Accreditation 360 - Updated Accreditation Manual: National Performance Goals

On Demand Webinar Transcript
August 2025

Slide 1 – 00:00
Welcome and thank you for joining us for this Joint Commission Accreditation three sixty webinar on the National Performance Goals Requirements. CE credit is available for this on demand webinar for 6 weeks following its release. We encourage healthcare organizations to share the link to this recording and the slides with their staff and colleagues. There is no limit on how many staff can take advantage of this educational webinar.

Slide 2 – 00:23
Before we begin the webinar content, we would like to offer just a few tips about webinar platform functionality. Use your computer speakers or headphones to listen. Feedback or dropped audio are common for streaming video. Refresh your screen if this occurs. You can pause the play back at any time. You can return and replay the video by using the same access link from your registration confirmation email. We have captioned this recording, and the slides are designed to follow Americans with Disabilities Act rules.

Slide 3 – 00:50
The slides are available now. There are many links provided throughout this webinar, but they are not clickable on screen. By downloading the slides, you'll be able to access links and also take notes. To access the slides now, within the viewing platform, on the left side of your navigation pane, select the icon that represents a document. A new pop-up window will open, and you can select the name of the file. A new browser window will open, and from it, you can download or print the PDF of the slides. After the Continuing Education period expires, slides will remain accessible on the Joint Commission's website at the link included at the bottom of this slide.

Slide 4 – 01:28
Many attending this webinar will wish to receive continuing education credit or qualifying education hours. All relevant information about continuing education credit is available within a handout we've included with this webinar and has also been communicated on the webinar registration page. The attachment includes the list of entities that will provide credit, the requirements for participants to earn credit, and information about how to complete the survey and obtain a certificate. So be sure to download that attachment to learn more. Credit is available for this webinar for 6 weeks following its release. For information on Joint Commission's continuing education policies, visit the link provided on the bottom of this slide.

Slide 5 – 02:07
The participant learning objectives are:
Discuss the rationale for the National Performance Goals standards rewrite/reorganization; Define the structure, organization, and requirements of the new National Performance Goals Chapter;
Apply guidance and resources to inform implementation.

Slide 6 – 02:25
All staff and subject matter experts have disclosed that they do not have any conflicts of interest. For example, financial arrangements, affiliations with, or ownership of organizations that provide grants, consultancies, honoraria, travel, or other benefits that would impact the presentation of today's webinar content.

Slide 7 – 02:44
Welcome to today's on-demand webinar for Accreditation three sixty: the new standard. We are very excited to introduce you to the new National Performance Goals Chapter.

Slide 8 – 02:54
This material has been prepared for you by Dr. Jennifer Anderson the Director of the Global Standards and Survey Methods team. Dr. Anderson oversees the development of all accreditation and certification standards and the accompanying survey process for both the domestic and international programs. Dr. Anderson is a perinatal clinical nurse specialist by background and has been with Joint Commission for 8 years.

Slide 9 – 03:18
During this webinar, we will be discussing the intent and purpose on why Joint Commission did a complete rewrite of the Comprehensive Accreditation Manual for Hospitals and the Comprehensive Accreditation Manual for Critical Access Hospitals. We will discuss the overall manual redesign, the updated and revised Survey Process Guide, and then we will discuss next steps, including what can you expect for your organization.

Slide 10 – 03:41
In the manual redesign, our goal was to create a more streamlined manual for organizations. We knew there was a need to create elements of performance that more directly conveyed alignment with the Centers for Medicare and Medicare Services, or CMS, Conditions of Participation, or the CoPs. It was important for us to be able to differentiate what requirements are Joint Commission requirements that rise above the regulatory requirements. This work of streamlining and more direct alignment led to an overall EP reduction of roughly 46% for Critical Access Hospitals, and 48% eliminated for Hospitals.

By significantly reducing the overall number of elements of performance, or EPs, and by providing clear, concise language, explicitly explain where an EP originates from, and by clarifying the intent of the elements of performance – we believe that these changes in the long run will lead to operational efficiencies for organizations when striving to maintain compliance with the requirements and preparing for triennial surveys.

Slide 11 – 04:39
Joint Commission maintains what we call a crosswalk between the CMS Conditions of Participation, and the elements of performance that you will find in our respective manuals. This crosswalk illustrates which of our EPs meet or exceed the intent of the CoPs. This is required for our deeming status with CMS.

We wanted to provide you an example of what the streamlining work actually looks like on our crosswalk. Today, to meet the intent of CoP 482.24(c)(2), your organization needs to comply with roughly 10 EPs to meet the intent of the CoP. In future state your organization will only need to comply with this 1 new, streamlined element of performance instead. This streamlining will help organizations, surveyors, and our standards interpretation group better understand what is expected to meet CoP requirements.

Slide 12 – 05:29
First, before we start doing a deep dive into the National Performance Goals chapter I wanted to provide a few notes about the manual redesign in general. Our elements of performance all have a standard number like MM oh-one-oh-one-oh-one for an example, and then the EPs are numbered as well. With the manual rewrite, we have had to almost completely renumber most of the standards and elements of performance. Because of the massive restructuring, we needed to start with a clean slate in our standards database. We've developed a tool that I will explain later called the disposition report to help you with this piece. Secondly, you'll note that the risk icon has been eliminated in the manual. We noted that the risk icon was antiquated from prior to the introduction of the SAFER matrix and is no longer relevant, so it has been eliminated.

Next, in order to do this work, we had to do a major overhaul of our current requirements. We evaluated every single element of performance. We first started with evaluating the EPs that were crosswalked to CoPs. In most cases, we determined it would be best to write a new standard that clearly stated what was in the CoP. Please remember, these are not "new" in the sense of expectations. We have always required organizations to comply with the CoPs, over the years, Joint Commission just created a complicated way to meet the intent with several elements of performance for one CoP. Now, we've made that connection much more clear. But, after we removed the requirements from the crosswalk, we needed to determine what to do with the old requirement. Next, we then evaluated if that requirement was still relevant, or was it redundant to the now CoP direct EP, or was this requirement even in the CMS State Operations Manual or Survey Process Guide. If yes, then it was deleted. This is where you will see a majority of the deleted requirements. They were redundant to either the newly written CoP aligned EP or current survey guidance connected to the CoPs. And so, what you will see the revised manual are the following chapters. As you see, most look the same, but there has been changes in each chapter except for the Accreditation Participation Requirements chapter.

