Directions for Replacement Pages
January 2018 CAMBHC Update 2

To update your print manual, please remove and recycle the pages listed in the table that follows and insert the replacement pages provided in this packet. For your convenience, check boxes appear in the “remove” and “replace with” columns to track the removal and addition of pages.

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What’s New
January 2018 CAMBHC Update 2
Effective as Noted

This “What’s New” section is intended to help get you up to speed regarding the substantive changes that have been made to the CAMBHC since its previous update. Major changes to requirements, accreditation policies and procedures, and other important information in this update include the following:

- Addition of “Safety Systems for Individuals Served” (SSIS) chapter to inform and educate behavioral health care organizations about the importance and structure of integrated safety systems for individuals served
- Completed Phase 4 of the Standards Review Project, resulting in the consolidation and movement of standards within the “Human Resources Management” (HRM), “Infection Prevention and Control” (IC), and “Rights and Responsibilities of the Individual” (RI) chapters
- Additional revisions made to the “Environment of Care” (EC) and “Life Safety” (LS) chapters as part of the alignment with the US Centers for Medicare & Medicaid and the 2012 Life Safety Code®
- Revised Medication Management (MM) standards to assure that they continue to reflect evidence-based practices and quality and safety issues that have emerged from the field in recent years, which also affects EC and Record of Care, Treatment, and Services (RC) standards

Introduction: How The Joint Commission Can Help You Move Toward High Reliability (INTRO)

Effective January 1, 2018

- About the Comprehensive Accreditation Manual for Behavioral Health Care:
  - Clarified the complimentary access to E-dition® and to The Joint Commission Connect™ extranet site and contents/purpose for each
  - Added new paragraph regarding e-Alerts access
  - Clarified access and availability details of Perspectives
  - Updated information detailing how standards changes are made
Table 2. Acronyms Used in This Manual: Updated acronyms

Accreditation Process Information: Added description for the new “Safety Systems for Individuals Served” (SSIS) chapter

Identifying Applicable Standards: Removed reference to the Standards for Office-Based Surgery Practices, which is no longer printed (content is available via E-dition only)

Assess Compliance with the Standards: Added references for more information on the Survey Analysis for Evaluating Risk™ (SAFER™) Matrix

Stimulate Improvement:
- Updated guidance on standards compliance frequently asked questions
- Updated Joint Commission Connect resources and tools listing specific to behavioral health care

Keep Up With Changes to the Standards:
- Revised section title to “Keep Current With Standards Changes via Perspectives” to clarify that the most up-to-date information is published in Perspectives
- Added bullet about e-Alerts subscriptions for new content and updates

Standards Questions: Updated guidance for submitting questions

Made minor editorial revisions

Safety Systems for Individuals Served (SSIS)

Effective January 1, 2018

New chapter

Accreditation Requirements

Accreditation Participation Requirements (APR)

No changes

Care, Treatment, and Services (CTS)

Effective January 1, 2018
- CTS.02.01.03, new EP 5: Added EP requiring organizations to gather health information about an individual from both inpatient and outpatient providers and, if necessary, documents why the records could not be obtained
- CTS.02.01.03, EPs 5–7: Renumbered as EPs 6–8, respectively
- Standard CTS.02.01.11: Deleted Note and the cross-reference to CTS.02.03.09, EP 1
- CTS.02.01.11, EP 1: Added the minimum screening parameters when conducting a nutritional assessment
- CTS.02.03.11, EP 1: Revised the cross-reference to CTS.03.01.09, EP 4
- CTS.03.01.05, EPs 1–3: Added a cross-reference to CTS.04.02.16, EP 5
- CTS.03.01.09, EP 1: Clarified that the organization will use a standardized tool or instrument to monitor an individual’s progress and added a Note
- CTS.03.01.09, new EP 2: Added EP requiring organization to gather and analyze data generated through standardized monitoring and use the results to inform goals and objectives
- CTS.03.01.09, EP 2: Renumbered as EP 3, and clarified that the organization will aggregate and analyze data gathered through standardized monitoring to evaluate the outcome of services provided and added a reference to Standard PI.02.01.01
- CTS.03.01.09, EP 3: Renumbered as EP 4
- CTS.04.01.07, EP 6: Deleted the cross-reference to CTS.04.02.27, EP 4
- CTS.04.02.16, EP 5: Deleted the cross-reference to RI.01.02.01, EP 8
- New Standard CTS.04.03.20 and its EPs 1 and 2: Added standard for inpatient crisis stabilization to supervise individuals served as needed to deter from detrimental behavior and for that supervision to be conducted by staff
- CTS.04.03.21, EP 2: Deleted the cross-reference to IC.02.01.01, EP 13
- CTS.04.03.21, EP 4: Deleted the cross-reference to EC.02.01.05, EP 4
- CTS.05.05.09, EP 1: Revised to clarify that physical holding is initiate by an authorized staff member
- CTS.05.05.09, EP 5: Deleted EP that required the documentation in the clinical/case record of the physical holding of a child or youth
- CTS.05.05.11, Note: Revised for clarity
- CTS.05.05.21, new EP 7: Added EP requiring the organization’s written policies and procedures regarding physical holding of a child or youth to include details about the initiation of physical holding by an authorized staff member
- CTS.05.05.21, EPs 7–12: Renumbered as EPs 8–13, respectively
- CTS.05.06.09, EP 1, Note: Revised for clarity
- CTS.05.06.35, new EP 18: Added EP requiring the organization’s written policies and procedures regarding restraint or seclusion to include details about debriefing
Made minor editorial revisions

Environment of Care (EC)

Effective January 1, 2018

- EC.01.01.01, EPs 3, 4, 6, and 8: Renumbered as EPs 4, 5, 7, and 9, respectively
- EC.02.03.01, EP 9, Note: Revised to direct user to full text of listed reference
- EC.02.03.01, new EP 13: Added EP requiring organizations to meet the fire protection requirements related to Chapter 15 of NFPA 99–2012
- EC.02.03.03, EP 1: Deleted the cross-reference to LS.02.01.70, EP 6
- EC.02.03.03, EP 3: Revised requirement that quarterly fire drills are unannounced and revised Note to direct user to full text of listed reference
- EC.02.03.05, EP 1: Revised an NFPA reference
- EC.02.03.05, EP 7: Revised an NFPA reference
- EC.02.03.05, EP: 14: Revised and added NFPA references
- EC.02.03.05, EP 17: Revised NFPA references
- EC.02.03.05, EP 20: Revised to include testing of sliding and rolling fire doors and revised Note to direct user to full text of listed reference
- EC.02.03.05, EP 25: Revised an NFPA reference
- EC.02.03.05, EP new 28: Added EP listing the documentation requirements of maintenance, testing, and inspection activities for EC.02.03.05, EPs 1–20 and 25
- EC.02.05.01, EPs 3, 4, 7, 9, and 10: Renumbered as EPs 4, 5, 8, 10, and 11, respectively
- EC.02.05.01, EP 8: Renumbered as EP 9 and revised an NFPA reference
- EC.02.05.03, EP 1: Deleted an NFPA reference
- EC.02.05.03, EP 2: Revised NFPA references
- EC.02.05.03, EP 3: Revised NFPA references
- EC.02.05.03, EP 4: Renumbered as EP 5 and revised NFPA references
- EC.02.05.03, EPs 10 and 11: Renumbered as EPs 11 and 13, respectively
- EC.02.05.03, new EP 14: Added EP requiring organizations to implement a policy to provide emergency backup for medication dispensing equipment
- EC.02.05.03, EP new 15: Added EP requiring organizations to implement a policy to provide emergency backup for refrigeration of medications
- EC.02.05.05, EP 7: Renumbered as EP 8
Comprehensive Accreditation Manual for Behavioral Health Care

- EC.02.05.07, EP 1: Clarified that organizations must perform a functional test monthly of emergency lighting systems and exit signs, as well as a visual inspection of other exit signs, and revised Note to direct user to full text of listed references and added an NFPA reference
- EC.02.05.07, EP 2: Revised to require an organization to perform a functional test of battery-powered lists and exit signs and added a cross-reference to LS.02.01.20, EP 29 and NFPA references
- EC.02.05.07, EP 4, Note: Revised to direct user to full text of listed reference
- EC.02.05.07, EP 5: Clarified that an organization’s test of the emergency generator begins with a cold start and added an NFPA reference
- EC.02.05.07, EP 6: Added an NFPA reference
- EC.02.05.07, EP 7: Revised to include manual transfer switches when an organization is testing and added an NFPA reference
- EC.02.06.05, EP 3: Revised to include general maintenance when assessing risks
- Made minor editorial revisions

Emergency Management (EM)

- No changes

Human Resources Management (HRM)

Effective January 1, 2018

- HRM.01.01.01, EPs 1, 2, 6, and 7: Combined and numbered as EP 1, related to each positions written job description
- HRM.01.03.01, EPs 3–6: Combined and numbered as EP 3, related to staff orientation
- HRM.01.03.01, EPs 8–14: Combined and numbered as EP 8, related to peer support services staff orientation
- HRM.01.05.01, EPs 1–3: Combined and numbered as EP 1, related to staff participation in education and training activities
- HRM.01.06.09, EPs 2–5: Combined and numbered as EP 2, related to staff communication training with nonverbal individuals or individuals with limited verbal skills
- Made minor editorial revisions
Infection Prevention and Control (IC)

Effective January 1, 2018

- IC.01.03.01, EPs 1–3: Combined and numbered as EP 1, related to identifying infection risks
- IC.01.03.01, EP 5: Renumbered as EP 3
- IC.01.04.01, EPs 1, 2, 4, and 5: Combined and numbered as EP 1, related to an organization’s written infection prevention and control goals
- IC.01.05.01, EP 6: Revised the cross-reference to HRM.01.03.01, EP 3
- IC.02.01.01, EP 7: Revised the cross-reference to HRM.01.03.01, EP 3
- IC.02.03.01, EPs 2 and 3: Combined and numbered as EP 2, related to the response to staff exposed to infectious disease
- IC.02.04.01, EP 2: Deleted the cross-reference to HRM.01.03.01, EP 4
- IC.02.04.01, EP 6: Deleted the cross-reference to IC.02.04.01, EP 1
- IC.03.01.01, EPs 1–4: Combined and numbered as EP 1, related to the evaluation of an organization’s infection prevention and control plan
- Made minor editorial revisions

Information Management (IM)

- No changes

Leadership (LD)

- Made minor editorial revisions

Life Safety (LS)

Effective January 1, 2018

- LS.01.01.01, EP 4, Note 3: Added a website reference and revised NFPA reference
- LS.01.01.01, EP 6: Added an NFPA reference
- LS.01.02.01, new EP 15: Added EP stating an organization’s interim life safety measure (ILSM) policy allows the use of ILSM measures not addressed in LS.01.02.01, EPs 2–14
- LS.02.01.10, EP 1: Revised an NFPA reference
- LS.02.01.10, EP 2: Revised and added NFPA references
- LS.02.01.10, EPs 3–5 and 8–11: Renumbered as EPs 6, 7, 9, and 12–15, respectively
- LS.02.01.10, EP 6: Renumbered as EP 10 and revised requirement for the fire rating of exit stairs in existing, non high-rise buildings
- LS.02.01.10, EP 7: Renumbered as EP 11 and clarified the type of devices complying with Section 7.2.1.8.2 of NFPA 101–2012
- LS.02.01.20, EP 1: Added a new requirement stating elevator lobby exit access door locking is permissible if compliant with the listed reference
- LS.02.01.20, EP 2: Deleted EP regarding the direction of egress swing in rooms serving an occupancy of 50 or more
- LS.02.01.20, EPs 3–6, 10–12, 14–18, 21–32, 35, and 36: Renumbered as EPs 5–8, 13–15, 18, 19, 22–24, 27, 2, 28–36, 38, 41, and 42, respectively
- LS.02.01.20, EP 7: Renumbered as EP 9, and added requirement stating means of egress, such as ramps and exit passageways, are in accordance with the listed reference
- LS.02.01.20, EP 8: Renumbered as EP 10, and revised requirement to state new stairs serving three or more stories and existing stairs serving five or more stories will have signs, including tactile lettering, identifying the story
- LS.02.01.20, EP 9: Renumbered as EP 12 and clarified the requirement for exit discharge passageways to the outside at grade level
- LS.02.01.20, new EP 11: Added EP regarding the capacity of the means of egress
- LS.02.01.20, EP 13: Renumbered as EP 16, and clarified the exit requirements for each floor and smoke compartments of a building
- LS.02.01.20, new EP 17: Added EP requiring every corridor to provide access to not less than two approved exits without passing through any intervening rooms or spaces
- LS.02.01.20, EP 19: Renumbered as EP 25, and revised to state that in new buildings the common path of travel does not exceed 100 feet
- LS.02.01.20, EP 20: Renumbered as EP 26, and added requirement regarding exit access corridors for sleeping rooms with less than eight beds
- LS.02.01.20, EP 33: Renumbered as EP 39, and added a new requirement regarding emergency lighting for the means of egress
- LS.02.01.20, EP 34: Renumbered as EP 40, and added requirement stating the emergency lighting system will power continuously illuminated exit and directional signs
- LS.02.01.30, EP 4: Renumbered as EP 5, and revised an NFPA reference
Comprehensive Accreditation Manual for Behavioral Health Care

- LS.02.01.30, EP 5: Renumbered as EP 6, and clarified the required storage and handling conditions of alcohol-based hand rubs
- LS.02.01.30, EPs 6–10, 13–18, 20–22, and 25: Renumbered as EPs 7–11, 14–19, 21–23, and 26, respectively
- LS.02.01.30, EP 11: Renumbered as EP 12, and clarified that the requirement is directed at corridor doors in new buildings, adding that positive latching hardware is required
- LS.02.01.30, EP 12: Renumbered as EP 13, and added that positive latching hardware is required
- LS.02.01.30, EP 19: Renumbered as EP 20, and revised to state that in new buildings doors in a means of egress swing in the opposite direction
- LS.02.01.34, EPs 1, 3, and 4: Renumbered as EPs 7, 9, and 10, respectively
- LS.02.01.34, EP 2: Added new requirement for detection in newly designated occupancies and the monitoring of fire alarm system wiring
- LS.02.01.34, new EPs 1, 3–6, 8: Added EPs requiring the installation of a fire alarm system in accordance with listed references, the location of manual alarm boxes, occupant notification in new and existing buildings, automatic activation and alternative power supply, and smoke detection systems
- LS.02.01.35, EP 7: Revised an NFPA reference
- LS.02.01.35, EP 9: Revised an NFPA reference
- LS.02.01.35, EP 11: Deleted an NFPA reference
- LS.02.01.40, EP 1, Note: Revised date
- LS.02.01.50, EP 1: Renumbered as EP 5, and clarified fireplaces are direct-vent fireplaces
- LS.02.01.50, EP 2: Renumbered as EP 7, and revised an NFPA reference
- LS.02.01.50, EPs 3–7: Renumbered as EPs 9–13, respectively
- LS.02.01.50, EP 8: Renumbered as EP 14, and revised an NFPA reference
- LS.02.01.70, EPs 3–5: Renumbered as EPs 5, 6, and 8, respectively
- LS.02.01.70, EP 6: Renumbered as EP 9, and deleted the cross-reference to EC.02.03.03, EP 1
- Made minor editorial revisions

Medication Management (MM)

Effective January 1, 2018

xii CAMBHC Update 2, January 2018
Standard MM.01.01.03: Revised the standard and rationale to include hazardous medications

MM.01.01.03, EP 1: Revised to include hazardous medications and updated and added websites to the footnote

MM.01.01.03, EPs 2 and 3: Revised to include hazardous medication and added icon

MM.04.01.01, EP 1, Note: Revised to include a description of signed and held over medication orders

MM.08.01.01, new EP 16: Added EP requiring the organization to have a policy to describe the types of medication overrides when automatic dispensing cabinets are used

Made minor editorial revisions

National Patient Safety Goals (NPSG)

Effective January 1, 2018

NPSG.07.01.01, EP 1: Revised the cross-reference to IC.01.04.01, EP 1

NPSG.07.01.01, EP 2: Revised the cross-reference to IC.01.03.01, EP 1

Performance Improvement (PI)

Effective January 1, 2018

PI.03.01.01, EP 2: Added a cross-reference to MM.08.01.01, EP 6

Record of Care, Treatment, and Services (RC)

Effective January 1, 2018

RC.02.01.01, EP 2: Revised to include documentation of the date and time medication is administered and added icon

RC.02.01.01, EP 4: Deleted the cross-reference to RI.01.03.01, EP 13

Standard RC.02.01.05: Revised standard to require documentation of physical holding of child or youth

RC.02.01.05, new EP 5: Added EP requiring an organization to document the physical holding of a child or youth, including what should be included in the clinical record

RC.02.01.05, new EP 6: Added EP related to the facilitation of performance improvement activities based on the documentation of physical holding
Rights and Responsibilities of the Individual (RI)

Effective January 1, 2018

- RI.01.01.01, EP 18: Revised the cross-reference to RI.01.02.01, EP 2
- RI.01.01.01, EP 23: Renumbered as EP 3
- RI.01.02.01, EP 6: Renumbered as EP 2, and revised the cross-reference to RI.01.03.01, EP 1
- RI.01.02.01, EPs 3 and 7: Combined and numbered as EP 4, respecting the decision of an individual served or surrogate decision maker to refuse care, treatment, or services
- RI.01.02.01, EP 4: Renumbered as EP 5
- RI.01.02.01, EPs 20 and 21: Combined and numbered as EP 20, related to information provided to an individual served or surrogate decision maker about outcomes and unanticipated events
- RI.01.03.01, EPs 1–3, 6, and 13: Combined and numbered as EP 1, related to informed consent
- RI.01.03.01, EPs 7, 9, and 11: Combined and numbered as EP 2, related to the informed consent process
- Standard RI.01.03.03 and its EP 1: Deleted standard and moved and revised EP 1 as RI.01.03.01, EP 3, requiring an organization to obtain and document informed consent in advance of making or using recordings or images of an individual served
- RI.01.03.05, EPs 4–7: Combined and numbered as EP 4, related to what an organization must document in a research consent form
- RI.01.04.01, EPs 1 and 2: Combined and numbered as EP 1, related to an organization’s responsibility to inform an individual served of the name of the staff members responsible for their care
- RI.01.05.01, EPs 1, 4, 5, 8, and 11: Combined and numbered as EP 1, related to following a written policy on physical health advance directives for organizations that elect the optional Behavioral Health Home certification
- RI.01.07.01, EPs 1 and 2: Renumbered as RI.01.07.01, EP 1, respectively: Combined requirements related to an organization establishing and informing individuals served of its complaint resolution process
- RI.01.07.03, EP 5: Revised the cross-reference to HRM.01.03.01, EP 3
RI.01.07.07, EPs 1 and 2: Combined and numbered as EP 1, related to an organization following a written policy that addresses individuals served who work for wages for the organization

RI.01.07.09, EPs 1–6: Combined and numbered as EP 1, related to the information individuals served receive about vocational rehabilitation organizations

RI.03.01.01, EPs 1–9: Combined and numbered as EP 1, related to the written policies a foster care agency must follow

RI.03.01.03, EPs 1–4: Combined and numbered as EP 1, related to the information a foster care agency’s written policies must address

RI.03.01.05, EPs 2–6: Combined and numbered as EP 2, related to the information a foster care agency must relay to a foster family

RI.03.01.05, EP 7: Revised the cross-reference to HRM.01.05.01, EP 1

Made minor editorial revisions

**Waived Testing (WT)**

No changes

**Accreditation Process Information**

**The Accreditation Process (ACC)**

*Currently effective*

- General Eligibility Requirements: Clarified that eligibility for methadone detoxification programs is three patients served within the past 12 months
- Tailored Survey Policy: Added footnote clarifying that contractual arrangements are evaluated for tailoring applicability on a case-by-case basis
- Complex Organization Survey Process: Noted that the electronic application for accreditation (E-App) specifies the manual(s) under which particular services are surveyed
- Organization and Functional Integration: Updated functional integration criteria
- Data Release to Government Agencies and Organizations with Which The Joint Commission Performs Coordinated Survey Activities: Removed the restriction that complaint information can be shared only if allegation(s) result in an on-site visit
Role of the Account Executive: Updated to reflect that an account executive is assigned to an applicant organization after The Joint Commission receives a nonrefundable deposit (in addition to the E-App).

Electronic Application for Accreditation (E-App): Added phone number organizations should contact for initial access to Joint Commission Connect.

Forfeiture of Survey Deposit: Added footnote clarifying circumstances in which accredited organizations are not charged a deposit.

During the Survey: Updated to reflect that “off-shift” survey activities could occur during early morning (as well as evening, night, and weekend) hours as necessary.

Survey Agenda: Made the following changes:
- Added language to reflect that surveyors will discuss the Survey Analysis for Evaluating Risk™ (SAFER™) reporting process during the opening and exit conferences as well as during daily briefings.
- Changed “planning” category to “preparedness” phase in Environment of Care and Emergency Management (EM) session to align with introduction to EM chapter.

Individual Tracer Activity: Added criterion addressing restraints/seclusion.

Risk Areas: Added language about how surveyors will assess and display the risk associated with findings by utilizing the SAFER Matrix.

How Accreditation Decisions Are Made: Changed wording from “insufficiently compliant” to “noncompliant” in regard to EPs that will be cited as Requirements for Improvement (RFIs).

Figure 5. SAFER Matrix placement and required follow-up activities: Revised language to align with updated Evidence of Standards Compliance (ESC) format.

Corrective ESC: Updated to include the components of leadership involvement and preventive analysis.

Additional Surveys: Included adding an optional certification as a reason for conducting an extension survey.

Made minor editorial revisions.

Effective January 1, 2018

Decision Rules for Organizations Seeking Initial Accreditation: Made the following changes:
Added introductory text regarding the approval of decision rules by executive leadership (language applies to organizations seeking reaccreditation as well)

In Denial of Accreditation (DA) decision rule DA07, replaced the bulleted list of how an organization provides information to The Joint Commission with the words “in any way”

Added new rule DA10 regarding practitioners who do not possess or are practicing outside the scope of a license, registration, or certification

Added new rule DA11 regarding organizations that do not possess a license, certificate, and/or permit

Decision Rules for Organizations Seeking Reaccreditation: Made the following changes:

Deleted Evidence of Standards Compliance (ESC) decision rule ESC03 regarding on-site evaluations to validate compliance with the relevant standards in a written ESC

Deleted Accreditation with Follow-up Survey (AFS) decision rule AFS04 (which involved at least two on-site ESC demonstrating the need for continued monitoring)

Deleted cross-reference to LD.04.02.03, EP 3 from AFS12 to align with LD chapter

Added new rule AFS13 regarding organizations that implement sufficient corrective action as demonstrated in an on-site validation survey (related to Preliminary Denial of Accreditation [PDA] rule PDA02)

In PDA05, replaced the bulleted list of how an organization provides information to The Joint Commission with the words “in any way”

Deleted cross-reference to LD.04.02.03, EP 3 from PDA10 to align with LD chapter

Added new rule PDA11 on what happens when the Immediate Threat to Health or Safety abatement survey has not demonstrated implementation of sufficient corrective action

Added new rule DA06 regarding organizations that receive a Preliminary Denial of Accreditation (PDA) decision in two sequential surveys

Standards Applicability Process (SAP)

Effective January 1, 2018
Foster Care and Shelter Services Applicability Grid

- Added applicability for the following EPs:
  - CTS.02.01.03, EP 5
  - CTS.03.01.09, EP 3
  - CTS.05.05.21, EP 7
  - EC.02.03.01, EP 13
  - EC.02.03.05, EP 28
  - EC.02.05.03, EPs 14 and 15
  - EC.02.05.07, EP 2
  - HRM.01.03.01, EPs 3–6, combined as EP 3
  - IC.01.04.01, EPs 1, 2, 4, and 5, combined as EP 1
  - LS.01.02.01, EP 15
  - LS.02.01.20, EPs 11 and 17
  - LS.02.01.30, EP 4, renumbered as EP 5
  - LS.02.01.34, EPs 1, 3–6, and 8
  - RC.02.01.05, EPs 5 and 6
  - RI.01.03.03, EP 1, moved to RI.01.03.01, EP 3

- Renumbered the following EPs:
  - CTS.05.05.21, EPs 7–12, as EPs 8–13
  - EC.01.01.01, EPs 3, 4, 6, and 8, as EPs 4, 5, 7, and 9
  - EC.02.05.01, EPs 3, 4, and 7–10: Renumbered as EPs 4, 5, and 8–11
  - EC.02.05.03, EPs 4 and 11, as EP 5 and 13
  - EC.02.05.05, EP 7, as EP 8
  - HRM.01.01.01, EPs 1, 2, 6, and 7, combined as EP 1
  - HRM.01.05.01, EPs 1–3, combined as EP 1
  - IC.01.03.01, EPs 1–3, combined as EP 1
  - IC.03.01.01, EPs 1–4, combined as EP 1
  - LS.02.01.10, EPs 3–11, as EPs 6, 7, and 9–15
  - LS.02.01.20, EPs 3–36, as EPs 5–10, 12–16, 18, 19, 22–27, 2, 28–36, and 38–42
  - LS.02.01.30, EPs 5–22 and 25, as EPs 6–23 and 26
  - LS.02.01.34, EPs 1, 3, and 4, as EPs 7, 9, and 10
  - LS.02.01.50, EPs 1–8, as EPs 2, 7, and 9–14
  - LS.02.01.70, EPs 3–6, as EPs 5, 6, 8, and 9
- RI.01.02.01, EPs 4 and 6, as EPs 5 and 2; EPs 3 and 7, combined as EP 4; EPs 20 and 21, as EP 20
- RI.01.03.01, EPs 1, 2, 3, and 13, combined as EP 1; EPs 7, 9, and 11, combined as EP 2
- RI.01.03.05, EPs 4–7, combined as EP 4
- RI.01.04.01, EPs 1 and 2, combined as EP 1
- RI.01.05.01, EPs 1, 4, 5, 8, and 11, combined as EP 1
- RI.01.07.01, EPs 1 and 2, combined as EP 1
- RI.01.07.07, EPs 1 and 2, combined as EP 1
- RI.01.07.09, EPs 1–6, combined as EP 1
- RI.03.01.01, EPs 1 and 2, combined as EP 1
- RI.03.01.05, EPs 1–6, combined as EP 1
- RI.03.01.07, EPs 1 and 2, combined as EP 1
- RI.03.01.09, EPs 1–6, combined as EP 1
- RI.03.01.03, EPs 1–4, combined as EP 1
- RI.03.01.05, EPs 2–6, combined as EP 2
- Removed applicability for the following EPs:
  - CTS.05.05.09, EP 5
  - RC.02.01.01, EP 2

Behavioral Health Care Settings Applicability Grid

- Added applicability for the following EPs:
  - CTS.02.01.03, EP 5
  - CTS.03.01.09, EP 3
  - CTS.04.03.20, EPs 1 and 2
  - CTS.05.06.35, EP 18
  - CTS.02.03.01, EP 13
  - EC.02.03.03, EP 3
  - EC.02.03.05, EP 28
  - EC.02.05.03, EPs 14 and 15
  - LS.01.02.01, EP 15
  - LS.02.01.10, EPs 10 and 11
  - LS.02.01.20, 1, 11, and 17; EPs 7–9, 13, 19, 20, 33, and 34, renumbered as EPs 9, 10, 12, 16, 25, 26, 39, and 40
  - LS.02.01.30, EPs 4, 11, and 19, renumbered as EPs 5, 12, and 20
  - LS.02.01.34, EPs 1, 3–6, and 8
  - MM.01.01.03, EPs 1–3
  - MM.03.01.01, EP 4
● MM.08.01.01, EP 16
● RI.01.03.03, EP 1, moved to RI.01.03.01, EP 3
● RI.01.03.05, EPs 4–7, combined as EP 4
● RI.01.04.01, EPs 1 and 2, combined as EP 1
● RI.01.05.01, EPs 1, 4, 5, 8, and 11, combined as EP 1
● RI.01.07.01, EPs 1 and 2, combined as EP 1
● RI.01.07.07, EPs 1 and 2, combined as EP 1

☐ Renumbered the following EPs:
● CTS.02.01.03, EP 5, as EP 6
● EC.01.01.01, EPs 3, 4, 6, and 8, as EPs 4, 5, 7, and 9
● EC.02.05.01, EPs 3, 4, and 7–10, as EPs 4, 5, and 8–11
● EC.02.05.03, EPs 4, 10, and 11, as EPs 5, 11, and 13
● EC.02.05.05, EP 7, as EP 8
● HRM.01.01.01, EPs 1, 2, 6, and 7, combined as EP 1
● HRM.01.03.01, EPs 3–6, combined as EP 3
● IC.01.03.01, EPs 1–3, combined as EP 1; EP 5, as EP 3
● IC.01.04.01, EPs 1, 2, 4, and 5, combined as EP 1
● IC.02.03.01, EPs 2 and 3, combined as EP 2
● IC.03.01.01, EPs 1–4, combined as EP 1
● LS.02.01.10, EPs 3–5 and 8–11, as EPs 6, 7, 9, and 12–15
● LS.02.01.10, EPs 5–10, 12–18, 20–22, and 25, as 6–11, 13–19, 21–23, and 26
● LS.02.01.34, EPs 1, 3, and 4, as EPs 7, 9, and 10
● LS.02.01.50, EPs 1–8, as EPs 5, 7, and 9–14
● LS.02.01.70, 3–6, as 5, 6, 8, and 9
● RI.01.02.01, EPs 4 and 6, as 5 and 2; EPs 3 and 7, combined as EP 4; EPs 20 and 21, combined as EP 20
● RI.01.03.01, EPs 1, 2, 3, and 13, combined as EP 1; EPs 7, 9, and 11, combined as EP 2

■ Behavioral Health Care Services Applicability Grid
☐ Added applicability for the following EPs:
● CTS.02.01.03, EP 5
● CTS.03.01.09, EP 2
● CTS.05.05.21, EP 7
Renumbered the following EPs:
- CTS.02.01.03, EPs 6 and 7, as EPs 7 and 8
- CTS.03.01.09, EP 3, as EP 4
- CTS.05.05.21, EPs 7–12, as 8–13
- HRM.01.01.01, EPs 1, 2, 6, and 7, combined as EP 1
- HRM.01.03.01, EPs 3–6, combined as EP 3
- HRM.01.05.01, EPs 1–3, combined as EP 1
- HRM.01.06.09, EPs 2–5, combined as EP 2
- RI.01.02.01, EPs 20 and 21, combined as EP 20
- RI.01.05.01, EPs 1, 4, 5, 8, and 11, combined as EP 1
- RI.01.07.09, EPs 1–6, combined as EP 1

Removed applicability for the following EPs:
- CTS.05.05.09, EP 5
- HRM.01.03.01, EPs 9–14

Sentinel Events (SE)

Effective January 1, 2018

Definition of Sentinel Event: Updated link in “severe, temporary harm” footnote
Responding to Sentinel Standards: Deleted paragraph referencing Standard RI.01.02.01 and EP 21
Appendix: Deleted Standard RI.01.02.01 and EP 21
Made minor editorial revisions

The Joint Commission Quality Report (QR)

Effective January 1, 2018
Comprehensive Accreditation Manual for Behavioral Health Care

- What Is the Joint Commission Quality Report?: Clarified the type of information available on the Quality Report website
- What Will My Quality Report Contain?: Removed reference to Quality Indicators that compare organizations on a state and national level
- How Does My Hospital Submit a Commentary?: Clarified the approval process necessary for submitting a commentary to accompany your Quality Report
- Updated or added web addresses throughout the chapter
- Made minor editorial revisions

**Required Written Documentation (RWD)**

*Effective January 1, 2018*

- Renumbered the following existing RWD requirements:
  - CTS.05.05.21, EP 12, as EP 14
  - EC.01.01.01, EPs 3, 4, 6, and 8, as EPs 4, 5, 7, and 9
  - EC.02.05.01, EPs 3 and 9, as EPs 4 and 10
  - IC.01.03.01, EP 5, as EP 3
  - RI.01.03.01, EPs 1–3, 6, and 13, as EP 1
  - RI.01.03.05, EPs 4–7, as combined EP 4
  - RI.01.05.01, EPs 1, 4, 5, 8, and 11, as combined EP 1
  - RI.03.01.01, EPs 1–9, as combined EP 1

- Added the following EPs:
  - CTS.02.01.03, EP 5
  - CTS.05.06.35, EP 18
  - EC.02.03.05, EP 28
  - EC.02.05.03, EPs 14 and 15
  - MM.01.01.03, EPs 2 and 3
  - MM.08.01.01, EP 16
  - RC.02.01.01, EP 2
  - RC.02.01.05, EP 5

- Deleted the following EPs:
  - HRM.01.01.01, EPs 2, 6, and 7
  - HRM.01.03.01, EPs 4–6
  - HRM.01.05.01, EPs 2 and 3
  - IC.01.04.01, EPs 2, 3, and 5
Early Survey Policy (ESP)

**Effective January 1, 2018**

- Renumbered the following existing ESP requirements:
  - CTS.05.05.21, EP 12, as EP 13
  - EC.01.01.01, EPs 3, 4, 6, and 8, as EPs 4, 5, 7, and 9
  - EC.02.05.01, EP 9, as EP 10
  - EC.02.05.03, EP 10, as EP 11
  - EC.02.05.05, EP 7, as EP 8
  - HRM.01.01.01, EPs 1, 2, 6, and 7, as EP 1
  - IC.01.03.01, EP 5, as EP 3
  - IC.01.04.01, EPs 1, 2, 4, and 5, as combined EP 1
  - LS.02.01.10, EPs 3–11, as EPs 6, 7, 9–15
  - LS.02.01.20, EPs 3–36, as EPs 5–10, 12–16, 18, 19, 22–27, 28–36, and 38–42
  - LS.02.01.30, EPs 4–22 and 25, as EPs 5–23 and 26
  - LS.02.01.34, EPs 1, 3, and 4, as EPs 7, 9, and 10
  - LS.02.01.50, EPs 1–8, as EPs 5, 7, and 9–14
  - LS.02.01.70, EPs 3–6, as EPs 5, 6, 8, and 9
  - RI.01.03.05, EPs 4–7, as combined EP 4
  - RI.03.01.01, EPS 1–9, as combined EP 1
  - RI.03.01.03, EPs 1–4, as combined EP 1

- Added the following EPs:
  - CTS.04.03.20, EPs 1 and 2
  - CTS.05.06.35, EP 18
  - EC.02.03.01, EP 13
  - EC.02.03.05, EP 28
  - EC.02.05.03, EPs 14 and 15
  - LS.01.02.01, EP 15
  - LS.02.01.20, EPs 11 and 17
  - LS.02.01.34, EPs 1, 3–6 and 8
  - MM.08.01.01, EP 16

- Made minor editorial revisions

**Opioid Treatment Programs (OTP)**
Effective January 1, 2018

- CTS.02.01.03, EPs 6 and 7: Renumbered as EPs 7 and 8, respectively
- CTS.03.01.05, EP 1: Added a cross-reference to CTS.04.02.16, EP 5
- EC.02.03.01, EP 9, Note: Revised to direct user to full text of listed reference
- HRM.01.01.01, EPs 1, 2, 6, and 7: Combined and numbered as EP 1, related to each positions written job description
- HRM.01.05.01, EPs 1–3: Combined and numbered as EP 1, related to staff participation in education and training activities
- IC.01.03.01, EPs 1 and 2: Combined and numbered as EP 1, related to identifying infection risks
- Standard MM.01.01.03: Revised the standard and rationale to include hazardous medications
- MM.04.01.01, EP 1, Note: Revised to include a description of signed and held over medication orders
- RC.02.01.01, EP 2: Revised to include documentation of the date and time medication is administered and added < D > icon
- RC.02.01.01, EP 4: Deleted the cross-reference to RI.01.03.01, EP 13
- RI.01.02.01, EP 6: Renumbered as EP 2, and revised the cross-reference to RI.01.03.01, EP 1
- RI.01.03.01, EPs 7 and 11: Combined and numbered as EP 2, related to the informed consent process and the listed discussion points
- RI.01.03.01, EP 13: Deleted EP regarding an organization obtaining informed consent in accordance with its policy and process (combined into EP 1)
- RI.01.03.05, EPs 4–7: Combined and numbered as EP 4, related to what an organization must document in a research consent form
- RI.01.07.01, EPs 1 and 2: Combined and numbered as EP 1, related to an organization establishing and informing individuals served of its complaint resolution process
- Made minor editorial revisions

**Foster Care (FC)**

Effective January 1, 2018

- RI.03.01.01, EPs 1–9: Combined and numbered as EP 1, related to the written policies a foster care agency must follow
RI.03.01.03, EPs 1–4: Combined and numbered as EP 1, related to the information a foster care agency’s written policies must address
RI.03.01.05, EPs 2–6: Combined and numbered as EP 2, respectively: Combined requirements related to the information a foster care agency must relay to a foster family
RI.03.01.05, EP 7: Revised the cross-reference to HRM.01.05.01, EP 1
Made minor editorial revisions

Behavioral Health Home (BHH)

Effective January 1, 2018

CTS.03.01.05, EPs 1–3: Added a cross-reference to CTS.04.02.16, EP 5
CTS.04.01.07, EP 6: Deleted the cross-reference to CTS.04.02.27, EP 4
HRM.01.03.01, EPs 3–6: Combined and numbered as EP 3, related to staff orientation
HRM.01.05.01, EPs 1–3: Combined and numbered as EP 1, related to staff participation in education and training activities
PI.03.01.01, EP 2: Added a cross-reference to MM.08.01.01, EP 6
RC.02.01.01, EP 2: Revised to include documentation of the date and time medication is administered and added < D > icon
RC.02.01.01, EP 4: Deleted the cross-reference to RI.01.03.01, EP 13
RI.01.02.01, EPs 3 and 7: Combined and numbered as EP 4, related to an organization respecting the decision of an individual served or surrogate decision maker to refuse care, treatment, or services
RI.01.02.01, EP 6: Renumbered as EP 2, and revised the cross-reference to RI.01.03.01, EP 1
RI.01.02.01, EPs 20 and 21: Combined and numbered as EP 20, related to information provided to an individual served or surrogate decision maker about outcomes and unanticipated events
RI.01.03.01, EPs 1–3, 6, and 13: Combined and numbered as EP 1, related to informed consent
RI.01.03.01, EPs 7, 9, and 11: Combined and numbered as EP 2, related to the informed consent process and the listed discussion points
- RI.01.03.03, EP 1: Combined and numbered as EP 3, clarified to require an organization to obtain and document informed consent in advance of making or using recordings or images of an individual served.
- Standard RI.01.03.03: Deleted Standard and moved EP 1 as RI.01.03.01, EP 1, regarding an individual’s right to withhold informed consent to produce or use gathered media, such as film or images.
- RI.01.03.05, EPs 4–7: Combined and numbered as EP 4, related to what an organization must document in a research consent form.
- RI.01.04.01, EPs 1 and 2: Combined and numbered as EP 1, related to an organization’s responsibility to inform an individual served of the name of the staff members responsible for their care.
- RI.01.05.01, EPs 1, 4, 5, 8, and 11: Combined and numbered as EP 1, related to following a written policy on physical health advance directives for organizations that elect the optional Behavioral Health Home certification.
- RI.01.07.01, EPs 1 and 2: Combined and numbered as EP 1, related to an organization establishing and informing individuals served of its complaint resolution process.
- RI.01.07.03, EP 5: Revised the cross-reference to HRM.01.03.01, EP 3.
- Made minor editorial revisions.

**Glossary**

*Effective January 1, 2018*
- Made minor editorial revisions.

**Index**

*Effective January 1, 2018*
- Updated index.
Comprehensive Accreditation Manual

2017 Update 2

CAMBHC for Behavioral Health Care
Effective January 1, 2018

Standards
Elements of Performance
Scoring
Accreditation Policies

The Joint Commission
Accreditation
Behavioral Health Care
The Joint Commission Mission

The mission of The Joint Commission is to continuously improve health care for the public, in collaboration with other stakeholders, by evaluating health care organizations and inspiring them to excel in providing safe and effective care of the highest quality and value.

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Introduction: How The Joint Commission Can Help You Move Toward High Reliability (INTRO)

The “Introduction: How The Joint Commission Can Help You Move Toward High Reliability” (INTRO) chapter is an introduction to Joint Commission accreditation and a user’s guide to understanding how the *Comprehensive Accreditation Manual for Behavioral Health Care (CAMBHC)* and its E-dition* are organized. There are four parts to guide you toward compliance and support your journey to high reliability:

1. Part I provides a brief overview of the value of Joint Commission accreditation, the Behavioral Health Care Accreditation Program, and its certification option.
2. Part II explains the organization and content of the *CAMBHC*.
3. Part III explains how you can use the *CAMBHC* to successfully achieve and maintain compliance with Joint Commission standards. Part III also provides tips and strategies for finding the information you need to stay current with Joint Commission standards and understand the on-site survey process.
4. Part IV provides a comprehensive list of contacts and resources you can use to get more information at The Joint Commission and Joint Commission Resources.

Read this chapter first to understand the Behavioral Health Care Accreditation Program and the structure and content of the *CAMBHC*. After you have a better understanding of the value of accreditation in improving and maintaining the quality of care, treatment, or services, maximizing the safety of the individual served, and stimulating performance improvement, read “The Accreditation Process” (ACC) chapter to understand the Joint Commission’s accreditation process, including eligibility for accreditation; the application process; accreditation surveys and what to expect before, during, after, and between surveys; accreditation decision rules; and review and appeal procedures.

I. Introduction to Joint Commission Accreditation

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
The Value of Joint Commission Accreditation

The Joint Commission’s Gold Seal of Approval® is a widely recognized benchmark representing the most comprehensive evaluation process in the health care industry. Joint Commission accreditation benefits your organization in the following ways:

- **Gives you a competitive advantage:** Achieving accreditation and specialty certification is a visible demonstration to individuals served and the community that your organization is committed to providing the highest quality of behavioral health care, treatment, or services. It also sets you apart from other organizations offering the same types of care, treatment, or services.

- **Assists with recognition from insurers, associations, and other third parties:** Many payers, regulatory agencies, government agencies, and managed care contractors require Joint Commission accreditation for reimbursement, for certification or licensure, and as a key element of their participation agreements and reimbursement practices.

- **Helps organize and strengthen your improvement efforts:** Accreditation encompasses state-of-the-art performance improvement concepts that help you continuously improve quality and standardize your processes of care, treatment, or services.

- **Helps health care organizations become high reliability organizations:** The Joint Commission offers numerous resources and information to help behavioral health care organizations move toward high reliability—that is, to consistently perform at high levels of quality and safety across all services and to maintain these levels over long periods. These resources help leadership commit to high reliability by making it a priority, establishing a safety culture throughout the organization that emphasizes trust and the reporting of unsafe conditions and improvement, and encouraging behavioral health care organizations to use Robust Process Improvement® (RPI®) tools and methodologies (such as Lean, Six Sigma, and change management) to systematically improve processes and avoid common, crucial failures.

- **Enhances staff education:** The accreditation process is designed to be educational. Joint Commission surveyors share best practice approaches and strategies that may help your behavioral health care organization better meet the intent of the standards and, more important, improve performance of day-to-day operations.

- **Provides access to experts in quality and safety:** The Joint Commission is committed to helping your behavioral health care organization move toward highly reliable care, treatment, or services. Through The Joint Commission, your behavioral health care organization has access to a range of professionals eager to see you succeed. It starts with the assignment of an account executive specializing in behavioral health care to...
help in day-to-day accreditation activities. You also have ready access to the clinical or engineering experts in our Standards Interpretation Group (SIG) as well as professional surveyors who visit your organization for on-site surveys and clinicians who are available to help provide expert analysis of sentinel events in the Office of Quality and Patient Safety.

Figure 1 illustrates how Joint Commission accreditation guides behavioral health care organizations in achieving, maintaining, and demonstrating consistent excellence in quality and safety. Part III of this chapter (Steps to Achieving and Maintaining Compliance) provides additional detail on other tools and resources available to accredited organizations.

**Figure 1.** The Joint Commission’s Behavioral Health Care Accreditation Program is designed to help behavioral health care organizations achieve, maintain, and demonstrate consistent excellence in the services they provide to individuals served. The program has several key components designed to work collectively to better power your overall performance improvement efforts.
The Joint Commission’s Behavioral Health Care Accreditation Program

The Joint Commission’s Behavioral Health Care Accreditation Program uses a person-centered quality framework and collaborative approach to help organizations proactively identify and address vulnerabilities to safeguard individuals served.

Addressing Complex Issues in Organizations Accredited Under the Behavioral Health Care Program

There are many factors that affect outcomes the individuals served in behavioral health care organizations experience. For example, a sufficient number of staff members to support the needs of an individual served will help prevent adverse outcomes such as abuse and neglect, suicide, and harm to self and others. Likewise, having educated, competent, and properly trained staff positively impacts the organization’s ability to assess, plan, and deliver safe, high-quality care, treatment, or services to its individuals served.

Research shows that some of the greatest challenges for behavioral health care organizations are addressing such complex issues affecting individuals served as history of trauma, abuse, or neglect; challenging behaviors; and avoiding restraint/seclusion. Staff and leadership are challenged with reducing resources to provide person-centered care, treatment, or services.

The Behavioral Health Care Accreditation Program helps providers achieve, maintain, and demonstrate consistent excellence in the services they provide. The standards specifically listed in Table 1 can help behavioral health care organizations begin to develop strategies to address the most challenging and complex issues affecting individuals served.

Note: Table 1 does not address all of the issues facing leaders in behavioral health care organizations.
Table 1. Standards That Address Complex Care, Treatment, or Service Issues in Behavioral Health Care Organizations

<table>
<thead>
<tr>
<th>Abuse/Neglect Prevention</th>
<th>Trauma Screening</th>
<th>Suicide Prevention</th>
<th>Preventing Harm to Self/Others</th>
<th>Promoting Person-Centered Care</th>
<th>Restraint/Seclusion Reduction</th>
<th>Safety Culture</th>
<th>Competent/Qualified Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>CTS.02.02.05</td>
<td>CTS.02.02.05</td>
<td>CTS.02.01.01</td>
<td>CTS.02.02.03</td>
<td>CTS.02.02.01</td>
<td>CTS.05.06.07</td>
<td>APR.09.01.01</td>
<td>HRM.01.01.01</td>
</tr>
<tr>
<td>RI.01.06.03</td>
<td>RI.01.06.03</td>
<td>RI.01.02.01</td>
<td>RI.01.06.03</td>
<td>RI.01.02.03</td>
<td>RI.05.06.03</td>
<td>HRM.01.04.01</td>
<td>HRM.01.06.09</td>
</tr>
</tbody>
</table>

Focusing on the individual served and following the direction provided in the standards in Table 1 will allow staff to begin to explore ways to improve care, treatment, or services to help individuals served in attaining the most favorable outcomes possible. The Intracycle Monitoring (ICM) process (discussed in more detail in “The Accreditation Process” [ACC] chapter) and the information on your Joint Commission Connect® extranet site, in combination with a focus on the complex issues addressed by these standards, will help you assess just how ready for accreditation your organization is and will allow you to continually assess your organization’s readiness going forward.

II. About the Comprehensive Accreditation Manual for Behavioral Health Care

The CAMBHC (and its web-based, fully searchable, electronic version called the Edition) contains Joint Commission standards (also known as requirements), elements of performance (EPs), National Patient Safety Goals® (NPSGs), and other requirements applicable to the care, treatment, or services a behavioral health care organization provides (see the “Identifying Applicable Standards” section in this chapter). The
CAMBHC includes all the information a behavioral health care organization needs to achieve and maintain continuous compliance with the Joint Commission’s accreditation and optional specialty certification standards. The manual also will help behavioral health care organizations engage in continuous performance improvement and will guide staff in developing processes to provide the highest quality of safe care, treatment, or services.

Upon initial application for accreditation and receipt of a deposit toward accreditation fees, a behavioral health care organization receives complimentary access to E-dition (which contains accreditation standards) and access to the Joint Commission Connect extranet (which contains various accreditation tools and resources). This secure extranet site also serves as the primary avenue for communication between an organization and The Joint Commission.

The Joint Commission may revise accreditation or certification standards periodically throughout the year and publish those changes online, in the accreditation manual, or in Joint Commission Perspectives®. This official Joint Commission newsletter publishes revised or updated standards, EPs, scoring, standards clarifications and interpretations, and other useful information as the year progresses. Your organization is responsible for meeting all applicable standards published in Perspectives, and staff need access to aid in your compliance efforts (see “Keep Current With Standards Changes via Perspectives” section). (Perspectives is available on your Joint Commission Connect extranet site, under the “Resources” tab or is available for purchase at www.jcrinc.com/the-joint-commission-perspectives/.) Modifications and clarifications to Joint Commission standards published in Perspectives can also be found online at https://www.jointcommission.org/standards_information/bhc_requirements.aspx.


Changes to the standards can be made for a variety of reasons, but they are always done with input from accredited organizations, health care professionals, providers, subject matter experts, consumers, government agencies, and/or employers and are informed by the scientific literature. New standards are added only if they relate to the quality of care and/or the safety of individuals served, have a positive impact on health outcomes, can
be accurately and readily measured, and relate to important issues that clearly support high-quality care, treatment, or services. Standards may also be revised in response to law and regulation changes.

Although The Joint Commission may announce revisions to accreditation standards throughout the year, those changes are made to the E-dition generally only twice a year: in the spring (with changes applicable July 1) and in the fall (with changes applicable January 1 of the following year). Accredited organizations receive one complimentary subscription to the E-dition as long as they maintain accreditation. The print version of the CAMBHC manual is published once a year in the fall and a print update service is available to keep your manual current through the year. The print manual or updates are only available for purchase at http://www.jcrinc.com/store/publications/manuals/. The “What’s New” table, provided with each print manual and accessible from the blue navigation bar across the top of the E-dition, offers a summary of the changes made since the CAMBHC was last published or posted.

How Is This Manual Organized?
This manual is organized into the following two sections for your convenience:

- Section 1: Accreditation Requirements (marked with gold tabs in the print version). These chapters include standards that are scored, and they appear in alphabetical order.
- Section 2: Accreditation Process Information (marked with blue tabs in the print version). This section includes information about the accreditation process, policies, procedures, and other related information.

Following is more detail about each section. See Table 2 for a list of acronyms used in this manual.

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACC</td>
<td>“The Accreditation Process” chapter</td>
</tr>
<tr>
<td>AFS</td>
<td>Accreditation with Follow-up Survey</td>
</tr>
<tr>
<td>APR</td>
<td>“Accreditation Participation Requirements” chapter</td>
</tr>
</tbody>
</table>

continued on next page
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>BHH</td>
<td>Behavioral Health Home Certification (also a chapter in this manual)</td>
</tr>
<tr>
<td>CAMBHC</td>
<td>Comprehensive Accreditation Manual for Behavioral Health Care</td>
</tr>
<tr>
<td>CSAT</td>
<td>Center for Substance Abuse Treatment</td>
</tr>
<tr>
<td>CTS</td>
<td>“Care, Treatment, and Services” chapter</td>
</tr>
<tr>
<td>DA</td>
<td>Denial of Accreditation</td>
</tr>
<tr>
<td>E-App</td>
<td>electronic application for accreditation</td>
</tr>
<tr>
<td>EC</td>
<td>“Environment of Care” chapter</td>
</tr>
<tr>
<td>EM</td>
<td>“Emergency Management” chapter</td>
</tr>
<tr>
<td>EP</td>
<td>element of performance</td>
</tr>
<tr>
<td>ESC</td>
<td>Evidence of Standards Compliance</td>
</tr>
<tr>
<td>ESP</td>
<td>Early Survey Policy (option for organizations not previously accredited)</td>
</tr>
<tr>
<td>FC</td>
<td>“Foster Care” chapter</td>
</tr>
<tr>
<td>FSA</td>
<td>Focused Standards Assessment</td>
</tr>
<tr>
<td>HAI</td>
<td>health care–associated infection</td>
</tr>
<tr>
<td>HIPAA</td>
<td>Health Insurance Portability and Accountability Act of 1996</td>
</tr>
<tr>
<td>HRM</td>
<td>“Human Resources Management” chapter</td>
</tr>
<tr>
<td>IC</td>
<td>“Infection Prevention and Control” chapter</td>
</tr>
<tr>
<td>ICM</td>
<td>Intracycle Monitoring</td>
</tr>
<tr>
<td>ILSM</td>
<td>Interim Life Safety Measures</td>
</tr>
<tr>
<td>IM</td>
<td>“Information Management” chapter</td>
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<tr>
<td>INTRO</td>
<td>“Introduction: How The Joint Commission Can Help You Move Toward High Reliability” chapter</td>
</tr>
<tr>
<td>LD</td>
<td>“Leadership” chapter</td>
</tr>
<tr>
<td>LS</td>
<td>“Life Safety” chapter</td>
</tr>
<tr>
<td>LTA</td>
<td>Limited, Temporary Accreditation</td>
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Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
### Table 2. (continued)

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>MM</td>
<td>“Medication Management” chapter</td>
</tr>
<tr>
<td>NPSG</td>
<td>National Patient Safety Goal (also a chapter in this manual)</td>
</tr>
<tr>
<td>OQPS</td>
<td>Office of Quality and Patient Safety</td>
</tr>
<tr>
<td>OSHA</td>
<td>Occupational Safety and Health Administration</td>
</tr>
<tr>
<td>OTP</td>
<td>Opioid treatment program (also a chapter in this manual)</td>
</tr>
<tr>
<td>PDA</td>
<td>Preliminary Denial of Accreditation</td>
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<tr>
<td>PFI</td>
<td>Plan for Improvement</td>
</tr>
<tr>
<td>PI</td>
<td>“Performance Improvement” chapter</td>
</tr>
<tr>
<td>POA</td>
<td>Plan of Action</td>
</tr>
<tr>
<td>POC</td>
<td>Plan of Correction</td>
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<tr>
<td>QR</td>
<td>“The Joint Commission Quality Report” chapter</td>
</tr>
<tr>
<td>RC</td>
<td>“Record of Care, Treatment, and Services” chapter</td>
</tr>
<tr>
<td>RCA</td>
<td>Root cause analysis</td>
</tr>
<tr>
<td>RFI</td>
<td>Requirement for Improvement</td>
</tr>
<tr>
<td>RI</td>
<td>“Rights and Responsibilities of the Individual” chapter</td>
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<tr>
<td>RWD</td>
<td>“Required Written Documentation” chapter</td>
</tr>
<tr>
<td>SAFER™</td>
<td>Survey Analysis for Evaluating Risk™</td>
</tr>
<tr>
<td>SAG</td>
<td>“Standards Applicability Grid” chapter</td>
</tr>
<tr>
<td>SAMHSA</td>
<td>Substance Abuse and Mental Health Services Administration</td>
</tr>
<tr>
<td>SAP</td>
<td>“Standards Applicability Process” chapter</td>
</tr>
<tr>
<td>SE</td>
<td>“Sentinel Events” chapter</td>
</tr>
<tr>
<td>SIG</td>
<td>Standards Interpretation Group</td>
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<tr>
<td>SSIS</td>
<td>“Safety Systems for Individuals Served” chapter</td>
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<tr>
<td>SOC™</td>
<td>Statement of Conditions™</td>
</tr>
<tr>
<td>WT</td>
<td>“Waived Testing” chapter</td>
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</table>
Accreditation Requirements
The first section of this manual contains the accreditation standards for the Behavioral Health Care Accreditation Program, which consists of Joint Commission standards, EPs, NPSGs, and other requirements applicable to all organizations accredited in the Behavioral Health Care Accreditation Program.

This manual contains the following standards chapters:

“Accreditation Participation Requirements” (APR): Consists of specific requirements for participation in the accreditation process and for maintaining an accreditation award.

“Care, Treatment, and Services” (CTS): Covers how care, treatment, and services are provided through the successful coordination and completion of a series of core processes.

“Environment of Care” (EC): Describes how to maintain a safe, functional, and effective environment for individuals served, staff, and other visitors in the organization.

“Emergency Management” (EM): Ensures that the organization has a disaster plan in place.

“Human Resources Management” (HRM): Outlines processes for staff management.

“Infection Prevention and Control” (IC): Helps organizations identify and reduce the risk of acquiring and transmitting infections.

“Information Management” (IM): Directs organizations to obtain, manage, and use information to provide, coordinate, and integrate care, treatment, and services.

“Leadership” (LD): Reviews structure and relationships of leadership and the maintenance of a culture of safety, quality, and operational performance.

“Life Safety” (LS): Covers fire protection systems, fire detection systems, and key fire safety building features that are challenging for behavioral health care organizations.

“Medication Management” (MM): Addresses the stages of medication use, including selection, storage, and safe management of medications, ordering, preparing and dispensing, administration, monitoring of effect, and evaluation of the processes.
“National Patient Safety Goals” (NPSG): Includes specific actions that organizations are expected to take to prevent medical errors, such as those caused by medication errors, harm associated with health care–associated infections, and safety concerns across varied behavioral health care populations.

“Performance Improvement” (PI): Focuses on using data to monitor performance, compiling and analyzing data to identify improvement opportunities, and taking action on improvement priorities.

“Record of Care, Treatment, and Services” (RC): Covers the planning function (components of clinical records, authentication, timeliness, and record retention) as well as documentation of items in the clinical/case record for an individual served.

“Rights and Responsibilities of the Individual” (RI): Addresses informed consent, participating in decision making, and respecting the rights of the individual served.

“Waived Testing” (WT): Covers policies, identifying staff responsible for performing and supervising waived testing, competency requirements, quality control, and record keeping.

This manual also contains an optional certification standards chapter, “Behavioral Health Home” (BHH), as described further in the “Accreditation Process Information” section.

Accreditation Process Information
The second section of this manual contains information about the accreditation process, policies, procedures, and other related information. The following chapters appear in this section:

“Safety Systems for Individuals Served” (SSIS): Informs and educates leadership about the importance and structure of an integrated safety system. This chapter is designed to clarify the relationship between Joint Commission accreditation and the safety of patients and individuals served. It does not contain new standards or requirements. Rather, the chapter describes how existing requirements can be applied to continually improve the safety of patients and individuals served. It also provides approaches and methods that may be adapted to remove risk of harm to patients and individuals served.
“The Accreditation Process” (ACC): Provides information about the Joint Commission’s policies and procedures covering the entire accreditation process, including the application process, types of surveys, Tailored Survey Policy, Intracycle Monitoring (ICM), and Focused Standards Assessment (FSA). The chapter also describes all components of the accreditation process, including the survey agenda, tracer methodology, the Joint Commission’s Information Accuracy and Truthfulness Policy, and the Public Information Policy. Details of the scoring and decision process, including the Accreditation Decision Rules, Evidence of Standards Compliance, and the review and appeal process, are also explained.

“Standards Applicability Process” (SAP): Lists the standards that are applicable to the different types of settings, services, and populations addressed in the CAMBHC. These user-friendly applicability grids allow you to quickly identify the services, as you identified them in your E-App, and related standards that apply to your behavioral health care organization. Refer to the SAP chapter for additional information on how to read and use the grids.

“Sentinel Events” (SE): Contains information on the Joint Commission’s Sentinel Event Policy, including the definition of a sentinel event, the goals of the policy, the adverse events that constitute sentinel events, sentinel event–related standards, and the various activities that surround the policy.

“The Joint Commission Quality Report” (QR): Provides an overview of publicly viewable accreditation information provided in the form of Quality Reports. It describes what Quality Reports are, how and when they are developed, how organizations can respond to them, and how the public and organizations can access and use them. It also includes information about the Joint Commission’s Quality Check® website, guidelines for submitting commentary, and marketing and communicating guidelines for using Quality Reports.

“Required Written Documentation” (RWD): Lists the standards that require written documentation beyond that required in the clinical/case record—that is, all the EPs marked with a © icon throughout the standards chapters. This chapter can be used as a checklist by accredited organizations to maintain continuous compliance with documentation requirements or by organizations seeking accreditation to verify compliance with those requirements.
“Early Survey Policy” (ESP): Lists the selected standards, EPs, and other requirements that are surveyed during the first survey when a behavioral health care organization has chosen the Early Survey Policy option. This chapter can be referenced as you prepare for first-time accreditation under the ESP. See “The Accreditation Process” (ACC) chapter for details on the ESP.

“Opioid Treatment Programs” (OTP): Lists the standards that apply only to Substance Abuse and Mental Health Services Administration (SAMHSA) and Center for Substance Abuse Treatment (CSAT)–certified opioid addiction treatment programs.

“Foster Care” (FC): Lists the standards that apply specifically to agencies providing foster or respite care.

“Behavioral Health Home Certification Option” (BHH): Describes The Joint Commission’s Behavioral Health Home model. It contains the additional standards necessary to achieve or maintain the optional Behavioral Health Home certification, along with the existing accreditation standards that relate most closely to the characteristics of a behavioral health home.

“Glossary” (GL): Provides definitions of many terms used throughout the manual.

“Index” (IX): Appears at the end of the print manual.

Identifying Applicable Standards

The print version of the CAMBHC includes all Joint Commission standards that apply to all organizations accredited under the Behavioral Health Care Accreditation Program and certified as a Behavioral Health Home. But not all standards in the print manual apply to the specific care, treatment, or services that your individual organization provides; your settings; or the populations you serve. You are not expected to comply with standards that do not apply to the services, settings, or populations of your organization.

For example, standards and EPs that apply only to organizations that are choosing to pursue certification as a behavioral health home are preceded by the following boldface lead-in phrase: For organizations that elect The Joint Commission Behavioral Health Home option. If you are unsure about the standards in the print manual that apply to your behavioral health care organization, please review the SAP chapter.
In contrast, the E-dition on your Joint Commission Connect extranet site provides a more customized manual based on the settings and services on your E-App. The E-App gives your organization the ability to select the specific settings that describe your behavioral health care organization and the specific services you provide. This selection, in turn, drives the standards applied to your organization by surveyors during the on-site survey process. To view your organization’s services in E-dition, click “Service Profile” on the top navigation bar. Check with your Joint Commission account executive if you have questions or to help ensure your E-App is complete and accurate.

Some organizations provide care, treatment, or services that are covered under more than one accreditation program and manual (for example, an organization that provides in-home services to individuals with intellectual/developmental disabilities and home health care to the elderly will be required to maintain compliance with certain standards in the home care accreditation manual, as well as the CAMBHC). The Joint Commission will work with your organization to determine whether standards from this and/or other accreditation manuals are applicable.

The Joint Commission surveys and accredits health care organizations using standards from one or more of eight accreditation programs (the names of the corresponding print manuals are indicated in parentheses):

1. Ambulatory Care (Comprehensive Accreditation Manual for Ambulatory Care):
   Surgery centers, community health centers, group practices, imaging centers, sleep labs, rehabilitation centers, telehealth providers, student health centers, urgent care clinics, and other ambulatory providers

2. Behavioral Health Care (Comprehensive Accreditation Manual for Behavioral Health Care):
   Organizations that provide mental health services, substance use treatment services, foster care services, programs or services for children and youth, child welfare, services for individuals with eating disorders, services for individuals with intellectual/developmental disabilities of various ages and in various organized service or program settings, case management services (including permanent housing support), peer-based recovery services, prevention and wellness promotion services, corrections-based services, and opioid treatment programs

   A hospital that offers limited services and is located more than 35 miles from a hospital or another critical access hospital, or is certified by the state as being a necessary provider of health care services to residents in the area. It maintains no more than 25 beds that could be used for inpatient/swing bed care. A critical access hospital...
hospital provides acute inpatient care for a period that does not exceed, on an annual average basis, 96 hours per patient. A critical access hospital can also have a psychiatric and/ or rehabilitation distinct part unit; each unit can have up to 10 beds.

4. Home Care (Comprehensive Accreditation Manual for Home Care): Organizations that provide home health services, personal care and support services, pharmacy services including infusion services and/or mail order and specialty pharmacies, long term care pharmacies and freestanding infusion centers, durable medical equipment services, and hospice services

5. Hospital (Comprehensive Accreditation Manual for Hospitals): General, acute psychiatric, pediatric, medical/surgical specialty, long term acute care, and rehabilitation hospitals

6. Laboratory Services (Comprehensive Accreditation Manual for Laboratory and Point-of-Care Testing): Clinical laboratories, point-of-care testing, assisted reproductive technology labs, and reference labs performing nonwaived testing

7. Nursing Care Centers (Comprehensive Accreditation Manual for Nursing Care Centers): Organizations that provide specialized services to patients or residents, which may include rehabilitative care, dementia-specific memory care, and long-term nursing care.

8. Office-Based Surgery Practices: A surgeon-owned or -operated organization (for example, a professional services corporation, private physician office, or small group practice) that provides invasive procedures and administers local anesthesia, minimal sedation, conscious sedation, or general anesthesia that renders three or fewer patients incapable of self-preservation at any time, and is classified as a business occupancy.

Contact your account executive with questions about eligibility or the services or settings that will be included in your survey.

**Understanding the Organization of the Standards Chapters**

Each standards chapter in the “Accreditation Requirements” section is organized as follows (see Figure 2):

- **Overview:** The overview is located at the beginning of each chapter. The overview explains the chapter’s purpose and the principles on which the standards were built.

- **Chapter outline:** This part shows how the chapter is laid out and provides a frame of reference for the numbering of standards.
Introduction: Some standards (or cluster of standards) have an introduction at the beginning, which provides information about the standard’s origin and any issues that surround it.

Standards: Standards (also known as requirements) are statements that define the performance expectations and/or structures or processes that must be in place for organizations to provide safe, high-quality care, treatment, and services.

Rationale: A rationale explains the purpose of a standard by providing additional background, justification, or other information, but it is not scored. In many cases, the rationale for a standard is self-evident; therefore, not every standard has a written rationale.

References: This part of a chapter is placed in parentheses following a standard to help identify related standards, whether they are located in the same chapter or a different chapter. These references should help the user to quickly find related standards concerning a particular topic.

Elements of performance (EPs): EPs are statements that detail the specific performance expectations and/or structures or processes that must be in place for an organization to provide high-quality care, treatment, and services. EPs are scored and determine an organization’s overall compliance with a standard. The EPs are numbered sequentially under each standard: EP 1, EP 2, EP 3, and so on. Some EPs in standards common across accreditation programs may not apply specifically to behavioral health care organizations and are omitted from this accreditation manual. Consequently, gaps may exist in the sequence. For example, if a standard lists EP 1, EP 2, and EP 5, this indicates that EP 3 and EP 4 do not apply to the Behavioral Health Care Accreditation Program and, therefore, your organization does not have to comply with them.

Notes: Notes are used to provide organizations and surveyors with additional or clarifying information about a specific EP.
**Figure 2.** Components of a standards chapter in the print manual. The components are further described in the “Understanding the Icons Used in the Manual” section.
Understanding the Icons Used in the Manual
You will notice features in the manual that will help you navigate the standards. Icons used throughout the accreditation requirements chapters provide clarity and ease of use.

The following icons can be found in this manual:

- The documentation icon (◎) indicates when written documentation is required to demonstrate full compliance with an EP. In addition, the word *written* usually appears in the text if an EP requires written documentation, which may be in either a paper or an electronic format. Because The Joint Commission’s focus is on performance and implementation rather than documentation, the EPs require documentation only when it is essential. A documentation icon is used to identify data collection and documentation requirements that are beyond information required to be in the clinical record. For example, an EP that requires a written procedure will include a ◎, but the icon is not applied to an EP that contains the required list of components of the clinical record. Other examples in which the documentation icon is used are for EPs that require a policy, a written plan, bylaws, a license, evidence of testing, data, performance improvement reports, medication labels, safety data sheets, or meeting minutes. Each EP that requires any of these types of documentation is listed in the “Required Written Documentation” (RWD) chapter in this manual.

- The risk icon (℞) identifies specific risks by accreditation program (not program segment). Risk is assessed by a system’s proximity to the individual served, probability of harm, severity of harm, and number of individuals served at risk. Risk categories identified by The Joint Commission are related to National Patient Safety Goals, accreditation program–specific risk areas, and RFIs identified during current accreditation cycle survey events. The print manual will show a single icon at the EP level for the National Patient Safety Goals and accreditation program–specific risk areas that are required to be addressed during the ICM process through the FSA. The third risk category—related to an organization’s own RFIs—will appear only in the ICM Profile on the organization’s *Joint Commission Connect* extranet site.

III. Steps to Achieving and Maintaining Compliance
Communicating critical information to staff and maintaining continuous compliance with Joint Commission standards are key to ensuring that safe, high-quality care, treatment, or services is provided to individuals served—yet these charges present a real
challenge for many organizations. Following are some helpful suggestions for successfully achieving continuous compliance with accreditation standards outlined in this accreditation manual.

**Become Familiar with the Standards**

Make the *CAMBHC* readily available to staff by keeping a copy or multiple copies of the print manual in an easily accessible location, such as a resource center or other central location. Let staff and others know that the manual is available and how they can access it.

Although there may be one or more staff members with sole accreditation responsibilities who should read all parts of each chapter in this manual, it is more likely that several individuals or teams will need to know and understand one or more sections or chapters. Therefore, it is important for organizations to make the information readily available to such staff.

The “Requesting Permission to Copy Content from the Manual” section provides contact information and guidelines for purchasing copies of the *CAMBHC* or *Standards for Behavioral Health Care*, requesting permission to make copies of your print manual, or purchasing a site license for the E-dition to make accreditation standards more widely available to staff.

**Use the Standards to Improve Care, Treatment, or Services**

Behavioral health care organizations face a number of complex issues and challenges when caring for individuals served. Table 1 lists some of the most common and challenging issues in behavioral health care organizations, as well as the standards in the *CAMBHC* that help organizations address these topics. Behavioral health care organizations should not view these standards—or any standards in the manual—as rules that must be followed just for Joint Commission survey purposes but should instead incorporate tasks and processes that help integrate these concepts into your daily operations because they directly affect the safety of individuals served and the quality of care, treatment, or services you provide.
Assess Compliance with the Standards

Determine whether your organization is in compliance and how consistently you are performing. This can be accomplished in a number of ways, including the following:

- Create or use a checklist to evaluate compliance for each standard, or turn each standard into a question. For example: Is the agency following its process to determine eligibility for care, treatment, or services? Does my organization have a screening procedure for the early detection of risk of eminent harm to self or others?
- Monitor closely the general Joint Commission website for free tools and resources provided.
- Turn accreditation standards into PowerPoint presentations, handouts, study aids, posters, or other staff education materials. They also can be rewritten as quizzes, tests, or worksheets to determine staff understanding.
- Use the ICM profile and FSA tool on your Joint Commission Connect extranet site to prepare for your initial survey or maintain compliance between surveys (see Figure 3). Contact your account executive for support.
- Compile information on your performance improvement activity for discussion during your on-site survey.
- Form a team to develop creative ways to assess, achieve, and maintain standards compliance, such as the following:
  - Question of the week or month
  - Standards-related posters
  - Column in a weekly all-staff newsletter or electronic bulletin board
- Speak to other accredited program coordinators. To find other accredited programs, go to http://www.qualitycheck.org and search by organization, service/setting, state, city, or zip code.
- Conduct a gap analysis for the activities required by the standards and evaluate your organization against each standard. Identify whether the standard is being (or has been) met or not met.
KEY MILESTONES IN THE ACCREDITATION PROCESS

Joint Commission Activities

- Full on-site survey is conducted using tracer methodology
- Summary of findings left for organization
- Accreditation decision rendered
- Quality Report™ posted on Quality Check®
- On-site FSA survey is scheduled to occur in 2 to 6 months following submission if requested
- SIG conducts TouchPoint conference call with organization (if requested) and reviews and approves POA from FSA (as necessary)
- SIG conducts TouchPoint conference call with organization (if requested) and reviews and approves POA from FSA (as necessary)
- On-site FSA survey is scheduled to occur in 2 to 6 months following submission if requested

Accredited Organization Activities

- On-site survey is scheduled
- Accreditation decision rendered
- Quality Report™ posted on Quality Check®
- On-site FSA survey is scheduled to occur in 2 to 6 months following submission if requested
- Organization completes and submits ESC
- Organization updates and submits E-App for resurvey
- On-site survey is scheduled

*Activities The Joint Commission completes appear above the timeline; activities conducted by the organization appear below the timeline.

FSA, Focused Standards Assessment; SIG, Standards Interpretation Group; POA, Plan of Action; E-App, electronic application; ICM, Intracycle Monitoring; ESC, Evidence of Standards Compliance.
Stimulate Improvement

After a standards assessment has been completed, there likely will be follow-up action needed to bring your organization into compliance. Following are tips to make sure your organization complies with Joint Commission standards and meets the needs of the individuals served for safe, high-quality care.

- Contact your Account Executive with questions about what standards apply to your organization or how to apply Accreditation Participation Requirements (see the “Account Executive” section for contact information).
- Educate key staff on how to access E-dition standards under the “Resources” section on your Joint Commission Connect extranet site. E-dition contains the most current standards in an electronic format.
- Create an online Joint Commission electronic bulletin board on your organization’s internal website to give staff updates about compliance, allow them to check standards, and post questions about the accreditation process.
- Use an internal online discussion board to help staff recognize existing compliance processes and to integrate new processes into everyday work.
- Use the ACC chapter to access accreditation policies and information about what happens before, during, after, and between surveys.
- Take note of any standards you need assistance with, and make an action plan to achieve compliance (see the “Assess Compliance with the Standards” section for more information).
- Seek answers to standards compliance questions online using the Standards Interpretation frequently asked questions (FAQs) at http://www.jointcommission.org/standards_information/jcfaq.aspx.
  - Save the link on your intranet or add it to your favorites list and encourage staff to regularly check the FAQs for behavioral health care or search by keyword.
  - When a FAQ provides helpful information, consider printing it out and inserting a copy of the FAQ in your manual, an accreditation binder, or an online discussion board to help clarify the intended rationale or requirement.
  - If you are unable to find the answer you need, accredited organizations may submit their own question using the online submission process on the FAQ page via your Joint Commission Connect extranet site (see the “Standards Questions” section for more information).
- Use resources and tools provided to all organizations on your Joint Commission Connect extranet site. In addition to E-dition, tools available on the site include the following:
Introduction: How The Joint Commission Can Help You Move Toward High Reliability

- Survey Planning Tools: Helpful information including a survey activity list, documentation list, and survey preparation notes to help you plan for the logistics and operational needs of an on-site survey.
- Survey Activity Guide: A resource to help you prepare for survey, including an abstract of each survey activity with logistical needs, session objectives, an overview of the session, and suggested participants.
- SAFER Matrix™ Information: A collection of resources to provide organizations with information related to the new Survey Analysis for Evaluating Risk™ (SAFER) process.
- Intracycle Monitoring (ICM) Profile: To assist with continuous compliance efforts, this profile identifies high-risk areas and utilizes the FSA tool to identify related standards marked with a risk icon R.
- Leading Practice Library: Real-life solutions that have been successfully implemented by health care organizations and reviewed by Joint Commission standards experts.
- Standards Boosterpaks®: Searchable guides intended to improve the understanding and consistency of standard interpretation by providing detailed information about a single standard or topic area associated with a high volume of inquiries or noncompliance in the health care field (for example, suicide risk).
- Targeted Solutions Tool®: An online application that guides health care organizations through a step-by-step process to accurately measure their organization’s actual performance, identify their barriers to excellent performance, and direct them to proven solutions that are customized to address their particular barriers.
- Standards Interpretation: A landing page that allows organizations to submit questions and view FAQs related to the interpretation of standards.

Keep Current With Standards Changes via Perspectives

It is strongly recommended that each month leadership and staff read Perspectives for the most up-to-date information about changes to standards and policies that are made throughout the year. Doing so allows you to learn about initiatives underway to support your efforts to achieve and sustain performance excellence. The current edition and the previous year of Perspectives are available on your Joint Commission Connect extranet site,
made available to organizations that are accredited or have applied for accreditation. Note the changes because **your organization is responsible for meeting all applicable standards published in *Perspectives*.**

- Check the Joint Commission website (http://www.jointcommission.org/standards_information/bhc_requirements.aspx) regularly for any revisions to behavioral health care standards published in *Perspectives*.
- Sign up for news and alerts, including standards changes, by clicking on “Sign up for News and Alerts” on the Joint Commission home page at http://www.jointcommission.org.
- Use the “What’s New” feature found on the blue navigation bar running along the top of the E-dition or at the front of the print manual to become familiar with changes that occurred since the last E-dition release.
- Check e-Alerts subscriptions on The Joint Commission website for new content or updates. For more information, visit https://www.jointcommission.org/ealerts/. Sign up for or update e-Alerts subscriptions at http://www.jointcommission.org/thickbox/NewsletterSignUp.aspx.

**IV. Get Extra Help**

All behavioral health care organizations—regardless of size and scope of services—are entitled to ask for and receive additional support during the accreditation cycle. The following items provide a broad list of accreditation contacts at The Joint Commission and information and guidelines for maximizing your accreditation resources from Joint Commission Resources.

**Getting Started with Accreditation**

Organizations not yet accredited can call Business Development at 630-792-5771 for information about:

- The benefits of Joint Commission behavioral health care accreditation and optional certification
- Information about obtaining behavioral health care accreditation and optional certification
- Request for initial application
**Account Executive**

Accredited organizations can call their assigned account executive at 630-792-3007 for information or with questions about the following:

- Scheduling of surveys
- Survey agenda or survey process
- Status of an Accreditation Survey Findings Report
- Content of an Accreditation Survey Findings Report
- ESC submission process
- Other survey activities
- Accessing and completing the Focused Standards Assessment

The name and contact information for your assigned account executive can be found on your Joint Commission Connect extranet site.

**Contacting The Joint Commission**

The Joint Commission’s main telephone number is 630-792-5000. The Joint Commission’s business hours are 8:30 A.M. to 5:00 P.M. central time, Monday through Friday.

Additional contact information can be found on The Joint Commission’s website at http://www.jointcommission.org. Access your Joint Commission Connect extranet site at https://customer.jointcommission.org/ (available to accredited organizations or those that have applied for accreditation) for organization-specific and general accreditation information and free resources.

**Standards Questions**

SIG provides answers to frequently asked questions online at https://www.jointcommission.org/standards_information/jcfaq.aspx. If you cannot find an answer to your question, accredited organizations may submit questions using the online submission process on the FAQ page or via your Joint Commission Connect extranet site (under “Resources and Tools”).
Requesting Permission to Copy Content from the Manual

Organizations accredited by The Joint Commission are allowed to make up to 10 copies of the print CAMBHC free of charge by e-mailing a request to permissions@jcrinc.com.

Call the Joint Commission Resources (JRC) Customer Service telephone number at 877-223-6866 (between 8:00 A.M. and 8:00 P.M. eastern time, Monday through Friday) or visit the JCR Store at http://jcrinc.com to purchase helpful compliance resources, including print copies of the manual, books and e-books, software programs, monthly newsletters, custom education, or consulting.
Safety Systems for Individuals Served (SSIS)

Introduction
The quality of care and the safety of individuals served are core values of The Joint Commission accreditation process. This is a commitment The Joint Commission has made to individuals served, patients, and families, as well as behavioral health care practitioners, staff, and organization leaders. This chapter exemplifies that commitment.

The intent of this “Safety Systems for Individuals Served” (SSIS) chapter is to provide behavioral health care organizations with a proactive approach to designing or redesigning services that aim to improve the quality of care and safety for the individual, an approach that aligns with the Joint Commission’s mission and its standards.

The Joint Commission partners with accredited behavioral health care organizations to improve behavioral health care delivery to protect individuals. Therefore, this chapter is focused on the following two guiding principles:

1. Assisting behavioral health care organizations with advancing knowledge, skills, and competence of staff and individuals served by recommending methods that will improve quality and safety processes.
2. Encouraging and recommending proactive quality and safety methods for the individuals served that will increase accountability, trust, and knowledge while reducing the impact of fear and blame.

Quality* and safety are inextricably linked. Quality behavioral health care is the degree to which its processes and results meet or exceed the needs and desires of the individuals it serves.¹ ² Those needs and desires include safety.

To ensure quality and safety in the behavioral health care setting, components of the management system should include the following:

¹ The Institute of Medicine defines quality as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. Source: Committee to Design a Strategy for Quality Review and Assurance in Medicare, Institute of Medicine. Medicare: A Strategy for Quality Assurance, vol. 1. Lohr KN, ed. Washington, DC: The National Academies Press, 1990.
Ensuring reliable processes
Decreasing variation and defects (waste)
Focusing on achieving better outcomes
Using evidence to ensure that a service is satisfactory

Safety of the individual emerges as a central aim of quality. Safety is what individuals served, patients, families, staff, and the public expect from Joint Commission–accredited organizations. While safety events may not be completely eliminated, harm to individuals can be reduced, and the goal is always zero harm. This chapter describes and provides approaches and methods that may be adapted by a behavioral health care organization that aims to increase the reliability of its complex systems while making visible and removing the risk of harm to the individual. Joint Commission–accredited organizations should be continually focused on eliminating system and process failures and human errors that may cause harm to individuals served, patients, families, and staff.\(^1,2\)

The ultimate purpose of The Joint Commission’s accreditation process is to enhance quality of care and safety for individuals served. Each requirement or standard, the survey process, the Sentinel Event Policy, and other Joint Commission initiatives are designed to help organizations reduce variation, reduce risk, and improve quality. Behavioral health care organizations should have an integrated approach to safety so that high levels of safe care can be provided for every individual in every care setting and service.

Behavioral health care organizations are complex environments that depend on strong leadership to support an integrated safety system that includes the following:
- Safety culture
- Validated methods to improve processes and systems
- Standardized ways to communicate and collaborate within their agency or outside of the organization
- Safely integrated technologies

In an integrated safety system, staff and leaders work together to eliminate complacency, promote collective mindfulness, treat each other with respect and compassion, and learn from their safety events, including close calls and other system failures that have not yet led to the harm of an individual.
What Does This Chapter Contain?

“Safety Systems for Individuals Served” (SSIS) chapter is intended to help inform and educate behavioral health care organizations about the importance and structure of an integrated safety system for the individuals they serve. This chapter describes how existing requirements can be applied to achieve improved patient safety; it does not contain any new requirements. It is also intended to help all behavioral health care providers understand the relationship between Joint Commission accreditation and the safety of the individual.

This chapter does the following:

- Describes an integrated safety system that focuses on the individual
- Discusses how behavioral health care organizations can develop into learning organizations
- Explains how organizations can continually evaluate the status and progress of their safety systems
- Describes how organizations can work to prevent or respond to safety events (Sidebar 1 defines key terminology)
- Serves as a framework to guide organization leaders as they work to improve safety for individuals in all behavioral health care settings
- Contains a list of standards and requirements related to safety systems (which will be scored as usual in their original chapters)
- Contains references that were used in the development of this chapter

This chapter refers to a number of Joint Commission standards. Standards cited in this chapter are formatted with the standard number in boldface type (for example, “Standard RI.01.01.01”) and are accompanied by language that summarizes the standard. For the full text of a standard and its element(s) of performance (EP), please see the Appendix.

Sidebar 1. Key Terms to Understand

- **Safety event:** An event, incident, or condition that could have resulted or did result in harm to an individual served or a patient.
- **Adverse event:** A safety event that resulted in harm to an individual served.

†The term “safety event” has been adapted for use in this chapter.
Becoming a Learning Organization

The need for sustainable improvement in the safety and quality of care an individual receives has never been greater. One of the fundamental steps to achieving and sustaining this improvement is to become a learning organization. A learning organization is one in which people learn continuously, thereby enhancing their capabilities to create and innovate. Learning organizations uphold five principles: team learning, shared visions and goals, a shared mental model (that is, similar ways of thinking), individual commitment to lifelong learning, and systems thinking. In a learning organization, safety events are seen as opportunities for learning and improvement. Therefore, leaders in learning organizations adopt a transparent, nonpunitive approach to reporting so that the organization can report to learn and can collectively learn from safety events. In order to become a learning organization, a behavioral health care organization must have a fair and just safety culture, a strong reporting system, and a commitment to put that data to work by driving improvement. Each of these require the support and encouragement of a behavioral health care organization’s executive leaders.

