The Joint Commission

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Joint Commission Perspectives®

THE OFFICIAL NEWSLETTER OF THE JOINT COMMISSION

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The Joint Commission Announces Inaugural UNIFY 2025 Conference

Health Care Industry Leaders Will Gather in Washington, DC, to Advance Patient Safety and Health Care Quality

The Joint Commission recently announced its inaugural UNIFY 2025 conference to convene health care leaders for discussion on the issues influencing health care quality and patient safety. The event will be held September 16–17, 2025, in Washington, DC.

UNIFY 2025 will include expert panels and sessions—featuring the National Quality Forum (NQF), National Association for Healthcare Quality (NAHQ), and others—to address critical challenges in health care, including but not limited to the following:

- Best practices for continuous improvement
- Insights on current health care trends
- Data-driven information to help achieve long-term success
- Artificial intelligence
- Responsible use of health data
- Performance improvement
- Pediatric emergency readiness

Marc Siegel, MD, Senior Medical Analyst for Fox News, and Clinical Professor of Medicine and Practicing Internist at NYU Langone Medical Center, will deliver a keynote address. In addition, sessions will provide Joint Commission accreditation and certification updates.

"Meaningful change is powered by knowledge, which is why we are bringing together leading health care experts and policymakers in patient safety and health care quality," says Jonathan B. Perlin, MD, PhD, MSHA, MACP, FACMI, President and Chief Executive Officer, The Joint Commission Enterprise. "In our role of enabling and affirming the highest standards of quality and safety, The Joint Commission is uniquely positioned to convene key leaders across health care to share actionable insights for empowering colleagues and stakeholders as effective changemakers. Together, we can help shape higher-performance and higher-value health care."

To learn more or to register, visit the UNIFY 2025 page on The Joint Commission's website. *See* future issues of *Perspectives* for details on UNIFY 2025 sessions, speakers, and other events. P

APPROVED: Revised Volume Eligibility Requirements for Select Cardiac and Stroke Certification Programs

Effective immediately The Joint Commission, in collaboration with the American Heart Association (AHA) and the American Stroke Association (ASA), has updated the eligibility requirements for the **Comprehensive Cardiac Center** (CCC) certification program and advanced disease-specific care certification programs, including those for **Comprehensive Heart Attack Center** (CHAC), **Comprehensive Stroke Center** (CSC), and **Primary Heart Attack Center** (PHAC).

The revised eligibility requirements include the following:

- **CCC–, CHAC–, and PHAC–certified** organizations no longer have percutaneous coronary intervention (PCI) volume requirements for eligibility.
- **CSC–certified** organizations are no longer required to provide care to 20 or more patients per year diagnosed with subarachnoid hemorrhage caused by an aneurysm; they now are required to care for 10 or more patients per year diagnosed with subarachnoid hemorrhage caused by an aneurysm.

To make these changes, The Joint Commission and the AHA/ASA conducted an extensive literature review about the relationship between patient volume and the quality and safety of care, as well as discussed with stakeholders and health care organizations The Joint Commission serves.

The revised eligibility requirements will publish online in the fall 2025 E-dition® update to the *Comprehensive Cardiac Center Certification Manual (CCC)* and *Comprehensive Certification Manual for Disease-Specific Care (DSC)*. In addition, the E-Application will update soon to reflect these changes. As the eligibility requirements are removed and updated, The Joint Commission will still collect volume data in the application to understand each program's volume.

Note that health care organizations may need to adhere to existing state regulations and/or requirements. For more information, please contact The Joint Commission.

Summary of Changes for the Spring 2025 Update to Joint Commission Manuals

The spring 2025 update to E-dition® for accreditation, certification, and verification manuals will be posted to the *Joint Commission Connect*® extranet site by late April, with changes effective July 1, 2025, unless otherwise noted. In addition, the 2025 hard-copy update services for the *Comprehensive Accreditation Manual for Behavioral Health Care and Human Services* and *Comprehensive Accreditation Manual for Hospitals* have mailed to those customers who purchased them (they are currently available for purchase).

The following table identifies the different media in which the update is available for each accreditation, certification, and verification program. Key revisions in the spring update for all these products are detailed in the section following this table.