Next, you will see that we developed a NEW Chapter called the "National Performance Goals" (NPG) which includes previous national patient safety goals and all requirements that go above the CMS CoPs and regulation with 2 exceptions which I will go into in a minute, a new physical environment chapter which is a combination of the old environment of care and life safety chapter. The Physical Environment Chapter, or the PE chapter, now matches the structure of the physical environment CoP, and you will notice that we eliminated the Waived Testing Chapter, but you will still find waived testing requirements, although much fewer, in the NPG chapter.

Slide 13 – 08:09
As I mentioned on the last slide, we did a deep dive analysis of every single EP that was no longer crosswalked to the CoPs. We worked with internal Joint Commission stakeholders and our department of research to determine if we needed to retain the element of performance because it was an important patient safety and quality topic. We evaluated the origin of each EP, reviewed if there was any current, relevant research, and reviewed how often each EP was identified as an opportunity on a recent surveys and made one of three determinations for each EP. 1) It would be retained because it was a relevant patient safety and quality topic that Joint Commission felt was important enough to elevate to a national performance goal, 2) move the EP into the survey process guide as guidance to assist organizations with compliance with the CoPs, or 3) delete the EP due to redundancy to other EPs, the CoPs or the survey guidance from CMS.

All EPs that received a retained disposition was then organized and simplified into national performance goals. These goals new goals are salient, important, measurable topics that Joint Commission feels make sense to require of organizations. One note we wanted to make is that the medical staff chapter was included in the rewrite, so you will see consolidations of EPs and movement due to renumbering, but the decision was made to keep this chapter whole and intact, so you will not see any EPs related to the medical staff chapter in the NPG chapter. All Medical Staff requirements are found in Medical Staff even in the future state.

Next, I'll give you an example of what you can find in the NPG chapter.

Slide 14 – 09:44
In the NPG chapter, you will find all requirements that rise above the CMS CoPs, but what you'll see here is they are grouped into 14 salient, measurable goals. Let's take workplace violence for an example found in the culture of safety goal. Today, to determine what EPs you need to comply with to meet Joint Commission's workplace violence requirements, you would need to look in the leadership, human resources, environment of care, and performance improvement chapter. January 1, you will find all requirements related to workplace violence in NPG.02.04.01 The hospital has a workplace violence prevention program.

One more example, our resuscitation/rapid response requirements are currently in Provision of Care, Nursing, Human Resources, Leadership, and Performance Improvement chapters. Now in Goal #1. These standards ensure that organizations review their clinical alarm safety systems, recognize and respond to changes in patient condition, they have resuscitative services available through the hospital, they develop and implement post-resuscitative care policies and procedures, and they review these cases for opportunities for improvement. Everything you need to comply with for resuscitation practices in one goal.

In the blue text box on these next few slides, you will see the overall topic of the goal and the concepts that are addressed within that goal. You may note that there are some goals here that are also addressed in the manual chapters that align with the CoPs. This helps further differentiate what is a CoP requirement and what is a requirement that goes above the CoPs.

Slide 15 – 11:18
On this slide, I want to point out 2 NPGs because they are exception to Joint Commission specific requirements only being in the NPG chapter. Suicide risk reduction remains as-is from the previous NPSG chapter, and most of these requirements are mapped to CoPs. We were concerned that if we moved these requirements to the CoP chapters, that we'd have to separate them into the appropriate chapter and it would appear as a "downgrade" which we definitely did not want to convey.

Also, you'll note that we have a staffing National performance goal. We took the opportunity to incorporate the staffing CoPs into a goal that states that the hospital is staffed to meet the needs of the patients it serves, and staff are competent to provide safe, quality care. We do NOT address staffing ratios. The staffing requirements are directly from the CoPs, plus Joint Commission specific requirements related to competency, training, and our previous PI requirement that require organizations to evaluate staffing when undesirable patterns or trends are identified.

Another thing to note on this slide is the Waived testing goal. You may be aware that there are no hospital CoPs that address waived testing, and in the CLIA regulations, they only mention that there is someone in charge of waived testing and that the organization follows the manufactures instructions for use, so we took this time to uncomplicate our waived testing requirements and simplify what is required in the NPG chapter, because these are not addressed in the CoPs.

Slide 16 – 12:44
We round out the NPG Chapter with goal 13 related to imaging safety and goal 14 related to medication management. During the manual rewrite – we took the opportunity to align our antibiotic stewardship requirements with the CoPs so you will find those under MM.18.01.01, but there are 2 requirements that are above the CoPs related to the oversight committee and measuring antibiotic usage that we felt were important to keep. Next, I will highlight the importance of each goal.

Slide 17 – 13:15
Now we will discuss the rationale for the National Performance Goals.

Slide 18 – 13:19
Ensuring that the correct patient receives the correct care at the correct time is foundational to patient safety and the responsibility of everyone who works in healthcare. Since 2003, Joint Commission–accredited hospitals are required to have patient care protocols and systems in place to ensure the correct patient receives the correct care at all times. The Universal Protocol for Safe Surgical Practices (including verification, site marking, and time-outs) has been required for two decades, and Joint Commission elevated three additional components to National Patient Safety Goals in 2009: correct use of patient identifiers, hand-off communications, and timely critical test reporting requirements. This 2025 National Performance Goal adds

the management of patient flow, monitoring changes in a patient's condition, and the availability of resuscitation services in this suite of requirements, recognizing that these key elements work together.

Joint Commission National Performance Goal for correct care, correct time focuses on longstanding quality and patient safety issues and ensures the patient is reliably identified as the person for whom service is recommended, and services and treatment are matched to that individual to reduce medical errors. Hospitals must: Have a process in place to correctly identify patients when providing care, treatment, and services. Report critical results of tests and diagnostic procedures in a timely manner. Manage the flow of patients throughout the hospital. Have a process for hand-off communications. Recognize and respond to changes in a patient's condition. Ensure resuscitative services are available throughout the hospital, develop and implement processes for post-resuscitation care, and review resuscitative care services to identify opportunities for improvement. Our universal protocol requirements remain the same.