1 For a list of specific safety events that are also considered sentinel events, see page SE-1 in the “Sentinel Events” (SE) chapter of this manual.
Leaders, staff, behavioral health care providers, and individuals served in a learning organization realize that every safety event (from close calls to events that cause major harm to individuals) must be reported. When events that have caused or could have caused harm are continuously reported, experts within the behavioral health care organization can define the problem, identify solutions, achieve sustainable results, and disseminate the changes or lessons learned to the rest of the organization. In a learning organization, the behavioral health care organization provides staff with information regarding improvements based on reported concerns. This helps foster trust that encourages further reporting.

**The Role of Behavioral Health Care Leaders in Safety (of the Individual Served)**

Behavioral health care leaders provide the foundation for an effective safety system for the individual served by doing the following:

- Promoting learning
- Motivating staff to uphold a fair and just safety culture
- Providing a transparent environment in which quality measures and harm to individuals are freely shared with staff
- Modeling professional behavior
- Removing intimidating behavior that might prevent safe behaviors
- Providing the resources and training necessary to take on improvement initiatives

For these reasons, many of the standards that are focused on the behavioral health care organization’s safety system appear in the Joint Commission’s Leadership (LD) standards, including Standard **LD.04.04.05** (which focuses on having an organization-wide, integrated safety program within performance improvement activities).

Without the support of behavioral health care leaders, organizationwide changes and improvement initiatives are difficult to achieve. Leadership engagement in safety and quality initiatives for individuals is imperative because 75% to 80% of all initiatives that require people to change their behaviors fail in the absence of leadership managing the change. Thus, leadership should take on a long-term commitment to transform their organization.
Safety Culture

A strong safety culture is an essential component of a successful safety system and is a crucial starting point for behavioral health care organizations striving to become learning organizations. In a strong safety culture, the organization has an unrelenting commitment to safety and to do no harm. Among the most critical responsibilities of behavioral health care leaders is to establish and maintain a strong safety culture within their organization. The Joint Commission’s standards address safety culture in Standard LD.03.01.01, which requires leaders to create and maintain a culture of safety and quality throughout their behavioral health care organization.

The safety culture of a behavioral health care organization is the product of individually held and group beliefs, values, attitudes, perceptions, competencies, and patterns of behavior that determine the organization’s commitment to quality and safety for individuals. Behavioral health care organizations that have a robust safety culture are characterized by communications founded on mutual trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of preventive measures.11 Organizations will have varying levels of safety culture, but all should be working toward a safety culture that has the following qualities:

- Staff and leaders that value transparency, accountability, and mutual respect.4
- Safety as everyone’s first priority.4
- Behaviors that undermine a culture of safety are not acceptable, and thus should be reported to organizational leadership by individuals served, patients, staff, and families for the purpose of fostering risk reduction.4,10,12
- Collective mindfulness is present, wherein staff realize that systems always have the potential to fail and staff are focused on finding hazardous conditions or close calls at early stages before an individual may be harmed.10 Staff do not view close calls as evidence that the system prevented an error but rather as evidence that the system needs to be further improved to prevent any defects.10,13
- Staff who do not deny or cover up errors but rather want to report errors to learn from mistakes and improve the system flaws that contribute to or enable safety events.6 Staff know that their leaders will focus not on blaming providers involved in errors but on the systems issues that contributed to or enabled the safety event.6,14
- By reporting and learning from safety events, staff create a learning organization.

A safety culture operates effectively when the organization fosters a cycle of trust, reporting, and improvement.10,15 In organizations that have a strong safety culture, behavioral health care providers trust their coworkers and leaders to support them when they identify and report a safety event.10 When trust is established, staff are more likely
to report safety events, and organizations can use these reports to inform their improvement efforts. In the trust-report-improve cycle, leaders foster trust, which enables staff to report, which enables the organization to improve. In turn, staff see that their reporting contributes to actual improvement, which bolsters their trust. Thus, the trust-report-improve cycle reinforces itself. (See Figure 1.)

In the trust-report-improve cycle, trust promotes reporting, which leads to improvement, which in turn fosters trust.

Leaders need to ensure that intimidating or unprofessional behaviors within the behavioral health care organization are addressed, so as not to inhibit anyone inside the organization from reporting safety concerns. Leaders should both educate staff and hold them accountable for professional behavior. This includes the adoption and promotion of a code of conduct that defines acceptable behavior as well as behaviors that undermine a culture of safety. The Joint Commission’s Standard LD.03.01.01, EP 4, requires that leaders develop such a code.

**Figure 1. The Trust-Report-Improve Cycle with Robust Process Improvement® (RPI®)**
Intimidating and disrespectful behaviors disrupt the culture of safety and prevent collaboration, communication, and teamwork, which is required for the safe and highly reliable care of individuals served. Disrespect is not limited to outbursts of anger that humiliate a member of the behavioral health care team; it can manifest in many forms, including the following:

- Inappropriate words (profane, insulting, intimidating, demeaning, humiliating, or abusive language)
- Shaming others for negative outcomes
- Unjustified negative comments or complaints about another provider’s care
- Refusal to comply with known and generally accepted practice standards, the refusal of which may prevent other providers from delivering quality care
- Not working collaboratively or cooperatively with other members of the interdisciplinary team
- Creating rigid or inflexible barriers to requests for assistance or cooperation
- Not returning pages or calls promptly

**A Fair and Just Safety Culture**

A fair and just safety culture is needed for staff to trust that they can report safety events without being treated punitively. In order to accomplish this, behavioral health care organizations should provide and encourage the use of a standardized reporting process for staff to report safety events. This is also built into the Joint Commission’s standards at Standard **LD.04.04.05**, EP 6, which requires leaders to provide and encourage the use of systems for blame-free reporting of a system or process failure or the results of proactive risk assessments. Reporting enables both proactive and reactive risk reduction. *Proactive risk reduction* solves problems before individuals served are harmed, and *reactive risk reduction* attempts to prevent the recurrence of problems that have already caused harm to an individual served.

A fair and just culture takes into account that people are human, fallible, and capable of mistakes, and that they work in systems that are often flawed. In the most basic terms, a fair and just culture holds people accountable for their actions but does not punish them for issues attributed to flawed systems or processes. Refer to Standard **LD.04.01.05**, EP 4, which requires that staff are held accountable for their responsibilities.
It is important to note that for some actions for which a person is accountable, he or she should be held culpable and some disciplinary action may then be necessary. (See Sidebar 2 for a discussion of tools that can help leaders determine a fair and just response to a safety event.) However, staff should never be punished or ostracized for reporting the event, close call, hazardous condition, or concern.

Sidebar 2. Assessing Staff Accountability

The aim of a safety culture is not a “blame-free” culture but one that balances learning with accountability. To achieve this, it is essential that leaders assess errors and patterns of behavior in a manner that is applied consistently, with the goal of eliminating behaviors that undermine a culture of safety. There has to exist within the behavioral health care organization a clear, equitable, and transparent process for recognizing and separating the blameless errors that fallible humans make daily from the unsafe or reckless acts that are blameworthy.¹⁻¹⁰

There are a number of sources for information (some of which are listed immediately below) that provide rationales, tools, and techniques that will assist an organization in creating a formal decision process to determine what events should be considered blameworthy and require individually directed action in addition to systems-level corrective actions. The use of a formal process will reinforce the culture of safety and demonstrate the organization’s commitment to transparency and fairness.

Reaching answers to these questions requires an initial investigation into the safety event to identify contributing factors. The use of the Incident Decision Tree (adapted by the United Kingdom’s National Patient Safety Agency from James Reason’s culpability matrix) or other formal decision process can help make determinations of culpability more transparent and fair.⁵

References
Data Use and Reporting Systems

An effective culture of safety is evidenced by a robust reporting system and use of measurement to improve. When health care organizations adopt a transparent, nonpunitive approach to reports of safety events or other concerns, the behavioral health care organization begins reporting to learn—and to learn collectively from adverse events, close calls, and hazardous conditions. This section focuses on data from reported safety events. Behavioral health care organizations should note that this is but one type of data among many that should be collected and used to drive improvement.

When there is continuous reporting for adverse events, close calls, and hazardous conditions, behavioral health care organizations can analyze the safety events, change the process or system to improve safety, and disseminate the changes or lessons learned to the rest of the organization.  

In addition to those mentioned earlier in this chapter, a number of standards relate to the reporting of safety information, including Performance Improvement (PI) Standard PI.01.01.01, which requires behavioral health care organizations to collect data to monitor their performance, and Standard LD.03.02.01, which requires behavioral health care organizations to use data and information to guide decisions and to understand variation in the performance of processes supporting safety and quality.

Behavioral health care organizations can engage frontline staff in internal reporting in a number of ways, including the following:

- Create a nonpunitive approach to safety event reporting
- Educate staff on identifying safety events that should be reported
- Provide timely feedback regarding actions taken on safety events
Effective Use of Data

Collecting Data
When behavioral health care organizations collect data or measure staff compliance with evidence-based care processes or outcomes for individuals served, they can manage and improve those processes or outcomes and, ultimately, improve safety for individuals.\textsuperscript{25} The effective use of data enables organizations to identify problems, prioritize issues, develop solutions, and track to determine success.\textsuperscript{9} Objective data can be used to support decisions, influence people to change their behaviors, and to encourage compliance with evidence-based care guidelines.\textsuperscript{9,26}

The Joint Commission requires behavioral health care organizations to collect and use data related to outcomes from care, treatment, or services provided to the individuals served, including any sustained harm. Some key Joint Commission standards related to data collection and use require behavioral health care organizations to do the following:

- Collect information to monitor conditions in the environment (Standard EC.04.01.01)
- Identify risks for acquiring and transmitting infections (Standard IC.01.03.01)
- Use data and information to guide decisions and to understand variation in the performance of processes supporting safety and quality (Standard LD.03.02.01)
- Have an organizationwide, integrated safety program within any performance improvement activities (Standard LD.04.04.05)
- Evaluate the effectiveness of the medication management system (Standard MM.08.01.01)
- Report deaths associated with the use of restraint and seclusion (Standard RC.02.01.05)
- Collect data to monitor performance (Standard PI.01.01.01)
- Improve performance on an ongoing basis (Standard PI.03.01.01)

Analyzing Data
Effective data analysis can enable a behavioral health care organization to better assess problems within its systems or organization similar to how providers assess the condition of an individual served based on behaviors, history, and other factors. Turning data into information is a critical competency of a learning organization and of effective management of change. When the right data are collected and appropriate analytic techniques are applied, it enables the behavioral health care organization to monitor the performance of a system, detect variation, and identify opportunities to improve. This
can help the behavioral health care organization not only understand the current performance of organizationwide systems but also can help it predict its performance going forward.  

Analyzing data with tools such as run charts, statistical process control (SPC) charts, and capability charts helps a behavioral health care organization determine what has occurred in a system and provides clues as to why the system responded as it did. Table 1 describes and compares examples of these tools. Please note that several types of SPC charts exist; this discussion focuses on the XmR chart, which is the most commonly used.
### Table 1. Defining and Comparing Analytical Tools

<table>
<thead>
<tr>
<th>Tool</th>
<th>When to Use</th>
<th>Example</th>
</tr>
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| Run Chart\(^1\)          | 1. When the behavioral health care organization needs to identify variation within a system  
2. When the behavioral health care organization needs a simple and straightforward analysis of a system  
3. As a precursor to an SPC chart                                                                                                                                  | ![Run Chart](Image)                                                                                                                                             |
| Statistical Process Control Chart | 1. When the behavioral health care organization needs to identify variation within a system and find indicators of why the variation occurred  
2. When the behavioral health care organization needs a more detailed and in-depth analysis of a system                                                                 | ![Statistical Process Control Chart](Image)                                                                                                                                 |
| Capability Chart\(^2\)   | When the behavioral health care organization needs to determine whether a process will function as expected, according to requirements or specifications                                                                 | ![Capability Chart](Image)                                                                                                                                 |

In the example above, the curve at the top of the chart indicates a process that is only partly capable of meeting requirements. The curve at the bottom of the chart shows a process that is fully capable.
Using Data to Drive Improvement

After data has been turned into information, leadership should ensure the following (in accordance with the requirements shown):\textsuperscript{27–29}

- Information is presented in a clear manner (Standard \textbf{LD.03.04.01}, EP 3)
- Information is shared with the appropriate groups throughout the organization (from the staff to governance) (Standards \textbf{LD.03.04.01}, \textbf{LD.04.04.05})
- Opportunities for improvement and actions to be taken are clearly articulated (Standards \textbf{LD.03.05.01}, EP 4; \textbf{LD.04.04.01})
- Improvements are celebrated or recognized

A Proactive Approach to Preventing Harm

Proactive risk reduction prevents harm before it reaches the individual served. By engaging in proactive risk reduction, a behavioral health care organization can correct process problems in order to reduce the likelihood of experiencing adverse events.

In a proactive risk assessment, the behavioral health care organization evaluates a process to see how it could potentially fail, to understand the consequences of such a failure, and to identify parts of the process that need improvement. A proactive risk assessment increases understanding within the organization about the complexities of process design and management—and what could happen if the process fails.

When conducting a proactive risk assessment, organizations should prioritize high-risk, high-volume areas. Areas of risk are identified from internal sources such as ongoing monitoring of the environment, results of previous proactive risk assessments, from results of data collection activities. Risk assessment tools should be accessed from credible external sources such as a Sentinel Event Alert, nationally recognized risk assessment tools, and peer review literature. Benefits of a proactive approach to the safety of individuals includes increased likelihood of the following:

- Identification of actionable common causes
- Avoidance of unintended consequences
Human errors are typically skills based, decision based, or knowledge based, whereas violations could be either routine or exceptional (intentional or negligent). Routine violations tend to include habitual “bending of the rules,” often enabled by management. A routine violation may break established rules or policies, and yet be a common practice within an organization. An exceptional violation is a willful behavior outside the norm that is not condoned by management, engaged in by others, and not part of the individual’s usual behavior. Source: Diller T, et al. The human factors analysis classification system (HFACS) applied to health care. *Am J Med Qual.* 2014 May–Jun;29(3):181–190.
Sidebar 3. Strategies for an Effective Risk Assessment

Although several methods could be used to conduct a proactive risk assessment, the following steps comprise one approach:

- Describe the chosen process (for example, through the use of a flowchart).
- Identify ways in which the process could break down or fail to perform its desired function, which are often referred to as “failure modes.”
- Identify the possible effects that a breakdown or failure of the process could have on individuals and the seriousness of the possible effects.
- Prioritize the potential process breakdowns or failures.
- Determine why the prioritized breakdowns or failures could occur, which may involve performing a hypothetical root cause analysis.
- Design or redesign the process and/or underlying systems to minimize the risk of the effects on individuals.
- Test and implement the newly designed or redesigned process.
- Monitor the effectiveness of the newly designed or redesigned process.

Tools for Conducting a Proactive Risk Assessment

A number of tools are available to help organizations conduct a proactive risk assessment. One of the best known of these tools is the Failure Modes and Effects Analysis (FMEA). An FMEA is used to prospectively examine how failures could occur during high-risk processes and, ultimately, how to prevent them. The FMEA asks “What if?” to explore what could happen if a failure occurs at particular steps in a process.\(^{31}\)

Behavioral health care organizations have other tools they can consider using in their proactive risk assessment. Some examples include the following:

- Institute for Safe Medication Practices Medication Safety Risk Assessment: This tool is designed to help reduce medication errors (for organizations such as opioid treatment providers). Visit https://www.ismp.org/selfassessments/default.asp for more information.
Potential problem analysis (PPA) is a systematic method for determining what could go wrong in a plan under development. The problem causes are rated according to their likelihood of occurrence and the severity of their consequences. Visit https://healthit.ahrq.gov/health-it-tools-and-resources/evaluation-resources/workflow-assessment-health-it-toolkit/all-workflow-tools for more information.

Process decision program chart (PDPC) provides a systematic means of finding errors with a plan while it is being created. After potential issues are found, preventive measures are developed, allowing the problems to either be avoided or a contingency plan to be in place should the error occur. Visit http://healthit.ahrq.gov/health-it-tools-and-resources/workflow-assessment-health-it-toolkit/all-workflow-tools/process-decision-program-chart.

Encouraging Participation of Individuals Served

To achieve the best outcomes, individuals served and families must be more actively engaged in decisions about their behavioral health care and must have broader access to information and support. Activation of the individual served is inextricably intertwined with the safety of the individual. Activated individuals are less likely to experience harm and unnecessary reassessments. Individuals who are less activated suffer poorer health outcomes and are less likely to follow their provider’s advice.32,33

An approach to care centered on the individual served can help behavioral health care organizations assess and enhance the activation of the individual. Achieving this requires leadership engagement in the effort to establish care centered on the individual as a top priority throughout the behavioral health care organization. This includes adopting the following principles:34

- Safety for the individual guides all decision making.
- Individuals served and families are partners at every level of care.
- Care centered on the individual and family-centered care is verifiable, rewarded, and celebrated.
- The behavioral health care provider responsible for the care of the individual served, or his or her designee, discloses to the individual and the family any unanticipated outcomes of care, treatment, or services.
- Though Joint Commission standards do not require apology, evidence suggests that individuals served benefit—and are less likely to pursue litigation—when behavioral health care providers disclose harm, express sympathy, and apologize.
■ Staffing levels are sufficient, and staff has the necessary tools and skills.
■ The behavioral health care organization has a focus on measurement, learning, and improvement.
■ Staff and behavioral health care providers must be fully engaged in care centered on the individual served and family-centered care as demonstrated by their skills, knowledge, and competence in compassionate communication.

Behavioral health care organizations can adopt a number of strategies to support and improve the activation of individuals served, including promoting culture change, adopting transitional care models, and leveraging health information technology capabilities.34

A number of Joint Commission standards address the rights of the individual served and provide an excellent starting point for behavioral health care organizations seeking to improve the activation of these individuals. These standards require that behavioral health care organizations do the following:

■ Respect, protect, and promote the rights of the individual (Standard RI.01.01.01)
■ Respect the right of the individual served to receive information in a manner he or she understands (Standard RI.01.01.03)
■ Respect the right of the individual to participate in decisions about his or her care, treatment, or services (Standard RI.01.02.01)
■ Honor the right of the individual to give or withhold informed consent (Standard RI.01.03.01)
■ Address decisions about care, treatment, or services received at the end of life with the individual (Standard RI.01.05.01)
■ Inform the individual about his or her responsibilities related to his or her care, treatment, or service (Standard RI.02.01.01)

Beyond Accreditation: The Joint Commission Is Your Safety Partner

To assist behavioral health care organizations on their journey toward creating highly reliable safety systems for individuals, The Joint Commission provides many resources, including the following:

■ Office of Quality and Patient Safety: An internal Joint Commission department that offers behavioral health care organizations guidance and support when they experience a sentinel event. Organizations can call the Sentinel Event Hotline (630-792-3700) to clarify whether a safety event is considered to be a sentinel event (and
therefore reviewable) or to discuss any aspect of the Sentinel Event Policy. The Office of Quality and Patient Safety assesses the thoroughness and credibility of a behavioral health care organization’s comprehensive systematic analysis as well as the action plan to help the organization prevent the hazardous or unsafe conditions from occurring again.

- **Joint Commission Center for Transforming Healthcare**: A Joint Commission not-for-profit affiliate that offers highly effective, durable solutions to some of health care’s most critical safety and quality problems to help behavioral health care organizations transform into high reliability organizations. For specific quality and safety issues the Center’s Targeted Solutions Tool® (TST®) guides behavioral health care organizations through a step-by-step process to measure their organization’s performance, identify barriers to excellence, and direct them to proven solutions. Two important TSTs include hand hygiene and hand-off communications. For more information, visit [http://www.centerfortransforminghealthcare.org](http://www.centerfortransforminghealthcare.org).

- **Standards Interpretation Group**: An internal Joint Commission department that helps organizations with their questions about Joint Commission standards. First, organizations can see if other organizations have asked the same question by accessing the Standards FAQs at [http://www.jointcommission.org/standards_information/jcfaq.aspx](http://www.jointcommission.org/standards_information/jcfaq.aspx). Thereafter, organizations can submit questions about standards to the Standards Interpretation Group by completing an online form at [https://web.jointcommission.org/sigsubmission/sigonlineform.aspx](https://web.jointcommission.org/sigsubmission/sigonlineform.aspx).

- **National Patient Safety Goals**: The Joint Commission’s yearly patient safety requirements based on data obtained from the Joint Commission’s Sentinel Event Database and recommended by a panel of patient safety experts. (For a list of the current National Patient Safety Goals, go to [http://www.jointcommission.org/standards_information/npsgs/](http://www.jointcommission.org/standards_information/npsgs/).

- **Sentinel Event Alert**: The Joint Commission’s periodic alerts with timely information about similar, frequently reported sentinel events, including root causes, applicable Joint Commission requirements, and suggested actions to prevent a particular sentinel event. (For archives of previously published Sentinel Event Alerts, go to [http://www.jointcommission.org/sentinel_event.aspx](http://www.jointcommission.org/sentinel_event.aspx).)

- **Quick Safety**: Quick Safety is a monthly newsletter that outlines an incident, topic, or trend in behavioral health care that could compromise the safety of an individual served. [http://www.jointcommission.org/quick_safety.aspx?archive=y](http://www.jointcommission.org/quick_safety.aspx?archive=y).
Joint Commission Resources: A Joint Commission affiliate that produces books and periodicals, holds conferences, provides consulting services, and develops software products (including AMP®, Tracers with AMP®, E-dition®, ECM Plus®, and CMSAccess®) for accreditation and survey readiness. (For more information, visit http://www.jcrinc.com.)

Webinars and podcasts: The Joint Commission and its affiliate, Joint Commission Resources, offer free webinars and podcasts on various accreditation and safety topics.

Speak Up™ program: The Joint Commission’s campaign to educate individuals served and patients about behavioral health care processes and potential safety issues and encourage them to speak up whenever they have questions or concerns about their safety. (For more information and education resources, go to http://www.jointcommission.org/speakup.)

Standards BoosterPaks™: Available for accredited or certified organizations through The Joint Commission Connect, organizations can access BoosterPaks that provide detailed information about a single standard or topic area that has been associated with a high volume of inquiries or noncompliance scores. Recent standards BoosterPak topics have included credentialing and privileging in nonhospital settings, waived testing, restraint and seclusion, management of hazardous waste, environment of care (including Standards EC.04.01.01, EC.04.01.03, and EC.04.01.05), and sample collection.

Leading Practice Library: Available for accredited or certified organizations through The Joint Commission Connect, organizations can access an online library of solutions to help improve safety. The searchable documents in the library are actual solutions that have been successfully implemented by behavioral health care organizations and reviewed by Joint Commission standards experts.

Joint Commission web portals: Through the Joint Commission website, organizations can access web portals with a repository of resources from The Joint Commission, the Joint Commission Center for Transforming Healthcare, Joint Commission Resources, and Joint Commission International on the following topics:

- Emergency management: http://www.jointcommission.org/emergency_management.aspx
Workplace violence prevention resources: https://www.jointcommission.org/workplace_violence.aspx

References


**Appendix. Key Safety Systems Requirements**

A number of Joint Commission standards have been discussed in the “Safety Systems for Individuals Served” (SSIS) chapter. However, many Joint Commission requirements address issues related to the design and management of safety systems, including the following examples.

**Environment of Care (EC)**

**Standard EC.04.01.01**
The organization collects information to monitor conditions in the environment.

**Elements of Performance for EC.04.01.01**

1. The organization establishes a process(es) for continually monitoring, internally reporting, and investigating the following:
   - Injuries to individuals served or others within the organization’s facilities
   - Occupational illnesses and staff injuries
Incidents of damage to its property or the property of others in locations it controls

Security incidents involving individuals served, staff, or others in locations it controls

Fire safety management problems, deficiencies, and failures

**Note 1:** All the incidents and issues listed above may be reported to staff in quality assessment, improvement, or other functions. A summary of such incidents may also be shared with the person designated to coordinate safety management activities.

**Note 2:** Review of incident reports often requires that legal processes be followed to preserve confidentiality. Opportunities to improve care, treatment, or services, or to prevent similar incidents, are not lost as a result of following the legal process.

Based on its process(es), the organization reports and investigates the following:

2. Problems and incidents related to each of the environment of care management plans.

3. Injuries to individuals served or others within the organization’s facilities.

4. Occupational illnesses and staff injuries.

**Note:** This requirement applies to issues in the workplace, such as back injuries or allergies. It does not apply to communicable diseases.

5. Incidents of damage to its property or the property of others in locations it controls.

14. The organization monitors environmental deficiencies, hazards, and unsafe practices.

15. Every 12 months, the organization evaluates each environment of care management plan, including a review of the plan’s objectives, scope, performance, and effectiveness.

**Note:** By evaluating the management plans, the organization can make sure that they remain relevant and useful guides for managing the environment of care. A review of the plans’ scope includes a determination of whether any new services, programs, or sites added in the past year need to be addressed by the plans or if new hazards have been introduced into the environment that now need to be covered. A review of the plans’ effectiveness could be accomplished through a review of incident reports as well as evaluation of other known problems that are not found on the incident reports.
(such as problems identified in the critique of a fire drill). A review of the plans’ objectives would include a determination of whether the previous year’s objectives were met and if any new objectives should be established to address problems identified in the review of the plans’ effectiveness.

**Standard EC.04.01.03**
The organization analyzes identified environment of care issues.

**Element of Performance for EC.04.01.03**
2. The organization uses the results of data analysis to identify opportunities to resolve environmental safety issues.

**Standard EC.04.01.05**
The organization improves its environment of care.

**Element of Performance for EC.04.01.05**
1. The organization takes action on the identified opportunities to resolve environmental safety issues.

**Infection Prevention and Control (IC)**

**Standard IC.01.03.01**
The organization identifies risks for acquiring and spreading infections.

**Elements of Performance for IC.01.03.01**
1. The organization identifies infection risks based on the following:
   - Its setting and population served
   - The care, treatment, or services it provides
   - For 24-hour care settings: Its monitoring of infection prevention and control activities and/or tracking and analyzing the occurrence of infections

**Note 1:** The infections that should be tracked are those that are most relevant to the organization’s setting, services, and population(s). The organization may contact its local health department for statistics and other information on some infections, and track other infections internally. For example, an organization may decide to track conjunctivitis itself but rely on health department statistics related to tuberculosis.
Note 2: The risk of infection will vary across behavioral health care settings. For example, infection risks in group homes, day treatment programs, and couples counseling will vary by hours of contact, number of individuals served, and location and type of service.

3. The organization establishes priorities among the risks it identified. The organization documents priority risk(s).

Leadership (LD)

Standard LD.03.01.01
Leaders create and maintain a culture of safety and quality throughout the organization.

Elements of Performance for LD.03.01.01
1. Leaders regularly evaluate the culture of safety and quality.
2. Leaders prioritize and implement changes identified by the evaluation.
4. Leaders develop a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety.
5. Leaders create and implement a process for managing behaviors that undermine a culture of safety.
8. All who work in the organization are able to openly discuss issues of safety and quality. (See also LD.04.04.05, EP 6)

Standard LD.03.02.01
The organization uses data and information to guide decisions and to understand variation in the performance of processes supporting safety and quality.

Elements of Performance for LD.03.02.01
1. Leaders set expectations for using data and information to improve the safety and quality of care, treatment, or services.
2. Leaders are able to describe how data and information are used to create a culture of safety and quality.
3. The organization uses processes to support systematic data and information use.
4. Leaders provide the resources needed for data and information use, including staff, equipment, and information systems.

5. The organization uses data and information in decision making that supports the safety and quality of care, treatment, or services. *(See also PI.02.01.01, EP 8)*

6. The organization uses data and information to identify and respond to internal and external changes in the environment.

7. Leaders evaluate how effectively data and information are used throughout the organization.

**Standard LD.03.04.01**
The organization communicates information related to safety and quality to those who need it, including staff, individuals served, families, and external interested parties.

**Elements of Performance for LD.03.04.01**

1. Communication processes foster the safety of the individual served and the quality of care.

2. Leaders are able to describe how communication supports a culture of safety and quality.

3. Communication is designed to meet the needs of internal and external users.

4. Leaders provide the resources required for communication, based on the needs of individuals served, staff, and administration.

5. Communication supports safety and quality throughout the organization. *(See also LD.04.04.05, EPs 6 and 12)*

6. When changes in the environment occur, the organization communicates those changes effectively.

7. Leaders evaluate the effectiveness of communication methods.
Standard LD.03.05.01
Leaders implement changes in existing processes to improve the performance of the organization.

Elements of Performance for LD.03.05.01
4. Leaders provide the resources required for performance improvement and change management, including sufficient staff, access to information, and training.

Standard LD.04.01.05
The organization effectively manages its programs or services.

Elements of Performance for LD.04.01.05
4. Staff are held accountable for their responsibilities.

Standard LD.04.04.01
Leaders establish priorities for performance improvement. (Refer to the “Performance Improvement” [PI] chapter.)

Elements of Performance for LD.04.04.01
1. Leaders set priorities for performance improvement activities and behavioral health outcomes. (See also PI.01.01.01, EPs 1 and 3)
2. Leaders give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities. (See also PI.01.01.01, EPs 14, 15, and 27)
3. Leaders reprioritize performance improvement activities in response to changes in the internal or external environment.
4. Performance improvement occurs organizationwide.

24. For organizations that elect The Joint Commission Behavioral Health Home option: Leaders set priorities for physical health care performance improvement activities and outcomes. (See also PI.01.01.01, EP 40)

Note: As an example, activities and outcomes may be related to individuals with multiple chronic physical health conditions.

25. For organizations that elect The Joint Commission Behavioral Health Home option: Leaders involve individuals served in performance improvement activities related to integrated care.
Note: This involvement may include activities such as participating on a quality committee or providing feedback on safety and quality issues.

Standard LD.04.04.05
The organization has an organizationwide, integrated safety program for individuals served.

Elements of Performance for LD.04.04.05

1. The leaders implement an organizationwide safety program for individuals served.

2. One or more qualified persons manage the safety program.

3. The scope of the safety program includes the full range of safety issues, from potential or no-harm errors (sometimes referred to as close calls [“near misses”] or good catches) to hazardous conditions and sentinel events.

4. All programs and services within the organization participate in the safety program.

5. As part of the safety program, the leaders create procedures for responding to system or process failures.

   Note 1: Responses might include continuing to provide care, treatment, or services to those affected, containing the risk to others, and preserving factual information for subsequent analysis.

   Note 2: For opioid treatment programs: Examples of reportable patient deaths include the following:
   - Drug-related deaths
   - Methadone or buprenorphine deaths
   - Unexpected or suspicious deaths
   - Treatment-context deaths that raise individual, family, community, or public concern

6. The leaders provide and encourage the use of systems for blame-free internal reporting of a system or process failure, or the results of a proactive risk assessment. (See also LD.03.01.01, EP 8; LD.03.04.01, EP 5; LD.04.04.03, EP 3)
Note: This EP is intended to minimize staff reluctance to report errors in order to help an organization understand the source and results of system and process failures. The EP does not conflict with holding individuals accountable for their blameworthy errors.

7. The leaders define patient safety event and communicate this definition throughout the organization.

Note: At a minimum, the organization’s definition includes those events subject to review in the “Sentinel Events” (SE) chapter of this manual. The definition may include any process variation that does not affect the outcome or result in an adverse event, but for which a recurrence carries significant chance of resulting in a serious adverse outcome or an adverse event, often referred to as a close call or near miss.

8. The organization conducts thorough and credible comprehensive systematic analyses (for example, root cause analyses) in response to sentinel events as described in the “Sentinel Events” (SE) chapter of this manual.

9. The leaders make support systems available for staff who have been involved in an adverse or sentinel event.

Note: Support systems recognize that conscientious health care workers who are involved in sentinel events are themselves victims of the event and require support. Support systems provide staff with additional help and support as well as additional resources through the human resources function or an employee assistance program. Support systems also focus on the process rather than blaming the involved persons.

11. To improve safety, the organization analyzes and uses information about system or process failures and, when conducted, the results of proactive risk assessments. (See also LD.04.04.03, EP 3)

12. The leaders disseminate lessons learned from comprehensive systematic analyses (for example, root cause analyses), system or process failures, and the results of proactive risk assessments to all staff who provide services for the specific situation. (See also LD.03.04.01, EP 5)

13. At least once a year, the leaders provide governance with written reports on the following:
   - All system or process failures
   - The number and type of sentinel events
   - Whether the individuals served and the families were informed of the event
All actions taken to improve safety, both proactively and in response to actual occurrences

14. The leaders encourage external reporting of significant adverse events, including voluntary reporting programs in addition to mandatory programs.

**Note:** Examples of voluntary programs include The Joint Commission Sentinel Event Database and the US Food and Drug Administration (FDA) MedWatch. Mandatory programs are often state initiated.

### Medication Management (MM)

**Standard MM.08.01.01**

The organization evaluates the effectiveness of its medication management system.

**Note 1:** This evaluation includes reconciling medication information. (Refer to NPSG.03.06.01 for more information)

**Note 2:** This standard is applicable only to organizations that prescribe, dispense, or administer medications.

### Elements of Performance for MM.08.01.01

1. **For organizations that prescribe, dispense, or administer medications:** The organization collects data on the performance of its medication management system. *(See also PI.01.01.01, EPs 14 and 15)*

   **Note:** This element of performance is also applicable to sample medications.

2. **For organizations that prescribe, dispense, or administer medications:** The organization analyzes data on its medication management system.

   **Note:** This element of performance is also applicable to sample medications.

3. **For organizations that prescribe, dispense, or administer medications:** The organization compares data over time to identify risk points, levels of performance, patterns, trends, and variations of its medication management system.

   **Note:** This element of performance is also applicable to sample medications.
5. **For organizations that prescribe, dispense, or administer medications:** Based on analysis of its data, the organization identifies opportunities for improvement in its medication management system. 

6. **For organizations that prescribe, dispense, or administer medications:** The organization takes action on improvement opportunities identified as priorities for its medication management system. (*See also* PI.03.01.01, EP 2) 

   **Note:** This element of performance is also applicable to sample medications.

7. **For organizations that prescribe, dispense, or administer medications:** The organization evaluates its actions to confirm that they resulted in improvements for its medication management system. 

8. **For organizations that prescribe, dispense, or administer medications:** The organization takes additional action when planned improvements for its medication management processes are either not achieved or not sustained. 

16. When automatic dispensing cabinets (ADCs) are used, the organization has a policy that describes the types of medication overrides that will be reviewed for appropriateness and the frequency of the reviews. A 100% review of overrides is not required.

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**Performance Improvement (PI)**

**Standard PI.01.01.01**
The organization collects data to monitor its performance.

**Elements of Performance for PI.01.01.01**

1. The leaders set priorities for data collection. (*See also* LD.04.04.01, EP 1)
2. The organization identifies the frequency for data collection.

The organization collects data on the following:

3. Performance improvement priorities identified by leaders. (*See also* LD.04.04.01, EP 1)

14. Significant medication errors. (*See also* LD.04.04.01, EP 2; MM.08.01.01, EP 1)
15. Significant adverse medication reactions. (See also LD.04.04.01, EP 2; MM.08.01.01, EP 1)

16. The organization collects data on the following:
   - Whether the individual served was asked about treatment goals and needs
   - Whether the individual served was asked if his or her treatment goals and needs were met
   - The view of the individual served regarding how the organization can improve the safety of the care, treatment, or services provided

   (See also RI.01.01.01, EP 17, for opioid treatment programs)

27. The organization collects data to measure the performance of high-risk, high-volume, problem-prone processes provided to high-risk or vulnerable populations, as defined by the organization. (See also LD.04.04.01, EP 2)

   **Note:** Examples of such processes include the use of restraints, seclusion, suicide watch, and behavior management and treatment.

31. **For foster care:** The agency collects data on its performance, including the safety of the placement and the maintenance or improvement of the individual’s level of functioning.

32. **For foster care:** The agency collects data on the permanency of the placement and the permanency of outcome when they are within the organization’s scope of services.

37. **For opioid treatment programs:** The program collects data about treatment outcomes and processes.

   **Note:** Examples of data collected include the following:
   - Use of illicit opioids, illegal drugs, and the problematic use of alcohol and prescription medications
   - Criminal activities and entry into the criminal justice system
   - Behaviors contributing to the spread of infectious diseases
   - Restoration of physical and mental health and functional status
   - Retention in treatment
   - Number of patients who are employed
   - Abstinence from drugs of abuse

   **For organizations that elect The Joint Commission Behavioral Health Home option:**
   The organization collects data on the following:
40. Disease management outcomes. (See also LD.04.04.01, EP 24)

41. The individual’s access to care within time frames established by the organization.

42. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization collects data on the following:
   - The individual’s experience and satisfaction related to access to care, treatment, or services and communication
   - The individual’s perception of the comprehensiveness of care, treatment, or services
   - The individual’s perception of the coordination of care, treatment, or services
   - The individual’s perception of the continuity of care, treatment, or services

   (Refer to PI.01.01.01, EP 16)

43. **For organizations that elect The Joint Commission Behavioral Health Home option:** All staff who are part of the behavioral health home actively participate in performance improvement activities.

48. **For organizations that provide eating disorders care, treatment, or services:** The organization collects data about care, treatment, or services outcomes. Examples of such data include the following:
   - If conducting follow-ups, confirmation of whether the individual is engaged in aftercare services and, if so, the type and frequency of those services.
   - Data collected from valid and reliable instruments used at admission and discharge that are self-administered by individuals served. Examples of such instruments include the Beck Depression Inventory (BDI), Eating Disorder Quality of Life (EDQOL), the SF-36, and Eating Disorder Inventory-3 (EDI-3).
   - Data collected from individuals’ satisfaction questionnaires.

**Standard PI.03.01.01**

The organization improves performance.

**Elements of Performance for PI.03.01.01**

2. The organization takes action on improvement priorities. (See also MM.08.01.01, EP 6)
4. The organization takes action when it does not achieve or sustain planned improvements.

11. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization uses the data it collects on the individual’s perception of the safety and quality of care, treatment, or services to improve its performance. This data includes the following:
   - The individual’s experience and satisfaction related to access to care, treatment, or services and communication
   - The individual’s perception of the comprehensiveness of care, treatment, or services
   - The individual’s perception of the coordination of care, treatment, or services
   - The individual’s perception of the continuity of care, treatment, or services

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**Record of Care, Treatment, and Services (RC)**

**Standard RC.02.01.05**

The clinical/case record contains documentation of the use of restraint and/or seclusion and documentation of physical holding of a child or youth.

**Elements of Performance for RC.02.01.05**

3. The organization documents the use of restraint and/or seclusion for behavioral health purposes in the clinical/case record, including the following:
   - Each episode of restraint and/or seclusion
   - The circumstances that led to the use of restraint and/or seclusion
   - Consideration or failure of nonphysical interventions
   - The rationale for the type of physical intervention used
   - Written orders for the use of restraint and/or seclusion
   - Each verbal order received from a licensed independent practitioner
   - Each in-person evaluation and reevaluation of the individual served
   - Each 15-minute assessment of the status of the individual served
   - Continuous monitoring of the individual served
   - Any preexisting medical conditions or any physical disabilities that would place the individual served at greater risk during restraint and/or seclusion
   - Any history of sexual or physical abuse that would place the individual at greater psychological risk during restraint and/or seclusion
That the individual served and/or his or her family was informed of the organization’s policy on the use of behavioral restraint and/or seclusion

That the individual served was notified of the use of restraint and/or seclusion

Behavior criteria for discontinuing restraint and/or seclusion

That the individual served was informed of the behavior criteria he or she needed to meet in order for restraint and/or seclusion to be discontinued

Assistance provided to the individual served to help him or her meet the behavior criteria for discontinuing the use of restraint and/or seclusion

Debriefing the individual served with staff following an episode of restraint and/or seclusion

Any injuries the individual served sustained and the treatment for these injuries

The death of the individual served while in restraint or seclusion

4. The method(s) used to document restraint and/or seclusion facilitates the collection and analysis of data for performance improvement activities.

5. The organization documents the use of physical holding of a child or youth for behavioral health purposes in the clinical/case record, including the following:

- Each episode of physical holding
- The circumstances that led to the use of physical holding
- Attempt at or failure of nonphysical interventions
- The rationale for the use of physical holding
- Names of the staff members who participated in the use of physical holding, including who did the holding and who observed the child’s or youth’s physical well-being
- Any preexisting medical conditions or any physical disabilities that would place the individual served at greater risk during physical holding
- Any history of sexual or physical abuse or other trauma that would place the individual at greater psychological risk during physical holding
- That the individual served and/or his or her family was informed of the organization’s policy on the use of physical holding
- That the individual’s parent(s) or guardian was notified of the use of physical holding
- Behavior criteria for discontinuing physical holding
- That the individual served was informed of the behavior criteria he or she needed to meet in order for physical holding to be discontinued
- Assistance provided to the individual served to help him or her meet the behavior criteria for discontinuing the use of physical holding
- Debriefing the individual served with staff following an episode of physical holding
- Any injuries the individual served sustained and the treatment for these injuries
- The death of the individual served while in a physical hold

6. The method(s) used to document physical holding facilitates the collection and analysis of data for performance improvement activities.

**Rights and Responsibilities of the Individual (RI)**

**Standard RI.01.01.01**
The organization respects the rights of the individual served.

**Elements of Performance for RI.01.01.01**

1. © The organization has written policies on the rights of the individual served.
2. The organization informs the individual served of his or her rights. *(See also RI.01.01.03, EPs 1–3)*
3. If an individual served is disoriented or lacks capacity to understand rights at the time of entry, he or she is informed again when he or she is able to understand.
4. The organization treats the individual served in a respectful manner that supports his or her dignity.
5. The organization respects the cultural and personal values, beliefs, and preferences of the individual served.
6. The organization respects the right of the individual served to privacy. *(See also IM.02.01.01, EPs 1–4)*

**Note:** *This element of performance (EP) addresses the personal privacy of the individual served. For EPs addressing security and safety, please see EC.02.01.01, EP 3 and EC.02.06.01, EP 1. For EPs addressing the privacy of health information, please refer to Standard IM.02.01.01.*
9. In 24-hour settings, the organization accommodates the right of the individual to pastoral and other spiritual services.

**Note:** The spiritual services of individuals are varied and may take place in the setting or outside of the setting, and may require special considerations regarding scheduling, space, or other accommodations. Within its capabilities, the organization accommodates this right.

10. In accordance with law and regulation, the organization allows the individual served to access and request amendment to his or her health information and to obtain information on disclosures of this information.

14. **For opioid treatment programs:** The program reviews rights and responsibilities with the patient at admission, at the end of the stabilization period, and when any changes have been made to the list of rights and responsibilities.

15. **For opioid treatment programs:** The program treats women respectfully and safely.

16. **For opioid treatment programs:** The medication schedule (dosing times/program hours) is the least intrusive and disruptive schedule for the majority of patients.

17. **For opioid treatment programs:** Satisfaction surveys allow patients to provide feedback on program policies and services. *(See also PI.01.01.01, EP 16)*

18. In 24-hour settings, individuals served are informed about the organization’s policies and procedures regarding the handling of medical emergencies. *(See also RI.01.02.01, EP 2)*

20. **For opioid treatment programs:** The program obtains written acknowledgement from patients that they received a copy of their rights and that these rights were discussed with them.

22. The organization informs the individual served of the program rules.

24. **For opioid treatment programs:** The program informs patients about the financial aspects of treatment, including the consequence of nonpayment of fees.

25. **For opioid treatment programs:** The program posts patients’ rights and responsibilities at the treatment site in a manner that makes the posting visible to patients.
26. **For opioid treatment programs:** The program informs patients upon admission about its obligation under state-specific requirements and its own policies and procedures to report suspected child abuse and neglect and other forms of abuse (such as violence against women).

30. **For organizations that provide 24-hour eating disorders care, treatment, or services:** The organization has a policy addressing those situations, if any, in which minors are permitted to leave the facility.

31. **For organizations that provide 24-hour eating disorders care, treatment, or services:** The organization obtains consent from a minor’s parent or guardian for the minor to have visitors.

32. **For organizations that provide 24-hour eating disorders care, treatment, or services:** The organization has a policy on Internet access for individuals served.

**Standard RI.01.01.03**

The organization respects the right of the individual served to receive information in a manner he or she understands.

**Elements of Performance for RI.01.01.03**

1. The organization provides information to the individual served in a manner tailored to his or her language and ability to understand. (*See also* CTS.06.02.03, EP 9; RI.01.01.01, EP 2)

2. The organization provides interpreting and translation services, as necessary. (*See also* RI.01.01.01, EP 2)

**Note:** *For organizations that elect The Joint Commission Behavioral Health Home option:* Language interpreting options may include trained bilingual staff, contract interpreting services, or employed language interpreters. These options may be provided in person or via telephone or video. The documents that are translated, and the languages into which they are translated, are dependent on the population(s) served by the organization.

3. The organization communicates with the individual served who has vision, speech, hearing, or cognitive impairments in a manner that meets the needs of that individual. (*See also* RI.01.01.01, EP 2)
Standard  RI.01.02.01
The organization respects the right of the individual served to collaborate in decisions about his or her care, treatment, or services.

Elements of Performance for RI.01.02.01

1. The organization involves the individual served in making decisions about his or her care, treatment, or services.
   
   Note: This involvement goes beyond mere presence at the time of discussion or decision making. Involvement connotes a collaborative process in which the organization actively engages the individual served in decision making regarding his or her care, treatment, or services.

2. When an individual served is unable to make decisions about his or her care, treatment, or services, or chooses to delegate decision making to another, the organization involves the surrogate decision maker in making these decisions. (See also RI.01.03.01, EP 1; RI.01.01.01, EP 18)

4. The organization respects the right of the individual served or surrogate decision maker to refuse care, treatment, or services, in accordance with law and regulation.

5. When an individual refuses care, treatment, or services, the organization fully informs the individual about its responsibility, in accordance with professional standards, to terminate the relationship with the individual upon reasonable notice, or to seek orders for involuntary treatment or other legal alternatives.

8. The individual served has the right to involve his or her family in decisions about care, treatment, or services. When there is a surrogate decision-maker, he or she can exercise the right to involve the family on behalf of the individual served, in accordance with law and regulation. (See also RI.01.07.01, EP 2; CTS.04.02.16, EP 5)

9. The organization accommodates the right of the individual served to request the opinion of a consultant.
   
   Note: This element of performance does not require the organization to pay for consultant services.

10. The organization accommodates the right of the individual served to request an internal review of his or her plan of care, treatment, or services.
11. The organization has a process for resolving disagreements about therapeutic issues.

20. The organization provides the individual served or surrogate decision-maker with the information about the following:
   - Outcomes of care, treatment, or services that the individual needs in order to participate in current and future behavioral health care decisions
   - Unanticipated events related to the individual’s care, treatment, or services that are sentinel events as defined by The Joint Commission (Refer to the Glossary for a definition of sentinel event.)

28. **For opioid treatment programs:** The program allows for patient choice in seeking alternative therapies and provides support to patients who choose to explore these alternatives.

   **Note:** Programs may provide culturally appropriate or popular and nonharmful alternative therapies, such as acupuncture or providing a space for a sweat lodge.

31. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization provides the individual served or surrogate decision-maker with the information about the outcomes of care, treatment, or services that the individual needs in order to participate in current and future physical health care decisions.

32. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization respects the individual’s right to make decisions about the management of his or her care, treatment, or services.

33. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization respects the individual’s right and provides him or her the opportunity to do the following:
   - Obtain care from other clinicians of the individual’s choosing within the behavioral health home
   - Seek a second opinion from a clinician of the individual’s choosing
   - Seek specialty care

   **Note:** *This element of performance does not imply financial responsibility on the part of the organization for any activities associated with these rights.*
34. **For opioid treatment programs:** The program provides the patient with information about providers in the community who are able to address any of the patient’s needs that the program cannot meet.

35. **For opioid treatment programs:** The program provides the patient with information about providers in the community should the patient be dissatisfied with the services received from the program.

**Standard RI.01.03.01**

The organization honors the right of the individual served to give or withhold informed consent.

**Elements of Performance for RI.01.03.01**

1. ⬜️ The organization follows a written policy on informed consent that describes the following:
   - The specific care, treatment, or services that require informed consent
   - Circumstances that would allow for exceptions to obtaining informed consent, such as situations involving threat of harm to self or others, child abuse, or elder abuse
   - When a surrogate decision-maker may give informed consent (See also RI.01.02.01, EP 2)

2. The informed consent process includes a discussion about the following:
   - The proposed care, treatment, or services for the individual served.
   - The goals and potential benefits and risks of the proposed care, treatment, or services.
   - Reasonable alternatives to the individual’s proposed care, treatment, or services. The discussion encompasses risks and benefits related to the alternatives and the risks related to not receiving the proposed care, treatment, or services.

3. ⬜️ The organization obtains and documents informed consent in advance if it makes and uses recordings, films, or other images of individuals served for internal use other than the identification, diagnosis, or treatment of the individual (for example, performance improvement and education). This informed consent includes an explanation of how the recordings, films, or other images will be used.
Note 1: The term “recordings, films, or other images” refers to photographic, video, digital, electronic, or audio media.

Note 2: This element of performance does not apply to the use of security cameras.

16. **For opioid treatment programs:** Before administering medication, the program obtains voluntary, written, informed consent from the patient for the prescribed medication-assisted treatment. The program’s informed consent policy makes certain that each patient voluntarily chooses maintenance treatment and that all relevant facts concerning the use of the opioid drug are clearly and adequately explained to the patient. Within 30 days post-admission, an appropriate program staff member reviews all relevant facts concerning the use of the opioid drug with the patient.

17. **For opioid treatment programs:** The program informs patients that the goal of medication-assisted treatment is to stabilize functioning.

18. **For opioid treatment programs:** The program informs patients that the provider will periodically discuss with them their present level of functioning, course of treatment, and future goals.

   **Note:** These discussions are not intended to place pressure on the patient to either withdraw from medication or remain on medication maintenance.

19. **For opioid treatment programs:** Patients are informed about their disease’s natural progression, including statistics about success after withdrawing from methadone.

20. **For opioid treatment programs:** The program informs patients about potential medication interactions with and adverse reactions to other substances, including those related to the use of alcohol, licit and illicit drugs, other prescribed or over-the-counter pharmacological agents, other medical procedures, and food.

   **Note:** The program should provide the patient with information about potential medication interactions throughout the course of care, treatment, or services, such as at the time of the treatment plan review and at the time there are changes to the patient’s medication dose.

21. **For opioid treatment programs:** The program informs all pregnant patients with concurrent HIV infection that HIV medication treatment is currently recommended to reduce perinatal transmission, and it provides pregnant patients with appropriate referrals and case management for this treatment.
Standard RI.01.05.01
For organizations that elect The Joint Commission Behavioral Health Home option:
The organization addresses decisions made by the individual served about physical
health care, treatment, or services received at the end of life. (For more information,
refer to Standard CTS.01.04.01.)

Elements of Performance for RI.01.05.01
1. For organizations that elect The Joint Commission Behavioral Health Home
   option: The organization follows a written policy on physical health advance
directives that address the following:
   - Whether the organization will honor physical health advance directives
   - Communicating its policy on physical health advance directives to the
     individuals it serves
   - For organizations that elect The Joint Commission Behavioral Health Home
     option: Informing all members of the integrated care team when an
     individual served has a physical health advance directive, and how to access it

10. For organizations that elect The Joint Commission Behavioral Health Home
    option: Upon request, the organization shares with the individual possible
        sources of help in formulating physical health advance directives.

Standard RI.02.01.01
The organization informs the individual served about his or her responsibilities related
to his or her care, treatment, or services.

Elements of Performance for RI.02.01.01
2. The organization informs the individual served about his or her responsibilities.
   
   **Note:** Information about the individual’s responsibilities can be shared verbally, in
   writing, or both.

3. For opioid treatment programs: The program obtains written acknowledgement
   from the patient that patient responsibilities were explained.
Accreditation Participation Requirements (APR)

Overview
This chapter consists of specific requirements for participation in the accreditation process and for maintaining an accreditation award.

For an organization seeking accreditation for the first time, compliance with most of the Accreditation Participation Requirements (APR) is assessed during the initial survey, including the Early Survey Policy Option. Please note that APR.09.01.01 and APR.09.02.01 are not assessed during the initial survey. For the accredited organization, compliance with the APRs is assessed throughout the accreditation cycle through on-site surveys, the Focused Standards Assessment (FSA), Evidence of Standards Compliance (ESC), and periodic updates of organization-specific data and information. Organizations are either compliant or not compliant with the APR. When an organization does not comply with an APR, the organization will be assigned a Requirement for Improvement (RFI) in the same context that noncompliance with a standard or element of performance generates an RFI. However, refusal to permit performance of a survey (APR.02.01.01) will lead to a denial of accreditation. Falsification of information (APR.01.02.01) will lead to preliminary denial of accreditation. All RFIs can impact the accreditation decision and follow-up requirements, as determined by established accreditation decision rules. Failure to resolve an RFI can ultimately lead to loss of accreditation.
Chapter Outline

I. Submission of Information to The Joint Commission
   A. Timely Submission of Information (APR.01.01.01)
   B. Accuracy of Information (APR.01.02.01)
   C. Changes in Information (APR.01.03.01)

II. Performance of Survey
   A. Performance of Survey at The Joint Commission’s Discretion (APR.02.01.01)

III. Focused Standards Assessment (FSA)
   A. Participating in the Focused Standards Assessment (APR.03.01.01)

IV. Performance Measurement — Not applicable to behavioral health care

V. External Evaluations
   A. Sharing Results of External Evaluations with The Joint Commission (APR.05.01.01)

VI. Accreditation-Related Consulting Services
   A. Prohibiting Use of Joint Commission Employees (APR.06.01.01)

VII. Survey Observations
   A. Joint Commission Management and Leadership Observing Surveys (APR.07.01.01)

VIII. Representation of Accreditation Status
   A. Accurately Representing Accreditation Status (APR.08.01.01)

IX. Reporting of Safety and Quality Concerns
   A. Notifying the Public about Reporting Safety and Quality Concerns (APR.09.01.01)
   B. Notifying Individuals Who Provide Care, Treatment, or Services about Reporting Safety and Quality Concerns (APR.09.02.01)
   C. Adhering to Joint Commission Guidelines for Describing Information in the Quality Report (APR.09.03.01)
   D. Providing Care, Treatment, Services, and an Environment That Pose No Risk of an Immediate Threat to Health or Safety (APR.09.04.01)
Requirements, Rationales, and Elements of Performance

APR.01.01.01
The organization submits information to The Joint Commission as required.

Element of Performance for APR.01.01.01

1. The organization meets all requirements for timely submissions of data and information to The Joint Commission.

   **Note 1:** The Joint Commission will impose the following consequence for failure to comply with this APR:

   If the organization consistently fails to meet the requirements for the timely submission of data and information to The Joint Commission, the organization will be required to undergo an Accreditation with Follow-up Survey. Failure to resolve this issue at the time of the Accreditation with Follow-up Survey may result in an accreditation decision change.

   **Note 2:** The proposed consequences address only compliance with the requirement itself. They do not address the content of the organization’s submissions to The Joint Commission. For example, if information in an organization’s electronic application for accreditation (E-App) leads to inaccuracies in the appropriate length of the survey and a longer survey is required, the organization will incur the additional costs of the longer survey. In addition, if there is evidence that the organization has intentionally falsified the information submitted to The Joint Commission, the requirement at APR.01.02.01, EP 1 and its consequences will apply. (See also APR.01.02.01, EP 1)

APR.01.02.01
The organization provides accurate information throughout the accreditation process.

Rationale for APR.01.02.01
The Joint Commission requires each organization seeking accreditation to engage in the accreditation process in good faith. Sound business practices require transparency in all reporting procedures to ensure the safety of the public and the people who work in the organization. Any organization that fails to participate in good faith by falsifying information or by failing to exercise due care and diligence to ensure the accuracy of such information may have its accreditation denied or removed by The Joint Commission.
Element of Performance for APR.01.02.01

1. The organization provides accurate information throughout the accreditation process. (See also APR.01.01.01, EP 1)

   **Note 1:** Information may be received in any of the following ways:
   - Provided verbally
   - Obtained through direct observation by, or in an interview or any other type of communication with, a Joint Commission employee
   - Derived from documents supplied by the organization to The Joint Commission
   - Submitted electronically by the organization to The Joint Commission

   **Note 2:** For the purpose of this requirement, falsification is defined as the fabrication, in whole or in part, and through commission or omission, of any information provided by an applicant or accredited organization to The Joint Commission. This includes redrafting, reformatting, or deleting document content. However, the organization may submit supporting material that explains the original information submitted to The Joint Commission. These additional materials must be properly identified, dated, and accompanied by the original documents.

APR.01.03.01

The organization reports any changes in the information provided in the application for accreditation and any changes made between surveys.

Element of Performance for APR.01.03.01

1. The organization notifies The Joint Commission in writing within 30 days of a change in ownership, control, location, capacity, or services offered.

   **Note:** When the organization changes ownership, control, location, capacity, or services offered, it may be necessary for The Joint Commission to survey the organization again. If the organization does not provide written notification to The Joint Commission within 30 days of these changes, the organization could lose its accreditation.

APR.02.01.01

The organization permits the performance of a survey at The Joint Commission’s discretion.
Element of Performance for APR.02.01.01

1. The organization permits the performance of a survey at The Joint Commission’s discretion.

APR.03.01.01

The organization fulfills requirements for Focused Standards Assessment.

Rationale for APR.03.01.01

The Focused Standards Assessment (FSA) helps organizations incorporate The Joint Commission standards into routine daily operations. When organizations use the FSA tool to self-assess, monitor, and improve services, individuals served are more likely to receive safe, high-quality care on a constant basis.

Elements of Performance for APR.03.01.01

1. The organization, at 12 and 24 months after its full triennial survey, updates and submits to The Joint Commission the full Focused Standards Assessment (FSA) and its Plan of Action on any recommendations cited. (Refer also to the “Focused Standards Assessment [FSA]” section in “The Accreditation Process” [ACC] chapter.)

Note 1: For organizations that select Options 1, 2, or 3, the requirement to transmit the FSA and its Plan of Action to The Joint Commission may not apply in part or in whole.

Note 2: Neither the full FSA nor FSA Options 1, 2, or 3 are due in the year of the organization’s triennial survey.

3. The organization exercising Option 1, 2, or 3 for the Focused Standards Assessment (FSA) attests at 12 and 24 months after its full triennial survey that the organization has decided not to participate in the submission of the full FSA.

Note: Neither the full FSA nor FSA Options 1, 2, or 3 are due in the year of the organization’s triennial survey.

4. The organization exercising Option 1 for the Focused Standards Assessment (FSA) completes an FSA and Plan of Action.

Note: The organization does not submit this information to The Joint Commission.
6. The organization exercising Option 2 for the Focused Standards Assessment agrees to undergo a limited survey and then submit a Plan of Action for recommendations cited as a result of the survey.

7. The organization exercising Option 3 for the Focused Standards Assessment agrees to undergo a limited survey.

   **Note:** The organization does not receive a written report after the survey.

**APR.05.01.01**

The organization allows The Joint Commission to review the results of external evaluations from publicly recognized bodies.

**Rationale for APR.05.01.01**

In order to conduct a meaningful accreditation survey, The Joint Commission collects information on many aspects of the organization’s performance. External bodies other than The Joint Commission evaluate areas related to safety and quality. These evaluations complement accreditation reviews but may have a different focus or emphasis. These evaluations may contain information The Joint Commission needs to make accreditation decisions.

**Element of Performance for APR.05.01.01**

1. When requested, the organization provides The Joint Commission with all official records and reports of licensing, examining, reviewing, or planning bodies.

**APR.06.01.01**

Applicants and accredited organizations do not use Joint Commission employees to provide accreditation-related consulting services.

**Element of Performance for APR.06.01.01**

1. The organization does not use Joint Commission employees to provide any accreditation-related consulting services.

   **Note:** Consulting services include, but are not limited to, the following:

   - Helping the organization to meet Joint Commission standards
   - Helping the organization to complete its Focused Standards Assessment (FSA)
   - Assisting the organization in remediying areas identified in its FSA as needing improvement
   - Conducting mock surveys
APR.07.01.01
The organization accepts the presence of Joint Commission surveyor management staff or a Board of Commissioners member in the role of observer of an on-site survey.

**Element of Performance for APR.07.01.01**

1. The organization allows Joint Commission surveyor management staff or a member of the Board of Commissioners to observe the on-site survey.

   **Note 1:** *The observer will not participate in the on-site survey process, including the scoring of standards compliance. Surveyor management staff will only participate in the survey process if he or she feels it is necessary to bring any potential findings or observations to the attention of the surveyor and the organization.*

   **Note 2:** *The organization will not incur any additional survey fees because an observer(s) is present.*

APR.08.01.01
The organization accurately represents its accreditation status and the programs and services to which Joint Commission accreditation applies.

**Elements of Performance for APR.08.01.01**

1. The organization’s advertising accurately reflects the scope of programs and services that are accredited by The Joint Commission.

2. The organization does not engage in any false or misleading advertising about its accreditation award.

APR.09.01.01
The organization notifies the public it serves about how to contact its organization management and The Joint Commission to report concerns about safety of the individual served and quality of care.

**Note:** *Methods of notice may include, but are not limited to, distribution of information about The Joint Commission, including contact information in published materials such as brochures and/or posting this information on the organization’s website.*

**Elements of Performance for APR.09.01.01**

1. The organization informs the public it serves about how to contact its management to report concerns about the safety and quality of care of the individual served.
2. The organization informs the public it serves about how to contact The Joint Commission to report concerns about the safety and quality of care of the individual served.

**APR.09.02.01**

Any person who provides care, treatment, or services can report concerns about safety or the quality of care to The Joint Commission without retaliatory action from the organization.

**Rationale for APR.09.02.01**

Any individual who provides care, treatment, or services should be free to raise concerns to The Joint Commission when the organization has not adequately prevented or corrected problems that can have or have had a serious adverse impact on individuals served. To support this culture of safety, the organization must communicate to staff that such reporting is permitted. Further, the organization must make it clear to staff that no formal disciplinary actions (for example, demotions, reassignments, or change in working conditions or hours) or informal punitive actions (for example, harassment, isolation, or abuse) will be threatened or carried out in retaliation for reporting concerns to The Joint Commission.

**Elements of Performance for APR.09.02.01**

1. The organization educates its staff and other persons who provide care, treatment, or services that concerns about the safety or quality of care provided in the organization may be reported to The Joint Commission.

2. The organization informs its staff that it will take no disciplinary or punitive action because an employee or other person who provides care, treatment, or services reports safety or quality-of-care concerns to The Joint Commission.

3. The organization takes no disciplinary or punitive action against employees or other persons who provide care, treatment, or services when they report safety or quality-of-care concerns to The Joint Commission.

**APR.09.03.01**

The organization is truthful and accurate when describing information in its Quality Report to the public.
Element of Performance for APR.09.03.01

1. The organization adheres to The Joint Commission’s published guidelines for how it describes information found in its Quality Report.

APR.09.04.01

The organization provides care, treatment, services, and an environment that pose no risk of an “Immediate Threat to Health or Safety,” also known as “Immediate Threat to Life” or ITL situation.

Element of Performance for APR.09.04.01

1. The organization provides care, treatment, services, and an environment that pose no risk of an “Immediate Threat to Health or Safety,” also known as “Immediate Threat to Life” or ITL situation.
Care, Treatment, and Services (CTS)

Overview
The “Care, Treatment, and Services” (CTS) chapter provides contemporary and relevant standards to organizations accredited through The Joint Commission’s Behavioral Health Care (BHC) Accreditation Program. The CTS chapter reflects the flow of care, treatment, or services as they are provided in behavioral health care organizations. Care, treatment, or services are provided through the successful coordination and completion of a series of core processes that include the following:
- Entry to care, treatment, or services
- Screening and assessment
- Planning of care, treatment, or services
- Delivery of care, treatment, or services
- Special behavioral procedures
- Continuity of care, treatment, or services

These core processes also address the following activities:
- Providing care, treatment, or services based on principles of recovery and resilience
- Providing individuals served with access to the appropriate programs or services with the appropriate staff
- Providing care, treatment, or services based on an individualized plan
- Teaching individuals served what they need to know about their care, treatment, or services
- Coordinating care, treatment, or services, if needed, when the individual is referred, transferred, or discharged

The core processes are related to each other through an integrated and cyclical process that may occur for any length of time depending on the needs of the individual served and the scope of services offered by the behavioral health care organization. The core processes of care, treatment, or services should not be seen as separate steps but rather as interrelated activities in an integrated and ongoing care, treatment, or services process. These cyclical processes may occur among multiple organizations or within a single
organization. However, the continuity of care, treatment, or services is always maintained for the individual served. The standards in the CTS chapter address the core processes in the integrated and cyclical process.

This chapter includes both standards and elements of performance (EPs) that are applicable to all behavioral health care organizations and those that have limited applicability based on the programs or services provided by an organization. When applicability is limited, a lead-in statement at the beginning of the EP clarifies the circumstances under which the EP is applicable to an organization. The CTS standards fall into three categories:

- Standards that are applicable to all behavioral health care settings
- Standards that are applicable to specific programs/services
- Standards that are applicable to specific populations with unique needs, including the following:
  - Individuals with addictions
  - Children/youth
  - Individuals with eating disorders
  - Individuals in foster care/respite care
  - Individuals with intellectual and developmental disabilities
  - Individuals in opioid treatment

The Joint Commission surveys many types of organizations under the behavioral health care standards. Accredited organizations may serve individuals throughout their life span or specialize in an age-related or disability group. Organizations also operate in a variety of settings from facility-based to community-based. The population(s) served, programs and services offered, and the setting in which the organization operates will factor into determining the applicable standards and EPs for each organization. To identify those requirements that are applicable to your organization, check the “Standards Applicability Process” chapter in the Comprehensive Accreditation Manual for Behavioral Health Care or select the appropriate service profile in The Joint Commission E-dition.
Chapter Outline

I. Entry to Care, Treatment, or Services
   A. Philosophy and Pre-screening (CTS.01.01.01)
   B. Waiting List (CTS.01.02.01)
   C. Preliminary Plan of Care, Treatment, or Services (CTS.01.03.01)
   D. Psychiatric Advance Directive (CTS.01.04.01)

II. Screening and Assessment
   A. Screening: Common Standards (CTS.02.01.01, CTS.02.01.03, CTS.02.01.05, CTS.02.01.06, CTS.02.01.07, CTS.02.01.09, CTS.02.01.11, CTS.02.01.13, CTS.02.01.15, CTS.02.01.17)
   B. Assessment: Common Standards (CTS.02.02.01, CTS.02.02.03, CTS.02.02.05, CTS.02.02.07, CTS.02.02.09)
   C. Additional Assessment Standards for Specific Populations (CTS.02.03.01, CTS.02.03.03, CTS.02.03.05, CTS.02.03.07, CTS.02.03.09, CTS.02.03.11)
   D. Additional Screening and Assessment Standards for Foster Care Parents and Respite Caregivers (CTS.02.04.01, CTS.02.04.03, CTS.02.04.05, CTS.02.04.07, CTS.02.04.09, CTS.02.04.11, CTS.02.04.13, CTS.02.04.15, CTS.02.04.17, CTS.02.04.19, CTS.02.04.21)

III. Planning Care, Treatment, or Services
   A. Planning: Common Standards (CTS.03.01.01, CTS.03.01.03, CTS.03.01.05, CTS.03.01.07, CTS.03.01.09)
   B. Additional Planning Standards for Specific Populations (CTS.03.02.01, CTS.03.02.03)

IV. Delivery of Care, Treatment, or Services
   A. Delivery of Care, Treatment, or Services: Common Standards (CTS.04.01.01, CTS.04.01.03); Behavioral Health Home (CTS.04.01.07)
   B. Delivery of Care, Treatment, or Services: Additional Standards for Specific Populations (CTS.04.02.01, CTS.04.02.03, CTS.04.02.05, CTS.04.02.07, CTS.04.02.09, CTS.04.02.11, CTS.04.02.13, CTS.04.02.15, CTS.04.02.16, CTS.04.02.17, CTS.04.02.18, CTS.04.02.19, CTS.04.02.21, CTS.04.02.23, CTS.04.02.25, CTS.04.02.27, CTS.04.02.29)
   C. Delivery of Care, Treatment, or Services: Additional Standards for Specific Services (CTS.04.03.01, CTS.04.03.03, CTS.04.03.05, CTS.04.03.07, CTS.04.03.09, CTS.04.03.11, CTS.04.03.13, CTS.04.03.15, CTS.04.03.17, CTS.04.03.19, CTS.04.03.20, CTS.04.03.21, CTS.04.03.23, CTS.04.03.25, CTS.04.03.27, CTS.04.03.29, CTS.04.03.31, CTS.04.03.33, CTS.04.03.35)

V. Special Behavioral Procedures
   A. Prohibited Actions (CTS.05.01.01)
   B. Exclusionary Time Out (CTS.05.02.01)
   C. Level System (CTS.05.03.01)
D. Individualized Behavioral Contingencies (CTS.05.04.01, CTS.05.04.03, CTS.05.04.05, CTS.05.04.07, CTS.05.04.09, CTS.05.04.11, CTS.05.04.13, CTS.05.04.15, CTS.05.04.17)

E. Physical Holding of Children and Youth (CTS.05.05.01, CTS.05.05.03, CTS.05.05.05, CTS.05.05.07, CTS.05.05.09, CTS.05.05.11, CTS.05.05.13, CTS.05.05.15, CTS.05.05.17, CTS.05.05.19, CTS.05.05.21)

F. Restraint and Seclusion (CTS.05.06.01, CTS.05.06.03, CTS.05.06.05, CTS.05.06.07, CTS.05.06.09, CTS.05.06.11, CTS.05.06.13, CTS.05.06.15, CTS.05.06.17, CTS.05.06.19, CTS.05.06.21, CTS.05.06.23, CTS.05.06.25, CTS.05.06.27, CTS.05.06.29, CTS.05.06.31, CTS.05.06.33, CTS.05.06.35)

VI. Continuity of Care, Treatment, or Services
   A. Case Management/Care Coordination/Community Integration (CTS.06.01.01, CTS.06.01.03, CTS.06.01.05, CTS.06.01.07, CTS.06.01.09, CTS.06.01.11, CTS.06.01.13, CTS.06.01.15)
   B. Transfer or Discharge (CTS.06.02.01, CTS.06.02.03, CTS.06.02.05)
   C. Transitional Programs/Services for Young Adults (CTS.06.03.01)

VII. Prevention and Wellness Promotion Services
   A. Prevention and Wellness Promotion Services (CTS.07.01.01, CTS.07.01.02, CTS.07.01.03)
Standards, Rationales, and Elements of Performance

Standard CTS.01.01.01

The organization accepts for care, treatment, or services only those individuals whose identified care, treatment, or service needs it can meet.

Note 1: For opioid treatment programs: If an individual eligible for treatment applies for admission to a comprehensive maintenance treatment program but cannot be placed within 14 days in a program that is within a reasonable geographic area, an opioid treatment program’s program sponsor may place the individual in interim maintenance treatment.

Note 2: For opioid treatment programs: There may be individuals in special populations who have a history of opioid use but are not currently physiologically dependent. Federal regulations waive the one-year history of addiction for these special populations, because these individuals are susceptible to relapse to opioid addiction, leading to high-risk behaviors with potentially life-threatening consequences. These populations include the following:
- Persons recently released from a penal institution
- Persons recently discharged from a chronic care facility
- Pregnant women
- Previously treated patients

Elements of Performance for CTS.01.01.01

1. ⚫ The organization has a written process for determining eligibility of individuals that includes the following:
   - The criteria to determine eligibility for care, treatment, or services
   - The information to be collected to determine eligibility for care, treatment, or services
   - The populations of individuals accepted or not accepted by the organization (for example, programs designed to treat adults that do not treat young children)
   - The procedures for accepting referrals

2. ⚫ For organizations that elect The Joint Commission Behavioral Health Home option: The organization defines in writing the population(s) served by the behavioral health home; the population(s) served by the behavioral health home can be a defined subset(s) of the population served by the organization as a whole.
3. The organization screens individuals for eligibility at the point of first contact with the organization, whether by phone, in person, or other.

4. After screening, the organization matches accepted individuals with the care, treatment, or services most appropriate to their needs.

5. The organization accepts individuals for care, treatment, or services according to established processes.

6. The organization provides information about the locations and hours during which care, treatment, or services are available.

7. When warranted, the organization provides information about resources available to the individual for the care of his or her dependents.

8. **For opioid treatment programs:** Patients may have access to the program after the program physician documents a diagnosis of addiction or dependence and determines that maintenance or withdrawal treatment is medically necessary.

9. **For opioid treatment programs:** The treatment program gives priority for admission to pregnant women who seek treatment and documents the reasons for denying admission to any pregnant applicant on an intake log or other accessible program records.

10. **For opioid treatment programs:** Services are provided during hours that meet the needs of the majority of patients, including before and/or after the traditional 8:00 A.M. to 5:00 P.M. working day, when possible.

11. **For opioid treatment programs:** Admission procedures use accepted medical criteria, such as those listed in the current Diagnostic and Statistical Manual for Mental Disorders, to determine that the person is currently addicted to or dependent on an opioid drug, and that the person became addicted or dependent at least one year before admission for treatment.

    **Note 1:** In order to determine the one-year history of addiction or dependence, the program may accept arrest records, medical records, information from significant others and relatives, and other information.

    **Note 2:** Patients generally are not admitted to opioid maintenance therapy for pain relief only.

12. **For opioid treatment programs:** Admission procedures use criteria for determining a diagnosis of addiction or dependence based on behavior.
Note: Behavior indicative of opioid addiction includes the following:
- Continuing use of the opiate despite known adverse consequences to self, family, or society
- Obtaining illicit opiates
- Using prescribed opiates inappropriately
- Previous attempts at tapering methadone or other drugs

13. **For opioid treatment programs:** An individual younger than 18 years is not eligible for maintenance treatment unless he or she has two documented, unsuccessful short-term withdrawal or drug-free treatment attempts within a 12-month period.

14. **For opioid treatment programs:** The program physician waives the admission criteria requiring a one-year history of addiction or dependence only in the following circumstances:
- The patient has been released from a penal institution in the last six months.
- The patient is pregnant.
- The patient was treated with an opioid agonist treatment medication within the last two years.

15. **For opioid treatment programs:** Admission procedures do not exclude patients that are not currently physiologically dependent.

16. **For opioid treatment programs:** Admission procedures include use of a central registry system (if applicable) or an alternative mechanism to prevent patients from enrolling in treatment provided by more than one clinic or individual practitioner.

    Note: In some cases, the program may, after obtaining the patient’s consent, contact other opioid treatment programs within a reasonable geographic distance (100 miles) to verify that the patient is not enrolled in another program.

17. **For opioid treatment programs:** Patients are limited to two withdrawal treatment episodes in one year.

18. **For opioid treatment programs:** When a physician makes a diagnosis and admits a patient after reviewing by telephone or fax the medical examination performed by another qualified health professional, the physician reviews and countersigns the patient record within 72 hours.

    Note: Standing orders for admitting patients are not acceptable.
19. **For opioid treatment programs:** Patients who are diagnosed with physical dependence and a pain disorder are eligible to receive medication-assisted treatment for maintenance or for medically supervised withdrawal in a program setting.

20. **For opioid treatment programs:** Patients in medication-assisted treatment are eligible to receive both medication-assisted treatment and adequate doses of opioid analgesics for pain.

21. **For opioid treatment programs:** If a patient is denied admission based on the results of the initial assessment, the program provides a full explanation to the patient and a referral to another program.

22. ⑤ **For opioid treatment programs:** If the opioid treatment program provides interim maintenance treatment, it has written authorization to do so both by the Substance Abuse & Mental Health Services Administration (SAMHSA) and by the chief public health officer in the state in which the program operates.

   **Note:** SAMHSA may revoke its authorization if the program does not comply with the federal requirements for interim maintenance treatment. Additionally, SAMHSA will consider revoking the interim maintenance authorization of the program if the state in which the program operates is not in compliance with the requirements of 42 CFR 8.11(g).

23. **For opioid treatment programs:** Interim maintenance treatment, if provided by the program, does not exceed the 120-day maximum allowed by federal regulations for opioid treatment programs.

24. ⑤ **For opioid treatment programs:** The program establishes and follows written criteria for prioritizing the transfer of patients from interim maintenance treatment to comprehensive maintenance treatment. These transfer criteria include a preference for admitting pregnant women to interim maintenance treatment and transferring them from interim maintenance to comprehensive maintenance treatment.

25. **For opioid treatment programs:** To receive interim maintenance, the patient must be fully eligible for admission to comprehensive maintenance.

**Standard CTS.01.02.01**

An organization that maintains waiting lists manages them in accordance with established organizational procedure and law and regulation.
Elements of Performance for CTS.01.02.01
1. The organization has a written procedure for managing waiting lists for services.
2. The organization implements its procedure for managing waiting lists for services.

Standard CTS.01.03.01
The organization develops a preliminary plan for care, treatment, or services, when needed.

Rationale for CTS.01.03.01
An organization may begin care, treatment, or services prior to completing the screening/assessment process for a number of reasons including the needs of, and safety issues related to, the individual served. At a minimum, the preliminary plan should address safety. This preliminary plan may focus on risks such as harm to self or others, elopement, sexual reactiveness, and other immediate safety concerns.

Elements of Performance for CTS.01.03.01
1. The organization develops a preliminary plan for care, treatment, or services when care, treatment, or services are initiated prior to completion of the screening and assessment process.
2. The preliminary plan for care, treatment, or services focuses on the individual’s safety.
3. The preliminary plan for care, treatment, or services addresses interventions in response to emergency needs, such as an immediate need for placement or danger to self or others.

Standard CTS.01.04.01
For organizations that serve adults with serious mental illness: The organization supports the adult’s decisions (psychiatric advance directive) about how care, treatment, or services are to be delivered during times when he or she is unable to make such decisions. (See also RI.01.05.01, EPs 1, 4, 5, 8, 10)

Rationale for CTS.01.04.01
During acute episodes of mental illness, adults can lose the capacity to give or withhold informed consent for care, treatment, or services. A psychiatric advance directive permits adults with serious mental illness to express their care, treatment, or service preferences or other instructions while competent to do so.
Note: Community-based programs serving adults with serious mental illness can be a resource for education about the value of psychiatric advance directives and assistance in determining whether to complete a psychiatric advance directive.

Elements of Performance for CTS.01.04.01

1. For organizations that serve adults with serious mental illness: The organization documents whether the adult has a psychiatric advance directive.

2. For organizations that serve adults with serious mental illness: Upon request, the organization shares with the adult sources of help in formulating psychiatric advance directives.

3. For organizations that serve adults with serious mental illness: If the adult has a psychiatric advance directive, clinical staff who are involved in the care, treatment, or services provided to that adult are aware that the psychiatric advance directive exists and know how to access it.

Introduction to Standards CTS.02.01.01 Through CTS.02.04.01—Screening and Assessment

The goal of screening and assessment is to determine the care, treatment, or services that will best meet the needs of the individual served initially and over time.

Accurately identifying the needs of the individual served is the basis for providing quality care, treatment, or services and depends on three processes:

1. Collecting data about the individual served’s current and past emotional and behavioral functioning, needs, strengths, preferences, and goals.

2. Analyzing data to produce information about the individual’s need for care, treatment, or services and to identify the need for additional data.

3. Making care, treatment, or service decisions based on the information developed about the needs, strengths, preferences, and goals of the individual served and his or her response to care, treatment, or services.
The information to be collected through screening and/or assessment is defined by the organization’s policies and procedures and depends on the emergent needs of and the care, treatment, or services sought by the individual served. As appropriate, information is collected from the individual’s family/guardian.

Information collected can indicate the need for more data or a more intensive assessment of the mental health, emotional, behavioral, vocational, educational, and nutritional functioning and legal status of the individual served. At a minimum, the need for further screening/assessment is determined by the care, treatment, or services sought; the individual’s presenting condition(s); and whether the individual agrees to care, treatment or services.

Please note that some of the screening/assessment standards apply to all organizations, such as the need to screen for the early detection of risk of imminent harm to self or others. Other screening/assessment standards apply to specific settings, programs/services or populations. Standards and elements of performance specific to settings, programs/services, or populations have a lead-in indicating specificity.

**Standard CTS.02.01.01**
The organization has a screening procedure for the early detection of risk of imminent harm to self or others.

**Elements of Performance for CTS.02.01.01**

1. The screening procedure determines the need for immediate intervention to protect the individual served or others. R

2. The organization has a process for responding when an immediate risk of harm is identified. R

   **Note:** The process may include referring the individual to another organization.

3. The organization responds when it determines the individual served poses an immediate risk of harm to self or others.

**Standard CTS.02.01.03**
The organization performs screenings and assessments as defined by the organization’s policy.
Elements of Performance for CTS.02.01.03

1. The organization assesses each individual served in accordance with organization policy.

2. The organization conducts each individual’s assessment within the time frame specified by the needs of the individual served, organization policy, and law and regulation.

3. The organization collects information during screenings and/or assessments about the following: The individual’s perceptions of his or her needs, preferences, and goals for care, treatment, or services.

4. The organization collects information during screenings and/or assessments about the following: When indicated and available, the family’s perceptions and preferences for care, treatment, or services.

5. When relevant to the individual’s current care, treatment, or services, as determined by the organization, the organization gathers behavioral and physical health information from both inpatient and outpatient providers who have treated the individual. When it is not possible to obtain this information, the organization documents the reason why it could not be obtained.

6. For acute 24-hour settings: A qualified, licensed independent practitioner is responsible for determining the degree of assessment and care for each individual treated in an emergency care area.

   Note: “Acute 24-hour settings” includes inpatient crisis stabilization or medical detoxification.

7. For opioid treatment programs: Patients receive a comprehensive evaluation that covers the following, based on the patient’s condition and needs: medical, psychosocial, vocational, educational, behavioral, family, financial, legal, health, and self-care needs.

   Note: For patients receiving interim maintenance treatment, the program is not required to provide rehabilitative, education, and other counseling services to the patient.

8. For opioid treatment programs: The comprehensive evaluation is conducted by one or more disciplines within approximately 30 days of admission or earlier when necessary.
Standard CTS.02.01.05

For organizations providing care, treatment, or services in non-24-hour settings: The organization implements a written process requiring a physical health screening to determine the individual’s need for a medical history and physical examination.
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Note 1: This standard does not apply to foster care and therapeutic foster care. (See also CTS.02.04.01, EP 1)

Note 2: If the organization conducts a physical examination on all individuals served, it is in compliance with this standard.

Elements of Performance for CTS.02.01.05

1. For organizations providing care, treatment, or services in non-24-hour settings: The organization has a written physical health screening process to determine whether an individual served is in need of a medical history and physical examination that is based on the population(s) served and, at a minimum, includes the following:
   - Data to be collected
   - Time frame for completion of the screening
   - Screening triggers that indicate the need for a medical history and physical examination

2. For organizations that elect The Joint Commission Behavioral Health Home option: If the screening triggers indicate the need for a medical history and physical examination, the behavioral health home arranges for the history and physical to occur in a time frame that meets the physical health care needs of the individual served.

3. For organizations providing care, treatment, or services in non-24-hour settings: The organization has a practitioner qualified by the scope of his or her license participate in developing the data to be collected and the physical health screening process.

4. For organizations providing care, treatment, or services in non-24-hour settings: The organization determines whether the date of the individual’s most recent physical examination exceeds one year. If the date exceeds one year, a medical history and physical examination is performed.

Note: Securing the individual’s agreement to receive a medical history and physical examination may be undertaken as a process, and the organization may incorporate this process into the individual’s plan for care, treatment, or services. If performing a medical history and physical examination is not within the organization’s scope of services, it may refer the individual to another organization. (Refer to CTS.03.01.07, EPs 1–3)
5. **For organizations providing care, treatment, or services in non-24-hour settings:**
The organization implements its written process.