Program	E-dition	Hard-Copy Update Service
Publication Month	**April 2025**	
Accreditation Programs		
Ambulatory Care	x	
Assisted Living Community	x	
Behavioral Health Care and Human Services	x	x
Critical Access Hospital	x	
Home Care	x	
Hospital	x	x
Laboratory and Point-of-Care Testing	x	
Nursing Care Center	x	
Office-Based Surgery	x	
Rural Health Clinic	x	
Telehealth	x	
Certification Programs		
Advanced Certification in Perinatal Care	x	
Centralized Sterilization Services	x	
Comprehensive Cardiac Center	x	
Disease-Specific Care, including advanced programs	x	
Health Care Equity	x	
Health Care Staffing Services	x	
Integrated Care	x	
Medication Compounding	x	
Palliative Care	x	
Patient Blood Management	x	
Responsible Use of Health Data	x	
Sustainable Healthcare	x	
Verification Program		
Maternal Levels of Care	x	

Significant Spring Revisions

- Redesigned the survey* report to offer a more user-friendly format, helping **all accredited, certified, and verified health care organizations** better understand and address their survey findings, **effective January 2025** (*see* the January 2025 issue of *Perspectives*)
- Revised the for-cause survey process for **all accredited, certified, and verified health care organizations** to help organizations better understand a for-cause survey, **effective immediately** (*see* the January 2025 issue of *Perspectives*)
- Revised the following participation requirements, **effective July 1, 2025** (*see* the April 2025 issue of *Perspectives*):
  - Accreditation Participation Requirements (APR) Standard APR.01.03.01, Element of Performance (EP) 1, for **all accreditation programs**
  - Certification Participation Requirements (CPR) Standard CPR.02, EP 1, for **all certification programs**
  - Verification Participation Requirements (VPR) Standard VPR.02, EP 1, for the **Maternal Levels of Care verification program**
- Approved a new EP in the APR chapter and associated decision rules for **assisted living communities**, **behavioral health care and human services** organizations, and **nursing care centers** to meet the minimum requirements necessary for quality/and or safety, **effective March 30, 2025** (*see* the March 2025 issue of *Perspectives*)
- Fully revised the "Emergency Management" (EM) chapter, including new and revised EM standards, for **assisted living communities** and **behavioral health care and human services** organizations, **effective July 1, 2025** (*see* the January 2025 issue of *Perspectives*)
- Fully revised the "Infection Prevention and Control" (IC) chapter, including new and revised requirements, for **behavioral health care and human services** organizations, **office-based surgery practices** (*see* the January 2025 issue of *Perspectives*), and **laboratories** (*see* the March 2025 issue of *Perspectives*), **effective July 1, 2025**
- Added new and revised requirements to provide a framework to develop effective workplace violence prevention strategies for **assisted living communities**, **nursing care centers**, **office-based surgery practices** (*see* the January 2025 issue of *Perspectives*), **ambulatory care** organizations, and **laboratories** (*see* the March 2025 issue of *Perspectives*), **effective July 1, 2025**
- Revised requirements for opioid treatment programs accredited under the **Behavioral Health Care and Human Services** accreditation program to align to a final rule issued by the Substance Abuse and Mental Health Services Administration (SAMHSA) related to medications for opioid use disorder (MOUD), **effective July 1, 2025** (*see* the April 2025 issue of *Perspectives*)
- Revised requirements for **deemed hospices** to align with US Centers for Medicare & Medicaid Services (CMS) Conditions of Participation (CoPs), **effective March 30, 2025** (*see* the April 2025 issue of *Perspectives*)
- Removed one optional ORYX® measure for 2025 for **critical access hospitals** and **hospitals**, **effective immediately** (*see* the February 2025 issue of *Perspectives*)
- Revised cardiac and stroke volume eligibility requirements, **effective immediately**, for **Comprehensive Cardiac Cente**r certification and advanced disease-specific care certification programs, including those for **Comprehensive Heart Attack Center** (CHAC), **Comprehensive Stroke Center** (CSC), and **Primary Heart Attack Center** (PHAC) (*see* page 3 in this issue of *Perspectives*)
- Enhanced the Certification Measure Information Process (CMIP) tool to display performance measures that are specifically applicable to **health care staffing firms**, expected to be available by the end of April 2025 (*see* the April 2025 issue of *Perspectives*) P

* In this article, the term *survey* also refers to certification and verification reviews.