Despite being categorized as "never events," recent literature demonstrates wrong site surgeries are still happening. One of the most commonly identified causes of wrong site surgery is an inability to follow established safety protocols. Joint Commission standards provide a framework for those protocols.

The standards under this goal include interventions to reduce the most common medical errors include surgical, diagnostic, and medication errors, equipment failures, patient falls, hospital-acquired infections, and communication failures. Handoffs occur frequently in hospitals and are associated with up to 80% of medical errors. Effective handoffs ensure that each caregiver has the necessary information to continue care seamlessly, reducing the risk of duplicated tests or conflicting treatment.

Slide 19 – 15:54
Goal Number 2 requires hospital leadership to foster a culture of safety. Fostering a shared commitment to safety at every level—where proactive risk prevention, open communication, and accountability are embedded in daily practices and decision-making—is essential for healthcare organizations to reduce medical errors, prevent staff burnout, and promote greater job satisfaction. However, persistent challenges continue to hinder effective collaboration, which can undermine these efforts. Establishing and adhering to clear quality standards plays a vital role in aligning teams, guiding consistent practices, and reinforcing a unified approach to patient safety and care excellence.

Joint Commission workplace safety standards, launched in 2010, aim to foster a robust, positive culture of safety culture in healthcare settings. Evidence shows that active leadership involvement in structured safety processes significantly improves both patient outcomes and workforce well-being. To support this, Joint Commission's standards emphasize strong, visible leadership commitment as essential to overcoming persistent challenges that compromise patient care and safety. It is important to note that during the development of the workplace safety requirements, Joint Commission engaged with leading experts in this area. It became very clear from the beginning that we needed to started with our definition of workplace violence and to go beyond the violent acts. We focus on not only violent acts, but also on the more covert acts, such as bullying, that are just as damaging to the workforce.

The Culture of Safety National Performance Goal, developed with broad healthcare stakeholder input, helps leadership foster and maintain a culture of safety that improves patient and workforce safety and quality. Specifically, Joint Commission standards require hospital leaders to:

- Regularly measure and evaluate safety culture using valid and reliable tools
- Develop and communicate the hospital's mission, vision, and goals to staff to guide actions
- Ensure the medical staff are represented in the hospital's governing body
- Address conflicts of interest and ethics

- Design a comprehensive safety program and work processes to focus individuals on safety and quality issues
- Develop and enforce a code of conduct applicable to both patients and staff that defines unacceptable behavior, including intimidating behaviors, and take actions to prevent/mitigate such behaviors
- Ensure the hospital has a workplace violence prevention program

We know that a poor safety culture in hospitals can create conditions that lead to negative patient outcomes, such as increased medical errors, adverse patient events, higher rates of patient injuries, staff burnout, decreased staff morale, reduced quality of care, legal issues, and reputational damage that can ultimately risk patient death. The Agency for Healthcare Research and Quality's research demonstrates that organizations with better safety cultures significantly improve multiple patient outcomes, including fewer hospital-acquired pressure ulcers, fewer patient falls, lower surgical infection rates, and fewer medication errors. Safety culture also benefits workers, resulting in fewer sharp-related and other injuries, better job satisfaction, improved staff retention, better reporting of safety events, and reduced burnout—contributing to greater healthcare worker retention and patient well-being. Joint Commission's Workplace Violence Prevention standards (described separately), added in 2022, work synergistically with the other culture of safety standards and address the recent rise of workplace violence.

Slide 20 – 19:15
Goal #3 contains all Joint Commission specific requirements for an organization's emergency management plan. Quality standards are essential for an effective emergency management programs as they build A hospital's ability to respond and recover from emergencies and disaster incidents is a regulatory and safety imperative. Hospital emergency management programs ensure hospitals can effectively respond to a wide range of emergencies and disasters. Joint Commission emergency management standards provide a comprehensive approach for improving resiliency to all types of disasters and are essential for protecting patients, staff, and infrastructure and for maintaining continuity of care.

Joint Commission has included accreditation standards for emergency management since 2009 and has evolved the requirements based on best practices. The standards leverage the National Fire Protection Agency, defined functions of an emergency management program (consisting of responsibilities, education, exercises, etc.) and provide a framework for ensuring effective operations during all phases of a disaster (mitigation, preparedness, response, and recovery). Hospitals must be able to meet increased demand and provide uninterrupted health care services (continuity planning), be self-sustaining for up to ninety-six hours (resource management), and prioritize use of critical resources (staffing, space, supplies). Since 2014, concepts of "disaster resiliency" have appeared in hospital emergency management programs. Disaster resiliency in hospitals is about the "capacity of hospitals to withstand, assimilate, and response to impacts of critical situations, all while ensuring the uninterrupted delivery of essential healthcare services." Hospitals should prioritize "efficient resource allocation, information technology infrastructure, in-service training, waste management, and a proactive organizational framework to build resilience," further suggesting that Joint Commission's 2025 standards continue to build upon key concepts of disaster readiness and resiliency.

The emergency management National Performance Goal provides a framework for disaster resiliency and outlines critical components of an emergency management program than focusing on specific types of disasters, Joint Commission standards promote a comprehensive, all-hazards approach for a broad spectrum of emergencies—natural, technological, biological, or human-caused. The Joint Commission specific requirements state that hospitals must:

- Ensure leadership provides oversight and support of the emergency management program
- Develop an emergency operations plan based on an all-hazards approach

- Have a communications plan that addresses how it will initiate and maintain communications during an emergency
- Maintain a staffing plan for managing all staff and volunteers during an emergency or disaster incident
- Maintain a plan for providing patient care and clinical support during an emergency or disaster incident
- Maintain a comprehensive plan that includes: Safety and security measures to implement during an emergency or disaster incident, managing resources and assets during an emergency or disaster incident, including plans for sustaining needs for up to 96 hours, disaster recovery, including strategies for damage assessments, restoring critical systems and essential services, returning to full operations, and family reunification.
- Provide emergency management education and training based on prioritized hazards identified in the hazard vulnerability analysis, and plan and conduct exercises to test its emergency operations plan and response procedures
- Evaluate its emergency management program, emergency operations plan, and continuity of operations plans.

