1. Pain Management for Behavioral Health Care

The spring 2019 update to E-dition® for accreditation and certification manuals will take effect on July 1, 2019, unless otherwise noted. The new “Care, Treatment and Services” (CTS) requirement, “to assess, then treat or refer individuals for treatment of physical pain” will apply to acute 24-hour settings where consistent nursing care and medical monitoring and supervision are in place (CTS.02.01.09, EP 3). For non-24-hour settings, a pain screen should be completed to identify when a pain assessment or evaluation is indicated (CTS.02.01.09, EP 1). If physical pain is identified, the organization treats or refers the individual for treatment (CTS.02.01.09, EP 2).

Before the July 1, 2019 standards take effect, it is recommended that hospitals prepare now by developing quality metrics as well as begin a medical record audit to monitor sustained compliance with new or revised pain management procedures.

Once the new standards take effect on July 1, 2019, organizations should develop a pain management Standard Operating Procedure (SOP) or policy and procedure. The SOP is intended to standardize the elements of the assessment or screen for all settings based upon age, condition, and the ability of the individual to comprehend. Moreover, hospitals should schedule training and education following any policy change or when new policies are implemented including new or revised pain management policies.

For additional information on pain management standards, please refer to the R3 Report, a complimentary publication of the Joint Commission.
2. Anticoagulation Therapy: Hospitals, Critical Access Hospitals, Ambulatory Centers, Nursing Care Centers and the Ambulatory Healthcare Program:

The National Patient Safety Goal (NPSG) .03.05.01 for anticoagulation therapy is intended to reduce the risk of medication adverse events as well as deliver appropriate and safe care to address concerns of direct oral anticoagulants such as for stroke prevention and atrial fibrillation.

The National Patient Safety Goal (NPSG) .03.05.01 applies to organizations that “initiate, manage, and adjust dosage for anticoagulation medications. It does not apply to organizations limited to the mechanical treatment of bleeding.” (December 2018, volume 38, Issue 12, Perspectives). Anticoagulant medications are considered high-risk as explained in the R3 report 19.

The NPSG has six (6) new elements of performance and two (2) existing elements of performance. Preparation to meet these standards requires developing evidenced based protocols and guidelines to manage anticoagulation therapy as well as the implementation of policies and procedures for reversal of anticoagulation. After development of evidenced based protocols, guidelines, procedures and education has been provided for applicable staff and providers, develop a process to monitor compliance with each element of performance.

The Joint Commission raised multiple questions and answers to further clarify the use of heparin for flushing lines, subcutaneous use, prophylactic use of heparin for deep vein thrombosis, what classes of medications apply to the NPSG, and if the standard applies if medication is not dispensed or administered. The following offers detailed answers to the questions raised:

1. Heparin used for flushing lines or used for subcutaneous administration: the NPSG does apply to heparin used for therapeutic use and administered by subcutaneous route. NPSG.03.05.01 is not applicable to heparin flushes used for line maintenance.

2. Therapeutic doses of heparin for deep vein thrombosis (DVT) prophylaxis after orthopedic surgery: the NPSG.03.05.01 does apply to the treatment of venous thromboembolism (VTE) but does not apply to short term prophylactic use of deep vein thrombosis related to procedures or hospitalization.

3. Anticoagulants included under NPSG.03.05.01: this NPSG applies to all classes of anticoagulants with the exception of Antiplatelet Agents-GP IIb/IIIa inhibitors. The examples provided in the requirements are not an exhaustive list (Heparin, Low Molecular Weight Heparin, Warfarin, Direct Oral Anticoagulants).

4. Organizations that monitor and provide patient education but do not dispense or administer anticoagulants: this NPSG does apply when anticoagulants are initiated, managed, and if doses are adjusted.

3. Suicide Risk Reduction: Clarification for the National Patient Safety Goal .15.01.01

National Patient Safety Goal (NPSG) .15.01.01, since its introduction in 2007, provides a framework intended to impact suicide rates in the United States. Since the goal was introduced, however, suicide remains the 10th leading cause of death in the country. The Joint Commission has responded by initiating standards revisions. The revisions are intended to heighten the focus on environments of care to ultimately improve safety through routine risk assessments, screening, staff training, and follow-up care.

