.03, EP 4) **R**

Note: *Sterilization is used for items such as implants and surgical instruments. High-level disinfection may also be used if sterilization is not possible, as is the case with flexible endoscopes*.

* For further information regarding performing intermediate and high-level disinfection of medical equipment, devices, and supplies, refer to the website of the Centers for Disease Control and Prevention (CDC) at https://www.cdc.gov/infectioncontrol/guidelines/disinfection/#r3 (Sterilization and Disinfection in Healthcare Settings).

Compliance Rate	In 2020, the noncompliance percentage for this EP was **46.28%**—that is, **261** of **564** hospitals surveyed did not comply with this requirement.

Surveyor Observations	Guidance/Interpretation
● An ultrasound transducer or probe used in a sterile body cavity was not sterilized in accordance with the manufacturer's instructions for use, as evidenced by the following: ❍ An intra-abdominal ultrasound transducer was reprocessed using high-level disinfection rather than sterilized in accordance with the manufacturer's instructions for use.	● The RFI must include the type of transducer (for example, surface, rectal, vaginal, sterile body) used that is out of compliance. ● Note that surface ultrasound transducers and endocavity probes are not the same device. ● Score here, at Standard IC.02.02.01, EP 2, only if it is directly observed that the organization is not compliant with the manufacturer's instructions for use or does not meet minimum reprocessing requirements based on intended use.

• An ultrasound transducer used on mucous membranes or nonintact skin was not reprocessed using high-level disinfection in accordance with the Spaulding Classification System (FDA requirement) or the manufacturer's instructions for use, as evidenced by the following: ❍ A vaginal (rectal or trans-esophageal) ultrasound transducer was reprocessed using low-/intermediate-level disinfection rather than high-level disinfection as required by the manufacturer's instructions for use. ❍ An ultrasound transducer used on nonintact skin was wiped with a disinfectant wipe prior to using the device on another patient.	• The RFI must include the type of transducer (for example, surface, rectal, vaginal, sterile body) used that is out of compliance. • Note that surface ultrasound transducers and endocavity probes are not the same device. • Score here, at Standard IC.02.02.01, EP 2, only if it is directly observed that the organization is not compliant with the manufacturer's instructions for use or does not meet minimum reprocessing requirements based on intended use.
• The organization did not follow the manufacturer's instructions for use of an ultrasound transducer sheath, as evidenced by the following: ❍ A sterile sheath was required in accordance with the manufacturer's instructions for use; however, the organization used a product that was not intended to be used as a sterile sheath. ❍ After using an ultrasound transducer sheath, the organization did not reprocess the transducer at the minimum level required by the manufacturer.	• Using a protective sheath does not negate the need to follow the ultrasound transducer's manufacturer's instructions for use when reprocessing unless specifically stated in the manufacturer's instructions for use.

The Joint Commission Journal on Quality and Patient Safety®

IMPROVEMENT FROM FRONT OFFICE TO FRONT LINE

This issue of *Perspectives* presents the **June 2021** 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.

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EDITORIALS

337 Let's Not Sleep on It: Hospital Sleep Is a Health Issue Too

N.H. Stewart, V.M. Arora

Sleep loss is common among hospitalized patients and can exacerbate chronic health issues. In this editorial in response to a study by Herscher and colleagues in this issue of the *Journal*, Stewart and Arora discuss the research that has been done on hospital sleep and the work that remains to address sleep as part of the health and well-being of hospitalized patients.

340 Prescribing Naloxone to High-Risk Patients in the Emergency Department: Is It Enough?

S.G. Weiner, J.A. Hoppe

Naloxone is a hallmark of harm reduction for patients with opioid use disorder, but prescription filling is difficult to track. In this editorial, Weiner and Hoppe ask whether interventions to increase naloxone prescription in the emergency department, such as that reported by Funke and colleagues in this issue of the *Journal*, are sufficient to prevent overdose deaths.

Process Improvement

343 A Sleep Hygiene Intervention to Improve Sleep Quality for Hospitalized Patients

M. Herscher, D. Mikhaylov, S. Barazani, D. Sastow, I. Yeo, A.S. Dunn, H.J. Cho

Sleep deprivation is a known problem among hospitalized patients. Given the hazardous effects of sedative and hypnotic medications, nonpharmacological approaches to promote sleep and improve sleep hygiene are needed. In this article, Herscher and colleagues report an intervention to improve self-reported sleep for patients on a general medicine ward using a nonpharmacologic sleep hygiene bundle.

347 Developing and Implementing a Dedicated Prone Positioning Team for Mechanically Ventilated ARDS Patients During the COVID-19 Crisis

M. Chiu, A. Goldberg, S. Moses, P. Scala, C. Fine, P. Ryan

Prone positioning (PP) has been shown to significantly decrease mortality in patients with moderate to severe acute respiratory distress syndrome, but the procedure itself carries risks. In this article, Chiu and colleagues report the training and redeployment of physical and occupational therapists from their regular roles to serve as a dedicated PP team during the COVID-19 pandemic.

354 Use of a Novel Patient-Flow Model to Optimize Hospital Bed Capacity for Medical Patients

Y. Hu, J. Dong, O. Perry, R.M. Cyrus, S. Gravenor, M.J. Schmidt

To avoid overcrowding and patient boarding, hospitals must have sufficient capacity in each inpatient unit to satisfy demand. However, there is no known method for determining the minimum number of beds in hospital inpatient units to achieve patient waiting-time targets. In this study, Hu and colleagues aimed to determine the relationship between patient waiting time–related performance measures and bed utilization to optimize inpatient unit capacity decisions.