Having an effective emergency management program in place is a functional component of disaster resiliency marked by the hospital's resource utilization, redundant systems, and its ability to rapidly respond to and recover from disasters. In addition to potential loss of life and disruptions in patient care, the economic impact of disasters on hospitals are devasting: As of 2023, the average cost of a cybersecurity incident in a hospital was approximately $10.93 million per breach. The 2025 California wildfires are projected to result in costs of hundreds of millions to low billions of dollars to US hospitals. Hurricanes Sandy (2012) and Harvey (2017) cost hundreds of millions of dollars in hospital damage in New York City and Houston. Hospital resiliency "plays a crucial role in mitigating the societal repercussions of disasters." Therefore, a comprehensive emergency management program "mitigates the impacts and minimizes mortality rates associated with such circumstances."

Slide 21 – 23:56
The role of quality standards in promoting safe and quality health care for all. Improving health care quality and safety means understanding and addressing the differences in health outcomes experienced by various patient groups within health care settings. This requires using insights gained through experience and observation to better meet patient needs and consistently deliver excellent care. Quality standards from Joint Commission help health care organizations identify gaps in care, track progress, and implement focused strategies to ensure every patient receives effective, timely, and personalized treatment.

A key strategy for improving health care quality and safety is addressing the differences in outcomes across various patient groups. In January 2023, Joint Commission introduced a National Performance Goal (NPG) focused on reducing disparities in care. New performance standards now require accredited organizations to evaluate and take action to close outcome gaps and reduce healthcare disparities.

Joint Commission's Health Care Equity National Performance Goal, developed with broad stakeholder input, directs organizations to:
- Designate an individual(s) to lead activities to improve health care equity for patients
- Assess patients' health-related social needs (HRSNs) and inform patients about community resources and support services
- Identify health care disparities by stratifying quality and safety data using the sociodemographic characteristics of their patients
- Take action to reduce disparities, monitor and report progress

Literature shows that hospitalized patients of color, women, veterans, people living in poverty, people with a disability, and other underserved communities often experience worse health outcomes and may face barriers to high quality care. For example:

- The maternal mortality rate for Black women is four times higher than that of non-Hispanic white women.
- Black, Hispanic, and female patients with pulmonary embolism have longer hospital lengths of stay, are less likely to undergo catheter-directed thrombolysis, and have higher odds of mortality and major bleeding compared to white male patients with the same condition.
- Women diagnosed with cardiovascular disease receive less intensive screening and treatment and are less frequently scheduled for cardiac procedures compared to men. Diagnostic accuracy is also lower in women than in men.

Data collected by Joint Commission during onsite surveys show organizations are meeting this NPG through a broad range of activities, often through community partnerships and enhanced resources and services. Preliminary evaluations show these interventions to improve care among targeted populations are working, measured across metrics including mortality rates, re-admission rates, adherence to chronic care medications, screening rates, and patient experience of care.

Slide 22 – 26:41

Infection prevention and control practices (or IPC) are essential in protecting patients, healthcare workers, and organizations from risk; enable early detection and intervention; reduce human error; and promote a culture of accountability. Quality standards introduced by Joint Commission help hospitals prepare and implement IPC processes that support ongoing, comprehensive risk assessments and targeted interventions.

Implementing infection prevention and control practices protects patients and health workers from avoidable infections. IPC is practiced at all levels—facility managers, leadership, staff, patients, and visitors—and all play a role. For over 50 years, Joint Commission has emphasized the importance of hospital infection control programs, by developing standards that set the bar for expectations that organizations must follow, establishing this requirement over ten years in advance of similar standards introduced by the Centers for Medicare & Medicaid Services (CMS). In 2024, Joint Commission streamlined its IPC standards to focus on the structures needed to support quality and safety and to align closer with laws and regulations, CMS Conditions of Participation (CoPs), and the CDC Core Infection Prevention and Control Core IPC practices. The 2025 national performance goals are further distilled.

The infection prevention and control practices focus on three critical IPC activities: infection risk assessment, preparedness for high-consequence infectious diseases, and hand hygiene. Hospitals must:

- Implement an IPC program with surveillance, prevention, and control activities that can:
- Annually identify and prioritize risks for infection, contamination, and exposure that pose risks to patients and staff.
- Locate risks specific to the geographic location, community, populations served, and services provided.
- Implement processes to support preparedness for high-consequence infectious diseases or special pathogens. Protocols must:
- Follow the “identify, isolate, and inform” approach.
- Require PPE and appropriate donning and doffing techniques.
- Support care of patients while in isolation.
- Address procedures for handling waste, including cleaning and disinfection of patient care spaces, surfaces, and equipment.
- Ensure training and competencies for staff who implement high-consequence diseases or special pathogens.

- Comply with either the Centers for Disease Control and Prevention (CDC) hand hygiene guidelines and/or the World Health Organization (WHO) hand hygiene guidelines and set goals for improvement.

Proactive risk assessment specific to each hospital is crucial for effective IPC practices. Without a comprehensive risk assessment, there is no way to determine potential harms and target interventions accordingly. Hospitals are the epicenter of outbreaks and pandemics. Preparing for high-consequence infectious diseases or special pathogens is highly variable and currently, hospitals are not required to implement training or competency assessments for special pathogens. Implementing a standardized approach will strengthen IPC practices to mobilize quickly when needed. Previous outbreaks, such as severe acute respiratory syndrome (SARS), H1N1 influenza, Middle East respiratory syndrome (MERS), Ebola, clade I mpox, Marburg virus, and COVID 19, have clearly demonstrated that emerging infectious diseases pose a real threat to human health and can cause significant disruptions in healthcare delivery systems at a local, national, and global scale.

Hand hygiene is the foundation of prevention and a well-established mechanism to prevent avoidable infections in hospitals. It is a SHEA/IDSA/APIC Practice Recommendation, with evidence that hospitals performing hand hygiene as indicated by CDC or WHO graded HIGH. Hand hygiene has been a National Patient Safety Goal since 2004 and was elevated to a National Performance Goal in 2025.