**Standard CTS.02.01.06**

**For organizations providing residential care:** The organization screens all individuals served to determine the individual’s need for a medical history and physical examination.

**Note 1:** *This standard does not apply to foster care, therapeutic foster care, and emergency shelters. (See CTS.02.04.01, EP 1)*

**Note 2:** *If the organization conducts a physical examination on all individuals served, it is in compliance with this standard.*

**Note 3:** “Residential care” includes residential settings, group home settings, and 24-hour therapeutic schools.

**Elements of Performance for CTS.02.01.06**

1. **For organizations providing residential care:** The organization has a written screening process to determine whether an individual served is in need of a medical history and physical examination that is based on the population(s) served and, at a minimum, includes the following:
   - Data to be collected
   - Time frame for completion of the screening
   - Screening triggers that indicate the need for a medical history and physical examination

2. **For organizations providing residential care:** A practitioner qualified by the scope of his or her license approves the organization’s screening process.

3. **For organizations providing residential care:** Individuals for whom a physical examination conducted by a practitioner qualified by the scope of his or her license is indicated are either examined by the organization or referred to an outside source within 30 calendar days after admission, or sooner if warranted by the individual’s physical health needs, and in accordance with law and regulation.

4. **For organizations providing residential care:** When a physical examination has been completed by a practitioner qualified by the scope of his or her license within the 12 months prior to the individual’s admission and the organization accepts this in lieu of conducting another physical examination, the organization notes any changes to the individual’s physical health condition and documents it...
in the individual’s clinical/case record. If any changes(s) to the individual’s physical health condition prompts any of the screening process triggers, a new medical history and physical examination is conducted.

5. **For organizations providing residential care:** The organization determines whether the date of the individual’s most recent physical examination exceeds one year. If the date exceeds one year, a medical history and physical examination is performed.

6. **For organizations providing residential care:** The organization implements its written process.

### Standard CTS.02.01.07

The organization completes a physical health assessment, including a medical history and physical examination.

**Note:** This standard does not apply to foster care and therapeutic foster care. (Refer to CTS.02.04.01, EP 1 for more information)

### Elements of Performance for CTS.02.01.07

1. **For inpatient crisis stabilization:** A physical health examination is performed by a licensed independent practitioner within 24 hours of admission.

   **Note 1:** Some physical health needs require completion of a physical health assessment within a shorter time frame.

   **Note 2:** If a medical history and physical examination has been completed by a licensed independent practitioner within 30 days before admission, a legible copy of this report may be used in the clinical/case record as the physical health assessment. Changes to the condition of the individual served since completion of the history and physical are recorded at the time of admission.

2. **For organizations that conduct outdoor/wilderness experiences:** A physical health examination is performed by a licensed independent practitioner within 30 days prior to participating in an outdoor/wilderness experience.

   **Note 1:** Some physical health needs require completion of a physical health assessment within a shorter time frame.

   **Note 2:** If a medical history and physical examination has been completed by a licensed independent practitioner within 30 days before participating in an outdoor/wilderness experience, a legible copy of this report may be used in the clinical/case
record as the physical health assessment. Changes to the condition of the individual served since completion of the history and physical are recorded at the time of admission to the program.

3. **For opioid treatment programs**: The program completes a medical evaluation within 14 days after treatment is initiated.

4. **For opioid treatment programs**: The physical assessment includes an examination of the following:
   - Clinical signs of addiction, such as old and fresh needle marks, constricted or dilated pupils, and/or an eroded or perforated nasal septum
   - Observable and reported presence of withdrawal signs and symptoms, such as yawning, rhinorrhea, lacrimation, chills, restlessness, irritability, perspiration, piloerection, nausea, and diarrhea

   **Note**: On-site “point of collection” devices may be useful in screening a patient’s current physiological dependence.

5. **For opioid treatment programs**: The program documents the patient’s medical and family history to determine current chronic or acute medical conditions, such as diabetes; renal diseases; hepatitis A, B, C, and D; HIV exposure; tuberculosis; sexually transmitted diseases; other infectious diseases; sickle-cell trait or anemia; pregnancy (including past history of pregnancy and current involvement in prenatal care); and chronic cardiopulmonary disease.

6. **For opioid treatment programs**: Based on the patient’s history and physical examination, the program evaluates the possibility of various conditions (such as infectious disease, liver or pulmonary conditions, cardiac abnormalities, psychiatric problems, dermatologic sequelae of addiction, and concurrent surgical problems).

   **Note**: This may be accomplished within the program itself, or by referring the patient to a cooperating agency or a consultant clinician.

7. **For opioid treatment programs**: Patients who test positive for viral hepatitis receive a referral for further evaluation and treatment, if necessary.

8. **For opioid treatment programs**: The program immunizes the patient, or refers the patient for immunization, against hepatitis A and B if not already immune, and against other viral hepatitis strains as those vaccines become available.
9. **For opioid treatment programs:** The program does not use telemedicine to substitute for a physical examination when one is needed. Telemedicine may be used to support the decision making of a physician when a provider qualified to conduct physical examinations and make diagnoses is physically located with the patient.

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**Standard CTS.02.01.09**

The organization screens all individuals served for physical pain.

**Rationale for CTS.02.01.09**

Physical pain can have physiological and psychological consequences. Therefore, organizations should screen for physical pain when individuals served receive behavioral health care, treatment, or services. Further assessment and treatment of the physical pain can be provided by the behavioral health organization, or the individual served may be referred to another organization for assessment and treatment.

**Elements of Performance for CTS.02.01.09**

1. The organization screens all individuals served to identify those for whom a physical pain assessment is indicated. (Refer to CTS.02.01.03 through CTS.02.01.07 for more information)

2. Individuals for whom a physical pain assessment is indicated are either assessed and treated by the organization or referred for assessment or treatment. **R**

   **Note:** Treatment strategies for pain may include pharmacologic and nonpharmacologic approaches. Strategies should reflect an approach centered on the individual and consider the individual's current presentation, the health care practitioner's clinical judgment, and the risks and benefits associated with the strategies, including potential risk of dependency, addiction, and abuse.

3. **For opioid treatment programs:** The program employs a multidisciplinary approach for treating patients with both chronic pain disorder and addiction, including both addiction medicine specialists and pain medicine specialists.

   **Note:** The site of such treatment may be either a medical clinic or an opioid treatment program, depending on the patient's needs and the best utilization of available resources.

4. **For opioid treatment programs:** Patients with pain management needs receive their regular opioid medication at adequate doses to treat addiction.
Standard CTS.02.01.11
The organization screens all individuals served for their nutritional status.

Rationale for CTS.02.01.11
The purpose of the nutritional screening is to identify individuals served who may have a nutritional risk(s) and require a nutritional assessment. Several nutritional screening triggers are provided in a note to this standard and may be used by behavioral health care organizations in their screening process. However, use of these specific nutritional triggers is not mandatory.

Elements of Performance for CTS.02.01.11
1. The organization screens all individuals served to identify those for whom a nutritional assessment is indicated. At a minimum, the screening includes questions about the following:
   - Food allergies
   - Weight loss or gain of ten pounds or more in the last three months
   - Decrease in food intake and/or appetite
   - Dental problems
   - Eating habits or behaviors that may be indicators of an eating disorder, such as bingeing or inducing vomiting
2. Individuals for whom a nutritional assessment is indicated are either assessed and treated by the organization or referred for assessment or treatment.
3. For organizations that assess nutritional status, the assessment identifies those individuals who may be at moderate or high nutritional risk.

Standard CTS.02.01.13
As relevant to the needs, preferences, interests, and goals of the individual served, the organization screens for the educational status of the individual served.

Elements of Performance for CTS.02.01.13
1. A screening identifies individuals for whom an educational assessment is indicated.
2. Individuals for whom an educational assessment is indicated are either assessed by the organization or referred for assessment.
3. For organizations that assess the educational status of individuals served, the information to be collected includes at least the following:

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
- Educational background
- Academic performance and preferred areas of study
- Attitude toward academic achievement
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Possibilities for future education

**Standard CTS.02.01.15**

As relevant to care, treatment, or services, the organization screens for the legal issues of the individual served.

**Elements of Performance for CTS.02.01.15**

1. A screening identifies individuals for whom a legal assessment is indicated.
2. Individuals for whom a legal assessment is indicated are either assessed by the organization or referred for assessment.
3. For organizations that assess the legal status of the individual, the information to be collected includes at least the following:
   - A legal history
   - A preliminary discussion to determine how much the individual's legal situation will influence his or her progress in care, treatment, or services, and the urgency of the legal situation
   - The relationship between the presenting conditions and legal involvement

**Standard CTS.02.01.17**

As relevant to the needs, preferences, interests, and goals of the individual served, the organization screens for the vocational status of the individual served.

**Elements of Performance for CTS.02.01.17**

1. The organization screens individuals for whom a vocational assessment is indicated, based on their needs, preferences, interests, and goals.
2. Individuals for whom a vocational assessment is indicated are either assessed by the organization or referred for assessment.

**Standard CTS.02.02.01**

The organization collects assessment data on each individual served.

**Elements of Performance for CTS.02.02.01**

1. As relevant to care, treatment, or services, the organization collects the following assessment data about each individual served:
   - Environment and living situation(s)
   - Leisure and recreational interests
   - Religion or spiritual orientation
Cultural preferences
- Childhood history
- Military service history, if applicable
- Financial issues
- Usual social, peer-group, and environmental setting(s)
- Language preference and language(s) spoken
- Ability to self-care
- Family circumstances, including bereavement
- Current and past trauma
- Community resources accessed by the individual served

Note 1: Relevance to care, treatment, or services may be determined by the individual’s presenting needs and the organization’s scope of care, treatment, or services.

Note 2: For certain populations, early identification of community resources is important to care, treatment, or services. Such populations include individuals with severe mental illness or disabilities and children and youth. Community resources for these groups encompass a wide range of services. These services are supportive (such as community mental health, sheltered living, day treatment, or activity programs) as well as commonly accessed by the general public (such as public transportation, banking, or retail stores). For youth or children in foster care or in-home services, resources might include community mental health centers, teen centers, YMCAs, or Jewish community centers. These sources of community services may be used as informational, discharge planning, supportive, or continuing care resources.

2. As relevant to care, treatment, or services, the assessment data collected about the individual’s emotional and behavioral functioning include at least the following:
   - History of emotional functioning
   - History of behavioral functioning
   - Addictive behaviors as a primary or a co-occurring condition(s), including the use of alcohol, other drugs, gambling, or other addictive behaviors by the individual served and family members
   - Current emotional functioning
   - Current behavioral functioning

3. The assessment data collected include the individual’s short- and long-term personal goal(s).

4. When indicated, the following evaluations are conducted:
- Mental status
- Psychological
- Psychiatric
- Intellectual and cognitive functioning

5. Family members are invited to participate in the assessment process as relevant to the care, treatment, or services provided, and the age and preference of the individual served.

6. **For organizations that elect The Joint Commission Behavioral Health Home option:** The assessment data collected include the individual’s short- and long-term physical health care goals.

7. **For organizations that elect The Joint Commission Behavioral Health Home option:** The assessment data collected include screening and/or assessment results for, at a minimum, the following chronic physical health conditions:
   - Diabetes
   - Hypertension
   - Heart disease
   - Asthma
   - Chronic obstructive pulmonary disease (COPD)
   - Hepatitis C
   - HIV/AIDS
   - Obesity
   - Any additional chronic physical health condition(s) the behavioral health home may regularly find in the population(s) it serves
   - Metabolic syndrome

   **Note:** Refer to http://www.heart.org for more information on metabolic syndrome.

8. **For organizations that elect The Joint Commission Behavioral Health Home option:** The assessment data collected include the individual’s ability to self-manage chronic behavioral and physical health conditions.

**Standard  CTS.02.02.03**

A complete and accurate assessment drives the identification and delivery of the care, treatment, or services needed by the individual served.
Elements of Performance for CTS.02.02.03

1. The organization collects information about the individual’s emotional and behavioral functioning and his or her needs, strengths, preferences, and goals.

2. The needs of the individual served are identified based on information from the assessment.

3. In collaboration with the individual served and, as appropriate, his or her family, the organization makes care, treatment, or service decisions that are based on information it has collected about the individual’s needs, strengths, preferences, and goals.

4. The organization matches the individual with care, treatment, or services that will meet his or her needs, strengths, preferences, and goals.

Standard CTS.02.02.05

The organization identifies individuals served who may have experienced trauma, abuse, neglect, or exploitation.

Rationale for CTS.02.02.05

The effect of trauma, abuse, neglect, or exploitation may be evidenced in the behavior of individuals served immediately or long after the event. The individual’s experience of trauma, abuse, neglect, or exploitation must be considered in the planning and delivery of care, treatment, or services. Although abuse, neglect, and exploitation are traumatic events, trauma includes a much broader array of life events that can adversely impact an individual’s functioning (for example, a child who experiences the death of a parent). Accordingly, only the specific traumas of abuse, neglect, and exploitation are required to be reported to authorities as specified in law and regulation.

Elements of Performance for CTS.02.02.05

1. The organization educates staff about trauma, abuse, neglect, and exploitation and how to refer individuals, as needed.  

   Note: Staff should be able to screen for trauma, abuse, neglect, and exploitation as indicated by the needs or conditions of the individual served. The organization may define who conducts the assessment for alleged or suspected trauma, abuse, neglect, and exploitation or when to refer to another organization.
2. The organization identifies individuals who may have experienced trauma, abuse, neglect, or exploitation during initial screening and assessment and on an ongoing basis.

3. The organization assesses the individual who may have experienced trauma, abuse, neglect, or exploitation or refers the individual for such assessment.

4. For organizations that make referrals, the organization maintains a list of private and public community agencies that provide or arrange for assessment and care of individuals who may have experienced abuse, neglect, or exploitation.

5. All cases of alleged or suspected abuse, neglect, or exploitation are reported to appropriate authorities in accordance with organization policy and law and regulation.

6. Organization leaders are immediately made aware of reports made to external authorities regarding alleged or suspected cases of abuse, neglect, or exploitation involving staff.

**Standard CTS.02.02.07**

The organization reassesses individuals served, as needed.

**Note:** The scope and intensity of any further assessments are based on the individual’s functioning; the setting; the individual’s preferences for care, treatment, or services; and the individual’s response to care, treatment, or services provided. Each individual may be reassessed for many reasons, including the following:

- To evaluate his or her response to care, treatment, or services
- To respond to a significant change in status and/or diagnosis or condition
- To satisfy legal or regulatory requirements
- To meet time intervals specified by the organization
- To meet time intervals determined by the course of the individual’s care, treatment, or services

**Elements of Performance for CTS.02.02.07**

1. The organization reassesses each individual served, as needed.

2. **For opioid treatment programs:** Assessments are updated quarterly during the patient’s first year of continuous treatment and semiannually during subsequent years.
Standard  CTS.02.02.09

For opioid treatment programs: The organization has a process to provide medical histories, physical examinations, and diagnostic and laboratory tests.

Elements of Performance for CTS.02.02.09

2.  

   For opioid treatment programs: The program conducts initial toxicology tests as part of the admission process.

   Note: The recommended medical laboratory analysis and diagnostic evaluation may include the following as medically appropriate for the patient:
   - Vital signs, including blood pressure, pulse, respirations, and temperature
   - TB skin test, and chest x-ray if the skin test is positive (including consideration for anergy)
   - Screening test for syphilis
   - Complete blood count (CBC) and lipid panel
   - Liver function tests and viral hepatitis marker tests
   - HIV testing and counseling
   - Tests appropriate for the screening or confirmation of illnesses or conditions based on concerns specific to the patient regarding renal function, electrolyte imbalance, metabolic syndromes, pain, and so forth
   - Pregnancy test
   - Neurological or psychological testing and assessment
   - Chest x-ray
   - Electrocardiogram (EKG)
   - Pap smear
   - Screening test for sickle-cell disease
   - Additional diagnostic testing based on the results of baseline screening tests, especially when those results have the potential to affect treatment decisions

3.  

   For opioid treatment programs: The medical assessment addresses symptoms of and risk factors for torsades de pointes and includes any follow-up tests that are indicated, such as an EKG or comprehensive electrophysiological assessment.

4.  

   For opioid treatment programs: On admission, the program tests the patient for opiates, methadone, amphetamines, cocaine, marijuana, and benzodiazepines. The need for testing for additional substances is determined by individual patient circumstances and local drug use patterns.
5. For opioid treatment programs: The program collects toxicological specimens in a manner that demonstrates trust and respect while taking reasonable steps to prevent falsification of samples.

Note: Direct observation, although necessary for some patients, is neither necessary nor appropriate for all patients.

6. For opioid treatment programs: The program uses drug and alcohol screening as aids to monitor and evaluate a patient’s progress in treatment.

7. For opioid treatment programs: The program performs drug tests for each patient on an ongoing basis as frequently as required by law and regulation.

8. For opioid treatment programs: For patients in interim maintenance treatment, the program performs a urine screen upon admission and performs at least two additional urine screens if the patient is present for the maximum of 120 days permitted for interim treatment.

9. For opioid treatment programs: The program’s clinicians determine the ongoing drug-testing regime by analyzing individual circumstances and community drug use patterns.

Note: Testing might include, but is not limited to, opiates, benzodiazepines, barbiturates, cocaine, marijuana, methadone and its metabolites, amphetamines, and alcohol.

10. For opioid treatment programs: Program staff discusses results of toxicology testing promptly with patients. The program documents both the results of toxicology tests and the follow-up therapeutic interventions in the patient record.

11. For opioid treatment programs: The program establishes and implements procedures for addressing potentially false positive and false negative toxicology test results.

12. For opioid treatment programs: The program includes confirmation testing such as gas chromatography-mass spectrometry (GC-MS) or liquid chromatography-mass spectrometry (LC-MS) as part of its established procedures for addressing potentially false-positive and false-negative urine or other toxicology test results.

* TIP 43 outlines principles for handling potentially false positive and negative test results. See TIP 43, “Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs” (CSAT 2005, chapter 9).
13. **For opioid treatment programs:** Clinicians determine the frequency of ongoing toxicological testing by evaluating the need for testing in relation to the patient’s stage in treatment.

14. **For opioid treatment programs:** Clinicians intervene when the patient discloses illicit drug use, has a positive drug test, or is suspected of diversion of opioid medication as evidenced by a lack of opioids or related metabolites in drug toxicology tests.

**Standard CTS.02.03.01**

**For organizations providing care, treatment, or services to a child or youth:** The organization facilitates and coordinates family or guardian involvement throughout the assessment process.

**Elements of Performance for CTS.02.03.01**

1. **For organizations providing care, treatment, or services to a child or youth:** The organization assesses the family’s or legal guardian’s expectations for and involvement in the assessment and initial and continuing care, treatment, or services.

2. **For organizations providing care, treatment, or services to a child or youth:** The organization clearly explains the family’s or legal guardian’s role in achieving care, treatment, or service goals.

3. **For organizations providing care, treatment, or services to a child or youth:** The organization establishes procedures that facilitate ongoing communication with the family or legal guardian about their perceptions of the child’s or youth’s needs and other issues.

4. **For organizations providing care, treatment, or services to a child or youth:** In conducting the assessment, the organization distinguishes between data provided by the family or legal guardian or referral sources and data based on the organization’s interaction with the child or youth.

**Standard CTS.02.03.03**

**For organizations providing care, treatment, or services to a child or youth:** The organization assesses the needs of children or youth.
Elements of Performance for CTS.02.03.03

1. **For organizations providing care, treatment, or services to a child or youth:**
   Assessment information defined by the organization to be collected during the initial assessment of a child or youth includes the following, as relevant to care, treatment, or services:
   - Legal custody status, including the clear identification of the legal guardian(s)
   - The use of a developmental perspective in evaluating all aspects of functioning, including the child’s or youth’s physical, emotional, cognitive, educational, nutritional, and social development
   - Assessment of normative development as related to chronological age
   - The child’s or youth’s leisure and recreational interests
   - The family history and current living situation
   - The family dynamics and their impact on the child’s or youth’s current needs
   - Family factors that should be considered in discharge planning

2. **For organizations providing care, treatment, or services to a child or youth:**
   When a physical health examination is done for a child or youth, it addresses the following:
   - Motor development and functioning
   - Sensorimotor functioning
   - Speech, hearing, and language functioning
   - Visual functioning
   - Immunization status
   - Oral health and oral hygiene

   (For more information about the physical health assessment, refer to Standard CTS.02.01.07.)

3. **For opioid treatment programs:** The program’s screenings and assessments tailored to adolescents make certain that medication-assisted treatment is the most appropriate treatment for these patients.

**Standard CTS.02.03.05**

**For organizations providing care, treatment, or services to individuals with intellectual and developmental disabilities:** The organization assesses the needs of the individual.
Elements of Performance for CTS.02.03.05

1. **For organizations providing care, treatment, or services to individuals with intellectual and developmental disabilities:** The organization bases the individual’s care, treatment, or services on his or her assessed needs and functioning.

2. **For organizations providing 24-hour care, treatment, or services to individuals with intellectual and developmental disabilities:** The individual served receives at least an annual physical examination.

3. **For organizations providing 24-hour care, treatment, or services to individuals with intellectual and developmental disabilities:** The physical examination includes the following:
   - Motor development and functioning
   - Sensorimotor functioning
   - Speech, hearing, and language functioning
   - Visual functioning
   - Immunization status
   - Oral health and oral hygiene

   (Refer to Standard CTS.02.01.07 for more information)

   **Note:** The physical examination can be performed by the organization or another provider.

4. **For organizations providing care, treatment, or services to individuals with intellectual and developmental disabilities:** The assessment includes the following:
   - Social history
   - Cognitive functioning
   - Family support
   - Support to family
   - Presenting conditions
   - Other disabilities
   - When possible, the causes of the individual’s disabilities
   - Additional needs related to age, such as senior services or early childhood intervention services

   (Refer to Standard CTS.02.02.01 for more information)
5. For organizations providing care, treatment, or services to individuals with intellectual and developmental disabilities: The emotional and behavioral functioning assessment also includes the following:
   - Adaptive behavior
   - Social functioning
   - Independent living skills
   - Talents, aptitudes, and interests
   - Need for assistive functioning

   (Refer to Standard CTS.02.02.01 for more information)

6. For organizations providing care, treatment, or services to individuals with intellectual and developmental disabilities: The vocational functioning assessment of older youth and adults also includes the following:
   - Vocational training history
   - Work history
   - Work interests
   - Work skills
   - Work-related behaviors

   (Refer to Standard CTS.02.01.17 for more information)

   Note: The assessments can be provided by the organization or another provider.

7. For organizations providing care, treatment, or services to individuals with intellectual and developmental disabilities: The educational assessment also includes the following:
   - Reading and math levels
   - Educational status/history
   - Intelligence testing
   - The current level of concrete and abstract reasoning

   (Refer to Standard CTS.02.01.13 for more information)

   Note: The assessments can be provided by the organization or another provider.

8. For organizations providing 24-hour care, treatment, or services to individuals with intellectual and developmental disabilities: Individuals are reassessed when there are changes in their functioning or living situation. The reassessment includes those elements of the assessment that are relevant to the changes identified.
Introduction to Standard CTS.02.03.07

Obtaining and interpreting information about substance abuse, chemical dependence, gambling, or other addictive behaviors is necessary to develop a plan of care, treatment, or services. By collecting the data and information on the elements of performance in Standard CTS.02.03.07, staff can assess the relationship of the physical state of each individual served to the dependence or addiction; assess the nature of the individual’s compulsion to use alcohol, drugs, or other addictive behaviors; assess the intensity of the individual’s mental preoccupation with alcohol, drugs, or other addictive behaviors; and distinguish among alcohol-related symptoms, drug-related symptoms, symptoms of other addictive behaviors, other preexisting physical problems, and or pathological behaviors.

Standard CTS.02.03.07

For organizations providing care, treatment, or services to individuals with addictions:
The assessment includes the individual’s history of addictive behaviors.

Elements of Performance for CTS.02.03.07

1. For organizations providing care, treatment, or services to individuals with addictions: The organization obtains the individual’s history of alcohol use, drug use, nicotine use, and other addictive behaviors. The history includes the following information:
   - Age of onset
   - Duration
   - Patterns of use (for example, continuous, episodic, binge)

2. For organizations providing care, treatment, or services to individuals with addictions: The organization obtains the individual’s history of mental, emotional, behavioral, legal, and social consequences of dependence or addiction.

3. For organizations providing care, treatment, or services to individuals with addictions: The organization obtains information related to the consequences of dependence or addiction (for example, legal problems, divorce, loss of family members or friends, job-related incidents, financial difficulties, blackouts, memory impairment).

4. For organizations providing care, treatment, or services to individuals with addictions: The organization obtains the individual’s history of physical problems associated with substance abuse, dependence, and other addictive behaviors.
5. **For organizations providing care, treatment, or services to individuals with addictions:** The organization obtains the history of the use of alcohol and other drugs, and other addictive behaviors by the individual’s family.

6. **For organizations providing care, treatment, or services to individuals with addictions:** The organization obtains the individual’s perception of the role of spirituality or religion in his or her life.

7. **For organizations providing care, treatment, or services to individuals with addictions:** Assessments of the individual served contain information about previous care, treatment, or services.

8. **For organizations providing care, treatment, or services to individuals with addictions:** Assessments of the individual served contain information about the individual’s response to previous care, treatment, or services.

9. **For organizations providing care, treatment, or services to individuals with addictions:** Assessments of the individual served contain information about the individual’s relapse history.

**Standard CTS.02.03.09**

For organizations providing care, treatment, or services to individuals with eating disorders: The organization assesses the individual’s food-related behaviors. (Refer to Standard CTS.04.02.17 for more information)

Note: This standard applies to all individuals with eating disorders regardless of setting.

**Elements of Performance for CTS.02.03.09**

1. **For organizations providing care, treatment, or services to individuals with eating disorders:** The organization assesses the individual’s beliefs, perceptions, attitudes, and behavior regarding food. (Refer to Standard CTS.02.01.11 for more information)

2. **For organizations providing care, treatment, or services to individuals with eating disorders:** The organization includes family observations regarding the individual’s food-related behavior in the assessment, when available.

**Standard CTS.02.03.11**

For organizations that provide eating disorders care, treatment, or services: The organization conducts additional assessments for individuals with eating disorders.
Elements of Performance for CTS.02.03.11

1. **For organizations that provide eating disorders care, treatment, or services:** After admitting an individual to its program, the organization performs or makes a documented referral for the following tests, screenings, and procedures based on the needs of the individual served and in a time frame that meets the needs of the individual and is consistent with organization policy:
   - Complete blood count
   - Comprehensive serum metabolic profile, including phosphorus and magnesium
   - Thyroid function test
   - Electrocardiogram (ECG), if clinically indicated
   - Body Mass Index (BMI)
   - Heart rate
   - Screening for eating disorder behaviors
   - Any additional laboratory testing, as determined by the organization and in accordance with the level of care provided

   *(See also CTS.03.01.09, EP 4)*

   **Note:** For non-24-hour settings, the program may accept test results from other providers completed within two weeks prior to admission.

2. **For organizations that provide eating disorders care, treatment, or services:** The organization gathers behavioral and physical health information from both inpatient and outpatient providers by whom the individual has been treated, and/or other eating disorders treatment programs in which the individual has participated, if available.

3. **For organizations that provide eating disorders care, treatment, or services:** The organization obtains or completes initial medical assessments, Diagnostic and Statistical Manual of Mental Disorders (DSM)-based diagnostic assessments, psychiatric evaluations, and nutritional assessments in accordance with the level of care provided, and within the time frame designated by the organization’s policies and procedures.

   **Note:** Psychological testing is completed as clinically indicated.
4. **For organizations that provide eating disorders care, treatment, or services:** The organization conducts complete assessments in accordance with the level of care provided and within the time frame designated by the organization’s policies and procedures.

5. **For organizations that provide 24-hour eating disorders care, treatment, or services:** The organization assesses the risk for falls for each individual served.

6. **For organizations that provide 24-hour eating disorders care, treatment, or services:** The organization implements interventions to reduce falls based on the individual’s assessed risk.

7. **For organizations that provide 24-hour eating disorders care, treatment, or services:** Individuals served are assessed and reassessed for refeeding syndrome based on the individual’s physiological status.

**Standard CTS.02.04.01**

**For foster care:** The agency screens and assesses each individual to determine needed services and placement.

**Elements of Performance for CTS.02.04.01**

1. **For foster care:** Each individual in foster care receives a physical status screening.

2. **For foster care:** Each individual in foster care receives a developmental status screening.

3. **For foster care:** Each individual in foster care receives an educational status screening.

4. **For foster care:** Each individual in foster care receives an emotional status screening.

5. **For foster care:** Each individual in foster care receives a behavioral status screening.

6. **For foster care:** Each individual in foster care receives a social status screening.

7. **For foster care:** Each individual in foster care receives a legal status screening.

8. **For foster care:** Each individual in foster care receives a spiritual status screening.

9. **For foster care:** Each individual in foster care receives a cultural and linguistic status screening.
10. **For foster care:** To the extent possible, the agency collects information about the individual served from the individual in foster care, the foster parents, the child’s or youth’s family of origin, and the guardian.

11. **For foster care:** The agency provides for a process for rapid assessment (triage) of the child’s or youth’s family resources to determine the appropriateness of foster or kinship care and to develop a preliminary plan.

   **Note:** *Family resources can include the family of origin and the extended family.*

12. **For foster care:** The agency develops a preliminary plan based on the triage assessment to meet the needs of the individual in foster care and match the foster home to the individual.

13. **For foster care:** The agency conducts an assessment to secure stable placement of the individual.

14. **For foster care:** The agency conducts an assessment within the time frame specified by the needs of the individual in foster care, agency policy, and law and regulation.

15. **For foster care:** Based on the assessment, the agency determines appropriateness of the match of the individual in foster care to a foster home.

16. **For foster care:** The agency arranges for the history and physical examination, any laboratory or diagnostic tests, dental examinations, and immunization status confirmation to be performed in a time frame that is in compliance with law and regulation and accommodates the best interest and welfare of the individual in foster care.

17. **For foster care:** If the state or county agency has done an initial assessment, the foster care agency receives and evaluates this information.

**Standard CTS.02.04.03**

*For foster and/or respite care:* The agency develops criteria to match a foster or respite home to an individual.

**Elements of Performance for CTS.02.04.03**

1. **For foster and/or respite care:** The agency develops criteria to match a foster or respite home to an individual that is based on an assessment to identify the needs of the individual and an assessment of the qualities of the foster or respite family.
2. **For foster and/or respite care:** The agency uses the criteria to match a foster or respite home to an individual.

3. **For foster and/or respite care:** The agency develops criteria to address emergency placements of individuals.

4. **For foster and/or respite care:** The agency uses the criteria to address emergency placements of individuals.

5. **For foster and/or respite care:** The assessment for emergency placement in foster or respite care contains basic information essential to the safety of the individual and the family.

**Standard CTS.02.04.05**

**For foster and/or respite care:** The agency assesses each prospective foster parent or respite caregiver to determine whether he or she is eligible to be a foster parent or respite caregiver.

**Elements of Performance for CTS.02.04.05**

1. **For foster and/or respite care:** Each prospective foster parent or respite caregiver receives an assessment of his or her capability that includes the following:
   - Physical health.

2. **For foster and/or respite care:** Each prospective foster parent or respite caregiver receives an assessment of his or her capability that includes the following:
   - Emotional capacity.

3. **For foster and/or respite care:** Each prospective foster parent or respite caregiver receives an assessment of his or her capability that includes the following:
   - Interpersonal relationships.

4. **For foster and/or respite care:** Each prospective foster parent or respite caregiver receives an assessment of his or her capability that includes the following:
   - Knowledge of developmental needs.

5. **For foster and/or respite care:** Each prospective foster parent or respite caregiver receives an assessment of his or her capability that includes the following:
   - Financial stability.

6. **For foster and/or respite care:** Each prospective foster parent or respite caregiver receives an assessment of his or her capability that includes the following:
   - Cultural and linguistic evaluations.
For foster and/or respite care: Each prospective foster parent or respite caregiver receives an assessment of his or her capability that includes the following: A willingness to be educated.

For foster and/or respite care: Each prospective foster parent or respite caregiver receives an assessment of his or her capability that includes the following: Criminal background checks, including background checks on any adult living in the home.

For foster and/or respite care: The assessment of a prospective foster parent or respite caregiver establishes the following:

- That the prospective foster parent or respite caregiver is free from any diseases or physical conditions that have been determined to be a detriment to the welfare of the individual in foster or respite care
- That the prospective foster parent or respite caregiver has the ability to nurture and provide care and supervision to the individual in foster or respite care
- That the prospective foster parent or respite caregiver demonstrates mental and emotional stability

For foster and/or respite care: The agency assesses a foster parent or respite caregiver on an ongoing basis, but no less than annually.

Note: This assessment may occur at various times throughout service as a foster parent or respite caregiver, such as at license renewal, when a new individual is placed in the home, when physical arrangements change in the home, or when background checks are necessary for any new adult who moves into the home.

Standard CTS.02.04.07

For foster care of children and youth: The agency assesses the needs of the family of origin.

Elements of Performance for CTS.02.04.07

1. For foster care of children and youth: The agency assesses the family of origin and determines the interventions necessary to keep the children or youth with their families or to reunify children and youth in foster care with their families.
Note: Some of the necessary interventions may include help with communication and problem-solving, parenting skills, behavioral contingencies techniques and skills, daily living skills, housing, child care, health care, mental health care, substance abuse care, family therapy, and employment.

2. For foster care of children and youth: Based on the results of the assessment, the family of origin is provided access or referral to care, treatment, or services that would alleviate or mitigate the causes of foster placement.

3. For foster care of children and youth: The family-of-origin assessment occurs at intake and regularly thereafter or as directed by the case plan of the placing agency authority.

4. For foster care of children and youth: The agency obtains relevant information from the family-of-origin assessment when that assessment is performed by another provider.

5. For foster care of children and youth: The family-of-origin assessment is made a part of the child’s or youth’s clinical/case record, and services are coordinated with the agency referring the child or youth.

Standard CTS.02.04.09
For foster care: The agency uses a defined process to determine out-of-home placement decisions.

Elements of Performance for CTS.02.04.09
1. For foster care: The agency clearly delineates the process for making out-of-home placement decisions that may involve protective services, voluntary placement, or court orders.

2. For foster care: The agency defines how it plans to carry out the voluntary placement agreement or judicial determination.

Standard CTS.02.04.11
For foster and/or respite care: The agency defines and uses criteria to determine the need for foster and/or respite care services.

Elements of Performance for CTS.02.04.11
1. For foster and/or respite care: The agency defines written criteria to determine the appropriateness of foster and/or respite care for an individual served.
2. **For foster and/or respite care:** The agency uses its criteria to determine the appropriateness of foster and/or respite care for an individual served.

3. **For foster and/or respite care:** At a minimum, criteria to determine the appropriateness of foster and/or respite care include the following:
   - Safety.

4. **For foster and/or respite care:** At a minimum, criteria to determine the appropriateness of foster and/or respite care include the following:
   - The need for care for adults and care and protection for children and youth.

5. **For foster and/or respite care:** At a minimum, criteria to determine the appropriateness of foster and/or respite care include the following:
   - Any need for intensive out-of-home care beyond foster and/or respite care.

6. **For foster and/or respite care:** At a minimum, criteria to determine the appropriateness of foster and/or respite care include the following:
   - The inability of family or friends to care for the individual.

7. **For foster and/or respite care:** At a minimum, criteria to determine the appropriateness of foster and/or respite care include the following:
   - The benefits to the individual of family-based care.

8. **For foster and/or respite care:** Agencies accepting referrals receive and review information from the public or custodial agency as part of intake.

9. **For foster and/or respite care:** Agencies accepting referrals determine if they can meet the needs of the individual.

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**Standard CTS.02.04.13**

**For foster and/or respite care:** The agency defines and uses criteria to identify prospective foster parents and/or respite caregivers.

**Elements of Performance for CTS.02.04.13**

1. **For foster and/or respite care:** The agency defines written criteria to identify prospective foster parents and/or respite caregivers.

2. **For foster and/or respite care:** The agency uses its written criteria to identify and select prospective foster parents and/or respite caregivers.

3. **For foster and/or respite care:** The agency determines a recruitment plan that includes targeting and marketing to attract prospective foster parents or respite caregivers.
Standard CTS.02.04.15

For foster and/or respite care: The agency develops and uses criteria to determine the number of individuals that can be placed in each foster and/or respite care home.

Elements of Performance for CTS.02.04.15

1. For foster and/or respite care: The agency develops written criteria to determine the number of individuals in foster care that can be placed in each foster and/or respite care home.

   Note: Criteria may include the following:
   - The individual’s needs (emotional, developmental, psychological, behavioral, age-related, history of legal involvement, history of mental health needs, special restrictions, special physical care needs)
   - Resources available to the foster parent and/or respite caregiver (education, respite)
   - Support services (for example, extended family support, church support, community support)
   - Anticipated length of placement
   - Special-needs training for foster parents and/or respite caregivers
   - Prior experience as a foster care and/or respite caregiver
   - For children and youth, the number of biological children and number of siblings

2. For foster and/or respite care: The agency uses its criteria to determine the number of individuals in foster and/or respite care that can be placed in each home.

3. For foster and/or respite care: The maximum number of individuals living in each home complies with state and federal law and regulation.

Standard CTS.02.04.17

For foster care: The agency uses guidelines in making placement decisions.

Elements of Performance for CTS.02.04.17

1. For foster care: The agency uses guidelines in making placement decisions.

   Note: Guidelines can either be developed and written by the agency or adopted in accordance with law and regulation.

2. For foster care: Guidelines for making placement decisions include the following:
Consideration for placing the child or youth with kinship care providers (if an appropriate kinship house can be located) before placing in a non-relative foster care provider

Consideration for community, schools, visitation, placing siblings together, and the proximity of the child or youth to the family of origin

Being culturally responsive to the characteristics of both the individual in foster care and the families, to the best of the agency’s ability

Consideration for any respiratory risks to an individual from passive smoke due to existing health issues, such as asthma

The utmost consideration for the safety and well-being of the individual in foster care

Note: The individual’s best interest and special needs are paramount when considering placement in close proximity to the parent’s home.

3. For individuals in foster care who are receiving educational services: To meet educational needs and prevent exacerbation of educational problems, the individual is placed, if possible, in his or her own community and school district for continuity of educational services.

Standard CTS.02.04.19

For foster and/or respite care: The agency determines the competence of and how to select foster parents and/or respite caregivers.

Elements of Performance for CTS.02.04.19

1. For foster and/or respite care: The agency develops a process to determine the competence and selection of foster parents and/or respite caregivers.

2. For foster and/or respite care: The agency follows its process to determine the competence and selection of foster parents and/or respite caregivers.

3. For foster and/or respite care: When determining competence and selection of foster parents and/or respite caregivers, the agency uses the following:
   - The application
   - The applicant’s references
   - Criminal background checks for all adults in the household
   - Child abuse registry checks for children and youth
   - Physical examinations
   - Home inspection reports
   - Language of the family
Interviews with foster parents and/or respite caregivers

4. **For foster and/or respite care:** When determining competence and selection of foster parents and/or respite caregivers, the agency uses criteria based on the applicant’s ability to care for individuals with special needs, such as physical or intellectual and developmental disabilities or emotional disturbances.

5. **For foster and/or respite care:** When determining competence and selection of foster parents and/or respite caregivers, the agency uses criteria based on competencies that match the level or type of foster and/or respite care.

6. ⬤ **For foster and/or respite care:** The agency has a written policy for circumstances under which unlicensed alternative care providers must have a safety check. The policy takes into consideration the level of risk involved with the situation.

Standard CTS.02.04.21

**For foster care for children and youth:** Individuals providing therapeutic foster care services receive ongoing training and supervision to maintain competence.

Elements of Performance for CTS.02.04.21

1. **For foster care for children and youth:** Individuals providing therapeutic foster care services receive ongoing training to maintain competence.

2. **For foster care for children and youth:** Individuals providing therapeutic foster care services receive ongoing supervision to maintain competence.

Introduction to Standards CTS.03.01.01 Through CTS.03.02.03—Planning Care, Treatment, or Services

The expressed needs, strengths, preferences, and goals of the individual served provide a contextual framework for the information and impressions collected from screening and assessment. Taken together, these sources provide a foundation for planning individualized care, treatment, or services. The individual served, as well as his or her family, as appropriate to the individual’s circumstances, are important participants in the care, treatment, and services planning process. Plans are modified in accordance with progress toward goals and changes in needs and preferences.
Standard CTS.03.01.01
The organization bases the planned care, treatment, or services on the needs, strengths, preferences, and goals of the individual served.

**Note:** For opioid treatment programs: Methadone has well-documented effects on several systems, including the respiratory, nervous, and cardiac systems, and the liver. Additionally, many medications including methadone can act to increase the QT interval on an electrocardiogram and potentially lead to torsades de pointes, a potentially life-threatening cardiac arrhythmia. Therefore, it is important for the program physician to consider all of the medications the patient is currently taking (including actual versus prescribed doses, illicit drugs, medically active adulterants potentially present in illicit substances, and medically active over-the-counter or natural remedies). Given consideration of this information, the program physician can determine whether the treatment drug will be methadone, buprenorphine, or another medication and whether the treatment indicated for the patient is induction, detoxification, or maintenance.

**Elements of Performance for CTS.03.01.01**

1. The needs, strengths, preferences, and goals of the individual served are identified based on the screening and assessment and are used in the plan for care, treatment, or services.

2. Care, treatment, or service decisions are collaborative and interdisciplinary when more than one discipline is involved in the care, treatment, or services of the individual served.

3. Planning for care, treatment, or services includes identifying objectives for the identified goals. *(See also CTS.03.01.03, EP 3)*

4. Planning for care, treatment, or services includes interventions and services necessary to meet the identified goals.

6. **For opioid treatment programs:** The program manages concurrent abuse of other drugs† within the context of the medication-assisted treatment.

7. **For opioid treatment programs:** The program establishes strategies to prevent or limit patients from acquiring and abusing prescriptions for controlled substances or other psychotropics from prescribers with whom the patients have ongoing relationships.

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† Principles for managing concurrent abuse of other drugs are described in TIP 43, “Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs” (CSAT 2005).
8. **For opioid treatment programs:** For patients with two or more unsuccessful withdrawal episodes within a 12-month period, the program physician assesses the patient to determine what other forms of treatment should be considered.

9. **For opioid treatment programs:** The program includes smoking and tobacco cessation as an integral part of the treatment of patients who use tobacco.

10. **For opioid treatment programs:** Patients diagnosed with diseases that must be reported to the public health department (such as tuberculosis or sexually transmitted diseases) are either treated by the program or are referred for further evaluation and treatment elsewhere.

11. **For opioid treatment programs:** The program provides patients with free or low-cost access to the immunizations recommended by the Centers for Disease Control and Prevention (CDC) either on site or through referral.

12. **For opioid treatment programs:** The program establishes linkages with community HIV/AIDS treatment programs, prevention programs, and social support services to continue opioid medication when AIDS becomes the patient’s primary health concern.

13. **For organizations that elect The Joint Commission Behavioral Health Home option:** The physical health goals of the individual served are identified based on the screening and assessment and used in the plan for care, treatment, or services.

14. **For organizations that elect The Joint Commission Behavioral Health Home option:** All physical and behavioral health care, treatment, or service decisions are collaborative and integrated when more than one discipline is involved in the care, treatment, or services provided to the individual served.

**Standard CTS.03.01.03**

The organization has a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served.

**Elements of Performance for CTS.03.01.03**

1. The organization develops a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served.

2. The plan for care, treatment, or services includes the following:
   - Goals that are expressed in a manner that captures the individual’s words or ideas
- Goals that build on the individual’s strengths
- Factors that support the transition to community integration when identified as a need during assessment
- The criteria and process for the individual’s expected successful transfer and/or discharge, which the organization discusses with the individual (For more information, refer to Standard CTS.06.02.01)

**Note 1:** Barriers that might need to be considered include co-occurring illnesses, cognitive and communicative disorders, developmental disabilities, vision or hearing disabilities, physical disabilities, and social and environmental factors.

**Note 2:** *For opioid treatment programs:* For patients receiving interim maintenance treatment, neither an initial treatment plan nor a periodic treatment plan evaluation is required.

3. The objectives of the plan for care, treatment, or services meet the following criteria:
   - They include identified steps to achieve the goal(s) *(See also CTS.03.01.01, EP 3)*
   - They are sufficiently specific to assess the progress of the individual served
   - They are expressed in terms that provide indices of progress

4. The organization re-evaluates and, when necessary, revises the goals and objectives of the plan for care, treatment, or services based on change(s) in the individual’s needs, preferences, and goals and his or her response to care, treatment, or services. If no change(s) occurs, the goals and objectives are re-evaluated at a specified time interval established by organization policy.

5. Reasons for deferring a goal, or the objectives leading toward or related to a goal, are documented.

6. The organization provides care, treatment, or services for each individual served according to the plan for care, treatment, or services.

7. *For opioid treatment programs:* The program includes recovery support services in patients’ treatment plans according to patients’ needs. Examples of such services include follow-up phone calls; face-to-face meetings; e-mails; and connecting patients to peer-to-peer services, 12-step or faith-based programs, and community groups.
8. **For opioid treatment programs:** Treatment plans are updated when there are changes in the patient’s problems, needs or response to treatment or, if no changes occur, at least quarterly during the patient’s first year of continuous treatment and semiannually during subsequent years.

9. **For opioid treatment programs:** The program offers people living with HIV/AIDS medication-assisted treatment that addresses medication side effects and toxicity.

10. **For opioid treatment programs:** The program supports a patient’s decision to breast-feed during methadone treatment, unless medically contraindicated, such as by the presence of HIV or HTLVI or II infection in the mother.

11. **For opioid treatment programs:** Voluntary withdrawal from medication-assisted treatment is medically supervised and occurs at a rate well tolerated by the patient and in accordance with sound clinical judgment.

   **Note:** Voluntary withdrawal can occur when the physician and patient agree to the process or when the patient requests withdrawal against medical advice. Voluntary supervised withdrawal is distinct from involuntary tapering or administrative withdrawal (refer to Standard CTS.06.02.01).

12. **For opioid treatment programs:** The program offers a variety of options to promote successful medically supervised withdrawal, including increased counseling prior to discharge and encouraging attendance at a 12-step or other mutual help program that accepts individuals receiving medication-assisted treatment.

13. **For opioid treatment programs:** The program advises patients of the risks of relapse following withdrawal and offers a relapse prevention program that includes counseling, naloxone, and opioid antagonist therapy.

14. **For opioid treatment programs:** The program provides medically supervised withdrawal after pregnancy only when clinically indicated or requested by the patient.

15. **For opioid treatment programs:** For medically supervised withdrawal against medical advice: The program explains the risks of leaving treatment and provides information about or referral to alternate treatment options.
16. **For opioid treatment programs: For medically supervised withdrawal against medical advice:** When a patient leaves the program abruptly, the program allows the patient to be readmitted without repeating the initial assessment procedures if the readmission is within 30 days.

17. **For opioid treatment programs: For medically supervised withdrawal against medical advice:** The program documents the reasons given by the patient for seeking medically supervised withdrawal against medical advice and documents all steps taken to avoid discharging the patient.

18. **For opioid treatment programs: For medically supervised withdrawal against medical advice:** If medically supervised withdrawal fails, the physician evaluates the appropriateness of resuming maintenance treatment.

19. **For opioid treatment programs: For medically supervised withdrawal against medical advice:** For a pregnant patient, the program informs the physician or agency providing prenatal care that the patient is undergoing medically supervised withdrawal, consistent with federal privacy standards.

20. **For organizations that elect The Joint Commission Behavioral Health Home option:** The plan for care, treatment, or services includes the following:
   - The physical health care needs of the individual
   - The physical health care goals of the individual
   - How the organization will meet those needs
   - How the organization will help the individual to work toward achieving his or her goals

21. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization identifies the verbal and written communication needs of the individual served, including his or her preferred language for discussing health care.

   **Note:** Examples of communication needs include the need for personal devices such as hearing aids or glasses, language interpreters, communication boards, and translated or plain language materials.

22. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization communicates with the individual served during the provision of care, treatment, or services in a manner that meets his or her verbal and written communication needs.
23. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization works in partnership with the individual served to achieve planned integrated care outcomes.

24. **For organizations that elect The Joint Commission Behavioral Health Home option:** The individual’s self-management goals related to behavioral and physical health conditions are identified and incorporated into the individual’s plan of care, treatment, or services. (Refer to RI.01.02.01, EP 1)

25. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization involves the individual served in the development of his or her plan of care, treatment, or services.

26. **For organizations that provide eating disorders care, treatment, or services:** The plan of care, treatment, or services specifies a diagnosis based on the current Diagnostic and Statistical Manual of Mental Disorders (DSM) and/or the current edition of the *International Classification of Diseases* (ICD).

27. **For organizations that provide eating disorders care, treatment, or services:** The plan of care, treatment, or services provides for sufficient nutritional rehabilitation to support regular and consistent weight when indicated (including expected rates of controlled weight gain of at least one pound per week), and/or measurable improvement in eating disorders behavior (for example, restricting, binge eating, purging).

**Standard CTS.03.01.05**

The plan for care, treatment, or services addresses the family’s involvement.

**Elements of Performance for CTS.03.01.05**

1. The family of the individual served is involved in developing the plan for care, treatment, or services upon consent from the individual (if an adult) or in accordance with law and regulation (if a minor). *(See also CTS.04.02.16, EP 5)*

2. The plan for care, treatment, or services reflects family participation in care, treatment, or services unless such participation is contraindicated. *(See also CTS.04.02.16, EP 5)*

3. The organization documents family participation (if any) in the individual’s record of care, treatment, or services. *(See also CTS.04.02.16, EP 5)*
Standard  **CTS.03.01.07**

When individuals served need additional care, treatment, or services not offered by the organization, referrals are made and documented in the clinical/case record. (For more information, refer to Standard CTS.04.01.01.)

**Elements of Performance for CTS.03.01.07**

1. When the organization does not directly provide care, treatment, or services needed by the individual served, it refers the individual to an outside source.

2. Concurrent care, treatment, or services provided by an outside source that are integral to meeting goals and objectives are addressed in the plan for care, treatment, or services.

3. The organization documents referrals of individuals served to outside sources in the clinical/case record.

4. **For opioid treatment programs:** The program completes referrals and follow-up for other health care needs within three months of admission.

5. **For opioid treatment programs:** The program educates all women of childbearing age about neonatal abstinence syndrome, its symptoms, its potential effect on their infants, and the need for treatment should it occur.

6. **For opioid treatment programs:** The program helps female patients with infants that may be susceptible to neonatal abstinence syndrome to obtain a comprehensive evaluation and treatment for the infant.

7. **For opioid treatment programs:** The program offers referrals to parenting support groups or other services to patients in medication-assisted treatment who have children.

   **Note:** Children of patients in medication-assisted treatment may also need a referral for services because they may have special mental health and cognitive needs, especially if abuse or neglect has occurred.

8. **For opioid treatment programs:** The program offers or provides referrals for child care services to patients in medication-assisted treatment who have children.

9. **For opioid treatment programs:** If the program refers the patient elsewhere for prenatal care, it seeks reciprocity in the exchange of pertinent clinical information about compliance with the recommended course of medical care, in accordance with federal privacy regulations.

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
10. **For opioid treatment programs:** If a pregnant woman refuses direct prenatal services or appropriate referral for such care, the program’s treating physician or designee has the patient formally acknowledge in writing that the program offered these services but the patient refused them.

11. **For opioid treatment programs:** The program refers the patient for appropriate treatment if the assessment identifies mental health needs.

**Standard CTS.03.01.09**

The organization assesses the outcomes of care, treatment, or services provided to the individual served.

**Rationale for CTS.03.01.09**

Organizations that provide care, treatment, or services continuously strive to improve the quality and safety of their processes (for more information, refer to the Performance Improvement” [PI] chapter). As part of this improvement process, the organization monitors the progress of the individual served and aggregates data about care, treatment, and service outcomes in order to improve the effectiveness of the care, treatment, or services provided.

**Elements of Performance for CTS.03.01.09**

1. The organization uses a standardized tool or instrument to monitor the individual’s progress in achieving his or her care, treatment, or service goals.

   **Note:** Ideally, the tool or instrument monitors progress from the individual’s perspective. The tool or instrument may be focused on a population or diagnostic category (such as depression or anxiety), or the tool or instrument may have a more global focus such as general distress, functional status, quality of life (especially in regard to intellectual/developmental disabilities and other physical and/or sensory disabilities), well-being, or permanency (especially in regard to foster care).

2. The organization gathers and analyses the data generated through standardized monitoring, and the results are used to inform the goals and objectives of the individual’s plan for care, treatment, or services as needed.

3. The organization evaluates the outcomes of care, treatment, or services provided to the population(s) it serves by aggregating and analyzing the data gathered through the standardized monitoring effort. (For more information, refer to Standard PI.02.01.01)
4. **For organizations that provide eating disorders care, treatment, or services:** The organization assesses outcomes of care, treatment, or services based on data collected at admission. Examples of such data include complete history and physical including height, weight, frequency of binge eating and purging (when applicable), eating disorder diagnosis, Body Mass Index (BMI), heart rate, date of last period, and other appropriate lab tests such as potassium, phosphorus, thyroid, hemoglobin, glucose, as determined by the organization and in accordance with the level of care provided. *(See also CTS.02.03.11, EP 1)*

**Standard CTS.03.02.01**

*For organizations providing care, treatment, or services to individuals with intellectual and developmental disabilities:* The organization addresses the needs, strengths, preferences, and goals of individuals.

**Elements of Performance for CTS.03.02.01**

1. **For organizations providing care, treatment, or services to individuals with intellectual and developmental disabilities:** Individuals served and, as appropriate, their families or advocates have the opportunity to participate in the planning process by expressing their needs and preferences, in regard to care, treatment, or services.

2. **For organizations providing care, treatment, or services to individuals with intellectual and developmental disabilities:** The organization reviews the individualized plan of care, treatment, or services when the following occurs:
   - Change(s) in functioning
   - Change(s) in living situation
   - Change(s) in employment status and situations
   - Bereavement for a significant other
   - Introduction of assistive technology
   - Other major change(s), or at least at intervals in accordance with organization policy

3. **For organizations providing care, treatment, or services to individuals with intellectual and developmental disabilities:** The organization accommodates the preferences of the individual served and his or her family, or, if it cannot, it finds the best options available.
4. **For organizations providing care, treatment, or services to individuals with intellectual and developmental disabilities:** When the individual’s identified needs, strengths, and preferences include developing skills for activities of daily living, the plan of care, treatment, or services includes the following:

- Goals sufficiently specific to evaluate the progress made toward developing skills for activities of daily living
- The interventions to be used
- The frequency of the use of the interventions

**Standard CTS.03.02.03**

**For foster care:** The agency develops and periodically reviews its case plans.

**Elements of Performance for CTS.03.02.03**

1. **For foster care:** The agency develops a case plan.
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2. **For foster care:** The agency evaluates the case plan in a time frame that is in accordance with organization policy and law and regulation.

3. **For foster care:** The agency involves relevant persons in evaluating the case plan.

   **Note:** These persons may include agency staff, the individual served, the foster parent(s), the family of origin (for children and youth only), and the representative of the state authority.

4. **For foster care:** The case plan is individualized based on an assessment of the emotional, behavioral, developmental, educational, spiritual, social, physical, cultural, linguistic, and legal status of the individual in foster care as well as that of the family of origin.

5. **For foster care:** The case plan identifies the permanency goal if the individual in foster care is a child or youth.

6. **For foster care:** The agency reviews and revises the case plan as needed to determine the continuing necessity for placement.

7. **For foster care:** The case planning process includes an assessment of preparation for transitional living when older youth or adults are discharged from foster care. (For more information on young adults preparing for transitional living, see Standard CTS.06.03.01)

   **Note:** Services for older youth or adults that help them develop skills necessary for independence include the following:
   - Employment career planning assessments
   - Financial management
   - Daily living skills (for example, cooking, transportation)
   - Completing high school or general educational development (GED)
   - Job search training
   - Vocational training

   Other possible services that prepare older youth or adults for independence include developing support systems and exploring educational needs such as GED programs/college, social/relationship skills, and parenting skills, when applicable.

8. **For foster care:** When the agency has custody of the individual in foster care, the agency is responsible for case planning.
9. **For foster care:** If the county or state agency retains custody and is responsible for the case plan, the foster care agency participates in developing and evaluating the plan.

**Introduction to Standards CTS.04.01.01 and CTS.04.01.03—Providing Care, Treatment, or Services**

The plan for care, treatment, or services, developed by staff for providing the care, treatment, or services and the individual served, provides direction for all involved. It helps to ensure that everyone knows what the responsibilities are for staff and individuals served, what care, treatment, or services will be provided, and when it will be provided. The following standards emphasize the coordination of care, treatment, or services as well as the education provided to the individual served about the provision of the care, treatment, or services.

**Standard CTS.04.01.01**

The organization coordinates the care, treatment, or services provided to an individual served as part of the plan for care, treatment, or services and in a manner consistent with the organization’s scope of care, treatment, or services. (For more information, refer to Standard CTS.03.01.07.)

**Rationale for CTS.04.01.01**

Care, treatment, or services should be coordinated among providers and between settings, independent of whether they are provided directly by the organization or by an outside source, so that the individual’s needs are addressed in a seamless, synchronized, and timely manner.

**Elements of Performance for CTS.04.01.01**

1. The organization coordinates the care, treatment, or services provided through internal resources to an individual served. **R**

2. For acute 24-hour settings, a registered nurse plans, assigns, supervises, provides, and evaluates nursing care to individuals served.
Note: “Acute 24-hour settings” includes inpatient crisis stabilization or medical detoxification.

3. The organization’s process for hand-off communication provides for the opportunity for discussion between the giver and receiver of information regarding the individual served.

Note: Such information may include the condition, care, treatment, medications, and services of the individual served, as well as any recent or anticipated changes to any of these.

4. When a temporary staff member covers for a permanent staff member, a documented review of any orders issued by the temporary staff member is conducted by the permanent staff member upon his or her return and within the time frame defined by the organization. (See also RC.01.03.01, EP 1)

5. When external resources are needed, the organization participates in coordinating care, treatment, or services with these resources.

6. The organization has a process to receive or share relevant information about the individual served to facilitate coordination and continuity when individuals are referred to other care, treatment, or service providers.

7. For organizations that provide eating disorders care, treatment, or services: If during the course of care, treatment, or services the individual served is transferred to a hospital, the organization provides the hospital with a clinical contact person who can provide information relevant to the individual’s eating disorder in support of the individual’s care, treatment, or services.

8. The activities detailed in the plan of care, treatment, or services are designed to occur in a time frame that meets the behavioral health needs of the individual served.

9. For organizations that elect The Joint Commission Behavioral Health Home option: The activities detailed in the plan of care, treatment, or services are designed to occur in a time frame that meets the physical health care needs of the individual served.

10. Before taking action on a verbal order or verbal report of a test result, staff members use a record and “read back” process to verify the information.
11. **For opioid treatment programs:** The program works with the criminal justice system to provide continuous treatment to patients who are incarcerated, on probation, or on parole.

12. **For opioid treatment programs:** When possible, the program manages comorbidities on site. When comorbidities cannot be managed on site, the program develops referral and consultative relationships with other agencies and providers that can provide services to treat patients for any psychiatric comorbid conditions, medical complications, and communicable diseases.

13. **For opioid treatment programs:** When a patient is being treated for mental health issues, the program and the mental health provider jointly review the prescribed medications.

14. **For opioid treatment programs:** The program provides medication-assisted treatment for alcohol use disorders, when appropriate, as well as counseling interventions for patients with a need for treatment.

15. **For opioid treatment programs:** When a patient has hepatitis C, the program coordinates its treatment with the agency responsible for medical treatment. Attention is paid to the patient’s adherence to the medication regimen and adverse events.

16. **For opioid treatment programs:** The program notifies the state health officer both when a patient begins and leaves interim maintenance treatment and notifies the state health officer in advance when the patient is transferred to a comprehensive maintenance treatment program. All such notifications are documented.

17. **For opioid treatment programs:** The program’s telemedicine services are conducted via an interactive audio and video telecommunications system that permits real-time communication between the health care provider at the distant site and the patient at the originating site.

18. **For opioid treatment programs:** The program periodically queries the prescription drug monitoring program (PDMP) throughout the course of each patient’s treatment (for example, quarterly) and, in particular, before ordering take-home doses as well as at other important clinical decision points.

19. **For organizations that elect The Joint Commission Behavioral Health Home option:** If an organization has multiple integrated care teams, each team provides care, treatment, or services for a designated panel of individuals.
20. **For organizations that elect The Joint Commission Behavioral Health Home option:** When an individual is referred to an external organization, the integrated care team does the following:
   - Assists the individual with making the referral appointment, when needed
   - Assists the individual in getting to the appointment, when needed
   - Tracks whether the individual kept the appointment
   - Reviews and tracks the care, treatment, or services provided to the individual

21. **For organizations that provide 24-hour eating disorders care, treatment, or services:** A registered nurse is either on duty or available 24 hours a day, 7 days a week.

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**Standard CTS.04.01.03**

The individual served receives education and training specific to the individual's needs and abilities consistent with the care, treatment, or services provided.

**Note:** *This standard does not apply to academic education.*

**Elements of Performance for CTS.04.01.03**

1. Education provided is based on the needs and abilities of the individual served.

2. The assessment of learning needs addresses the individual’s cultural and religious beliefs, emotional barriers, desire and motivation to learn, physical or cognitive limitations, and barriers to communication.

3. Education provided to the individual served is coordinated among the disciplines providing care, treatment, or services.

4. Based on the assessed needs and abilities of the individual served and the organization’s scope of care, treatment, or services, the individual is educated about the following:
   - The plan for care, treatment, or services
   - Basic health practices and safety
   - The safe and effective use of medications
   - Nutrition interventions, modified diets, and oral health, as needed
   - Habilitation or rehabilitation techniques to help him or her reach the maximum level of independence possible

5. The content of the education provided to the individual served is presented in an understandable manner.
6. Teaching methods accommodate various learning styles.

7. The individual’s comprehension of the education provided is evaluated.

8. For opioid treatment programs: The program provides each patient with an orientation and ongoing education that includes: The nature of addictive disorders.

9. For opioid treatment programs: The program provides each patient with an orientation and ongoing education that includes: The benefits of treatment and nature of the recovery process, including the phases of treatment.

10. For opioid treatment programs: The program provides each patient with an orientation and ongoing education that includes: Clinic guidelines, rules, and regulations, including the requirement to sign a formal agreement of consent, and fees and billing procedures.

11. For opioid treatment programs: The program provides each patient with an orientation and ongoing education that includes: Noncompliance and discharge procedures, including administrative withdrawal from medication.

12. For opioid treatment programs: The program provides each patient with an orientation and ongoing education that includes: Toxicology testing procedures.

13. For opioid treatment programs: The program provides each patient with an orientation and ongoing education that includes: Dispensing medication.

14. For opioid treatment programs: The program provides each patient with an orientation and ongoing education that includes: Potential drug interactions.

15. For opioid treatment programs: The program provides each patient with an orientation and ongoing education that includes: Any agreements needed in order to exchange appropriate information within the network of consultants and referral agencies (in accordance with HIPAA regulations).

16. For opioid treatment programs: The program provides each patient with an orientation and ongoing education that includes: The availability of any 12-step or other mutual help group that is accepting of medication-assisted treatment and of the benefits of peer support.

17. For opioid treatment programs: The program counsels patients known to be using benzodiazepines, even by prescription, as to their risk and provides them with overdose prevention education and naloxone.

18. For opioid treatment programs: The program documents that it informed and counseled the pregnant patient about the latest patient information sheets and product inserts for methadone.

19. For opioid treatment programs: If prenatal care is not available on site or by referral, or if the pregnant patient refuses prenatal care, the treatment program offers basic prenatal instruction on maternal, physical, and dietary care. Provision of the education is documented in the clinical record.

20. For opioid treatment programs: The program offers or refers the patient education and training for all patients who are parents or refers patients to parenting skills.

21. For opioid treatment programs: The program offers reproductive health education and referrals for contraceptive services.

22. For opioid treatment programs: The program educates patients about HIV/AIDS, including testing procedures, confidentiality, reporting, follow-up care, counseling, safer sex, social responsibilities, universal precautions, and sharing of intravenous injection equipment.

23. For opioid treatment programs: The program provides education to patients about viral hepatitis and its effects on physical and mental health, including prevention, treatment, and the effects of treatment on dosage levels of opioid medications.

24. For opioid treatment programs: The program provides education to patients about preventing HIV infection and other prevalent infectious diseases, such as hepatitis, sexually transmitted infections, and tuberculosis.

25. For organizations that elect The Joint Commission Behavioral Health Home option: The organization identifies the health literacy needs of the individual served.
Note: Typically this is an interactive process. For example, individuals may be asked to demonstrate their understanding of information provided by explaining it in their own words.

26. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization incorporates the health literacy needs of the individual served into his or her education.

27. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization educates the individual served on self-management support, based on his or her individual needs.

28. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization provides education to the individual served on the benefits of integrating behavioral and physical health care including, at a minimum, how improvements in either behavioral or physical health can positively affect the other.

**Standard CTS.04.01.07**

**For organizations that elect The Joint Commission Behavioral Health Home option:**

The organization provides excellent access to integrated care, treatment, or services.

**Elements of Performance for CTS.04.01.07**

1. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization provides individuals served with the ability to do the following 24 hours a day, 7 days a week:
   - Contact the behavioral health home to request an appointment
   - Request prescription renewal
   - Request clinical advice for urgent health needs

   **Note:** This ability may be provided through a number of methods, including telephone, e-mail, flexible hours, websites, and portals.

2. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization offers flexible scheduling to accommodate the individual’s care, treatment, or service needs.

   **Note:** This may include open access scheduling, same-day or next available appointments, group visits, expanded hours, and arrangements with other organizations.
3. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization has a process to respond to an individual’s urgent care needs 24 hours a day, 7 days a week.

4. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization facilitates individuals’ online access to their health information within four business days after the information is available to the integrated care team. This information includes diagnostic test results, lab results, summary lists, and medication lists.

5. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization uses a certified electronic health record to provide appointment reminders to individuals.

6. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization provides individuals with contact information for the team coordinator on their integrated care team.

**Standard CTS.04.02.01**

For organizations providing care, treatment, or services to individuals with intellectual and developmental disabilities: The organization recognizes and addresses the personal preferences of the individual served.

**Note:** The personal preferences of the individual served are addressed by the organization to the extent feasible.

**Elements of Performance for CTS.04.02.01**

1. **For organizations providing care, treatment, or services to individuals with intellectual and developmental disabilities:** The organization’s philosophy is to recognize and support the preferences of each individual served.

2. **For organizations providing care, treatment, or services to individuals with intellectual and developmental disabilities:** To the extent feasible for each individual served, the organization fosters a quality of life comparable to that experienced by most people.

3. **For organizations providing care, treatment, or services to individuals with intellectual and developmental disabilities:** The setting of care, treatment, or services supports the personal experiences, appearance, and behavior of each individual served.
4. **For organizations providing care, treatment, or services to individuals with intellectual and developmental disabilities:** The social and living environment offers the individual a variety of social and community experiences that facilitate the development of self-awareness, independence, and use of personal strengths and skills.

5. **For organizations providing care, treatment, or services to individuals with intellectual and developmental disabilities:** The individual served participates in formulating policies that affect his or her living and social environment.

### Standard CTS.04.02.03

**For organizations providing care, treatment, or services to individuals with intellectual and developmental disabilities:** The organization provides for the health maintenance of all individuals with intellectual and developmental disabilities, including early detection and remediation of health needs.

### Elements of Performance for CTS.04.02.03

1. **For organizations providing 24-hour care to individuals with intellectual and developmental disabilities:** Height is monitored at least quarterly for children and youth until cessation of growth.

2. **For organizations providing 24-hour care to individuals with intellectual and developmental disabilities:** Weight is monitored at least quarterly, or more frequently if needed, as determined by the individual’s physical health care practitioner.

3. **For organizations providing 24-hour care to individuals with intellectual and developmental disabilities:** The organization provides needed assistive technology directly, through contractual arrangement, or by referral to an outside source.

4. **For organizations prescribing anticonvulsant drugs to individuals with intellectual and developmental disabilities and seizure activity:** Physicians define the frequency and method of monitoring anticonvulsant drug levels. (For more information, refer to standard MM.07.01.01)

5. **For organizations prescribing anticonvulsant drugs to individuals with intellectual and developmental disabilities and seizure activity:** Anticonvulsant drug levels are monitored regularly as part of the individual’s physical health maintenance program, and the findings are documented in the clinical/case record. (For more information, refer to standard MM.07.01.01)
6. For organizations providing physical therapy to individuals with intellectual and developmental disabilities: A qualified individual supervises and coordinates the physical therapy services.

**Standard CTS.04.02.05**

For organizations providing care, treatment, or services to individuals with intellectual and developmental disabilities: The organization records the use of assistive technology in the clinical/case record.

**Element of Performance for CTS.04.02.05**

1. For organizations providing care, treatment, or services to individuals with intellectual and developmental disabilities: The organization includes the following in the clinical/case record of individuals who use assistive technology:
   - The condition that requires the assistive technology
   - The schedule or conditions for using the assistive technology
   - The intended results of using the assistive technology

**Standard CTS.04.02.07**

For foster care: The foster parent(s) receives information and education to meet the needs of the individuals placed in his or her care.

**Elements of Performance for CTS.04.02.07**

1. For foster care: Each foster parent receives preservice orientation, in-service training, and ongoing education.

For foster care: Orientation of each foster parent includes information on the following:

2. Philosophy and practices of the agency.
3. The foster parent’s role.
4. The agency’s policies and procedures regarding discipline.
5. The agency’s role in helping the foster parent serve individuals placed in his or her care.

For foster care: Education is provided to each foster parent about the following:

6. The individual’s specific behavioral problems and health conditions.
7. Community resources.
8. First aid.

10. The individual’s medications.

11. Infection prevention and control.

12. The health risks of passive smoking.

13. Provision of emergency medical and mental health services, as needed.

14. The agency’s visitation policies and scheduling of the visits.

15. Sitter policies.

16. **For foster care:** Each foster parent also participates in agency-approved education as required.

**Standard CTS.04.02.09**

**For respite care:** The respite caregiver receives information needed to meet the needs of the individual placed in his or her care.

**Element of Performance for CTS.04.02.09**

1. **For respite care:** The information provided by the organization to each respite caregiver includes the following:
   - Needs, strengths, and preferences of the individual served
   - Medication(s) for the individual served
   - First aid
   - Safety
   - Provision of emergency medical care
   - Specific health conditions of the individual served

**Standard CTS.04.02.11**

**For organizations providing care, treatment, or services to children or youth:** The plan for care, treatment, or services reflects needed educational services for every child or youth whose care, treatment, or services cause a significant absence from school.

**Elements of Performance for CTS.04.02.11**

1. **For organizations providing care, treatment, or services to children or youth:** An individual education plan is developed for each child or youth whose care, treatment, or services cause a significant absence from school.
2. For organizations providing care, treatment, or services to children or youth:
Qualified individuals provide educational services to children and youth whose care, treatment, or services cause a significant absence from school.

Standard CTS.04.02.13
For organizations providing care, treatment, or services to children or youth: The organization provides academic education to children and youth as needed.

Rationale for CTS.04.02.13
Providing academic education helps maintain the educational and intellectual development of children and youth who are receiving behavioral health care, treatment or services. State or local laws may specify requirements for meeting academic needs when children or youth are not able to attend their usual school because they are receiving behavioral health care, treatment, or services.

Elements of Performance for CTS.04.02.13
1. For organizations providing care, treatment, or services to children or youth: The organization defines the length of stay and absence from school that would require providing educational services in accordance with applicable law and regulation.

2. For organizations providing care, treatment, or services to children or youth: The organization has a written policy that addresses the role of education as a therapeutic activity and protects children and youth from losing ground academically while receiving care, treatment, or services.

Standard CTS.04.02.15
For organizations providing care, treatment, or services to children or youth: The organization facilitates educational continuity for children and youth.

Elements of Performance for CTS.04.02.15
1. For organizations providing care, treatment, or services to children or youth: The organization facilitates communication with the child’s or youth’s school about past academic functioning and achievement.

2. For organizations providing care, treatment, or services to children or youth: The organization promotes regular communication among teachers, clinical and child-care staff, and parent or guardian.
3. **For organizations providing care, treatment, or services to children or youth:** The organization provides consistent intervention between teachers and clinical and child-care staff, as defined in the plan for care, treatment, or services.

### Standard CTS.04.02.16

**For organizations that provide eating disorders care, treatment, or services:** The organization provides additional care, treatment, or services that support the needs of individuals with eating disorders.

### Elements of Performance for CTS.04.02.16

1. **For organizations that provide eating disorders care, treatment, or services:** Each individual served receives core care, treatment, or service components (psychosocial, medical, nutritional, and psychiatric) according to his or her assessed needs. This includes, but is not limited to, individual therapy, group therapy, family therapy (as applicable), medical monitoring, medication monitoring (as applicable), and nutritional counseling.

2. **For organizations that provide eating disorders care, treatment, or services:** The organization is knowledgeable about evidence-based guidelines for treatment of individuals with eating disorders, such as the American Psychiatric Association Eating Disorder Treatment Guidelines, the Guidelines of the British National Institute for Clinical Excellence (NICE Guidelines), or the American Academy of Child and Adolescent Psychiatry Practice Parameter for the Assessment and Treatment of Children and Adolescents With Eating Disorders.

3. **For organizations that provide eating disorders care, treatment, or services:** A registered dietitian is available to provide for individuals’ nutritional needs, including assessing, educating, and counseling individuals, parents and/or guardians, and staff on food- and nutrition-related issues.

4. **For organizations that provide eating disorders care, treatment, or services:** A registered dietitian designs, implements, and manages safe and effective nutrition-related strategies that enhance growth and development; support recovery from disordered eating; and promote lifelong health.

5. **For organizations that provide eating disorders care, treatment, or services:** The organization attempts to engage family members who have not acknowledged the organization’s efforts to involve them in the individual’s care, treatment, or services, in accordance with the needs and preferences of the individual served. *(See also CTS.03.01.05, EPs 1–3)*
Standard CTS.04.02.17

For organizations providing care, treatment, or services to individuals with eating disorders: The organization monitors the individual’s weight and food-related behaviors. (Refer to CTS.02.03.09 for more information)

Note: This standard applies to all individuals with eating disorders regardless of setting.

Elements of Performance for CTS.04.02.17

1. For organizations providing care, treatment, or services to individuals with eating disorders: The organization monitors the individual’s weight in accordance with organizational policy.

2. For organizations providing care, treatment, or services to individuals with eating disorders: The organization monitors the individual’s food-related behaviors.

Standard CTS.04.02.18

For organizations that provide 24-hour eating disorders care, treatment, or services: The organization supervises individuals served as needed.

Elements of Performance for CTS.04.02.18

1. For organizations that provide 24-hour eating disorders care, treatment, or services: The organization supervises the daily activities of individuals served as needed to prevent them from engaging in behavior that could be detrimental to their health, such as excessive or inappropriate exercise, inappropriate use of laxatives, or self-induced vomiting.

2. For organizations that provide 24-hour eating disorders care, treatment, or services: Supervision is conducted by staff; the organization prohibits one individual served from supervising another.

Introduction to Standards CTS.04.02.19 and CTS.04.02.21

Individuals with severe mental illness and other vulnerable populations receiving behavioral health care, treatment, or services (such as children) often do not receive the care needed to maintain their physical health. Receiving primary physical health care in conjunction with behavioral health care provides the individual with an integrated approach to care that supports improved outcomes.
Primary physical health care is a basic level of physical health care that includes programs and services addressing the promotion of physical health, early diagnosis of disease or disability, treatment of acute and chronic illnesses, and prevention of disease. Primary physical health care includes health maintenance and education of the individual served, which can include wellness programs or education on diet, smoking cessation, the benefits of physical activity, and risk factors for cardiovascular disease.

Examples of common acute health issues treated through primary physical health care include:
- Flu symptoms
- Sore throats
- Minor lacerations
- Sprains

Examples of common chronic health issues treated through primary physical health care include:
- Hypertension, heart failure, and angina
- Diabetes
- Asthma and COPD
- Arthritis

Examples of other care provided through primary physical health care include:
- Medical history and physical examination
- Screenings and diagnostic tests (such as blood pressure, blood sugar level, cholesterol, tuberculosis, sexually transmitted diseases, and HIV)
- Vaccinations
- Wellness or education programs
- Family planning services

Standard CTS.04.02.19 addresses behavioral health care organizations that provide primary physical health care to individuals served—either directly provide primary physical health care or have a contract with another organization to provide this care on the behavioral health care organization’s behalf. For more information on contracted services, refer to Standard LD.04.03.09.

Standard CTS.04.02.21 addresses behavioral health care organizations that have a formal agreement (such as a memorandum of understanding or letter of agreement) with another organization to refer individuals served to that organization for primary physical health care. In this case, the primary physical health care organization is not providing
physical health care on the behalf of the behavioral health care organization; rather, it has agreed to provide primary physical health care to those individuals who are referred to it by the behavioral health care organization, in accordance with the details of the agreement between the two organizations (these details will vary depending on the organizations involved). The primary physical health care organization retains responsibility for the care, treatment, and services it provides to those individuals referred to it by the behavioral health care organization. It is important to note that these standards are applicable only to organizations that are already engaged in these activities.

**Standard CTS.04.02.19**

The organization provides basic prevention, screening, and physical health care services.

**Note:** This standard is applicable only to organizations that directly provide primary physical health care either at their own facility or by contracting with another organization to provide primary physical health care on behalf of the behavioral health care organization. It applies whether the organization provides this service to all the individuals it serves or to only a distinct population of individuals.

**Rationale for CTS.04.02.19**

An integrated approach to health care yields the best results for the individual served. This means addressing both the behavioral and physical health care needs of the individual. Behavioral health care organizations that provide primary physical health care either directly or through a contracted service with another organization need to address certain basic aspects of this care.

**Elements of Performance for CTS.04.02.19**

1. For organizations that directly provide primary physical health care to individuals served: The organization provides education to the individual served on the value of prevention, screening, and routine physical health care. (For more information, refer to Standard RI.01.01.03)

2. For organizations that directly provide primary physical health care to individuals served: The organization provides prevention, screening, and primary physical health care services that are appropriate to the age, gender, and needs of the individual.
3. **For organizations that directly provide primary physical health care to individuals served:** The organization communicates its role in supporting individuals in receiving primary physical health care to the individual and, as appropriate, his or her family.

4. **For organizations that directly provide primary physical health care to individuals served:** The organization makes available to the primary physical health care provider the individual’s needs, strengths, preferences, and goals and other information needed to facilitate physical health care, with the permission of the individual and in accordance with law and regulation.

5. **For organizations that directly provide primary physical health care to individuals served:** The organization provides for physical health care, treatment, and services not directly provided by the organization through a referral (for example, diagnostic and laboratory tests).

6. **For organizations that directly provide primary physical health care to individuals served:** The organization provides education to the individual on the self-management of a physical illness or condition when indicated by the physical health care needs of the individual. (For more information, refer to Standard RI.01.01.03)

7. **For organizations that directly provide primary physical health care to individuals served:** With the permission of the individual served, the organization supports the individual in receiving primary physical health care which, at a minimum, includes helping the individual to do the following:
   - Follow up on tests, medications, and treatments
   - Manage any fear or reluctance about receiving physical health care
   - Obtain and keep appointments

   **Note:** *Helping the individual to obtain and keep appointments may include accompanying the individual to appointments, calling the individual to remind him or her of appointments, providing transportation to and from appointments, and other activities within the scope of the organization’s resources.*

8. **For organizations that directly provide primary physical health care to individuals served:** The organization maintains communication between itself and the primary physical health care provider regarding the individual’s care, treatment, or services, with the permission of the individual and in accordance with law and regulation.
9. **For organizations that directly provide primary physical health care to individuals served:** The organization educates its primary physical health care staff on how to interact with the behavioral health population(s) it serves.

**Standard CTS.04.02.21**

The organization provides basic prevention, screening, and physical health care services to individuals served through a referral agreement with a primary physical health care provider.

**Note:** This standard is applicable only to organizations that have a formal agreement to refer individuals to a particular organization for primary physical health care. It applies whether the organization provides this service to all the individuals it serves or to only a distinct population of individuals.

**Rationale for CTS.04.02.21**

An integrated approach to health care yields the best results for the individual served. This means addressing both the behavioral and physical health care needs of the individual. Behavioral health care organizations that have a formal agreement with another organization to refer the individuals they serve to that organization for primary physical health care, treatment, and services need to address certain basic aspects of this process.

**Elements of Performance for CTS.04.02.21**

1. **For organizations that refer individuals served to another organization for primary physical health care:** The organization informs the individual served of the value of prevention, screening, and routine physical health care. (For more information, refer to Standard RI.01.01.03)

2. **For organizations that refer individuals served to another organization for primary physical health care:** The organization refers the individual for prevention, screening, and primary physical health care services that are appropriate to the age, gender, and needs of the individual.

3. **For organizations that refer individuals served to another organization for primary physical health care:** The organization communicates its role in supporting individuals who are referred for primary physical health care to the individual and, as appropriate, his or her family.
4. **For organizations that refer individuals served to another organization for primary physical health care:** The organization shares with the primary physical health care provider the individual’s needs, strengths, preferences, and goals and other information needed to facilitate physical health care, with the permission of the individual and in accordance with law and regulation.

**Standard CTS.04.02.23**

**For organizations that elect The Joint Commission Behavioral Health Home option:**
The organization provides or facilitates the provision of prevention, screening, and primary physical health care, treatment, or services as part of integrated care.

**Elements of Performance for CTS.04.02.23**

1. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization makes available to the integrated care team all information needed to facilitate the delivery of integrated physical and behavioral health care, treatment, or services.

2. **For organizations that elect The Joint Commission Behavioral Health Home option:** The behavioral health home staff have access to a primary physical health care clinician for consultation purposes at all times.

3. **For organizations that elect The Joint Commission Behavioral Health Home option:** The behavioral health home staff have access to a behavioral health care clinician for consultation purposes at all times.

**Standard CTS.04.02.25**

**For organizations that elect The Joint Commission Behavioral Health Home option:**
The organization is accountable for facilitating the provision of integrated care to the individual served.

**Elements of Performance for CTS.04.02.25**

1. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization manages transitions in care and facilitates the individual’s access to integrated care, treatment, or services including the following:
   - Acute care
   - Management of chronic care
   - Preventive services that are age- and gender-specific
   - Behavioral health care needs
- Oral health care
- Vision care
- Urgent and emergent care

Note: Some of these services may be obtained through the use of community resources as available, or in collaboration with other organizations.

2. For organizations that elect The Joint Commission Behavioral Health Home option: The integrated care, treatment, or services address various phases of the lifespan of the individuals it serves, including end-of-life care when relevant to the population(s) served. (For more information, refer to Standard RI.01.05.01)

3. For organizations that elect The Joint Commission Behavioral Health Home option: The organization provides disease and chronic care management services to the individuals it serves, as needed or as clinically indicated.

4. For organizations that elect The Joint Commission Behavioral Health Home option: The organization communicates its role in supporting individuals who require specialty physical health assessment, care, treatment, or services to the individual and, as appropriate, his or her family, with the permission of the individual and in accordance with law and regulation.

5. For organizations that elect The Joint Commission Behavioral Health Home option: The organization makes certain that the specialty physical health care, treatment, or services provider receives all the information about the individual’s behavioral and physical health that is needed to facilitate the specialty physical health assessment(s) and care, treatment, or services, with the permission of the individual and in accordance with law and regulation.

Standard CTS.04.02.27
For organizations that elect The Joint Commission Behavioral Health Home option: The integrated care team works in partnership with the individual served to support the continuity of care and the provision of comprehensive and coordinated care, treatment, or services.