Consistent Interpretation

Joint Commission Surveyors' Observations Related to Conducting a Time-Out Before an Invasive Procedure

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

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

This month, **Consistent Interpretation** focuses on patient safety related to the time-out process before an invasive procedure to ensure that the correct patient will undergo the scheduled procedure.

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

Universal Protocol (UP) Standard UP.01.03.01: A time-out is performed before the procedure.	
EP 1: Conduct a time-out immediately before starting the invasive procedure or making the incision. R	
Compliance Rate	In 2023, the noncompliance percentage for this EP was **0.94%**—that is, **13** of **1,386** hospitals surveyed did not comply with this requirement.
Noncompliance Implications	Wrong surgery—including wrong site, wrong procedure, wrong patient, and wrong implant—should never happen. However, it remains an ongoing problem in health care that compromises patient safety and negatively affects outcomes. *Wrong surgery* is defined in the Sentinel Event Policy* as a 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. Wrong surgeries continue to be one of the most frequently reported sentinel events to The Joint Commission. In 2023 and 2024 there were 112 and 127, respectively, voluntarily reported events classified as wrong surgeries. There are many contributing factors to wrong site, wrong patient, or wrong procedure errors that can lead to mistakes in identifying the correct patient, surgical site, and/or planned procedure, including but not limited to the following: ● Poor communication among health care providers ● Rushed procedures ● Inadequate patient identification methods ● Multiple surgeons involved in a case ● Unusual time pressures ● Lack of standardized protocols ● Distractions ● Staffing issues ● Insufficient training ● Lack of shared mental model across care team ● Fixating on or being preoccupied with tasks, which limits situational awareness ● Similar patient names/demographics

* For the full Sentinel Event Policy, *see* the "Sentinel Event Policy" (SE) chapter on E-dition®, its counterpart, the *Comprehensive Accreditation Manual*, or the Sentinel Event Policy and Procedures page on The Joint Commission's website.

† In the Sentinel Event Policy, *invasive procedure* is defined as *A procedure in which skin or mucous membranes and/or connective tissue are incised or punctured, an instrument is introduced through a natural body orifice, or foreign material is inserted into the body for diagnostic or treatment-related purposes. Examples of invasive procedures include central line and chest tube insertions, biopsies and excisions, and all percutaneous procedures (for example, cardiac, electrophysiology, interventional radiology). Exclusions include venipuncture, which is defined as a collection of blood from a vein.*

	Conducting a well-executed time-out immediately before incision or the start of an invasive procedure is that final assessment that uses source documents, such as informed consent and history and physical (H&P), to confirm the correct patient, site, and procedure. To ensure a well-executed time-out, all team members must be present and activities suspended to the extent possible so that team members can actively focus on confirming the patient, site, and procedure. The Joint Commission encourages organizations to monitor time-out practices in areas where surgical and nonsurgical invasive procedures are performed to ensure full-team compliance. The results can then be used for ongoing education and training. Examples of common findings during survey include the following: ● Staff engaging in other activities rather than participating in the process ● Missing team members ● Proceduralists or other team members leave following the time-out to complete other unrelated activities ● Lack of understanding as to which procedures the Universal Protocol requirements apply