Slide 23 – 30:41
Effective pain management for patients with acute and chronic pain is a critical part of medical care, which includes safe prescribing practices to prevent misuse, addiction, and diversion. Providers must carefully navigate regulatory and public health guidelines without undermining patient access to necessary treatments.

The Joint Commission included pain management standards as part of its accreditation process in 2001. In response to revised clinical practice guidelines from the Centers for Disease Control and Prevention (CDC) and increasing regulation, Joint Commission and other stakeholders reevaluated existing approaches to pain management and prescribing practices to ensure the safe use of opioids and optimize other pharmacologic and non-pharmacologic approaches to pain management. Joint Commission pain standards emphasize multimodal pain management strategies, require organizations to identify and monitor patients at high risk for opioid-related harm, and encourage non-pharmacologic and non-opioid pain treatments.

The 2025 Joint Commission standards reflect consensus-based practices and guiding principles to ensure hospitals prioritize pain management and safe prescribing practices. As healthcare organizations are held accountable to regulatory and public health guidelines, Joint Commission standards establish a framework to help navigate the delicate balance of safe and effective patient care, guideline adherence, and community health.

The pain management and safe prescribing national performance goal requires:
- Hospital leadership and clinical staff to work together to establish pain management and assessment, including safe opioid prescribing, as an organizational priority, including: Leadership accountability, Monitoring, Staff education, and access to the Prescription Drug Monitoring databases.
- Hospitals provide nonpharmacologic pain treatment modalities
- Hospitals assess and manage the patient's pain and minimize risk associated with treatment through using defined criteria to screen, assess, and reassess
- Identifying treatment strategies and treatment plans based on evidence-based practices that involve the patient
- Monitoring patients identified as high risk for adverse outcomes and involve family in discharge planning and risks

- Identify opioid treatment programs and provides referrals where appropriate
- Hospitals collect and analyze data on pain assessment and management to increase safety and quality for patients.

Slide 24 – 33:04
Providing safe and informed care to all patients is a fundamental responsibility of any healthcare system. Ensuring patients are informed, active participants in their care improves health outcomes. The provision of safe care can go beyond the walls of a hospital and by following standards that assess patients' safety outside of the healthcare setting, hospitals can further optimize outcomes. Joint Commission's quality standards go beyond those required by the Centers for Medicare & Medicaid Services (CMS) to specify and require best practices for patient-informed and safe care.

For over two decades, Joint Commission standards have helped to foster effective communication between patient and physician by outlining specific details and criteria for fully engaging patients in their care and obtaining informed consent. Joint Commission requires hospitals to communicate in a way patients can understand and sets standards for the informed consent process. Since 2004, Joint Commission has also required organizations to use written criteria to identify those patients who may be victims of physical assault, sexual assault, sexual molestation, domestic abuse, or elder or child abuse and neglect, including considering the risk and resources needed to support patients who are potentially at risk post-discharge.

Joint Commission patients' rights standards enhance patient protection and engagement in their care by requiring hospitals to:
- Ensure patients receive information in a way they understand (e.g., interpretation and translation, adaptations for patients with vision, hearing, speech, or cognitive impairment) and are treated with dignity and respect
- Respect the patient's right to give or withhold informed consent (defined by written policy and following a defined process)
- Evaluate at entry to the hospital and on an on-going basis whether patients may be victims of abuse, neglect, or exploitation using defined criteria and:
- Maintaining of list of community agencies to provide care and support for referrals
- Educating staff on recognizing and acting on possible abuse and neglect
- Reporting internal cases of possible abuse, neglect, or exploitation
- Providing resources to patient populations that need protective services

Research shows that miscommunication can lead to medical errors, reduced adherence to treatment, and poor health outcomes. When patients understand their treatment options and engage in decision-making, they are more likely to adhere to care plans and experience better outcomes. Respecting a patient's cultural, spiritual, and personal values throughout the care process is foundational to enhance trust, communication, and patient engagement

Hospitals are often the first point of contact for individuals experiencing abuse and neglect, making it critical to identify these potential victims. The lack of a thorough and robust process to identify trauma puts the organization at risk for missing essential information that could guide treatment decisions and impact individual outcomes. Joint Commission standards: Promote early screening to identify at-risk individuals and intervene before harm escalates and focus on getting patients, who may be potential victims, access to needed community services and resources.

Slide 25 – 36:07
Goal 8, as I mentioned earlier, is an exception to NPG chapter being comprised of the Joint Commission specific requirements. Suicide is a significant public health issue that impacts many patient populations; therefore, we felt it was important to keep this previous National Patient Safety Goal in the new National Performance Goals chapter. Importantly, many people experiencing suicidal thoughts or behaviors first seek help in healthcare settings, making these environments critical for early identification and intervention. By requiring evidence-based and compassionate care, Joint Commission guides hospitals to play a vital role in early identification of suicide risk and interventions to reduce harm.

In response to a persistent lack of improvement in suicide rates, and since suicide is the 11th leading cause of death in the United States, Joint Commission held five technical expert panel meetings between June 2017 and March 2018 to explore and reevaluate current hospital practices relative to suicide prevention. In 2019, Joint Commission implemented new safety goal requirements designed to improve the quality and safety of care for patients who are being treated for behavioral health conditions and those who are identified as high risk for suicide.

The new 2025 national performance goals align with Centers for Medicare & Medicaid Services (CMS) Conditions of Participation (CoPs). These standards and the CoPs together provide the framework for reducing patients' risk of suicide during their hospitalization and transition back to the community. Hospitals must:

- (For Psychiatric units in hospitals): Assess features in the physical environment that could be used to attempt suicide and take necessary action to minimize the risks
- Screen all patients being treated primarily for a behavioral health condition for suicide ideation using a validated screening tool
- Use an evidence-based process to assess patients who screen positive
- Document patients' overall level of risk for suicide and the plan to mitigate, and follow written policies and procedures addressing the care of patients identified at risk (training for staff, guidelines for reassessment, monitoring)
- Plan counselling and follow up care at discharge
- Monitor implementation and effectiveness for policies and procedures for screening, assessment, and management of patients at risk and take action to mitigate.