Elements of Performance for CTS.04.02.27
1. For organizations that elect The Joint Commission Behavioral Health Home option: The organization identifies the composition of the integrated care team.
2. **For organizations that elect The Joint Commission Behavioral Health Home option:** The members of the integrated care team provide comprehensive and coordinated care, treatment, or services and maintain the continuity of care, treatment, or services.

   **Note:** The provision of care, treatment, or services may include making internal and external referrals.

3. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization designates one member of the integrated care team to serve as team coordinator. This team member is accountable for coordinating the provision and continuity of the integrated care, treatment, or services and facilitating the individual’s access to all needed care, treatment, or services, whether behavioral or physical.

   **Note 1:** Coordination of integrated care, treatment, or services may include coordinating internal and external referrals and coordinating the development and evaluation of plans of care, treatment, or services.

   **Note 2:** Portions of these activities may be delegated to other staff members by the team coordinator, with accountability remaining with the team coordinator.

4. **For organizations that elect The Joint Commission Behavioral Health Home option:** The integrated care team participates in the development of the individual’s plan of care, treatment, or services.

5. **For organizations that elect The Joint Commission Behavioral Health Home option:** The integrated care team assesses individuals for health risk behaviors.

**Standard CTS.04.02.29**

**For organizations that provide eating disorders care, treatment, or services:** The multidisciplinary care, treatment, or services team supports the continuity and provision of care, treatment, or services.

**Elements of Performance for CTS.04.02.29**

1. **For organizations that provide eating disorders care, treatment, or services:** The organization has a multidisciplinary care, treatment, or services team that consists of at least the following:
   - A licensed clinician with experience and/or training in treating eating disorders
- A doctor of medicine or osteopathy with experience and/or training in treating eating disorders, either on staff or available to the team during regular hours of operation. If individuals served are under the age of 13, the MD or DO is a pediatrician. If the MD or DO is not on staff, an advanced practice nurse with experience and/or training in treating eating disorders and licensed to prescribe medications is on staff.
- A psychiatrist or clinical psychologist with experience and/or training in treating eating disorders, either on staff or available to the team 24 hours a day, 7 days a week
- A registered dietitian
- A registered nurse, unless there is an advanced practice nurse on staff

**Note:** The MD or DO who is part of the team does not need to be employed by the organization or on the organization’s staff; but the organization does need to have an established relationship with an MD or DO who has experience or training in treating eating disorders to whom the organization can refer individuals when needed. The MD or DO could be the individual’s primary care physician, if he or she has experience or training in treating eating disorders.

2. **For organizations that provide eating disorders care, treatment, or services:** If individuals served are less than 18 years of age, the organization has access to consultation from a child or adolescent psychiatrist.

**Note:** The psychiatrist may be either on staff or otherwise available to the multidisciplinary team, such as via a teleconference link.

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**Introduction to Standards CTS.04.03.01 Through CTS.04.03.13—Vocational Rehabilitation and Employment Assistance**

Attaining and maintaining meaningful employment is, for some individuals, an important element in achieving personal satisfaction, independence, and social integration into the community. Organizations may or may not assist individuals within this life domain. When provided, the services may include a distinct vocational rehabilitation program or less formal employment assistance.
Organizations that operate a distinct vocational rehabilitation program typically have designated staff that provide assessment services, skills training, supported employment, or work activities, or a combination of these services.

Organizations may also assist the individuals served to prepare for, gain, maintain, and/or improve their employment situation. Less formal than vocational rehabilitation, employment assistance is incorporated into the individual’s overall plan for care, treatment, or services and is provided by direct care staff otherwise already assisting the individual served with life domains.

**Standard CTS.04.03.01**

*For organizations providing employment assistance:* The organization assists the individual served in preparing for, gaining, maintaining, and/or improving employment, in accordance with the plan for care, treatment, or services.

**Rationale for CTS.04.03.01**

For many individuals served in behavioral health settings, a meaningful life in the community often includes employment. Organizations may assist an individual in identifying his or her interests and strengths relative to employment, as well as determining his or her immediate needs and future goals for gaining or maintaining employment and/or improving an employment situation.

**Elements of Performance for CTS.04.03.01**

1. *For organizations providing employment assistance:* The organization assists the individual served in determining his or her desire to work.

2. *For organizations providing employment assistance:* The organization assists the individual served in identifying his or her personal interests, values, and vocational preferences.

3. *For organizations providing employment assistance:* The organization assists the individual served in identifying his or her employment needs.

4. *For organizations providing employment assistance:* The organization assists the individual served in identifying or refining his or her employment goals.

5. *For organizations providing employment assistance:* The organization assists the individual served in identifying employment opportunities (for example, reviewing employment ads, browsing the Internet) and in preparations to secure employment (for example, preparing resumes, completing applications).
6. **For organizations providing employment assistance:** The organization assists the individual served in developing the skills and supports needed to maintain employment.
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Standard CTS.04.03.03

For organizations that provide vocational rehabilitation services: The organization monitors changes in the local job market to facilitate employment of the individual served.

Elements of Performance for CTS.04.03.03

1. For organizations that provide vocational rehabilitation services: The organization establishes and maintains relationships with other agencies providing employment services, vocational rehabilitation, and state vocational rehabilitation departments.

   Note: Vocational rehabilitation is defined as a service or program designed to attain, retain, or restore vocational skills of persons experiencing limited functioning. Vocational rehabilitation services may include vocational evaluation services, employment skills training, work activities, and supportive employment.

2. For organizations that provide vocational rehabilitation services: The organization establishes and maintains relationships with the business community.

3. For organizations that provide vocational rehabilitation services: The organization makes staff available to employers upon request to address stigma issues and concerns (for example, speakers, educators, referrals).

4. For organizations that provide vocational rehabilitation services: The organization monitors employment and unemployment trends in the community.

5. For organizations that provide vocational rehabilitation services: The organization makes improvements to service design and offerings in response to employers’ changing personnel and skill needs.

Standard CTS.04.03.05

For organizations that provide vocational rehabilitation services: The organization assists the individual served in determining his or her desire for training and assessing needs, strengths, preferences, and goals related to training.

Elements of Performance for CTS.04.03.05

1. For organizations that provide vocational rehabilitation services: The organization assists the individual served in determining his or her desire for training.

For organizations that provide vocational rehabilitation services: The organization assists the individual served in assessing his or her potential for the following:
2. Pre-employment education/training.
3. Training and education at the work site.
4. Skill building, both pre-employment and at the work site.
5. Assistance coaching.
6. Long-term training and support needs.
7. Peer and family support in these endeavors.

**Standard CTS.04.03.07**

For organizations that provide vocational rehabilitation services: The organization assists the individual served in assessing his or her needs related to securing and maintaining employment.

**Elements of Performance for CTS.04.03.07**

For organizations that provide vocational rehabilitation services: The organization assists the individual served in determining his or her need for help with the following:

1. Personal grooming and appearance.
2. Assistive technologies or accommodations.
3. Transportation.
5. Benefits counseling and management of wages.
7. Safety risks.
8. Flexibility in terms of scheduling and transportation.
9. Assessment and support planning coordination with other service providers.
10. Family or community support.

**Standard CTS.04.03.09**

For organizations that provide vocational rehabilitation services: The organization assists the individual served in assessing his or her skills and supports related to securing and maintaining employment.
Elements of Performance for CTS.04.03.09

For organizations that provide vocational rehabilitation services: The organization assists the individual served in assessing his or her skills and supports through a review of the following:

1. Previous work history including volunteer activities.
2. Skills and experiences in seeking employment (for example, completing applications, interviewing).
3. Current work skills and the potential for improving skills or developing new ones.
4. Educational background.
5. Cognitive skills and abilities.
6. Physical abilities.
7. Work habits related to tardiness, absenteeism, dependability, honesty, and relations with coworkers and supervisors.

Standard CTS.04.03.11

For organizations that provide vocational rehabilitation services: The organization assists the individual served in assessing his or her interests related to securing and maintaining employment.

Elements of Performance for CTS.04.03.11

1. For organizations that provide vocational rehabilitation services: The organization assists the individual served in assessing his or her own expectations for the personal, financial, and social benefits of working.

2. For organizations that provide vocational rehabilitation services: The organization assists the individual served in assessing his or her own aptitudes, interests, and motivations toward involvement in various job-related activities.

3. For organizations that provide vocational rehabilitation services: The organization assists the individual served in assessing his or her own desire for career planning assistance.
Standard CTS.04.03.13

For organizations that provide vocational rehabilitation services: The organization assists the individual served to gain employment if such a goal is part of his or her plan for care, treatment, or services.

Elements of Performance for CTS.04.03.13

1. For organizations that provide vocational rehabilitation services: The organization assists the individual served in developing a plan for employment that focuses on the individual’s employment goals and objectives.

2. For organizations that provide vocational rehabilitation services: The organization develops a written employment plan that is specific to the individual served.

3. For organizations that provide vocational rehabilitation services: The written employment plan includes the following:
   - The types of employment, school, and/or training for which the individual served is qualified or interested
   - The goals of the individual served
   - Barriers to employment (for example, transportation, written or verbal communication skills, child care needs)
   - Resources available to address barriers
   - Assessment of employment opportunities available to the individual served based on preferences, barriers, and available positions within the local job market
   - A description of how wages may impact existing benefits
   - Alternatives to any lost benefits

4. For organizations that provide vocational rehabilitation services: The organization documents decisions that the individual served has made regarding accepting or declining employment opportunities.

5. For organizations that provide vocational rehabilitation services: The organization reviews opportunities and procedures for requesting changes to the employment plan with the individual served.

6. For organizations that provide vocational rehabilitation services: Once employment has occurred, the organization assesses the individual’s satisfaction with his or her employment on a timetable established by the organization.
7. For organizations that provide vocational rehabilitation services: The organization monitors employer satisfaction with an individual that they employ, according to a schedule determined by the organization.

Standard CTS.04.03.15

For 24-hour settings: In accordance with the needs of the individual served, good standards of personal hygiene and grooming are taught and maintained, particularly bathing, brushing teeth, caring for hair and nails, and using the toilet, with due regard for privacy.

Elements of Performance for CTS.04.03.15

1. For 24-hour settings: Articles for grooming and personal hygiene based on the age, developmental level, and needs of the individual served are available and accessible.

2. For 24-hour settings: The individual served is encouraged to take responsibility for maintaining his or her own living quarters and for day-to-day housekeeping activities of the program, according to the individual’s ability.

3. For 24-hour settings: An oral care program is implemented as indicated by the needs of the individual served and includes the following components:
   - The method(s) of providing or referring individuals for regular dental care
   - The method(s) for providing emergency dental care
   - The proper storage and labeling of oral hygiene supplies
   - As needed, labeling, cleaning, and storing of oral prostheses and appliances

4. For 24-hour settings: The organization offers education on grooming activities based on the needs of the individual served.

5. For 24-hour settings: The individual served has access to the services of a barber or beautician, either in the organization or community.

6. For 24-hour settings: Individuals served get the help needed to perform self-care activities and, when indicated, assume responsibility for self-care.

7. For 24-hour settings: Incontinent individuals are cleaned or bathed immediately after voiding or soiling, with due regard for privacy.
Standard  CTS.04.03.17
For organizations that use activity therapies: Activity therapies that are used to support achievement of a specific goal(s) are incorporated into the plan for care, treatment, or services.

Elements of Performance for CTS.04.03.17
1. For organizations that use activity therapies: The individual’s plan for care, treatment, or services identifies activity therapies provided to support achievement of a specific goal(s).
2. For organizations that use activity therapies: Activity therapies provided to support achievement of a specific goal(s) reflect the individual's interests and preferences.

Standard  CTS.04.03.19
For 24-hour settings: The organization provides recreational and diversional activities.

Elements of Performance for CTS.04.03.19
1. For 24-hour settings: The organization selects diversional or recreational activities based on the age(s) and population(s) served.
2. For 24-hour settings: The organization’s diversional or recreational activities include, whenever possible, each individual served.
3. For 24-hour settings: The organization arranges for safe access to the outdoors as appropriate to the population(s) served and when individuals served experience long lengths of stay.

Standard  CTS.04.03.20
For inpatient crisis stabilization: The organization supervises individuals served as needed.

Elements of Performance for CTS.04.03.20
1. For inpatient crisis stabilization: The organization supervises the daily activities of individuals served as needed to prevent them from engaging in behavior that could be detrimental to their health.
2. For inpatient crisis stabilization: Supervision is conducted by staff; the organization prohibits one individual served from supervising another.
Standard  CTS.04.03.21

For organizations that use animal-assisted therapy: The therapy is provided safely and in accordance with the individual’s plan of care, treatment, or services.

Note: Animal-assisted therapy is distinct from having pets in the organization. This standard does not apply to pets kept in the organization.

Rationale for CTS.04.03.21

In a variety of behavioral health care settings it is recognized that therapeutic animals may be of benefit to individuals served of all ages. Benefits reported include reduced stress; lower blood pressure; lower cholesterol; improved motivation; decreased loneliness, grief, and fear; and an improvement in taking responsibility for self. However, when animals are used for therapeutic purposes in behavioral health care settings there are safety and therapeutic concerns that must be addressed for the individual served, staff, and animals. These safety issues are addressed in Standard CTS.04.03.21.

Elements of Performance for CTS.04.03.21

1. For organizations that use animal-assisted therapy: Each individual is assessed to determine whether he or she is a candidate for animal-assisted therapy and whether the individual has any contraindications to animal-assisted therapy.

2. For organizations that use animal-assisted therapy: The organization establishes procedures for the safety of the individuals served.

3. For organizations that use animal-assisted therapy: Training of the staff includes the following:
   - Safe handling of animals
   - Therapeutic goals of the animal-assisted therapy
   - Safety of individuals served
   - Supervision of the individuals served during animal-assisted therapy

   (Refer to Standard HRM.01.05.01 for more information on staff training.)

4. For organizations that use animal-assisted therapy: The organization establishes guidelines for selecting animals that include the following:
   - Population(s) of individuals served
   - Health of animals
   - Vaccination status
   - Temperament of the animals
Introduction to Standards CTS.04.03.23 and CTS.04.03.25

While outdoor/wilderness experiences may involve unique opportunities to enhance the emotional, psychological, and social functioning of the individual served, they also have inherent risks. Safety processes and the training and experience of the outdoor/wilderness staff are the major components in minimizing risks and ensuring therapeutic outcomes. Standards CTS.04.03.23 and CTS.04.03.25 have been developed to assist organizations with eliminating or reducing the possibility of injury or harm from an outdoor/wilderness experience.

Standard CTS.04.03.23

For organizations that conduct outdoor/wilderness experiences: The organization safely conducts outdoor/wilderness experiences.

Note: This standard refers to an activity conducted for therapeutic reasons in remote areas away from the organization’s premises (for example, a wilderness experience). It does not refer to daily activities that may be conducted outside, such as going to community parks, participating in park district activities, and visiting the zoo.

Elements of Performance for CTS.04.03.23

1. For organizations that conduct outdoor/wilderness experiences: Prior to the individual served engaging in an outdoor/wilderness experience, the organization communicates to its staff any special precautions related to the individual of which staff should be aware.

2. For organizations that conduct outdoor/wilderness experiences: The organization has a written plan to manage emergency situations that could occur during an outdoor/wilderness experience that includes the following:
   - How the organization will contact staff during the experience
   - How staff will contact the organization during the experience
   - How to handle a natural emergency (for example, weather, fire, landslide)
   - How to conduct an evacuation
   - How to remove an individual served from the experience

3. For organizations that conduct outdoor/wilderness experiences: The organization establishes a mechanism by which it will maintain a means of contact with all staff participating in the outdoor/wilderness experience.
4. **For organizations that conduct outdoor/wilderness experiences:** The organization determines what identifying information is to be carried by each individual served during an outdoor/wilderness experience.

5. **For organizations that conduct outdoor/wilderness experiences:** The organization develops and communicates to staff the guidelines for permissible activities based on the level of risk involved in each activity.
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6. **For organizations that conduct outdoor/wilderness experiences:** The organization communicates the level of acceptable risk for the outdoor/wilderness activity to the outdoor/wilderness experience’s direct care staff.

7. **For organizations that conduct outdoor/wilderness experiences:** Prior to the individual’s enrollment in the outdoor/wilderness experience, the organization provides the individual and his or her guardian with a complete and accurate description of all planned off-site activities.

8. **For organizations that conduct outdoor/wilderness experiences:** The organization provides individuals served with the instruction needed to minimize the risk of physical or psychological harm associated with each outdoor/wilderness activity.

**Standard CTS.04.03.25**

**For organizations that conduct outdoor/wilderness experiences:** Organizations determine that staff who engage in an outdoor/wilderness experience are qualified and competent.

**Note 1:** *This standard refers to an activity conducted for therapeutic reasons in remote areas away from the organization’s premises (for example, a wilderness experience). It does not refer to daily activities that may be conducted outside, such as going to community parks, participating in park district activities, and visiting the zoo.*

**Note 2:** *Requirements for assessing competence appear in the “Human Resources Management” (HRM) chapter.*

**Elements of Performance for CTS.04.03.25**

1. **For organizations that conduct outdoor/wilderness experiences:** The outdoor/wilderness experience staff are qualified and physically able to lead the experience.

2. **For organizations that conduct outdoor/wilderness experiences:** The outdoor/wilderness experience staff are qualified to provide first aid and basic life support (CPR).

3. **For organizations that conduct outdoor/wilderness experiences:** The organization assigns staff to an outdoor/wilderness experience based on the sex of the individuals served.

4. **For organizations that conduct outdoor/wilderness experiences:** Staff are trained in using the outdoor/wilderness experience as a therapeutic intervention.
Standard CTS.04.03.27
For organizations providing family support services: The plan for care, treatment, or services identifies the role of families.

Note: Family support is distinct from family therapy and family counseling.

Elements of Performance for CTS.04.03.27

1. For organizations providing family support services: The individual served determines the role of family members and their access to information in accordance with his or her age, and law and regulation.

2. For organizations providing family support services: Family members providing support are involved in developing the plan for care, treatment, or services when indicated by the individual served.

3. For organizations providing family support services: The plan for care, treatment, or services reflects the roles and participation of family members designated by the individual served to provide support.

Standard CTS.04.03.29
For organizations providing family support services: Family members are offered information, assistance, and education as needed to facilitate their roles and participation in meeting the needs of the individual served.

Note: Family support is distinct from family therapy and family counseling.

Elements of Performance for CTS.04.03.29

For organizations providing family support services: Family members providing support are offered information, assistance, and education as needed from the organization on at least the following:

1. Their roles and responsibilities.

2. Crisis recognition.

3. Available community resources to respond to a crisis.

Standard CTS.04.03.31
For organizations providing peer support: The plan for care, treatment, or services addresses the involvement of peer support when provided.
Rationale for CTS.04.03.31
Peer support provided to individuals served by peers with similar life experiences can be helpful in the recovery process. It is therefore important for the organization sponsoring or offering peer support services to delineate the scope of these services and identify a range or practice for peers, which may include consumer advocacy.

Elements of Performance for CTS.04.03.31
1. **For organizations providing peer support**: The individual served determines the amount of information that can be accessed by, and the involvement of, peers providing support.
2. **For organizations providing peer support**: Peers providing support assist in developing the plan for care, treatment, or services, when indicated by the individual served.
3. **For organizations providing peer support**: The plan for care, treatment, or services reflects the inclusion of peer support, as determined by the individual served.

Standard CTS.04.03.33
**For organizations providing food services**: The organization has a process for preparing and/or distributing food and nutrition products.

Elements of Performance for CTS.04.03.33
1. **For organizations providing food services**: Food and nutrition products are provided to the individual served as appropriate to the care, treatment, or services being provided.
2. **For organizations providing food services**: Food and nutrition products are prepared under proper conditions of sanitation, temperature, light, moisture, ventilation, and security.
3. **For organizations providing food services**: Food and nutrition products are stored under proper conditions of sanitation, temperature, light, moisture, ventilation, and security.
4. **For organizations providing food services**: Cultural, religious, and ethnic food preferences of the individual served are honored when possible, unless contraindicated.
5. **For organizations providing food services:** Staff assist the individual served who requires help eating.

6. **For organizations providing food services:** Special diets and altered diet schedules are accommodated.

7. **For organizations providing food services:** Meals and snacks are served at times that are normal and appropriate for the age of the individual served.

8. **For organizations providing food services:** The organization assigns responsibility for preparing, storing, distributing, and administering food and nutrition therapy products.

9. **For organizations providing food services:** The dining areas used by individuals served are adequately supervised.

**Standard CTS.04.03.35**

The organization responds to medical emergencies according to organization policy and procedures.

**Elements of Performance for CTS.04.03.35**

1. ☐ The organization develops a written policy and procedures for responding to medical emergencies such as respiratory arrest and cardiac arrest.

2. Policy and procedures that address medical emergencies include the following:
   - Availability of first aid and basic life support services
   - Emergency transfer to another organization
   - Placement of a phone call to 911

3. The organization responds to medical emergencies according to organization policy and procedures.

4. ☐ **For opioid treatment programs:** The program’s offices and waiting areas display the names and telephone numbers of whom to contact in case of emergency or 911 or similar local emergency resources.

5. **For opioid treatment programs:** The program has staff on duty who are trained and proficient in the following:
   - Cardiopulmonary resuscitation (CPR) through an evidence-based training program
   - Management of opiate overdose
   - Management of medical emergencies
Other appropriate techniques

6. **For opioid treatment programs:** The program provides patients with a mechanism to address medical or psychiatric emergencies occurring outside of program hours of operation.

7. **For opioid treatment programs:** The program provides each patient with an identification card that identifies the opioid use disorder pharmacotherapy being administered through the program as well as the emergency contact information so that appropriate clinical information and dosing information can be obtained in an emergency.

**Introduction to Standards CTS.05.01.01 Through CTS.05.06.35—Special Behavioral Procedures**

Special procedures may be emergency procedures or planned interventions, but both have the potential for leading to abuse or causing harm. For that reason, these procedures/interventions require well-developed policies, thorough training of all staff involved, and careful monitoring and evaluation to ensure that risk of abuse is prevented and risk of harm is minimized or eliminated. Special procedures include exclusionary time-outs, level systems, individualized behavioral contingency programs, physical holding of children/youth, and restraint and seclusion.

Physical holds, seclusion, and restraint of any individual served are special emergency procedures that may be required to prevent harm to the individual served or others. However, they are intrusive, have a potential for harm, and may be traumatizing. All behavioral health care organizations that use these procedures should have, as their first priority, an active program to prevent the use of physical holds and restraint and seclusion. This begins by building a culture of safety and respect and includes thorough orientation of staff in approaches that will avoid the use of these procedures as much as possible. If these procedures are used, they must be carefully supervised by qualified clinical staff and be well documented. Data on these procedures are collected, analyzed, and used by leadership to reduce their usage as much as possible.
Standard **CTS.05.01.01**
The organization prohibits the use of any procedure that physically harms or is a psychological risk to the individual served.

**Elements of Performance for CTS.05.01.01**
At a minimum, the following are prohibited:

1. Procedures that deny any basic needs, such as nutritious food, water, shelter, and essential and safe clothing.

At a minimum, the following is prohibited:

2. Corporal punishment.

At a minimum, the following are prohibited:

3. Fear-eliciting procedures.

At a minimum, the following is prohibited:

4. The use of intimidation, force, or threat.

Standard **CTS.05.02.01**
*For organizations that use exclusionary time-out:* Time-out for behavioral reasons is provided safely and based on the needs of the individual served.

**Rationale for CTS.05.02.01**
Exclusionary time-out is one of several interventions that can help an individual served regain self-control; however, it can present the potential for misuse. Therefore, it is important for the organization to plan how it will use exclusionary time-out. This includes imposing a 30-minute time limit on an exclusionary time-out. The time limit serves two functions: it helps to make certain that the individual served is not left in the exclusionary time-out for an excessive length of time, and it allows staff to evaluate the effectiveness of the intervention, including whether another intervention would be more effective. It is important to note that exclusionary time-out is not the same as seclusion; please see the Glossary for definitions of both terms.

**Elements of Performance for CTS.05.02.01**

1. *For organizations that use exclusionary time-out:* Written policies and procedures limit the use of time-out for behavioral reasons to no more than 30 minutes.
2. **For organizations that use exclusionary time-out:** The organization implements its written policies and procedures limiting the use of time-out for behavioral reasons.

3. **For organizations that use exclusionary time-out:** The time-out for behavioral reasons is consistent with the individual’s plan for care, treatment, or services.

4. **For organizations that use exclusionary time-out:** The time-out for behavioral reasons occurs only in an unlocked room.

5. **For organizations that use exclusionary time-out:** The individual served is educated about the conditions under which time-outs for behavioral reasons are used.

6. **For organizations that use exclusionary time-out:** Age and cognitive functioning of the individual served are considered in time-out conditions.

**Standard CTS.05.03.01**

**For organizations that use level systems:** Level systems that apply to a group are individualized.

**Note:** This standard applies to any service or program that groups individuals served by their needs and behaviors and then uses methodologies such as level systems, group contingencies, and group consequences that are associated with privileges and restrictions. Organizations inform staff, individuals served, and families of the use of these methodologies.

**Elements of Performance for CTS.05.03.01**

1. **For organizations that use level systems:** At admission, the individual served and, as appropriate, his or her family are educated about and agree to the organization’s use of level systems.

2. **For organizations that use level systems:** Requirements for moving through level systems are known and achievable, and such requirements are equitably and fairly applied to all individuals served.

3. **For organizations that use level systems:** Behavior of the individual served is separately monitored for compliance.

4. **For organizations that use level systems:** Group consequences are based on collective group outcomes and not based on the behavior of a single individual.
5. **For organizations that use level systems:** Group consequences respect the rights of each individual served.

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**Introduction to Standards CTS.05.04.01 Through CTS.05.04.17—Individualized Behavioral Contingencies**

The purpose of the standards addressing individualized behavioral contingencies is to ensure the safety and rights of the individual served. These standards evaluate whether the applied behavioral technique is safe and whether it infringes upon the rights of the individual served. All of the individualized behavioral contingency standards apply only to formal individualized behavioral contingencies programs which include contingencies, restrictions, and exposures to aversive stimuli. These programs typically administer a well-defined response(s) to a specific target behavior(s), or exposure to a triggering stimulus to develop appropriate responses by the individual. Such responses are outside the range of routine interactions/interventions between staff and individuals served. These interventions are not emergency procedures but individually planned and are considered therapeutic interventions. When the individualized behavioral contingency utilizes a brief physical contact or other brief restraint in response to repetitive and intractable behavior that is severely self-injurious or injurious to others, the individual has not responded to traditional interventions, and the individual is unable to contract with staff for safety, the restraint standards do not apply. Please note that any restriction of the rights of an individual served is to be in accordance with the “Rights and Responsibilities of the Individual” (RI) chapter of this manual.

**Standard CTS.05.04.01**

*For organizations that use individualized behavioral contingencies:* Individualized behavioral contingencies are used in accordance with a process established by care, treatment, or services leaders.

**Elements of Performance for CTS.05.04.01**

1. **For organizations that use individualized behavioral contingencies:** Written policies and procedures that govern the use of individualized behavioral contingencies are developed by care, treatment, or services leaders.
2. **For organizations that use individualized behavioral contingencies:** The organization implements written policies and procedures that govern the use of individualized behavioral contingencies.

3. **For organizations that use individualized behavioral contingencies:** Policies and procedures support the use of individualized behavioral contingencies as therapeutic interventions that foster adaptive behaviors and make certain that such therapeutic interventions are not used exclusively for behavior control. 

4. **For organizations that use individualized behavioral contingencies:** Policies and procedures require that the selection of individualized behavioral contingencies considers both the appropriateness of the contingencies and minimizing the restrictiveness of the interventions.

5. **For organizations that use individualized behavioral contingencies:** The organization’s leaders approve the individualized behavioral contingencies to be used in the organization.

**Standard CTS.05.04.03**

**For organizations that use individualized behavioral contingencies:** Individuals served and, as appropriate, their families participate in selecting the individualized behavioral contingencies used for the individual.

**Elements of Performance for CTS.05.04.03**

1. **For organizations that use individualized behavioral contingencies:** Before implementing individualized behavioral contingencies, the individual served and, as appropriate, his or her family are educated about and agree to the organization’s use of the contingencies.

2. **For organizations that use individualized behavioral contingencies:** Before implementing individualized behavioral contingencies, the individual served and, as appropriate, his or her family collaborate with the organization to determine and agree to the target behaviors for which the contingencies may be used.

3. **For organizations that use individualized behavioral contingencies:** The individual served and, as appropriate, his or her family collaborate with the organization on and agree to the selection of a specific individualized behavioral contingency or contingencies for the individual served.
4. **For organizations that use individualized behavioral contingencies:** The individual served and, as appropriate, his or her family participate in identifying antecedents to and consequences of the target behavior.

5. **For organizations that use individualized behavioral contingencies:** When the individualized behavioral contingency for an individual served includes an aversive procedure(s), written informed consent for the contingency is obtained.

**Standard CTS.05.04.05**

**For organizations that use individualized behavioral contingencies:** Individualized behavioral contingencies are based on an assessment of the individual served and the target behavior.

**Elements of Performance for CTS.05.04.05**

1. **For organizations that use individualized behavioral contingencies:** Individualized behavioral contingencies are based on an assessment of the individual served.

2. **For organizations that use individualized behavioral contingencies:** Assessment of the individual served addresses environmental and contextual factors associated with the target behavior.

3. **For organizations that use individualized behavioral contingencies:** Assessment of the individual served addresses skill deficits associated with the target behavior.

4. **For organizations that use individualized behavioral contingencies:** Assessment of the individual served addresses performance deficits associated with the target behavior.

5. **For organizations that use individualized behavioral contingencies:** Assessment of the individual served addresses the identification of strengths associated with the target behavior.

6. **For organizations that use individualized behavioral contingencies:** Assessment of the individual served addresses frequency, duration, and intensity of the target behavior.

7. **For organizations that use individualized behavioral contingencies:** The assessment of the effectiveness of the target behavior is ongoing.
**Standard  CTS.05.04.07**

For organizations that use individualized behavioral contingencies: Individualized behavioral contingencies support the acquisition and reinforcement of adaptive/replacement behaviors.

**Elements of Performance for CTS.05.04.07**

1. **For organizations that use individualized behavioral contingencies:** The individualized behavioral contingencies identify and teach adaptive/replacement behaviors.

2. **For organizations that use individualized behavioral contingencies:** Adaptive/replacement behaviors are assessed to determine whether appropriate behavior is exhibited.

**Standard  CTS.05.04.09**

For organizations that use individualized behavioral contingencies: An individualized behavioral contingencies plan is aligned with the needs of the individual served and assessment results and is documented in the clinical/case record in accordance with the organization’s policy.

**Elements of Performance for CTS.05.04.09**

1. **For organizations that use individualized behavioral contingencies:** The organization develops a written, detailed, and individualized behavioral contingencies plan.

   **Note:** The plan may be a separate document or incorporated into the overall plan for care, treatment, or services.

For organizations that use individualized behavioral contingencies: The individualized behavioral contingencies plan includes at least the following:

2. Target behavior.

3. Adaptive/replacement behavior.

4. **For organizations that use individualized behavioral contingencies:** The individualized behavioral contingencies plan includes at least the following:
   - Method of implementation-strategy
   - Support
   - Teaching methods
   - Motivation and reward, if used
Frequency

Circumstances under which the plan will be implemented

For organizations that use individualized behavioral contingencies: The individualized behavioral contingencies plan includes at least the following:

5. Condition for discontinuation.
6. All interventions attempted and the results.

Standard CTS.05.04.11

For organizations that use individualized behavioral contingencies: Each individualized behavioral contingencies plan that includes the use of aversive contingencies is reviewed and approved by both a clinical leader(s) and a person(s) external to the organization.

Elements of Performance for CTS.05.04.11

1. For organizations that use individualized behavioral contingencies: The use of aversive behavioral contingencies is subject to internal and external review before a plan for care, treatment, or services that includes aversive contingencies is implemented. R

2. For organizations that use individualized behavioral contingencies: The use of aversive behavioral contingencies is reviewed and approved by both a clinical leader(s) and a person(s) external to the organization (for example, an outside expert, an advocate, a human rights committee). R

For organizations that use individualized behavioral contingencies: The review of the use of aversive behavioral contingencies includes the following:

3. Consideration of less restrictive alternatives, nonaversive procedures, and less aversive contingencies.
5. A time frame for implementing the plan and discontinuing the plan.
6. Other criteria established by the organization.

7. For organizations that use individualized behavioral contingencies: The organization prohibits individuals served from implementing an individualized behavioral contingency or special procedure. R
Standard  CTS.05.04.13
For organizations that use individualized behavioral contingencies: Qualified and competent staff design and review the individualized behavioral contingencies plans.

Note: Requirements for assessing competence appear in the “Human Resources Management” (HRM) chapter.

Elements of Performance for CTS.05.04.13
1. For organizations that use individualized behavioral contingencies: Staff designing individualized behavioral contingencies plans have qualifications, training, experience, and knowledge related to designing behavioral contingencies plans.
2. For organizations that use individualized behavioral contingencies: Staff supervising and monitoring individualized behavioral contingencies plans have qualifications, training, experience, and knowledge related to supervising and monitoring behavioral contingencies procedures and plans.
3. For organizations that use individualized behavioral contingencies: Staff determining changes to or discontinuation of behavioral contingencies have qualifications, training, experience, and knowledge related to determining the need for changes or discontinuation of behavioral contingencies.

Standard  CTS.05.04.15
For organizations that use individualized behavioral contingencies: Staff involved in implementing the individualized behavioral contingencies plan are trained, competent, and supervised.

Note: Requirements for assessing competence appear in the “Human Resources Management” (HRM) chapter.

Elements of Performance for CTS.05.04.15
1. For organizations that use individualized behavioral contingencies: The organization educates and assesses staff on the skills and knowledge needed to implement the individualized behavioral contingencies plan.
2. For organizations that use individualized behavioral contingencies: Staff demonstrate competence in a specific individualized behavioral contingency before implementing the contingency.
3. For organizations that use individualized behavioral contingencies: Staff are supervised.
**Standard CTS.05.04.17**

For organizations that use behavioral contingencies: The organization collects and analyzes data about the individual’s responses to his or her behavioral contingencies in order to monitor and improve the use of behavioral contingencies.

**Elements of Performance for CTS.05.04.17**

1. For organizations that use individualized behavioral contingencies: Outcomes of interventions for the individual are measured for frequency of occurrence of replacement behavior(s).

2. For organizations that use individualized behavioral contingencies: Outcomes of interventions for the individual are measured for frequency of occurrence of problem behavior(s).

**Introduction to Standards CTS.05.05.01 Through CTS.05.05.21—Physical Holding of Children/Youth**

**Applicability of the Physical Holding of Children/Youth Standards**

The behavioral health care standards for physical holding of children/youth apply to any use of physical holding of children/youth for behavioral health reasons.

**Exceptions to the Applicability of Physical Holding of Children/Youth Standards**

The standards for physical holding of children/youth do not apply to the following circumstances:

- The use of brief physical contact on an individual served who receives such a procedure through an individualized behavioral contingency program (Refer to Standards CTS.05.04.01 through CTS.05.04.17 for standards on individualized behavioral contingencies).
Forensic restrictions and restrictions imposed by correction and law enforcement authorities for security purposes. However, restraint or seclusion use related to the clinical care of an individual served under forensic or correction restrictions is surveyed under these standards.

- The use of protective equipment such as helmets or other adaptive support in response to the individual’s assessed physical needs (for example, postural support, orthopedic appliances)

**Introduction to the Standards**

**Use of physical holding of children/youth:** The use of physical holding of children/youth poses an inherent risk to the physical safety and psychological well-being of the individual served and staff. Therefore, physical holding of children/youth is used only in an emergency when there is an imminent risk of an individual served physically harming herself or himself or others, including staff. Nonphysical interventions are the first choice, unless safety demands an immediate physical response.

**Reducing the use of physical holding of children/youth:** Because physical holding of children/youth has the potential to produce serious consequences, such as physical and psychological harm, loss of dignity, violation of the rights of an individual served, and even death, organizations continually explore ways to prevent, reduce, and strive to eliminate physical holding of children/youth through effective performance improvement initiatives.

**The leaders’ role:** The leaders’ role is to create an environment that minimizes circumstances that give rise to physical holding of children/youth and that maximizes safety when physical holding of children/youth is used. This requires allocating sufficient resources, providing initial and ongoing education, and integrating physical holding of children/youth into performance improvement activities. The result is an organization-wide approach to physical holding of children/youth that seeks to prevent and reduce and strives to eliminate its use. When used, the organization protects the health and safety of the child/youth served while preserving his or her dignity, rights, and well-being.

**The family’s role:** Throughout the standards, there are references to the involvement of the family of the child/youth in the decisions and activities related to the use of physical holding of children/youth. While this is intended to promote communication with providers and support and advocacy for the individual served, there are instances in
which such family participation may be inappropriate because it could have a deleterious effect on the child/youth and her or his rights. In these instances, the standards related to family involvement would not apply.

**Standard CTS.05.05.01**

*For organizations that use physical holding on a child or youth:* The leaders establish and communicate the organization’s philosophy on physical holding of children or youth.

**Elements of Performance for CTS.05.05.01**

1. *For organizations that use physical holding on a child or youth:* At a minimum, the organization’s philosophy addresses the following:
   - Its commitment to minimize the use of physical holding of children or youth
   - Prevention of emergencies that have the potential to lead to the use of physical holding of children or youth
   - Non-physical interventions as preferred interventions with input from the child or youth and parent or guardian
   - Limitation of the use of physical holding of children and youth to emergencies in which there is an imminent risk of a child or youth physically harming himself or herself, staff, or others
   - Responsibility to facilitate the discontinuation of physical holding of children or youth as soon as possible
   - Raising awareness among staff about how physical holding of children or youth may be experienced by the child or youth
   - Preserving the safety and dignity of the child or youth when physical holding is used

2. *For organizations that use physical holding on a child or youth:* The organization’s philosophy on the use of physical holding of children and youth is communicated to the child or youth served, the parent(s) or guardian, and staff.

**Standard CTS.05.05.03**

*For organizations that use physical holding on a child or youth:* Staffing is set to minimize circumstances that give rise to physical holding of children or youth and to maximize safety when physical holding is used.

**Note:** Requirements related to ongoing education and the continuous assessment of staff competence are addressed in the “Human Resources Management” (HRM) chapter.
Elements of Performance for CTS.05.05.03

For organizations that use physical holding on a child or youth: The organization bases its staffing on a variety of factors, including the following:

1. Staff qualifications.
2. The physical design of the environment.
3. Emotional and behavioral functioning of the children and youth served.
4. Age and developmental functioning of the children and youth served.

Standard CTS.05.05.05

For organizations that use physical holding on a child or youth: Staff are trained and competent to minimize the use of physical holding of children and youth and, when use is indicated, to use physical holding safely.

Note: Requirements related to ongoing education and the continuous assessment of staff competence are addressed in the “Human Resources Management” (HRM) chapter.

Elements of Performance for CTS.05.05.05

1. For organizations that use physical holding on a child or youth: The organization educates staff about minimizing the use of physical holding of children and youth and, before staff participate in any use of physical holding of children or youth, assesses the competence of staff to use this procedure safely.

2. For organizations that use physical holding on a child or youth: To minimize the use of physical holding of children and youth, staff involved in the use of physical holding receive ongoing training in and demonstrate an understanding of the following:
   - The underlying causes of threatening behaviors exhibited by children and youth
   - That sometimes a child or youth may exhibit an aggressive behavior that is related to his or her medical condition and not related to his or her emotional condition (for example, threatening behavior that may result from delirium in fevers)
   - How staff behaviors can affect the behaviors of the child or youth
   - De-escalation, mediation, self-protection, and other techniques such as timeout
   - Helping the child or youth regain self-control
Recognizing readiness for discontinuing physical holding of a child or youth

How to recognize signs of physical distress in the child or youth who is being physically held

Recognizing how age, developmental considerations, gender issues, ethnicity, and history of sexual or physical abuse may affect the way in which a child or youth reacts to physical contact

3. **For organizations that use physical holding on a child or youth:** Staff involved in physical holding of children and youth receive ongoing training and demonstrate competence in the safe use of physical holding techniques.

4. **For organizations that use physical holding on a child or youth:** The staff assigned to monitor the physical well-being of the child or youth being physically held demonstrate competence in the following:

- Recognizing signs and symptoms of breathing difficulties
- Providing hydration as needed
- Checking circulation
- Recognizing signs of any incorrect application of physical holding
- Recognizing when to contact a medically trained practitioner or emergency medical services to evaluate and/or treat the physical status of the child or youth *(See also CTS.05.05.09, EP 4)*

5. **For organizations that use physical holding on a child or youth:** There are always staff available who are competent to initiate first aid and CPR.

**Standard CTS.05.05.07**

For organizations that use physical holding on a child or youth: The initial assessment and reassessments of each child or youth assists the organization in obtaining information about the child or youth that could help minimize the use and impact of physical holding.

**Elements of Performance for CTS.05.05.07**

1. **For organizations that use physical holding on a child or youth:** The initial assessment and reassessments of a child or youth identify techniques that would help the child or youth control his or her behavior.

2. **For organizations that use physical holding on a child or youth:** The initial assessment and reassessments of a child or youth identify pre-existing medical conditions or any physical disabilities and limitations that would place the child or youth at greater risk during a physical hold.
3. **For organizations that use physical holding on a child or youth:** The initial assessment and reassessments of a child or youth identify any history of sexual or physical abuse or other traumas that would place the child or youth at greater psychological risk during physical holding.

4. **For organizations that use physical holding on a child or youth:** When indicated, the child or youth served and/or his or her family helps in identifying techniques that would help minimize the use of physical holding.

5. **For organizations that use physical holding on a child or youth:** The parent(s) or guardian of the child or youth is notified of a physical hold episode. *(See also CTS.05.05.21, EP 6)*

### Standard CTS.05.05.09

**For organizations that use physical holding on a child or youth:** Physical holding of children and youth is used in a safe manner.

### Elements of Performance for CTS.05.05.09

1. **For organizations that use physical holding on a child or youth:** Physical holding is initiated by an authorized staff member in accordance with law and regulation and organization policy.

2. **For organizations that use physical holding on a child or youth:** The organization prohibits the use of physical holding techniques that restrict the flow of air to the child’s or youth’s lungs.

3. **For organizations that use physical holding on a child or youth:** The organization has a written process on physical holding of children and youth that identifies the techniques approved for use.

4. **For organizations that use physical holding on a child or youth:** A staff member not physically holding the child or youth is assigned to observe the child’s or youth’s physical well-being. *(See also CTS.05.05, EP 4)*

### Standard CTS.05.05.11

**For organizations that use physical holding on a child or youth:** Nonphysical techniques are the preferred intervention in managing behaviors of children and youth.
Element of Performance for CTS.05.05.11

1. For organizations that use physical holding on a child or youth: Whenever possible, the organization uses nonphysical techniques in managing behaviors of children and youth.

Note: Such techniques may include implementing a crisis response plan, redirecting the focus of the child or youth, employing verbal de-escalation and positive behavioral support, or using sensory modulation.

Standard CTS.05.05.13

For organizations that use physical holding on a child or youth: Physical holding is limited to emergencies in which there is an imminent risk of a child or youth physically harming himself or herself, staff, or others, and when nonphysical interventions would not be effective.

Elements of Performance for CTS.05.05.13

1. For organizations that use physical holding on a child or youth: Physical holding is used only when nonphysical interventions are ineffective or not viable and when there is an imminent risk of a child or youth physically harming himself or herself, staff, or others. R

2. For organizations that use physical holding on a child or youth: When a physical hold is used, information learned from the initial assessment of the child or youth is considered.

3. For organizations that use physical holding on a child or youth: The organization does not permit physical holding for any other purpose, such as coercion, discipline, convenience, or retaliation by staff. R

4. For organizations that use physical holding on a child or youth: The use of physical holding is not based on the history of past physical holding of the child or youth or solely on a history of dangerous behavior.

Standard CTS.05.05.15

For organizations that use physical holding on a child or youth: The physical hold is discontinued when the child or youth regains control of his or her behavior.
Elements of Performance for CTS.05.05.15

1. **For organizations that use physical holding on a child or youth:** As early as feasible in the physical holding process, the child or youth is made aware of the reason(s) for physical holding and reassured that the physical hold will be discontinued as soon as the child or youth regains control of his or her behavior.

   **Note:** Examples of regaining control include the ability of the child or youth to contract for safety, whether the child or youth is oriented to the environment, and/or cessation of verbal threats.

2. **For organizations that use physical holding on a child or youth:** The physical hold is discontinued as soon as the child or youth regains control of his or her behavior.

Standard CTS.05.05.17

**For organizations that use physical holding on a child or youth:** The child or youth and staff participate in a debriefing about the physical holding episode.

Elements of Performance for CTS.05.05.17

1. **For organizations that use physical holding on a child or youth:** The child or youth and involved staff participate in a debriefing following each episode of physical holding.

2. **For organizations that use physical holding on a child or youth:** The debriefing about each episode of physical holding occurs as soon as possible.

3. **For organizations that use physical holding on a child or youth:** The debriefing about each episode of physical holding is used to do the following:
   - Identify what led to the incident and what could have been handled differently.
   - Ascertain that the physical well-being, psychological comfort, and right to privacy of the child or youth were addressed.
   - Assess the impact of the holding on the child’s or youth’s emotional functioning.
   - When indicated, modify the child’s or youth’s plan for care, treatment, or services.

4. **For organizations that use physical holding on a child or youth:** Information obtained and documented from debriefings is used in performance improvement activities.
Standard CTS.05.05.19

For organizations that use physical holding on a child or youth: The organization collects data on the use of physical holding.

Rationale for CTS.05.05.19

Data collection on physical holds for children/youth is important because it provides pertinent information that can be used to analyze physical holds and make improvements (see CTS.05.05.21, EP 12). This data can be used in the organization’s active efforts to eliminate or reduce to the absolute minimum the use of physical holding for children/youth.

Elements of Performance for CTS.05.05.19

1. For organizations that use physical holding on a child or youth: The leaders determine the frequency with which data on the use of physical holding are aggregated and reported to leadership.

2. For organizations that use physical holding on a child or youth: Individual identifiers are included in data collected on the use of physical holding.

3. For organizations that use physical holding on a child or youth: Data on all physical holding episodes are collected and classified for all settings/locations and include the following:
   - Setting or location
   - Shift
   - Staff who initiated the process
   - The number of minutes of each physical hold
   - Date and time each physical hold was initiated
   - Day of the week each physical hold occurred
   - Whether injuries were sustained by the child or youth or staff
   - Age of the child or youth
   - Sex of the child or youth
   - Debriefing data
   - Multiple instances of physical holding of the child or youth within a 12-hour time frame
   - The number of physical holds per child or youth
   - Use of psychoactive medications to enable discontinuation of a physical hold
4. **For organizations that use physical holding on a child or youth:** The administrative and clinical leader(s) are made aware when a child or youth experiences a physical hold longer than 30 minutes and when a child or youth experiences multiple episodes of holding within a 12-hour period.

5. **For organizations that use physical holding on a child or youth:** The organization evaluates the number of physical holding episodes per child or youth served.

### Standard CTS.05.05.21

**For organizations that use physical holding on a child or youth:** The organization’s policies and procedures address the prevention of the use of physical holding and, when employed, guide its use.

### Elements of Performance for CTS.05.05.21

**For organizations that use physical holding on a child or youth:** The organization has written policies and procedures regarding physical holding that include details about the following:

1. 🕰 Staffing.
2. 🕰 Staff competence and training.
3. 🕰 Initial assessment of the child or youth.
4. 🕰 The role of nonphysical techniques.
5. 🕰 Limiting physical holding to emergencies.
6. 🕰 Notification of the parent(s) or guardian of the child or youth. *(See also CTS.05.05.07, EP 5)*
7. 🕰 Initiation of physical holding by an authorized staff member.
8. 🕰 Monitoring of the child or youth.
9. 🕰 Discontinuation of the physical hold.
10. 🕰 Debriefing.
11. 🕰 Reporting injuries and deaths to the organization’s leadership and appropriate external agencies consistent with applicable law and regulation.
12. 🕰 Documentation of physical holding.
13. Data collection and the integration of physical holding into performance improvement activities.

Introduction to Standards CTS.05.06.01 Through CTS.05.06.35—Restraint and Seclusion

Applicability of Behavioral Health Care Restraint and Seclusion Standards

The behavioral health care standards for restraint and seclusion apply to any use of restraint and seclusion for behavioral health reasons.

Exceptions to the Applicability of Restraint and Seclusion Standards

The standards for restraint and seclusion do not apply in the following circumstances:

- Instances in which an individual served is restricted to an unlocked room or area, consistent with a program’s rules or regulations and organization policy(ies) and procedure(s), such as quiet time before bedtime or homework time.
- The use of a brief physical hold on an individual served who receives such a procedure through an individualized behavioral contingency program (Refer to Standards CTS.05.04.01 through CTS.05.04.17 for standards on individualized behavioral contingencies).
- Forensic restrictions and restrictions imposed by correction and law enforcement authorities for security purposes. However, restraint or seclusion use related to the clinical care of an individual served under forensic or correction restrictions is surveyed under these standards.
- The use of protective equipment such as helmets or other adaptive support in response to the individual’s assessed physical needs (for example, postural support, orthopedic appliances)

Introduction to the Standards

Use of restraint and seclusion: The use of restraint and seclusion poses an inherent risk to the physical safety and psychological well-being of the individual served and staff. Therefore, restraint and seclusion are used only in an emergency when there is an
imminent risk of an individual served physically harming herself or himself or others, including staff. Nonphysical interventions are the first choice, unless safety demands an immediate physical response.
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Reducing the use of restraint and seclusion: Because restraint and seclusion have the potential to produce serious consequences, such as physical and psychological harm, loss of dignity, violation of the rights of an individual served, and even death, organizations continually explore ways to prevent, reduce, and strive to eliminate restraint and seclusion through effective performance improvement initiatives.

The leaders’ role: The leaders’ role is to create an environment that minimizes circumstances that give rise to restraint and seclusion use and that maximizes safety when restraint or seclusion is used. This requires allocating sufficient resources, providing initial and ongoing education, and integrating restraint and seclusion into performance improvement activities. The result is an organizationwide approach to restraint and seclusion that seeks to prevent and reduce and strives to eliminate their use and, when they are used, protects the health and safety of the individual served while preserving his or her dignity, rights, and well-being.

The family’s role: Throughout the standards, there are references to the involvement of the family of the individual served in the decisions and activities related to the use of restraint or seclusion. While this is intended to promote communication with providers and support and advocacy for the individual served, there are instances in which such family participation may be inappropriate because it could have a deleterious effect on the individual served and her or his rights. In these instances, the standards related to family involvement would not apply.

**Standard CTS.05.06.01**

For organizations that use restraint or seclusion: The leaders establish and communicate the organization’s philosophy on restraint and seclusion to all staff with direct care responsibility.

**Elements of Performance for CTS.05.06.01**

1. For organizations that use restraint or seclusion: At a minimum, the organization’s philosophy addresses the following:
   - Its commitment to prevent, reduce, and strive to eliminate restraint and seclusion
   - Prevention of emergencies that have the potential to lead to the use of restraint or seclusion
   - Nonphysical interventions as preferred interventions
- Limitation of the use of restraint and seclusion to emergencies in which there is an imminent risk of an individual physically harming himself or herself, staff, or others
- Its responsibility to facilitate the discontinuation of restraint or seclusion as soon as possible
- Raising awareness among staff about how restraint or seclusion may be experienced by the individual served
- Preserving the safety and dignity of the individual served when restraint or seclusion is used

2. **For organizations that use restraint or seclusion:** The organization’s philosophy on restraint or seclusion is communicated to all members of the organization who have direct care responsibility.

3. **For organizations that use restraint or seclusion:** The organization’s philosophy on restraint or seclusion is communicated to the individual served.

### Standard CTS.05.06.03

**For organizations that use restraint or seclusion:** Staffing and assignments are set to minimize circumstances that give rise to restraint or seclusion use and to maximize safety when restraint or seclusion is used.

**Note:** Requirements related to ongoing education and the continuous assessment of staff competence are addressed in the “Human Resources Management” (HRM) chapter.

### Elements of Performance for CTS.05.06.03

**For organizations that use restraint or seclusion:** The organization bases its staffing on a variety of factors, including the following:

1. Staff qualifications.
2. The physical design of the environment.
3. Diagnoses.

**For organizations that use restraint or seclusion:** The organization bases its staffing and assignments on a variety of factors, including the following:

5. Acuity levels.
For organizations that use restraint or seclusion: The organization bases its staffing on a variety of factors, including the following:

6. Age and developmental functioning of individuals served.

Standard CTS.05.06.05

For organizations that use restraint or seclusion: Staff are trained and competent to minimize the use of restraint and seclusion and, when use is indicated, to use restraint or seclusion safely.

Elements of Performance for CTS.05.06.05

1. For organizations that use restraint or seclusion: The organization educates staff about minimizing the use of restraint and seclusion and, before they participate in any use of restraint or seclusion, assesses the competence of staff to use them safely.

2. For organizations that use restraint or seclusion: To minimize the use of restraint and seclusion, all direct care staff and any other staff involved in the use of restraint and seclusion receive ongoing training in and demonstrate an understanding of the following:
   - The underlying causes of threatening behaviors exhibited by individuals served
   - That sometimes an individual served may exhibit an aggressive behavior that is related to an individual’s medical condition and not related to his or her emotional condition (for example, threatening behavior that may result from delirium in fevers)
   - How staff behaviors can affect the behaviors of individuals served
   - De-escalation, mediation, self-protection, and other techniques such as timeout
   - How to recognize signs of physical distress in individuals who are being held, restrained, or secluded

3. For organizations that use restraint or seclusion: Staff who are authorized to apply restraint or seclusion receive the training and demonstrate the competence as required in Standard CTS.05.06.05, EP 2.

4. For organizations that use restraint or seclusion: Direct care staff members receive ongoing training in and demonstrate competence in the safe use of restraint, including physical holding techniques, take-down procedures, and the application and removal of mechanical restraints.
5. **For organizations that use restraint or seclusion:** Staff who are authorized to perform 15-minute assessments of individuals in restraint or seclusion receive the training and demonstrate the competence as required in Standard CTS.05.06.05, EP 2.

6. **For organizations that use restraint or seclusion:** Staff authorized to perform 15-minute assessments receive ongoing training and demonstrate competence in the following:
   - Taking vital signs and interpreting their relevance to the physical safety of the individual in restraint or seclusion

   **Note:** *Taking vital signs may include the use of a pulse oximeter to assess the oxygenation status of the individual in restraint or seclusion.*
   - Recognizing nutritional and hydration needs
   - Checking circulation and range of motion in the extremities
   - Addressing hygiene and elimination
   - Addressing physical and psychological status and comfort
   - Helping individuals meet behavior criteria for discontinuing restraint or seclusion
   - Recognizing readiness for discontinuing restraint or seclusion
   - Recognizing signs of any incorrect application of restraints
   - Recognizing when to contact a medically trained licensed independent practitioner or emergency medical services to evaluate and/or treat the physical status of the individual

7. **For organizations that use restraint or seclusion:** Staff who, in the absence of a licensed independent practitioner, are authorized to initiate restraint or seclusion, and/or perform evaluations/re-evaluations of individuals in restraint or seclusion to assess their readiness for discontinuation or establish the need to secure a new order, receive training and demonstrate competence as required in Standard CTS.05.06.05, EPs 1–6.

8. **For organizations that use restraint or seclusion:** Staff are educated about and demonstrate competence in the following:
   - Recognizing how age, developmental considerations, gender issues, ethnicity, and history of sexual or physical abuse may affect the way in which an individual served reacts to physical contact
   - Using behavior criteria for discontinuing restraint or seclusion and how to help individuals in meeting these criteria
9. **For organizations that use restraint or seclusion:** A sufficient number of staff with direct care responsibility receive additional training so that staff who are competent to initiate first aid and CPR are available at all times.

10. **For organizations that use restraint or seclusion:** The organization has a plan for providing emergency medical services.

11. **For organizations that use restraint or seclusion:** The viewpoints of individuals who have experienced restraint or seclusion are incorporated into staff training and education to help staff better understand all aspects of restraint and seclusion.

12. **For organizations that use restraint or seclusion:** Whenever possible, individuals who have experienced restraint or seclusion contribute to the training and education curricula and/or participate in staff training and education.

   **Note:** Requirements related to ongoing education and the continuous assessment of staff competence are addressed in the “Human Resources Management” (HRM) chapter.

**Standard CTS.05.06.07**

**For organizations that use restraint or seclusion:** The initial assessment of each individual at admission or intake assists in obtaining information about the individual that could help minimize the use of restraint or seclusion.

**Elements of Performance for CTS.05.06.07**

1. **For organizations that use restraint or seclusion:** The initial assessment of an individual who is at risk of harming himself or herself, staff, or others identifies techniques that would help the individual control his or her behavior.

2. **For organizations that use restraint or seclusion:** When indicated, the initial assessment of an individual who is at risk of harming himself or herself, staff, or others identifies the individual’s need for methods or tools to manage his or her aggressive behavior.

3. **For organizations that use restraint or seclusion:** The initial assessment of an individual who is at risk of harming himself or herself, staff, or others identifies preexisting medical conditions or any physical disabilities and limitations that would place the individual at greater risk during restraint or seclusion.
4. **For organizations that use restraint or seclusion:** The initial assessment of an individual who is at risk of harming himself or herself, staff, or others identifies any history of sexual or physical abuse or other trauma that would place the individual at greater psychological risk during restraint or seclusion.

5. **For organizations that use restraint or seclusion:** As appropriate, the individual served and/or his or her family helps in identifying techniques that would help minimize the use of restraint or seclusion.

6. **For organizations that use restraint or seclusion:** The individual served and his or her family are educated about the organization’s philosophy on restraint and seclusion to the extent that such information is not clinically contraindicated.

7. **For organizations that use restraint or seclusion:** The family’s role, including their notification of a restraint or seclusion episode, is discussed with the individual served and, as appropriate, his or her family, and in conjunction with the right to confidentiality of the individual served.

**Standard CTS.05.06.09**

For organizations that use restraint or seclusion: Nonphysical techniques are the preferred intervention in managing behaviors of individuals served.

**Element of Performance for CTS.05.06.09**

1. **For organizations that use restraint or seclusion:** Whenever possible, the organization uses nonphysical techniques in managing behaviors of individuals served.

   **Note:** Such techniques may include implementing a crisis response plan, redirecting the focus of the individual, employing verbal de-escalation and positive behavioral support, or using sensory modulation.

**Standard CTS.05.06.11**

For organizations that use restraint or seclusion: Restraint or seclusion is limited to emergencies in which there is an imminent risk of an individual served physically harming himself or herself, staff, or others, and when nonphysical interventions would not be effective.
Elements of Performance for CTS.05.06.11

1. **For organizations that use restraint or seclusion:** Restraint or seclusion is used only when nonphysical interventions are ineffective or not viable and when there is an imminent risk of an individual served physically harming himself or herself, staff, or others.  

2. **For organizations that use restraint or seclusion:** The type of physical intervention (restraint or seclusion) selected considers information learned from the initial assessment of the individual served.

3. **For organizations that use restraint or seclusion:** The organization does not permit restraint or seclusion for any other purpose, such as coercion, discipline, convenience, or retaliation by staff.

4. **For organizations that use restraint or seclusion:** The use of restraint or seclusion is not based on the restraint or seclusion history of an individual served or solely on a history of dangerous behavior.

Standard CTS.05.06.13

For organizations that use restraint or seclusion: A licensed independent practitioner orders the use of restraint or seclusion.

**Note:** This standard is not to be construed to limit the authority of a doctor of medicine or osteopathy to delegate tasks to physician assistants and advanced practice nurses to the extent recognized under state law or a state’s regulatory mechanism and allowed by the organization.

Elements of Performance for CTS.05.06.13

1. **For organizations that use restraint or seclusion:** All restraint and seclusion are applied and continued pursuant to an order by the licensed independent practitioner who is primarily responsible for the ongoing care of the individual served, or his or her licensed independent practitioner designee, or other licensed independent practitioner.

**Note:** Because restraint and seclusion use is limited to emergencies (in which a licensed independent practitioner may not be immediately available), the organization may authorize qualified, trained staff members who are not licensed independent practitioners to initiate restraint or seclusion before an order is obtained from the
licensed independent practitioner. In addition, restraint and seclusion may be ordered by licensed practitioners (for example, registered nurses, licensed social workers) if permitted by state law and by the organization.

2. **For organizations that use restraint or seclusion:** As soon as possible, but no longer than one hour after the initiation of restraint or seclusion, qualified staff do the following:
   - Notifies and obtains an order (verbal or written) from the licensed independent practitioner
   - Consults with the licensed independent practitioner about the physical and psychological condition of the individual served

3. **For organizations that use restraint or seclusion:** The licensed independent practitioner does the following:
   - Reviews with staff the physical and psychological status of the individual served
   - Determines whether restraint or seclusion should be continued
   - Supplies staff with guidance in identifying ways to help the individual regain control so that restraint or seclusion can be discontinued
   - Supplies an order for restraint or seclusion

**Standard CTS.05.06.15**

**For organizations that use restraint or seclusion:** The family of the individual served is notified promptly of the use of restraint or seclusion.

**Elements of Performance for CTS.05.06.15**

1. **For organizations that use restraint or seclusion:** The organization asks the individual served whether his or her family is to be informed about the individual’s care, treatment, or services.

2. **For organizations that use restraint or seclusion:** The organization asks the individual’s family whether they want to be informed about the individual’s care, treatment, or services.

3. **For organizations that use restraint or seclusion:** In cases in which the individual served has consented to have the family kept informed about his or her care, treatment, or services and the family has agreed to be notified, staff attempts to contact the family as soon as possible to notify them of the use of restraint or seclusion.
Standard CTS.05.06.17

For organizations that use restraint or seclusion: A licensed independent practitioner sees and evaluates the individual in restraint or seclusion in person.

Elements of Performance for CTS.05.06.17

1. For organizations that use restraint or seclusion: The licensed independent practitioner primarily responsible for the ongoing care, treatment, or services of the individual served, or his or her licensed independent practitioner designee, or other licensed independent practitioner, evaluates the individual in restraint or seclusion in person within four hours of the initiation of restraint or seclusion for individuals ages 18 or older, and within two hours of initiation for children and youth ages 17 and under.

2. For organizations that use restraint or seclusion: At the time of the in-person evaluation of the individual in restraint or seclusion, the licensed independent practitioner does the following:
   - Works with the individual and staff to identify ways to help the individual regain control
   - Revises the individual’s plan for care, treatment, or services as needed
   - If necessary, provides a new written order

3. For organizations that use restraint or seclusion: The licensed independent practitioner evaluates the individual in restraint or seclusion in person within 24 hours of the initiation of restraint or seclusion if the individual is no longer in restraint or seclusion when an original verbal order expires.

Standard CTS.05.06.19

For organizations that use restraint or seclusion: Written and verbal orders for initial and continuing use of restraint and seclusion are time limited.

Elements of Performance for CTS.05.06.19

1. For organizations that use restraint or seclusion: Written and verbal orders for restraint and seclusion are limited to the following:
   - Four hours for adults ages 18 and older
   - Two hours for children and youth ages 9 to 17
   - One hour for children under age 9
2. **For organizations that use restraint or seclusion:** Orders for restraint or seclusion are not written as a standing order or for use on an as-needed basis (that is, PRN).

3. **For organizations that use restraint or seclusion:** If restraint or seclusion use needs to continue beyond the expiration of the time-limited order, a new order for restraint or seclusion is obtained from the licensed independent practitioner primarily responsible for ongoing care, treatment, or services of the individual served, or his or her licensed independent practitioner designee, or other licensed independent practitioner.

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**Standard CTS.05.06.21**

For organizations that use restraint or seclusion: Individuals in restraint or seclusion are regularly re-evaluated.

**Elements of Performance for CTS.05.06.21**

1. **For organizations that use restraint or seclusion:** By the time the order for restraint or seclusion expires, the individual served is evaluated in person by one of the following:
   - The licensed independent practitioner primarily responsible for the ongoing care, treatment, or services of the individual served
   - His or her licensed independent practitioner designee
   - Another licensed independent practitioner or qualified, trained individual authorized by the organization to perform this function

2. **For organizations that use restraint or seclusion:** In conjunction with reevaluation of the individual in restraint or seclusion, a new written or verbal order is given by the licensed independent practitioner primarily responsible for the individual’s ongoing care, treatment, or services, or his or her licensed independent practitioner designee, or other licensed independent practitioner if the restraint or seclusion is to be continued.

3. **For organizations that use restraint or seclusion:** The licensed independent practitioner or other qualified, authorized staff member re-evaluates the efficacy of the treatment plan of the individual served and works with the individual to identify ways to help him or her regain control.
4. **For organizations that use restraint or seclusion:** If the licensed independent practitioner of the individual served, or his or her licensed independent practitioner designee, is not the licensed independent practitioner who gave the order, the licensed independent practitioner of the individual served is notified of the individual’s status if the restraint or seclusion is continued.

5. **For organizations that use restraint or seclusion:** The individual in restraint or seclusion is re-evaluated as follows:
   - Every four hours for adults ages 18 and older
   - Every two hours for children and youth ages 9 to 17
   - Every hour for children under age 9

6. **For organizations that use restraint or seclusion:** The licensed independent practitioner conducts an in-person re-evaluation of the individual in restraint or seclusion at least every eight hours for adults ages 18 and older and every four hours for children and youth ages 17 and younger.

**Standard CTS.05.06.23**

**For organizations that use restraint or seclusion:** Clinical leaders are told of individuals who experience extended or multiple episodes of restraint or seclusion.

**Elements of Performance for CTS.05.06.23**

1. **For organizations that use restraint or seclusion:** Clinical leaders are immediately notified when an individual remains in restraint or seclusion for more than 12 hours or experiences, within 12 hours, two or more separate episodes of restraint or seclusion of any duration.

2. **For organizations that use restraint or seclusion:** Clinical leaders are notified every 24 hours if an individual remains in restraint or seclusion for more than 12 hours or experiences, within 12 hours, two or more separate episodes of restraint or seclusion of any duration.

**Standard CTS.05.06.25**

**For organizations that use restraint or seclusion:** Individuals in restraint or seclusion are assessed and assisted.

**Elements of Performance for CTS.05.06.25**

1. **For organizations that use restraint or seclusion:** The organization prohibits the use of restraint techniques that restrict the flow of air to the individual’s lungs.
2. **For organizations that use restraint or seclusion:** A staff member who is trained and competent in accordance with Standard CTS.05.06.05 assesses the individual at the initiation of restraint or seclusion and every 15 minutes thereafter.

3. **For organizations that use restraint or seclusion:** Staff assessment of the individual at initiation of restraint or seclusion and every 15 minutes thereafter includes, as relevant to the type of restraint or seclusion, the following:
   - Signs of any injury associated with applying restraint or seclusion
   - Nutrition and hydration status
   - Circulation and range of motion in the extremities
   - Vital signs
   - Hygiene and elimination
   - Physical and psychological status and comfort
   - Readiness for discontinuation of restraint or seclusion

4. **For organizations that use restraint or seclusion:** Staff help individuals in restraint or seclusion to meet behavior criteria for discontinuing restraint or seclusion.

**Standard CTS.05.06.27**

**For organizations that use restraint or seclusion:** Individuals in restraint or seclusion are monitored.

**Elements of Performance for CTS.05.06.27**

1. **For organizations that use restraint or seclusion:** Monitoring of individuals in restraint or seclusion is done through continuous in-person observation by an assigned staff member who is competent and trained in accordance with Standard CTS.05.06.05.

2. **For organizations that use restraint or seclusion:** After the first hour, an individual in seclusion without restraints may be continuously monitored using simultaneous video and audio equipment, if consistent with the individual’s condition or wishes.

**Standard CTS.05.06.29**

**For organizations that use restraint or seclusion:** Restraint and seclusion use are discontinued when the individual served meets the behavior criteria for their discontinuation.
**Elements of Performance for CTS.05.06.29**

1. **For organizations that use restraint or seclusion**: As early as feasible in the restraint or seclusion process, the individual served is made aware of the rationale for restraint or seclusion and the behavior criteria for its discontinuation.

   **Note**: Examples of behavior criteria include the ability of an individual served to contract for safety, whether the individual is oriented to the environment, and/or cessation of verbal threats.

2. **For organizations that use restraint or seclusion**: Restraint or seclusion is discontinued as soon as the individual served meets his or her behavior criteria.

**Standard CTS.05.06.31**

**For organizations that use restraint or seclusion**: The individual served and staff participate in a debriefing about the restraint or seclusion episode.

**Elements of Performance for CTS.05.06.31**

1. **For organizations that use restraint or seclusion**: The individual served and, if appropriate, the individual’s family participate with staff members who were involved in the episode and who are available in a debriefing about each episode of restraint or seclusion.

2. **For organizations that use restraint or seclusion**: The debriefing about each episode of restraint or seclusion occurs as soon as possible, but no longer than 24 hours after the episode.

3. **For organizations that use restraint or seclusion**: The debriefing about each episode of restraint or seclusion is used to do the following:
   - Identify what led to the incident and what could have been handled differently
   - Ascertain that the physical well-being, psychological comfort, and right to privacy of the individual served were addressed
   - Counsel the individual served for any trauma that may have resulted from the incident
   - When indicated, modify the individual’s plan for care, treatment, or services

4. **For organizations that use restraint or seclusion**: Information obtained and documented from debriefings is used in performance improvement activities.
Standard CTS.05.06.33

For organizations that use restraint or seclusion: The organization collects data on the use of restraint and seclusion.

Elements of Performance for CTS.05.06.33

1. For organizations that use restraint or seclusion: The leaders determine the frequency with which data on the use of restraint and seclusion are aggregated.

2. For organizations that use restraint or seclusion: Individual identifiers are included in data collected on the use of restraint or seclusion.

3. For organizations that use restraint or seclusion: Data on all restraint and seclusion episodes are collected from and classified for all settings/locations by the following:
   - Shift
   - Staff who initiated the process
   - The length of each episode
   - Date and time each episode was initiated
   - Day of the week each episode was initiated
   - The type of restraint used
   - Whether injuries were sustained by the individual or staff
   - Age of the individual
   - Sex of the individual
   - Debriefing data

For organizations that use restraint or seclusion: Particular attention is paid to the following restraint and seclusion data:

4. Multiple instances of restraint or seclusion experienced by an individual within a 12-hour time frame.

5. The number of episodes per individual served.

6. Instances of restraint or seclusion that extend beyond 12 consecutive hours.

7. Use of psychotropic medications as an alternative to, or to enable discontinuation of, restraint or seclusion.

8. For organizations that use restraint or seclusion: Licensed independent practitioners participate in measuring and assessing use of restraint and seclusion for all individuals served.
Standard  CTS.05.06.35

For organizations that use restraint or seclusion: Organization policies and procedures address prevention of restraint and seclusion and, when employed, guide their use.

Elements of Performance for CTS.05.06.35

For organizations that use restraint or seclusion: The organization has written policies and procedures regarding restraint or seclusion that include details about the following:

1. Staffing.
2. Staff competence and training.
3. Initial assessment of the individual served.
4. The role of nonphysical techniques in behavioral contingencies.
5. Limiting the use of restraint or seclusion to emergencies.
6. Notification of the family of the individual served when restraint or seclusion is initiated.
7. Ordering of restraint and seclusion by a licensed independent practitioner.
8. In-person evaluations of the individual in restraint or seclusion.
9. Initiation of restraint or seclusion by staff other than a licensed independent practitioner.
10. Time-limited orders.
11. Reassessment of the individual in restraint or seclusion.
12. Monitoring the individual in restraint or seclusion.
13. Discontinuation of restraint or seclusion.
14. Post-restraint or seclusion practices.
15. Reporting injuries and deaths to the organization’s leadership and external agencies in accordance with law and regulation.
16. Documentation of restraint or seclusion.
17. Data collection and the integration of restraint or seclusion data into performance improvement activities.
18. **Debriefing.**

**Standard CTS.06.01.01**

*For organizations providing case management/care coordination services:* Case management/care coordination services are based on the individual’s needs, preferences, goals, and community resources available to the individual.

**Elements of Performance for CTS.06.01.01**

1. *For organizations providing case management/care coordination services:* The individual served and, as appropriate, his or her family are partners with organization staff in service planning.

2. *For organizations providing case management/care coordination services:* With the assistance of staff, the individual served and, as appropriate, his or her family, identify needs, preferences, and goals for the following:
   - Housing
   - Employment
   - Education
   - Transportation
   - Crisis support
   - Health care and behavioral health services (for example, medication, therapy)
   - Financial services and benefits
   - Assistance with housekeeping
   - Assistance with personal hygiene
   - Assistance with the retention and improvement of other skills related to activities of daily living
   - Social support and adaptive skills
   - Support of spirituality
   - Schools
   - Leisure and recreational activities for children, youth, and adults
   - Parental support for children and youth
   - Interaction with the criminal or juvenile justice system, if applicable

3. *For organizations providing case management/care coordination services:* Staff coordinating case management/care coordination services assist the individual served in identifying, using, and accessing family, neighborhood, and community supports and services.
4. **For organizations providing case management/care coordination services**: Staff coordinating case management/care coordination services support informed choice by individuals served.
CAMBHC Update 2, January 2018

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5. **For organizations providing case management/care coordination services**: Staff coordinating case management/care coordination services assist the individual served in achieving the individual’s personal goals of independent living.

6. **For organizations providing case management/care coordination services**: The individual served and staff coordinating case management/care coordination services evaluate all services provided directly or through referral to the individual served on a periodic basis, as defined by the organization.

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**Standard CTS.06.01.03**

*For organizations providing community integration services*: The individual served, with assistance from the organization, determines his or her needs and wants for education, training, and support to help him or her progress toward independent living and community integration.

**Elements of Performance for CTS.06.01.03**

1. **For organizations providing community integration services**: Needs, preferences, and goals of the individual served guide the following:
   - The type of education, training, and support provided
   - The intensity of education, training, and support provided
   - The duration of education, training, and support provided

2. **For organizations providing community integration services**: Needs, preferences, and goals of the individual served, and the organization’s scope of services, guide the provision to the individual of educational opportunities about the following:
   - Personal grooming and hygiene
   - Housekeeping
   - Shopping for necessities
   - Meal preparation and healthy eating
   - Budgeting
   - Banking
   - Accessing public transportation
   - Use of community resources
   - Communication skills
   - Social skills
   - Leisure and recreational activities for children, youth, and adults
   - Volunteer activity
Illness self-management (for example, symptom management, medication management), including what to do in case of a crisis or health problem

**Standard CTS.06.01.05**

For organizations that elect The Joint Commission Behavioral Health Home option:

Case management/care coordination services are based on the needs, preferences, and goals of the individual served and on the community resources available.

**Elements of Performance for CTS.06.01.05**

1. **For organizations that elect The Joint Commission Behavioral Health Home option:** The individual served and, as appropriate, his or her family are partners with the integrated care team in care, treatment, or service planning.

2. **For organizations that elect The Joint Commission Behavioral Health Home option:** With the assistance of the integrated care team, the individual served and, as appropriate, his or her family identify needs, preferences, and goals for the following:
   - Housing
   - Employment
   - Education
   - Transportation
   - Crisis support
   - Integrated health services
   - Illness self-management (for example, symptom management, medication management), including what to do in case of a health crisis or urgent health problem
   - Habilitation and rehabilitation services
   - Financial services and benefits
   - Assistance with housekeeping
   - Assistance with personal hygiene
   - Assistance with the retention and improvement of other skills related to activities of daily living
   - Social support and adaptive skills
   - Support of spirituality
   - Schools
   - Leisure and recreational activities
   - Parental support for children and youth
   - Interaction with the criminal or juvenile justice system, if applicable
3. **For organizations that elect The Joint Commission Behavioral Health Home option:** The integrated care team assists the individual served in identifying, using, and accessing family, neighborhood, and community supports and services.

4. **For organizations that elect The Joint Commission Behavioral Health Home option:** The integrated care team supports informed choice by individuals served.

5. **For organizations that elect The Joint Commission Behavioral Health Home option:** The integrated care team assists the individual served in achieving his or her personal goals of independent living.

6. **For organizations that elect The Joint Commission Behavioral Health Home option:** The individual served and the integrated care team evaluate all services provided directly or through referral to the individual served on a periodic basis, as defined by the organization.

**Standard CTS.06.01.07**

For organizations that elect The Joint Commission Behavioral Health Home option:
The individual served, with assistance from the organization, determines his or her needs, preferences, and goals regarding training and support to help him or her progress toward independent living and community integration.

**Elements of Performance for CTS.06.01.07**

1. **For organizations that elect The Joint Commission Behavioral Health Home option:** Needs, preferences, and goals of the individual served guide the following:
   - The type of training and support provided
   - The intensity of training and support provided
   - The duration of training and support provided

2. **For organizations that elect The Joint Commission Behavioral Health Home option:** Needs, preferences, and goals of the individual served and the organization’s scope of services guide the provision of training and support opportunities regarding the following:
   - Personal grooming and hygiene
   - Housekeeping
   - Shopping for necessities
   - Meal preparation and healthy eating
   - Money management
Introduction to Standards CTS.06.01.09 Through CTS.06.01.15—Housing Support Services

The housing support services standards are related to a “housing first” or “rapid rehousing” program model and aimed at assisting individuals with serious mental illness, substance use disorders, or other behavioral health care issues. These standards are applicable only to behavioral health care organizations that are providing case management services related to a housing first or rapid rehousing program model; they are not a mandate for all accredited behavioral health care organizations to offer such services. For organizations providing these case management services, the standards are designed to help “raise the bar” and ensure a uniform provision of services from one organization to the next. The standards also help lay out a program for those organizations that are considering such services.

The distinguishing feature of a housing first program model is that individuals served are placed into private, permanent housing without any requirement to participate in behavioral or physical health care, treatment, or services of any kind, except to meet with the organization’s case management staff on a regular basis. Case management staff can then actively work with the individuals to engage them in other available physical and behavioral health care, treatment, or services in support of their goals.

These standards are intended to help develop an organization’s potential to not only address the housing and behavioral health needs of individuals with serious mental illness, substance use disorders, or other behavioral health care issues, but to also address their physical health issues. Research has shown that when an individual’s housing needs
are met and are secure, improvements can often be made in other areas of the individual’s life. This would indicate a potentially strong connection between secure housing and improved health.

**Standard CTS.06.01.09**

For organizations providing case management of housing support services to homeless individuals: The organization places individuals served into housing that is affordable and readily available.

**Elements of Performance for CTS.06.01.09**

1. For organizations providing case management of housing support services to homeless individuals: The organization makes its housing support services known to the community.

   **Note:** This can be done by various means, such as visiting the community and speaking with homeless individuals who may benefit from the services, or building relationships with other organizations in the community that routinely interact with homeless individuals such as hospitals, police departments, shelters, and homeless outreach services.

2. For organizations providing case management of housing support services to homeless individuals: The organization gathers information on the individual’s preferences regarding choices in housing related to location, size, and other features and provides support in meeting those preferences when possible.

3. For organizations providing case management of housing support services to homeless individuals: The organization places no time limits on housing tenure.

4. For organizations providing case management of housing support services to homeless individuals: The organization places individuals served into affordable housing options.

   **Note:** If the organization refers the individual to an outside source for financial assistance, the funds from the outside source are readily available to the individual.

5. For organizations providing case management of housing support services to homeless individuals: The organization places individuals served into housing that provides private living areas that are not shared with other tenants.
Note 1: A private living area could be an entire apartment or house, a private bedroom or suite with access to a communal living area, or another living arrangement that offers the individual some private living area. What is offered to the individual will be dependent on what options are available in the community and the needs of the individual served.

Note 2: Rapid rehousing programs may place individuals into housing that does not offer a private living area.

6. **For organizations providing case management of housing support services to homeless individuals:** There is at least one staff member who is skilled in locating properties and negotiating with landlords.

7. **For organizations providing case management of housing support services to homeless individuals:** The organization’s staff establish open communication with property management staff regarding any issues that might arise for individuals served so that organization staff can assist those individuals as needed. Such issues could include serving as an intermediary between property management staff and the individual served or assisting with transportation needs.

8. **For organizations providing case management of housing support services to homeless individuals:** Before an individual is placed into housing, the organization makes certain that the housing meets all applicable safety regulations, in accordance with law and regulation and organization policy.

**Standard CTS.06.01.11**

For organizations providing case management of housing support services to homeless individuals: The organization places a minimum of contingencies on individuals served.

**Elements of Performance for CTS.06.01.11**

1. **For organizations providing case management of housing support services to homeless individuals:** The organization works with individuals served to establish regular face-to-face meetings between the individual and staff, as determined by the individual’s needs and preferences. These efforts are documented.

2. **For organizations providing case management of housing support services to homeless individuals:** The organization offers individuals served access to housing without any requirements to participate in social, behavioral, or physical health care, treatment, or services.
3. **For organizations providing case management of housing support services to homeless individuals:** The organization respects the right of the individual served to choose, modify, or refuse care, treatment, or services at any time.

4. **For organizations providing case management of housing support services to homeless individuals:** The organization evaluates the need for and uses a variety of assertive engagement strategies when working with individuals served.

5. **For organizations providing case management of housing support services to homeless individuals:** The organization can demonstrate that, although it cannot require the individual to do so, it encourages the individual on an ongoing basis, through the application of a motivational interviewing approach, to participate in social, behavioral, or physical health care, treatment, or services.

6. **For organizations providing case management of housing support services to homeless individuals:** The organization helps individuals served to understand and adhere to their lease or sublease.

7. **For organizations providing case management of housing support services to homeless individuals:** The organization demonstrates good faith efforts to rapidly rehouse individuals served who have lost their housing due to eviction, when indicated. These efforts are documented.

   **Note:** *Decisions to rehouse are made on a case-by-case basis.*

8. **For organizations providing case management of housing support services to homeless individuals:** The organization continues to offer individuals served access to social, behavioral, or physical health care, treatment, or services even if they lose their housing due to eviction or short-term inpatient treatment, to the extent consistent with staff’s and other individuals’ safety.

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**Standard CTS.06.01.13**

For organizations providing case management of housing support services to homeless individuals: The organization offers an array of services to individuals who are receiving housing support services.

**Elements of Performance for CTS.06.01.13**

1. **For organizations providing case management of housing support services to homeless individuals:** The organization provides assistance with move-in and securing the essential furniture and appliances, as needed.
Note: Assistance can be provided through referral or an agreement with another organization that provides such services.

2. **For organizations providing case management of housing support services to homeless individuals:** As needed, the organization facilitates individuals’ access to behavioral health care, treatment, or services. Examples of such care, treatment, or services include the following:
   - Assessing individuals’ symptoms and responses to medication
   - Monitoring individuals’ psychiatric medical conditions and psychiatric medications
   - If individuals are hospitalized, communicating directly with each individual’s inpatient psychiatric prescriber
   - Providing medication education
   - Making referrals as needed

3. **For organizations providing case management of housing support services to homeless individuals:** As needed, the organization facilitates individuals’ access to physical health care, treatment, or services. Examples of such care, treatment, or services include the following:
   - Managing individuals’ medications
   - Administering and documenting medication treatment
   - Screening individuals for medical problems and side effects
   - Communicating and coordinating services with other medical providers
   - Engaging in health promotion, prevention, and education activities
   - Making referrals as needed
   - Locating a health home for the individual

4. **For organizations providing case management of housing support services to homeless individuals:** At a minimum, the organization performs screenings, brief interventions, and referrals for substance use care, treatment, or services.

Note: These services may be provided either by the organization or through referral.