The revised NPSG.15.01.01 targets the following elements of a suicide prevention program:

- Environmental assessment
- Screening for suicide
- Assessment of patients who screen positive for suicide
- Staff training
- Follow-up care

The Joint Commission raised multiple questions and answers to further clarify actionable duties hospitals should implement to meet heightened standards under Suicide Risk Reduction. NPSG.15.01.01 EP 3 mandates that Suicide Risk Reduction incorporates protective factors. Examples of protective factors are restated and provided below:

1. Safe, secure, monitored environment (e.g. inpatient hospitalization)
2. Receiving clinical care for mental, physical, and substance abuse disorders
3. Easy access to a variety of clinical interventions and support for help seeking
4. Family and community support (connectedness)
5. Support from ongoing medical and mental health care relationships
6. Skills in problem solving, conflict resolution, and nonviolent ways of handling disputes
7. Cultural and religious beliefs that discourage suicide and support instincts for self-preservation

NPSG.15.01.01 EP 3 further mandates that Suicide Risk Reduction incorporate the assessment of risk factors into the hospital’s efforts to implement the revised standards. The assessments are highly tailored to each patient. As such, it is recommended that staff be trained to look for as well as ask clear questions that will give the hospital opportunity to evaluate real, existing patient risk factors including the following:

1. Family history of suicide
2. Family history of child maltreatment
3. Previous suicide attempt(s)
4. History of mental disorders, particularly clinical depression
5. History of alcohol and substance abuse
6. Feelings of hopelessness
7. Impulsive or aggressive tendencies
8. Cultural and religious beliefs (e.g., belief that suicide is noble resolution of a personal dilemma)
9. Local epidemics of suicide
10. Isolation, a feeling of being cut off from other people
11. Barriers to accessing mental health treatment
12. Loss (relational, social, work, or financial)
13. Physical illness
14. Easy access to lethal methods
15. Unwillingness to seek help because of the stigma attached to mental health and substance abuse disorders or to suicidal thoughts.

The Joint Commissions offers additional FAQs including screening requirements, validated screening tools, medication administration, etc. Access and review the comprehensive listing and discussion of these most frequently asked questions.
4. Understanding the Care Environment

Behavioral health facilities, both in-patient and out-patient, treating patients at high risk for suicide are required to evaluate and improve often distinct and diverse environments of care. Healthcare environments are widespread across the country depending on locations and patient populations. Because each facility faces their own set of unique challenges, it is critical that facilities leaders and staff work collaboratively to study and execute plans of care that includes environmental risk assessments. Risk assessments are tools that list all the environment risks that could be harmful to each patient such as any anchor points, cords, and door handles that can be used for hanging.

Moreover, psychiatric hospitals must operate at a higher safety standard that is ligature resistant. On the other hand, general hospitals are not required to be ligature resistant; however, general hospitals are still required to meet critical standards of care intended to mitigate suicide risks.

For example, if a patient on a general medical unit is at high risk for suicide, the patient would need 1:1 monitoring since their IV tubing, wall oxygen, telemetry wires, etc. cannot be removed. In this case, monitoring is an actionable element of the risk mitigation plan.

Overall, hospitals are required to develop highly tailored risk mitigation plans to create and maintain environments of care that ultimately meets the National Patient Safety Goals for .15.01.01.

The following are updates that took effect on February 20, 2019. The following revised goals offer more detailed, specific guidance including didactic instructions that align with ongoing research.

1. “Behavioral health care organizations, psychiatric hospitals, and psychiatric units in general hospitals should conduct environmental risk assessments to be ligature resistant.
2. Non-psychiatric units in general hospitals are not expected to be ligature resistant; however, the units should minimize risks in the environment for patients identified at risk for suicide.
3. Individuals being treated or evaluated for behavioral health conditions as their primary reason for care need to be screened for suicide risk using a validated tool. (The goal does not require universal screening.)
4. Organizations must develop a plan to mitigate suicide based on an individual’s overall level of risk.
5. Organizations must follow written policies and procedures for counseling and follow-up care for individuals identified as at risk for suicide.”


Most Frequently Cited Clinical Standards and Elements of Performance (EPs)

1. The following are the top ten most frequently cited clinical standards and elements of performance for full and initial hospital surveys from October 01, 2017 to October 01, 2018.

Clinical elements of performance include all chapters in the hospital accreditation program except for the Environment of Care and Life Safety Code Chapters.

IC.02.02.01 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.

For example, this standard is frequently cited because of:

- Issues with not following manufacturers guidelines during high level disinfection such as the of cleaning brushes, proper use of enzymatic, cleaning and maintaining equipment;
- An enzymatic cleaning agent was not being used properly (wrong amount of enzymatic, or wrong amount of water) on soiled instruments as required by the manufacturer or the hospital policy and procedure;
- The hospital did not develop a process for properly loading the instrument washer or cleaning instrument trays;

- Biological indicators were not being logged or the amount of time of incubation was not documented.

IC.02.02.01, EP 4: The organization implements infection prevention and control activities when doing the following: Storing medical supplies and devices.

Examples of frequently cited observations include:

- Observing an expired pediatric suction catheter found in pediatric cart,
- Dirty items and clean patient supplies were stored comingled together,
- Ultrasound probes not covered during storage.
- Point of care testing instruments such used for testing blood glucose are stored at the nurse’s station visibly soiled.