Research shows that suicide is a significant public health issue that affects individuals across all demographics, regardless of age, gender, ethnicity, or background. Given people experiencing suicidal thoughts or behaviors often first seek help in healthcare settings, it is essential healthcare providers follow current guidelines and provide compassionate care. In doing so, healthcare organizations can prevent suicide deaths and promote recovery and resilience among individuals and their families. To further assist healthcare organizations, Joint Commission maintains a comprehensive information center. This resource center is publicly available and offers collections of curated resources with actionable strategies and tools to support organizations' suicide risk prevention initiatives.

Slide 26 – 39:11
Goal 9 is related to safe transplant practices. Since 2005, Joint Commission has elevated the profound consequences of tissue transplant-related adverse events through targeted standards that guide hospital prevention protocols. Complications from tissue transplants can lead to graft failure, immune response, and transmission of infections that affect patient health, such as viruses, bacteria, fungi, and others. While rare, infections due to mishandling of tissues or improper donor screening and testing still occur. Joint Commission's tissue transplant safety standards, elevated to a National Performance Goal in 2025, require hospitals to establish and follow safe tissue transplant procedures to minimize that risk.

Joint Commission tissue safety standards ensure the hospital develops and implements safe transplant practices. Hospitals must:

- Implement standardized procedures for managing tissues (acquisition, receipt, storage, and distribution of tissues) and confirm tissue suppliers are U.S. Food and Drug administration (FDA)-registered with required state licenses
- Trace all tissues bi-directionally from the donor or tissue supplier to the recipient(s) or other final disposition, including discard, and from the recipient(s) or other final disposition back to the donor or tissue supplier
- Using defined protocols, investigate adverse events related to tissue use or donor infections such as disease transmission or other complications suspected of being related to the use of the tissue

The U.S. Food and Drug Administration (FDA) and key stakeholders such as the Centers for Disease Control (CDC), American Association of Peri Operative Nursing (AORN), the Organ Procurement and Transplantation Network (OPTN), and the American Association of Tissue Banks (AATB) require tissue transplant safety measures and reporting of suspected donor-derived disease transmissions. Despite this oversight, outbreaks continue to occur. In 2021, there was a tuberculosis (TB) outbreak involving 113 patients across eighteen states after surgical implantation of contaminated bone allographs. In 2023, a second nationwide TB outbreak was narrowly prevented after two patients died from contaminated bone allographs. This second outbreak of bone allograft-related TB underscored the urgent need to ensure tissue transplant safety protocols are implemented at hospitals.

Joint Commission's tissue transplant safety standards are based in laws and regulations such as the FDA regulations for tissue management under 21 CFR Parts 1270 and 1271. In 2025, these standards were elevated to National Performance Goals (NPGs) to further protect patients and organizations from risk.

The standards, developed with broad healthcare stakeholder input, align with those of key industry players such as the American Association of Tissue Banks, the premier standard setting body promoting safety and use of human tissue.

Slide 27 – 42:03
Goal #10. Waived tests are categorized as "simple laboratory examinations and procedures that have an insignificant risk of an erroneous result." Common examples include blood glucose testing, fetal occult blood tests, and rapid strep tests. While risk is minimal risk, Joint Commission standards ensure quality and safety while performing waived tests in hospital settings.

All facilities in the US performing laboratory testing on human specimens for purposes of health assessment are regulated under the Clinical Laboratory Improvement Amendment (CLIA) requirements. However, certain tests are "waived" from the CLIA requirements due to their simplicity and minimal risk. The Food and Drug Administration (FDA) determines which tests meet the "waived" criteria when it reviews a manufacturer's application for a test system waiver and maintains this list. While waived tests are typically simple, they are not completely error proof. It is important that healthcare personnel perform these tests correctly and according to manufacturer's instructions to avoid errors or serious health impacts. Errors can lead to patient harm, including misdiagnosis, delayed or inappropriate treatment, and medication errors, as well as legal or regulatory risks. Joint Commission standards align with CLIA and go beyond regulatory requirements to ensure safety and quality while performing waived tests in hospital settings.

The 2025 waived testing national performance goal requires:

- Policies and procedures for waived tests are established, current, approved and readily available. Hospitals ensure:

- The person from the hospital whose name appears on the CLIA certificate, or a qualified designee, established written policies and procedures for waived tests that include specific criteria
- Policies or procedures for each waived test are consistent with manufacturer's instructions for use and include specific operational policies
- Staff performing waived tests are competent
- Staff who perform waived testing have been trained for each test that they are authorized to perform and this training is documented.
- Competence for waived testing is assessed and documented according to hospital policy at defined intervals, but at least at the time of orientation and annually thereafter. Competency is assessed using more than one method (e.g., performance of a test on a blind specimen, periodic observation of routine work, monitoring of quality control performance, written testing.

Slide 28 – 44:23
Goal 11 Focuses on creating a safe physical environment for both patients and workers. Safety and security risks are inherent in health care settings and can impact patients, visitors, and staff. It is important to have systems and processes in place to identify these risks in advance so the hospital can prevent or effectively respond to such incidents.

Safety incidents are usually accidental — stemming from the structure of the physical environment, performing routine tasks, or uncontrollable events like weather. However, security incidents are often intentional, involving threats such as violence, theft, infant abduction, or unrestricted access to medication. These risks affect anyone within the hospital environment. Joint Commission's physical environment standards focus on systems and processes to address both patient safety and worker safety and are in alignment with the Conditions of Participation (CoPs) set forth by Centers for Medicare & Medicaid Servies (CMS). National performance goals focus on key activities to prevent and mitigate safety and security risks.

Joint Commission standards augment CMS CoPs to address critical individual and environmental risks.
Hospitals are required to:
Manage security risks by:

- Control access to and from areas identified as security sensitive
- Develop and implement policies and procedures to follow in the event of a security incident, including infant and pediatric abductions
- Develop and implement policies and procedures to monitor, internally report and investigate injuries, incidents of property damage, safety and security incidents, hazardous materials and waste spills and exposures, fire safety management problems, deficiencies, and failures, medical or laboratory equipment problems, utility system management problems, systems, and errors.