5. **For organizations providing case management of housing support services to homeless individuals:** The organization facilitates inpatient physical and behavioral health care, treatment, or services as follows:
   - Initiating admission as necessary
   - Consulting with inpatient staff regarding need for admission
   - Consulting with inpatient staff regarding an individual’s care, treatment, or services
Consulting with inpatient staff regarding discharge planning
Receiving notification of an individual’s discharge from inpatient care, treatment, or services

6. **For organizations providing case management of housing support services to homeless individuals:** The organization offers individuals opportunities to provide input to the housing support services program, including serving on committees and governing bodies, and serving as peer advocates.

7. **For organizations providing case management of housing support services to homeless individuals:** The organization has provisions in place for after-hours emergency care.

8. **For organizations providing case management of housing support services to homeless individuals:** The organization educates the individual served about its policies and procedures regarding housing opportunities; the array of care, treatment, or services provided by the organization; and how to access after-hours emergency care.

**Standard CTS.06.01.15**

For organizations directly providing both housing support services and behavioral or physical health care, treatment, or services to homeless individuals: A multidisciplinary care, treatment, or services team coordinates the provision of care, treatment, or services.

**Elements of Performance for CTS.06.01.15**

1. **For organizations directly providing both housing support services and behavioral or physical health care, treatment, or services to homeless individuals:** The organization has a multidisciplinary care, treatment, or services team that is comprised of practitioners who meet the needs of the individual served and consists of at least the following:
   - Physician or advanced practice nurse or physician assistant
   - Social worker or case manager

2. **For organizations directly providing both housing support services and behavioral or physical health care, treatment, or services to homeless individuals:** If there is a peer specialist on the staff, he or she has full professional status on the multidisciplinary care, treatment, or services team.
3. **For organizations directly providing both housing support services and behavioral or physical health care, treatment, or services to homeless individuals:** The multidisciplinary care, treatment, or services team meets on a regular basis, as determined by the organization and according to the needs of the individual served.

4. **For organizations directly providing both housing support services and behavioral or physical health care, treatment, or services to homeless individuals:**
   At each meeting the multidisciplinary care, treatment, or services team does the following:
   - On an ongoing basis, conducts a brief, clinically relevant review of individuals served including any recent contact with them
   - Documents the status of the individuals reviewed
   - Develops a staff schedule based on individuals’ schedules and emerging needs, and the need for proactive contact to avert future problems

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**Introduction to Standards CTS.06.02.01 Through CTS.06.02.05—Transfer or Discharge**

The provision of effective care, treatment, or services may occur over time from a variety of providers. As individuals served move across a continuum of care, treatment, or services, in accordance with their needs, strengths, preferences, and goals, it is essential to maintain communication and coordination among providers.

**Standard CTS.06.02.01**

When an individual served is transferred or discharged, the continuity of care, treatment, or services is maintained.

**Elements of Performance for CTS.06.02.01**

1. The organization has a process for addressing the continuity of care, treatment, or services after discharge or transfer that includes the following:
   - The transfer of responsibility for care, treatment, or services for the individual served from one staff, organization, organizational program, or service to another
   - The reason(s) for transfer or discharge when moving from one staff, organization, organizational program, or service to another
■ Mechanisms for internal and external transfer
■ Identification of the person who has accountability and responsibility for the safety of the individual served during an external transfer

2. **For opioid treatment programs:** The discharge planning process addresses relapse prevention.

3. **For opioid treatment programs:** The discharge planning process addresses any physical and mental health problems following medically supervised withdrawal.
   
   **Note:** For example, the program might address the need for counseling or appropriate medication to help with sleep disorders, depression, and other problems.

4. **For opioid treatment programs:** The discharge planning process addresses referrals for continuing outpatient care after the last dose of medication and planning for re-entry to maintenance treatment if relapse occurs.

5. **For opioid treatment programs:** Psychosocial treatment is continued for patients electing to discontinue medication-assisted therapy.

6. **For opioid treatment programs:** The program has a process for tracking patients and reinstituting medication-assisted therapy at the first sign of relapse or impending relapse.
   
   **Note:** It may not be possible for the program to track each patient, especially patients that leave the program, but it is important for the program to have processes in place in order to reinstitute medication-assisted therapy when possible.

7. **For opioid treatment programs:** The program provides the opportunity for patients receiving only long-term medication-assisted therapy to receive psychosocial services again if the need emerges.

8. **For opioid treatment programs:** The program’s process for administrative withdrawal is implemented on an individual basis and follows the principles involved in medically supervised withdrawal from medication.
   
   **Note:** Administrative withdrawal is usually involuntary and might be initiated based on nonpayment of fees, disruptive behavior, or incarceration. The principles followed for any medically supervised withdrawal also apply for administrative withdrawal; namely, that sound clinical judgment is followed; the time frame is generally 30 days but is adjusted by the physician depending on clinical factors; and a variety of supportive options are available to the patient.
9. **For opioid treatment programs:** When a pregnant patient is discharged, the program refers her for prenatal care and documents the name, address, and telephone number of the physician who will be caring for the patient after discharge.

10. **For opioid treatment programs:** The program makes decisions about administrative withdrawal on a case-by-case basis.

   **Note:** Ongoing multidrug use is not necessarily a reason for discharge, unless the patient refuses recommended care.

11. **For opioid treatment programs:** If practical under the circumstances and with due regard for patient and staff safety, before administrative discharge, the program conducts a crisis assessment to address suicide risk, danger to self or others, risk of relapse or overdose, urgent or critical medical conditions, and immediate threats.

12. **For opioid treatment programs:** When the program makes an administrative decision to discharge a patient from medication-assisted treatment, the program offers a schedule of medically supervised withdrawal that is well-tolerated by the patient and based on clinical judgment. The offer is documented.

13. **For opioid treatment programs:** During medically supervised administrative withdrawal, the program documents the patient’s condition in the clinical/case record.

14. **For opioid treatment programs:** Upon discharge following medically supervised administrative withdrawal, the program provides the patient with referrals to an alternate treatment program. These referrals are documented.

**Standard CTS.06.02.03**

When an individual served is discharged or transferred, the organization bases the discharge or transfer on the assessed needs of the individual and the organization’s capabilities.

**Elements of Performance for CTS.06.02.03**

1. The organization identifies the physical and psychosocial needs for continuing care of the individual served.

2. Individuals served are told in a timely manner of the need to plan for discharge or transfer to another organization or level of care, treatment, or services.
3. Planning for transfer or discharge involves the individual served, his or her family, if applicable, and staff.

Note: Family includes legal guardian and surrogate decision-maker (refer to the Glossary).

4. When the individual served is transferred, information provided to the individual includes the following:
   - The reason he or she is being transferred
   - Alternatives to transfer, if any

5. The organization discusses discharge and transfer plans, or changes in these plans, with the individual served and, with the individual’s consent, his or her family. If the individual is a child or youth, the organization acts in accordance with law and regulation.

6. When the individual served is discharged, information provided to the individual and his or her family, if applicable, includes the following:
   - The reason he or she is being discharged
   - The anticipated need for continued care, treatment, or services after discharge

Note: Continued care, treatment, or services includes, as needed, special education, adult day care, case management, home health services, hospice, long term care, outpatient care, support groups, rehabilitation services, and community mental health services.

7. When indicated, the individual served is educated about how to obtain further care, treatment, or services to meet his or her identified needs.

8. When indicated and before discharge, the organization arranges for or helps the family arrange for care, treatment, or services needed to meet the needs of the individual served after discharge.

9. The organization provides the individual served and his or her family, if applicable, discharge instructions in a form the individual can understand. (See also RI.01.01.03, EP 1)

10. For organizations that provide eating disorders care, treatment, or services: The discharge plan includes the following:
   - Level of care recommended, based on current assessment
   - Specific recommendations for follow-up treatment
   - Medication education, as needed
Contact information for follow-up appointments

**Standard CTS.06.02.05**

When individuals served are transferred or discharged, pertinent information related to the care, treatment, or services provided is exchanged with other providers.

**Elements of Performance for CTS.06.02.05**

1. The organization communicates pertinent information to any organization or provider to which the individual served is transferred or discharged.

2. The information shared includes the following:
   - The reason for transfer or discharge
   - Relevant biopsychosocial status at transfer or discharge
   - A summary of care, treatment, or services provided and progress made toward goals
   - Community resources or referrals provided to the individual served

3. For organizations that provide eating disorders care, treatment, or services: Upon written consent of the individual served, after-care providers will be given a copy of the discharge summary prior to discharge whenever possible but no later than within two weeks of discharge.

**Standard CTS.06.03.01**

For organizations that provide care, treatment, or services to young adults with life transition needs: The organization assists young adults with their life transitions in accordance with their needs.

**Rationale for CTS.06.03.01**

Many young adults who receive behavioral health care services do not have the resources and support that prepare them for adulthood. They may have experienced traumatic events, had difficulties in school, and experienced difficult and damaging relationships both with adults and peers. They may not be prepared or able to meet all of the demands and responsibilities of adulthood. This is particularly true of young adults who have been in foster care.

The organization has a responsibility to assess the young adult in all key life areas, determine her/his needs and preferences, and either provide the transitional services or make appropriate referrals.
Elements of Performance for CTS.06.03.01

1. **For organizations that provide care, treatment, or services to young adults with life transition needs:** The organization addresses life transition needs of young adults.
   
   **Note:** An organization may address the needs for transition services through referral or discharge planning based on the organization’s scope of care, treatment, or services.

2. **For organizations that provide care, treatment, or services to young adults with life transition needs:** Organizations that provide young adult life transition services assess the young adult’s needs related to independent functioning in the following areas:
   - Handling finances
   - Finding employment
   - Receiving and completing education
   - Finding housing
   - Receiving health care
   - Engaging in social support
   - Any other needs as determined by the organization

3. **For organizations that provide care, treatment, or services to young adults with life transition needs:** Organizations that provide young adult life transition services provide assistance based on the individual’s assessed needs.

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**Introduction to Standards CTS.07.01.01 Through CTS.07.01.03**

Changes in the behavioral health care environment have led to renewed interest in community-based prevention and wellness promotion services. Because of the value of such services, it is important that they are provided in a safe manner and reflect contemporary thinking. Examples of these services include:

- Substance abuse prevention
- Assistance for at-risk youth
- Suicide prevention
- Parenting skills
- Depression screening
- Resilience-building activities
Child abuse and neglect prevention  
Domestic violence prevention  
Truancy prevention  
Sexual abuse prevention  
Health and wellness, including life skills and HIV prevention/education

Prevention and wellness promotion services provide information and/or experiences that raise an individual’s awareness of, and help to support, healthy choices and life practices. These services are designed to assist individuals in coping with the stresses of life and establishing and maintaining healthy lifestyles. These services can either target the general public or target a subgroup of the population whose members are at higher-than-average risk of experiencing a mental health or substance abuse issue. Prevention and wellness promotion services are community-based and therefore do not necessitate the opening of an individual or family clinical/case record, although members of the defined population may be receiving care, treatment, or services.

Community-based prevention and wellness promotion services do not include similar types of services that are provided to an individual served in conjunction with, or as a result of, his or her needs and are included in the plan for care, treatment, or services. The provision of these types of services is addressed in the “Care, Treatment, and Services” (CTS) chapter. They also do not include activities such as participating in a speaker’s bureau, distributing pamphlets at a community health fair, displaying a poster on a wall, and other similar activities.

Community-based prevention and wellness promotion services are typically funded through outside sources. However, it could be difficult for some organizations to secure funding or grants as only certain types of organizations or programs are eligible to receive funding, and funding streams are limited. Also, for many organizations, such services are not relevant to their mission, vision, and goals. For these reasons, these standards apply only to organizations that are providing community-based prevention and wellness promotion services. They are also intended to provide guidance to organizations that are contemplating providing these services. No organization is required to provide these services.

**Standard CTS.07.01.01**

For organizations that provide prevention and wellness promotion services: The organization’s prevention and wellness promotion services are planned.
Elements of Performance for CTS.07.01.01

1. **For organizations that provide prevention and wellness promotion services:** The organization has a written plan for providing prevention and wellness promotion services that are relevant to its mission and the scope of its services.

2. **For organizations that provide prevention and wellness promotion services:** The organization seeks input about the needs of the community served relative to prevention and wellness promotion services; the organization uses this information to guide its planning process.

3. **For organizations that provide prevention and wellness promotion services:** The organization identifies those resources within the community (if any) that will be utilized to support the provision of the organization’s prevention and wellness promotion services.

4. **For organizations that provide prevention and wellness promotion services:** When the organization develops prevention and wellness promotion services, it determines whether evidence-based practices, promising or emerging practices, or expert consensus exist for the services it plans to provide. If such information does exist, the organization determines whether it will use it to develop its services.

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**Standard CTS.07.01.02**

**For organizations that provide prevention and wellness promotion services:** The organization’s prevention and wellness promotion services are managed.

Elements of Performance for CTS.07.01.02

1. **For organizations that provide prevention and wellness promotion services:** The organization provides prevention and wellness promotion services designed to meet the needs of an identified community. Communities are identified according to various factors, such as age, sex, ethnicity, culture, and other defining traits.

2. **For organizations that provide prevention and wellness promotion services:** Staff who provide prevention and wellness promotion services are either trained or certified to provide such services. Training can be provided by the organization.
3. **For organizations that provide prevention and wellness promotion services:**
   When new prevention and wellness promotion services are begun, the organization establishes baseline demographics of the population(s) that will receive these services by gathering its own data or utilizing existing data.

**Standard CTS.07.01.03**

For organizations that provide prevention and wellness promotion services: The organization’s prevention and wellness promotion services are evaluated.

**Elements of Performance for CTS.07.01.03**

1. **For organizations that provide prevention and wellness promotion services:** The organization identifies the aggregate data it will collect regarding the services it provides, such as the number of individuals receiving the services and the number of hours spent providing the services.

2. **For organizations that provide prevention and wellness promotion services:** The organization evaluates its prevention and wellness promotion services.

3. **For organizations that provide prevention and wellness promotion services:** The organization takes action to improve its prevention and wellness promotion services.

4. **For organizations that provide prevention and wellness promotion services:** The organization regularly reports to leadership on the prevention and wellness promotion services.
Environment of Care (EC)

Overview
The goal of this chapter is to promote a safe, functional, and supportive environment within the organization so that quality and safety are preserved. The environment of care is made up of three basic elements:

- The building or space, including how it is arranged and special features that protect individuals served, visitors, and staff
- Equipment used to support care, treatment, or services or to safely operate the building or space
- People, including those who work within the organization, individuals served, and anyone else who enters the environment, all of whom have a role in minimizing risks

This chapter stresses the importance of managing risks in the environment of care, which are different from the risks associated with the provision of care, treatment, or services. Any organization, regardless of its size or location, faces risks in the environment, including those associated with safety and security, fire, hazardous materials and waste, and utility systems. When staff are educated about the elements of a safe environment, they are more likely to follow processes for identifying, reporting, and taking action on environmental risks.

The standards in this chapter apply to buildings in which care, treatment, or services are provided. The chapter does not apply to buildings in which only administrative functions are performed. In those situations where behavioral health care services are not provided in buildings, such as wilderness programs, the requirements in this chapter apply to defined areas where outdoor activities take place.

About This Chapter
The standards are organized around the concepts of planning, implementation, and evaluation of results. The chapter calls for written plans for managing risks in each of these areas. Organizations may choose to address all required components of the environment in a single management plan or in several different plans. If an organization has multiple sites, it may have separate management plans for each of its locations, or it may choose to have one comprehensive set of plans. In any case, the organization must address specific risks and the unique conditions at each of its sites.

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
The standards address the need to identify someone to manage environmental risks as well as to intervene when situations threaten people or property; both responsibilities may be assigned to one person. It is important to remember that the standards in this chapter do not prescribe a particular structure (such as a safety committee) or individual (such as one employee hired to be a safety officer) for managing the environment, nor do they prescribe how required planning activities are conducted.

Important aspects of the environment addressed in the standards include the following:

- Safety and security. This section addresses risks in the physical environment, access to security-sensitive areas, product recalls, and smoking.
- Hazardous materials. This section addresses risks associated with hazardous materials.
- Fire safety. This section addresses risks from fire, smoke, and other products of combustion; fire response plans; fire drills; management of fire detection, alarm, and suppression equipment and systems; and measures to implement during construction or when the *Life Safety Code*® cannot be met.
- Utilities. This section addresses inspection and testing of operating components and management of disruptions.

**Note:** *Emergency management standards are located in a separate chapter.*

**Other Issues for Consideration**

1. The organization that provides care, treatment, or services in space it does not own (for example, in leased or complimentary space) may want to communicate with the property owner about maintenance expectations for building equipment and features not under its control. For example, an organization may need access to the maintenance documents. This organization and the property owner may want to discuss any building or equipment problems that could adversely affect the safety or health of individuals served, staff, and other people coming to the organization, as well as the property owner’s plan to resolve such issues.

2. A number of elements of performance describe time frames for completing certain tasks or functions. The Joint Commission recognizes that it will not always be possible to meet the exact time frames cited in the requirements. For evaluation purposes, therefore, the following intervals are acceptable:
   - Every 36 months/every 3 years = 36 months from the last event, plus or minus 45 days

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- Annually/every 12 months/once a year/every year = 1 year from the last event, plus or minus 30 days
- Every 6 months = 6 months from the last event, plus or minus 20 days
- Quarterly/every quarter = every three months, plus or minus 10 days
- Monthly/30-day intervals/every month = 12 times a year, once per calendar month
- Every week = once per calendar week
Chapter Outline

I. Plan (EC.01.01.01)

II. Implement
   A. Safety and Security (EC.02.01.01, EC.02.01.03, EC.02.01.05)
   B. Hazardous Materials and Waste (EC.02.02.01)
   C. Fire Safety (EC.02.03.01, EC.02.03.03, EC.02.03.05)
   D. Medical Equipment (EC.02.04.03)
   E. Utilities (EC.02.05.01, EC.02.05.03, EC.02.05.05, EC.02.05.07)
   F. Other Physical Environment Requirements (EC.02.06.01, EC.02.06.03, EC.02.06.05)

III. Staff Demonstrate Competence (EC.03.01.01)

IV. Monitor and Improve (EC.04.01.01, EC.04.01.03, EC.04.01.05)
Standards, Rationales, and Elements of Performance

Standard EC.01.01.01

The organization plans activities that minimize risks in the environment of care.

Note: One or more persons can be assigned to manage risks associated with the management plans described in this standard.

Rationale for EC.01.01.01

Risks are inherent in the environment because of the types of care provided and the equipment and materials that are necessary to provide that care. The best way to manage these risks is through a systematic approach that involves the proactive evaluation of the harm that could occur. By identifying one or more individuals to coordinate and manage risk assessment and reduction activities—and to intervene when conditions immediately threaten life and health—organizations can be more confident that they have minimized the potential for harm. Risks in the environment include safety and security for people, the handling of hazardous materials, the potential for fire, and utility systems.

Written management plans help the organization manage risks. These plans are not the same as operational plans, but they do provide a framework for managing the environment of care. These plans should also address the scope and objectives of risk assessment and management, describe the responsibilities of individuals or groups, and give time frames for specific activities identified in the plan.

Note: It is not necessary to have a separate plan for each of the areas identified in the standard; they may all be contained in a single document.

Elements of Performance for EC.01.01.01

1. Leaders identify an individual(s) to manage risk, coordinate risk reduction activities in the environment of care, collect information on deficiencies, and disseminate summaries of actions and results.

Note 1: This information is disseminated to individuals with responsibility for the issues being addressed.

Note 2: Deficiencies include injuries, problems, or use errors.
4. ☐ The organization has a written plan for providing a safe environment for everyone who enters the organization’s facilities.

**Note:** Facilities include both leased and owned spaces.

5. ☐ The organization has a written plan for providing a secure environment for everyone who enters the organization’s facilities.

**Note:** Facilities include both leased and owned spaces.

The organization has a written plan for managing the following:

7. ☐ Fire safety.

9. ☐ Utility systems.

**Standard EC.02.01.01**

The organization manages safety and security risks.

**Rationale for EC.02.01.01**

Safety and security risks are present in most health care environments. These risks affect all individuals in the organization—individuals served, visitors, and those who work in the organization. It is important to identify these risks in advance so that the organization can prevent or effectively respond to incidents. In some organizations, safety and security are treated as a single function, although in others they are treated as separate functions.

Safety risks may arise from the structure of the physical environment or the performance of everyday tasks, or be related to situations beyond the organization’s control, such as the weather. Safety incidents are most often accidental. On the other hand, security incidents are often intentional. Security protects individuals and property against harm or loss. Examples of security risks include workplace violence, theft, and unrestricted access to medications. Security incidents are caused by individuals from either outside or inside the organization.

**Elements of Performance for EC.02.01.01**

1. ☐ The organization implements its process to identify safety and security risks associated with the environment of care that could affect individuals served, staff, and other people coming to the organization’s facilities. □
Note: Risks are identified from internal sources such as ongoing monitoring of the environment, results of root cause analyses, results of proactive risk assessments of high-risk processes, and from credible external sources such as Sentinel Event Alerts.

3. The organization takes action to minimize identified safety and security risks associated with the physical environment. 

5. The organization maintains all grounds and equipment.

8. The organization controls access to and from areas it identifies as security sensitive.

11. The organization acts in accordance with product notices and recalls. (See also MM.05.01.17, EPs 1–4)

13. For opioid treatment programs: The organization establishes procedures for handling physical or verbal threats, acts of violence, inappropriate behavior, or other escalating and potentially dangerous situations. This includes situations in which security guards or police need to be summoned.

Standard EC.02.01.03

The organization prohibits smoking except in specific circumstances.

Elements of Performance for EC.02.01.03

1. The organization develops a written policy prohibiting smoking in buildings, except in specific circumstances for adult individuals served in 24-hour-care settings. The organization defines specific circumstances that may result in exceptions to the policy for individuals served.

Note: The scope of this EP is concerned with all smoking types—tobacco, electronic, or other.

3. If the organization decides that certain adult individuals served may smoke in 24-hour-care buildings, the clinical staff develops written criteria identifying the circumstances under which those individuals may smoke.

6. The organization takes action to maintain compliance with its smoking policy.

Standard EC.02.01.05

For foster care: The agency places individuals in foster care in physically safe environments.

Note: This standard applies to foster care agencies that make placement decisions.
Elements of Performance for EC.02.01.05

1. **For foster care:** The foster care agency defines, in writing, criteria for assessing the safety of the foster care family’s physical environment.

   **For foster care:** The foster care agency uses defined criteria to assess the following aspects of safety in the foster care home:

   2. The adequacy of sanitary conditions.
   3. Minimizing the risk of injury from toxic materials and medications.
   4. Minimizing the risk of injury from pets; this includes verifying that pet vaccinations are current, in accordance with law and regulation.
   5. Minimizing the risk of injury from firearms in the home.
   6. Other issues as identified by national or state organizations and local, state, tribal, and federal law (such as licensing standards).

7. **For foster care:** The foster care agency verifies that fire protection equipment (for example, smoke detectors, portable fire extinguishers) is inspected, tested, and maintained in a time frame determined by the organization.

8. **For foster care:** The foster care agency verifies that emergency procedures for responding to fire are in place.

9. **For foster care:** The foster care agency verifies the existence of a door for the sleeping room of the individual in foster care.

10. **For foster care:** The foster care agency verifies the existence of at least two of the following means of escape from the sleeping room of the individual in foster care:
   - An operable exterior window large enough for emergency escape
   - A door leading directly to the outside
   - Access to a means of escape such as an unenclosed stairway

11. **For foster care:** The foster care agency verifies the existence of a smoke detector on each floor and near the sleeping room of the individual in foster care.

13. **For foster care:** The foster care agency reassesses safety during the periodic evaluation of the case plan, or as required by law and regulation. The safety assessment is documented.

**Standard EC.02.02.01**
The organization manages risks related to hazardous materials.
Rationale for EC.02.02.01
Hazardous materials cause harm if they are not managed properly. Examples of such materials include chemicals, such as cleaning products, solvents, and pesticides. Federal, state, or local regulations often guide the handling, use, and storage of hazardous materials. The organization identifies materials it uses that need special handling to minimize the risks of unsafe use and improper disposal.

Element of Performance for EC.02.02.01
2. The organization manages hazardous materials from receipt through final use or disposal. (See also IC.02.01.01, EP 6; MM.01.01.03, EP 3)

Standard EC.02.03.01
The organization manages fire risks.

Rationale for EC.02.03.01
The organization’s plan for fire response is an essential part of achieving a fire-safe environment. It is important that this response be evaluated in drill scenarios or actual fire situations in order to assess performance of staff and fire safety equipment. Testing the fire response plan should involve realistic situations, although actual evacuation of individuals served during the drills is not required.

An effective fire plan accounts for the needs of the population served. For example, the plan should address how individuals in restraints will be protected during a fire.

Elements of Performance for EC.02.03.01
1. The organization minimizes the potential for harm from fire, smoke, and other products of combustion.
4. The organization maintains free and unobstructed access to all exits.

Note: This requirement applies to all buildings classified as business occupancy. The “Life Safety” (LS) chapter addresses the requirements for all other occupancy types.

5. In buildings housing three or fewer individuals served, the organization provides doors for sleeping rooms of the individuals served.†
6. In buildings housing three or fewer individuals served, the organization provides at least two of the following from the individual’s sleeping room:

† The “Life Safety” (LS) chapter contains sleeping room requirements for buildings housing four or more individuals served.
An operable, exterior window large enough for emergency escape
A door leading directly to the outside
Access to another means of escape such as an unenclosed stairway

7. In buildings housing three or fewer individuals served, the organization installs a smoke detector in or near the individual’s sleeping room.

8. In buildings housing three or fewer individuals served, the organization establishes emergency procedures for responding to fire (including identifying primary and secondary means of escape).

9. The written fire response plan describes the specific roles of staff and licensed independent practitioners at and away from a fire’s point of origin, including when and how to sound and report fire alarms, how to contain smoke and fire, how to use a fire extinguisher, how to assist and relocate individuals served, and how to evacuate to areas of refuge.

Note: For full text, refer to NFPA 101-2012: 18/19.7.1; 7.2.

13. The organization meets all other Health Care Facilities Code fire protection requirements, as related to NFPA 99-2012: Chapter 15.

**Standard EC.02.03.03**
The organization conducts fire drills.

**Elements of Performance for EC.02.03.03**

1. The organization conducts fire drills once per shift per quarter in each building defined as a health care occupancy by the *Life Safety Code*. The organization conducts quarterly fire drills in each building defined as an ambulatory health care occupancy by the *Life Safety Code*. (See also LS.01.02.01, EP 11)

Note 1: Evacuation of individuals served during drills is not required.

Note 2: When drills are conducted between 9:00 P.M. and 6:00 A.M., the organization may use alternative methods to notify staff instead of activating audible alarms.

Note 3: In leased or rented facilities, drills need be conducted only in areas of the building that the organization occupies.
2. The organization conducts fire drills every 12 months from the date of the last drill in each area that is defined as a business occupancy by the Life Safety Code and in which care, treatment, or services are provided.

Note: In leased or rented facilities, drills need to be conducted only in areas of the building that the organization occupies.

3. When quarterly fire drills are required, they are unannounced and held at unexpected times and under varying conditions. Fire drills include transmission of fire alarm signal and simulation of emergency fire conditions.

Note 1: When drills are conducted between 9:00 P.M. and 6:00 A.M., the organization may use alternative methods to notify staff instead of activating audible alarms.

Note 2: For full text, refer to NFPA 101-2012: 18/19: 7.1.7; 7.1; 7.2; 7.3.

4. Staff who work in buildings where individuals served are housed or treated participate in drills according to the organization’s fire response plan.

5. The organization critiques fire drills to evaluate fire safety equipment, fire safety building features, and staff response to fire.

Standard EC.02.03.05
The organization maintains fire safety equipment and fire safety building features.

Note: This standard does not require organizations to have the types of fire safety equipment and building features described in the elements of performance of this standard. However, if these types of equipment or features exist within the building, then the following maintenance, testing, and inspection requirements apply.

Elements of Performance for EC.02.03.05

1. At least quarterly, the organization tests supervisory signal devices on the inventory (except valve tamper switches). The results and completion dates are documented.

Note 1: For additional guidance on performing tests, see NFPA 72-2010: Table 14.4.5.
Note 2: Supervisory signals include the following: control valves; pressure supervisory; pressure tank, pressure supervisory for a dry pipe (both high and low conditions), steam pressure; water level supervisory signal initiating device; water temperature supervisory; and room temperature supervisory.

2. (⃝) Every 6 months, the organization tests vane-type and pressure-type water flow devices and valve tamper switches on the inventory. The results and completion dates are documented.

Note 1: For additional guidance on performing tests, see NFPA 72-2010: Table 14.4.5.

Note 2: Mechanical water-flow devices (including, but not limited to, water motor gongs) are tested quarterly. The results and completion dates are documented. (For full text, refer to NFPA 25-2011: Table 5.1.1.2)

3. (⃝) Every 12 months, the organization tests duct detectors, heat detectors, manual fire alarm boxes, and smoke detectors on the inventory. The results and completion dates are documented.

Note: For additional guidance on performing tests, see NFPA 72-2010: Table 14.4.5; 17.14.

4. (⃝) Every 12 months, the organization tests visual and audible fire alarms, including speakers and door-releasing devices on the inventory. The results and completion dates are documented.

Note: For additional guidance on performing tests, see NFPA 72-2010: Table 14.4.5.

5. (⃝) Every 12 months, the organization tests fire alarm equipment on the inventory for notifying off-site fire responders. The results and completion dates are documented.

Note: For additional guidance on performing tests, see NFPA 72-2010: Table 14.4.5.

6. (⃝) For automatic sprinkler systems: The organization tests electric motor–driven fire pumps monthly and diesel engine–driven fire pumps weekly under no-flow conditions. The results and completion dates are documented.

Note: For additional guidance on performing tests, see NFPA 25-2011: 8.3.1; 8.3.2.
7. ⚫️ For automatic sprinkler systems: Every six months, the organization tests water-storage tank high- and low-water level alarms. The results and completion dates are documented.

**Note:** For additional guidance on performing tests, see NFPA 25-2011: 9.3; Table 9.1.1.2.

8. ⚫️ For automatic sprinkler systems: Every month during cold weather, the organization tests water-storage tank temperature alarms. The results and completion dates are documented.

**Note:** For additional guidance on performing tests, see NFPA 25-2011: 9.2.4; Table 9.1.1.2.

9. ⚫️ For automatic sprinkler systems: Every 12 months, the organization tests main drains at system low point or at all system risers. The results and completion dates are documented.

**Note:** For additional guidance on performing tests, see NFPA 25-2011: 13.2.5; 13.3.3.4; Table 13.1.1.2; Table 13.8.1.

10. ⚫️ For automatic sprinkler systems: Every quarter, the organization inspects all fire department water supply connections. The results and completion dates are documented.

**Note:** For additional guidance on performing tests, see NFPA 25-2011: 13.7; Table 13.1.1.2.

11. ⚫️ For automatic sprinkler systems: Every 12 months, the organization tests fire pumps under flow. The results and completion dates are documented.

**Note:** For additional guidance on performing tests, see NFPA 25-2011: 8.3.3.

12. ⚫️ Every 5 years, the organization conducts hydrostatic and water-flow tests for standpipe systems. The results and completion dates are documented.

**Note:** For additional guidance on performing tests, see NFPA 25-2011: 6.3.1; 6.3.2; Table 6.1.1.2.

13. ⚫️ Every 6 months, the organization inspects any automatic fire-extinguishing system in a kitchen. The results and completion dates are documented.

**Note 1:** Discharge of the fire-extinguishing systems is not required.
Note 2: For additional guidance on performing inspections, see NFPA 96-2011: 11.2.

14. Every 12 months, the organization tests carbon dioxide and other gaseous automatic fire-extinguishing systems. The results and completion dates are documented.

Note 1: Discharge of the fire-extinguishing systems is not required.


15. At least monthly, the organization inspects portable fire extinguishers. The results and completion dates are documented.

Note 1: There are many ways to document the inspections, such as using bar-coding equipment, using check marks on a tag, or using an inventory.

Note 2: Inspections involve a visual check to determine correct type of and clear and unobstructed access to a fire extinguisher, in addition to a check for broken parts and full charge.

Note 3: For additional guidance on inspection of fire extinguishers, see NFPA 10-2010: 7.2.2; 7.2.4.

16. Every 12 months, the organization performs maintenance on portable fire extinguishers, including recharging. Individuals performing annual maintenance on extinguishers are certified. The results and completion dates are documented.

Note 1: There are many ways to document the maintenance, such as using bar-coding equipment, using check marks on a tag, or using an inventory.

Note 2: For additional guidance on maintaining fire extinguishers, see NFPA 10-2010: 7.1.2; 7.2.2; 7.2.4; 7.3.1.

17. The organization conducts hydrostatic tests on standpipe occupant hoses 5 years after installation and every 3 years thereafter. The results and completion dates are documented.

Note: For additional guidance on hydrostatic testing, see NFPA 1962-2008: Chapter 7 and NFPA 25-2011: Chapter 6.
18. ☐ The organization operates fire and smoke dampers one year after installation and then at least every six years to verify that they fully close. The results and completion dates are documented.

**Note:** For additional guidance on performing tests, see NFPA 90A-2012: 5.4.8; NFPA 80-2010: 19.4; NFPA 105-2010: 6.5.

19. ☐ Every 12 months, the organization tests automatic smoke-detection shutdown devices for air-handling equipment. The results and completion dates are documented.

**Note:** For additional guidance on performing tests, see NFPA 90A-2012: 6.4.1.

20. ☐ Every 12 months, the organization tests sliding and rolling fire doors, smoke barrier sliding or rolling doors, and sliding and rolling fire doors in corridor walls and partitions for proper operation and full closure. The results and completion dates are documented.

**Note:** For full text, refer to NFPA 80-2010: 5.2.14.3; NFPA 105-2010: 5.2.1; 5.2.2.

25. ☐ The organization has annual inspection and testing of door assemblies by individuals who can demonstrate knowledge and understanding of the operating components of the door being tested. Testing begins with a pre-test visual inspection; testing includes both sides of the opening.

**Note:** For additional guidance on testing of door assemblies, see NFPA 101-2012: 7.2.1.5.10.1; 7.2.1.5.11; 7.2.1.15; NFPA 80-2010: 4.8.4; 5.2.1; 5.2.3; 5.2.4; 5.2.6; 5.2.7; 6.3.1.7; NFPA 105-2010: 5.2.1.

28. ☐ Documentation of maintenance, testing, and inspection activities for EC.02.03.05, EPs 1–20, 25 (including fire alarm and fire protection features) includes the following:

- Name of the activity
- Date of the activity
- Inventory of devices, equipment, or other items
- Required frequency of the activity
- Name and contact information, including affiliation, of the person who performed the activity
- NFPA standard(s) referenced for the activity
- Results of the activity
Standard EC.02.04.03

The organization inspects, tests, and maintains medical equipment.

Element of Performance for EC.02.04.03

3. The organization has a process for inspecting, testing as needed, and maintaining all medical equipment that it owns and operates, which is based on manufacturers’ recommendations, risk levels, or current organization experience. These activities are documented.

Note: This process does not encompass medical equipment owned by individuals served or other organizations.

Standard EC.02.05.01

The organization manages risks associated with its utility systems.

Elements of Performance for EC.02.05.01

4. The organization identifies inspection and maintenance activities for all operating components of utility systems.

Note: Organizations may use different approaches to maintenance. For example, activities such as predictive maintenance, reliability-centered maintenance, interval-based maintenance, corrective maintenance, or metered maintenance may be selected to provide for dependable performance.

5. The organization identifies the frequencies for inspecting, testing, and maintaining all operating components of the utility systems, based on criteria such as manufacturers’ recommendations, risk levels, or organization experience.

8. The organization has information about the distribution of its utility systems.

9. The organization labels utility system controls to facilitate partial or complete emergency shutdowns.

Note 1: Examples of utility system controls that should be labeled are utility source valves, utility system main switches and valves, and individual circuits in an electrical distribution panel.
Note 2: For example, the fire alarm system’s circuit is clearly labeled as Fire Alarm Circuit; the disconnect method (that is, the circuit breaker) is marked in red; and access is restricted to authorized personnel. Information regarding the dedicated branch circuit for the fire alarm panel is located in the control unit. For additional guidance, see NFPA 101-2012: 18/19.3.4.1; 9.6.1.3; NFPA 72-2010: 10.5.5.2.

10. The organization has written procedures for responding to utility system disruptions.

11. The organization’s procedures address shutting off the malfunctioning system and notifying staff in affected areas.

13. The organization responds to utility system disruptions as described in its procedures.

16. In non–critical care areas, the ventilation system provides required pressure relationships, temperature, and humidity.

Note: Examples of non–critical care areas are general care nursing units; clean and soiled utility rooms in acute care areas; laboratories, pharmacies, diagnostic and treatment areas, food preparation areas, and other support departments.

18. Medical gas storage rooms and transfer and manifold rooms comply with NFPA 99-2012: 9.3.7.

19. The emergency power supply system’s equipment and environment are maintained per manufacturers’ recommendations, including ambient temperature not less than 40°F; ventilation supply and exhaust; and water jacket temperature (when required). (For full text, refer to NFPA 99-2012: 9.3.10)

Standard EC.02.05.03

The organization has a reliable emergency electrical power source.

Elements of Performance for EC.02.05.03

1. For facilities that were constructed, or had a change in occupancy type, or have undergone an electrical system upgrade since 1983, the organization has a Type 1 or Type 3 essential electrical system in accordance with NFPA 99, 2012 edition. This essential electrical system must be divided into three branches, including the life safety branch, critical branch, and equipment branch. Both the life safety branch and the critical branch are kept independent of all other wiring and
equipment, and they transfer within 10 seconds of electrical interruption. Each branch has at least one automatic transfer switch. For additional guidance, see NFPA 99-2012: 6.4.2.2.

The organization provides emergency power within 10 seconds for the following:

2. Alarm systems, as required by the Life Safety Code.
   
   **Note:** For guidance in establishing a reliable emergency power system (that is, an essential electrical distribution system), see NFPA 99-2012: 6.4.1.1; 6.4.2.2; NFPA 110-2010: 4.1; Table 4.1(b).

3. Exit route and exit sign illumination, as required by the Life Safety Code.
   
   **Note:** For guidance in establishing a reliable emergency power system (that is, an essential electrical distribution system), see NFPA 99-2012: 6.4.1.1; 6.4.2.2; NFPA 110-2010: 4.1; Table 4.1(b).

5. Emergency communication systems, as required by the Life Safety Code.
   
   **Note:** For guidance in establishing a reliable emergency power system (that is, an essential electrical distribution system), see NFPA 99-2012: 6.4.2.2; NFPA 110-2010: 4.1; Table 4.1(b).

11. Emergency lighting at emergency generator locations. The organization’s emergency power system (EPS) has a remote manual stop station (with identifying label) to prevent inadvertent or unintentional operation. A remote annunciator (powered by storage battery) is located outside the EPS location.

   **Note:** For guidance in establishing a reliable emergency power system (that is, an essential electrical distribution system), refer to NFPA 99-2012: 6.4.1.1.6; 6.4.1.1.17; 6.4.2.2; NFPA 110-2010: 5.6.5.6; 7.3.1.

13. When elevators exist in 24-hour-care settings, the organization has a method for safely evacuating nonambulatory individuals when power is lost.

   **Note:** Acceptable solutions include providing elevators with emergency power or using evacuation techniques such as carrying.

14. The organization implements a policy to provide emergency backup for essential medication dispensing equipment identified by the organization, such as automatic dispensing cabinets, medication carousels, and central medication robots.

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
15. ☐ The organization implements a policy to provide emergency backup for essential refrigeration for medications identified by the organization, such as designated refrigerators and freezers.

**Note:** Examples of emergency backup can include emergency power, battery-based indoor generators, or other actions describing how dispensing and administration of medications will continue when emergency backup is needed.

### Standard EC.02.05.05

The organization inspects, tests, and maintains utility systems.

**Note:** At times, maintenance is performed by an external service. In these cases, organizations are not required to possess maintenance documentation but have access to such documentation during survey and as needed.

#### Elements of Performance for EC.02.05.05

1. When performing repairs or maintenance activities, the organization has a process to manage risks associated with air-quality requirements; infection control; utility requirements; noise, odor, dust, vibration; and other hazards that affect care, treatment, or services for individuals served, staff, and visitors.

2. ☐ The organization tests utility system components on the inventory before initial use and after major repairs or upgrades. The completion dates and test results are documented.

The organization inspects, tests, and maintains the following:

3. ☐ Utility systems. The completion dates and test results are documented.

8. The organization meets NFPA 99-2012: Health Care Facilities Code requirements related to electrical systems and heating, ventilation, and air conditioning (HVAC). (For full text, refer to NFPA 99-2012: Chapters 6 and 9)

### Standard EC.02.05.07

The organization inspects, tests, and maintains emergency power systems.
**Note:** This standard does not require organizations to have the types of emergency power equipment described in the elements of performance of this standard. However, if these types of emergency equipment exist within the building, then the following maintenance, testing, and inspection requirements apply. This does not apply to generators used only for convenience purposes.

**Rationale for EC.02.05.07**

Emergency electrical power supply systems may fail during a power disruption, leaving the organization unable to deliver safe care, treatment, or services to individuals. Testing these systems for sufficient lengths of time at regular frequencies increases the likelihood of detecting reliability problems and reduces the risk of losing this critical resource when it is most needed.

**Elements of Performance for EC.02.05.07**

1. 🟢 At least monthly, the organization performs a functional test of emergency lighting systems and exit signs required for egress and task lighting for a minimum duration of 30 seconds, along with a visual inspection of other exit signs. The test results and completion dates are documented. (For full text, refer to NFPA 101-2012: 7.9.3; 7.10.9; NFPA 99-2012: 6.3.2.2.11.5)

2. 🟢 Every 12 months, the organization performs a functional test of battery-powered lights on the inventory required for egress and exit signs for a duration of 1½ hours. The test results and completion dates are documented. (See also LS.02.01.20, EP 39) (For full text, refer to NFPA 101-2012: 7.9.3; 7.10.9; NFPA 99-2012: 6.3.2.2.11.5)

3. 🟢 The organization performs a functional test of Level 1 stored emergency power supply systems (SEPSS) on a monthly basis and performs a test of Level 2 SEPSS on a quarterly basis. Test duration is for five minutes or as specified for its class (whichever is less). The organization performs an annual test at full load for 60% of the full duration of its class. The test results and completion dates are documented.

**Note 1:** Non-SEPSS battery backup emergency power systems that the organization has determined to be critical for operations during a power failure (for example, laboratory equipment or electronic medical records) should be properly tested and maintained in accordance with manufacturers’ recommendations.
**Note 2:** Level 1 SEPSS are intended to automatically supply illumination or power to critical areas and equipment essential for safety to human life. Included are systems that supply emergency power for such functions as illumination for safe exiting, ventilation where it is essential to maintain life, fire detection and alarm systems, public safety communications systems, and processes where the current interruption would produce serious life safety or health hazards to individuals served, the public, or staff.

**Note 3:** Class defines the minimum time for which the SEPSS is designed to operate at its rated load without being recharged. For additional guidance, see NFPA 111-2010: 8.4.

4. ☑ At least weekly, the organization inspects the emergency power supply system (EPSS), including all associated components and batteries. The results and completion dates of weekly inspections are documented. *(For full text, refer to NFPA 110-2010: 8.3.1; 8.3.3; 8.3.4; 8.4.1)*

5. ☑ At least monthly, the organization tests each emergency generator beginning with a cold start under load for at least 30 continuous minutes. The cooldown period is not part of the 30 continuous minutes. The test results and completion dates are documented. *(For full text, refer to NFPA 99-2012: 6.4.4.1)*

6. The monthly tests for diesel-powered emergency generators are conducted with a dynamic load that is at least 30% of the nameplate rating of the generator or meets the manufacturer’s recommended prime movers’ exhaust gas temperature. If the organization does not meet either the 30% of nameplate rating or the recommended exhaust gas temperature during any test in EC.02.05.07, EP 5, then it must test the emergency generator once every 12 months using supplemental (dynamic or static) loads of 50% of nameplate rating for 30 minutes, followed by 75% of nameplate rating for 60 minutes, for a total of 1½ continuous hours. *(For full text, refer to NFPA 99-2012: 6.4.4.1)*

**Note:** Tests for non-diesel-powered generators need only be conducted with available load.

7. ☑ At least monthly, the organization tests all automatic and manual transfer switches on the inventory. The test results and completion dates are documented. *(For full text, refer to NFPA 99-2012: 6.4.4.1)*
Introduction to Standard EC.02.06.01

Features of the organization’s space influence the outcomes and satisfaction of individuals served and promote safety. The physical space also affects families, staff, and others in the organization.

These features of the environment of care include the following:
- Quality of natural and artificial light
- Privacy
- Size and configuration of space
- Security for individuals served and their belongings
- Clear access to internal and external doors
- Level of noise
- Space that allows staff to work efficiently

When designed into and managed as part of the environment, these elements create safe and suitable surroundings that support the dignity of the individual served and allow ease of interaction. The physical environment balances an individual’s rights against his or her needs and safety and the environment in which care, treatment, or services are provided. In particular, the leaders consider the safety, rights, and security of the individual served when approving the use of structural restraints.

The standards do not specifically address all of these features. However, organizations may wish to consider these aspects of the environment when they design and manage spaces. Decisions on what features to pursue should be based on data, such as information about the satisfaction of the individual served, data collected from staff, and evidence-based design guidelines.

Standard EC.02.06.01

The organization establishes and maintains a safe, functional environment.

Elements of Performance for EC.02.06.01

1. Interior spaces meet the needs of the individuals served for safety and suitability for the care, treatment, or services provided.

4. The organization provides outside areas for use by individuals served, based on the individual’s needs and suitable to the individual’s age or other characteristics.

   Note: Outdoor areas may include facility grounds, nearby parks and playgrounds, and adjacent countryside.
5. The organization provides storage space to meet the needs of the individual served.

8. Waiting and reception areas are adequate in size and number and staffed according to the needs of the individuals served.

9. Restrooms are adequate in size and number for people using the facility.

10. **For opioid treatment programs:** The use of physical space, including bathrooms, reflects the special needs of female patients.

11. Lighting is suitable for care, treatment, or services.

12. Lighting is controlled by the individuals served, consistent with care, treatment, or services provided.

19. Drinking fountains or water coolers are available for the individuals served.

20. Areas used by individuals served are safe, clean, and comfortable.

24. Furnishings and equipment should reflect the ability and needs of the individual served.

25. Door locks and other structural restraints (such as fences) have the following characteristics:
   - They are consistent with the organization’s mission, program goals, program policy, and law and regulation.
   - They provide the least-restrictive environment.
   - They meet the needs of the individual served.
   - They provide for emergency access to locked, occupied spaces.

26. The organization keeps furnishings and equipment safe and in good repair.

36. **For opioid treatment programs:** The program has private, individual offices available for counseling.

**Standard EC.02.06.03**
The organization establishes and maintains a safe and functional dining environment when food is provided.

**Elements of Performance for EC.02.06.03**

1. The dining environment encourages eating and socialization.

2. Dining areas are free from loud and distracting noises.
3. Dining areas are arranged to seat small groups.

4. Consistent with program goals, facilities for preparing snacks and meals for special occasions are available.

5. The facilities for serving snacks, preparing meals, and engaging in recreational activities support the participation of the individuals served.

**Standard EC.02.06.05**

The organization manages its space during demolition, renovation, or new construction.

**Note:** These elements of performance are applicable to all occupancy types.

**Rationale for EC.02.06.05**

In addition to fire safety, there are other hazards and risks resulting from demolition, renovation, or new construction that must be addressed. It is important to plan and conduct risk assessments before construction begins. Authoritative guidelines and state regulations can provide valuable information to guide demolition, renovation, or new construction.

**Elements of Performance for EC.02.06.05**

1. The organization uses design criteria when planning for new, altered, or renovated space that are consistent with applicable local, state, and federal law and regulation.

2. When planning for demolition, construction, renovation, or general maintenance, the organization conducts a preconstruction risk assessment for air quality requirements, infection control, utility requirements, noise, vibration, and other hazards that affect care, treatment, and services.

   **Note:** See LS.01.02.01 for information on fire safety procedures to implement during construction or renovation.

3. The organization takes action based on its assessment to minimize risks during demolition, construction, renovation, or general maintenance.

**Standard EC.03.01.01**

Staff are familiar with their roles and responsibilities relative to the environment of care.
Rationale for EC.03.01.01
People are the key to successfully managing risks in the physical environment. Plans and procedures are of no value if those who work in the organization do not know how to follow them. Everyone who works in the organization is responsible for safety, and it is important for them to know how to identify and minimize risks, what actions to take when an incident occurs, and how to report it.

Element of Performance for EC.03.01.01
2. Staff can describe or demonstrate actions to take in the event of an environment of care incident.

Standard EC.04.01.01
The organization collects information to monitor conditions in the environment.

Elements of Performance for EC.04.01.01
1. The organization establishes a process(es) for continually monitoring, internally reporting, and investigating the following:
   ▪ Injuries to individuals served or others within the organization’s facilities
   ▪ Occupational illnesses and staff injuries
   ▪ Incidents of damage to its property or the property of others in locations it controls
   ▪ Security incidents involving individuals served, staff, or others in locations it controls
   ▪ Fire safety management problems, deficiencies, and failures

Note 1: All the incidents and issues listed above may be reported to staff in quality assessment, improvement, or other functions. A summary of such incidents may also be shared with the person designated to coordinate safety management activities.

Note 2: Review of incident reports often requires that legal processes be followed to preserve confidentiality. Opportunities to improve care, treatment, or services, or to prevent similar incidents, are not lost as a result of following the legal process.

Based on its process(es), the organization reports and investigates the following:

2. Problems and incidents related to each of the environment of care management plans.
3. Injuries to individuals served or others within the organization’s facilities.
4. Occupational illnesses and staff injuries.
Note: This requirement applies to issues in the workplace, such as back injuries or allergies. It does not apply to communicable diseases.

5. Incidents of damage to its property or the property of others in locations it controls.

14. The organization monitors environmental deficiencies, hazards, and unsafe practices.

15. Every 12 months, the organization evaluates each environment of care management plan, including a review of the plan’s objectives, scope, performance, and effectiveness.

Note: By evaluating the management plans, the organization can make sure that they remain relevant and useful guides for managing the environment of care. A review of the plans’ scope includes a determination of whether any new services, programs, or sites added in the past year need to be addressed by the plans or if new hazards have been introduced into the environment that now need to be covered. A review of the plans’ effectiveness could be accomplished through a review of incident reports as well as evaluation of other known problems that are not found on the incident reports (such as problems identified in the critique of a fire drill). A review of the plans’ objectives would include a determination of whether the previous year’s objectives were met and if any new objectives should be established to address problems identified in the review of the plans’ effectiveness.

Standard EC.04.01.03
The organization analyzes identified environment of care issues.

Element of Performance for EC.04.01.03

2. The organization uses the results of data analysis to identify opportunities to resolve environmental safety issues.

Standard EC.04.01.05
The organization improves its environment of care.

Element of Performance for EC.04.01.05

1. The organization takes action on the identified opportunities to resolve environmental safety issues.
Emergency Management (EM)

Overview
An emergency is an unexpected or sudden event that significantly disrupts an organization’s ability to provide care, treatment, or services, or disrupts an organization’s setting. Emergencies can be either human-made (such as negligence or a criminal act) or natural (such as an electrical system failure or a tornado) or a combination of both. Emergencies that can threaten any behavioral health care organization include power failures, flooding, and communication breakdowns. A disaster is a type of emergency that, due to its complexity, scope, or duration, threatens the organization’s capabilities and requires outside assistance to sustain care, safety, or security.

Emergency management consists of four phases: mitigation, preparedness, response, and recovery. These phases occur over time; mitigation and preparedness generally occur before an emergency, and response and recovery occur during and after an emergency. The precursor activity to mitigation is the identification of risks and vulnerabilities. Identifying risks and vulnerabilities is the first step toward composing a comprehensive Emergency Management Plan (EMP). The EMP document may reflect response strategies ranging from continuing a full scope of care, treatment, or services, to rescheduling non-urgent appointments, to closing temporarily. The organization’s structure and the functioning-level of the populations it serves will determine the complexity of its EMP. For example, 24-hour settings are likely to have extensive emergency response plans, whereas office-based counseling clinics are likely to have simpler plans.

No organization can predict the nature of a future emergency, nor can it predict the date of its arrival. However, behavioral health care organizations can plan for managing the following critical areas of their organizations so that they can respond effectively regardless of the cause(s) of an emergency:
- Care, treatment, or services for individuals served
- Communications
- Resources and assets
- Safety and security
- Staff responsibilities
When behavioral health care organizations consider their capabilities in these areas, they are taking an approach to emergency management that supports a level of preparedness sufficient to address a range of emergencies. This approach lays the foundation for developing a responsive Emergency Management Plan for emergencies that may escalate in complexity, scope, or duration.

**About This Chapter**

The “Emergency Management” (EM) chapter guides organizations through the planning activities that occur prior to developing the Emergency Management Plan (EMP). The chapter also describes the essential components that comprise the EMP such as preparedness activities, response procedures, and identification of the staff responsible for these activities. Finally, the chapter guides organizations through evaluating the effectiveness of the EMP.

The planning activities described in Standard EM.01.01.01 help the organization to focus its strategy for mitigating the potential effects of emergencies, as well as its preparedness strategy for organizing and mobilizing essential resources. The organization will use its EMP document (described in Standard EM.02.01.01 and subsequent standards) to define its response to emergencies and to help position it for recovery after the emergency has passed. After the EMP is in place, it is tested through emergency response exercises (drills) in order to evaluate its effectiveness and use lessons learned to improve response strategies (described in Standard EM.03.01.03). Adjustments to the EMP should be made based on emergency response exercises and responses to actual emergencies (described in Standard EM.03.01.03).

Additional standards in other chapters are integral to organizationwide emergency preparedness, including processes for the following:

- Maintaining continuity of information (refer to Standard IM.01.01.03)
- Responding (as appropriate to service provided) to outbreaks of infectious disease (refer to Standard IC.01.06.01)
Chapter Outline

I. Foundation for the Emergency Management Plan (EM.01.01.01)

II. The Plan for Response and Recovery
   A. General Requirements (EM.02.01.01)
   B. Specific Requirements
      1. Communications (EM.02.02.01)
      2. Resources and Assets (EM.02.02.03)
      3. Security and Safety (EM.02.02.05)
      4. Staff (EM.02.02.07)
      5. Individuals Served (EM.02.02.11)

III. Evaluation (EM.03.01.03)
Standards, Rationales, and Elements of Performance

Standard EM.01.01.01
The organization engages in planning activities prior to developing its Emergency Management Plan.

Rationale for EM.01.01.01
An emergency in a behavioral health care organization can suddenly and significantly affect its ability to provide services. Therefore, the organization needs to engage in planning activities that prepare it to form its Emergency Management Plan. These activities include considering likely emergencies and identifying risks when developing strategies for emergency preparedness. During these activities, the organization will consider hazards, such as adverse weather conditions, power outages, fire, or flooding, which could affect the organization’s location.

Elements of Performance for EM.01.01.01

1. The organization’s leaders, including the leaders of each program and service, participate in planning activities prior to developing an Emergency Management Plan.

2. The organization identifies potential emergencies that could affect demand for its services or its ability to provide those services. (See also IC.01.06.01, EP 4)

   Note: Some organizations refer to this process of identifying potential emergencies as a hazard vulnerability analysis (HVA). Organizations have flexibility in creating either a single HVA that accurately reflects all locations where individuals are served by the organization, or multiple HVAs for the different locations where individuals are served. Some remote sites may be significantly different from the main site (for example, in terms of hazards and population served); in such situations, a separate HVA is appropriate.

3. The organization prioritizes the potential emergencies it has identified.

   Note: An organization may choose to consult with a public health department for information on priority risks in the community or region that could potentially impact the individuals served.

4. The organization determines what its role will be, if any, in the community response plan.
5. The organization uses its prioritized emergencies as a basis for defining mitigation activities (that is, activities designed to reduce the risk of and potential damage from an emergency).

Note: Mitigation, preparedness, response, and recovery are the four phases of emergency management. They occur over time: Mitigation and preparedness generally occur before an emergency, and response and recovery occur during and after an emergency.

6. The organization uses its prioritized emergencies as a basis for defining the preparedness activities that will organize and mobilize essential resources. (See also IM.01.01.03, EPs 1–4)

Standard EM.02.01.01
The organization has an Emergency Management Plan.

Note: The organization’s Emergency Management Plan (EMP) is designed to coordinate its communications, resources and assets, safety and security, staff responsibilities, utilities, and clinical and support activities during an emergency (refer to Standards EM.02.02.01, EM.02.02.03, EM.02.02.05, EM.02.02.07, and EM.02.02.11). Although emergencies have many causes, the effects on these areas of the organization and the required response effort may be similar. This “all hazards” approach supports a general response capability that is sufficiently nimble to address a range of emergencies of different duration, scale, and cause. For this reason, the plan’s response procedures address the prioritized emergencies but are also adaptable to other emergencies that the organization may experience.

Rationale for EM.02.01.01
A successful response effort relies on a comprehensive and flexible Emergency Management Plan that guides decision making regarding how the behavioral health care organization will respond to emergencies, including plans to continue care, treatment, or services or to close in specified circumstances. The plan also supports decision-making at the onset of an emergency and as an emergency evolves. While the Emergency Management Plan can be designed in a variety of ways, it must address response procedures that are adaptable in supporting key areas that could be affected by different types of emergencies.
Elements of Performance for EM.02.01.01

1. The organization’s leaders participate in the development of the Emergency Management Plan.

2. The organization has a written Emergency Management Plan that describes the response procedures to follow when emergencies occur. (See also EM.02.02.11, EP 1; EM.03.01.03, EP 5)

Note 1: The response procedures address the prioritized emergencies but can also be adapted to other emergencies that the organization may experience. Response procedures could include the following:
- Maintaining or expanding services
- Conserving resources
- Curtailing services
- Supplementing resources from outside the local community
- Closing the organization to new individuals for service
- Staged evacuation
- Total evacuation

Note 2: Organizations that do not provide 24-hour care may plan to close in response to an emergency; their activities may be focused on notification and communication to individuals served and strategies for resuming service following the emergency.

4. The organization has a written Emergency Management Plan that describes the recovery strategies, actions, and individual responsibilities necessary to restore the organization’s care, treatment, or services after an emergency.

5. The Emergency Management Plan describes the processes for initiating and terminating the organization’s response and recovery phases of the emergency, including under what circumstances these phases are activated.

Note: Mitigation, preparedness, response, and recovery are the four phases of emergency management. They occur over time: Mitigation and preparedness generally occur before an emergency, and response and recovery occur during and after an emergency.

6. The Emergency Management Plan identifies the staff member(s) responsible for activating the response and recovery phases of the emergency response.
8. If the organization experiences an actual emergency, the organization implements its response procedures.

9. For opioid treatment programs: The program identifies an alternative dosing location to be used in the event of an emergency and registers the location with the US Drug Enforcement Administration (DEA) if it is not already an opioid treatment program.

**Standard EM.02.02.01**

As part of its Emergency Management Plan, the organization prepares for how it will communicate during emergencies.

**Rationale for EM.02.02.01**

The behavioral health care organization maintains reliable communication capabilities for the purpose of communicating response efforts to staff, individuals served, and external organizations. The organization establishes backup communication processes and technologies (for example, cell phones, text messages, landlines, bulletin boards, fax machines, Amateur Radio, television and radio newscasts) to communicate essential information if primary communication systems fail.

**Elements of Performance for EM.02.02.01**

1. The Emergency Management Plan describes how staff will be notified when emergency response procedures have been initiated.

3. For organizations that participate in the community’s response plan, the Emergency Management Plan describes how the organization will notify external authorities that emergency response measures have been initiated.

14. The organization establishes backup communication processes or technologies for use in the event that internal or external systems fail during an emergency.

**Note:** Examples of such processes or technologies may include use of text messaging, reverse 911 systems, announcements on local radio or television, website updates, signage where care, treatment, or services are provided, or informational wallet cards or brochures.

15. For opioid treatment programs: The program maintains a 24-hour telephone answering capability to respond to facility emergencies.

16. **For opioid treatment programs:** A roster of patients and a log of medication dosages are accessible to the staff member on call for verification purposes.
17. The organization implements the components of its Emergency Management Plan that require advance preparation to support communications during an emergency.

    **Note:** Some components of the Emergency Management Plan are not implemented unless an emergency is imminent. Other components, however, can and should be implemented in advance so that the organization is as prepared as possible.

### Standard EM.02.02.03

As part of its Emergency Management Plan, the organization prepares for how it will manage resources and assets during emergencies.

    **Note:** Assets include space, equipment, transportation, and other types of nonconsumables; financial assets are not addressed at this standard.

### Rationale for EM.02.02.03

The behavioral health care organization that continues to provide care, treatment, or services during emergencies needs to determine how resources and assets (that is, supplies, equipment, and facilities) will be managed internally and, when necessary, solicited and acquired from external sources. The organization should also recognize the risk that some resources may not be available from planned sources, particularly in emergencies of long duration or broad geographic scope, and that contingency plans will be necessary for critical supplies. This situation may occur when multiple organizations are vying for a limited supply from the same vendor.

### Elements of Performance for EM.02.02.03

1. **For organizations that plan to provide service during an emergency:** The Emergency Management Plan describes how the organization will obtain and replenish medications and related supplies that will be required in response to an emergency.

    **Note:** This element of performance applies only to organizations that plan to administer medications.

3. **For organizations that plan to provide service during an emergency:** The Emergency Management Plan describes how the organization will obtain and replenish nonmedical supplies (for example, batteries, soap, towels) that will be required in response to an emergency.

11. **For organizations that plan to provide service during an emergency:** The Emergency Management Plan provides processes for managing space.
12. **For organizations that plan to provide service during an emergency:** The organization implements the components of its Emergency Management Plan that require advance preparation to provide for resources and assets during an emergency. *(See also EM.02.02.11, EP 1)*

**Note:** Some components of the Emergency Management Plan are not implemented unless an emergency is imminent. Other components, however, can and should be implemented in advance so that the organization is as prepared as possible.

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**Standard EM.02.02.05**

As part of its Emergency Management Plan, the organization prepares for how it will manage security and safety during an emergency.

**Rationale for EM.02.02.05**
The behavioral health care organization has a responsibility to protect individuals it serves if an emergency occurs while they are on site.

**Elements of Performance for EM.02.02.05**

1. The Emergency Management Plan describes how internal security and safety will be provided during an emergency.

**Note:** It is recognized that individuals may be served in a variety of settings, including wilderness camps and other locations where the organization has limited control over the environment. In such situations, the organization takes steps to mitigate risks in selecting the site or collaborating with the site’s staff to support security and safety should an emergency occur. Educating staff and individuals served about emergency procedures further supports security and safety at these sites.

10. The organization implements the components of its Emergency Management Plan that require advance preparation to support internal security and safety during an emergency.

**Note:** Some components of the Emergency Management Plan are not implemented unless an emergency is imminent. Other components, however, can and should be implemented in advance so that the organization is as prepared as possible.

**Standard EM.02.02.07**

As part of its Emergency Management Plan, the organization prepares for how it will manage staff during an emergency.
Rationale for EM.02.02.07
In order to provide safe and effective care, treatment, or services, staff roles are well defined in advance. Staff roles and responsibilities may be documented in the Emergency Management Plan through a variety of formats (for example, job action sheets, checklists, flowcharts).

Elements of Performance for EM.02.02.07
The Emergency Management Plan describes the following:

2. The roles and responsibilities of staff during an emergency.
3. The process for assigning staff to all essential staff functions.
4. The Emergency Management Plan identifies the staff member(s) to whom staff report in emergencies.
10. The organization implements the components of its Emergency Management Plan that require advance preparation to manage staff during an emergency.

Note: Some components of the Emergency Management Plan are not implemented unless an emergency is imminent. Other components, however, can and should be implemented in advance so that the organization is as prepared as possible.

Standard EM.02.02.11
As part of its Emergency Management Plan, the organization prepares for how it will manage individuals it serves in the event of an emergency.

Elements of Performance for EM.02.02.11
1. The Emergency Management Plan describes how the organization will manage its activities related to care, treatment, or services. (See also EM.02.01.01, EP 2; EM.02.02.03, EP 12)

Note: Activities related to care, treatment, or services might include scheduling, modifying, or discontinuing services; controlling information about individuals served; sharing information about individuals served with their family or guardian, as appropriate; making referrals; transporting individuals served; and providing security.

3. The Emergency Management Plan describes how the organization will evacuate its occupied space.
11. The organization implements the components of its Emergency Management Plan that require advance preparation to manage the individuals it serves in the event of an emergency.

**Note:** Some components of the Emergency Management Plan are not implemented unless an emergency is imminent. Other components, however, can and should be implemented in advance so that the organization is as prepared as possible.

**Standard EM.03.01.03**

The organization evaluates the effectiveness of its Emergency Management Plan.

**Elements of Performance for EM.03.01.03**

1. As an emergency response exercise, the organization activates its Emergency Management Plan once a year at each site included in the plan for non-24-hour settings; 24-hour settings are required to activate the plan twice each year.

**Note 1:** If the organization activates its Emergency Management Plan in response to one or more actual emergencies, these emergencies can serve in place of emergency response exercises.

**Note 2:** Tabletop sessions, though useful, are not acceptable substitutes for these exercises.

5. Emergency response exercises incorporate likely disaster scenarios that allow the organization to evaluate its handling of individuals served, communications, resources and assets, internal security, and staff. *(See also EM.02.01.01, EP 2)*

13. Representatives from administrative, support, and clinical services participate in the evaluation of all emergency response exercises and all responses to actual emergencies.

14. The evaluation of all emergency response exercises and all responses to actual emergencies includes the identification of deficiencies and opportunities for improvement. This evaluation is documented.


**Note:** When modifications requiring substantive resources cannot be accomplished by the next emergency response exercise, interim measures are put in place until final modifications can be made.
17. Subsequent emergency response exercises reflect modifications and interim measures as described in the modified Emergency Management Plan.
Human Resources Management (HRM)

Overview
The contribution that human resources management makes to an organization’s ability to provide safe, quality care, treatment, and services cannot be overestimated. The quality of the organization’s staff will, in large part, determine the quality of the care, treatment, and services it provides. A module on Human Resources and Training in Mental Health Organizations from the World Health Organization’s Mental Health Policy and Service Guidance Package – 2005 states that “human resources are the most valuable asset of a mental health service. Such a service relies on the competence and motivation of its personnel to promote mental health and provide care for people with mental disorders. Once staff are qualified, continuing education, training, and supervision should be developed for the provision of the best quality care that meets users’ needs.”

After staff are hired, even the smallest organization has a responsibility to see that they receive the education and training they need in order to provide quality care, treatment, and services.

About This Chapter
The standards and elements of performance in this chapter address the organization’s responsibility to establish and verify staff qualifications, orient staff, and provide staff with the training they need to support the care, treatment, and services the organization provides. After staff are on the job, human resources must provide for the assessment of staff competence and performance.

Chapter Outline

I. Staff
   A. Staffing (HRM.01.01.01, HRM.01.01.03)
   B. Qualifications (HRM.01.02.01)
   C. Orientation (HRM.01.03.01)
   D. Supervision (HRM.01.04.01)
   E. Education and Training (HRM.01.05.01)
   F. Competence (HRM.01.06.01, HRM.01.06.03, HRM.01.06.05, HRM.01.06.07, HRM.01.06.09)
   G. Performance Evaluation (HRM.01.07.01)
Standards, Rationales, and Elements of Performance

Standard HRM.01.01.01
The organization develops written job descriptions.

Elements of Performance for HRM.01.01.01

1. Each position has a written job description that identifies the following:
   - The minimum qualifications of the position
   - The competencies of the position, which include the minimum skills, knowledge, and experience required for the position
   - The duties and responsibilities of the position

   Note: A written contract may replace a job description. (For more information on contracted services, refer to Standard LD.04.03.09.)

3. For opioid treatment programs: The program physician(s) has experience in addiction medicine or psychiatry, including medication-assisted treatment, and has completed an accredited residency training program.

   Note: Board certification in his or her primary medical specialty and in addiction psychiatry or addiction medicine is preferred.

5. For opioid treatment programs: In states that permit nonlicensed addictions counselors, programs develop job descriptions in accordance with standards put forward by a formal body such as those published by the National Certification Commission for Addiction Professionals.

8. Governance or its designee approves the job descriptions.

   Note: See the Glossary for the definition of governance.

Standard HRM.01.01.03
The organization determines how staff function within the organization.

Elements of Performance for HRM.01.01.03

1. All staff who provide care, treatment, or services possess a current license, certification, or registration, in accordance with law and regulation and organization policy.
2. Staff practice within the scope of their license, certification, or registration and as required by law and regulation and organization policy.

Note: For opioid treatment programs: The organization will have a federal exemption in place to allow midlevel medical practitioners to write medication orders in opioid treatment programs.

3. Staff practice within the scope of their job description.

4. For opioid treatment programs: The program’s telemedicine services do not expand the scope of practice of a health care provider or permit practice in a jurisdiction (the location of the patient) where the provider is not licensed.

5. For opioid treatment programs: The program reviews the individual licensing, scope of practice, and supervision requirements of its state with regard to the duties of authorized health care professionals within the program, such as advanced practice nurses, physician assistants, and advanced practice pharmacists.

Standard HRM.01.02.01
The organization verifies and evaluates staff qualifications.

Elements of Performance for HRM.01.02.01

1. The organization performs primary source verification of staff licensure, certification, or registration in accordance with law and regulation and organization policy at the time of hire and the time of renewal.

Note 1: A primary verification source may designate another agency to communicate credentials information. The designated agency can then be used as a primary source.

Note 2: An external organization (for example, a credentials verification organization [CVO]) may be used to verify credentials information. A CVO must meet the CVO guidelines identified in the Glossary.

Note 3: In some instances, a staff member may also work for another Joint Commission–accredited organization. If the other organization has completed primary source verification of the staff member’s license, certification, or registration; can attest to that fact; and is willing to share that information with the behavioral health care organization, then primary source verification does not need to be completed a second time by the behavioral health care organization. The credentialing information would need to be made available upon demand during a Joint Commission survey.
2. The organization verifies and documents that the job applicant has the education and experience required by the job duties and responsibilities, unless this information has already been verified by the entity that issued his or her licensure, certification, or registration.

Note 1: The verification of required training informs the organization of the knowledge and competencies of staff. Verification of the specific credential must be obtained from the primary source. Primary source includes federal and state licensing boards, letters from professional schools and letters from postgraduate education or postdoctoral programs for completion of training. Designated equivalent sources include, but are not limited to, the following:
- State licensing boards
- The entity issuing the license, certification, or registration
- The American Medical Association (AMA) Physician Masterfile for verification of a physician’s US and Puerto Rico medical school graduation and residency completion
- The American Board of Medical Specialties (ABMS) for verification of a physician’s board certification
- The Educational Commission for Foreign Medical Graduates (ECFMG) for verification of a physician’s graduation from a foreign medical school
- The American Osteopathic Association (AOA) Physician Database for predoctoral education accredited by the AOA Bureau of Professional Education, postdoctoral education approved by the AOA Council on Postdoctoral Training, and Osteopathic Specialty Board Certification
- The Federation of State Medical Boards (FSMB) for all actions against a physician’s medical license
- The American Academy of Physician Assistants Profile for physician assistant education and National Commission on Certification of Physician Assistants (NCCPA) certification

Note 2: A primary source of verified information may designate to an agency the role of communicating credentials information. The designated agency then becomes acceptable to be used as a primary source.

Note 3: An external organization (for example, a credentials verification organization [CVO]) or a Joint Commission–accredited health care organization functioning as a CVO may be used to collect credentialing information. Both of these organizations must meet the CVO guidelines listed in the Glossary.
3. The organization verifies the identity of the job applicant by viewing a valid picture identification issued by a state or federal agency (for example, a driver’s license or passport).

4. The organization obtains a criminal background check on the job applicant as required by law and regulation or organization policy. Criminal background checks are documented.

5. Staff comply with health screening in accordance with law and regulation or organization policy. Health screening compliance is documented.

   **Note:** Organizations should consider the applicability of the Americans with Disabilities Act to their assignment of job duties and responsibilities, and, if applicable, review their policies and procedures. In addition, federal entities are required to comply with the Rehabilitation Act of 1974.

6. The organization uses the following information to make decisions about hiring and assigning staff job duties and responsibilities:
   - Verified licensure, certification, or registration required by law or regulation and organization policy
   - Verified education and experience
   - Results of criminal background check(s), in accordance with law and regulation and organization policy
   - Outcomes of applicable health screenings and staff member’s health statement, in accordance with law and regulation and organization policy
   - Evaluation of any challenges to licensure or registration
   - Evaluation of any voluntary or involuntary relinquishment of license or registration
   - Evaluation of any voluntary or involuntary limitation, reduction, or loss of clinical responsibilities
   - Evaluation of any professional liability actions that resulted in a final judgment against the staff member

7. The organization queries the National Practitioner Data Bank (NPDB) for information on physicians and dentists at the time of hire, and at least every two years thereafter.

8. **For opioid treatment programs:** The program maintains individualized personnel files as a record of employment. The personnel files contain the following:
Employment and credentialing data
- Employment application data
- Date of employment
- Up-to-date licensing and credentialing data
- Detailed job descriptions
- Performance evaluations
- Training records

**Standard HRM.01.03.01**

The organization provides orientation to staff.

**Elements of Performance for HRM.01.03.01**

1. The organization determines the key safety content of orientation provided to staff.

   **Note:** Key safety content may include specific processes and procedures related to the provision of care, treatment, or services and the environment of care.

2. The organization orients its staff to the key safety content before staff provides care, treatment, or services. Completion of this orientation is documented.

3. The organization orients staff on the following:
   - Policies and procedures related to job duties and responsibilities.
   - Their specific job duties and responsibilities. *(See also IC.01.05.01, EP 6; IC.02.01.01, EP 7)*
   - Sensitivity to cultural diversity based on their job duties and responsibilities.

   **Note:** Sensitivity to cultural diversity means being aware of and respecting cultural differences. This does not mean that staff have to be conversant with every culture that they may encounter in the organization.

   - The rights of individuals served, including the ethical aspects of care, treatment, or services. *(See also RI.01.07.03, EP 5)*

   Completion of this orientation is documented.

7. **For organizations that sponsor or offer peer support services:** The organization orients staff to working collaboratively with persons providing peer support.

8. **For organizations that sponsor or offer peer support services:** The organization orients persons providing peer support services to the following:
   - Their roles and responsibilities
Communication techniques
Methods to provide support for the individual served
Consumer advocacy
Methods for disengaging from their relationship with the individual with whom they are working
Crisis recognition
Procedures for responding to a crisis both for the individuals served and themselves

15. **For opioid treatment programs:** Before providing patient care, staff receive education specific to the medication-assisted treatment used in the program and tailored to the patient population.

16. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization orients staff on the following:
   - Behavioral health conditions most commonly found in the population(s) served
   - Chronic physical health conditions most commonly found in the population(s) served

17. **For organizations that elect The Joint Commission Behavioral Health Home option:** If the organization sponsors or offers peer support services, it orients staff providing peer support services to their roles and responsibilities as members of the integrated care team (for example, participating in activities that promote healthy choices and lifestyles).

**Standard HRM.01.04.01**
Staff are supervised effectively.

**Elements of Performance for HRM.01.04.01**

1. The scope and depth of supervision that staff receive is based on their job duties and responsibilities; their experience with the care, treatment, or services they are providing; and the population(s) served.

   **Note:** Refer to the Glossary for definition of staff.

2. Consultation is available to direct care staff.

3. Staff provide and/or oversee the supervision of students when they provide care, treatment, or services as part of their training.
Note: Monitoring is not required when it is provided by the student’s educational institution.

**Standard HRM.01.05.01**
Staff participate in education and training.

**Elements of Performance for HRM.01.05.01**

1. Staff participate in education and training as follows:
   - To maintain or increase their competency
   - Whenever changes in their responsibilities require it

   **Note:** Education and training are only required if an assessment of staff skills and competencies indicates a need for their provision.
   - To meet specific needs of the population(s) served by the organization

   Staff participation is documented. (See also RI.03.01.05, EP 7)

4. For organizations that sponsor or offer peer support services: The organization has a process for persons who are providing peer support services to receive education and training that enhances their knowledge and skills.

5. For opioid treatment programs: The program implements an individual annual training plan for each staff member.

6. For opioid treatment programs: The program provides staff with training in the specific characteristics and needs of women participating in their treatment program.

7. For opioid treatment programs: Staff receive education about all forms of viral hepatitis and their effects on the health of the patient.

8. For opioid treatment programs: Staff have resources for problem solving and troubleshooting patient care issues (for example, vomiting medication, aggressive or disruptive behavior).

9. For foster care: Staff involved in foster care participate in training that is specific to their responsibilities.

10. For organizations that elect The Joint Commission Behavioral Health Home option: Staff providing direct care, treatment, or services participate in additional education and training that is specific to the following:
Behavioral health conditions most commonly found in the population(s) served
Chronic physical health conditions most commonly found in the population(s) served
Care, treatment, or services that are centered on the individual served
Strategies for engaging individuals served in participating in their care, treatment, or services
How equipment or technology related to the provision of primary physical health care is used

Introduction to Standards HRM.01.06.01 Through HRM.01.07.01

A close relationship exists between competence assessment and performance evaluation. Sometimes this relationship can be confusing. Competence assessment lets the organization know whether its staff have the ability to use specific skills and to employ the knowledge necessary to perform their jobs. When the organization defines specific competencies, it should consider the needs of the population(s) it serves and the kinds of care, treatment, and services it provides.

Where competency assessment focuses on specific knowledge, skill, and ability, performance evaluations are broader in scope. Performance evaluations are not only focused on a staff member’s competence; they also include other expectations that have been established for each staff member. For example, a performance evaluation might include expectations relative to whether a staff member participates in education and training offered by the organization, or how well he or she carries out job responsibilities and manages time.
What competency assessments and performance evaluations share is the requirement that they are performed at least once every three years or more frequently, in accordance with law and regulation. This does not mean, however, that they have to be performed together at the same time. Some organizations, often those that are smaller in size, may choose to combine competency assessments with performance evaluations. Others may choose to handle these activities separately. If the organization chooses to combine the activities, it needs to make sure that the performance evaluation contains specific competencies. However these two activities are conducted, feedback on performance is most useful to staff if it is given whenever an opportunity arises.

**Standard HRM.01.06.01**

Staff are competent to perform their job duties and responsibilities.

**Elements of Performance for HRM.01.06.01**

1. For each of its programs or services, the organization defines the competencies it requires of staff members who provide care, treatment, or services.  
   
   **Note:** Competencies may be based on the programs or services provided and the populations served. (See also NPSG.03.06.01, EP 3)

2. Staff with the educational background, experience, or knowledge related to the skills being reviewed assess competence.

   **Note:** When a suitable individual cannot be found to assess staff competence, the organization can utilize an outside individual for this task. If a suitable individual inside or outside the organization cannot be found, the organization may consult the competency guidelines from an appropriate professional organization to make its assessment.

3. The organization conducts an initial assessment of staff competence. This assessment is documented.

4. The organization assesses staff competence whenever job duties and responsibilities change.

5. Staff competence is assessed and documented once every three years, or more frequently as required by organization policy or in accordance with law and regulation.

6. The organization takes action when a staff member’s competence does not meet expectations.
Note: Actions may include, but are not limited to, providing additional training or supervision, or modifying job duties and responsibilities.

7. For foster care: Staff demonstrate cultural and age-specific competence.

Standard HRM.01.06.03
Staff who assess individuals with substance abuse, dependence, and other addictive behaviors and who plan services for and deliver services to these individuals have specific competencies.

Elements of Performance for HRM.01.06.03

1. Staff who assess, plan services for, and deliver services to individuals with substance abuse, dependence, and other addictive behaviors demonstrate knowledge about such behaviors and their treatment.

2. Staff who assess individuals with substance abuse, dependence, and other addictive behaviors and who plan services for and deliver services to these individuals have the knowledge and skills to do the following:
   - Establish rapport, systematically gather data, determine the readiness of the individual for treatment and change, and apply accepted criteria for diagnosis of substance use disorders
   - Screen for psychoactive substance toxicity, intoxication, and withdrawal symptoms
   - Screen for danger to self or others
   - Screen for co-occurring mental health issues
   - Analyze and interpret data to determine treatment recommendations and priorities
   - With the individual served, formulate mutually agreed-upon, measurable treatment goals and objectives
   - Demonstrate adherence to accepted ethical and behavioral standards of conduct
   - Participate in continuing professional development

Note: This does not mean that every staff member must have all of these competencies; rather the total complement of staff together possess all of these competencies.

3. For opioid treatment programs: Staff understand the benefits and limitations of toxicological testing procedures.
4. **For opioid treatment programs:** Staff are knowledgeable about strategies for treating alcohol, cocaine, and other drug abuse.

5. **For opioid treatment programs:** Staff responsible for coordinating medical and psychiatric care are knowledgeable about medication-assisted therapy.

6. **For opioid treatment programs:** Trained and qualified substance abuse counselors provide services to meet the needs of patients and are sufficient in number to provide reasonable and prompt access by patients to counseling.

7. **For opioid treatment programs:** The staff members responsible for establishing referrals with other health care organizations and practitioners are knowledgeable about pharmacotherapy treatment (drug interactions, acute withdrawal, and overdose), actively seek patient consent to talk with other providers, and check their state’s prescription drug monitoring program (PDMP).

**Standard HRM.01.06.05**

Staff who provide care, treatment, or services to children or youth have specific competencies.

**Elements of Performance for HRM.01.06.05**

1. Staff who provide care, treatment, or services to children or youth demonstrate an understanding of the developmental milestones of children or youth.

2. When assessing staff competence, supervisors use the findings from performance improvement activities when it relates to competence of staff. *(See also PI.02.01.01, EP 8)*

3. The person responsible for administrative and clinical direction of care, treatment, or services provided to children or youth is qualified by training, experience, or documented competence.

**Standard HRM.01.06.07**

Security or correctional staff responsible for conducting activities customarily performed by clinical staff have specific competencies.

**Elements of Performance for HRM.01.06.07**

Security or correctional staff know the following:

1. How to respond to unusual clinical events.
2. The organization’s channels of clinical, security, and administrative communication.

3. The distinction between administrative and clinical seclusion and/or restraint.

**Standard HRM.01.06.09**

*For organizations that provide care, treatment, or services to individuals with intellectual and/or developmental disabilities:*

Staff responsible for providing services for persons with intellectual disabilities have specific competencies.

**Elements of Performance for HRM.01.06.09**

1. *For organizations that provide care, treatment, or services to individuals with intellectual and/or developmental disabilities:* In accordance with the needs of the population served, staff are trained in proper feeding techniques.

2. *For organizations that provide care, treatment, or services to individuals with intellectual and/or developmental disabilities:* In accordance with the needs of the population served, staff are educated in the following:
   - Communication with nonverbal individuals or individuals with limited verbal skills
   - Prevention and management of behavior that is harmful to self or others
   - Teaching activities of daily living and life domain skills
   - Adherence to the principles of normalization

6. *For organizations that provide care, treatment, or services to individuals with intellectual and/or developmental disabilities:* A qualified intellectual and/or developmental disabilities professional is responsible for coordinating services for each individual served.

7. *For organizations that provide care, treatment, or services to individuals with intellectual and/or developmental disabilities:* The qualified intellectual and/or developmental disabilities professional who is responsible for coordinating services for each individual served understands their needs and the range, intensity, and duration of care, habilitation, or rehabilitation they require.

**Standard HRM.01.06.11**

*For organizations providing case management of housing support services to homeless individuals:* Staff who provide care, treatment, or services to individuals in housing support services programs have specific competencies.
Elements of Performance for HRM.01.06.11

1. **For organizations providing case management of housing support services to homeless individuals:** Staff are trained in and use evidence-based or accepted case management practices.

2. **For organizations providing case management of housing support services to homeless individuals:** Staff are trained in communication and advocacy skills.