IC.02.01.01, EP 1: The hospital implements its infection prevention and control activities, including surveillance, to minimize, reduce, or eliminate the risk of infection.

Examples of frequently cited observations include:

- The kitchen floor was noticeably soiled in the food preparation and clean storage area of the kitchen.
- Dishwasher water temperatures were not being monitored in the kitchen,
- A sterile instrument supply cart did not have a solid bottom,
- Monthly cleaning of the walls, ceiling and storage shelves in the compounding area of the pharmacy was not documented as required by hospital policy.

* Joint Commission Update, Health Systems Corporate Liaisons, November 2018, Mark G. Pelletier, RN, MS
2. The following are the top ten most frequently cited Environment of Care and Life Safety Code elements of performance for full and initial hospital surveys from October 01, 2017 to October 01, 2018.

Examples of cited observations include:

- Electrical junction boxes with exposed wires obstructed by objects (equipment, furniture etc.) and missing or open covers.
- Three duplex outlets in the kitchen were damaged and needed to be replaced.
- Electrical panels were found unlocked in space with public access.
- Electrical switches were broken.
- Electric hot water heater had exposed live electrical wiring.
- Walk in meat freezer temperature log was not kept at the temperature required per hospital policy.

EC.02.06.01, EP 1: Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided. Examples of frequently cited observations for this standard include needles and syringes stored in an unsecured drawer, a medication room without a door, an electrical outlet near the sink was not protected by ground fault outlets and ceiling tiles observed stained and/or missing.

EC.02.05.05 EP 6: The hospital inspects, tests, and maintains the following: Infection control utility system components on the inventory. The completion date and the results of the activities are documented.

Examples of cited observations include:

- Kitchen dishwasher cycles not at required temperatures
- Inspections are incomplete for air handlers serving critical areas such as:
  - OR
  - Sterile Processing
  - Compounding Pharmacy
  - Isolation Rooms

5 Joint Commission Update, Health Systems Corporate Liaisons, November 2018, Mark G. Pelletier, RN, MS
3. The following are the most frequently cited elements of performance for ambulatory care surveys from January 01, 2018 to September 30, 2018:

Examples of observations for the ambulatory setting for IC.02.02.01 EP 2:
For example, this standard is frequently cited because of issues with
- Not preparing instruments at the point of use after an invasive procedure,
- Not following manufacturer’s instructions for use when using high level disinfection solutions such as Cidex® OPA,
- No performance testing of the ultrasonic cleaner based upon the manufacturer’s instructions for use.
- Incomplete logs noted for the Trophon® high level disinfection system.

4. The following are the most frequently cited standards for behavioral healthcare surveys from January 01, 2018 to September 30, 2018.

Examples of observations for the behavioral settings for NPSG .15.01.01 EP 1:
- Patients were not assessed for characteristics that increase and decrease risk for suicide such as identifying patient characteristics that would decrease suicide risk, i.e. protective factors.
- In a partial hospital program, there was a suicide risk assessment completed, however, there were no environmental factors included in the assessment that may increase or decrease the risk for suicide;
- A patient who had purposely overdosed on a medication prior to admission to a partial hospital program, the overdose and subsequent suicide risk was not identified on the master treatment plan.
- At the time of admission to an intensive outpatient program, the patient self-reported as moderately suicidal and moderately hopeless. A suicide risk assessment was not conducted at the time of admission or after one week in the program.

Joint Commission Update, Health Systems Corporate Liaisons, November 2018, Mark G. Pelletier, RN, MS
The lead article in May’s edition of The Source, titled “Tackling Workplace Violence, The Role of Leadership,” discusses hospital leadership’s role in confronting workplace violence. The Joint Commission looks to leadership and leadership’s planning and strategy practices to increase or improve safety in hospitals. Thus, the focus of this spotlight on workplace violence illustrates methodologies proven to improve leadership’s role to prevent workplace violence.

Most notably, the Joint Commission highlights action and action-oriented changes where leadership does more than “talk” about safety and policy; and instead, makes shifts in workplace culture by implementing real time education and awareness training to ensure staff knows how to recognize risk of violence in the organization and knows how and when to report a risk of violence. Other actionable measures that hospital leadership should implement into their workplace culture includes coaching staff on teamwork and team training as well as practicing de-escalation techniques.

For additional information on workplace safety, please refer to the following resources:

- [Sentinel Event Alert 59: Physical and verbal violence against health care workers](#)
- [Guidelines for Preventing Workplace Violence, OSHA](#)
- [Quick Safety; De-escalation in Health Care, Issue 47, January 2019](#)

If you would like to learn more or are looking for additional resources and guidance from the Joint Commission, please reach out to our team directly. We look forward to hearing from you.

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