Building on CMS's COP utility system requirements, Joint Commission requires written procedures for disruptions, emergency backup for essential medication dispensing equipment, and essential refrigeration.

Coordinate administrative and clinical decisions for incarcerated patients, regarding:

- Use of seclusion and restraint for nonclinical purposes
- Imposition of disciplinary restrictions
- Restrictions of rights
- Plan for discharge and continuing care
- Length of stay.

Implement fall reduction interventions based on the patient population, setting, and individual patient's assessed risks.

Ensuring safety and security is fundamental to providing safe and effective care. Safety and security incidents can disrupt hospital operations, delay care, create legal liabilities, and cause severe harm to patients. The focus on systems failures, rather than individual errors, as the foundation for organizational safety is well-established in healthcare. As such, Joint Commission standards require implementation of hospital-wide policies and protocols to prevent, monitor, internally report and investigate all security and safety incidents when they happen, and ensure all staff know what to do in the event of a security breach, patient abduction, or accident. Utility system management is governed by CMS under its Emergency Preparedness Final rule, as well as National Fire Protection and align with 2025 performance goals. However, standards ensuring emergency back-up for essential medication dispensing systems go beyond. Addressing this safety risk is crucial to ensure patients continue to receive medications and thus avoid delays or interruptions that could negatively impact care and is alignment with professional pharmacy association guidelines.

Caring for incarcerated patients can present security risks. Hospitals must ensure they are providing high quality patient care, while also upholding a secure environment for all patients, staff, and visitors.

Patient falls are the most common cause of preventable injury and remain a significant safety risk in hospital. In US hospitals. Between 700,000 and 1 million patients fall each year, and roughly 30% of these falls result in injury. Joint Commission's requirement to implement fall risk reduction strategies tailored to population, setting and individual risk aligns with research and key stakeholder best practice recommendations to reduce falls.

Slide 29 – 48:29
Workforce shortages have long strained the healthcare system, undermining the delivery of safe, timely, and effective care. Adequate and appropriate staffing is essential not only for ensuring positive patient outcomes but also for reducing burnout among healthcare professionals. Joint Commission's quality standards play a critical role in addressing these challenges by guiding hospitals toward safe staffing practices that align care delivery with patient needs.

Since the early 2000s, Joint Commission has provided specific standards for safe staffing, as appropriate clinical and ancillary staffing is crucial for optimal patient outcomes in all healthcare settings. Numerous studies demonstrate the deleterious effects of chronic inappropriate staffing on patient safety, care delivery, and caregiver well-being. In July 2025, Joint Commission elevated its staffing standards to a National Performance Goal to assure continued quality and safety of patient care as hospitals continue to face staffing challenges.

These safe staffing standards require the hospital to be appropriately staffed to meet the needs of its patients and ensure staff are competent to provide safe, quality care. Joint Commission standards supplement the Centers for Medicare & Medicaid Services (CMS) Conditions for Participation (CoPs) for staffing with additional expectations for verification, training, education, and ongoing performance improvement monitoring. The CoPs and additional standards require:

- The leadership team ensures that there is adequate qualified ancillary staff to meet the needs of the population served and determines how staff function within the organization.
- The nurse executive directs the implementation of a nurse staffing plan(s).
- For psychiatric hospitals that use Joint Commission for accreditation for deemed purposes: The psychiatric hospital develops and implements staffing plans according to laws and regulations.
- Verification that staff complete all requirements for employment and practice within their scope of practice.
- Provision of education and training and evaluation of staff competence.
- Evaluation of staffing during performance improvement activities, such as adequacy of staffing that is included as a factor when undesirable trends, patterns, or variations exist.

Slide 30 – 50:39
Millions of people in the U.S. undergo radiology-based imaging tests like MRI, CT, and X-ray scans each year either for diagnostic or emergency use. Quality standards introduced by Joint Commission help to protect people from excessive radiation exposure and MRI-related injuries through requirements to support safe imaging practices.

Since 2008, Joint Commission established specific accreditation standards to address MRI, CT, and fluoroscopy radiation safety. In response to ongoing risks, such as MRI-related patient injuries, unnecessary or inappropriate fluoroscopy dosing, and excessive CT radiation, Joint Commission maintains specific requirements to promote consistent, evidence-informed protection of patients.

The imaging safety standards focus on actions to reduce MRI, CT and fluoroscopy radiation safety events. Hospitals must:

- Define and verify qualifications and education requirements for imaging services staff.
- Have a designated leader and follow current safe imaging practices.
- Manage imaging safety risks through MRI environmental risk reduction, such as restriction of site access and screening of staff and patients, and adhering to best practices for CT operation, such as dosing as low as reasonably achievable (ALARA).
- Collect data and track and respond to incidents related to imaging safety.

Published literature has documented the dangers of ionizing radiation exposure, CT radiation, and MRI safety risks. These included tissue reactions and alteration of cells and DNA that could lead to future cancers if exposure is prolonged (defined as >25% intended radiation dose), MRI-related injuries such as thermal injuries (burns), projectile events, and acoustic injuries. While Centers for Medicare & Medicaid Services (CMS) Conditions of Participation at 42 CFR 482.26 and 42 CFR 482.53, govern the provision of radiologic and nuclear medicine services, these NPG standards rise above and beyond the CoPs with requirements supported by multiple professional societies as essential for high-quality care given the continued occurrence of adverse events.

As additional evidence of the continued need for emphasis on MRI pre-procedure screening, the American Medical Association recently added specific payment (CPT) codes for these activities.

Slide 31 – 53:10
Medication management plays a crucial role in treating various conditions but carries a high risk of error that can lead to potential patient harm. Following evidence-informed protocols can reduce these errors and improve safety. Poor medication management can lead to significant patient harm, as well as complications that require costly interventions. Common errors include administering the wrong drug, dose, or route or providing medication to the wrong patient. In 2010, Joint Commission added new standards for medication safety and elevated the topic to a National Patient Safety Goal; in 2017 Joint Commission updated the standards to address anticoagulant medication risk and foster antibiotic stewardship. Anticoagulant medications pose an increased risk of harm due to complex dosing, insufficient monitoring, and inconsistent patient compliance.