3. **For organizations providing case management of housing support services to homeless individuals:** Staff are knowledgeable about Fair Housing rules and regulations.

Standard HRM.01.07.01

The organization evaluates staff performance.

Elements of Performance for HRM.01.07.01

1. The organization evaluates staff based on performance expectations that reflect their job descriptions.

   **Note:** For contracted staff, a written contract may replace a job description. (For more information on contracted services, refer to Standard LD.04.03.09.)

2. The organization evaluates staff performance in accordance with law and regulation and organization policy, but at least once every three years. This evaluation is documented.

3. If the organization has conducted any performance improvement activities that relate to staff providing direct care, treatment, or services, and performance findings from these activities are available, the organization uses those findings when evaluating staff performance. (*See also* PI.02.01.01, EP 8)

4. The organization confirms each staff member’s adherence to organization policies, procedures, rules, and regulations.
Infection Prevention and Control (IC)

Overview
Behavioral health care organizations have varied levels of infection risk because of the variety of settings in which care, treatment, and services are provided. Behavioral health care, treatment, and services are delivered in diverse settings such as counseling offices, residential settings, schools, community centers, jails and prisons, and family homes. The diversity of the settings for behavioral health care services presents unique challenges; behavioral health care is frequently provided in nontraditional settings that may not have direct access to medical resources.

The design and scope of infection prevention and control activities are based on the risks that the organization faces for the spread of infections in the places where it provides care, treatment, and services (such infections are known as health care–associated infections [HAIs]). For example, a program serving children must anticipate infection prevention and control issues very differently than a program serving clients in opioid treatment programs. Antibiotic-resistant infections have raised concern that infections can be acquired in almost any setting. However, reducing the risk of spreading infection among individuals served and staff is achievable with reasonable steps in prevention and control.

The infection prevention and control activities you adopt need to be reasonable to follow, protecting the individuals you serve through activities that are practical, current, and effective. For example, respiratory etiquette can be encouraged in all settings by having tissue and hand sanitizer gel available. To create a successful program, leadership should have input and lend support. After an effective program is in place, the organization takes measures so that the program operates according to plan and is properly evaluated.

About This Chapter
The processes outlined in the “Infection Prevention and Control” (IC) chapter are applicable to all infections or potential sources of infection that may affect individuals served in the behavioral health care setting. The standards are designed to assist behavioral health care organizations both large and small, in all settings, in developing
and maintaining an effective approach. It is recognized that lifestyle and other factors beyond the organization’s control or scope of service will affect infection risk; however, the organization’s infection control activities apply only to those locations where care, treatment, or services are provided.

These standards address activities of planning, implementation, and evaluation and are based on the following conditions necessary to establish and carry out effective infection prevention and control practices. Every behavioral health care organization, regardless of its size, setting, or services, should do the following:

- Recognize that infection prevention and control play an important role in its efforts to improve safety and quality of care for the individuals served
- Demonstrate leadership’s commitment to infection prevention and control by endorsing and participating in the organization’s efforts to control infection; provide resources, and encourage improvement
- See that staff collaborates with each other when designing and implementing infection prevention and control activities
- Regularly assess its infection prevention and control activities
- Coordinate its activities with the larger community
Chapter Outline

I. Planning
   A. Responsibility (IC.01.01.01)
   B. Resources (IC.01.02.01)
   C. Risks (IC.01.03.01)
   D. Goals (IC.01.04.01)
   E. Activities (IC.01.05.01)
   F. Increased Number of Infectious Individuals (IC.01.06.01)

II. Implementation
   A. Activities (IC.02.01.01)
   B. Medical Supplies and Devices (IC.02.02.01)
   C. Transmission of Infections (IC.02.03.01)
   D. Influenza Vaccinations (IC.02.04.01)

III. Evaluation and Improvement (IC.03.01.01)
Standards, Rationales, and Elements of Performance

Introduction to Standards IC.01.01.01 Through IC.01.06.01 – Planning

For infection prevention and control activities to be effective, they need to be well managed. Toward that end, behavioral health care organization leadership assigns one or more persons to be responsible for development of the activities and their management. Depending on the size of the organization and its resources, this person can be an employee, a contractor, or a consultant; however, accountability remains with the behavioral health care organization. After this person is in place, he or she can begin collaborating with other key staff in the organization who can perform a risk assessment and put in place infection prevention and control activities.

The person or persons assigned to infection prevention and control activities may want to consult with community leaders and other outside infection control experts who can provide important information about the organization’s population(s) served and associated health risks.

The behavioral health care organization can then set goals related to outcomes or processes that help to prevent or reduce the potential spread of infections in the places where individuals are served by the organization. Based on these goals, the organization develops practical and effective infection prevention and control activities.

Standard IC.01.01.01

The organization identifies the individual(s) responsible for managing infection prevention and control.

Element of Performance for IC.01.01.01

3. The organization assigns responsibility for the management of infection prevention and control activities.

Note: The assigned individual need not be a nurse or other medical practitioner.
Standard IC.01.02.01
Organization leaders allocate needed resources for infection prevention and control activities.

Elements of Performance for IC.01.02.01

2. **For 24-hour care settings:** The organization arranges for laboratory services when needed to prevent the spread of infection within the organization.

   **Note:** *The role taken by the behavioral health care organization in coordinating laboratory services will depend on the services provided. In many cases, the behavioral health care organization can refer the individual served only to a licensed independent practitioner who is qualified to order laboratory testing. In some cases, the organization may have a licensed independent practitioner on staff who is qualified to order laboratory testing, or it may have arrangements in place for sending laboratory tests out.*

3. The organization provides staff and individuals served with supplies to support infection prevention and control activities.

   **Note:** *Examples of such supplies may include liquid hand sanitizers, gloves, tissue, and cleaning supplies. The organization’s infection control activities apply only to those locations where care, treatment, or services are provided; the organization is not required to provide supplies for use outside of these locations."

Standard IC.01.03.01
The organization identifies risks for acquiring and spreading infections.

Rationale for IC.01.03.01
Before developing its infection prevention and control activities, the behavioral health care organization needs to consider the risks of infections that are most likely to affect the individuals it serves. Understanding the risks will help the organization to better determine the most effective actions it can take to prevent infections. Effective prevention can minimize risks to individuals served and reduce the need to implement infection control activities that may be more resource intensive.

Elements of Performance for IC.01.03.01

1. The organization identifies infection risks based on the following:
   - Its setting and population served
   - The care, treatment, or services it provides
For 24-hour care settings: Its monitoring of infection prevention and control activities and/or tracking and analyzing the occurrence of infections.

**Note 1:** The infections that should be tracked are those that are most relevant to the organization’s setting, services, and population(s). The organization may contact its local health department for statistics and other information on some infections, and track other infections internally. For example, an organization may decide to track conjunctivitis itself but rely on health department statistics related to tuberculosis.

**Note 2:** The risk of infection will vary across behavioral health care settings. For example, infection risks in group homes, day treatment programs, and couples counseling will vary by hours of contact, number of individuals served, and location and type of service.

3. The organization establishes priorities among the risks it identified. The organization documents priority risk(s).

**Standard IC.01.04.01**

Based on the priority risk(s), the organization sets goals to minimize the possibility of spreading infections.

**Note 1:** See NPSG.07.01.01 for hand hygiene guidelines.

**Note 2:** Goals can be process and/or outcome goals.

**Element of Performance for IC.01.04.01**

1. The organization’s written infection prevention and control goals include the following:
   - Addressing its priority risk(s)
   - Limiting unprotected exposure to germs

**Note:** One method to limit exposure is to follow basic hygiene practices
   - Limiting the spread of infections associated with the use of medical supplies (such as needles and syringes) and devices (such as the organization’s glucose meters)
   - Improving staff compliance with hand hygiene guidelines (See also NPSG.07.01.01, EP 1)

**Standard IC.01.05.01**

The organization has an infection prevention and control plan.
Rationale for IC.01.05.01
The organization has a plan for infection prevention and control to support consistency in the activities that prevent the spread of infection. Such activities help protect individuals served and staff from infectious disease even if the organization is not specifically aware that an infection is present. Furthermore, when the organization is aware of or is notified of the presence of an infection, the organization with a plan will be better prepared to respond quickly to prevent its spread within the organization, and to access external information and assistance (for example, through the local health department) if needed.

The local health department may support organizations by following 10 general steps to investigate an outbreak of infectious disease:
1. Prepare for fieldwork (that is, research the disease, gather supplies and equipment, make administrative arrangements such as travel, and consult with local contacts to define roles and activities)
2. Establish the existence of an outbreak
3. Verify the diagnosis
4. Define and identify cases
5. Describe and orient the data in terms of time, place, and person
6. Develop hypothesis
7. Evaluate hypothesis
8. Refine hypothesis and carry out additional studies
9. Implement control and prevention measures
10. Communicate findings

Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion

Elements of Performance for IC.01.05.01

1. When developing infection prevention and control activities, the organization uses accepted practices in preventing the spread of infections where individuals are served.

* When considering accepted practices, the organization may find it useful to consult guidelines available from the Centers for Disease Control and Prevention: Healthcare Infection Control Practices Advisory Committee (CDC/HICPAC) at http://www.cdc.gov/hai/. Although portions of these guidelines apply only in acute care settings, much of the information is relevant regardless of the setting of care.
2. The organization’s infection prevention and control plan includes a written description of the activities, including surveillance, to minimize or reduce the risk of infection.

Note: The purpose of surveillance is to support the organization’s efforts to reduce the risk of spreading infections where individuals are served. Information from the surveillance activities is used within the organization to improve processes and outcomes related to infection prevention and control.

3. The organization’s written infection prevention and control plan includes a description of its method for evaluating its infection prevention and control activities.

5. The organization describes in writing its response when it becomes aware of or is notified of an outbreak of infectious disease among its staff or individuals served. (See also IC.02.01.01, EP 5)

Note: An outbreak is an occurrence of more than expected cases of disease or other health condition among a specific group during a specified time frame, exceeding the typical number of cases for that setting. In some cases the behavioral health care organization may not be aware that an outbreak has occurred until it is notified by an external entity. When the organization does become aware of an outbreak in its organization, its response should be immediate and practical. It may include measures such as notifying staff and individuals served that they may have been exposed, contacting the health department for guidance, or closing temporarily to properly disinfect the setting.

6. Everyone who works in the organization has responsibilities for preventing and controlling infection. (See also HRM.01.03.01, EP 3)

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Standard IC.01.06.01
The organization prepares to respond to an increased number of infectious individuals.

Rationale for IC.01.06.01
Some behavioral health care organizations may experience an emergency situation which results in an increase in infections among the individuals they serve, or an increase in demand for their services by new individuals who have infections. The organization will need to determine what its response will be to this increase; responses can range from expanding services to closing services, depending upon the organization’s mission, services, staffing, relationship with the local health department, legal obligation to accept certain individuals for care, role in the community, or other factors.
Elements of Performance for IC.01.06.01

2. The organization obtains current clinical and epidemiological information from its resources regarding new infections that could cause an increased number of infectious individuals.

   **Note:** Some behavioral health care organizations may experience an increase in infections among the individuals currently served, including individuals who come from outside the immediate geographic area.

3. The organization has a method for communicating critical information to staff about emerging infections that could cause an increase in the number of infectious individuals served.

4. The organization plans how it will respond to an increased number of infectious individuals. This plan is documented. *(See also EM.01.01.01, EP 2)*

   **Note:** One acceptable response is to decide not to accept individuals for service.

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**Introduction to Standards IC.02.01.01 Through IC.02.03.01 – Implementation**

The activities of infection prevention and control should be practical and involve collaboration among staff. Everyone who works in the behavioral health care organization has a role. Important infection prevention and control information should be available to staff, individuals served, and their families. Precautions need to be taken consistent with the organization’s setting, services, and individuals served (including, where necessary, using personal protective equipment such as gloves and masks); and any infection that spreads within the organization should be investigated. All staff should observe good hand hygiene practices and respiratory etiquette (for example, coughing and sneezing into a tissue) with individuals served and their colleagues. This will reduce risks from hand-to-hand spread, as well as when handling pens, door handles, toys, assistive devices, and other items in the office or wherever individuals are served. Cleaning and disinfecting surfaces and common items, such as tabletops and keyboards, will further minimize infection risks.
Surveillance activities are designed to guide the organization in identifying risks or occurrences of infections, help staff determine the most reasonable and effective actions to address the risks and occurrences, and generate feedback on the effectiveness of the prevention and control steps that were implemented.

**Standard IC.02.01.01**

The organization implements its infection prevention and control plan.

**Elements of Performance for IC.02.01.01**

1. The organization implements its planned infection prevention and control activities and practices, including surveillance, to reduce the risk of infection.

   **Note:** The purpose of surveillance is to support the organization’s efforts to reduce the risk of spreading infections where individuals are served. Information from the surveillance activities is used within the organization to improve processes and outcomes related to infection prevention and control.

2. The organization uses standard precautions, including the use of personal protective equipment (such as gloves and face shields), to reduce the risk of infection.

3. In addition to standard precautions, the organization takes other precautions in response to the way suspected or identified infections are spread within the organization’s setting or population of individuals served.

   **Note:** “Other precautions” are infection prevention and control measures used in response to the specific way suspected or identified infections are spread. These “other precautions” are also known as “transmission-based” precautions. Transmission-based precautions include contact, droplet, airborne, or a combination of these precautions.

4. To prevent the spread of infections, the organization investigates outbreaks of infectious disease within the organization. (See also IC.01.05.01, EP 5)

   **Note:** An outbreak is an occurrence of more than expected cases of disease or other health condition among a specific group during a specified time frame, exceeding the typical number of cases for that setting. In some cases the behavioral health care

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1 For further information regarding standard precautions, refer to the website of the Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/hai/ (Infection Control in Healthcare Settings).

2 For further information regarding transmission-based precautions, refer to the website of the Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/hai/ (Infection Control in Healthcare Settings).
organization may not be aware that an outbreak has occurred until it is notified by an external entity. When the organization does become aware of an outbreak in its organization, its response should be immediate and practical. It may include measures such as notifying staff and individuals served that they may have been exposed, contacting the health department for guidance, or closing temporarily to properly disinfect the setting.

6. The organization stores and disposes of infectious waste (such as used sharps and body fluids) in a manner that minimizes the risk of infection. (See also EC.02.02.01, EP 2)

7. **For 24-hour care settings:** The organization communicates to staff and individuals served and, when permitted by individuals served, their families about their respective roles in preventing and controlling infection. (See also HRM.01.03.01, EP 3)

   **Note:** The communication can be verbal or written, using posters, brochures, or other resources.

8. The organization reports infection surveillance, prevention, and control information to organization staff consistent with their responsibilities for infection prevention and control activities.

9. The organization reports information about the occurrence of infections to local, state, and federal public health authorities in accordance with law and regulation.

   **Note:** The local health department can provide guidance about what types of infections should be reported.

13. The organization reduces the risks associated with animals, including potential problems with cleanliness, immunizations, and management of waste.

**Standard IC.02.02.01**

The organization reduces the risk of infections associated with medical supplies and devices.

**Note:** This standard applies only to organizations that use medical supplies and devices.
Rationale for IC.02.02.01

Individuals served are at risk of developing an infection from contact with medical supplies and devices. Failure to properly clean or disinfect, and use or store, medical supplies and devices not only poses risks for the individual seeking services, but also carries the risk for person-to-person spread of infections.

There are several steps involved in the cleaning and disinfecting of medical supplies and devices. It is critical that staff follow standardized practices to minimize infection risks related to medical supplies and devices. In order to maintain a reliable system for controlling this process, organizations pay attention to the following:

- Orientation, training, and competency of health care workers who are processing medical supplies and devices
- Supervision of the health care workers who are processing medical supplies and devices
- Standardization of process regardless of whether it is centralized or decentralized
- Reinforcing the process (for example, the use of placards which list the steps to be followed, according to manufacturer’s guidelines)
- Ongoing quality monitoring

Elements of Performance for IC.02.02.01

The organization implements infection prevention and control activities when doing the following:

1. Cleaning and performing low-level disinfection of medical supplies and devices.\(^5\)

   **Note:** Low-level disinfection is used for items such as blood glucose meters. Additional cleaning and disinfecting is required for medical supplies and devices used by individuals who require the use of other precautions in addition to standard precautions. These “other precautions” are also known as “transmission-based” precautions.

3. Disposing of medical supplies and devices.

4. Storing medical supplies and devices.

\(^5\) For further information regarding cleaning and performing low-level disinfection of medical supplies, refer to the website of the Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/hicpac/Disinfection_Sterilization/acknowldg.html.

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.

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CAMBHC Update 2, January 2018
Standard IC.02.03.01
The organization works to prevent the spread of infectious disease among individuals served and staff.

Elements of Performance for IC.02.03.01
1. The organization arranges for screening of staff for exposure and/or immunity to infectious disease when workplace contact with infections is possible, and as required by law and regulation or organization policy.

2. When staff have, are suspected of having, or have been occupationally exposed to an infectious disease that puts others at risk, the organization refers them for assessment and potential testing, prophylaxis/treatment, or counseling.

4. When individuals served have been exposed to an infectious disease, the organization refers them for assessment and potential testing, prophylaxis/treatment, or counseling.

Introduction to Standard IC.02.04.01
Influenza vaccination for staff is a major safety issue in the United States. Unvaccinated individuals who become infected are contagious at least one day before any signs or symptoms of influenza appear and therefore these individuals can infect others without knowing they are contagious. Both government and professional organizations emphasize increasing safety for those receiving health care by decreasing their exposure to the influenza virus while receiving this care. One way to improve safety for individuals served is for the organization’s staff to receive the influenza vaccination annually.

According to the US Department of Health and Human Services, vaccination is an effective preventive measure against influenza and can prevent many illnesses, deaths, and losses in productivity. Health care personnel (HCP) are considered a high priority for expanding influenza vaccine use. Achieving and sustaining high influenza vaccination coverage among HCP is intended to help protect HCP and their patients and reduce disease burden and health care costs (see http://www.hhs.gov/ash/initiatives/hai/hcpflu.html).

The Joint Commission’s Standard IC.02.04.01 reflects current science and the national focus on influenza vaccination. It requires that each organization has an influenza vaccination program and that the influenza vaccination is offered to staff. However, The
Joint Commission does not mandate influenza vaccination for staff as a condition of Joint Commission accreditation. Additionally, The Joint Commission does not require accredited organizations to pay for the influenza vaccination for its staff. The decision on whether to pay for the influenza vaccination for staff will need to be made independently by each accredited organization.

**Standard IC.02.04.01**
The organization facilitates staff receiving the influenza vaccination.

**Note:** This standard is not applicable to staff providing care, treatment, or services off site through telephone consultation or technology-based services.

**Elements of Performance for IC.02.04.01**

1. The organization establishes an annual influenza vaccination program that facilitates staff receiving the influenza vaccination.

2. The organization educates staff about, at a minimum, the influenza vaccine; non-vaccine control and prevention measures; and the diagnosis, transmission, and impact of influenza.

3. The organization either offers the influenza vaccination to staff on site or facilitates staff obtaining influenza vaccination off site.

4. The organization includes in its infection control plan the goal of improving influenza vaccination rates. (For more information, refer to Standard IC.01.04.01.)

5. The organization sets incremental influenza vaccination goals, consistent with achieving the 90% rate established in the national influenza initiatives for 2020.

**Note:** The US Department of Health and Human Services’ Action Plan to Prevent Healthcare-Associated Infections is located at [http://www.hhs.gov/ash/initiatives/hai/hcpflu.html](http://www.hhs.gov/ash/initiatives/hai/hcpflu.html).

6. The organization has a written description of the methodology used to determine influenza vaccination rates.

**Note:** The National Quality Forum (NQF) Measure Submission and Evaluation Worksheet 5.0 provides recommendations for the numerator and denominator for NQF performance measure #0431 Influenza Vaccination Coverage Among Healthcare Personnel (see [http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=68275](http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=68275)). While The Joint Commission recommends that organizations
7. The organization collects and reviews the reasons given by staff for declining the influenza vaccination. This collection and review occurs at least annually.

8. The organization improves its vaccination rates according to its established goals at least annually. (For more information, refer to Standards PI.02.01.01 and PI.03.01.01.)

   **Note:** Organizations with a small number of staff (10 or less) providing care, treatment, or services may present the data in a manner other than a percentage (for example, raw numbers).

9. The organization provides influenza vaccination rate data to organization leaders at least annually.

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**Introduction to Standard IC.03.01.01 – Evaluation and Improvement**

Infection prevention and control is a continuous cycle of activities that consists of risk assessment, planning, implementation (including surveillance), evaluation, improvement, and reassessment. Evaluation and improvement of the infection prevention and control activities are essential steps in the organization’s efforts to prevent and control infections.

**Standard IC.03.01.01**

The organization evaluates the effectiveness of its infection prevention and control plan.

**Elements of Performance for IC.03.01.01**

1. The organization evaluates its infection prevention and control plan annually and whenever its priority risk(s) significantly change(s). The evaluation includes a review of the following:
   - The infection prevention and control priority risk(s)
The infection prevention and control goals *(See also NPSG.07.01.01, EP 2)*

6. Findings from the evaluation are communicated at least annually to leadership.

7. The organization uses the findings of its evaluation of the infection prevention and control plan when revising the plan.
Information Management (IM)

Overview
Every episode of care generates health information that must be managed systematically by the organization. All data and information used by the organization are categorized, filed, and maintained. The system should accurately capture health information generated by the delivery of care, treatment, or services. Health information should be accessed by authorized users who will use health information to provide safe, quality care, treatment, or services. Unauthorized access can be limited by the adoption of policies that address the privacy, security, and integrity of health information.

Depending on the type of organization, the system used for information management may be basic or sophisticated. As technology develops, many organizations find their information management systems in a state of transition from paper to fully electronic or a combination of the two. Regardless of the type of system used, these standards are designed to be equally compatible with noncomputerized systems and evolving technologies.

About This Chapter
As with other chapters, planning is the initial focus of “Information Management” (IM). A well planned system meets the internal and external information needs of the organization with efficiency and accuracy. Planning also provides for continuity in the event that the organization’s operations are disrupted or fail. The organization also plans to protect the privacy, security, and integrity of the data and information it collects, which results in preserving confidentiality. The chapter concludes with a standard on maintaining accurate health information.

Requirements in this chapter apply to all types of information managed by the organization, unless the requirement specifically limits the type of information to health information. The definition of health information used in this manual intentionally reflects the definition of health information used in the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Refer to the Glossary for a definition of health information.
Chapter Outline

I. Planning for Management of Information (IM.01.01.01, IM.01.01.03)

II. Health Information
   A. Protecting the Privacy of Health Information (IM.02.01.01, IM.02.01.03)
   B. Capturing, Storing, and Retrieving Data (IM.02.02.01, IM.02.02.03)

III. Knowledge-Based Information (IM.03.01.01)
Standards, Rationales, and Elements of Performance

Introduction to Standard IM.01.01.01
Planning is the most critical part of the organization’s information management process and requires the collaborative involvement of all levels and areas of the organization. The organization’s plan for information management considers the full spectrum of data generated and used by the organization; financial data, human resources data, supply inventories, and health information are examples of the different types of data that are considered in the information management planning process. Planning for the management of information does not necessarily result in a single, comprehensive written information management plan; however, planning does establish clear relationships between the organization’s needs and its goals. In addition to the organization’s goals, the organization’s mission, services, staff, safety practices for individuals served, modes of service delivery, resources, and technology are considered during the information management planning process.

The flow of information within the organization, as well as to and from external organizations, is another important consideration for information management planning. Planning takes into account the data and information required to support relationships with outside providers, services, contractors, purchasers, and payers. By identifying internal and external information needs, organizations can make information available when and where it is needed. Organizations that understand the flow of information can achieve efficient data collection and distribution, along with effective security of health information.

Standard IM.01.01.01
The organization plans for managing information.

Elements of Performance for IM.01.01.01
2. The organization identifies how data and information enter, flow within, and leave the organization.

Note: The flow of data and information within the organization includes how it moves into and out of storage.
6. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization uses health information technology to do the following:

- Support the continuity of care and the provision of integrated care, treatment, or services
- Document and track care, treatment, or services
- Support disease management, including educating the individual about disease management
- Support preventive care, treatment, or services
- Create reports for internal use and external reporting
- Facilitate electronic exchange of information among providers
- Support performance improvement

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**Introduction to Standard IM.01.01.03**

The primary goal of the information continuity process is to return the organization to normal operations as soon as possible with minimal downtime and no data loss. The organization needs to be prepared for events that could impact the availability of data and information regardless of whether interruptions are scheduled or unscheduled (due to a local or regional disaster or an emergency). Interruptions to an organization’s information system can potentially have a devastating impact on its ability to deliver quality care, treatment, or services and continue its business operations. Planning for emergency situations helps the organization mitigate the impact that interruptions, emergencies, and disasters have on its ability to manage information. The organization plans for interruptions by training staff on alternative procedures, testing the organization’s Emergency Management Plan, conducting regularly scheduled data backups, and testing data restoration procedures.

Regardless of whether an organization uses a paper-based system or an electronic system, a plan to address the process for information continuity, including knowledge-based information, should be in place. Organizations that plan for maintaining access to electronic information systems by using various electronic backup and restoration procedures can quickly recover from interruptions with minimal downtime and data loss.

**Standard IM.01.01.03**

The organization plans for continuity of its information management processes.
Elements of Performance for IM.01.01.03

1. ☐ The organization has a written plan for managing interruptions to its information processes (paper-based, electronic, or a mix of paper-based and electronic). (*See also* EM.01.01.01, EP 6)

   The plan for managing interruptions to electronic information systems addresses the following:

   2. Scheduled and unscheduled interruptions. (*See also* IM.03.01.01, EP 1; EM.01.01.01, EP 6)

   3. Training for staff on alternative procedures to follow when systems are unavailable. (*See also* EM.01.01.01, EP 6)

   4. Backup of the electronic information systems. (*See also* EM.01.01.01, EP 6)

Introduction to Standard IM.02.01.01

The privacy of health information is a critical information management concern. Privacy of health information applies to electronic, paper, and verbal communications. Protecting the privacy of health information is the responsibility of the entire organization. Organizations protect privacy by limiting the use of information to only what is needed to provide care, treatment, or services.*

* For additional guidance about limiting the use of information, refer to 45 CFR 164.502(b) and 164.514(d) under “Minimum Necessary” within the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
Privacy, along with security, results in the confidentiality of health information. Health information is kept confidential when the information is secure (kept from intentional harm) and its use is limited (privacy). The end result of protecting the security and privacy of the information system is the preservation of confidentiality. To illustrate this relationship, confidentiality is violated in situations when an individual’s health information is used or accessed by someone who does not have permission to access the information or uses it for purposes outside of delivering care, treatment, or services. A confidentiality violation occurs when someone is able to bypass security measures and systems to gain access to health information.* Although maintaining the confidentiality of health information and providing access to appropriate care providers can be challenging, the organization’s written policy on the privacy of health information can assist the organization in meeting both goals simultaneously.

**Standard IM.02.01.01**
The organization protects the privacy of health information.

**Elements of Performance for IM.02.01.01**

1. (©) The organization has a written policy addressing the privacy of health information. *(See also RI.01.01.01, EP 7)*

2. The organization implements its policy on the privacy of health information. *(See also RI.01.01.01, EP 7)*

3. The organization uses health information only for purposes permitted by law and regulation or as further limited by its policy on privacy. *(See also MM.01.01.01, EP 1; RI.01.01.01, EP 7)*

4. The organization discloses health information only as authorized by the individual served or as otherwise consistent with law and regulation. *(See also RI.01.01.01, EP 7)*

**Note: For opioid treatment programs:** Patients in addiction treatment programs and opioid treatment programs have the right to confidentiality in accordance with federal regulations (42 CFR).
Introduction to Standard IM.02.01.03
The integrity and security of health information are closely related. Health information is collected and processed through various information sources and systems throughout the organization. As a result, breaches in security can lead to the unauthorized disclosure or alteration of health information. When this occurs, the integrity of the data and information is compromised. Even simple mistakes, such as writing the incorrect date of service or diagnosis, can undermine data integrity just as easily as intentional breaches. For these reasons, an examination of the use of paper and electronic information systems is considered in the organization’s approach to maintaining the security and integrity of health information. Regardless of the type of system, security measures should address the use of security levels, passwords, and other forms of controlled access. Because information technology and its associated security measures are continuously changing, the organization should do its best to stay informed about technological developments and best practices that can help it improve information security and therefore protect data integrity.

Monitoring access to health information can help organizations be vigilant about protecting health information security. Regular security audits can identify system vulnerabilities in addition to security policy violations. For example, as part of the process, the organization could identify system users who have altered, edited, or deleted information. The results from this audit process can be used to validate that user permissions are appropriately set. Conducting security audits can be particularly effective in identifying when employee turnover causes vulnerabilities in security because user access and permissions were not removed or updated.

Standard IM.02.01.03
The organization maintains the security and integrity of health information.

Elements of Performance for IM.02.01.03

1. The organization has a written policy that addresses the security of health information, including access, use, and disclosure.

2. The organization has a written policy addressing the integrity of health information against loss, damage, unauthorized alteration, unintentional change, and accidental destruction.

3. The organization has a written policy addressing the intentional destruction of health information.
4. ☐ The organization has a written policy that defines when and by whom the removal of health information is permitted.

**Note:** *Removal refers to those actions that place health information outside the organization’s control.*

5. The organization protects against unauthorized access, use, and disclosure of health information.

6. The organization protects health information against loss, damage, unauthorized alteration, unintentional change, and accidental destruction.

7. The organization controls the intentional destruction of health information.

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**Standard IM.02.02.01**

The organization effectively manages the collection of health information.

**Rationale for IM.02.02.01**

Within the organization, health information can come from multiple sources. The use of standardized formats and terminology can help clarify information that is used by different individuals for various purposes. Capturing data in standardized language can lead to greater data integrity and reliability, as well as increased ease of use by internal and external systems and users. The more consistent the organization’s efforts are to capture accurate data in standardized language, the more likely the organization will be to rely on that data for reimbursement, risk management, performance improvement, and infection surveillance.

**Elements of Performance for IM.02.02.01**

2. ☐ The organization uses standardized terminology, definitions, abbreviations, acronyms, symbols, and dose designations.

3. The organization follows its list of prohibited abbreviations, acronyms, symbols, and dose designations, which includes the following:
   - U, u
   - IU
   - Q.D., QD, q.d., qd
   - Q.O.D., QOD, q.o.d, qod
   - Trailing zero (X.0 mg)
   - Lack of leading zero (.X mg)
   - MS
   - MSO₄
MgSO₄

**Note 1:** A trailing zero may be used only when required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report the size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

**Note 2:** The prohibited list applies to all orders, preprinted forms, and medication-related documentation. Medication-related documentation can be either handwritten or electronic.

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**Introduction to Standard IM.02.02.03**

Standardizing the collection of data, a concept that is supported by the requirements of Standard IM.02.02.03, helps with the effective dissemination of data and information. Consistency in data collection systems (paper-based, electronic, or a combination) creates the foundation for retrieving and disseminating data and information in the most useful format. For information about data collection and dissemination, visit the websites of the Office of the National Coordinator for Health Information Technology (ONC) (http://www.healthit.gov/) and the Certification Commission for Healthcare Information Technology (CCHIT) (http://www.cchit.org).

**Standard IM.02.02.03**

The organization retrieves, disseminates, and transmits health information in useful formats.

**Rationale for IM.02.02.03**

Access to accurate information enables the organization to deliver, analyze, and improve care, treatment, or services. In order to be useful, data and information should be disseminated in formats that meet user needs and that facilitate accurate interpretation of the information. The intended use of information should be considered when developing forms, screen displays, and standard or ad hoc reports.

**Elements of Performance for IM.02.02.03**

2. The organization’s storage and retrieval systems make health information accessible when needed for care, treatment, or services of the individual served.
3. The organization disseminates data and information in useful formats within
time frames that are defined by the organization and consistent with law and
regulation.

12. The organization retains data and information for time frames consistent with
law and regulation.

**Standard IM.03.01.01**

Knowledge-based information resources are available, current, and authoritative.

**Element of Performance for IM.03.01.01**

1. The organization provides access to knowledge-based information resources. (*See also* IM.01.01.03, EP 2)
Leadership (LD)

Overview
The safety and quality of care, treatment, or services depend on many factors, including the following:

- A culture that fosters safety as a priority for everyone who works in the organization
- The planning and provision of services that meet the needs of individuals served
- The availability of resources—human, financial, and physical—for providing care, treatment, or services
- The existence of competent staff and other care providers
- Ongoing evaluation of and improvement in performance

Management of these important functions is the direct responsibility of leaders; they are, in effect, responsible for the care, treatment, or services that the organization provides to the individuals it serves. In organizations with a governing body, governance has ultimate responsibility for this oversight. In larger organizations, different persons or groups may be assigned different responsibilities, and they bring with them different skills, experience, and perspectives. In these situations, the way that the leaders interact with each other and manage their assigned accountabilities can affect overall organization performance. In smaller organizations, these responsibilities may be handled by just one or two persons. This chapter addresses the role of leaders in managing their diverse and, at times, complex responsibilities.

Leaders shape the organization’s culture, and the culture, in turn, affects how the organization accomplishes its work. A healthy, thriving culture is built around the organization’s mission and vision, which reflect the core values and principles that the organization finds important. Leaders must ask some basic questions in order to provide this focus: How does the organization plan to meet the needs of its population? By what ethical standards will the organization operate? What does the organization want to accomplish through its work? Once leaders answer these questions, the culture of the organization will begin to take shape. Leaders also have an obligation to set an example of how to work together to fulfill the organization’s mission.

On a more practical level, leaders oversee operations and guide the organization on a day-to-day basis. They keep operations running smoothly so that the important work of the organization—serving its individuals—can continue.
To meet their obligations effectively, leaders must collaborate, which means working together in a spirit of collegiality to achieve a common end. In smaller organizations, this may mean that a single leader or small group of leaders works closely with staff in order to meet the organization’s managerial needs. In this case, key staff share governance and decision making with senior leadership in order to direct the day-to-day operations, assess needs, secure resources, and plan for the future. Senior managers direct the day-to-day operations of the organization; governance determines what resources the organization needs and then secures those resources.

**Proactive Risk Assessment**

By undertaking a proactive risk assessment, an organization can correct process problems and reduce the likelihood of experiencing adverse events. An organization can use a proactive risk assessment to evaluate a process to see how it could fail, to understand the consequences of such a failure, and to identify parts of the process that need improvement. The term “process” applies broadly to care, treatment, or services provided to the individual served, such as therapy and medication administration.

Proactive risk assessments are useful for analyzing new processes before they are implemented. Processes need to be designed with a focus on quality and reliability to achieve desired outcomes and protect individuals served. Proactive risk assessments are also used to evaluate existing processes that have the greatest potential for affecting patient safety. An organization’s choice of which process it will assess may be based in part on information published periodically by The Joint Commission about frequently occurring sentinel events and processes that pose high risk.

A proactive risk assessment increases understanding within the organization about the complexities of process design and management and what could happen if the process fails. If an adverse event occurs, the organization may be able to use the information gained from the prior risk assessment to minimize the consequences of the event—and to avoid simply reacting to it.

Although there are several methods that could be used to conduct a proactive risk assessment, the following steps make up one approach:

1. Describe the chosen process (for example, through the use of a flowchart).
2. Identify ways in which the process could break down or fail to perform its desired functions, which is often referred to as failure mode.
3. Identify the possible effects that a breakdown or failure of the process could have on individual served and the seriousness of the possible effects.
4. Prioritize the potential process breakdowns or failures.
5. Determine why the prioritized breakdowns or failures could occur, which may involve performing a hypothetical root cause analysis.
6. Design or redesign the process and/or underlying systems to minimize the risk of the effects on individuals served.
7. Test and implement the newly designed or redesigned process.
8. Monitor the effectiveness of the newly designed or redesigned process.

**About This Chapter**

This chapter is divided into four sections: “Leadership Structure,” “Leadership Relationships,” “Organization Culture and System Performance Expectations,” and “Operations.” The organization’s culture, systems, and leadership structure and relationships all come together to shape and drive its operations.

The standards in the “Leadership Structure” section identify and define the various leadership groups and their responsibilities. The standards in “Leadership Relationships” address the development of the organization’s mission, vision, and goals, as well as communication among leaders. The standards in the “Organization Culture and System Performance Expectations” section focus on the framework for the organization’s culture and systems. These standards also demonstrate how leaders help shape the culture of an organization and how culture, in turn, affects important systems within the organization (for example, data use, planning, communication, changing performance, staffing). The standards in the “Operations” section address the functions that are important to high-quality care, treatment, or services and the safety of the individual served. Some leaders may not be directly involved in the day-to-day operations of the organization, but the decisions they make and the initiatives they implement do affect operations.
Chapter Outline

I. Leadership Structure
   A. Leadership Structure (LD.01.01.01)
   B. Governance Accountabilities (LD.01.03.01)
   C. The Chief Executive Responsibilities (LD.01.04.01)
   D. Leaders’ Knowledge (LD.01.07.01)

II. Leadership Relationships
   A. Mission, Vision, and Goals (LD.02.01.01)
   B. Communication Among Leaders (LD.02.03.01)

III. Organization Culture and System Performance
   A. Culture of Safety and Quality (LD.03.01.01)
   B. Using Data and Information (LD.03.02.01)
   C. Organizationwide Planning (LD.03.03.01)
   D. Communication (LD.03.04.01)
   E. Change Management and Performance Improvement (LD.03.05.01)
   F. Staffing (LD.03.06.01)

IV. Operations
   A. Administration (LD.04.01.01, LD.04.01.03, LD.04.01.05, LD.04.01.07, LD.04.01.08, LD.04.01.09, LD.04.01.11)
   B. Ethical Issues (LD.04.02.01, LD.04.02.03, LD.04.02.05)
   C. Meeting the Needs of the Individual Served (LD.04.03.01, LD.04.03.05, LD.04.03.07, LD.04.03.09)
   D. Managing Safety and Quality (LD.04.04.01, LD.04.04.03, LD.04.04.05, LD.04.04.09)
Standards, Rationales, and Elements of Performance

Introduction to Leadership Structure, Standards LD.01.01.01 Through LD.01.07.01
Each organization, regardless of its complexity, has a structured leadership. Many leadership responsibilities directly affect the provision of care, treatment, or services as well as the day-to-day operations of the organization. In some cases, these responsibilities will be shared among leaders, and in other cases, a particular leader has primary responsibility. Certain leaders may have several different roles. Regardless of the organization’s structure, it is important that leaders carry out all their responsibilities.

A variety of people may work in the organization, including licensed independent practitioners, staff, volunteers, students, and independent contractors. These standards describe the overall responsibility of governance for the safety and quality of care, treatment, or services provided by all of these people.

How well leaders work together is key to effective organization performance, and the standards emphasize this. Leaders with different responsibilities—governance, management, and the clinical staff—bring different skills, experiences, and perspectives to the organization. Working together means that leaders have the opportunity to participate in discussions and have their opinions heard. Depending on the topic and the organization, a variety of people may participate in decision making, and the governing body may delegate decision making to certain leaders. Final decisions, however, are always the ultimate responsibility of governance; this key principle is assumed in any standard that describes how leaders work together.

Standard LD.01.01.01
The organization has a leadership structure.

Rationale for LD.01.01.01
Every organization has a leadership structure to support operations. Many functions need to be carried out, including governance, administration, and oversight of care, treatment, or services. In some organizations leaders have distinct roles in carrying out these functions; in others a single person may perform all leadership functions.
Elements of Performance for LD.01.01.01

1. The organization identifies those responsible for governance.
2. Governance identifies those responsible for planning, management, and operational activities.
3. Governance identifies those responsible for the provision of care, treatment, or services.
4. For opioid treatment programs: The program’s administrative organization is comprised of, at a minimum, a program sponsor, program director or manager, and medical director.

Standard LD.01.03.01

Governance is ultimately accountable for the safety and quality of care, treatment, or services.

Rationale for LD.01.03.01

Governance’s ultimate responsibility for safety and quality derives from its legal responsibility and operational authority for organization performance. In this context, governance provides for internal structures and resources, including staff, that support safety and quality.

Elements of Performance for LD.01.03.01

1. Governance defines in writing its responsibilities.
2. Governance provides for organization management and planning.
3. Governance approves the organization’s written scope of services.
4. Governance selects the chief executive.
5. Governance provides for the resources needed to maintain safe, quality care, treatment, or services.
6. Governance works with other leaders to annually evaluate the organization’s performance in relation to its mission, vision, and goals.

Standard LD.01.04.01

A chief executive manages the organization.
Elements of Performance for LD.01.04.01

The chief executive provides for the following:

1. Information and support systems.
3. Physical and financial assets.

12. **For opioid treatment programs:** Persons in positions of authority are professionally and culturally competent.

   **Note:** These people are able to work effectively with the local community and/or receive input from members of minority groups or advisors who are knowledgeable about gender, ethnicity, and language issues.

13. **For opioid treatment programs:** The program formally designates a program sponsor and a medical director.

14. **For opioid treatment programs:** The medical director is responsible for all medical services performed by the program.

15. **For opioid treatment programs:** All medical care is the responsibility of the program’s physician(s).

16. **For opioid treatment programs:** The program’s medical director is a physician licensed in the jurisdiction where the program is located.

**Standard LD.01.07.01**

Leaders have the knowledge needed for their roles in the organization or they seek guidance to fulfill their roles.

**Elements of Performance for LD.01.07.01**

2. Leaders are oriented to all of the following:

   - The organization’s mission and vision
   - The organization’s safety and quality goals
   - The organization’s structure and the decision-making process
   - The development of the budget as well as the interpretation of the organization’s financial statements
   - The population(s) served by the organization and any issues related to that population(s)
   - The separate and interdependent responsibilities and accountabilities of leaders as they relate to supporting the mission of the organization and to providing safe and quality care
Applicable law and regulation

3. Governance provides leaders with access to information and training in areas where they need additional skills or expertise.

**Introduction to Leadership Relationships, Standards LD.02.01.01 and LD.02.03.01**

How well leaders work together and manage conflict affects an organization’s performance. In fulfilling its role, the governance involves senior managers and leaders of the clinical staff in governance and management functions.

Good relationships thrive when leaders work together to develop the mission, vision, and goals of the organization; encourage honest and open communication; and address conflicts of interest.

**Standard LD.02.01.01**

The mission, vision, and goals of the organization support the safety and quality of care, treatment, or services.

**Rationale for LD.02.01.01**

The primary responsibility of leaders is to provide for the safety and quality of care, treatment, or services. The purpose of the organization’s mission, vision, and goals is to define how the organization will achieve safety and quality. The leaders are more likely to be aligned with the mission, vision, and goals when they create them together. The common purpose of the organization is most likely achieved when it is understood by all who work in or are served by the organization.

**Elements of Performance for LD.02.01.01**

1. Leaders work together to create the organization’s mission, vision and goals.
2. The organization’s mission, vision, and goals guide the actions of leaders.
3. Leaders communicate the mission, vision, and goals to staff and the population(s) the organization serves.
4. For foster care: The agency’s mission, vision, and values are defined.
5. **For foster care:** The agency develops strategic, operational, and program-related plans and written policies to carry out the vision and to achieve the mission.

**Standard LD.02.03.01**
Leaders regularly communicate with each other on issues of safety and quality.

**Rationale for LD.02.03.01**
Leaders, who provide for safety and quality, must communicate with each other on matters affecting the organization and those it serves. The safety and quality of care, treatment, or services depend on open communication. Ideally, this will result in trust and mutual respect among those who work in the organization.

**Element of Performance for LD.02.03.01**
1. Leaders discuss issues that affect the organization and the population(s) it serves, including the following:
   - Performance improvement activities
   - Reported safety and quality issues
   - Proposed solutions and their impact on the organization’s resources
   - Reports on key quality measures and safety indicators
   - Safety and quality issues specific to the population served
   - Input from the population(s) served

**Introduction to Organization Culture and System Performance Expectations, Standards LD.03.01.01 Through LD.03.06.01**
An organization’s culture reflects the beliefs, attitudes, and priorities of its members, and it influences the effectiveness of performance. Although there may be a dominant culture, in many larger organizations diverse cultures exist that may or may not share the same values. In fact, diverse cultures can exist even in smaller organizations. Organization performance can be effective in either case. Successful organizations will work to develop a culture of safety and quality.

In a culture of safety and quality, everyone is focused on maintaining excellence in performance. They accept the safety and quality of care, treatment, or services as personal responsibilities and work together to minimize any harm that might result from
unsafe or poor quality of care, treatment, or services. Leaders create this culture by demonstrating their commitment to safety and quality and by taking actions to achieve the desired state. In a culture of this kind, one finds teamwork, open discussions of concerns about safety and quality, and the encouragement of and reward for internal and external reporting of safety and quality issues. The focus of attention is on the performance of systems and processes instead of any one person, although reckless behavior and a blatant disregard for safety are not tolerated. Organizations are committed to ongoing learning and have the flexibility to accommodate changes in technology, science, and the environment.

Leaders provide for the effective functioning of the organization with a focus on safety and quality. Leaders plan, support, and implement key systems critical to this effort. The Joint Commission has identified five key systems that influence the effective performance of an organization:

1. Using data
2. Planning
3. Communicating
4. Changing performance
5. Staffing

The following diagram illustrates the role of leadership in the performance of these systems.
Leadership provides the foundation for effective performance. The five key systems serve as pillars that are based on the foundation set by leadership and, in turn, support the many organizationwide processes (such as screening or assessment) that are important to individual care, treatment, or services. Culture permeates the entire structure.

The five key systems are interrelated and need to function well together. The integration of these systems throughout the organization will facilitate the effective performance of the organization as a whole. Leaders develop a vision and goals for the performance of these systems and evaluate their performance. Leaders use results to develop strategies for future improvements.

Performance of many aspects of these systems may be directly observable. But in many cases organizations demonstrate compliance through performance in standards located in other sections of this manual. These Leadership standards are cited when patterns of performance suggest organizationwide issues.
The effective performance of these systems results in a culture in which safety and quality are priorities. The organization demonstrates this through a proactive, nonpunitive culture that is monitored and sustained by related reporting systems and improvement initiatives.

Many of the concepts in the following section have long existed in the standards.

**Standard LD.03.01.01**
Leaders create and maintain a culture of safety and quality throughout the organization.

**Rationale for LD.03.01.01**
Safety and quality thrive in an environment that supports teamwork and respect for other people, regardless of their position in the organization. Leaders demonstrate their commitment to quality and set expectations for those who work in the organization. Leaders evaluate the culture on a regular basis using a variety of methods, such as formal surveys, focus groups, staff interviews, and data analysis.

Leaders encourage teamwork and create structures, processes, and programs that allow this positive culture to flourish. Staff behavior that intimidates others and affects morale or staff turnover undermines a culture of safety and can be harmful to individuals served. Leaders must address such behavior at all levels of the organization, including management, clinical and administrative staff, licensed independent practitioners, and governing body members.

**Elements of Performance for LD.03.01.01**
1. Leaders regularly evaluate the culture of safety and quality.
2. Leaders prioritize and implement changes identified by the evaluation.
3. Leaders develop a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety.
4. Leaders create and implement a process for managing behaviors that undermine a culture of safety.
5. All who work in the organization are able to openly discuss issues of safety and quality. *(See also LD.04.04.05, EP 6)*

**Standard LD.03.02.01**
The organization uses data and information to guide decisions and to understand variation in the performance of processes supporting safety and quality.
Rationale for LD.03.02.01
Data help organizations make the right decisions. When decisions are supported by data, organizations are more likely to move in directions that help them achieve their goals. Successful organizations measure and analyze their performance. When data are analyzed and turned into information, this process helps organizations see patterns and trends and understand the reasons for their performance. Many types of data are used to evaluate performance, including data on outcomes of care, performance on safety and quality initiatives, the satisfaction of the individuals served, process variation, and staff perceptions.

Elements of Performance for LD.03.02.01

1. Leaders set expectations for using data and information to improve the safety and quality of care, treatment, or services.
2. Leaders are able to describe how data and information are used to create a culture of safety and quality.
3. The organization uses processes to support systematic data and information use.
4. Leaders provide the resources needed for data and information use, including staff, equipment, and information systems.
5. The organization uses data and information in decision making that supports the safety and quality of care, treatment, or services. (See also PI.02.01.01, EP 8)
6. The organization uses data and information to identify and respond to internal and external changes in the environment.
7. Leaders evaluate how effectively data and information are used throughout the organization.

Standard LD.03.03.01
Leaders use organizationwide planning to establish structures and processes that focus on safety and quality.

Rationale for LD.03.03.01
Planning is essential to the following:
- The achievement of short- and long-term goals
- Meeting the challenge of external changes
- The design of services and work processes
- The creation of communication channels
The improvement of performance

The introduction of innovation

Planning includes contributions from the populations served, from those who work for the organization, and from other interested groups or persons such as families or consumer advocates.

**Elements of Performance for LD.03.03.01**

1. Planning activities focus on improving the safety of individuals served and behavioral health care quality.
2. Leaders can describe how planning supports a culture of safety and quality.
3. Planning is systematic, and it involves designated persons and information sources.
4. Leaders provide the resources needed to support the safety and quality of care, treatment, or services.
5. Safety and quality planning is organizationwide.
6. Planning activities adapt to changes in the environment.
7. Leaders evaluate the effectiveness of planning activities.

**Standard LD.03.04.01**

The organization communicates information related to safety and quality to those who need it, including staff, individuals served, families, and external interested parties.

**Rationale for LD.03.04.01**

Effective communication is essential among persons and groups within the organization, and between the organization and external parties. Poor communication often contributes to adverse events and can compromise safety and quality of care, treatment, or services. Effective communication is timely, accurate, and usable by the audience.

**Elements of Performance for LD.03.04.01**

1. Communication processes foster the safety of the individual served and the quality of care.
2. Leaders are able to describe how communication supports a culture of safety and quality.
3. Communication is designed to meet the needs of internal and external users.
4. Leaders provide the resources required for communication, based on the needs of individuals served, staff, and administration.

5. Communication supports safety and quality throughout the organization. *(See also LD.04.04.05, EPs 6 and 12)*

6. When changes in the environment occur, the organization communicates those changes effectively.

7. Leaders evaluate the effectiveness of communication methods.

**Standard LD.03.05.01**

Leaders implement changes in existing processes to improve the performance of the organization.

**Rationale for LD.03.05.01**

Change is inevitable, and agile organizations are able to manage change and rapidly execute new plans. The ability of leaders to manage change is necessary for performance improvement, for successful innovation, and to meet environmental challenges. The organization integrates change into all relevant processes so that its effectiveness can be sustained, assessed, and measured.

**Elements of Performance for LD.03.05.01**

1. Structures for managing change and performance improvements exist that foster the safety of the individual served and the quality of care, treatment, or services.

2. Leaders are able to describe how the organization’s approach to performance improvement and its capacity for change support a culture of safety and quality.

3. The organization has a systematic approach to change and performance improvement.

4. Leaders provide the resources required for performance improvement and change management, including sufficient staff, access to information, and training.

5. The management of change and performance improvement supports both safety and quality throughout the organization.

6. The organization’s internal structures can adapt to changes in the environment.

7. Leaders evaluate the effectiveness of processes for the management of change and performance improvement.
Standard  LD.03.06.01

Those who work in the organization are focused on improving safety and quality.

Rationale for LD.03.06.01

The safety and quality of care, treatment, or services are highly dependent on the people who work in the organization. The mission, scope, and complexity of services define the design of work processes and the skills and number of persons needed. In a successful organization, work processes and the environment make safety and quality paramount. This standard, therefore, applies to all those who work in or for the organization, including staff and licensed independent practitioners.

Elements of Performance for LD.03.06.01

1. Leaders design work processes to focus staff on safety and quality issues.
2. Leaders are able to describe how those who work in the organization support a culture of safety and quality.
3. Leaders provide for a sufficient number and mix of staff to support safe, quality care, treatment, or services.
4. Those who work in the organization are competent to complete their assigned responsibilities.
5. Those who work in the organization adapt to changes in the environment.
6. Leaders evaluate the effectiveness of those who work in the organization to promote safety and quality.
7. For foster care: The agency has the administrators, supervisors, and staff necessary to support its scope and volume of services, in accordance with law and regulation.
8. For foster care: The agency has qualified and competent staff necessary to provide the type(s) of services it makes available, in accordance with law and regulation.
9. For foster care: The agency has a process for determining staffing based on the number and types of foster care recipients and foster families served.

Note: The process considers staff training and experience, time for foster family resource development, foster family recruitment, licensing activities, case complexity, home monitoring, and home study.
Introduction to Operations, Standards LD.04.01.01 Through LD.04.04.05

Although some leaders may not be involved in the day-to-day, hands-on operations of the organization, their decisions and work affect, either directly or indirectly, every aspect of operations. They are the driving force behind the culture of the organization. Leaders establish the ethical framework in which the organization operates, create policies and procedures, and secure resources and services that support client safety and quality care, treatment, or services. Policies, procedures, resources, and services are all influenced by the culture of the organization and, in turn, influence the culture.

**Standard LD.04.01.01**
The organization complies with law and regulation.

**Elements of Performance for LD.04.01.01**

1. The organization is licensed, is certified, or has a permit, in accordance with law and regulation, to provide the care, treatment, or services for which the organization is seeking accreditation from The Joint Commission. *(See also WT.01.01.01, EP 1; WT.04.01.01, EP 1)*

2. The organization provides care, treatment, or services in accordance with licensure requirements, laws, and rules and regulations.

3. Leaders act on or comply with reports or recommendations from external authorized agencies, such as accreditation, certification, or regulatory bodies.

14. **For opioid treatment programs:** The program complies with Occupational Safety and Health Administration (OSHA) workplace health and safety standards.

**Standard LD.04.01.03**
The organization develops an annual operating budget and, when needed, a long-term capital expenditure plan.

**Elements of Performance for LD.04.01.03**

1. Leaders solicit comments from those who work in the organization when developing the operational and capital budgets.

3. The operating budget reflects the organization’s goals and objectives.

4. Governance monitors or approves an annual operating budget and, when needed, a long-term capital expenditure plan.
5. Leaders monitor the implementation of the budget and long-term capital expenditure plan.

7. The organization has a process that provides for an annual objective evaluation of its financial ability to provide care, treatment, or services.

Note: A full audit need not take place, but key measures that support sound financial practices or reveal warning signs requiring a follow-up are to be used. Examples of such measures include cash flow, accounts receivable, and current ratio.

**Standard LD.04.01.05**
The organization effectively manages its programs or services.

**Rationale for LD.04.01.05**
Leaders at the program or service level create a culture that enables the organization to fulfill its mission and meet its goals. They support staff and instill in them a sense of ownership of their work processes. Leaders may delegate work to qualified staff, but the leaders are responsible for the care, treatment, or services provided in their areas.

**Elements of Performance for LD.04.01.05**

2. Programs or services providing care are directed by one or more qualified professionals or by a qualified licensed independent practitioner with clinical responsibilities.

3. The organization defines, in writing, the responsibility of those with administrative and clinical direction of its programs or services.

4. Staff are held accountable for their responsibilities.

5. Leaders provide for the coordination of care, treatment, or services among the organization’s different programs or services.

16. **For opioid treatment programs:** Physicians have authority over the medical and nursing aspects of medication-assisted treatment and retain autonomy so as to ensure ongoing medical decisions are individualized according to the needs of each patient, the clinical course of treatment, and the standards of medical practice.

17. **For opioid treatment programs:** In programs where either could occur, the program clearly distinguishes between patients who are cared for by a physician in accordance with the rules under DATA 2000 and those who are cared for in an OTP facility in accordance with 42 CFR 8.12.
18. **For opioid treatment programs:** The program’s medical director is responsible for assuring all medical, psychiatric, nursing, pharmacy, toxicology, and other services offered by the program are conducted in compliance with federal regulations at all times.

19. **For opioid treatment programs:** The medical director is present at the program a sufficient number of hours to assure regulatory compliance and carry out those duties specifically assigned to the medical director by law and regulation.

20. **For opioid treatment programs:** The medical director either directly provides the required services to the program’s patients or assures that the needed services are provided by appropriately trained and licensed providers in compliance with federal and state regulation.

21. **For opioid treatment programs:** The day-to-day management of the program is assigned to the program director or manager who assumes the duties assigned by the program sponsor.

   **Note:** In some programs, the program sponsor may also serve as the program director or manager.

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**Standard LD.04.01.07**

The organization has policies and procedures that guide and support care, treatment, or services.

**Elements of Performance for LD.04.01.07**

1. Leaders review and approve policies and procedures that guide and support care, treatment, or services.

2. The organization manages the implementation of policies and procedures.

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**Standard LD.04.01.08**

For foster care: Staff caseloads are consistent with the level of care, treatment, or services provided to recipients of foster care.

**Elements of Performance for LD.04.01.08**

1. **For foster care:** The agency has a process for assigning and adjusting staff caseloads based on the level of care, treatment, or services provided to recipients of foster care.
2. **For foster care:** The agency follows its process for assigning and adjusting caseloads.

3. **For foster care:** The caseload size is in accordance with law and regulation.

**Standard LD.04.01.09**

Policies and procedures guide the provision of program services and define the goals and scope of services offered.

**Elements of Performance for LD.04.01.09**

1. **For opioid treatment programs:** Procedures are in place to ensure continuity of care for patients in the event of the voluntary or involuntary closure of the program. The procedures provide for orderly transfer of patients, records, and assets to other programs or practitioners.

2. **For opioid treatment programs:** The program’s written policies provide for assigning female patients to counselors who are sensitive to and trained to address their individual needs, such as domestic violence or sexual abuse.

3. **For opioid treatment programs:** The program establishes written policies and procedures for follow-up primary care of new mothers and well-baby care for their infants.

4. **For opioid treatment programs:** Written policies and procedures apply equally to women with concurrent HIV infection or HIV diagnosis, regardless of whether they are pregnant. These women receive the same services and treatment opportunities.

5. **For opioid treatment programs:** The program offers treatment for groups organized with their special needs in mind, such as gender, sexual minority, seniors, and language.

6. **For opioid treatment programs:** The option of participation in groups comprised of the same sex is available to all patients.

7. **For opioid treatment programs:** The program does not limit the psychosocial services offered to patients receiving “0” dose levels.

8. **For opioid treatment programs:** The program establishes procedures for admitting patients to short- or long-term withdrawal treatment.
9. **For opioid treatment programs:** Policies and procedures are reviewed and recertified at least annually.

10. ⓜ **For opioid treatment programs:** Programs providing treatment with multiple medications using both the OTP and office-based opioid treatment (OBOT) models of service delivery develop clear written policies and procedures for assigning patients to a specific model and establish criteria for determining a specific pharmacotherapy.

11. ⓜ **For opioid treatment programs:** If the program offers inpatient detoxification services, it develops written policies and procedures to provide the service so that treatment can be matched to the individual needs and preferences of the patient. These include careful review of the risks and benefits of detoxification; obtaining thorough informed consent from patients choosing this treatment option; and providing accompanying relapse prevention counseling, overdose prevention education (may include an FDA-approved naloxone kit), and aftercare plans that include a strategy to transition to medication-assisted treatment if needed.

12. ⓜ **For foster care:** The agency has a written nondiscriminatory policy for selecting foster parents.

13. ⓜ **For foster care:** The agency develops specific written policies and procedures on the following:
   - Reporting and handling of physical, mental, and sexual abuse
   - Receiving and responding to comments, questions, or complaints from the family of origin, the individual served, and the foster parents
   - Removing an individual from the foster home if there is suspicion that he or she is in danger
   - Actions to take in the event of the closure of foster homes, whether voluntary or by termination orders

**Standard LD.04.01.11**
The organization makes space and equipment available as needed for the provision of care, treatment, or services.

**Note:** This standard is applicable only to those settings that are under the control of the behavioral health care organization.
Rationale for LD.04.01.11
The resources allocated to services provided by the organization have a direct effect on an individual’s outcomes. Leaders should place highest priority on high-risk or problem-prone processes that can affect an individual’s safety. Examples include infection control, medication management, and others defined by the organization.

Elements of Performance for LD.04.01.11
3. The interior and exterior space provided for care, treatment, or services meets the needs of individuals served.
4. The grounds, equipment, and special activity areas are safe, maintained, and supervised.
5. The leaders provide for equipment, supplies, and other resources.

Standard LD.04.02.01
The leaders address any conflict of interest involving staff that affects or has the potential to affect the safety or quality of care, treatment, or services.

Elements of Performance for LD.04.02.01
1. The leaders define conflict of interest involving staff. This definition is in writing.
2. The leaders develop a written policy that defines how the organization will address conflicts of interest involving staff.
3. Existing or potential conflicts of interest involving staff, as defined by the organization, are disclosed.
4. The organization reviews its relationships with other care providers, educational institutions, manufacturers, and payers to determine whether conflicts of interest exist and whether they are within law and regulation.
5. Policies, procedures, and information about the relationship between care, treatment, or services and financial incentives are available upon request to all individuals served and staff.

Standard LD.04.02.03
Ethical principles guide the organization’s business practices.
Elements of Performance for LD.04.02.03

1. The organization has a process that allows staff, individuals served, and families to address ethical issues or issues prone to conflict.

2. The organization uses its process to address ethical issues or issues prone to conflict.

3. The organization follows ethical practices for marketing and billing.

4. Marketing materials accurately represent the organization and address the care, treatment, or services that the organization provides either directly or by contractual arrangement.

5. Care, treatment, or services are provided based on the needs of individuals served, regardless of compensation or financial risk-sharing with those who work in the organization, including staff.

7. Individuals served receive information about charges for which they will be responsible.

8. For organizations that provide eating disorders care, treatment, or services: The organization’s program materials indicate the following:
   - The program’s setting(s), scope of services, and population(s) served
   - Availability of and/or the process for transfer to other settings of care, if necessary, such as acute hospital, psychiatric facility, or other setting
   - Pertinent information regarding availability of care, treatment, or services based on particular population characteristics (for example, only one half of available beds are open to adolescents; only females are served by the program; individuals must treat chemical dependency issues prior to entering program)
   - Description of the members of the multidisciplinary team providing care, treatment, or services

9. For organizations that provide eating disorders care, treatment, or services: The organization is able to provide individuals served and their families, if applicable, with information on insurance coverage accepted by the organization, the availability of any financial assistance, and whether or not the facility is considered in-network for the individual’s insurance company.
Standard **LD.04.02.05**

When internal or external review results in the denial of care, treatment, or services, or payment, the organization makes decisions regarding the ongoing provision of care, treatment, or services, and discharge or transfer, based on the assessed needs of the individual served.

**Rationale for LD.04.02.05**

The organization is professionally and ethically responsible for providing care, treatment, or services within its capability and law and regulation. At times, such care, treatment, or services are denied because of payment limitations. In these situations, the decision to continue providing care, treatment, or services or to discharge the individual is based solely on the individual’s identified needs.

**Element of Performance for LD.04.02.05**

1. Decisions regarding the provision of ongoing care, treatment, or services, discharge, or transfer are based on the assessed needs of the individual served, regardless of the recommendations of any internal or external review.

Standard **LD.04.03.01**

The organization provides services that meet needs of the individual served.

**Elements of Performance for LD.04.03.01**

1. The needs of the population(s) served guide decisions about which services will be provided directly or through referral, consultation, contractual arrangements, or other agreements.

19. **For foster care:** The leaders work with policymakers and involve the community in foster care through education and awareness.

20. **For foster care:** Entry into the appropriate level of care is based on the proper assessment.

21. **For foster care:** Services are planned based on the characteristics and identified needs of the individual served.

22. **For foster care:** The agency plans services based on the agency’s commitments, which include collaborative relationships with agencies that are separately funded or contracted with to provide services to the family of origin or with agencies that supplement the operating agency’s services.
23. **For foster care:** The agency plans services with community vendors (for example, medical, dental, educational) to guarantee access for the individual with identified needs that are not provided for by the agency.

24. **For foster care:** The agency plans services with the foster parents’ involvement in making decisions about the foster care (for example, policies and program issues).

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**Standard LD.04.03.05**

Services are defined through the collaboration of the organization’s leaders with leaders of the various communities served by the organization and other external organizations.

**Rationale for LD.04.03.05**

**For opioid treatment programs:** As part of the planning process, the organization determines which essential services it will provide directly to patients based on their identified needs and in compliance with applicable law and regulation. The organization can decide to provide some services through referral, consultation, or contractual agreement.

Services are provided, or referrals made, for patients who have coexisting health and psychosocial issues. Coexisting health and psychosocial issues or needs can include the following:

- Learning problems
- Medical problems
- Chronic pain disorder
- Mental health and family problems
- Use or abuse of multiple drugs and/or alcohol
- HIV or other sexually transmitted diseases
- Infectious diseases
- Pregnancy and prenatal care
- Vocational and employment needs
- Legal services needs

When possible, comorbidities are concurrently managed on site. Coexisting conditions, especially in patients from disenfranchised populations, are most effectively treated at a single site.

**Note 1:** *Managing chronic pain includes consulting with a specialist in pain medicine, when possible and appropriate.*
Note 2: Programs should establish a mechanism to evaluate mental health medication jointly with the mental health provider. If possible and indicated, programs may even dispense such medications in conjunction with the daily methadone dose.

Elements of Performance for LD.04.03.05

1. A process is in place for physician input in planning for the provision of medical services.

2. The severity of the needs of the individual served determines the resources used to meet those needs.

4. For opioid treatment programs: The program selects its location based on community need and impact.

5. For opioid treatment programs: The program solicits input from the community and uses both solicited and unsolicited input from the community to determine the program’s impact in the neighborhood.

6. For opioid treatment programs: The program obtains input from patients related to identified community concerns, and considers both patient and community input when developing or revising its policies and procedures.

7. For opioid treatment programs: The program has written policies and procedures that address community problems (such as patient loitering and medication diversion). Program operations do not adversely affect community life.

8. For opioid treatment programs: The program establishes a liaison with community leaders in order to foster good relations.

Note: Examples of community leaders include publicly elected representatives; local health, substance abuse, and social and/or human service agency directors; business organization leaders; community and health planning agency directors; grassroots community organization leaders; local police and law enforcement officials; and religious and spiritual leaders.

9. For opioid treatment programs: The program has a written community relations plan that is specific to the configuration and needs of the program within its community.
10. **For opioid treatment programs:** The community relations plan includes goals and procedures and identifies the program staff who will function as community relations coordinators.

11. **For opioid treatment programs:** The community relations plan addresses how the program will establish a liaison with the community representatives to share information about the program, the community, and mutual issues.

12. **For opioid treatment programs:** The community relations plan addresses how the program will serve as a community resource on substance abuse and related health and social issues as well as how it will promote the benefit of medication-assisted treatment in preserving public health.

13. **For opioid treatment programs:** The program documents its community relations efforts and community contacts.

14. **For opioid treatment programs:** The program evaluates its community relations efforts over time and addresses any outstanding problems.

15. **For opioid treatment programs:** The program’s building is clean and orderly, and the physical setting does not impede pedestrian or traffic flow.

16. **For opioid treatment programs:** The program has a communication mechanism so that interested parties and potential patients can obtain general information about the program outside regular operating hours.

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**Standard LD.04.03.07**

Individuals with comparable needs receive the same standard of care, treatment, or services throughout the organization.

**Rationale for LD.04.03.07**

Comparable standards of care means that the organization can provide the services that individuals need within established time frames and that those providing care, treatment, or services have the required competence. Organizations may provide different services to individuals with similar needs as long as his or her outcome is not affected. Different settings, processes, or payment sources should not result in different standards of care.

**Elements of Performance for LD.04.03.07**

1. Variances in staff, setting, or payment source do not affect outcomes of care, treatment, or services in a negative way.
4. **For foster care:** The agency plans services so that the same level of care or service is offered to every individual served. These services are planned according to each individual’s needs regardless of how the service is provided, such as through family of origin, through kinship care, or through foster care.

**Introduction to Oversight of Care, Treatment, or Services Provided Through Contractual Agreement, Standard LD.04.03.09**

The same level of care should be delivered to all individuals served regardless of whether services are provided directly by the organization or through contractual agreement. Leaders provide oversight to make sure that care, treatment, or services provided directly are safe and effective. Likewise, leaders must also oversee contracted services to make sure that they are provided safely and effectively. Standard LD.04.03.09 outlines the requirements for leadership oversight of care, treatment, or services provided through contractual agreement.

The only contractual agreements subject to the requirements in Standard LD.04.03.09 are those for the provision of care, treatment, or services provided to individuals served by the organization. This standard does not apply to contracted services that are not directly related to care, treatment, or services. In addition, contracts for consultation or referrals are not subject to the requirements in Standard LD.04.03.09. However, regardless of whether or not a contract is subject to this standard, the actual performance of any contracted service is evaluated at the other standards in this manual appropriate to the nature of the contracted service.

**Monitoring Contracted Services**

The expectations that leaders set for the performance of contracted services should reflect basic principles of risk reduction, safety, staff competence, and performance improvement. Although leaders have the same responsibility for oversight of contracted services outside the organization’s expertise as they do for contracted services within the organization’s expertise, it is more difficult to determine how to monitor such services. In these cases, information from relevant professional organizations can provide
guidance for setting expectations. In addition, the organization may want to consider expectations related to responsiveness, communication, follow-up, or the rights of the individual served.

The elements of performance do not prescribe the methods for evaluating contracted services; leaders are expected to select the best methods for their organization to oversee the quality and safety of services provided through contractual agreement. Examples of sources of information that may be used for evaluating contracted services include the following:

- Review of information about the contractor’s Joint Commission accreditation or certification status
- Direct observation of the provision of care
- Audit of documentation, including clinical/case records
- Review of incident reports
- Review of periodic reports submitted by the person or organization providing services under contractual agreement
- Collection of data that address the efficacy of the contracted service
- Review of performance reports based on indicators required in the contractual agreement
- Input from staff and individuals served
- Review of studies on the individual’s satisfaction
- Review of results of risk management activities

In the event that contracted services do not meet expectations, leaders take steps to improve care, treatment, or services. In some cases, it may be best to work with the contractor to make improvements, whereas in other cases it may be best to renegotiate or terminate the contractual relationship. When leaders anticipate the renegotiation or termination of a contractual agreement, planning needs to occur so that the continuity of care, treatment, or services is not disrupted.

**Credentialing and Assigning of Clinical Responsibilities**

In most cases, each licensed independent practitioner providing services through a contractual agreement must be credentialed and privileged by the organization using his or her services, following the process described in the “Human Resources” (HR) chapter. However, there is one special circumstance when this is not required: Off-site services provided by a Joint Commission–accredited contractor.
Standard LD.04.03.09
Care, treatment, or services provided through contractual agreement are provided safely and effectively.

Elements of Performance for LD.04.03.09

1. Clinical leaders have an opportunity to provide advice about the sources of clinical services to be provided through contractual agreement.

2. The organization describes, in writing, the nature and scope of services provided through contractual agreements.

3. Designated leaders approve contractual agreements.

4. Leaders monitor contracted services by establishing expectations for the performance of the contracted services.

Note: When the organization contracts with another accredited organization for care, treatment, or services to be provided off site, it can do the following:
- Verify that all licensed independent practitioners who will be providing care, treatment, or services have appropriate clinical responsibilities by obtaining, for example, a copy of the list of clinical responsibilities.
- Specify in the written agreement that the contracted organization will ensure that all contracted services provided by licensed independent practitioners will be within the scope of their clinical responsibilities.

5. Leaders monitor contracted services by communicating the expectations in writing to the provider of the contracted services.

Note: A written description of the expectations can be provided either as part of the written agreement or in addition to it.

6. Leaders monitor contracted services by evaluating these services in relation to the organization’s expectations.

7. Leaders take steps to improve contracted services that do not meet expectations.

Note: Examples of improvement efforts to consider include the following:
- Increase monitoring of the contracted services.
- Provide consultation or training to the contractor.
- Renegotiate the contract terms.
- Apply defined penalties.
- Terminate the contract.
8. When contractual agreements are renegotiated or terminated, the organization maintains the continuity of care.

10. Reference and contract laboratory services meet the federal regulations for clinical laboratories and maintain evidence of the same.

**Standard LD.04.04.01**
Leaders establish priorities for performance improvement. (Refer to the “Performance Improvement” [PI] chapter.)

**Elements of Performance for LD.04.04.01**

1. Leaders set priorities for performance improvement activities and behavioral health outcomes. (*See also* PI.01.01.01, EPs 1 and 3)

2. Leaders give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities. (*See also* PI.01.01.01, EPs 14, 15, and 27)

3. Leaders reprioritize performance improvement activities in response to changes in the internal or external environment.

4. Performance improvement occurs organizationwide.

24. **For organizations that elect The Joint Commission Behavioral Health Home option:** Leaders set priorities for physical health care performance improvement activities and outcomes. (*See also* PI.01.01.01, EP 40)

   **Note:** As an example, activities and outcomes may be related to individuals with multiple chronic physical health conditions.

25. **For organizations that elect The Joint Commission Behavioral Health Home option:** Leaders involve individuals served in performance improvement activities related to integrated care.

   **Note:** This involvement may include activities such as participating on a quality committee or providing feedback on safety and quality issues.

**Standard LD.04.04.03**
New or modified services or processes are well designed.

**Elements of Performance for LD.04.04.03**

1. The organization’s design of new or modified services or processes incorporates the needs of the individuals served, staff, and others.
2. The organization’s design of new or modified services or processes incorporates the results of performance improvement activities.

3. The organization’s design of new or modified services or processes incorporates information about potential risks to the individuals served. (See also LD.04.04.05, EPs 6 and 11)

   **Note:** A proactive risk assessment is one of several ways to assess potential risks to the individuals served. For suggested components, refer to the “Proactive Risk Assessment” section at the beginning of this chapter.

4. The organization’s design of new or modified services or processes incorporates evidence-based information in the decision-making process.

   **Note:** For example, evidence-based information could include practice guidelines, successful practices, information from current literature, and clinical standards.

5. The organization’s design of new or modified services or processes incorporates information about sentinel events.

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**Introduction to Standard LD.04.04.05**

This standard describes a safety program that integrates safety priorities into all processes, functions, and services within the organization, including care of the individual served, support, and contract services. It addresses the responsibility of leaders to establish an organizationwide safety program; to proactively explore potential system failures; to analyze and take action on problems that have occurred; and to encourage the reporting of adverse events and close calls ("near misses"), both internally and externally. The organization’s culture of safety and quality supports the safety program (refer to Standard LD.03.01.01).

This standard does not require the creation of a new structure or office in the organization. It only emphasizes the need to integrate safety activities related to the individual served, both existing and newly created, with the organization’s leadership, which is ultimately responsible for this integration.

**Standard LD.04.04.05**

The organization has an organizationwide, integrated safety program for individuals served.
Elements of Performance for LD.04.04.05

1. The leaders implement an organizationwide safety program for individuals served.

2. One or more qualified persons manage the safety program.

3. The scope of the safety program includes the full range of safety issues, from potential or no-harm errors (sometimes referred to as close calls [“near misses”] or good catches) to hazardous conditions and sentinel events.

4. All programs and services within the organization participate in the safety program.

5. As part of the safety program, the leaders create procedures for responding to system or process failures.

   Note 1: Responses might include continuing to provide care, treatment, or services to those affected, containing the risk to others, and preserving factual information for subsequent analysis.

   Note 2: For opioid treatment programs: Examples of reportable patient deaths include the following:
   - Drug-related deaths
   - Methadone or buprenorphine deaths
   - Unexpected or suspicious deaths
   - Treatment-context deaths that raise individual, family, community, or public concern

6. The leaders provide and encourage the use of systems for blame-free internal reporting of a system or process failure, or the results of a proactive risk assessment. (See also LD.03.01.01, EP 8; LD.03.04.01, EP 5; LD.04.04.03, EP 3)

   Note: This EP is intended to minimize staff reluctance to report errors in order to help an organization understand the source and results of system and process failures. The EP does not conflict with holding individuals accountable for their blameworthy errors.

7. The leaders define patient safety event and communicate this definition throughout the organization.
8. The organization conducts thorough and credible comprehensive systematic analyses (for example, root cause analyses) in response to sentinel events as described in the “Sentinel Events” (SE) chapter of this manual.

9. The leaders make support systems available for staff who have been involved in an adverse or sentinel event.

Note: Support systems recognize that conscientious health care workers who are involved in sentinel events are themselves victims of the event and require support. Support systems provide staff with additional help and support as well as additional resources through the human resources function or an employee assistance program. Support systems also focus on the process rather than blaming the involved persons.

11. To improve safety, the organization analyzes and uses information about system or process failures and, when conducted, the results of proactive risk assessments. (See also LD.04.04.03, EP 3)

12. The leaders disseminate lessons learned from comprehensive systematic analyses (for example, root cause analyses), system or process failures, and the results of proactive risk assessments to all staff who provide services for the specific situation. (See also LD.03.04.01, EP 5)

13. At least once a year, the leaders provide governance with written reports on the following:
   - All system or process failures
   - The number and type of sentinel events
   - Whether the individuals served and the families were informed of the event
   - All actions taken to improve safety, both proactively and in response to actual occurrences

14. The leaders encourage external reporting of significant adverse events, including voluntary reporting programs in addition to mandatory programs.
Note: Examples of voluntary programs include The Joint Commission Sentinel Event Database and the US Food and Drug Administration (FDA) MedWatch. Mandatory programs are often state initiated.

Standard LD.04.04.09
For organizations that elect The Joint Commission Behavioral Health Home option:
The organization uses clinical practice guidelines and/or evidence-based practices to evaluate and treat specific diagnoses, conditions, or symptoms for both physical and behavioral health care.

Note: Clinical practice guidelines and evidence-based practices include both nationally recognized guidelines and practices and guidelines and practices developed by individual organizations to address their particular circumstances.

Elements of Performance for LD.04.04.09
1. For organizations that elect The Joint Commission Behavioral Health Home option: The organization identifies clinical practice guidelines and/or evidence-based practices to evaluate and treat specific diagnoses, conditions, or symptoms for both physical and behavioral health care that are relevant to the population(s) served by the behavioral health home.

2. For organizations that elect The Joint Commission Behavioral Health Home option: The organization uses clinical practice guidelines and/or evidence-based practices to evaluate and treat specific diagnoses, conditions, or symptoms for both physical and behavioral health care.

3. For organizations that elect The Joint Commission Behavioral Health Home option: The organization manages and evaluates the implementation of clinical practice guidelines and/or evidence-based practices that have been selected to evaluate and treat specific diagnoses, conditions, or symptoms for both physical and behavioral health care.

4. For organizations that elect The Joint Commission Behavioral Health Home option: The leaders of the organization review and approve the clinical practice guidelines and/or evidence-based practices that have been selected to evaluate and treat specific diagnoses, conditions, or symptoms for both physical and behavioral health care.
5. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization monitors and reviews, then modifies as necessary, its clinical practice guidelines and/or evidence-based practices for continued applicability and effectiveness.
Life Safety (LS)

Overview

Applicability of the Standards
This chapter applies to settings in behavioral health care organizations that provide sleeping arrangements for individuals as a required part of their care, treatment, or services. The Joint Commission applies selected residential occupancy requirements to these settings that are contained in the National Fire Protection Association’s (NFPA) Life Safety Code* (101-2012). There are two types of buildings covered by the residential occupancy requirements: “Lodging or Rooming Houses” for 4 to 16 occupants (LS.04.01.20 – LS.04.01.70) and “Hotels and Dormitories” for 17 or more occupants (LS.04.02.20 – LS.04.02.70).

Some behavioral health care organizations providing crisis stabilization services lock doors so that individuals served are prohibited from leaving the building or space. There are some provisions in the residential occupancy chapters of the Life Safety Code related to doors locked on the inside that can be easily opened in an emergency. In cases where the locked doors do not meet the provisions in the Life Safety Code, the behavioral health care organization will need to meet the health care occupancy requirements that begin with Standard LS.02.01.10.

Standards LS.01.01.01 and LS.01.02.01 apply to all behavioral health care organizations that need to meet the requirements of the Life Safety Code.

In some cases, behavioral health care organizations have apartments where individuals served may choose to live (not as a required part of care, treatment, or services). The Joint Commission does not typically survey these types of living arrangements. The Joint Commission would only apply the Life Safety Code if these living arrangements were a required part of care, treatment, or services.

When the behavioral health care organization occupies space in a building that it does not own, The Joint Commission will assess that space and all exits from that space to the outside at grade level. The Joint Commission will also expect to see that the behavioral

* Life Safety Code® is a registered trademark of the National Fire Protection Association, Quincy, MA.
health care organization works with the landlord to make sure that supporting building systems comply with the *Life Safety Code*. Examples of such systems include fire alarms and automatic sprinklers.

**About This Chapter**

Fire is a concern for everyone, but it is a special concern for behavioral health care organizations where clients stay overnight because they are often unable to move to safety by themselves. The *Life Safety Code* considers several options for fire protection: creating safe areas (smoke compartments) that allow people to remain in their locations and “defend in place”; moving people to safe areas within the building; and, as a last resort, moving people out of the building. Behavioral health care facility design and related features help prevent, detect, and suppress fires. The measures that behavioral health care organizations must take to protect occupants from the dangers of fire constitute the content of this chapter. These standards focus on the importance of a fire-safe environment and buildings; however, The Joint Commission recognizes that people are equally important in reducing the risk of fire. The responsibilities of managing a safe environment (for example, identifying fire risks, conducting fire drills, maintaining fire protection equipment) by those who work in the behavioral health care organization are addressed in the “Environment of Care” (EC) chapter.

From time to time, building codes are updated to incorporate new technology that often cannot be introduced easily into older buildings. These settings tend to rely more on passive systems (such as doors and walls) for fire protection. In new buildings, fire protection is more often provided by active systems, such as fire alarms and automatic sprinkler systems. This chapter addresses both existing and new residential occupancies. Buildings are considered existing residential occupancies if final plans for additions, renovations, or changes in occupancy were approved by the local authority having jurisdiction before July 5, 2016. Existing Hotels and Dormitories requirements are found in Chapter 29 of the *Life Safety Code*. Buildings with final plans for new construction, additions, renovations, or changes in occupancy approved by the local authority having jurisdiction after July 5, 2016, are considered new residential occupancies. New Hotels and Dormitories requirements are found in Chapter 28 of the *Life Safety Code*. Requirements for both new and existing Rooming and Lodging Houses are found in Chapter 26.

also provided in those rare cases when a different edition or NFPA Code is used as a source. The *Life Safety Code* may contain provisions to the requirements in this chapter. Compliance with these provisions is considered as meeting the *Life Safety Code* and is acceptable to The Joint Commission.

This chapter addresses a number of topics contained in the *Life Safety Code*, including:

- General life safety design and building construction
- The means of egress, including design of space, travel distances, egress illumination, and signage
- Protection provided by door features, fire windows, stairs, and other vertical openings; corridors; smoke barriers; and interior finishes
- Fire alarm notification, including audible and coded alarms
- Suppression of fires, including sprinkler systems
- Building services, including elevators and chutes
- Decorations, furnishings, and portable heaters
Chapter Outline

I. Administrative Activities
   A. Statement of Conditions (LS.01.01.01)
   B. Interim Life Safety Measures (LS.01.02.01)

II. Health Care Occupancy
   A. All Health Care Occupancy Buildings
      1. General Building Requirements (LS.02.01.10)
      2. Means of Egress Requirements (LS.02.01.20)
      3. Protection (LS.02.01.30)
         a. Fire Alarm (LS.02.01.34)
         b. Extinguishment (LS.02.01.35)
      4. Special Provisions (LS.02.01.40)
      5. Building Services (LS.02.01.50)
      6. Operating Features (LS.02.01.70)

III. Ambulatory Health Care Occupancy—Not applicable to behavioral health care

IV. Residential Occupancy
   A. Lodging or Rooming Houses
      1. Means of Escape Requirements (LS.04.01.20)
      2. Protection Requirements (LS.04.01.30)
      3. Building Services (LS.04.01.50)
   B. Hotels and Dormitories
      1. Means of Egress Requirements (LS.04.02.20)
      2. Protection Requirements (LS.04.02.30)
      3. Special Provisions (LS.04.02.40)
      4. Building Services (LS.04.02.50)
Standards, Rationales, and Elements of Performance

**Introduction to Standard LS.01.01.01**

Behavioral health care organizations must be vigilant about fire safety. An ongoing assessment of compliance with the *Life Safety Code* is an effective way to identify and minimize risks. The electronic Statement of Conditions™ (SOC) is used in a management process that continually identifies, assesses, and resolves *Life Safety Code* deficiencies. The SOC includes two main sections: Basic Building Information (BBI) and a Plan for Improvement (PFI). The behavioral health care organization uses the BBI to identify the life safety features of its building(s). When a behavioral health care organization has multiple sites, one BBI form is prepared for each site; however, a single BBI form may cover multiple buildings at that site if they are physically connected. Alternatively, the behavioral health care organization may prepare a separate BBI form for each building. In either case, the behavioral health care organization must address specific risks and the unique conditions at each of its sites and buildings.