Surveyor Observations	**Guidance/Interpretation**
● The organization did not require a time-out for procedures it defined as invasive (for example, peripherally inserted central catheter [PICC] line, central line insertion, joint injection). ● A time-out was not performed after the surgeon arrived to conduct a cesarean section. ● According to staff, no time-out is performed before a tooth extraction. ● A surgeon who participated in a time-out exited the operating suite to conduct a history and physical (H&P) on a different pre-op patient. However, when the surgeon returned to the operating suite, a repeat time-out was not performed.	● Note that the Universal Protocol is for invasive procedures only. Organization policy should define what is considered an invasive procedure, such as joint injections. ● Procedures such as electroconvulsive therapy, external beam radiation, and closed reduction are not considered invasive. For such procedures, score at National Patient Safety Goal (NPSG) Standard NPSG.01.01.01, EP 1,* if the patient is not properly identified. ● Score at Standard UP.01.03.01, EP 5, if the time-out is not documented. ● The organization determines if a time-out is required before acupuncture. At a minimum, the patient's identification must be confirmed in accordance with Standard NPSG.01.01.01, EP 1. ● See Provision of Care, Treatment, and Services (PC) Standard PC.01.02.15, EP 10,† for imaging procedures such as the following: ❍ Computed tomography (CT) ❍ Magnetic resonance imaging (MRI) ❍ Nuclear medicine (NM) services ❍ Positron emission tomography (PET) ● The organization determines the required elements of a time-out/pause for procedures that may be completed by a single team member or proceduralist (such procedures may include but are not limited to PICC line and epidural). At a minimum, the following elements must be completed: ❍ Confirming the correct patient and procedure ❍ Marking the site prior to the procedure, as applicable ● For procedures that may be completed by a single team member or proceduralist, The Joint Commission recognizes a pause by the practitioner to confirm the minimum requirements. The organization determines the type and/or amount of required documentation. Note that the organization cannot consider the confirmation pause a time-out. Therefore, the survey focuses on the organization's confirmation process and evidence that the pause occurred. The organization determines what/where/how this information is documented.

* Standard **NPSG.01.01.01, EP 1**: Use at least two patient identifiers when administering medications, blood, or blood components; when collecting blood samples and other specimens for clinical testing; and when providing treatments or procedures. The patient's room number or physical location is not used as an identifier. **R**

(*See also* MM.05.01.09, EPs 7, 10; PC.02.01.01, EP 10)

† Standard **PC.01.02.15, EP 10**: **For hospitals that provide diagnostic computed tomography (CT), magnetic resonance imaging (MRI), positron emission tomography (PET), or nuclear medicine (NM) services:** Prior to conducting a diagnostic imaging study, the hospital verifies the following:

- Correct patient
- Correct imaging site
- Correct patient positioning
- **For CT only:** Correct imaging protocol
- **For CT only:** Correct scanner parameters

Note: *This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.*

EP 2: The time-out has the following characteristics: R

- It is standardized, as defined by the hospital.
- It is initiated by a designated member of the team.
- It involves the immediate members of the procedure team, including the individual performing the procedure, the anesthesia providers, the circulating nurse, the operating room technician, and other active participants who will be participating in the procedure from the beginning.

Compliance Rate	In 2023, the noncompliance percentage for this EP was **10.39%**—that is, **144** of **1,386** hospitals surveyed did not comply with this requirement.
Noncompliance Implications	*See* pages 6–7 for noncompliance implications.

Surveyor Observations	Guidance/Interpretation
• During a time-out, team members did not pay attention and/or participate in the process. • A radiologist, registered nurse, technician, and patient participated in a time-out before a procedure. Another physician joined and completed a major portion of the procedure after the time-out was completed. However, an additional time-out was not performed when the physician joined the team. • After completing a time-out, the proceduralist left the procedure room to scrub and returned to perform the procedure. Organization policy required a second time-out to be performed when the proceduralist returned to the room, but the second time-out was not performed.	• Score here, at Standard UP.01.03.01, EP 2, if all team members (for example, scrub tech setting up Mayo stand, circulating nurse reviewing the patient chart, anesthesia provider drawing medications) are not present during the time-out. • Immediate members may include but are not limited to the following: ❍ Surgeon ❍ All surgical assistants ❍ Anesthesia providers ❍ Circulating nurse ❍ Operating room/surgical technician(s) ❍ Any other members participating in the procedure

EP 3: When two or more procedures are being performed on the same patient, and the person performing the procedure changes, perform a time-out before each procedure is initiated. R

Compliance Rate	In 2023, all surveyed hospitals complied with this requirement.
Noncompliance Implications	*See* pages 6–7 for noncompliance implications.

Surveyor Observations	Guidance/Interpretation
• After the initial time-out was completed, a physician assistant joined a coronary artery procedure and performed a vein graft without a separate time-out.	• Score here, at UP.01.03.01, EP 3, only if the second proceduralist is doing a separate procedure or primarily responsible for a portion of the initial procedure.