National Performance Goal 14 increases medication safety and reduces risk through the following requirements:

- When an onsite pharmacy is not open 24 7, a qualified healthcare professional reviews the medication order in a pharmacist's absence.
- Establishing policies and procedures related to automatic dispensing cabinets (ADCs) when used in the organization
- Standardizes and limits the number of drug concentrations available

- Follows a process to communicate & has written substitution protocols for medication shortages and outages
- The hospital labels all medication, medication containers (including syringes, medicine cups, and basins), and other solutions on and off the sterile field in perioperative and other procedural settings, and when they are not immediately administered.
- Labeling occurs when any medication or solution is transferred from original packaging to another container & as soon as it is prepared, and the labels include name, strength, amount of medication or solution, diluent name and volume, and expiration date and time.
- The hospital reduces the likelihood of patient harm associated with the use of anticoagulant therapy.
- The hospital maintains and communicates accurate patient medication information.
- And finally, the hospital has an active antibiotic stewardship program.

Research shows that the reported incidence of medication errors in acute hospitals is approximately 6.5 per 100 admissions. Joint Commission standards, in alignment with regulatory standards such as Centers for Medicare & Medicaid Services (CMS) Conditions of Participation and United States Pharmacopeia (USP), focus on safety risks inherent in medication storage, labeling, and dispensation of medications. Requirements are consistent with consensus-based guidelines, such as those set forth by ISMP Guidelines for safe medication use in perioperative and procedural settings. Antibiotic stewardship is a high priority given an estimated 2.8 million antibiotic-resistant infections and more than 35,000 related deaths each year.

Medication management continues to be a subject of intense scrutiny and complexity. The standards are consistently identified as opportunities for improvement on Joint Commission surveys and are referenced in over 50 Joint Commission Frequently Scored Standards publications. Given the intricacy and numerous risk points involved, many Joint Commission specific medication safety standards are included as 2025 National Performance Goals.

Slide 32 – 56:27
Next, we will provide some brief details about the new survey process guide that is replacing the survey activity guide.

Slide 33 – 56:33
Along with the manual rewrite, we also completely redid our survey process guide. This new survey process guide will replace the organization and surveyor Survey Activity Guide. There will be one SPG that is grouped by CoP and aligns with the CMS State Operations Manual and the interpretive guidelines that include the “must” directive. There is also a National Performance goal chapter for any requirements that are not found in another tool or module. As you can see in the sample, we’ve created 3 columns. One is the Joint Commission standard and EPs, middle is the CoP language, and on the far right, is the exact survey activity you can expect from the surveyors during your triennial survey. The survey activity uses the I-DO acronym and is categorized by interviews, highlighting questions the surveyors will ask. The documentation we will review, and observations our surveyors will be guided to make during tracer activity. Our survey process remains the same. We will still conduct tracers in individual areas in the hospital – we hope that organizations will use the survey process guide as a prep tool and can even use the SPG as a checklist to prepare.

Slide 34 – 57:40
We understand what a big change this is for everyone, but we do think this will be a very positive change to improve accuracy and consistency in survey reports. We’ve reduced redundancy where similar topics were covered under numerous EPs, direct connection with appropriate CoPs and regulation, and important initiatives and topics now covered under 1 NPG versus throughout multiple chapters in the manual.

Slide 35 – 58:02
Internally, we've developed processes to make it easier for organizations to ask questions specific to the rewrite that you will find on the standards interpretation group page. You will be able to choose to ask a question related to current standards or the rewrite. Internal staff are meeting twice a week to answer these questions to ensure consistency in interpretation and intent. From these questions we will develop FAQs to continue to help organizations during this transformation. We will also have regular release of on-demand webinars that will be occurring by manual chapters.

Slide 36 – 58:34
We have developed a Disposition Report to help our accredited organizations see at a glance what revisions were made. The report contains information about where concepts have moved from their previous EP location to their new EP location, and there is a disposition column to describe the type of revision that occurred.

For each of the current standards and EPs listed on the left side of the table, the disposition column identifies what has happened to the requirement. Let's go over the several options that may appear in the disposition column. They are shown on the slide: moved to a new location, moved and revised, EP split into multiple EPs, or a consolidation of several requirements into one. In some cases, you will see new language. This is because that EP language was revised to convey alignment with the language in Conditions of Participation. The overall concept is not new, but now the EP text matches the CoP language more closely. There are also situations where an EP has been deleted – either the requirement is no longer necessary because it no longer addresses current patient or safety concerns or it is now redundant to a more direct EP or moved to Survey Process Guide (or SPG). The phrase "moved to SPG" means that the details behind a requirement and the information on how this requirement will be evaluated are provided in the SPG document.
For the requirements that were retained, the new locations and EP text are shown on the right side of the table and will be effective January 1st, 2026.

Slide 37 – 1:00:01
Additional resources that can help with implementation of the national performance goals addressing suicide risk and excellent health outcomes for all can be found on our website with the links provided on this slide. To access the standards, the survey process guide and disposition report, use the link listed under standards resources.

Slide 38 – 1:00:20
To ask questions about the National Performance Goal chapter and requirements, please submit your questions using the link provided at the top of the slide. Joint Commission staff monitor this site closely.

If you have questions about webinar operations or obtaining Continuing Education credit, please submit them via email to: tjcwebinarnotifications@jointcommission.org.

Slide 39 – 1:00:41
All Accreditation 360 webinar recording links, slides, transcripts, and Q&A documents can be accessed on the Joint Commission's webpage via the link displayed at the bottom of this slide.

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Slide 40 – 1:01:01
Before this webinar concludes, a few words about the survey. We use your feedback to inform future content, determine education gaps, and assess the quality of our educational programs. A QR code will appear on the

next slide. You can use your mobile device to scan and access the survey. If you prefer to take the survey later, an automated email also delivers the link to the survey.

After you complete and submit your survey responses, you will be redirected to a page from which you can print or download a blank Certificate that you complete by adding your own name and credentials. In case you miss that opportunity to download, an automated email will also be sent to you that includes the link to the certificate.

Slide 41 – 1:01:42
We'll leave this slide up for a few moments so participants to scan the survey QR code. Thank you for attending this On Demand Joint Commission webinar.