The behavioral health care organization should establish the qualifications of the individuals(s) it selects to assess compliance with the *Life Safety Code*. These individuals are not required to have any specific education or experience, although knowledge of the *Life Safety Code* and its application in unique occupancies is important. Qualifications should be based on the scope of the *Life Safety Code* assessment activities and the complexity of the building and occupancy being assessed.

**Standard LS.01.01.01**

The organization designs and manages the physical environment to comply with the *Life Safety Code*.

*Note:* This standard applies to behavioral health care settings that provide sleeping arrangements for four or more individuals served as a required part of their care, treatment, or services.
Elements of Performance for LS.01.01.01

1. The organization assigns an individual(s) to assess compliance with the Life Safety Code and manage the Statement of Conditions (SOC) when addressing survey-related deficiencies.

2. In time frames defined by the organization, the organization performs a building assessment to determine compliance with the “Life Safety” (LS) chapter.

3. The organization maintains current and accurate drawings denoting features of fire safety and related square footage.
   Fire safety features include the following:
   - Areas of the building that are fully sprinklered (if the building is partially sprinklered)
   - Locations of all hazardous storage areas
   - Locations of all fire-rated barriers
   - Locations of all smoke-rated barriers
   - Sleeping and non-sleeping suite boundaries, including the size of the identified suites
   - Locations of designated smoke compartments
   - Locations of chutes and shafts
   - Any approved equivalencies or waivers

4. When the organization plans to resolve a deficiency through a Survey-Related Plan for Improvement (SPFI), the organization meets the 60-day time frame.

   **Note 1:** If the corrective action will exceed the 60-day time frame, the organization must request a time-limited waiver within 30 days from the end of survey.

   **Note 2:** If there are alternative systems, methods, or devices considered equivalent, the organization may submit an equivalency request using its Statement of Conditions (SOC).

   **Note 3:** For further information on waiver and equivalency requests, see https://www.jointcommission.org/life_safety_code_information_resources/ and NFPA 101-2012: 1.4.

6. The organization does not remove or minimize an existing life safety feature when such feature is a requirement for new construction. Existing life safety features, if not required by the Life Safety Code, can be either maintained or removed. (For full text, refer to NFPA 101-2012: 4.6.12.2; 4.6.12.3; 18/19.7.9)
Standard  LS.01.02.01

The organization protects occupants during periods when the *Life Safety Code* is not met or during periods of construction.

**Note:** *This standard applies to behavioral health care settings that provide sleeping arrangements for four or more individuals served as a required part of their care, treatment, or services.*

**Elements of Performance for LS.01.02.01**

2. ② When the organization identifies *Life Safety Code* deficiencies that cannot be immediately corrected or during periods of construction, the organization evacuates the building or notifies the fire department (or other emergency response group) and initiates a fire watch when a fire alarm system is out of service more than 4 out of 24 hours or a sprinkler system is out of service more than 10 hours in a 24-hour period in an occupied building. Notification and fire watch times are documented. (For full text, refer to NFPA 101-2012: 9.6.1.6; 9.7.6; NFPA 25-2011: 15.5.2)

When the organization identifies *Life Safety Code* deficiencies that cannot be immediately corrected or during periods of construction, the organization does the following:

3. Posts signage identifying the location of alternative exits to everyone affected.

4. Inspects exits in affected areas on a daily basis. The organization determines when these inspections are needed.

5. Provides temporary but equivalent fire alarm and detection systems for use when a fire system is impaired. The organization determines when these systems are needed.

6. Provides additional firefighting equipment. The organization determines when to provide this equipment.

7. Uses temporary construction partitions that are smoke-tight, or made of noncombustible or limited-combustible material that will not contribute to the development or spread of fire. The organization determines when to use these partitions.
8. Increases surveillance of buildings, grounds, and equipment, giving special attention to construction areas and storage, excavation, and field offices. The organization determines when to increase surveillance.

9. Enforces storage, housekeeping, and debris-removal practices that reduce the building’s flammable and combustible fire load to the lowest feasible level. The organization determines when these practices are needed.

10. Provides additional training to those who work in the organization on the use of firefighting equipment. The organization determines when to provide additional training.

11. Conducts one additional fire drill per quarter. The organization determines when these additional fire drills are needed. (See also EC.02.03.03, EP 1)

12. ☐ Inspects and tests temporary systems monthly. The completion date of the tests is documented. The organization determines when these inspections and tests are needed.

13. The organization conducts education to promote awareness of building deficiencies, construction hazards, and temporary measures implemented to maintain fire safety. The organization determines when this education is needed.

14. The organization trains those who work in the organization to compensate for impaired structural or compartmental fire safety features. The organization determines when this training is needed.

**Note:** Compartmentalization is the concept of using various building components (for example, fire-rated walls and doors, smoke barriers, fire-rated floor slabs) to prevent the spread of fire and the products of combustion so as to provide a safe means of egress to an approved exit. The presence of these features varies, depending on the building occupancy classification.

15. The organization’s policy allows the use of other ILSMs not addressed in EPs 2–14.

**Note 1:** The organization’s ILSM policy addresses Life Safety Code Requirements for Improvement (RFI) that are not immediately corrected during survey.

**Note 2:** The “other” ILSMs used are documented by selecting “other” and annotating the associated text box in the organization’s Survey-Related Plan for Improvement (SPFI) within the Statement of Conditions™ (SOC).
Standard LS.02.01.10

Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.

**Note:** This standard applies to behavioral health care settings that provide sleeping arrangements as a required part of their care, treatment, or services and that lock doors to prohibit individuals served from leaving the building or space.

Rationale for LS.02.01.10

A building should be designed, constructed, and maintained in order to minimize danger from the effects of fire, including smoke, heat, and toxic gases. The structural characteristics of the building, as well as its age, determine the types of fire protection features that are needed. The features covered in this standard include the structure, automatic sprinkler systems, building separations, and doors.

**Note:** When remodeling or designing a new building, the organization should also satisfy any requirements of other codes and standards (local, state, or federal) that may be more stringent than the Life Safety Code. Also, the Life Safety Code contains special considerations for minor and major renovation.

Elements of Performance for LS.02.01.10


2. When building rehabilitation occurs, the organization incorporates NFPA 101-2012: Chapters 18, 19, and 43. (For full text, refer to NFPA 101-2012: Chapter 43; 18/19.1.1.4.3; 18.4.3.1–18.4.3.5; 19.4.3)

6. Fire barriers are continuous from outside wall to outside wall or from one fire barrier to another, or a combination thereof, including continuity through all concealed spaces, such as those found above a ceiling, including interstitial spaces. For those fire barriers terminating at the bottom side of an interstitial space, the construction assembly forming the bottom of the interstitial space must have a fire resistance rating not less than that of the fire barrier. (For full text, refer to NFPA 101-2012: 8.3.1.2)

7. Common walls that are between buildings or within buildings (occupancy separation) are fire rated for two hours. (For full text, refer to NFPA 101-2012: 18/19.1.1.4;18/19.1.3.3; 18/19.1.3.4; 8.2.2.2)
9. The fire protection ratings for opening protectives in fire barriers, fire-rated smoke barriers, and fire-rated smoke partitions are as follows:

- Three hours in three-hour barriers and partitions
- Ninety minutes in two-hour barriers and partitions
- Forty-five minutes in one-hour barriers and partitions
- Twenty minutes in thirty-minute barriers and partitions

(For full text, refer to NFPA 101-2012: 8.3.4; 8.3.3.2; Table 8.3.4.2)

**Note:** Labels on fire door assemblies must be maintained in legible condition.

10. In existing buildings that are not a high rise and are protected with automatic sprinkler systems, exit stairs (or new exit stairs connecting three or fewer floors) are fire rated for one hour. In new construction, exit stairs connecting four or more floors are fire rated for two hours. (For full text, refer to NFPA 101-2012: 7.1.3.2.1)

11. Fire-rated doors within walls and floors have functioning hardware, including positive latching devices and self-closing or automatic-closing devices (either kept closed or activated by release device complying with NFPA 101-2012: 7.2.1.8.2). Gaps between meeting edges of door pairs are no more than \( \frac{1}{8} \) of an inch wide, and undercuts are no larger than \( \frac{3}{8} \) of an inch. Fire-rated doors within walls do not have unapproved protective plates greater than 16 inches from the bottom of the door. Blocking or wedging open fire-rated doors is prohibited. (For full text, refer to NFPA 101-2012: 8.3.3.1; NFPA 80-2010: 4.8.4.1; 5.2.13.3; 6.3.1.7; 6.4.5; 7.2.1.8.2)

12. Doors requiring a fire rating of \( \frac{3}{4} \) of an hour or longer are free of coverings, decorations, or other objects applied to the door face, with the exception of informational signs, which are applied with adhesive only. (For full text, refer to NFPA 80-2010: 4.1.4)

13. Ducts penetrating the walls or floors with a fire resistance rating of less than 3 hours are protected by dampers that are fire rated for 1½ hours; ducts penetrating the walls or floors with a fire resistance rating of 3 hours or greater are protected by dampers that are fire rated for 3 hours. (For full text, refer to NFPA 101-2012: 8.3.5.7; 9.2.1; NFPA 90A-2012: 5.4.1; 5.4.2)

14. The space around pipes, conduits, bus ducts, cables, wires, air ducts, or pneumatic tubes penetrating the walls or floors are protected with an approved fire-rated material.
**Note:** Polyurethane expanding foam is not an accepted fire-rated material for this purpose. *(For full text, refer to NFPA 101-2012: 8.3.5)*


**Standard LS.02.01.20**

The organization maintains the integrity of the means of egress.

**Note:** This standard applies to behavioral health care settings that provide sleeping arrangements as a required part of their care, treatment, or services and that lock doors to prohibit individuals served from leaving the building or space.

**Rationale for LS.02.01.20**

Buildings in which individuals are served must be designed and maintained so individuals can be protected in place or moved to safe places in the building (instead of evacuated to a place outside the building). Organizations should make sure that a sufficient number of exits exist and that they are configured to provide protection from fire. Egress doors should not be locked in a way that restricts passage to safety. Means of egress include corridors, stairways, and doors that allow individuals to leave a building or to move between specific spaces in a building. They allow individuals to escape from fire and smoke and, therefore, are an integral part of a fire protection strategy.

**Note:** The *Life Safety Code* does permit select doors to be locked when there are clinical reasons to restrict the movement of the individual served.

**Elements of Performance for LS.02.01.20**

1. Doors in a means of egress are not equipped with a latch or lock that requires the use of a tool or key from the egress side, unless a compliant locking configuration is used, such as a delayed-egress locking system as defined in NFPA 101-2012: 7.2.1.6.1 or access-controlled egress door assemblies as defined in NFPA 101-2012: 7.2.1.6.2. Elevator lobby exit access door locking is allowed if compliant with 7.2.1.6.3. *(For full text, refer to NFPA 101-2012: 18/19.2.2.2.4; 18/19.2.2.2.5; 18/19.2.2.2.6)*

2. Doors to sleeping rooms for individuals served are not locked unless the clinical needs of individuals served require specialized security or where individuals served pose a security threat and staff can readily unlock doors at all times. *(For full text, refer to NFPA 101-2012: 18/19.2.2.2.2; 18/19.2.2.2.5.1; 18/19.2.2.2.5.2)*

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
5. Walls containing horizontal exits are fire rated for two or more hours, extend from the lowest floor slab to the floor or roof slab above, and extend continuously from exterior wall to exterior wall. (For full text, refer to NFPA 101-2012: 7.2.4.3.1; 18/19.2.2.5)

6. Doors in new buildings that are a part of horizontal exits have approved vision panels, are installed without a center mullion, and swing in the opposite direction of one another. Doors in existing construction are not required to swing with egress travel. (For full text, refer to NFPA 101-2012: 18.2.2.5.6; 18.2.2.5.4; 19.2.2.5.3)

7. When horizontal exit walls in new buildings terminate at outside walls at an angle of less than 180 degrees, the outside walls are fire rated for 1 hour for a distance of 10 or more feet. Openings in the walls in the 10-foot span are fire rated for ¾ of an hour. (For full text, refer to NFPA 101-2012: 7.2.4.3.4)

8. Outside exit stairs are separated from the interior of the building by walls with the same fire rating required for enclosed stairs. The wall extends vertically from the ground to a point 10 feet or more above the top landing of the stairs or roofline (whichever is lower) and extends 10 feet or more horizontally. (For full text, refer to NFPA 101-2012: 18/19.2.2.3; 7.2.2.6.3)

9. Stairs and ramps serving as a required means of egress have handrails and guards on both sides in new buildings and on at least one side in existing buildings. Ramps, exit passageways, fire and slide escapes, alternating tread devices, and areas of refuge are in accordance with NFPA 101-2012: 7.2.5–7.5.12. (For full text, refer to NFPA 101-2012: 18/19.2.2.3; 18/19.2.2.6–18/19.2.2.10; 7.2.2.4; 7.2.5–7.2.12)

10. New stairs serving three or more stories and existing stairs serving five or more stories have signs on each floor landing in the stairwell that identify the story, the stairwell, the top and bottom, and the direction to and story of exit discharge. Floor level information is also presented in tactile lettering. The signs are placed five feet above the floor landing in a position that is easily visible when the door is open or closed. (For full text, refer to NFPA 101-2012: 18/19.2.2.3; 7.2.2.5.4)

11. The capacity of the means of egress is in accordance with NFPA 101-2012: 7.3. (For full text, refer to NFPA 101-2012: 18/19.2.3.1)
12. Exits discharge to the outside at grade level or through an approved exit passageway that is continuous and provides a level walking surface. The exit discharge is a hard-packed, all-weather travel surface that is free from obstructions and terminates at a public way or at an exterior exit discharge. (For full text, refer to NFPA 101-2012: 18/19.2.7; 7.1.7; 7.1.10.1; 7.2.6; 7.7.2)

13. An exit enclosure is not used for any purpose that has the potential to interfere with its use as an exit and, if so designated, as an area of refuge. Open space within the exit enclosure is not used for any purpose that has the potential to interfere with egress. (For full text, refer to NFPA 101-2012: 18/19.2.2.3; 7.1.3.2.3; 7.2.2.5.3.1)

14. Exits, exit accesses, and exit discharges (means of egress) are clear of obstructions or impediments to the public way, such as clutter (for example, equipment, carts, furniture), construction material, and snow and ice. (For full text, refer to NFPA 101-2012: 18/19.2.5.1; 7.1.10.1; 7.5.1.1)

Note 1: Wheeled equipment (such as equipment and carts currently in use, equipment used for lift and transport of individuals served, and medical emergency equipment not in use) that maintains at least five feet of clear and unobstructed corridor width is allowed, provided there is a fire plan and training program addressing its relocation in a fire or similar emergency. (For full text, refer to NFPA 101-2012: 18/19.2.3.4 (4))

Note 2: Where the corridor width is at least eight feet and the smoke compartment is fully protected by an electrically supervised smoke detection system or is in direct supervision of facility staff, furniture that is securely attached is allowed provided it does not reduce the corridor width to less than six feet, is only on one side of the corridor, does not exceed 50 square feet, is in groupings spaced at least 10 feet apart, and does not restrict access to building service and fire protection equipment. (For full text, refer to NFPA 101-2012: 18/19.2.3.4 (5))

15. When stair doors are held open and the sprinkler or fire alarm system activates the release of one door in a stairway, all doors serving that stairway close. (For full text, refer to NFPA 101-2012: 18/19.2.2.2.7; 18/19.2.2.2.8)

16. Each floor of a building has at least two exits that are remote from each other and accessible from every part of the floor. Each smoke compartment has two distinct egress paths to exits that do not require entry into the same adjacent smoke compartment. (For full text, refer to NFPA 101-2012: 18/19.2.4.1–18/19.2.4.4)
17. Every corridor provides access to at least two approved exits in accordance with NFPA 101-2012: 7.4 and 7.5 without passing through any intervening rooms or spaces other than corridors or lobbies. (For full text, refer to NFPA 101-2012: 18/19.2.5.4)

18. In new buildings, exit corridors are at least eight feet wide, unless otherwise permitted by the Life Safety Code. In new psychiatric buildings, exit corridors are at least six feet wide, unless otherwise permitted by the Life Safety Code. (For full text, refer to NFPA 101-2012: 18.2.3.4; 18.2.3.5)

19. In existing buildings, exit corridors are at least 48 inches in clear width where serving as a means of egress from sleeping rooms for individuals served. If modifying existing buildings with exit corridors that exceed eight feet, the exit corridors cannot be reduced to less than eight feet. (For full text, refer to NFPA 101-2012: 4.6.12.2; 19.2.3.4)

22. Exit access doors and exit doors are free of mirrors, hangings, or draperies that might conceal, obscure, or confuse the direction of exit. (For full text, refer to NFPA 101-2012: 18/19.2.1; 18/19.2.5.1; 7.1.10.2; 7.5.2.2.1)

23. Doors to new boiler rooms, new heater rooms, and new mechanical equipment rooms located in a means of egress are not held open by an automatic release device. (For full text, refer to NFPA 101-2012: 18.2.2.2.7)

24. The corridor width is not obstructed by wall projections. (For full text, refer to NFPA 101-2012: 18/19.2.3.3)

Note: When corridors are six feet wide or more, it is allowable for certain objects to project into the corridor, such as hand rub dispensers or computer desks that are retractable. The objects must be no more than 36 inches wide and cannot project more than 6 inches into the corridor. These items must be installed at least 48 inches apart and above the handrail height. (For full text, refer to NFPA 101-2012: 18/19.2.3.4)

25. In new buildings, no dead-end corridor is longer than 30 feet, and the common path of travel does not exceed 100 feet. (For full text, refer to NFPA 101-2012: 18.2.5.2)

Note: Existing dead-end corridors are permitted to be used if it is impractical and unfeasible to alter them. (For full text, refer to NFPA 101-2012: 19.2.5.2)
26. Sleeping rooms for individuals served open directly onto an exit access corridor. Sleeping rooms with less than eight beds may have one intervening room to reach an exit access corridor provided the intervening room is equipped with an approved automatic smoke detection system. (For full text, refer to NFPA 101-2012: 18/19.2.5.6.1–18/19.2.5.6.4)

27. Sleeping rooms for individuals served that are larger than 1,000 square feet have at least two exit access doors remotely located from each other. Rooms not used as sleeping rooms for individuals served that are larger than 2,500 square feet have at least two exit access doors remotely located from each other. (For full text, refer to NFPA 101-2012: 18/19.2.5.5)

28. Suites are separated from the remainder of the building by corridor walls or existing barriers and doors that limit the transfer of smoke. (For full text, refer to NFPA 101-2012: 18/19.2.5.7.1.2; 18/19.3.6)

29. Suites are subdivided by means of noncombustible or limited-combustible partitions or partitions constructed with fire retardant–treated wood enclosed with noncombustible or limited-combustible materials. These partitions are not required to be fire rated. (For full text, refer to NFPA 101-2012: 18/19.2.5.7.1.4)

30. Suites of sleeping rooms for individuals served larger than 1,000 square feet are provided with at least two exit access doors remotely located from each other, with one exiting directly to a corridor. The second exit may go into another suite (provided the two suites are separated with a corridor wall), an exit stair, exit passageway, or exit door to the exterior. (For full text, refer to NFPA 101-2012: 18/19.2.5.7.2.1(B); 18/19.2.5.7.2.2)

31. Suites not used as sleeping rooms for individuals served that are larger than 2,500 square feet have at least two exit access doors remotely located from each other, with one directly exiting to a corridor. The second exit may go into another suite (provided the two suites are separated with a corridor wall), an exit stair, exit passageway, or exit door to the exterior. (For full text, refer to NFPA 101-2012: 18/19.2.5.7.3.2; 18/19.2.5.7.3.1(B))

32. For existing buildings, suites of sleeping rooms for individuals served are limited to 5,000 square feet or less. If the existing building has an approved electrically supervised sprinkler system and total coverage automatic smoke detection system, the suite is permitted to be increased to 7,500 square feet. (For full text, refer to...
NFPA 101-2012: 9.6.2.9; 19.3.4; 19.3.5.7; 19.3.5.8.) If the suite is provided with direct visual supervision, an approved electrically supervised sprinkler system, and a total coverage (complete) smoke detection system, the suite is permitted to be increased to 10,000 square feet. (For full text, refer to NFPA 101-2012: 9.6.2.9; 19.2.5.7.2.1(D)(1)(a); 19.2.5.7.2.3; 19.3.4; 19.3.5.8)

33. For new buildings, sleeping suites for individuals served are allowed to be 7,500 square feet. If the suite has total coverage smoke detection and direct visual supervision, the suite can be up to 10,000 square feet. (For full text, refer to NFPA 101-2012: 18.2.5.7.2.3; 18.2.5.7.2.1(D)(1)(a); 18.3.4)

34. Care suites for individuals served not used for sleeping are limited to 10,000 square feet. (For full text, refer to NFPA 101-2012: 18/19.2.5.7.3.3)

35. For new buildings, sleeping and non-sleeping care suites for individuals served have a travel distance to an exit access door of 100 feet or less from any point in the suite. The travel distance between any point in the suite and an exit is 200 feet. (For full text, refer to NFPA 101-2012: 18.2.5.7.2.4; 18.2.5.7.3.4)

36. For existing buildings, sleeping and non-sleeping care suites for individuals served have a travel distance to an exit access door of 100 feet or less from any point in the suite. The travel distance between any point in the suite and an exit is either 150 feet if the building is not protected throughout by an approved electrically supervised sprinkler system or 200 feet if the building is fully protected by an approved electrically supervised sprinkler system. (For full text, refer to NFPA 101-2012: 19.2.5.7.2.4; 19.2.5.7.3.4)

38. Means of egress are adequately illuminated at all points, including angles and intersections of corridors and passageways, stairways, stairway landings, exit doors, and exit discharges. (For full text, refer to NFPA 101-2012: 18/19.2.8; 7.8.1.1)

39. Illumination in the means of egress, including exit discharges, is arranged so that failure of any single light fixture or bulb will not leave the area in darkness (less than 0.2 foot candles). Emergency lighting of at least 1½-hours duration is provided automatically in accordance with NFPA 101-2012: 7.9. (See also EC.02.05.07, EP 2) (For full text, refer to NFPA 101-2012: 18/19.2.8; 18/19.2.9.1; 7.8.1.4; 7.9.2)
40. Exit signs are visible when the path to the exit is not readily apparent. Signs are adequately lit and have letters that are four or more inches high (or six inches high if externally lit). Exit and directional signs displayed with continuous illumination are also served by the emergency lighting system unless the building is one story with less than 30 occupants, and the line of exit travel is obvious. (For full text, refer to NFPA 101-2012: 18/19.2.10; 7.10.1.4; 7.10.1.5.1; 7.10.5; 7.10.6; 7.10.7)

41. Signs reading “NO EXIT” are posted on any door, passage, or stairway that is neither an exit nor an access to an exit but may be mistaken for an exit. (For full text, refer to NFPA 101-2012: 18/19.2.10.1; 7.10.8.3)


**Standard LS.02.01.30**

The organization provides and maintains building features to protect individuals from the hazards of fire and smoke.

**Note:** This standard applies to behavioral health care settings that provide sleeping arrangements as a required part of their care, treatment, or services and that lock doors to prohibit individuals served from leaving the building or space.

**Rationale for LS.02.01.30**

Fire and smoke are special concerns in health care organizations because of the inability of some individuals served to evacuate without assistance from staff. If not properly protected, the building can put individuals served at risk because smoke and fire can travel through openings in a building. To facilitate safe evacuation, the effects of fire and smoke can be contained when sections of a building are separated into multiple compartments. In addition, interior finishes need to be controlled to minimize smoke and toxic gases. Openings are necessary and include such features as heating, ventilating, and air conditioning (HVAC) systems, elevator shafts, and trash and laundry chutes. Organizations should design and maintain these openings to contain fire to a compartment or floor.
Elements of Performance for LS.02.01.30

1. In new construction, vertical openings, including exit stairs, are enclosed by one-hour fire-rated walls when connecting three or fewer floors and two-hour fire-rated walls when connecting four or more floors. Existing vertical openings, including exit stairs, are enclosed with a minimum of one-hour fire-rated construction.

   **Note:** These vertical openings include, but are not limited to, shafts (including elevator, light and ventilation), communicating stairs, ramps, trash chutes, linen chutes, and utility chases. (For full text, refer to NFPA 101-2012: 8.6; 18/19.3.1; 7.1.3.2.1)

2. All new hazardous areas have doors that are self-closing or automatic-closing, except for laboratories using flammable or combustible materials deemed less than a severe hazard and storage rooms greater than 50 square feet, but less than 100 square feet that are used for storage of combustible material. Hazardous areas have a fire barrier with a one-hour fire-resistive rating. These areas include, but are not limited to, boiler and fuel-fired heater rooms, central/bulk laundries larger than 100 square feet, paint shops, repair shops, soiled linen rooms, trash collection rooms with containers exceeding 64 gallons, laboratories considered a severe hazard, and storage rooms larger than 100 square feet that contain combustible material. (For full text, refer to NFPA 101-2012: 18.3.2.1; 18.3.2.2; 18.3.2.3; 18.3.2.4; Table 18.3.2.1)

3. All existing hazardous areas have doors that are self-closing or automatic-closing. These areas are protected by either a fire barrier with one-hour fire-resistive rating or an approved electrically supervised automatic sprinkler system. Hazardous areas include, but are not limited to, boiler and fuel-fired heater rooms, central/bulk laundries larger than 100 square feet, paint shops, repair shops, soiled linen rooms, trash collection rooms with containers exceeding 64 gallons, laboratories employing flammable or combustible materials deemed less than a severe hazard, and storage rooms greater than 50 square feet used for storage of equipment and combustible supplies. (For full text, refer to NFPA 101-2012: 19.3.2.1; 19.3.2.2; 19.3.2.3; 19.3.2.4)

5. Where residential or commercial cooking equipment is used to prepare meals for less than 31 people in a smoke compartment, one cooking facility is allowed to be open to the corridor provided all of the requirements at NFPA 101-2012: 18/19.3.2.5 are met.
6. Alcohol-based hand rubs (ABHR) are stored and handled in accordance with NFPA 101-2012: 8.7.3.1, unless all of the following conditions are met:

- Corridor is at least six feet wide
- ABHR does not exceed 95% alcohol
- Maximum individual dispenser capacity is 0.32 gallon of fluid (0.53 gallon in suites) or 18 ounces of NFPA Level 1–classified aerosols
- Dispensers have a minimum of four feet of horizontal spacing between them
- Dispensers are not installed within one inch of an ignition source
- If floor is carpeted, the building is fully sprinkler protected
- Operation of the dispenser complies with NFPA 101-2012: 18/19.3.2.6(11)
- ABHR is protected against inappropriate access
- Not more than an aggregate of 10 gallons of fluid or 135 ounces of aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room
- Storing more than five gallons of fluid in a single smoke compartment complies with NFPA 30

7. Existing wall and ceiling interior finishes are rated Class A or B for limiting smoke development and the spread of flames. Newly installed wall and ceiling interior finishes are rated Class A. (For full text, refer to NFPA 101-2012: 18/19.3.3; 10.2)

8. Newly installed interior floor finishes in corridors of smoke compartments with an approved automatic sprinkler system is at least Class II. Existing floor finishes are not restricted. (For full text, refer to NFPA 101-2012: 18/19.3.3; 10.2.7)

9. Corridors must be separated from all other areas by approved partitions, unless the space is permitted to be open in accordance with NFPA 101-2012: 18/19.3.6.1.

10. In existing buildings, corridor wall partitions are fire resistance rated for ½ hour, continuous from the floor slab to the floor or roof slab above, extended through any concealed spaces (such as those above suspended ceilings and interstitial spaces), properly sealed, and constructed to limit the transfer of smoke. (For full text, refer to NFPA 101-2012: 19.3.6.2)

11. Within corridors in smoke compartments that are protected throughout with an approved supervised sprinkler system, partitions are allowed to terminate at the ceiling if the ceiling is constructed to limit the passage of smoke. The passage of smoke can be limited by an exposed, suspended-grid acoustical tile ceiling with
penetrating items such as sprinkler piping and sprinklers that penetrate the ceiling, ducted heating, ventilating, and air-conditioning (HVAC) supply and return-air diffusers, speakers, and recessed lighting fixtures. (For full text, refer to NFPA 101-2012: 18/19.3.6.2)

12. In new buildings, all corridor doors are constructed to resist the passage of smoke, hinged so that they swing, and doors do not have ventilating louvers or transfer grills (with the exception of bathrooms, toilets, and sink closets that do not contain flammable or combustible materials). Undercuts are no larger than one inch. **Positive latching hardware is required.** Roller latches are prohibited. (For full text, refer to NFPA 101-2012: 18.3.6.3.1; 18.3.6.3.5; 18.3.6.4; 18.3.6.5; 18.3.6.3.10; 18.3.6.3.11)

13. In existing buildings, all corridor doors are constructed of 1¾-inch or thicker solid bonded wood core or constructed to resist fire for not less than 20 minutes, and the doors do not have ventilating louvers or transfer grills (with the exception of bathrooms, toilets, and sink closets that do not contain flammable or combustible materials). **Positive latching hardware is required.** Roller latches are prohibited.

**Note:** For existing doors, it is acceptable to use a device that keeps the door closed when a force of five pounds is applied to the edge of the door. (For full text, refer to NFPA 101-2012: 19.3.6.3.1; 19.3.6.3.2; 19.3.6.3.5; 19.3.6.3.6)

14. In smoke compartments without sprinkler systems, fixed fire windows in corridor walls are 25% or less of the size of the corridor walls in which they are installed. Existing window installations that conform to previously accepted Life Safety Code criteria (such as a size of 1,296 square inches or less, made with wired glass or fire-rated glazing, and set in approved metal frames) are permitted. (For full text, refer to NFPA 101-2012: 19.3.6.2.7; 8.3.3.8; 8.3.3.9; 8.3.3.11)

15. Openings in vision panels or doors in corridor walls (other than in smoke compartments containing sleeping rooms for individuals served) are installed at or below one half the distance from the floor to the ceiling. These openings may not be larger than 80 square inches in new buildings or larger than 20 square inches in existing buildings.

**Note:** Openings may include, but are not limited to, mail slots and pass-through windows in areas such as laboratories, pharmacies, and cashier stations. (For full text, refer to NFPA 101-2012: 18/19.3.6.5)
16. Corridors serving adjoining areas are not used for a portion of an air supply, air return, or exhaust air plenum.

Note: Incidental air movement between rooms and corridors (such as isolation rooms) because of the need for pressure differentials in organizations is permitted. In such cases, the direction of airflow is not the focus for this element of performance. For the purpose of fire protection, air transfer should be limited to the amount necessary to maintain positive or negative pressure differentials. (For full text, refer to NFPA 101-2012: 19.5.2.1; NFPA 90A-2012: 4.3.12.1; 4.3.12.1.3.2)

17. In new buildings, at least two smoke compartments are provided for every story with sleeping or treatment rooms for individuals served and for those stories that have an occupant capacity of 50 or more people, regardless of use. Smoke barriers have a minimum one-hour fire resistance rating; the maximum size of each smoke compartment is limited to 22,500 square feet. Space shall be provided on each side of smoke barriers to adequately accommodate the total number of occupants in adjoining compartments. The travel distance from any point within the compartment to a smoke barrier door is no more than 200 feet. (For full text, refer to NFPA 101-2012: 18.3.7.1; 18.3.7.3; 18.3.7.5)

18. In existing buildings, at least two smoke compartments are provided for every story that has more than 30 individuals served in sleeping rooms. Smoke barriers have a minimum ½-hour fire resistance rating; the maximum size of each smoke compartment is limited to 22,500 square feet. Space shall be provided on each side of smoke barriers to adequately accommodate the total number of occupants in adjoining compartments. The travel distance from any point within the smoke compartment to a smoke barrier door is no more than 200 feet. (For full text, refer to NFPA 101-2012: 19.3.7.1; 19.3.7.3; 19.3.7.5)

19. Smoke barriers extend from the floor slab to the floor or roof slab above, through any concealed spaces (such as those above suspended ceilings and interstitial spaces), and extend continuously from exterior wall to exterior wall. All penetrations are properly sealed. (For full text, refer to NFPA 101-2012: 18/19.3.7.3; 8.2.3; 8.5.2; 8.5.6; 8.7)

Note: Polyurethane expanding foam is not an accepted fire-rated material for this purpose.
20. Doors in smoke barriers are self-closing or automatic-closing, constructed of 1¾-inch or thicker solid bonded wood core or constructed to resist fire for not less than 20 minutes, and fitted to resist the passage of smoke. The gap between meeting edges of door pairs is no wider than ⅛ of an inch. In new buildings, undercuts are no larger than ¾ of an inch, and doors in a means of egress swing in the opposite direction. (For full text, refer to NFPA 101-2012: 18.3.7.6; 18/19.3.7.8; 8.5.4.1; NFPA 80-2010: 4.8.4.1; 6.3.1.7.1)

21. In smoke compartments without sprinkler systems, fixed fire windows in corridor walls are 25% or less of the size of the corridor walls in which they are installed. Existing window installations that conform to previously accepted Life Safety Code criteria (such as 1,296 square inches or less, wired glass or fire-rated glazing, and are set in approved metal frames) are permitted. (For full text, refer to NFPA 101-2012: 19.3.7.6; 8.3.3; 8.5.4.5)

22. In new buildings, the smoke damper is not required in the duct passing through a smoke barrier. In existing buildings, ducts that penetrate smoke barriers are protected by approved smoke dampers that close when a smoke detector is activated. The detector is located either within the duct system or in the area serving the smoke compartment. In existing buildings protected by an approved automatic sprinkler system, the damper is not required in the duct. (For full text, refer to NFPA 101-2012: 18/19.3.7.3; 8.3.5.1; 8.5.5; 8.5.5.7)

23. Approved smoke dampers protect air transfer openings extending through smoke barriers in ceiling spaces that are used as an unducted common plenum for either supply or return air. (For full text, refer to NFPA 101-2012: 18/19.3.7.3; 8.5.5.2)


**Standard LS.02.01.34**

The organization provides and maintains fire alarm systems.

**Note:** This standard applies to behavioral health care settings that provide sleeping arrangements as a required part of their care, treatment, or services and that lock doors to prohibit individuals served from leaving the building or space.
Elements of Performance for LS.02.01.34

1. A fire alarm system is installed with systems and components to provide effective warning of fire in any part of the building in accordance with NFPA 70-2012, National Electric Code and NFPA 72-2010, National Fire Alarm Code.

2. The master fire alarm control panel is located in an area with a smoke detector or in an area that is continuously occupied and protected, which is an area enclosed with one-hour fire-rated walls and ¾-hour fire-rated doors. In areas not continuously occupied and protected, a smoke detector is installed at each fire alarm control unit. In a newly designated occupancy, detection is also installed at notification appliance circuit power extenders and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. (For full text, refer to NFPA 101-2012: 18/19.3.4.1; 9.6)

3. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas are not required at exits if manual alarm boxes are located at all nurse’s stations or other continuously attended staff location, provided alarm boxes are visible, continuously accessible, and 200 feet of travel distance is not exceeded. (For full text, refer to NFPA 101-2012: 18/19.3.4.2.1; 18/19.3.4.2.2; 9.6.2.5)

4. In new buildings, occupant notification is provided automatically in accordance with NFPA 101-2012: 9.6.3 by audible and visual signals. Positive alarm sequence in accordance with 9.6.3.4 is permitted in buildings protected throughout by a sprinkler system. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of a fire. Annunciation zoning for the fire alarm and sprinklers is provided by audible and visual indicators; zones are not larger than 22,500 square feet per zone. (For full text, refer to NFPA 101-2012: 18.3.4.3–18.3.4.4.3; 9.6.4)

5. In existing buildings, occupant notification is provided automatically in accordance with NFPA 101-2012: 9.6.3 by audible and visual signals. Positive alarm sequence in accordance with 9.6.3.4 is permitted in buildings protected throughout by a sprinkler system. In critical care areas, visual alarms are
The fire alarm system monitors approved automatic sprinkler system components. (For full text, refer to NFPA 101-2012: 18.3.5.1; 19.3.5.3; 9.7.2.1)

2. The fire alarm system is connected to water flow alarms. (For full text, refer to NFPA 101-2012: 18.3.5.1; 19.3.5.3; 9.7.2)

3. Piping supports for approved automatic sprinkler systems are not damaged or loose. (For full text, refer to NFPA 101-2012: 18.3.5.1; 19.3.5.3; NFPA 25-2011: 5.2.3.1; 5.2.3.2)

4. Piping for approved automatic sprinkler systems is not used to support any other item. (For full text, refer to NFPA 25-2011: 5.2.2.2)
5. Sprinkler heads are not damaged. They are also free from corrosion, foreign materials, and paint and have necessary escutcheon plates installed. (For full text, refer to NFPA 101-2012: 18.3.5.1; 19.3.5.3; 9.7.5; NFPA 25-2011: 5.2.1.1.1; 5.2.1.1.2; NFPA 13-2010: 6.2.6.2.2; 6.2.7.1)

6. There are 18 inches or more of open space maintained below the sprinkler deflector to the top of storage.

   **Note:** Perimeter wall and stack shelving may extend up to the ceiling when not located directly below a sprinkler head. (For full text, refer to NFPA 101-2012: 18.3.5.1; 19.3.5.3; 9.7.1.1; NFPA 13-2010: 8.5.5.2; 8.5.5.2.1; 8.5.5.3)

7. At least six spare sprinkler heads, with associated wrenches, are kept in a cabinet that will not exceed 100°F. (For full text, refer to NFPA 101-2012: 18.3.5.1; 19.3.5.3; 9.7.1.1; NFPA 25-2011: 5.4.1.4; 5.4.1.6; NFPA 13-2010: 6.2.9; 6.2.9.1; 6.2.9.3; 6.2.9.6)

8. In both new buildings and existing buildings, the clothing closets in sleeping rooms for individuals served are not required to have sprinkler protection if the closet does not exceed six square feet. (For full text, refer to NFPA 101-2012: 18/19.3.5.10)

9. In new buildings, quick response sprinklers are installed in smoke compartments with sleeping rooms for individuals served. (For full text, refer to NFPA 101-2012: 18.3.5.6)

10. The travel distance from any point to the nearest portable fire extinguisher is 75 feet or less. Portable fire extinguishers have appropriate signage, are installed either in a cabinet or secured on a hanger made for the extinguisher, and are at least four inches off the floor. Those fire extinguishers that are 40 pounds or less are installed so the top is not more than 5 feet above the floor. (For full text, refer to NFPA 101-2012: 18/19.3.5.12; 9.7.4.1; NFPA 10-2010: 6.2.1.1; 6.1.3.3.1; 6.1.3.4; 6.1.3.8)

11. Class K–type portable fire extinguishers are located within 30 feet of grease-producing ranges, griddles, broilers, or cooking appliances that use vegetable or animal oils or fats, such as deep fat fryers. A placard is conspicuously placed near the extinguisher stating that the fire protection system should be activated prior to using the fire extinguisher. (For full text, refer to NFPA 101-2012: 18/19.3.2.5.1; NFPA 96-2011: 10.10.2; NFPA 10-2010: 5.5.5; 6.6.2)
12. Grease-producing cooking devices such as deep fat fryers, ranges, griddles, or broilers have an exhaust hood, an exhaust duct system, and grease removal devices without mesh filters. (For full text, refer to NFPA 101-2012: 18/19.3.2.5.1; NFPA 96-2011: 6.1)

13. The automatic fire extinguishing system for grease-producing cooking devices does the following: deactivates the fuel source, activates the building fire alarm system, and controls the exhaust fans as designed. (For full text, refer to NFPA 101-2012: 18/19.3.2.5.1; NFPA 96-2011: 10.4; 10.6.1; 10.6.2; 8.2.3)


**Standard LS.02.01.40**

The organization provides and maintains special features to protect individuals from the hazards of fire and smoke.

**Note:** This standard applies to behavioral health care settings that provide sleeping arrangements as a required part of their care, treatment, or services and that lock doors to prohibit individuals served from leaving the building or space.

**Elements of Performance for LS.02.01.40**

1. High-rise buildings have an approved automatic sprinkler system that meets the requirements of NFPA 101-2012: 18/19.4.2. (For full text, refer to NFPA 101-2012: 11.8)

   **Note:** Organizations that do not have approved automatic sprinkler systems in high-rise buildings (over 75 feet tall) as of July 5, 2016, have 12 years to install them.


**Standard LS.02.01.50**

The organization provides and maintains building services to protect individuals from the hazards of fire and smoke.

**Note:** This standard applies to behavioral health care settings that provide sleeping arrangements as a required part of their care, treatment, or services and that lock doors to prohibit individuals served from leaving the building or space.
Elements of Performance for LS.02.01.50

5. **Direct-vent fireplaces** in sleeping areas for individuals served must meet the provisions of NFPA 101-2012: 18/19.5.2.2; 18/19.5.2.3.

7. **Elevators** are equipped with the following:
   - Firefighters’ service key recall
   - Smoke detector automatic recall
   - Firefighters’ service emergency in-car key operation
   - Machine room smoke detectors
   - Elevator lobby smoke detectors

Existing elevators that have a travel distance of 25 feet or more above or below the level that best serves the needs of firefighters also meet these requirements. (For full text, refer to NFPA 101-2012: 18/19.5.3; 9.4.2; 9.4.3)

9. In new buildings, the inlet door assemblies for linen- and waste-chute services are fire rated for one hour (or for 1½ hours in chutes of four stories or more). In existing buildings, the inlet door assemblies for linen- and waste-chute services are fire rated for ¾ of an hour (or for one hour if it opens into a corridor). (For full text, refer to NFPA 101-2012: 18/19.5.4; 8.3.3.1; 9.5; NFPA 82-2009: 5.2.3.1.3)

10. All linen and waste chute inlet and discharge service doors have both self-closing and positive-latching devices.

   **Note:** Discharge doors may be held open with fusible links or electrical hold-open devices. (For full text, refer to NFPA 101-2012: 18/19.5.4; 8.3.3.1; 9.5; NFPA 82-2009: 5.2.3.2.3)

11. Linen- and waste-chute discharge door assemblies are fire rated the same as the chute. (For full text, refer to NFPA 101-2012: 18/19.5.4; 9.5; NFPA 82-2009: 5.2.4; 5.2.3.2)

12. In buildings more than two stories high, an approved automatic sprinkler system is located above the top of the linen and waste chute service openings on the lowest service levels and above the service door opening on alternate floor levels. (For full text, refer to NFPA 101-2012: 18/19.5.4.3; 9.7; NFPA 82-2009: 5.2.6)

13. Trash chutes discharge into collection rooms that are not used for any other purpose and are separated from the corridor and have a minimum fire resistance rating not less than that specified for the chute. In existing buildings, if the trash
collection room is protected with an approved automatic sprinkler system, linen collection may also occur. (For full text, refer to NFPA 101-2012: 18/19.5.4.4; 19.5.4.5; NFPA 82-2009: 5.2.4.1)


**Standard LS.02.01.70**

The organization provides and maintains operating features that conform to fire and smoke prevention requirements.

*Note: This standard applies to behavioral health care settings that provide sleeping arrangements as a required part of their care, treatment, or services and that lock doors to prohibit individuals served from leaving the building or space.*

**Elements of Performance for LS.02.01.70**

1. Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored; these areas have signs that read “NO SMOKING” or display the international symbol for no smoking. In facilities where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs that prohibit smoking in hazardous areas are not required. (For full text, refer to NFPA 101-2012: 18/19.7.4)

*Note: The secondary sign exception is not applicable to medical gas storage areas.*

2. In areas where smoking is permitted, ashtrays are safely designed and made of noncombustible material. Metal containers with self-closing cover devices in which ashtrays can be emptied are readily available to all areas where smoking is permitted. (For full text, refer to NFPA 101-2012: 18/19.7.4)

5. Decorations (for example, photos, paintings, other art) directly attached to the walls, ceiling, and non-fire-rated doors are permitted provided they do not exceed 20% of the wall, ceiling, or door areas in spaces in nonsprinklered smoke compartments; 30% in spaces in sprinklered smoke compartments; 50% inside patient sleeping rooms that do not exceed four people in sprinklered smoke compartments. (For full text, refer to NFPA 101-2012: 18/19.7.5.6)

6. Soiled linen and trash receptacles larger than 32 gallons are stored in a room protected as a hazardous area. (For full text, refer to NFPA 101-2012: 18/19.7.5.7)
Note: Containers that are 96 gallons or less and are labeled and listed as meeting the requirements of FM Approval Standard 6921 (or equivalent) and are used solely for recycling clean waste (including records of individuals served awaiting destruction) are permitted in an unprotected area. Those containers that are greater than 96 gallons are stored in a hazardous storage area.

8. Portable space heaters are prohibited in smoke compartments containing sleeping rooms and treatment areas for individuals served. Non-sleeping rooms that are occupied by staff and separated from the corridor are permitted to have portable space heaters, but must contain heating elements not exceeding 212°F. (For full text, refer to NFPA 101-2012: 18/19.7.8)

Note: For this element of performance, nurses stations are considered patient treatment areas.


Standard LS.04.01.20

The organization maintains the integrity of the means of escape.

Note 1: This standard applies to behavioral health care settings that provide sleeping arrangements for 4 to 16 individuals served as a required part of their care, treatment, or services.

Note 2: If the organization locks doors so that individuals served are prohibited from leaving the building or space, then Standards LS.02.01.10 through LS.02.01.70 apply.

Note 3: See Standard EC.02.03.03 for fire drill requirements.

Rationale for LS.04.01.20

Means of egress include any corridors, stairways, and doors that allow individuals to leave a building or to move between specific spaces in a building. They allow individuals to escape from fire and smoke, and therefore, are an integral part of any fire protection strategy. The organization should make sure that a sufficient number of exits exist and that they are configured to provide safe passage from fire. It is important that egress doors are not locked in a way that restricts passage to safety.

Elements of Performance for LS.04.01.20

1. Sleeping rooms above or below the level of an exit discharge have one of the following as the primary means of escape:
- An interior stairway
- Exterior stairway
- Horizontal exit
- Existing fire escape stairway

(For full text and any exceptions, refer to NFPA 101-2000: 26.2.1.1)

2. Sleeping rooms have a primary and secondary means of escape. (For full text and any exceptions, refer to NFPA 101-2000: 26.2.1.2)

3. Every story that has more than 2,000 square feet has a separate primary means of escape, or the travel distance to the primary means of escape is less than 75 feet. (For full text and any exceptions, refer to NFPA 101-2000: 26.2.1.3)

4. Doors and paths of travel to a means of escape are at least 28 inches wide. (For full text and any exceptions, refer to NFPA 101-2000: 26.2.3)

5. Closet doors are capable of being opened from the inside, and bathroom doors are capable of being opened from the outside. (For full text and any exceptions, refer to NFPA 101-2000: 26.2.4 and 26.2.5)

6. Interior stairways are enclosed with ½-hour fire-rated walls, and stairway doors are positive latching and are self-closing or automatic-closing upon detection of smoke. (For full text and any exceptions, refer to NFPA 101-2000: 26.2.2 and NFPA 80-1999: 2-4.4.3)

7. Nothing is stored in interior stairways. (For full text and any exceptions, refer to NFPA 101-2000: 7.2.2.5.3)

8. Exit doors are unlocked in the direction of egress when the building is occupied. (For full text and any exceptions, refer to NFPA 101-2000: 26.2.7)


**Standard LS.04.01.30**

The organization maintains and protects vertical openings, fire alarm systems, and separation of sleeping rooms.

**Note 1:** This standard applies to behavioral health care settings that provide sleeping arrangements for 4 to 16 individuals served as a required part of their care, treatment, or services.
**Note 2:** If the organization locks doors so that individuals served are prohibited from leaving the building or space, then Standards LS.02.01.10 through LS.02.01.70 apply.

**Rationale for LS.04.01.30**

Openings, such as doors and stairways, must be able to protect the safety of the occupants in an emergency situation. The fire alarm system is also an important safety feature: immediate notification allows occupants an opportunity to access vertical openings and leave the building in safety.

**Elements of Performance for LS.04.01.30**

1. Vertical openings in the primary means of escape are protected by fire-rated construction of $\frac{1}{2}$ hour and limit the transfer of smoke. (For full text and any exceptions, refer to NFPA 101-2000: 26.3.1.1)
This page is blank due to revisions through the CAMBHC update.
2. Existing wall and ceiling interior finishes are rated Class A, B, or C for preventing smoke and the spread of flames. (For full text and any exceptions, refer to NFPA 101-2000: 26.3.2.2)

3. The building is equipped with a manual fire alarm system. (For full text and any exceptions, refer to NFPA 101-2000: 26.3.3.1)

4. The building has an audible alarm that notifies individuals of fire without delay. (For full text and any exceptions, refer to NFPA 101-2000: 26.3.3.3 and 9.6.3)

5. Sleeping rooms have approved, single-station smoke alarms powered by the building’s electrical service.

   **Note:** Existing buildings may have battery-powered smoke detectors as long as a written policy exists with procedures defining testing, maintenance, and battery replacement. These activities are documented. (For full text and any exceptions, refer to NFPA 101-2000: 26.3.3.5 and 9.6.2.10)

6. Sleeping rooms are separated from escape route corridors by walls and doors that are smoke resistant and do not have louvers, transoms, or transfer grills. (For full text and any exceptions, refer to NFPA 101-2000: 26.3.4)

7. Sleeping rooms without sprinklers have doors that are self-closing or automatically close when smoke is detected, have latching that keeps the door closed, and are not obstructed in any way that would prevent the door from closing. (For full text and any exceptions, refer to NFPA 101-2000: 26.3.4)


**Standard LS.04.01.50**

The organization provides and maintains building services to protect individuals from the hazards of fire and smoke.

**Note 1:** This standard applies to behavioral health care settings that provide sleeping arrangements for 4 to 16 individuals served as a required part of their care, treatment, or services.

**Note 2:** If the organization locks doors so that individuals served are prohibited from leaving the building or space, then Standards LS.02.01.10 through LS.02.01.70 apply.
Elements of Performance for LS.04.01.50

1. All fuel-fired heaters are fully vented to the outside when used. (For full text and any exceptions, refer to NFPA 101-2000: 26.5.2.2)


Standard LS.04.02.20

The organization maintains the integrity of the means of egress.

Note 1: This standard applies to behavioral health care settings that provide sleeping arrangements for 17 or more individuals served as a required part of their care, treatment, or services.

Note 2: If the organization locks doors so that individuals served are prohibited from leaving the building or space, then Standards LS.02.01.10 through LS.02.01.70 apply.

Rationale for LS.04.02.20

Means of egress include any corridors, stairways, and doors that allow individuals to leave a building or to move between specific spaces in a building. They allow individuals to escape from fire and smoke, and therefore, are an integral part of any fire protection strategy. The organization should make sure that a sufficient number of exits exist and that they are configured to provide protection from fire. Egress doors must not be locked in a way that restricts passage to safety.

Elements of Performance for LS.04.02.20

1. Interior exit stairways are enclosed with 1-hour fire-rated walls if the building is protected with an approved automatic sprinkler system or if stairs connect no more than three floors. If the stairs connect four or more floors, then a 2-hour fire-rated enclosure is required. (For full text and any exceptions, refer to NFPA 101-2000: 28/29.2.2.1.2 and 7.1.3.2.1)

2. Each floor contains at least two exits. (For full text and any exceptions, refer to NFPA 101-2000: 28/29.2.4)

3. Exits are not locked, blocked, or compromised. (For full text and any exceptions, refer to NFPA 101-2000: 28/29.2.2.2.2 and 7.1.10.1)

4. Exit doors are at least 28 inches wide (32 inches wide in new buildings) and are always unlocked in the direction of egress when the building is occupied. (For full text and any exceptions, refer to NFPA 101-2000: 7.2.1.2.3)
5. Exits are arranged so that common paths of travel are no longer than 35 feet (or no longer than 50 feet when there is an approved automatic sprinkler system). Dead-end corridors are no longer than 50 feet (or no longer than 35 feet in new buildings). (For full text and any exceptions, refer to NFPA 101-2000: 28/29.2.5.2 and 2.5.3)

6. In new buildings, all rooms or suites of rooms larger than 2,000 square feet have two or more exit access doors that are remote from each other. (For full text and any exceptions, refer to NFPA 101-2000: 28.2.5.4)

7. The travel distance from any sleeping room door to the nearest exit is 100 feet or less (200 feet or less when there is an approved automatic sprinkler system); travel distance within a sleeping room or suite to a corridor door is 75 feet or less (125 feet or less when there is an approved automatic sprinkler system). (For full text and any exceptions, refer to NFPA 101-2000: 28/29.2.6.2 and 28/29.2.6.1)

8. The travel distance from the end of the exit enclosure to an exterior door leading to a public way does not exceed 100 feet. The travel distance leading to a public way in buildings with sprinklers does not exceed 150 feet. (For full text and any exceptions, refer to NFPA 101-2000: 28/29.2.7.3)

9. All means of egress are continuously illuminated along paths of travel. (For full text and any exceptions, refer to NFPA 101-2000: 28/29.2.8)

10. All buildings with more than 25 sleeping rooms have an automatic source of emergency lighting capable of generating one foot-candle for a period of 1½-hours throughout the means of egress. (For full text and any exceptions, refer to NFPA 101-2000: 28/29.2.9)

11. The means of egress is marked with exit signs that are illuminated by a reliable source and have letters 4 or more inches high (or 6 inches high in new buildings and when externally lit). (For full text and any exceptions, refer to NFPA 101-2000: 28/29.2.10, 7.10.5.1, 7.10.6.1, and 7.10.7.1)

12. When signs are required in new buildings, they are visible for 100 feet and are internally illuminated. (For full text and any exceptions, refer to NFPA 101-2000: 28/29.2.10 and 7.10.1.4)

Standard **LS.04.02.30**
The organization provides and maintains building features to protect individuals from the hazards of fire and smoke.

**Note 1:** This standard applies to behavioral health care settings that provide sleeping arrangements for 17 or more individuals served as a required part of their care, treatment, or services.

**Note 2:** If the organization locks doors so that individuals served are prohibited from leaving the building or space, then Standards LS.02.01.10 through LS.02.01.70 apply.

**Rationale for LS.04.02.30**
Fire and smoke are concerns in organizations because some clients are unable to evacuate without the help of staff. The effects of fire and smoke can be contained when sections of a building are separated into multiple compartments and when interior finishes are controlled. Remember that smoke and fire can travel through vertical openings in a building. Necessary openings may include heating, ventilating, and air conditioning (HVAC) systems, elevator shafts, and trash and laundry chutes. The organization should design and maintain these openings to contain smoke and fire to a single floor.

**Elements of Performance for LS.04.02.30**

1. In existing buildings, all non-exit stairways, elevator shafts, and other vertical openings are enclosed with ½-hour fire-rated construction. New stairs that connect no more than three floors are fire-rated for 1 hour; for new stairs connecting four or more floors the fire rating is 2 hours. (For full text and any exceptions, refer to NFPA 101-2000: 28/29.3.1.1 and 8.2.5.4)

2. Floors below the level of exit discharge that are used for storage, heating equipment, or purposes other than residential occupancies do not have unprotected openings to floors used for residential purposes. (For full text and any exceptions, refer to NFPA 101-2000: 28/29.3.1.2)

3. Hazardous areas are protected by walls and doors in accordance with NFPA 101-2000, 28/29.3.2. (For full text and any exceptions, refer to NFPA 101-2000: 28/29.3.2.2)

**Note:** Use the following information to assess protection of hazardous areas and to identify any deficient areas:
Boiler/fuel-fired heater rooms
- Existing boiler/fuel-fired heater rooms have approved automatic sprinkler systems, or have 1-hour fire-rated walls with ¾-hour fire-rated doors.
- New boiler/fuel-fired heater rooms have approved automatic sprinkler systems and have 1-hour fire-rated walls with ¾-hour fire-rated doors.

Central/bulk laundries larger than 100 square feet
- Existing laundries have approved automatic sprinkler systems, or have 1-hour fire-rated walls with ¾-hour fire-rated doors. If the laundry has a sprinkler system, no enclosure is required.
- New laundry rooms have approved automatic sprinkler systems and have 1-hour fire-rated walls with ¾-hour fire-rated doors.

Employee locker rooms have approved automatic sprinkler systems, or have 1-hour fire-rated walls with ¾-hour fire-rated doors.

Gift or retail shops
- Existing shops larger than 100 square feet have approved automatic sprinkler systems, or have 1-hour fire-rated walls with ¾-hour fire-rated doors. If the shop has a sprinkler system, no enclosure is required.
- New shops have approved automatic sprinkler systems, or have 1-hour fire-rated walls with ¾-hour fire-rated doors.

Guest laundries
- Existing guest laundries larger than 100 square feet have approved automatic sprinkler systems, or have 1-hour fire-rated walls with ¾-hour fire-rated doors. If the guest laundry has a sprinkler system, no enclosure is required.
- New guest laundries 100 square feet or smaller have approved automatic sprinkler systems, or have 1-hour fire-rated walls with ¾-hour fire-rated doors. If the guest laundry has a sprinkler system, no enclosure is required.
- New guest laundries larger than 100 square feet have approved automatic sprinkler systems and have 1 hour fire rated walls with ¾-hour fire-rated doors.

Maintenance shops have approved automatic sprinkler systems and have 1-hour fire-rated walls with ¾-hour fire-rated doors.
Storage rooms or spaces have approved automatic sprinkler systems, or have 1-hour fire-rated walls with ¾-hour fire-rated doors. Storage rooms and spaces of 24 square feet or smaller that are directly accessible from a room or suite require no separation or fire protection.

Trash rooms have approved automatic sprinkler systems and have 1-hour fire-rated walls with ¾-hour fire-rated doors.

4. Existing wall and ceiling interior finishes of exit enclosures are rated Class A or B to limit the development of smoke and the spread of flames. New wall and ceiling interior finishes are rated Class A. (For full text and any exceptions, refer to NFPA 101-2000: 28/29.3.3.2)

5. The interior finish of exit access corridors is Class A or B for preventing smoke and the spread of flames. (For full text and any exceptions, refer to NFPA 101-2000: 28/29.3.3.2)

6. The fire alarm system is initiated by the approved automatic sprinkler system, or the fire detection system, or by manual pull stations, including manual pull stations that are at a central location under continuous supervision by a staff member. (For full text and any exceptions, refer to NFPA 101-2000: 28/29.3.4.2)

7. The building has an audible alarm system that notifies occupants about fire without delay. (For full text and any exceptions, refer to NFPA 101-2000: 28/29.3.4.3.1 and 9.6.3)

8. New buildings that are not required to have an automatic sprinkler system have corridor smoke detection systems. (For full text and any exceptions, refer to NFPA 101-2000: 28.3.4.4)

9. Sleeping rooms, and living areas within a sleeping room or suite, have approved, single-station smoke alarms powered by the building’s electrical service. (For full text and any exceptions, refer to NFPA 101-2000: 28/29.3.4.5 and 9.6.2.10)

10. Unless exceptions apply, new buildings are protected throughout by an approved automatic sprinkler system. (For full text and any exceptions, refer to NFPA 101-2000: 28.3.5)
11. Portable fire extinguishers are provided in all hazardous areas unless the building is protected by an approved automatic sprinkler system. (For full text and any exceptions, refer to NFPA 101-2000: 28/29.3.5.5)

12. Corridor walls are constructed to resist the passage of smoke. In existing buildings, corridor walls are fire-rated for ½ hour, and in new buildings the rating is for 1 hour. (For full text and any exceptions, refer to NFPA 101-2000: 28/29.3.6.1)

13. Existing buildings with an approved automatic sprinkler system may have unrated corridor walls that resist the passage of smoke; in new buildings, corridor walls are fire rated for ½ hour. (For full text and any exceptions, refer to NFPA 101-2000: 28/29.3.6.1)

14. Doors opening to exit access corridors are fire-rated for 20 minutes, are self-closing, and are equipped with latches that keep the doors tightly closed. Such doors do not need to be rated in buildings with approved automatic sprinkler systems. (For full text and any exceptions, refer to NFPA 101-2000: 28/29.3.6.2 and 28/29.3.6.3)

15. Exit access corridors do not have unprotected openings and transoms, louvers, or transfer grills. (For full text and any exceptions, refer to NFPA 101-2000: 28/29.3.6.4 and 28/29.3.6.5)

16. Doors fire-rated for ¾ hour do not have coverings, decorations, or other objects applied to the door face, except for informational signs. (For full text and any exceptions, refer to NFPA 80-1999: 1-3.5)

17. Nonrated protective plates do not extend more than 16 inches above the bottom of the door. (For full text and any exceptions, refer to NFPA 80-1999: 2-4.5)

18. In existing buildings, sleeping room floors for individuals served have at least two smoke compartments when the building does not have sprinkler systems and the corridor length is more than 150 feet. (For full text and any exceptions, refer to NFPA 101-2000: 29.3.7)

19. In existing buildings, the maximum travel distance from a sleeping room corridor door to a smoke barrier door is 150 feet or less. (For full text and any exceptions, refer to NFPA 101-2000: 29.3.7)

**Standard LS.04.02.40**

The organization provides and maintains special features to protect individuals from the hazards of fire and smoke.

**Note 1:** *This standard applies to behavioral health care settings that provide sleeping arrangements for 17 or more individuals served as a required part of their care, treatment, or services.*

**Note 2:** *If the organization locks doors so that individuals served are prohibited from leaving the building or space, then Standards LS.02.01.10 through LS.02.01.70 apply.*

**Element of Performance for LS.04.02.40**

1. High-rise buildings have an approved automatic sprinkler system that meets the requirements of NFPA 101-2000: 28/29.4.

**Standard LS.04.02.50**

The organization provides and maintains building services that protect individuals from the hazards of fire and smoke.

**Note 1:** *This standard applies to behavioral health care settings that provide sleeping arrangements for 17 or more individuals served as a required part of their care, treatment, or services.*

**Note 2:** *If the organization locks doors so that individuals served are prohibited from leaving the building or space, then Standards LS.02.01.10 through LS.02.01.70 apply.*

**Elements of Performance for LS.04.02.50**

1. All fuel-fired heaters are fully vented to the outside when used. (For full text and any exceptions, refer to NFPA 101-2000: 28/29.5.2.2)

Medication Management (MM)

Overview
Medication management is an important component of care, treatment, or services in behavioral health care organizations. However, medications are also capable of causing great harm if the incorrect dose or medication is inadvertently administered. To eliminate any potential harm that could be caused by medications, behavioral health care organizations need to develop an effective and safe medication management system.

A safe medication management system addresses an organization’s medication processes. In a behavioral health care organization, a medication management system can address any of the following processes based on the organization’s scope of care, treatment, or services:
- Planning
- Selection and procurement
- Storage
- Ordering
- Preparing and dispensing
- Administration
- Monitoring
- Evaluation

The “Medication Management” (MM) chapter addresses these critical processes, including those undertaken by the organization and those provided through contracted services. However, the specifics of the medication management system used by the organization can vary depending on the care, treatment, or services it provides. All, some, or none of the medication processes addressed in this chapter may be within the scope of a particular behavioral health care organization. The organization needs to identify the medication processes it provides and be in compliance with the applicable standards and elements of performance. The MM chapter is not applicable to behavioral health care organizations that do not provide any type of pharmaceutical services or medications to the individuals they serve.

Effective and safe medication management also involves staff working closely together. The medication management standards address activities involving various staff within an organization’s medication management system, such as prescribers. Additionally, an
effective medication management system includes mechanisms for reporting potential and actual medication-related errors and a process to improve medication management and the safety of the individuals served based on this information.

In essence, a well planned and implemented medication management system supports the safety of the individual served and improves the quality of care by doing the following:

- Reducing variation, errors, and misuse
- Using evidence-based practices to develop medication management processes
- Managing critical processes to promote safe medication management throughout the organization
- Standardizing equipment and handling processes, including those for sample medications, across the organization to improve the medication management system
- Monitoring the medication management process for efficiency, quality, and safety

**About This Chapter**

The goal of the medication management standards is to provide a framework for an effective and safe medication management system. Effective and safe medication management is dependent on carefully implementing medication management processes based on the care, treatment, or services provided by the organization. Planning provides the groundwork for the following critical areas of performance outlined in this chapter:

- Managing high-alert and hazardous medications
- Selecting and procuring medications
- Storing medications
- Managing emergency medications
- Controlling medications brought into the organization by patients, their families, and licensed independent practitioners
- Managing medication orders
- Preparing medications
- Labeling medications
- Dispensing medications
- Retrieving recalled or discontinued medications
- Administering medications
- Managing investigational medications
- Monitoring patients’ reactions to medications
- Responding to real or potential adverse drug events, adverse drug reactions, and medication errors
Selected elements of performance (EPs) that are applicable to sample medications include a note that states, “This element of performance is also applicable to sample medications.” The Joint Commission is not endorsing the use of sample medications. The note is only intended to identify which Medication Management EPs are applicable to sample medications for organizations that permit their use. Medication Management EPs that do not include this note are not applicable to sample medications.
Chapter Outline

I. Planning
   A. Medication Planning (MM.01.01.01, MM.01.01.03, MM.01.01.05)
   B. Look-alike/Sound-alike Medications (MM.01.02.01)

II. Selection and Procurement (MM.02.01.01)

III. Storage (MM.03.01.01, MM.03.01.03, MM.03.01.05)

IV. Ordering and Transcribing (MM.04.01.01)

V. Preparing and Dispensing (MM.05.01.01, MM.05.01.07, MM.05.01.09, MM.05.01.11, MM.05.01.13, MM.05.01.15, MM.05.01.17, MM.05.01.19)

VI. Administration (MM.06.01.01, MM.06.01.03, MM.06.01.05)

VII. Monitoring (MM.07.01.01, MM.07.01.03)

VIII. Evaluation (MM.08.01.01)
Standards, Rationales, and Elements of Performance

Standard MM.01.01.01

The organization plans its medication management processes.

Note: This standard is applicable to organizations that engage in any of the medication management processes.

Rationale for MM.01.01.01

Medication management is often complicated, involving many staff and processes. For this reason, the organization plans each part of the process with care so that safety and quality are maintained. This planning may involve the coordinated efforts of multiple staff.

Elements of Performance for MM.01.01.01

1. For organizations that engage in any aspect of the medication management process: The organization has a written policy that describes that the following information about the individual served is accessible to staff who participate in the medication management process: R
   - Age
   - Sex
   - Diagnoses/conditions
   - Allergies
   - Sensitivities
   - Height and weight (when necessary)
   - Drug and alcohol use and abuse
   - Current medications
   - Pregnancy and lactation information (when necessary)
   - Any additional information required by the organization

(See also IM.02.01.01, EP 3)

Note: This element of performance is also applicable to sample medications.

2. For organizations that engage in any aspect of the medication management process: The organization implements its policy to make information about the individual served accessible to prescribers and staff who participate in the management of the individual’s medications. R

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
**Note 1:** This element of performance does not apply in emergency situations.

**Note 2:** This element of performance is also applicable to sample medications.

**Standard MM.01.01.03**
The organization safely manages high-alert and hazardous medications.

**Note:** This standard is applicable to organizations that engage in any of the medication management processes.

**Rationale for MM.01.01.03**
High-alert medications are those medications that bear a heightened risk of causing significant harm to an individual served and/or sentinel events when they are used in error and, as a result, require special safeguards to reduce the risk of errors. Examples of high-alert medications include opioids, insulin, anticoagulants, and neuromuscular blocking agents. Lists of high-alert medications are available from organizations such as the Institute for Safe Medication Practices (ISMP).†

Hazardous drugs and medications are those in which studies in animals or humans indicate that exposure to them has a potential for causing cancer, developmental or reproductive toxicity, genotoxicity, or harm to organs. An example of a hazardous drug is one that contains antineoplastic agents or other ingredients that cause the aforementioned risks. Lists of hazardous drugs are available from the National Institute for Occupational Safety and Health (NIOSH).†

For safe management, the organization needs to develop its own lists of both high-alert medications and hazardous drugs. These should be based on the organization’s unique utilization patterns, its own internal data about medication errors and sentinel events, and known safety issues published in professional literature. It is up to the organization to determine whether medications that are new to the market are high alert or hazardous. In addition, the organization may separately choose to include other drugs that require special precautions such as investigational medications, controlled substances, and psychotherapeutic medications.

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† For a list of hazardous drugs, see [https://www.cdc.gov/niosh/docs/2016-161/pdfs/2016-161.pdf](https://www.cdc.gov/niosh/docs/2016-161/pdfs/2016-161.pdf).
Elements of Performance for MM.01.01.03

1. ☐ The organization identifies, in writing, its high-alert and hazardous medications.†

Note: This element of performance is also applicable to sample medications.

2. ☐ The organization has a process for managing high-alert and hazardous medications.

Note: This element of performance is also applicable to sample medications.

3. ☐ The organization implements its process for managing high-alert and hazardous medications. (See also EC.02.01.01, EP 2)

Note: This element of performance is also applicable to sample medications.

7. ☐ For opioid treatment programs: On a daily basis, the program documents the total number of milligrams of medication dispensed.

8. ☐ For opioid treatment programs: The program creates an ongoing accurate inventory of all medications received, dispensed, and disposed.

9. ☐ For opioid treatment programs: The program has a written diversion control plan.

10. For opioid treatment programs: The diversion control plan includes a mechanism for periodic monitoring of clinical and administrative activities to reduce the risk of medication diversion.

Note: One mechanism for monitoring might be to have security or staff regularly walk around the clinic’s hallways, alleys, and parking lot to assess whether there is a loitering or diversion problem close to the treatment site. Another example is to examine both dosing and take-home dispensing practices to identify potential weaknesses that could lead to diversion problems. Additionally, the program could periodically consult with law enforcement in the community and in areas where patients live to discuss the perceived and actual problems encountered.

11. For opioid treatment programs: The diversion control plan includes specific activities for reducing diversion and identification of those responsible for managing these activities.

† For a list of high-alert medications, see http://www.ismp.org/Tools/highAlertMedicationLists.asp. For a list of hazardous drugs, see https://www.cdc.gov/niosh/docs/2016-161/pdfs/2016-161.pdf.
12. **For opioid treatment programs:** The program obtains patient input on the program’s policies and procedures regarding its diversion control plan (DCP), and how those policies and procedures are implemented.

13. **For opioid treatment programs:** The program develops written policies and procedures to govern the use of and response to prescription drug monitoring program (PDMP) information for diversion control.

**Standard MM.01.01.05**
The organization monitors the use of psychotropic medications.

**Rationale for MM.01.01.05**
Because of the risks associated with the use of psychotropic medications, monitoring their use is an important activity for any organization that uses these medications. Establishing formal monitoring processes helps the organization to successfully perform this activity.

**Element of Performance for MM.01.01.05**
1. **For** If psychotropic medications are prescribed, the organization establishes written policies and procedures addressing the following:  
   - The use of multiple psychotropic agents in the same class  
   - The use of high-dose pharmacotherapy  
   - The prevention, identification, and management of side effects, including tardive dyskinesia

**Standard MM.01.02.01**
The organization addresses the safe use of look-alike/sound-alike medications.

**Elements of Performance for MM.01.02.01**
1. **For** The organization develops a list of look-alike/sound-alike medications it stores, dispenses, or administers.  

   **Note 1:** One source of look-alike/sound-alike medications is The Institute for Safe Medication Practices (http://www.ismp.org/Tools/confuseddrugnames.pdf).

   **Note 2:** This element of performance is also applicable to sample medications.

2. The organization takes action to prevent errors involving the interchange of the medications on its list of look-alike/sound-alike medications.

   **Note:** This element of performance is also applicable to sample medications.
3. The organization annually reviews and, as necessary, revises its list of look-alike/sound-alike medications. 

**Note:** This element of performance is also applicable to sample medications.

**Standard MM.02.01.01**

The organization selects and procures medications.

**Note:** This standard is applicable only to organizations that operate a pharmacy.

**Elements of Performance for MM.02.01.01**

1. **For organizations that operate a pharmacy:** The organization develops criteria for determining which medications are available for dispensing to individuals served. 

   **Note:** This element of performance is also applicable to sample medications.

2. **For organizations that operate a pharmacy:** The organization develops and approves criteria for selecting medications, which include the following:
   - Indications for use
   - Effectiveness
   - Drug interactions
   - Potential for errors and abuse
   - Adverse drug events
   - Sentinel event advisories
   - Other risks
   - Costs

   **Note:** This element of performance is also applicable to sample medications.

3. **For organizations that operate a pharmacy:** Before using a medication new to the organization, the organization determines a method to monitor the response of the individual served. (*See also MM.07.01.01, EP 2*)

   **Note:** This element of performance is also applicable to sample medications.

5. **For organizations that operate a pharmacy:** The organization makes a written list of medications readily available to prescribers.

   **Note:** Sample medications are not required to be on the list.
7. **For organizations that operate a pharmacy:** The organization has a process to select, approve, and procure medications that are not on its list of medications.  

   **Note:** This element of performance is also applicable to sample medications.

8. **For organizations that operate a pharmacy:** The organization implements the process to select, approve, and procure medications that are not on its medication list.  

   **Note:** This element of performance is also applicable to sample medications.

9. **For organizations that operate a pharmacy:** Medications designated as available for dispensing are reviewed at least annually based on emerging safety and efficacy information.

11. **For organizations that operate a pharmacy:** The organization communicates medication shortages and outages to prescribers and staff who participate in medication management.

13. **For organizations that operate a pharmacy:** The organization implements its approved medication substitution protocols for shortages and outages.

### Standard MM.03.01.01

The organization safely stores medications.

**Note:** This standard is applicable only to organizations that store medications at their sites.

### Rationale for MM.03.01.01

Medication storage is designed to assist in maintaining medication integrity, promote the availability of medications when needed, minimize the risk of medication diversion, and reduce potential dispensing errors. Law and regulation and manufacturers’ guidelines further define the organization’s approach to medication storage including guidelines for medications that require refrigeration.

### Elements of Performance for MM.03.01.01

2. **For organizations that store medications:** The organization stores medications according to the manufacturers’ recommendations or a pharmacist’s instructions.  

   **Note:** This element of performance is also applicable to sample medications.
3. **For organizations that store medications:** The organization stores controlled (scheduled) medications to prevent diversion, in accordance with law and regulation. ❘

   **Note:** *This element of performance is also applicable to sample medications.*

4. ☐ **For organizations that store medications:** The organization has a written policy addressing the control of medication between receipt by staff and administration of the medication, including safe storage, handling, wasting, security, disposition, and return to storage. ❘

   **Note:** *This element of performance is also applicable to sample medications.*

5. **For organizations that store medications:** The organization safely handles medications between receipt by staff and administration of the medications. ❘

   **Note:** *This element of performance is also applicable to sample medications.*

6. **For organizations that store medications:** The organization prevents unauthorized individuals from accessing medications in accordance with its policy and law and regulation. ❘

   **Note:** *This element of performance is also applicable to sample medications.*

7. **For organizations that store medications:** The organization labels stored medications with the contents, expiration date, and any applicable warnings provided by the pharmacy. ❘

   **Note:** *This element of performance is also applicable to sample medications.*

8. **For organizations that store medications:** The organization removes all expired, damaged, and/or contaminated medications and stores them separately from medications available for administration. *(See also MM.05.01.19, EP 1)* ❘

   **Note:** *This element of performance is also applicable to sample medications.*

18. **For organizations that store medications:** The organization inspects all medication storage areas periodically, as defined by the organization, to verify that medications are stored properly. ❘

   **Note:** *This element of performance is also applicable to sample medications.*

25. **For opioid treatment programs:** The program stores methadone and buprenorphine separately from other medications.
Note: Methadone and buprenorphine may be stored together in the same safe, with each product documented in a separate inventory.

Standard MM.03.01.03
The organization safely manages emergency medications and supplies.

Rationale for MM.03.01.03
Emergencies involving individuals served occur occasionally in behavioral health care settings. The organization, therefore, needs to plan how it will address such emergencies and what medications and supplies it will need, if any. Although the processes may be different, the organization treats emergency medications with the same care for safety as it does medications in nonemergency settings.

Elements of Performance for MM.03.01.03
1. Organization leaders decide which, if any, emergency or first aid medications and their associated supplies will be readily accessible in areas used to provide care, treatment, or services, based on the population(s) served. R
3. Whenever possible, emergency medications are available in the most ready-to-administer forms. R
6. When emergency medications or supplies are used, the organization replaces them as soon as possible to maintain a full stock. R

Standard MM.03.01.05
The organization safely controls medications brought into the organization by individuals served, their families, or prescribers.

Note: This standard is applicable only to organizations in which staff administer medications or self-administration of medications is allowed within the organization’s facilities.

Rationale for MM.03.01.05
A number of valid reasons exist for allowing the individual served to use his or her own medications in an organization. The organization needs to control the use of these medications in order to protect the safety of the individual served and the quality of care provided. Therefore, the organization needs to define its responsibilities for the safe use of these medications.
Elements of Performance for MM.03.01.05

1. **For organizations in which staff administer medications or self-administration is allowed within the organization’s facilities:** The organization defines in writing when medications brought into the organization by individuals served, their families, or prescribers can be administered. 

   **Note:** This element of performance is also applicable to sample medications.

2. **For organizations in which staff administer medications or self-administration is allowed within the organization’s facilities:** Before use or administration of a medication brought into the organization by an individual, his or her family, or a prescriber, the organization identifies the medication and visually evaluates the medication’s integrity. *(See also MM.05.01.07, EP 3; MM.06.01.01, EP 4)*

   **Note:** This element of performance is also applicable to sample medications.

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**Introduction to Standard MM.04.01.01**

Medication errors may occur when staff are communicating or transcribing medication orders. Verbal and telephone orders are particularly susceptible to error. The organization is responsible for reducing the potential for medication errors and the misinterpretation of these medication orders. As part of this process, the organization determines the required elements of a medication order, the type of medication orders that are deemed acceptable for use, and the actions to take when medication orders are incomplete, illegible, or unclear. Clear understanding and communication between staff and prescribers involved in the medication process are essential.

**Standard MM.04.01.01**

Medication orders are clear and accurate.

**Note:** This standard is applicable only to organizations that prescribe medications. The elements of performance in this standard do not apply to prescriptions written by a prescriber who is not affiliated with the organization.

**Elements of Performance for MM.04.01.01**

1. **For organizations that prescribe medications:** The organization has a written policy that identifies the specific types of medication orders that it deems acceptable for use.
Note: There are several different types of medication orders. Medication orders commonly used include the following:

- As needed (PRN) orders: Orders acted on based on the occurrence of a specific indication or symptom
- Standing orders: A prewritten medication order and specific instructions from the prescriber to administer a medication to an individual in clearly defined circumstances as specified in the instructions
- Automatic stop orders: Orders that include a date or time to discontinue a medication
- Taper orders: Orders in which the dose is decreased by a particular amount with each dosing interval
- Range orders: Orders in which the dose or dosing interval varies over a prescribed range, depending on the situation or status of the individual served
- Signed and held orders: New prewritten (held) medication orders and specific instructions from a licensed independent practitioner to administer medication(s) to an individual served or patient in clearly defined circumstances that become active upon the release of the orders on a specific date(s) and time(s)
- Orders for medication-related devices (for example, inhalers, nebulizers, glucometers)
- Orders for investigational medications
- Orders for herbal products
- Orders for medications at discharge or transfer

2. For organizations that prescribe medications: The organization has a written policy that defines the required elements of a complete medication order. 

3. For organizations that prescribe medications: The organization has a written policy that defines when indication for use is required as part of the medication order. 

4. For organizations that prescribe medications: The organization has a written policy that defines precautions for ordering medications with look-alike or sound-alike names. 

5. For organizations that prescribe medications: The organization has a written policy that defines actions to take when medication orders are incomplete, illegible, or unclear. 

7. For organizations that prescribe medications: The organization reviews and updates preprinted order sheets to support clarity, accuracy, and safety. 

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
8. **For organizations that prescribe medications:** The organization prohibits summary (blanket) orders to resume previous medications.

9. **For organizations that prescribe medications:** A diagnosis, condition, or indication for use exists for each medication ordered.

   **Note:** This information can be anywhere in the clinical/case record and need not be on the order itself. For example, it might be part of the medical history.

13. **For organizations that prescribe medications:** The organization implements its policies for medication orders.

16. **For opioid treatment programs:** The program provides therapeutic doses of medications for each individual patient as determined by the program physician. Programwide dosage caps or ceilings are not used.

   **Note:** Opioid maintenance therapy has three desired effects: preventing onset of signs of opioid abstinence for at least 24 hours, reducing or eliminating drug hunger or craving, and blocking effects of illicitly acquired or self-administered opiates.

17. **For opioid treatment programs:** Each dose of opioid medication is individually determined by the physician and based on the package insert. Deviations from the approved labeling are documented by the physician.
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18. **For opioid treatment programs:** When the patient requires a medication that is not provided by the program, the program makes a referral that meets the needs and preferences of the patient.

19. **For opioid treatment programs:** The initial methadone dose for a newly admitted pregnant patient and the subsequent induction and maintenance dosing strategy reflect the same dosing protocols used for all other patients.

20. **For opioid treatment programs:** The duration or the dosage level of medication is based only on clinical indications.

23. **For opioid treatment programs:** The initial full-day dose of methadone is based on current guidelines and the physician’s evaluation of the patient’s history and present condition, and on knowledge of local conditions such as the relative purity of available street drugs.

   **Note:** The initial dose needs to be reflective of the patient’s drug use history and should be the lowest dose possible. Current Center for Substance Abuse Treatment guidelines recommend that for each new patient, the initial dose of methadone is not to exceed 30 mg and the total dose for the first day is not to exceed 40 mg, unless the program physician documents in the patient’s clinical/case record that 40 mg did not suppress withdrawal symptoms.

24. **For opioid treatment programs:** A physician assesses the patient and adjusts the medication dosage as needed when the program switches from one generic formulation to another and differences in the effective dose cause clinically relevant complaints.

   **Note:** Caution should also be exercised when a patient has missed several doses of medication because his or her tolerance may have changed.

25. **For opioid treatment programs:** The program prohibits the use of standing orders regarding the dose, schedule, or re-administration of methadone because of the unique pharmacologic properties, the well-established potential for fatalities in the induction period, and the risk of relapse during medically supervised withdrawal.

26. **For opioid treatment programs:** A physician may write a very short cascading order incorporating a clinical opiate withdrawal scale (COWS) score or other objective measure in order to titrate the dose of a specific individual only if appropriately trained and qualified staff (as determined by licensing criteria or
credentialing) are available to evaluate the ongoing appropriateness of the physician’s treatment plan and recognize the need for the patient to be re-evaluated prior to completion of the full course of the order.

27. **For opioid treatment programs:** The program’s physicians and other health care providers, as permitted, register to use their state’s prescription drug monitoring program (PDMP) and query it for each newly admitted patient prior to initiating dosing.

**Standard MM.05.01.01**
The organization reviews the appropriateness of all medication orders for medications to be dispensed in the organization.

**Note:** *This standard is applicable only to organizations that operate a pharmacy.*

**Elements of Performance for MM.05.01.01**

1. **For organizations that operate a pharmacy:** Before dispensing, a pharmacist reviews all prescription or medication orders unless a prescriber controls the ordering, preparing, and dispensing of the medication, or delaying the order would harm the individual served, in accordance with law and regulation.  