EP 4: During the time-out, the team members agree, at a minimum, on the following: R

- Correct patient identity
- The correct site
- The procedure to be done

Compliance Rate	In 2023, the noncompliance percentage for this EP was **0.94%**—that is, **13** of **1,386** hospitals surveyed did not comply with this requirement.
Noncompliance Implications	*See* pages 6–7 for noncompliance implications.

Surveyor Observations	Guidance/Interpretation
• The time-out did not confirm the patient's identity and/or did not use two identifiers. • The time-out did not confirm the correct side of the procedure where laterality needed to be considered.	• For a final time-out, the organization determines a standardized response for its team members to acknowledge and agree with the patient's identification, procedure, and procedure site. Examples of a standardized response may include but are not limited to the following: ❍ Verbal response ❍ Gesture of affirmation, such as the following: ● Head nod ● Raised hands ● Fist-to-five • If a patient's identification band is not available and/or visible during the time-out (that is, the identification is covered by draping), a pre-draping patient identification confirmation may be conducted by a team member who will remain with the patient throughout the time-out. In addition, an ankle identification band can be used. • Score at Standard UP.01.03.01, EP 2, if all team members (for example, scrub tech setting up Mayo stand, circulating nurse reviewing the patient chart, anesthesia provider drawing medications) are not present during the time-out.

EP 5: Ⓓ Document the completion of the time-out. **R**

Note: *The hospital determines the amount and type of documentation.*

Compliance Rate	In 2023, the noncompliance percentage for this EP was **3.39%**—that is, **47** of **1,386** hospitals surveyed did not comply with this requirement.
Noncompliance Implications	*See* pages 6–7 for noncompliance implications.

Surveyor Observations	Guidance/Interpretation
• A time-out was not documented before a procedure, such as a colonoscopy, that the organization identified as invasive.	• Note that the Universal Protocol is for invasive procedures only. Organization policy should define what is considered an invasive procedure, such as joint injections. Procedures such as electroconvulsive therapy, external beam radiation, and closed reduction are not considered invasive. • Score here, at Standard UP.01.03.01, EP 5, if a time-out was conducted before an invasive procedure but was not documented. • The organization determines the required elements of a time-out/pause for procedures that may be completed by a single team member or proceduralist (such procedures may include but are not limited to peripherally inserted central catheter [PICC] line and epidural). At a minimum, the following elements must be completed: ❍ Confirming the correct patient and procedure ❍ Marking the site prior to the procedure, as applicable • For procedures that may be completed by a single team member or proceduralist, The Joint Commission recognizes a pause by the practitioner to confirm the minimum requirements. The organization determines the type and/or amount of required documentation. Note that the organization cannot consider the confirmation pause a time-out. Therefore, the survey focuses on the organization's confirmation process and evidence that the pause occurred. The organization determines what/where/how this information is documented. • Score at Standard NPSG.01.01.01, EP 1, if the patient is not properly identified.

The Joint Commission Journal on Quality and Patient Safety®

IMPROVEMENT FROM FRONT OFFICE TO FRONT LINE

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

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Editorial

239 Leveraging Approaches and Tools of Implementation Science and Configurational Comparative Methods in Quality Improvement

G. Matias; N.R. Nadig; R. Huang

Quality improvement (QI)– and implementation science (IS)–focused investigations share contextual factors and follow similar steps. In this editorial in response to an article by Ciemens and colleagues in this issue of the *Journal*, Matias and colleagues explore the advantages of collaboration between IS and QI experts.

Process Improvement

OPEN ACCESS

241 Using Implementation Science–Informed Strategies to Improve Transitions of Care for Patients with Venous Thromboembolism

E.L. Ciemins; C.C. Grant; M. Tallam; C. Rattelman; C. Lindberg; R.A. Williams; P.S. Christensen; N.M. Thygeson

Venous thromboembolism (VTE) is a common cause of preventable hospital death, and most VTEs diagnosed in the outpatient setting are directly linked to a recent hospitalization or surgery. In this type 2 effectiveness-implementation hybrid study, Ciemens and colleagues developed and implemented interventions tailored to local context and team dynamics to improve care for patients with VTE in six US health systems.