Opioid Prescribing Processes

364 Increasing Naloxone Prescribing in the Emergency Department Through Education and Electronic Medical Record Work-Aids

M. Funke, M.C. Kaplan, H. Glover, N. Schramm-Sapyta, A. Muzyk, J. Mando-Vandrick, A. Gordee, M. Kuchibhatla, E. Sterrett, S.A. Eucker

Providing home naloxone can save lives, but emergency department implementation remains challenging. Funke and colleagues aimed to increase prescribing of naloxone to emergency department patients with opioid use disorder and opioid overdose by employing a model for improvement methodology, a multidisciplinary team, and high-reliability interventions.

Adverse Events

376 Assessing Patients' Experiences with Medical Injury Reconciliation Processes: Item Generation for a Novel Survey Questionnaire

J.S. Schulz-Moore, M. Bismark, C. Jenkinson, M.M. Mello

Traditional processes of dispute resolution for medical injury involve considerable stress for families and care providers, but there is a lack of suitable instruments for assessing injured patients' experiences. Schulz-Moore and colleagues used findings from previous studies and patients' experiences of non-litigation resolution of medical injuries to generate items for a patient experience questionnaire that medical facilities can use to assess how well resolution met patients' needs.

INNOVATION REPORT

385 Development of a Novel and Scalable Simulation-Based Teamwork Training Model Using Within-Group Debriefing of Observed Video Simulation

C.D.G. Goodwin, E. Velasquez, J. Ross, A.M. Kueffer, A.C. Molefe, L. Modali, G. Bell, M. Delisle, A.A. Hannenberg

Although the health care industry has recognized simulation training as the optimal approach for teaching crucial communication and teamwork skills, this training is inaccessible and underutilized for most health care professionals in the United States. In this article, Goodwin and colleagues report the design process of an adapted simulation training created to overcome key barriers to scaling simulation-based teamwork training—access to technology, time away from clinical work, and availability of trained simulation educators.

RESEARCH LETTER

392 Linguistic Structure of Surgical Checklists

K. Brook, K.K.T. Meyer, R. Ortega

Preprocedure checklists are standard practice to enhance communication and review safety steps for prevention of patient harm during surgical procedures, but suboptimal use of the checklist may have a negative impact on team function. Brook and colleagues explored the literature on the linguistic structure of checklists and how they are enacted to determine the effect linguistic structure has on checklist efficacy.

SENTINEL EVENT ALERT

394 *Sentinel Event Alert* 63: Optimizing Smart Infusion Pump Safety with DERS

The Joint Commission's most recent *Sentinel Event Alert* describes actions health care organizations can take to reduce the risk of errors caused by the misuse of smart infusion pumps, particularly errors that can be avoided by the optimal use of dose error reduction software (DERS).

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

- Approved new and revised resuscitation standards for **critical access hospitals** and **hospitals** (*see* page 11 in this issue for the full article)
- Approved new and revised requirements related to workplace violence prevention for **critical access hospitals** and **hospitals** (*see* page 13 in this issue for the full article)
- Approved new and revised requirements related to sprinkler heads for **behavioral health care and human services** organizations, **critical access hospitals**, and **hospitals** (*see* page 15 in this issue for the full article)
- Revised Accreditation Participation Requirements (APR) related to performance measures for **assisted living communities**, **critical access hospitals**, and **hospitals** (*see* page 16 in this issue for the full article)
- Approved revisions to Leadership (LD) and Performance Improvement (PI) requirements for **all accreditation programs except assisted living communities** (*see* page 17 in this issue for the full article)
- Revised the sentinel event definition for **all accreditation programs** (*see* page 18 in this issue for the full article)
- Revised requirements, updated performance measure requirements, and converted to a full off-site review process for **Health Care Staffing Services** (HCSS) organizations seeking initial HCSS certification or recertification (*see* page 20 in this issue for the full article)
- Approved requirement revisions for the advanced certification program for **ventricular assist devices** (*see* page 24 in this issue for the full article)
- Updated data collection requirements for **Comprehensive Cardiac Center**, **Acute Stroke Ready Hospital**, **Comprehensive Stroke Center**, **Primary Stroke Center**, **Thrombectomy-Capable Stroke Center**, and **Ventricular Assist Device** certification (*see* page 27 in this issue for the full article)

CURRENTLY IN FIELD REVIEW

- No standards currently in field review

Note: *Please visit the Standard Field Reviews pages on The Joint Commission's website for more information. Field reviews usually span six weeks; dates are subject to change.*

CURRENTLY BEING RESEARCHED OR IN DEVELOPMENT

- New and revised requirements to incorporate updated American Heart Association/American Stroke Association Acute Ischemic Stroke Guidelines in all disease-specific care **advanced stroke programs**
- Quality and safety issues related to electronic health records
- New and revised requirements for **Comprehensive Heart Attack Center**, **Primary Heart Attack Center**, and **Acute Heart Attack Ready** advanced disease-specific care certification programs to align with clinical practice guidelines
- New and revised requirements on antimicrobial stewardship for **critical access hospitals** and **hospitals**
- New and revised Emergency Management (EM) requirements for **critical access hospitals** and **hospitals**
- Revised Environment of Care (EC) requirements for **all accreditation programs**
- Strategies to reduce health care disparities for **all accreditation programs**
- Quality and safety issues related to telehealth

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Perspectives (ISSN 1044-4017) is published monthly by Joint Commission Resources, 1515 West 22nd Street, Suite 1300W, Oak Brook, IL 60523.