252 Improving Time to Diagnosis and Management of Pediatric Patients with Acute Neurologic Dysfunction

S.P. Spencer; N.H. Forman; M.G. Chung; T. Dachenhaus; A.I. Drapeau; C. Gerity; R. Iglesias; J.Y. Jones; M.E. Lovett; J.C. Leonard

Many pediatric emergency departments (PEDs) implement stroke alerts for children presenting with neurologic dysfunction. However, most such patients have a non-stroke diagnosis better evaluated using magnetic resonance imaging (MRI). Spencer and colleagues created a Neuro Deterioration clinical pathway using fast MRI to reduce time from PED arrival to completion of radiologic report in PED patients presenting with new neurologic dysfunction.

Leadership

261 Voices of Frontline Leaders: Challenges and Opportunities from Frontline Primary Care Clinic Leaders in a Safety-Net Health Care System

J. Wallace; R. Pierce; T.J. Staff; R. Allyn

Research has shown that higher direct supervisor composite leadership scores correlate with decreased provider burnout and increased professional fulfillment. Wallace and colleagues interviewed frontline physician leaders of primary care clinics regarding their approach to leadership, prior training and support, opinions related to provider burnout, and ideas for improvement.

Patient Engagement

270 Patient and Family Engagement in Infection Prevention During the COVID-19 Pandemic: A Q-Methodology Study with Stakeholders from a Canadian University Health Care Center

N. Clavel; J. Paquette; A. Briand; A. Biron; L. Bernard; C. Gélinas; M. Lavoie-Tremblay

Efforts to reduce health care–associated infections usually focus on the practices of health care professionals and nonclinical staff, often overlooking the potential role of patients and family members. In this mixed methods study, Clavel and colleagues explored stakeholders' viewpoints on how patients and families should engage in preventing health care–associated infections in hospital settings.

Accreditation Compliance

279 Complying with Joint Commission Health Equity Requirements: Medical-Legal Partnership Data and Health-Related Social Needs

A.B. Tartarilla; L. Porter; J.J. Horgan; P.D. Hahn; G. Drost; D.A. Graham; M.M. Garvin; V.L. Ward

Medical-legal partnerships (MLPs) are a hospital-based resource for patients and families to address health-related legal needs, which often align closely with health-related social needs (HRSNs). The Joint Commission established health equity requirements with a focus on obtaining patient-specific data for HRSNs in the populations a hospital serves to address the root causes of disparities. In this study, Tartarilla and colleagues examined data for pediatric patients referred to a hospital's MLP as an example of using legal referral data to obtain HRSN data to comply with these requirements.

Care Transitions

286 Increasing Utilization of an In-Home Remote Exam Device in a Complex Care Center

M. Pfarr; S. Callahan; C. Curry; K. Jerardi; K. Pulda; M. Rummel; D. Smith-Sokol; J. Stalf; J. Thomson; H. Sauers-Ford

Telehealth and remote exam devices allow providers to engage with children with medical complexity (CMC) in their home environment and alleviate caregiver burdens with in-person visits. In this study, Pfarr and colleagues aimed to increase the percentage of telehealth visits in which a remote exam device was used in a complex care center from 0% to 50% over a six-month period.

Review Article

293 Safety Interventions in Cardiac Anesthesia: A Systematic Review

L. O'Callaghan; S. Ahern; A. Doyle

A comprehensive understanding of effective, evidence-based risk reduction strategies is necessary to improve patient safety in cardiac anesthesia. O'Callaghan and colleagues conducted a literature review to identify studies involving the introduction of a tool or intervention to improve patient safety and human factors in cardiac anesthesia.

Innovation Report

305 Training Hospital Nurses to Write Detailed Narratives and Describe Contributing Factors in Incident Reports: The SAFER Education Program

T.N. Cohen; T.K. Nuckols; C.T. Berdahl; E.G. Seferian; S.G. McCleskey; A.J. Henreid; D.W. Leang; M.A. Lupera; B.L. Coleman

Incident reporting systems in hospitals receive numerous reports from nurses, but these reports often lack detailed, actionable information. To enrich the information captured by incident reports, Cohen and colleagues developed an educational program to train nurses to write detailed narratives and describe contributing factors.

Joint Commission Perspectives®

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