4. **For organizations that operate a pharmacy:** All medication orders are reviewed for the individual’s allergies or potential sensitivities.  

5. **For organizations that operate a pharmacy:** All medication orders are reviewed for existing or potential interactions between the medication ordered, food, alcohol, and medications the individual served is currently taking.  

6. **For organizations that operate a pharmacy:** All medication orders are reviewed for the appropriateness of the medication, dose, frequency, and route of administration.  

7. **For organizations that operate a pharmacy:** When clinically indicated, medication orders are reviewed for current or potential impact as indicated by laboratory values.  

8. **For organizations that operate a pharmacy:** All medication orders are reviewed for therapeutic duplication.  

9. **For organizations that operate a pharmacy:** All medication orders are reviewed for other contraindications (for example, age, medical conditions, body weight).
11. **For organizations that operate a pharmacy**: After the medication order has been reviewed, all concerns, issues, or questions about the order are clarified with the prescriber before dispensing.

**Standard MM.05.01.07**
The organization safely prepares medications for administration.

**Note:** This standard is applicable only to organizations that prepare medications for administration.

**Elements of Performance for MM.05.01.07**

2. **For organizations that prepare medications for administration**: Staff use clean or sterile techniques and maintain clean, uncluttered, and functionally separate areas for medication preparation.

**Note:** Sterile technique (also called aseptic technique) refers to practices that are designed to minimize exposure to germs and maintain sterility of the medication through the use of “no touch” procedures; the use of sterile gloves, supplies, and instruments (for example, needles and syringes); and the use of a sterile field. In contrast, clean technique refers to practices designed to reduce exposure to germs, and include the use of hand washing, clean instruments, and a clean environment. Clean technique does not require the use of sterile technique or sterile supplies. The technique used for medication preparation depends on the need for sterility (for example, intravenous solutions) versus cleanliness (for example, oral products).

3. **For organizations that prepare medications for administration**: During preparation, staff visually inspect the medication for particulates, discoloration, or other loss of integrity. *(See also MM.03.01.05, EP 2; MM.06.01.01, EP 4)*

**Standard MM.05.01.09**
Medications are labeled.

**Note:** This standard is applicable only to organizations that dispense or administer medications.

**Rationale for MM.05.01.09**
A label on every medication and medication container has long been a standard of practice and is required by law and regulation.
Elements of Performance for MM.05.01.09

1. **For organizations that dispense or administer medications:** Medication containers are labeled whenever medications are prepared but not immediately administered.  
   
   **Note 1:** An immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to an individual served, and administers to that individual without any break in the process.

   **Note 2:** This element of performance is also applicable to sample medications.

2. **For organizations that dispense or administer medications:** Information on medication labels is displayed in accordance with law and regulation.  
   
   **Note:** This element of performance is also applicable to sample medications.

3. **For organizations that dispense or administer medications:** All medications dispensed or administered in the organization are correctly labeled with the medication name, strength, and amount (if not apparent from the container).  
   
   **Note:** This element of performance is also applicable to sample medications.

4. **For organizations that dispense or administer medications:** All medications dispensed or administered in the organization are correctly labeled with the expiration date when not used within 24 hours.

5. **For organizations that dispense or administer medications:** All medications dispensed or administered in the organization are correctly labeled with the expiration time when expiration occurs in less than 24 hours.

7. **For organizations that dispense or administer medications:** All individualized medications that are dispensed or administered to multiple individuals are labeled with the name of the individual.

   **For organizations that dispense or administer medications:** All individualized medications that are dispensed or administered to multiple individuals are also labeled with the following:

   8. The location where the medication is to be delivered. *(See also NPSG.01.01.01, EP 1)*

   **Note:** The location is not to be used as an identifier of the individual during administration of a medication, as indicated by NPSG.01.01.01, EP 1.
9. **For organizations that dispense or administer medications:** When dispensing or preparing individualized medications for administration to multiple individuals, the label also includes directions for use and applicable accessory and cautionary instructions. 

10. **For organizations that dispense or administer medications:** When an individualized medication(s) is prepared by someone other than the person administering the medication, the label includes the name of the individual served. 

**For organizations that dispense or administer medications:** When an individualized medication(s) is prepared for administration by someone other than the person administering the medication, the label includes the following:

11. The location where the medication is to be delivered. (*See also NPSG.01.01.01, EP 1*)

   **Note:** The location is not to be used as an identifier during administration of a medication, as indicated by NPSG.01.01.01, EP 1.

12. **For organizations that dispense or administer medications:** When an individualized medication(s) is prepared for administration by someone other than the staff administering the medication, the label includes directions for use and applicable accessory and cautionary instructions.

**Standard MM.05.01.11**

The organization safely dispenses medications.

**Note:** This standard is applicable only to organizations that operate a pharmacy.

**Elements of Performance for MM.05.01.11**

1. **For organizations that operate a pharmacy:** The organization dispenses quantities of medications that are consistent with the needs of the individual served.

   **Note:** This element of performance is also applicable to sample medications.

2. **For organizations that operate a pharmacy:** The organization dispenses medications and maintains records in accordance with law and regulation, licensure, and professional standards of practice.

   **Note 1:** Dispensing practices and recordkeeping include antidiversion strategies.

   **Note 2:** This element of performance is also applicable to sample medications.
3. **For organizations that operate a pharmacy:** The organization dispenses medications within time frames it defines to meet the needs of the individuals served.

4. **For organizations that operate a pharmacy:** Medications are dispensed in the most ready-to-administer forms commercially available and, if feasible, in unit doses that have been repackaged by the pharmacy or licensed repackager.

7. **For opioid treatment programs:** Doses of methadone or other approved medications are adjusted as needed if a program switches from one generic formulation to another and differences in effective dose cause clinically relevant complaints.

8. **For opioid treatment programs:** A procedure is established for calibrating medication dispensing instruments consistent with manufacturers’ recommendations in order to ensure accurate patient dosing and substance tracking.

9. **For opioid treatment programs:** The program authorizes appropriate staff members to dispense methadone and buprenorphine to patients admitted for treatment.

10. **For opioid treatment programs:** The program dispenses methadone only in an oral form that is formulated in such a way as to reduce its potential for parenteral abuse.

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**Standard MM.05.01.13**

The organization safely obtains medications when the pharmacy is closed.

**Note:** *This standard is applicable only to organizations that operate a pharmacy.*

**Elements of Performance for MM.05.01.13**

1. **For organizations that operate a pharmacy:** The organization has a process for providing medications to meet the needs of the individual served when the pharmacy is closed.

7. **For organizations that operate a pharmacy:** The organization implements its process for providing medications to meet the needs of the individual served when the pharmacy is closed.
8. **For opioid treatment programs:** The program maintains an up-to-date written plan for emergency administration of medications in the event the program must be closed temporarily. The plan describes how patients will be informed of these emergency arrangements.

9. **For opioid treatment programs:** Medication dosages and other pertinent patient information are available on a 24-hour, 7-day-a-week basis in case of patient emergency.

**Standard MM.05.01.15**

**For organizations that do not operate a pharmacy but administer medications:** The organization safely obtains prescribed medications.

**Elements of Performance for MM.05.01.15**

1. **For organizations that do not operate a pharmacy but administer medications:** The organization has a process for obtaining medications to meet the needs of the individual served.

2. **For organizations that do not operate a pharmacy but administer medications:** If the organization obtains medications from a pharmacy that is not open 24 hours a day, 7 days a week, the organization has a process for obtaining medications from another source for urgent or emergent conditions when the pharmacy is closed.

3. **For organizations that do not operate a pharmacy but administer medications:** The organization implements its process for obtaining medications from a pharmacy or licensed pharmaceutical supplier.

4. **For organizations that do not operate a pharmacy but administer medications:** The organization validates that all medications coming into the organization are appropriately labeled.

5. **For organizations that do not operate a pharmacy but administer medications:** If an unlabeled medication comes into the organization, the organization takes action to have the medication correctly labeled.

**Note:** For example, if a medication from a contractual pharmacy is not labeled, the organization notifies the pharmacy in order to obtain a correctly labeled medication.
Standard MM.05.01.17
Organizations that operate a pharmacy or distribute sample medications follow a process to retrieve recalled or discontinued medications.

Elements of Performance for MM.05.01.17

1. **For organizations that operate a pharmacy or distribute sample medications:** The organization has a written policy describing how it will retrieve and handle medications within the organization that are recalled or discontinued for safety reasons by the manufacturer or the US Food and Drug Administration (FDA). *(See also EC.02.01.01, EP 11)*

   **Note:** This element of performance is also applicable to sample medications.

2. **For organizations that operate a pharmacy or distribute sample medications:** The organization implements its policy on retrieving and handling medications when they are recalled or discontinued for safety reasons. *(See also EC.02.01.01, EP 11)*

   **Note:** This element of performance is also applicable to sample medications.

3. **For organizations that operate a pharmacy or distribute sample medications:** When a medication is recalled or discontinued for safety reasons by the manufacturer or the US Food and Drug Administration (FDA), the organization notifies the prescribers and those who dispense or administer the medication. *(See also EC.02.01.01, EP 11)*

   **Note:** This element of performance is also applicable to sample medications.

4. **For organizations that operate a pharmacy or distribute sample medications:** When required by law and regulation or organization policy, the organization informs individuals served that their medication has been recalled or discontinued for safety reasons by the manufacturer or the US Food and Drug Administration (FDA). *(See also EC.02.01.01, EP 11)*

   **Note:** This element of performance is also applicable to sample medications.

Standard MM.05.01.19
The organization safely manages unused, expired, or returned medications.

**Note:** This standard is applicable only to organizations that administer medications.
Rationale for MM.05.01.19
The organization accounts for, controls, and disposes of previously dispensed but unused, expired, or returned medications in order to keep individuals safe and prevent diversion.

Elements of Performance for MM.05.01.19
1. **For organizations that administer medications:** The organization determines how it will manage unused, expired, or returned medications. *(See also MM.03.01.01, EP 8)*
   
   **Note:** This element of performance is also applicable to sample medications.

2. **For organizations that administer medications:** When the organization accepts unused, expired, or returned medications, it has a process for destroying the medications or returning the medications to a pharmacy’s control that includes procedures for preventing diversion.
   
   **Note:** This element of performance is also applicable to sample medications.

3. **For organizations that administer medications:** The organization determines if and when outside sources are used for destruction of medications.
   
   **Note:** This element of performance is also applicable to sample medications.

4. **For organizations that administer medications:** The organization implements its process for managing unused, expired, or returned medications.
   
   **Note:** This element of performance is also applicable to sample medications.

Standard MM.06.01.01
The organization safely administers medications.

**Note:** This standard is applicable only to organizations that administer medications.

Elements of Performance for MM.06.01.01
1. **For organizations that administer medications:** The organization defines, in writing, the staff that are authorized to administer medication, with or without supervision, in accordance with law and regulation. *(See also MM.06.01.03, EP 1)*
   
   **Note:** This element of performance is also applicable to sample medications.

2. **For organizations that administer medications:** Only authorized staff administer medications.
Note 1: This does not prohibit self-administration of medications by individuals served, when indicated. (See also MM.06.01.03, EP 1)

Note 2: This element of performance does not apply to foster parents.

3. For organizations that administer medications: Before administration, the staff member administering the medication verifies that the medication selected matches the medication order and product label. R

4. For organizations that administer medications: Before administration, the staff member administering the medication visually inspects the medication for particulates, discoloration, or other loss of integrity. (See also MM.03.01.05, EP 2; MM.05.01.07, EP 3) R

5. For organizations that administer medications: Before administration, the staff member administering the medication verifies the medication has not expired. R

7. For organizations that administer medications: Before administration, the staff member administering the medication verifies that the medication is being administered at the proper time, in the prescribed dose, and by the correct route. R

Note: For opioid treatment programs: Medications that are best administered by directly observed therapy (DOT)—such as tuberculosis and psychiatric medications—can be given at the same time as the opioid dose.

8. For organizations that administer medications: Before administration, the staff member administering the medication discusses any unresolved concerns about the medication with supervisory staff or the prescriber. R

9. For organizations that administer medications: The following individuals are informed about any potential clinically significant adverse medication reactions or other concerns regarding a new medication: R
   - Individuals served
   - Legal guardian if the individual served has one
   - Family if authorized by the individual served

(See also MM.06.01.03, EPs 3–6)

Note: The term “adverse medication reaction” is synonymous with the term “adverse drug reaction.”
11. **For opioid treatment programs:** Every dose of medication is recorded on an administration sheet at the time the dose is administered or dispensed, and recorded on the patient’s individual medication dose history. 

12. **For opioid treatment programs:** For patients in interim maintenance treatment, treatment medication is administered only under observation; unsupervised or “take-home” use is not allowed.

**Standard MM.06.01.03**
Self-administered medications are administered safely and accurately.

**Note:** The term “self-administered medication(s)” may refer to medications administered by a family member.

**Elements of Performance for MM.06.01.03**

1. ☐ If self-administration of medications is allowed, the organization has a written policy that addresses the training and supervision of the individual served to guide the safe and accurate self-administration of medications. *(See also MM.06.01.01, EPs 1 and 2)*

   **Note:** Self-administration includes those instances when an individual served independently uses a medication that is stored by the organization.

2. **For organizations that allow self-administration of medications:** The organization implements its policy for medication self-administration.

3. **For organizations that allow self-administration of medications:** When the individual’s medications are prescribed or dispensed by the organization, the organization educates the individual and his or her family about the medication name, type, and reason for use. *(See also MM.06.01.01, EP 9)*

4. **For organizations that allow self-administration of medications:** When the individual’s medications are prescribed or dispensed by the organization, the organization educates the individual and his or her family about how to administer medication, including special instructions, time of day, route, and dose. *(See also MM.06.01.01, EP 9)*
5. **For organizations that allow self-administration of medications:** When the individual’s medications are prescribed or dispensed by the organization, the organization educates the individual and his or her family about the anticipated actions and potential side effects of the medication administered. *(See also MM.06.01.01, EP 9)*

6. **For organizations that allow self-administration of medications:** When the individual’s medications are prescribed or dispensed by the organization, the organization educates the individual and his or her family about monitoring the effects of the medication. *(See also MM.06.01.01, EP 9)*

7. **For organizations that allow self-administration of medications:** When the individual’s medications are prescribed or dispensed by the organization, the organization determines that the individual or the family member who administers the medication is competent at medication administration before allowing him or her to administer medications.

10. **For opioid treatment programs:** The program’s written policies allow for unsupervised, or “take-home,” doses of medication based on physician judgment and staff assessment of the patient’s behavior. The policies do not include provisions that prohibit all patients from approval for take-home medication. *(Note: Policies that prohibit take-home doses for all patients are inappropriate because they preclude individualized patient care.)*

11. **For opioid treatment programs:** The program’s medical director authorizes procedures for determining the eligibility of patients in comprehensive maintenance treatment for take-home doses of medication that include consideration of the following:

    - Absence of recent use of drugs, including alcohol
    - Regularity of clinic attendance
    - Absence of serious behavior problems at the clinic
    - Absence of recent known criminal activity, such as drug dealing
    - Stability of the patient’s home environment and social relationships
    - Length of time in maintenance treatment
    - Assurance that the take-home medication(s) can be safely stored within the patient’s home
    - Whether the benefit the patient will derive from decreasing clinic attendance outweighs the potential risks of diversion
Note: *A physical is not required to determine eligibility for take-home medication.*

12. **For opioid treatment programs:** A multidisciplinary team provides recommendations and input for the physician’s review for decisions allowing take-home medications.

13. **For opioid treatment programs:** The medical director makes certain that the program’s policies for the approval of take-home medication do not create barriers to patients continuing in treatment.

14. **For opioid treatment programs:** A physician makes the final decision on approval for take-home medications and documents the reasons for the decision in the patient’s record.

15. **For opioid treatment programs:** Decisions regarding take-home medications are reviewed periodically (according to the criteria for take-home eligibility and any other clinically relevant factors) and documented in the patient record.

16. **For opioid treatment programs:** The number and quantity of take-home doses are restricted as follows:

   - First 90 days of treatment: maximum of one unsupervised dose per week
   - Second 90 days of treatment: maximum of two unsupervised doses per week
   - Third 90 days of treatment: maximum of three unsupervised doses per week
   - Remaining months of the first year: maximum of six unsupervised doses per week
   - After one year of continuous treatment: maximum of 14 unsupervised doses of medication
   - After two years of continuous treatment: maximum of one-month supply; however, the patient must make monthly visits.

17. **For opioid treatment programs:** There are written policies that guide decisions about additional occurrences of take-home medication on a temporary basis in exceptional circumstances, such as documented family or medical emergencies. The program obtains approval for the exception from the Center for Substance Abuse Treatment.

18. **For opioid treatment programs:** The program establishes criteria for determining a patient’s eligibility for take-home doses of medication on days when the program is closed.
Note: The patient’s eligibility needs to be determined before the first dose of take-home medication on a day the program is closed, but does not need to be reassessed each day the program is closed. However, it would be appropriate to reassess the patient’s eligibility if the patient tests positive for illicit drugs or is known to have recently diverted methadone.

19. For opioid treatment programs: The program has a written policy regarding random call-backs.

20. For opioid treatment programs: Take-home medications are packaged in individual, child-proof containers. 

21. For opioid treatment programs: The patient is informed of his or her responsibility to keep opioid medications secure.

22. For opioid treatment programs: The program educates patients receiving unsupervised (take-home) medication about using a locked container to inconspicuously and safely transport take-home medication and store the medication at home.

23. For opioid treatment programs: The program records the chain of custody for transporting methadone when a patient is transferring to a different level of care or a new location and the program provides sufficient medication to cover the time until the patient arrives at the new location.

24. For opioid treatment programs: The program establishes procedures to accommodate traveling patients.

25. For opioid treatment programs: The program develops a standard process to record chain-of-custody of dispensed take-home doses not dispensed directly to the patient.

26. For opioid treatment programs: The program determines whether patients who need to travel but do not meet criteria for take-home medications can receive guest dosing.

27. For opioid treatment programs: For alcohol use disorders, the program is able to assess patients’ recent use of alcohol via toxicology tests and Breathalyzer results as a means of establishing safety for dosing and take-homes.

Standard MM.06.01.05
The organization safely manages investigational medications.
Note 1: This standard is applicable only to organizations that use investigational medications.

Note 2: Refer to the Glossary for the definition of investigational medications.

Rationale for MM.06.01.05
Investigational medications can be of great help to the individual served. In some cases, investigational medications may represent one of a few options in the individual's plan of care. Although behavioral health care organizations do not regularly use investigational medications, there are some instances in which these medications are used. In such instances, the organization contributes to the safety of individuals served who are participating in investigational or clinical medication studies by controlling and monitoring the use of these medications.

Note: For a discussion of the rights of individuals served regarding the use of investigational medications, see Standard RI.01.03.05.

Elements of Performance for MM.06.01.05
1. For organizations that use investigational medications: The organization has a written process addressing the use of investigational medications that includes review, approval, supervision, and monitoring.

4. For organizations that use investigational medications: The organization implements its process addressing the use of investigational medications.

Standard MM.07.01.01
The organization monitors individuals served to determine the effects of their medication(s).

Note: This standard is applicable only to organizations that prescribe or administer medications.

Elements of Performance for MM.07.01.01
1. For organizations that prescribe or administer medications: The organization monitors the side effects and effectiveness of the medications, as reported by the individual served or his or her family.

Note: This element of performance is also applicable to sample medications.
2. **For organizations that prescribe or administer medications:** The organization monitors the response of the individual served to his or her medications by taking into account information from the clinical/case record, and the individual’s response. *(See also MM.02.01.01, EP 3)*

**Note 1:** Monitoring response to medications is an important assessment activity. In particular, monitoring the response to the first dose of a new medication is essential to safety because any adverse reactions, including serious ones, are more unpredictable if the medication has never been used before with the individual.

**Note 2:** This element of performance is also applicable to sample medications.

3. **For organizations that prescribe or administer medications:** When a medication is prescribed within the organization, the prescriber takes into account information from the clinical/case record, relevant lab values, medication profile, and the individual’s response.

**Note:** This element of performance is also applicable to sample medications.

7. **For opioid treatment programs:** The maintenance dose is individually determined based on monitoring of the effects of the patient’s treatment.

**Note:** The medication dose and the interval between doses may require adjustments for patients who have concurrent health conditions or atypical metabolic patterns, or if the patient takes other prescribed medications that alter rates of opioid medication metabolism.

8. **For opioid treatment programs:** The program maintains patients who become pregnant during treatment on the pre-pregnancy dosage, if effective, and applies the same medication dosages as used with any other nonpregnant patient.

9. **For opioid treatment programs:** The methadone dose is carefully monitored for pregnant patients. Monitoring is especially important during the third trimester when biological changes, induced by pregnancy, can alter the rate at which methadone is metabolized or eliminated from the system. In these cases, an increased or a split dose may be necessary.

10. **For opioid treatment programs:** The physician evaluates the patient’s stability and response to take-home medication and adjusts the dosage at regular intervals.

11. **For opioid treatment programs:** For women of childbearing potential, the physician conducts an assessment for pregnancy before initiating medically supervised withdrawal.
12. **For opioid treatment programs:** If a pregnant patient elects to withdraw from methadone and stays in the program, a physician experienced in addiction medicine supervises the withdrawal process with regular fetal assessments as appropriate for gestational age as part of the withdrawal process. The withdrawal is not initiated before 14 weeks or after 32 weeks of gestation.

**Standard MM.07.01.03**

The organization responds to actual or potential adverse medication events, significant adverse medication reactions, and medication errors.

**Note 1:** *This standard is applicable only to organizations that prescribe or administer medications.*

**Note 2:** *See the Glossary for definitions of “adverse medication event” and “significant adverse medication reaction.”*

**Rationale for MM.07.01.03**

Adverse medication reactions and medication errors place individuals served at considerable risk. To maintain safe, quality care, organizations must have systems in place to respond to and monitor an individual in the event of an adverse medication reaction or medication error.

**Elements of Performance for MM.07.01.03**

1. **For organizations that prescribe or administer medications:** The organization has a written process to respond to actual adverse medication events, significant adverse medication reactions, and significant medication errors.

   **Note:** *This element of performance is also applicable to sample medications.*

2. **For organizations that prescribe or administer medications:** The organization’s written process addresses prescriber notification in the event of a significant adverse medication event, significant adverse medication reaction, or a significant medication error.

   **Note:** *This element of performance is also applicable to sample medications.*

3. **For organizations that prescribe or administer medications:** The organization complies with internal and external reporting requirements for significant adverse medication events, significant adverse medication reactions, or significant medication errors.

   **Note:** *This element of performance is also applicable to sample medications.*
5. **For organizations that prescribe or administer medications:** The organization implements its process for responding to significant adverse medication events, significant adverse medication reactions, or significant medication errors. 

   **Note:** *This element of performance is also applicable to sample medications.*

7. **For opioid treatment programs:** Medication blood levels are obtained when clinically indicated.

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**Standard MM.08.01.01**

The organization evaluates the effectiveness of its medication management system.

**Note 1:** *This evaluation includes reconciling medication information. (Refer to NPSG.03.06.01 for more information)*

**Note 2:** *This standard is applicable only to organizations that prescribe, dispense, or administer medications.*

**Elements of Performance for MM.08.01.01**

1. **For organizations that prescribe, dispense, or administer medications:** The organization collects data on the performance of its medication management system. *(See also PI.01.01.01, EPs 14 and 15)*

   **Note:** *This element of performance is also applicable to sample medications.*

2. **For organizations that prescribe, dispense, or administer medications:** The organization analyzes data on its medication management system.

   **Note:** *This element of performance is also applicable to sample medications.*

3. **For organizations that prescribe, dispense, or administer medications:** The organization compares data over time to identify risk points, levels of performance, patterns, trends, and variations of its medication management system.

   **Note:** *This element of performance is also applicable to sample medications.*

5. **For organizations that prescribe, dispense, or administer medications:** Based on analysis of its data, the organization identifies opportunities for improvement in its medication management system.

6. **For organizations that prescribe, dispense, or administer medications:** The organization takes action on improvement opportunities identified as priorities for its medication management system. *(See also PI.03.01.01, EP 2)*

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Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
Note: This element of performance is also applicable to sample medications.

7. **For organizations that prescribe, dispense, or administer medications:** The organization evaluates its actions to confirm that they resulted in improvements for its medication management system. 

8. **For organizations that prescribe, dispense, or administer medications:** The organization takes additional action when planned improvements for its medication management processes are either not achieved or not sustained.

16. When automatic dispensing cabinets (ADCs) are used, the organization has a policy that describes the types of medication overrides that will be reviewed for appropriateness and the frequency of the reviews. A 100% review of overrides is not required.
### Applicability for Medication Management Type

This grid is meant to be a resource to determine which Medication Management (MM) standards and elements of performance (EPs) apply to your organization based on the type of medication management processes conducted within your organization.

**Note:** The Applicability for Medication Management Type grid is not a guideline for Opioid Treatment Programs (OTPs). Because of this, the standards and EPs that apply only to Opioid Treatment Programs are not reflected below. Please see the “Standards Applicability Process” (SAP) chapter.

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Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
National Patient Safety Goals (NPSG)

Chapter Outline

National Patient Safety Goals

I. Goal 1 – Improve the accuracy of the identification of individuals served.
   A. Use of Two Individual Served Identifiers (NPSG.01.01.01)

II. Goal 3—Improve the safety of using medications.
    A. Reconciling Medication Information (NPSG.03.06.01)

III. Goal 7—Reduce the risk of health care–associated infections.
    A. Meeting Hand Hygiene Guidelines (NPSG.07.01.01)

IV. Goal 15—The organization identifies safety risks inherent in the population of the individuals it serves.
    A. Identifying Individuals at Risk for Suicide (NPSG.15.01.01)
Requirements, Rationales, and Elements of Performance

Goal 1
Improve the accuracy of the identification of individuals served.

NPSG.01.01.01
Use at least two identifiers when providing care, treatment, or services.

Note: Treatments covered by this goal include high-risk interventions and certain high risk medications (for example, methadone). In some settings, use of visual recognition as an identifier is acceptable. Such settings include those that regularly serve an individual (for example, therapy) or serve only a few individuals (for example, a group home). These are settings in which the individual stays for an extended period of time, staff and populations served are stable, and individuals receiving care are well-known to staff.

Rationale for NPSG.01.01.01
Errors involved in misidentification of the individual served can occur in virtually all stages of diagnosis and treatment. The intent for this goal is two-fold: first, to reliably identify the individual as the person for whom the service or treatment is intended; second, to match the service or treatment to that individual. Acceptable identifiers may be the individual’s name, an assigned identification number, telephone number, or other person-specific identifier.

Elements of Performance for NPSG.01.01.01

1. Use at least two identifiers of the individual served when administering medications or collecting specimens for clinical testing. The room number or physical location of the individual served is not used as an identifier. (See also MM.05.01.09, EPs 8 and 11) R

2. Label containers used for specimens in the presence of the individual served. R
**Goal 3**

Improve the safety of using medications.

**Introduction to Reconciling Medication Information**

The large number of people receiving care, treatment, or services who take multiple medications and the complexity of managing those medications make medication reconciliation an important safety issue. In medication reconciliation, a clinician compares the medications the individual served should be using (and is actually using) to the new medications that are ordered for the individual and resolves any discrepancies.

The Joint Commission recognizes that organizations face challenges with medication reconciliation. The best medication reconciliation requires a complete understanding of what the individual served was prescribed and what medications he or she is actually taking. It can be difficult to obtain a complete list from every individual in an encounter, and accuracy is dependent on the ability and willingness of the individual served to provide this information. A good faith effort to collect this information is recognized as meeting the intent of the requirement. As more sophisticated systems evolve (such as centralized databases for prescribing and collecting medication information), the effectiveness of these processes will grow.

This National Patient Safety Goal (NPSG) focuses on the risk points of medication reconciliation. The elements of performance in this NPSG are designed to help organizations reduce negative outcomes associated with medication discrepancies. Some aspects of the care, treatment, or services that involve the management of medications are addressed in the standards rather than in this goal. These include coordinating information during transitions in care both within and outside of the organization (CTS.04.01.01), education of the individual on safe medication use (CTS.04.01.03), and communications with other providers (CTS.06.02.05).
In settings where medications are not routinely prescribed or administered, this NPSG provides organizations with the flexibility to decide what medication information they need to collect based on the services they provide. It is often important for clinicians to know what medications the individual is taking when planning care, treatment, or services, even in situations where medications are not used. A new requirement in this NPSG addresses the individual’s role in medication safety: it requires organizations to inform the individual served about the importance of maintaining updated medication information.

**NPSG.03.06.01**
Maintain and communicate accurate medication information for the individual served.

**Rationale for NPSG.03.06.01**
There is evidence that medication discrepancies can affect outcomes. Medication reconciliation is intended to identify and resolve discrepancies—it is a process of comparing the medications an individual is taking (and should be taking) with newly ordered medications. The comparison addresses duplications, omissions, and interactions, and the need to continue current medications. The types of information that clinicians use to reconcile medications include (among others) medication name, dose, frequency, route, and purpose. Organizations should identify the information that needs to be collected to reconcile current and newly ordered medications and to safely prescribe medications in the future.

**Elements of Performance for NPSG.03.06.01**

1. **Obtain and/or update information on the medications the individual served is currently taking.** This information is documented in a list or other format that is useful to those who manage medications. 

   **Note 1:** The organization obtains the individual’s medication information during the first contact. The information is updated when the individual’s medications change.

   **Note 2:** Current medications include those taken at scheduled times and those taken on an as-needed basis. See the Glossary for a definition of medications.

   **Note 3:** It is often difficult to obtain complete information on current medications from the individual served. A good faith effort to obtain this information from the individual and/or other sources will be considered as meeting the intent of the EP.
2. Define the types of medication information (for example, name, dose, route, frequency, purpose) to be collected in non-24-hour settings based on situations of individuals served and characteristics of different settings.

3. **For organizations that prescribe medications:** Compare the medication information the individual served brought to the organization with the medications ordered for the individual by the organization in order to identify and resolve discrepancies.

   **Note:** Discrepancies include omissions, duplications, contraindications, unclear information, and changes. A qualified staff member, identified by the organization, does the comparison. (See also HRM.01.06.01, EP 1)

4. **For organizations that prescribe medications:** Provide the individual served (or family as needed) with written information on the medications the individual should be taking at the end of the encounter (for example, name, dose, route, frequency, purpose).

   **Note:** When the only additional medications prescribed are for a short duration, the medication information the organization provides includes only those medications. For more information about communications to other providers of care when the patient is discharged or transferred, refer to Standard CTS.06.02.05.

5. **For organizations that prescribe medications:** Explain the importance of managing medication information to the individual served.

   **Note:** Examples include instructing the individual served to give a list to his or her primary care physician; to update the information when medications are discontinued, doses are changed, or new medications (including over-the-counter products) are added; and to carry medication information at all times in the event of emergency situations. (For information on education of the individual served, refer to Standard CTS.04.01.03.)

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**Goal 7**

Reduce the risk of health care–associated infections.

**NPSG.07.01.01**

Comply with either the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines or the current World Health Organization (WHO) hand hygiene guidelines.
Note: This standard applies only to organizations that provide physical care.

Rationale for NPSG.07.01.01
According to the Centers for Disease Control and Prevention, each year, millions of people acquire an infection while receiving care, treatment, or services in a health care organization. Consequently, health care–associated infections (HAIs) are a safety issue affecting all types of health care organizations. One of the most important ways to address HAIs is by improving the hand hygiene of health care staff. Compliance with the World Health Organization (WHO) or Centers for Disease Control and Prevention (CDC) hand hygiene guidelines will reduce the transmission of infectious agents by staff to individuals served, thereby decreasing the incidence of HAIs. To ensure compliance with this National Patient Safety Goal, an organization should assess its compliance with the CDC and/or WHO guidelines through a comprehensive program that provides a hand hygiene policy, fosters a culture of hand hygiene, and monitors compliance and provides feedback.

Following safe hand hygiene practices is important in all organizations; however, the risk to individuals served increases when there is physical contact. In these situations, it is more important to follow formal hand hygiene guidelines. This requirement, therefore, applies only to organizations that provide physical care.

Elements of Performance for NPSG.07.01.01
1. Implement a program that follows categories IA, IB, and IC of either the current Centers for Disease Control and Prevention (CDC) or the current World Health Organization (WHO) hand hygiene guidelines. (See also IC.01.04.01, EP 1)  
   Note: This element of performance applies only to organizations that provide physical care.

2. Set goals for improving compliance with hand hygiene guidelines. (See also IC.03.01.01, EP 1)  
   Note: This element of performance applies only to organizations that provide physical care.

3. Improve compliance with hand hygiene guidelines based on established goals.  
   Note: This element of performance applies only to organizations that provide physical care.
Goal 15
The organization identifies safety risks inherent in the population of the individuals it serves.

NPSG.15.01.01
Identify individuals at risk for suicide.

Rationale for NPSG.15.01.01
Suicide of an individual served while in a staffed, round-the-clock care setting is a frequently reported type of sentinel event. Identification of individuals at risk for suicide while under the care of or following discharge from a health care organization is an important step in protecting these at-risk individuals.

Elements of Performance for NPSG.15.01.01
1. Conduct a risk assessment that identifies specific characteristics of the individual served and environmental features that may increase or decrease the risk for suicide. R

2. Address the immediate safety needs and most appropriate setting for treatment of the individual served. R

3. When an individual at risk for suicide leaves the care of the organization, provide suicide prevention information (such as a crisis hotline) to the individual and his or her family. R
Performance Improvement (PI)

Overview
All organizations want better outcomes for the individuals they serve and, therefore, are concerned about improving the safety and quality of the care, treatment, and services they provide. The best way to achieve this is by first measuring the performance of processes that support care and then by using that data to make improvements. The standards in this chapter stress the importance of using data to influence positive change.

About This Chapter
Leaders have ultimate responsibility for performance improvement. They set performance improvement priorities and provide the resources needed to achieve improvement. They make sure that all individuals who work in the organization participate in performance improvement activities. The leaders’ responsibilities are more fully described in the “Leadership” (LD) chapter. (Standards LD.03.01.01 through LD.03.06.01 describe the management of important organizationwide systems that support safety and quality. Standard LD.04.04.01 addresses the need for leaders to establish performance improvement priorities.)

Collecting data is the foundation of performance improvement (see Standard IM.01.01.01 for managing information and Standard IM.02.02.03 for retrieving, disseminating, and transmitting behavioral and physical health information in usable formats). Based on its setting, scope, and services, the organization selects measures that are meaningful to the organization and that address the needs of the individuals served. In addition, The Joint Commission has identified important processes (see Standard PI.01.01.01) that should always be measured because they involve risk and can harm the individuals served.

Regardless of how much data the organization collects, data are not useful if they are not analyzed. Analysis identifies trends, patterns, and performance levels that suggest opportunities for improvement. The organization can then make improvements based on the analysis. Of course, there is always the chance that analysis may reveal that more opportunities for improvement exist than an organization can manage at one time. In this case, leaders need to set priorities for improvement.
After a change has been made, the organization monitors that change by collecting and analyzing data to make sure the desired improvement is achieved and sustained. Organizations should identify the results that will signify sustained improvement. If the improvement does not meet expectations, the organization makes additional changes, and the cycle starts again. These principles of performance improvement also apply whenever the organization wants to design new processes, such as a new service or an information management system (see Standard LD.04.04.03).

The standards in this chapter address the fundamental principles of performance improvement: collecting data, analyzing them, and taking action to improve.
Chapter Outline

I. Data Collection (PI.01.01.01)
II. Data Analysis (PI.02.01.01)
III. Performance Improvement (PI.03.01.01)
Introduction to Standard PI.01.01.01
Data provide organizations with important information that can be used in a variety of ways. Collecting data on performance, outcomes, and other activities is the first step in helping the organization improve its ability to provide quality care, treatment, and services. The organization can collect data from many areas, including internal data obtained from staff, individuals served, records, and observations. Data are also available from quality control, risk management activities, and research studies. Other valuable data can be obtained from external sources, such as regulators and insurers. The Joint Commission has identified important areas that should be measured regularly. In addition, the organization should establish data priorities particular to its needs.

Standard PI.01.01.01
The organization collects data to monitor its performance.

Elements of Performance for PI.01.01.01
1. The leaders set priorities for data collection. *(See also LD.04.04.01, EP 1)*
2. The organization identifies the frequency for data collection.

The organization collects data on the following:

3. Performance improvement priorities identified by leaders. *(See also LD.04.04.01, EP 1)*

14. Significant medication errors. *(See also LD.04.04.01, EP 2; MM.08.01.01, EP 1)*

15. Significant adverse medication reactions. *(See also LD.04.04.01, EP 2; MM.08.01.01, EP 1)*

16. The organization collects data on the following:
   - Whether the individual served was asked about treatment goals and needs
   - Whether the individual served was asked if his or her treatment goals and needs were met
The view of the individual served regarding how the organization can improve the safety of the care, treatment, or services provided

(See also RI.01.01.01, EP 17, for opioid treatment programs)

27. The organization collects data to measure the performance of high-risk, high-volume, problem-prone processes provided to high-risk or vulnerable populations, as defined by the organization. (See also LD.04.04.01, EP 2)

Note: Examples of such processes include the use of restraints, seclusion, suicide watch, and behavior management and treatment.

31. For foster care: The agency collects data on its performance, including the safety of the placement and the maintenance or improvement of the individual’s level of functioning.

32. For foster care: The agency collects data on the permanency of the placement and the permanency of outcome when they are within the organization’s scope of services.

37. For opioid treatment programs: The program collects data about treatment outcomes and processes.

Note: Examples of data collected include the following:

- Use of illicit opioids, illegal drugs, and the problematic use of alcohol and prescription medications
- Criminal activities and entry into the criminal justice system
- Behaviors contributing to the spread of infectious diseases
- Restoration of physical and mental health and functional status
- Retention in treatment
- Number of patients who are employed
- Abstinence from drugs of abuse

For organizations that elect The Joint Commission Behavioral Health Home option:

The organization collects data on the following:

40. Disease management outcomes. (See also LD.04.04.01, EP 24)

41. The individual’s access to care within time frames established by the organization.

42. For organizations that elect The Joint Commission Behavioral Health Home option: The organization collects data on the following:
The individual’s experience and satisfaction related to access to care, treatment, or services and communication
- The individual’s perception of the comprehensiveness of care, treatment, or services
- The individual’s perception of the coordination of care, treatment, or services
- The individual’s perception of the continuity of care, treatment, or services

(Refer to PI.01.01.01, EP 16)

43. **For organizations that elect The Joint Commission Behavioral Health Home option**: All staff who are part of the behavioral health home actively participate in performance improvement activities.

48. **For organizations that provide eating disorders care, treatment, or services**: The organization collects data about care, treatment, or services outcomes. Examples of such data include the following:
- If conducting follow-ups, confirmation of whether the individual is engaged in aftercare services and, if so, the type and frequency of those services.
- Data collected from valid and reliable instruments used at admission and discharge that are self-administered by individuals served. Examples of such instruments include the Beck Depression Inventory (BDI), Eating Disorder Quality of Life (EDQOL), the SF-36, and Eating Disorder Inventory-3 (EDI-3).
- Data collected from individuals’ satisfaction questionnaires.

**Introduction to Standard PI.02.01.01**

When data are collected, they are compiled and analyzed. When the organization analyzes data over time, it transforms raw data into useful information. Analysis of data from internal sources allows the organization to identify patterns and trends and to monitor its performance. The organization may also have access to external databases that allow it to compare its performance with other organizations on a specific topic.
Data displays may help with analysis. There are many different ways to display data, including simple bar or pie charts or more sophisticated run or control charts. The display should match the question being studied. For example, something being studied over time might be displayed in a run chart or histogram. The display can be handwritten, created in a simple spreadsheet, or generated by more complex statistical software.

**Standard PI.02.01.01**
The organization compiles and analyzes data.

**Elements of Performance for PI.02.01.01**

4. The organization analyzes and compares internal data over time to identify levels of performance, patterns, trends, and variations.

8. The organization uses the results of data analysis to identify improvement opportunities. (*See also* HRM.01.06.05, EP 2; HRM.01.07.01, EP 3; LD.03.02.01, EP 5)

9. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization uses patient registries, health information technology (HIT), and/or electronic health records (EHRs) to collect, analyze, and compare data in order to improve the outcomes of the individuals served.

**Standard PI.03.01.01**
The organization improves performance.

**Elements of Performance for PI.03.01.01**

2. The organization takes action on improvement priorities. (*See also* MM.08.01.01, EP 6)

4. The organization takes action when it does not achieve or sustain planned improvements.

11. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization uses the data it collects on the individual’s perception of the safety and quality of care, treatment, or services to improve its performance. This data includes the following:
   - The individual’s experience and satisfaction related to access to care, treatment, or services and communication
The individual’s perception of the comprehensiveness of care, treatment, or services
The individual’s perception of the coordination of care, treatment, or services
The individual’s perception of the continuity of care, treatment, or services
Record of Care, Treatment, and Services (RC)

Overview
The “Record of Care, Treatment, and Services” (RC) chapter contains information about the components of a complete clinical/case record. A highly detailed document when seen in its entirety, the clinical/case record comprises all data and information gathered about an individual served from the moment he or she enters the organization to the moment of discharge or transfer. As such, the clinical/case record functions not only as a historical record of an individual’s episode(s) of care, but also as a method of communication among staff that can facilitate the continuity of care and aid in making decisions about care, treatment, or services.

Whether the organization keeps paper records, electronic records, or both, the contents of the record remain the same. Special care should be taken by organizations that are transitioning from paper to electronic systems, as the period of transition can present increased opportunity for errors in recordkeeping that can affect the delivery of safe, quality care.

About This Chapter
Within this chapter is a comprehensive set of requirements for compiling and maintaining the clinical/case record. The separate components of a complete clinical/case record are listed and arranged within common groups (demographic, clinical, and additional information). This chapter also contains documentation requirements for screenings, assessments, and reassessments; restraint and seclusion; the care, treatment, or services provided; and discharge. The standards provide policies and procedures that guide the compilation, completion, authentication, retention, and release of records.
Chapter Outline

I. Plan
   A. Clinical/Case Record Components (RC.01.01.01)
   B. Authentication (RC.01.02.01)
   C. Timeliness (RC.01.03.01)
   D. Audit (RC.01.04.01)
   E. Retention (RC.01.05.01)

II. Implement
   A. Care, Treatment, or Services (RC.02.01.01, RC.02.01.05)
   B. Orders (RC.02.03.07)
   C. Discharge Information (RC.02.04.01)

III. Foster Care (RC.03.01.01, RC.03.01.03)
Standards, Rationales, and Elements of Performance

Standard RC.01.01.01
The organization maintains complete and accurate clinical/case records.

Elements of Performance for RC.01.01.01
1. The organization defines the components of a complete clinical/case record.
5. The clinical/case record contains the information needed to support the diagnosis or condition of the individual served.
6. The clinical/case record contains the information needed to justify the care, treatment, or services provided to the individual served.
7. The clinical/case record contains information that documents the course and result of the care, treatment, or services provided to the individual served.
8. The clinical/case record contains information about the care, treatment, or services provided to the individual served that promotes continuity of care among providers.
9. The organization uses standardized formats to document the care, treatment, or services it provides to individuals served.
11. All entries in the clinical/case record are dated.
12. The organization tracks the location of all components of the clinical/case record.

Standard RC.01.02.01
Entries in the clinical/case record are authenticated.

Elements of Performance for RC.01.02.01
1. Only authorized staff make entries in the clinical/case record.
2. The organization defines the types of entries in the clinical/case record made by staff that require countersigning, in accordance with law and regulation.
3. The author of each clinical/case record entry is identified in the clinical/case record.
4. Entries in the clinical/case record are authenticated by the author. Information introduced into the clinical/case record through transcription or dictation is authenticated by the author.

**Note 1:** Authentication can be verified through electronic signatures, written signatures or initials, rubber-stamp signatures, or computer key.

**Note 2:** For paper-based records, signatures entered for purposes of authentication after transcription or for verbal orders are dated when required by law or regulation or organization policy. For electronic records, electronic signatures will be date-stamped.

5. The staff identified by the signature stamp or method of electronic authentication is the only staff who uses it.

**Standard RC.01.03.01**

Documentation in the clinical/case record is entered in a timely manner.

**Elements of Performance for RC.01.03.01**

1. The organization has a written policy that requires timely entry of information into the clinical/case record. *(See also CTS.04.01.01, EP 4)*

2. The organization defines the time frame for completion of the clinical/case record following discharge.

3. The organization implements its policy requiring timely entry of information into the clinical/case record of the individual served.

**Standard RC.01.04.01**

The organization audits its clinical/case records.

**Element of Performance for RC.01.04.01**

1. According to a time frame it defines, the organization reviews its clinical/case records to confirm that the required information is present, accurate, legible, authenticated, and completed on time.

**Standard RC.01.05.01**

The organization retains its clinical/case records.
Elements of Performance for RC.01.05.01

1. ☐ The retention time of the clinical/case record is determined by its use and organization policy, in accordance with law and regulation.

8. Original clinical/case records are not released unless the organization is responding to law and regulation.

Standard RC.02.01.01
The clinical/case record contains information that reflects the care, treatment, or services provided to the individual served.

Elements of Performance for RC.02.01.01

1. The clinical/case record contains the following demographic information:
   - The name, address, date of birth, and sex of the individual served
   - The name and contact information for the individual’s family and any legally authorized representative
   - The preferred language and any special communication needs of the individual served

   **Note:** Special communication needs may include sign language.

2. ☐ The clinical/case record of the individual served contains the following clinical information:
   - The reason(s) for admission for care, treatment, or services
   - The initial diagnosis, diagnostic impression(s), or condition(s)
   - Any findings of assessments and reassessments
   - Any allergies to food
   - Any allergies to medications
   - Any conclusions or impressions drawn from the medical history and physical examination
   - Any diagnoses or conditions established during the course of care, treatment, or services
   - Any consultation reports
   - Any observations relevant to care, treatment, or services
   - The response to care, treatment, or services
   - Any emergency care, treatment, or services provided prior to arrival
   - Any progress notes
   - Any medications ordered or prescribed
Any medications administered, including the strength, dose, route, date and time of administration
Any access site for medication, administration devices used, and rate of administration (for intravenous therapy)
Any adverse drug reactions
Treatment goals, plan of care, and revisions to the plan of care, treatment, or services
Orders for diagnostic and therapeutic tests and procedures and their results

4. As needed to provide care, treatment, or services, the clinical/case record contains the following additional information:
- Any advance directives
- Any informed consent
- Any documentation of protective services
- Any documentation of consent by the individual served, family, or guardian for admission; care, treatment, or services; evaluation; continuing care; or research
- Any records of communication with the individual served, such as telephone calls or e-mail
- Any documentation of involvement in care, treatment, or services by the individual served and, when necessary, his or her family
- Any information on unusual occurrences, such as complications; accidents or injuries to the individual served; procedures that place the individual served at risk or cause pain; other illnesses or conditions that affect care, treatment, or services; or the death of the individual served
- Any indications for and episodes of special procedures

22. When a person with intellectual disabilities, or his or her family or advocate, is unable or unwilling to participate in planning of care, treatment, or services, it is documented in the clinical/case record.

27. When more than one member of the family is receiving individual care, treatment, or services, a separate clinical/case record is maintained for each family member.

Note: Separate clinical/case records are not needed for family members participating in family therapy or counseling only.
28. **For organizations that elect The Joint Commission Behavioral Health Home option:** The clinical/case record of the individual served contains the following behavioral and physical health information:
   - All behavioral and physical health diagnoses and conditions that have required care, treatment, or services
   - All hospital admissions
   - All hospital re-admissions
   - All urgent care and emergency department visits

   (Refer to RC.02.01.01, EP 2)

29. **For organizations that elect The Joint Commission Behavioral Health Home option:** For the purpose of identifying disparities in care, treatment, or services, the clinical/case record contains the individual’s race and ethnicity.

30. **For organizations that elect The Joint Commission Behavioral Health Home option:** The clinical/case record includes the individual’s self-management goals related to integrated care and the individual’s progress toward achieving those goals.

**Standard RC.02.01.05**

The clinical/case record contains documentation of the use of restraint and/or seclusion and documentation of physical holding of a child or youth.

**Elements of Performance for RC.02.01.05**

3. The organization documents the use of restraint and/or seclusion for behavioral health purposes in the clinical/case record, including the following:
   - Each episode of restraint and/or seclusion
   - The circumstances that led to the use of restraint and/or seclusion
   - Consideration or failure of nonphysical interventions
   - The rationale for the type of physical intervention used
   - Written orders for the use of restraint and/or seclusion
   - Each verbal order received from a licensed independent practitioner
   - Each in-person evaluation and reevaluation of the individual served
   - Each 15-minute assessment of the status of the individual served
   - Continuous monitoring of the individual served
   - Any preexisting medical conditions or any physical disabilities that would place the individual served at greater risk during restraint and/or seclusion
- Any history of sexual or physical abuse that would place the individual at greater psychological risk during restraint and/or seclusion
- That the individual served and/or his or her family was informed of the organization’s policy on the use of behavioral restraint and/or seclusion
- That the individual served was notified of the use of restraint and/or seclusion
- Behavior criteria for discontinuing restraint and/or seclusion
- That the individual served was informed of the behavior criteria he or she needed to meet in order for restraint and/or seclusion to be discontinued
- Assistance provided to the individual served to help him or her meet the behavior criteria for discontinuing the use of restraint and/or seclusion
- Debriefing the individual served with staff following an episode of restraint and/or seclusion
- Any injuries the individual served sustained and the treatment for these injuries
- The death of the individual served while in restraint or seclusion

4. The method(s) used to document restraint and/or seclusion facilitates the collection and analysis of data for performance improvement activities.

5. □ The organization documents the use of physical holding of a child or youth for behavioral health purposes in the clinical/case record, including the following:
   - Each episode of physical holding
   - The circumstances that led to the use of physical holding
   - Attempt at or failure of nonphysical interventions
   - The rationale for the use of physical holding
   - Names of the staff members who participated in the use of physical holding, including who did the holding and who observed the child’s or youth’s physical well-being
   - Any preexisting medical conditions or any physical disabilities that would place the individual served at greater risk during physical holding
   - Any history of sexual or physical abuse or other trauma that would place the individual at greater psychological risk during physical holding
   - That the individual served and/or his or her family was informed of the organization’s policy on the use of physical holding
   - That the individual’s parent(s) or guardian was notified of the use of physical holding
   - Behavior criteria for discontinuing physical holding
That the individual served was informed of the behavior criteria he or she needed to meet in order for physical holding to be discontinued

Assistance provided to the individual served to help him or her meet the behavior criteria for discontinuing the use of physical holding

Debriefing the individual served with staff following an episode of physical holding

Any injuries the individual served sustained and the treatment for these injuries

The death of the individual served while in a physical hold

6. The method(s) used to document physical holding facilitates the collection and analysis of data for performance improvement activities.

**Standard RC.02.03.07**

Qualified staff receive and record verbal orders.

**Note:** Verbal orders may include medication, laboratory tests, dietary, or restraint and seclusion.

**Elements of Performance for RC.02.03.07**

1. The organization identifies, in writing, the staff who are authorized to receive and record verbal orders, in accordance with law and regulation.

2. Only authorized staff receive and record verbal orders.

3. Documentation of verbal orders includes the date and the names of staff who gave, received, recorded, and implemented the orders.

4. Verbal orders are authenticated within the time frame specified by law and regulation.

**Standard RC.02.04.01**

The organization documents the discharge information of the individual served.

**Element of Performance for RC.02.04.01**

3. The clinical/case record contains the following:
   - A concise discharge summary that includes the reason for acceptance for care, treatment, or services
   - The care, treatment, or services provided
   - The condition at discharge of the individual served
Information provided to the individual served and his or her family (for example, written discharge instructions, medication regimen, follow-up care)

**Note 1:** A discharge summary is not required when individuals served are seen for brief interventions, as defined by the clinical staff. In these instances, a final progress note may be substituted for the discharge summary.

**Note 2:** When individuals served are transferred to a different program within the organization, and staff change, a transfer summary may be substituted for the discharge summary. If the staff do not change, a progress note may be used.

**Standard RC.03.01.01**

**For foster care:** The agency defines and maintains information specific to the individual served and his or her family for continuity of care and initiation of improvement in its performance.

**Elements of Performance for RC.03.01.01**

1. **For foster care:** The agency defines in writing, and in accordance with law and regulation, the following:
   - Who has what level of access to information (for example, individuals served, family of origin, guardians, attorneys, foster parents)
   - The circumstances under which information may be released
   - The length of time records are kept
   - The individual served, family of origin or adoptive family, and foster family
   - The right of the individual served, family of origin or adoptive family, and the foster family to confidentiality and accessibility of information

2. **For foster care:** The agency has a plan to maintain a current life book for the child, or a similar way of providing such information.

**Note:** This chronological record of a child’s life is created by the child or the caregivers. Items in this book follow the child and will reflect significant life events, up to and including the present placement. The information may include developmental milestones, school information, placement records and reasons for moves, family history, awards and achievements, relationships, goals, information about and descriptions of birth parents and siblings (for example, family tree, pictures), and information about foster families.
3. **For foster care:** The agency implements its processes for accessing information, maintaining confidentiality of information, and for children/youth, maintaining a current life book.

4. **For foster care:** Information maintained by the agency includes the following:
   - Case records that include social and legal information, family of origin history, school reports, incident reports (for example, behavior problems, illness, injuries), medical and dental records and history, birth and developmental history, immunization records, placement authorization, case plan, progress reports, school information, and family of origin and foster care contacts
   - Contracts, correspondence, incident reports, and placement and other records or reports needed for the continuity of care

**Standard RC.03.01.03**

**For foster care:** The agency maintains foster family information.

**Elements of Performance for RC.03.01.03**

1. **For foster care:** The foster family record contains copies of licensing certificates and reports.

2. **For foster care:** The foster family record contains the application to provide foster care, references, background checks, and all assessment reports.

3. **For foster care:** The foster family record contains correspondence, including records of compliments and complaints.

4. **For foster care:** The foster family record contains evidence of training.

5. **For foster care:** Foster family records are retained in accordance with law and regulation and organizational policy.
Rights and Responsibilities of the Individual (RI)

Overview
When the organization recognizes and respects the rights of individuals served, it is providing an important aspect of care that has been shown to encourage individuals to become more informed and involved in their care, treatment, or services. These individuals ask questions and develop better relationships with the staff providing care, treatment, or services. This acknowledgement of rights helps the individual feel supported by the organization and the staff.

Recognizing and respecting the rights of individuals directly affects the provision of care. Care, treatment, or services should be provided in a way that respects and fosters the individual’s dignity, autonomy, positive self-regard, civil rights, and involvement in his or her care. In a climate of respect and trust, communication is enhanced, and issues that might lead to problems in safety or quality can be prevented or addressed. Care, treatment, or services should also be carefully planned and provided with regard to the individual’s personal values, beliefs, and preferences.

Recognizing and respecting the rights of the individual are, however, only part of the story. Individuals also have the obligation to take on certain responsibilities. The organization defines these responsibilities and then explains them to the individual. When individuals understand and accept their responsibilities, the concept of partnership becomes a dynamic component of the individual’s experience of care, treatment, or services.

A mere list of rights cannot by itself guarantee those rights. The organization shows its support of the individual’s rights through its interactions with them and by involving them in decisions about their care, treatment, or services. The standards in this chapter address the following processes and activities:

- Informing individuals of their rights
- Helping individuals understand and exercise their rights
- Respecting values, beliefs, and preferences of the individual
- Informing individuals of their responsibilities regarding their care, treatment, or services
About This Chapter

This chapter presents a series of requirements that help organizations to recognize and respect the rights of individuals served. These requirements address the following:

- Identification of fundamental, overarching rights
- The right to effective communication
- The right to participate in decisions related to care, treatment, or services
- The right to informed consent
- The right to know staff providing care, treatment, or services
- Individual rights
- Responsibilities of the individual served
- The rights of the individual in foster care settings

Note: This chapter addresses the role of a surrogate decision-maker who may participate in situations in which the individual served cannot or chooses not to make decisions. Instead of stating “individual served or surrogate decision-maker” in each occurrence where the surrogate decision-maker may need to play a role, “individual served” is used with the understanding that if the individual served is unable or chooses not to make decisions, the surrogate decision-maker may do so, in accordance with law and regulation.
Chapter Outline

I. Rights of the Individual
   A. Developing and Communicating the Individual’s Rights
      1. Charge to Organizations (RI.01.01.01)
   B. Participation in Care, Treatment, or Service Decisions (RI.01.02.01)
   C. Informed Consent (RI.01.03.01, RI.01.03.05)
   D. Right to Know (RI.01.04.01, RI.01.04.03)
   E. End-of-Life Issues (RI.01.05.01)
   F. Personal Rights (RI.01.06.03, RI.01.06.05, RI.01.06.07)
   G. Services Provided by Organizations to Respect Individual’s Rights
      (RI.01.07.01, RI.01.07.03, RI.01.07.07, RI.01.07.09)

II. Individual’s Responsibilities (RI.02.01.01)

III. Foster Care
   A. Rights of Individuals Served in Foster Care (RI.03.01.01)
   B. Foster Care and Rights of the Family of Origin (RI.03.01.03)
   C. Foster Care and Rights of the Foster Family (RI.03.01.05)
Standards, Rationales, and Elements of Performance

Standard RI.01.01.01
The organization respects the rights of the individual served.

Rationale for RI.01.01.01
This standard focuses on how the organization respects the rights of the individual served during his or her encounter with the organization. This encounter is characterized by viewing the individual as a whole person, not merely as a condition or illness to manage. Because the quality of the relationship between the provider and the individual can have an impact on the individual’s effective participation in care, treatment, or services, this relationship should be respectful and not biased by the individual’s diagnosis or condition. A mere list of rights cannot guarantee the rights of the individual. An organization puts its respect for the individual’s rights into action through its policies and procedures and the ways that staff interact with the individual and involve him or her in care, treatment, or services.

Elements of Performance for RI.01.01.01

1. ☑ The organization has written policies on the rights of the individual served.

2. The organization informs the individual served of his or her rights. (See also RI.01.01.03, EPs 1–3)

3. If an individual served is disoriented or lacks capacity to understand rights at the time of entry, he or she is informed again when he or she is able to understand.

4. The organization treats the individual served in a respectful manner that supports his or her dignity.

5. The organization respects the cultural and personal values, beliefs, and preferences of the individual served.

6. The organization respects the right of the individual served to privacy. (See also IM.02.01.01, EPs 1–4)

Note: This element of performance (EP) addresses the personal privacy of the individual served. For EPs addressing security and safety, please see EC.02.01.01, EP 3 and EC.02.06.01, EP 1. For EPs addressing the privacy of health information, please refer to Standard IM.02.01.01.
9. In 24-hour settings, the organization accommodates the right of the individual to pastoral and other spiritual services.

**Note:** The spiritual services of individuals are varied and may take place in the setting or outside of the setting, and may require special considerations regarding scheduling, space, or other accommodations. Within its capabilities, the organization accommodates this right.

10. In accordance with law and regulation, the organization allows the individual served to access and request amendment to his or her health information and to obtain information on disclosures of this information.

14. **For opioid treatment programs:** The program reviews rights and responsibilities with the patient at admission, at the end of the stabilization period, and when any changes have been made to the list of rights and responsibilities.

15. **For opioid treatment programs:** The program treats women respectfully and safely.

16. **For opioid treatment programs:** The medication schedule (dosing times/program hours) is the least intrusive and disruptive schedule for the majority of patients.

17. **For opioid treatment programs:** Satisfaction surveys allow patients to provide feedback on program policies and services. (*See also* PI.01.01.01, EP 16)

18. In 24-hour settings, individuals served are informed about the organization’s policies and procedures regarding the handling of medical emergencies. (*See also* RI.01.02.01, EP 2)

20. **For opioid treatment programs:** The program obtains written acknowledgement from patients that they received a copy of their rights and that these rights were discussed with them.

22. The organization informs the individual served of the program rules.

24. **For opioid treatment programs:** The program informs patients about the financial aspects of treatment, including the consequence of nonpayment of fees.

25. **For opioid treatment programs:** The program posts patients’ rights and responsibilities at the treatment site in a manner that makes the posting visible to patients.
26. **For opioid treatment programs:** The program informs patients upon admission about its obligation under state-specific requirements and its own policies and procedures to report suspected child abuse and neglect and other forms of abuse (such as violence against women).

30. **For organizations that provide 24-hour eating disorders care, treatment, or services:** The organization has a policy addressing those situations, if any, in which minors are permitted to leave the facility.

31. **For organizations that provide 24-hour eating disorders care, treatment, or services:** The organization obtains consent from a minor’s parent or guardian for the minor to have visitors.

32. **For organizations that provide 24-hour eating disorders care, treatment, or services:** The organization has a policy on Internet access for individuals served.

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**Standard RI.01.01.03**

The organization respects the right of the individual served to receive information in a manner he or she understands.

**Rationale for RI.01.01.03**

Because communication is a cornerstone of safe and quality care, every individual served has the right to receive information in a manner he or she understands. Effective communication allows individuals to participate more fully in their care, treatment, or services. When an individual understands what is being said about his or her care, treatment, or services, he or she is more likely to participate fully in his or her behavioral health care. Communicating effectively with individuals served is also critical to the informed consent process and helps practitioners and organizations give the best possible care. For communication to be effective, the information provided must be accurate, timely, complete, unambiguous, and understood by the individual served. Restrictions to communication should be based only on therapeutic justification.

The individual served has the right to receive information in a manner that he or she understands. Many individuals of varying circumstances require alternative communication methods: individuals who speak and/or read languages other than English; individuals who have limited literacy in any language; individuals who have visual or hearing impairments; individuals with cognitive impairments; and children. The organization has many options available to assist in communication with these individuals, such as interpreters, translated written materials, pen and paper, communi-
cation boards, and speech therapy. It is up to the organization to work with the individual served to determine which method works the best for his or her circumstances.

There are laws, regulations, and a body of literature that are relevant to the use of interpreters. These include Title VI of the Civil Rights Act, 1964; Executive Order 13166; policy guidance from the Office of Civil Rights regarding compliance with Title VI, 2004; Title III of the Americans with Disabilities Act, 1990; and state laws (many states have laws and regulations that require the provision of language assistance). Organizations may wish to reference these sources for additional information on providing interpreting and translation services to the individuals they serve.

**Elements of Performance for RI.01.01.03**

1. The organization provides information to the individual served in a manner tailored to his or her language and ability to understand. (*See also* CTS.06.02.03, EP 9; RI.01.01.01, EP 2)

2. The organization provides interpreting and translation services, as necessary. (*See also* RI.01.01.01, EP 2)

   **Note:** For organizations that elect The Joint Commission Behavioral Health Home option: Language interpreting options may include trained bilingual staff, contract interpreting services, or employed language interpreters. These options may be provided in person or via telephone or video. The documents that are translated, and the languages into which they are translated, are dependent on the population(s) served by the organization.

3. The organization communicates with the individual served who has vision, speech, hearing, or cognitive impairments in a manner that meets the needs of that individual. (*See also* RI.01.01.01, EP 2)

**Standard RI.01.02.01**

The organization respects the right of the individual served to collaborate in decisions about his or her care, treatment, or services.
Rationale for RI.01.02.01
Effective behavioral health care requires the involvement of individuals served, and their families or surrogate decision-makers where necessary. An understanding of the care, treatment, or service goals, of how various activities support these goals, and of unexpected outcomes or issues will enhance decision making and assist in preventing or resolving problems in care, treatment, or services.

Elements of Performance for RI.01.02.01

1. The organization involves the individual served in making decisions about his or her care, treatment, or services.

   **Note:** This involvement goes beyond mere presence at the time of discussion or decision making. Involvement connotes a collaborative process in which the organization actively engages the individual served in decision making regarding his or her care, treatment, or services.

2. When an individual served is unable to make decisions about his or her care, treatment, or services, or chooses to delegate decision making to another, the organization involves the surrogate decision maker in making these decisions. (*See also* RI.01.03.01, EP 1; RI.01.01.01, EP 18)

4. The organization respects the right of the individual served or surrogate decision maker to refuse care, treatment, or services, in accordance with law and regulation.

5. When an individual refuses care, treatment, or services, the organization fully informs the individual about its responsibility, in accordance with professional standards, to terminate the relationship with the individual upon reasonable notice, or to seek orders for involuntary treatment or other legal alternatives.

8. The individual served has the right to involve his or her family in decisions about care, treatment, or services. When there is a surrogate decision-maker, he or she can exercise the right to involve the family on behalf of the individual served, in accordance with law and regulation. (*See also* RI.01.07.01, EP 2; CTS.04.02.16, EP 5)

9. The organization accommodates the right of the individual served to request the opinion of a consultant.

   **Note:** This element of performance does not require the organization to pay for consultant services.
10. The organization accommodates the right of the individual served to request an internal review of his or her plan of care, treatment, or services.

11. The organization has a process for resolving disagreements about therapeutic issues.

20. The organization provides the individual served or surrogate decision-maker with the information about the following:
   - Outcomes of care, treatment, or services that the individual needs in order to participate in current and future behavioral health care decisions
   - Unanticipated events related to the individual’s care, treatment, or services that are sentinel events as defined by The Joint Commission (Refer to the Glossary for a definition of sentinel event.)

28. For opioid treatment programs: The program allows for patient choice in seeking alternative therapies and provides support to patients who choose to explore these alternatives.

   Note: Programs may provide culturally appropriate or popular and nonharmful alternative therapies, such as acupuncture or providing a space for a sweat lodge.

31. For organizations that elect The Joint Commission Behavioral Health Home option: The organization provides the individual served or surrogate decision-maker with the information about the outcomes of care, treatment, or services that the individual needs in order to participate in current and future physical health care decisions.

32. For organizations that elect The Joint Commission Behavioral Health Home option: The organization respects the individual’s right to make decisions about the management of his or her care, treatment, or services.

33. For organizations that elect The Joint Commission Behavioral Health Home option: The organization respects the individual’s right and provides him or her the opportunity to do the following:
   - Obtain care from other clinicians of the individual’s choosing within the behavioral health home
   - Seek a second opinion from a clinician of the individual’s choosing
   - Seek specialty care

   Note: This element of performance does not imply financial responsibility on the part of the organization for any activities associated with these rights.
34. **For opioid treatment programs:** The program provides the patient with information about providers in the community who are able to address any of the patient’s needs that the program cannot meet.

35. **For opioid treatment programs:** The program provides the patient with information about providers in the community should the patient be dissatisfied with the services received from the program.

**Standard RI.01.03.01**
The organization honors the right of the individual served to give or withhold informed consent.

**Rationale for RI.01.03.01**
Obtaining informed consent presents an opportunity to establish a mutual understanding between the individual served and the staff about the care, treatment, or services that the individual will receive. Informed consent is not merely a signed document. It is a process that considers needs and preferences of the individual and is in compliance with law and regulation. Utilizing the informed consent process helps the individual to participate fully in decisions about his or her care, treatment, or services. If an individual refuses to give informed consent, and is posing a threat to himself or herself or others, the organization may be permitted, in accordance with law and regulation, to take an alternative course of action, including providing care, treatment, or services without informed consent.

**Elements of Performance for RI.01.03.01**

1. The organization follows a written policy on informed consent that describes the following:
   - The specific care, treatment, or services that require informed consent
   - Circumstances that would allow for exceptions to obtaining informed consent, such as situations involving threat of harm to self or others, child abuse, or elder abuse
   - When a surrogate decision-maker may give informed consent (See also RI.01.02.01, EP 2)

2. The informed consent process includes a discussion about the following:
   - The proposed care, treatment, or services for the individual served.
   - The goals and potential benefits and risks of the proposed care, treatment, or services.
® Reasonable alternatives to the individual’s proposed care, treatment, or services. The discussion encompasses risks and benefits related to the alternatives and the risks related to not receiving the proposed care, treatment, or services.

3. The organization obtains and documents informed consent in advance if it makes and uses recordings, films, or other images of individuals served for internal use other than the identification, diagnosis, or treatment of the individual (for example, performance improvement and education). This informed consent includes an explanation of how the recordings, films, or other images will be used.

Note 1: The term “recordings, films, or other images” refers to photographic, video, digital, electronic, or audio media.

Note 2: This element of performance does not apply to the use of security cameras.

16. For opioid treatment programs: Before administering medication, the program obtains voluntary, written, informed consent from the patient for the prescribed medication-assisted treatment. The program’s informed consent policy makes certain that each patient voluntarily chooses maintenance treatment and that all relevant facts concerning the use of the opioid drug are clearly and adequately explained to the patient. Within 30 days post-admission, an appropriate program staff member reviews all relevant facts concerning the use of the opioid drug with the patient.

17. For opioid treatment programs: The program informs patients that the goal of medication-assisted treatment is to stabilize functioning.

18. For opioid treatment programs: The program informs patients that the provider will periodically discuss with them their present level of functioning, course of treatment, and future goals.

Note: These discussions are not intended to place pressure on the patient to either withdraw from medication or remain on medication maintenance.

19. For opioid treatment programs: Patients are informed about their disease’s natural progression, including statistics about success after withdrawing from methadone.
20. **For opioid treatment programs:** The program informs patients about potential medication interactions with and adverse reactions to other substances, including those related to the use of alcohol, licit and illicit drugs, other prescribed or over-the-counter pharmacological agents, other medical procedures, and food.

   **Note:** The program should provide the patient with information about potential medication interactions throughout the course of care, treatment, or services, such as at the time of the treatment plan review and at the time there are changes to the patient’s medication dose.

21. **For opioid treatment programs:** The program informs all pregnant patients with concurrent HIV infection that HIV medication treatment is currently recommended to reduce perinatal transmission, and it provides pregnant patients with appropriate referrals and case management for this treatment.

### Standard RI.01.03.05

The organization protects the individual served and respects his or her rights during research, investigation, and clinical trials.

**Note:** This standard applies when organizations conduct or permit individuals served to participate in research investigations or clinical trials.

### Rationale for RI.01.03.05

An organization that conducts (or permits within its organization) research, investigations, or clinical trials involving human subjects knows that its first responsibility is to the health and well-being of the research subjects. To protect and respect the research subjects’ rights, the organization reviews the research protocols. If another institution’s Institutional Review Board (IRB) reviews the research protocols, the organization does not need to perform this activity.

**Note:** The federal human subject protection standards generally assume that (1) all participation in new interventions is voluntary; (2) confidentiality of client records and research data is assured; (3) written, informed consent is obtained; (4) the risks/benefits of participation are explained to participants; (5) participation does not jeopardize ongoing treatment; and (6) the research does not impose an undue burden on participants. (The full federal human subject protection standards are published in 45 CFR, Part 46.)
Elements of Performance for RI.01.03.05

2. To help the individual served determine whether or not to participate in research, investigation, or clinical trials, the organization either provides the individual with all of the following information or confirms that the individual is provided with this information by the principal investigator:
   ■ An explanation of the purpose of the research
   ■ The expected duration of the individual’s participation
   ■ A clear description of the procedures to be followed
   ■ A statement of the potential benefits, risks, discomforts, and side effects
   ■ Alternative care, treatment, or services available that might prove advantageous to the individual

3. The organization informs the individual served that refusing to participate in research, investigation, or clinical trials or discontinuing participation at any time will not jeopardize his or her access to care, treatment, or services unrelated to the research.

4. The organization documents the following in the research consent form:
   ■ That the individual served received information to help determine whether or not to participate in the research, investigation, or clinical trials
   ■ That the individual served was informed that refusing to participate in research, investigation, or clinical trials or discontinuing participation at any time will not jeopardize his or her access to care, treatment, or services unrelated to the research
   ■ The name of the person who provided the information and the date the form was signed
   ■ The right to privacy, confidentiality, and safety of the individual served

Standard RI.01.04.01

The organization respects the right of the individual served to receive information about the staff responsible for his or her care, treatment, or services.

Elements of Performance for RI.01.04.01

1. The organization informs the individual served of the following:
   ■ The name of the staff member who has primary responsibility for his or her care, treatment, or services
   ■ The name of the staff member(s) who will provide his or her care, treatment, or services
6. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization informs the individual served of the scope of the license, certification, or registration of each behavioral health home staff member who possesses such a credential.

**Standard RI.01.04.03**

For organizations that elect The Joint Commission Behavioral Health Home option: The organization provides individuals served with information about the functions and services of the behavioral health home.

**Elements of Performance for RI.01.04.03**

1. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization provides information to the individual served about:
   The mission, vision, and goals of the behavioral health home. (Refer to LD.02.01.01, EP 3)

   **Note:** This may include how it provides for integrated care that is centered on the individual served, a systems-based approach to quality and safety, and enhanced access for individuals served.

2. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization provides information to the individual served about:
   The scope of care, treatment, or services and types of services provided by the behavioral health home.

3. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization provides information to the individual served about:
   How the behavioral health home functions, including the following:
   - The process for assigning or selecting clinicians
   - Involving the individual in his or her plan of care, treatment, or services
   - Obtaining and tracking referrals
   - Coordinating the individual’s integrated care
   - Collaborating with clinicians who provide specialty care or second opinions
4. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization provides information to the individual served about:
How to access the behavioral health home for care or information both during and after regular hours of operation.

5. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization provides information to the individual served and, when needed, his or her family or surrogate decision-maker about:
The individual’s responsibilities, including providing his or her health history and current medications, and participating in self-management activities. (Refer to RI.01.01.03, EPs 1–3 and RI.02.01.01, EP 2)

   **Note:** Individuals’ responsibilities will vary depending on their abilities and unique circumstances. In some cases, family members or surrogate decision-makers may be able to help individuals meet their responsibilities.

6. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization provides information to the individual served about:
The individual’s right to obtain care from other clinicians within the behavioral health home, to seek a second opinion, and to seek specialty care. (Refer to RI.01.02.01, EPs 9, 31, and 32)

**Standard RI.01.05.01**

For organizations that elect The Joint Commission Behavioral Health Home option:
The organization addresses decisions made by the individual served about physical health care, treatment, or services received at the end of life. (For more information, refer to Standard CTS.01.04.01.)

**Elements of Performance for RI.01.05.01**

1. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization follows a written policy on physical health advance directives that address the following:
   - Whether the organization will honor physical health advance directives
   - Communicating its policy on physical health advance directives to the individuals it serves
   - **For organizations that elect The Joint Commission Behavioral Health Home option:** Informing all members of the integrated care team when an individual served has a physical health advance directive, and how to access it
10. **For organizations that elect The Joint Commission Behavioral Health Home option:** Upon request, the organization shares with the individual possible sources of help in formulating physical health advance directives.

**Standard RI.01.06.03**
The individual served has the right to be free from neglect; exploitation; and verbal, mental, physical, and sexual abuse.

**Elements of Performance for RI.01.06.03**

1. The organization determines how it will protect the individual served from neglect, exploitation, and abuse that could occur while he or she is receiving care, treatment, or services. R

2. The organization evaluates all allegations, observations, and suspected cases of neglect, exploitation, and abuse that occur within the organization.

3. The organization reports allegations, observations, and suspected cases of neglect, exploitation, and abuse to appropriate authorities based on its evaluation of the suspected events and in accordance with law and regulation.

7. The organization takes steps to protect the individual served from neglect, exploitation, and abuse that could occur while he or she is receiving care, treatment, or services. R

8. **For opioid treatment programs:** The program takes steps to prevent patients from being harassed or exploited by other patients or staff.

**Standard RI.01.06.05**
The individual served has the right to an environment that preserves dignity and contributes to a positive self-image.

**Elements of Performance for RI.01.06.05**

1. The organization’s environment of care supports the positive self-image and dignity of the individual served.

4. The organization allows the individual served to keep and use personal clothing and possessions, unless this infringes on others’ rights or is therapeutically contraindicated.

**Note:** Personal items belonging to individuals served are taken and secured by staff only when therapeutically indicated.
6. If the organization provides clothing, the clothing is suitable to the season, age appropriate, and socially appropriate (that is, similar to that worn by persons in the external environment), and sufficient to permit laundering, cleaning, and repair.

9. The individual served has the right to an environment that minimizes distractions that interfere with therapeutic activities.

12. In 24-hour settings, the individual served has a right to an environment that promotes awareness of day, time, and season.

13. □ In 24-hour settings, the organization supports the use of personal displays by supplying the necessary equipment (such as bulletin boards) and developing written rules that govern personal displays.

17. In 24-hour settings, when the organization restricts the visitors, mail, telephone calls, or other forms of communication of the individual served, the restrictions are determined with the participation of the individual served, and with his or her family when such participation is deemed beneficial.

18. In 24-hour settings, when the organization restricts the visitors, mail, telephone calls, or other forms of communication of the individual served beyond the established program rules, these additional restrictions and their clinical necessity are documented in the clinical/case record.

20. In 24-hour settings, restrictions on communication are reduced or eliminated as soon as they are no longer therapeutically indicated.

27. In 24-hour settings, in rooms with more than one individual served, privacy is provided for dressing.

Note: Privacy for dressing may be achieved by curtains or other partitions in the room, or by use of a separate room or bathroom for dressing.

29. □ In 24-hour settings, no more than eight individuals may sleep in a room unless there is documentation in policy or in the individual plan of care of the justification for allowing more than eight individuals to sleep in a room.

30. In 24-hour settings, sleeping areas are assigned based on privacy and security needs.

**Standard RI.01.06.07**

Individuals served have a right to exercise citizenship privileges.
Element of Performance for RI.01.06.07

1. In 24-hour settings, the organization helps individuals served with citizenship privileges to exercise these privileges, including their voting privileges.

   **Note:** Examples of such help may include providing brochures, helping individuals obtain absentee ballots or apply for state identification, or facilitating transportation. Help may vary depending on the organization and population served.

Standard RI.01.07.01

The individual served and his or her family have the right to have complaints reviewed by the organization.

Elements of Performance for RI.01.07.01

1. The organization establishes a complaint resolution process and informs the individual served and his or her family about it.

   **Note:** If the individual served has a surrogate decision-maker, he or she will be informed of and involved in the complaint resolution process.

4. The organization reviews and, when possible, resolves complaints from the individual served and his or her family.

6. The organization acknowledges receipt of the complaint and notifies the individual served and, when appropriate, his or her family of the outcome of the complaint.

7. The organization provides the individual served (and when deemed beneficial, his or her family) with the phone number and address needed to file a complaint with the relevant state authority.

28. For opioid treatment programs: The program develops and makes available written policies and procedures addressing patient grievances.

29. For opioid treatment programs: The policies and procedures specify the minimum elements of due process applicable based on the program’s setting and resources, and include the following:
   - Providing the patient with a written decision that includes the reason for the decision
   - Maintaining the right of patients to appeal the decision to a final, unbiased source
Making every attempt, before a patient is discharged, to accommodate his or her desire to remain in opioid therapy at an alternative treatment program

- Using involuntary withdrawal only as a last resort and applying it in the most humane manner possible, consistent with the safety and well-being of the patient, staff, and other patients

- As a result of the patient filing a grievance, not changing the patient’s dose of opioids or other medications without his or her knowledge, unless the patient has signed a document waiving such consent

**Standard RI.01.07.03**
The individual served has the right to access protective and advocacy services.

**Elements of Performance for RI.01.07.03**

1. When the organization serves a population of individuals that need protective services (for example, guardianship or advocacy services, conservatorship, or child or adult protective services), it provides resources to help the family and the courts determine the individual’s needs for such services.

4. The organization has a written process for providing a personal advocate. This written process includes the conditions under which a personal advocate is indicated, and his or her role and responsibilities.

5. The organization informs staff and individuals served about the process for providing information on personal advocates. *(See also HRM.01.03.01, EP 3)*

6. The organization determines what its role will be, if any, in assessing the need for protective services, making recommendations, and providing protective services for individuals served.

7. When the organization does not provide protective services, staff make referrals for individuals determined to need such services.

8. Recommendations about the need for guardianship are based on a separate review process independent of considerations used in planning and providing care, treatment, or services.

**Standard RI.01.07.07**
The organization protects the rights of individuals served who work for or on behalf of the organization.
Note: This standard is applicable only to organizations that permit individuals served to work for or on behalf of the organization.

**Elements of Performance for RI.01.07.07**

1. The organization follows a written policy that addresses situations in which individuals served work for wages for or on behalf of the organization.

3. Wages paid to individuals served who work for or on behalf of the organization are in accordance with law and regulation.

4. The organization incorporates into the plan of care, treatment, or service the work performed by the individual served for or on behalf of the organization.

5. Individuals served have the right to refuse to work for or on behalf of the organization.

**Standard RI.01.07.09**

Individuals served receive information about the organization providing vocational rehabilitation services.

**Rationale for RI.01.07.09**

Individuals served need sufficient information to make informed choices about who is providing services.

**Elements of Performance for RI.01.07.09**

1. Individuals served receive information about the vocational rehabilitation organization, including the following:
   - Types and scope of integrated and community-based services provided.
   - Qualifications of staff providing services.
   - The organization’s ability to serve an individual and meet his or her needs.
   - Costs of services to the individual (if any).
   - Expected duration of the services.
   - Options for auxiliary and ancillary services.

**Standard RI.02.01.01**

The organization informs the individual served about his or her responsibilities related to his or her care, treatment, or services.
Rationale for RI.02.01.01
The quality and safety of care, treatment, or services is enhanced when individuals served are partners in the behavioral health care process. In addition, organizations are entitled to reasonable and responsible behavior on the part of individuals (and where necessary, their families). When organizations inform individuals and their families about their responsibilities, the topics that are discussed may include the following:

- Providing information about present complaints, past and current functioning, hospitalizations, medications, and other matters related to their behavioral and physical health
- Sharing expectations of and satisfaction with the organization
- Asking questions when they do not understand their care, treatment, or services or what they are expected to do
- Following instructions for their plan of care, treatment, or services, and expressing concerns about their ability to follow the proposed plan of care, treatment, or services
- Accepting consequences for the outcomes of care, treatment, or services if they do not follow the planned care, treatment, or services
- Following the organization’s policies and procedures
- Showing respect and consideration of organization’s staff and property, as well as other individuals and their property
- Meeting financial commitments

Elements of Performance for RI.02.01.01

2. The organization informs the individual served about his or her responsibilities.

   **Note:** Information about the individual’s responsibilities can be shared verbally, in writing, or both.

3. ☐ For opioid treatment programs: The program obtains written acknowledgement from the patient that patient responsibilities were explained.

Standard RI.03.01.01

For foster care: The foster care agency respects the rights of individuals in foster care.

Elements of Performance for RI.03.01.01

1. ☐ For foster care: The foster care agency follows written policies that support the following:
   - The participation of individuals in foster care in developing their case plan.
Note: Children, youth, and adults can be served in foster care programs. Children can participate in developing their case plan as appropriate to their age and maturity.

- Allowing Individuals to maintain contact with their biological families, including siblings, unless otherwise indicated in the case plan.
- Allowing individuals to access routine, preventive, and emergency medical, vision, behavioral health, dental, and rehabilitation care.
- Allowing individuals to access educational services.
- Individuals in maintaining contact with their ethnocultural heritage.
- Allowing individuals to participate in recreational skill building and social opportunities.
- Prohibiting individuals in foster care from being harased or abused.
- Supporting individuals in developing and expressing their own spirituality.

Standard RI.03.01.03
For foster care: The rights of the family of origin are respected.

Elements of Performance for RI.03.01.03

1. ☐ For foster care: The foster care agency’s written policies address the following:
   - The right of the family of origin to participate in the case plan of the individual in foster care, unless otherwise indicated in the case plan.
   - The right of the family of origin to maintain contact with the individual in foster care, unless otherwise indicated in the case plan.
   - The right of the family of origin to services that address the conditions that led to foster placement.

Note: These services may be provided by the agency or by referral, with the goal of having the individual returned to the family of origin.

Standard RI.03.01.05
For foster care: The agency providing foster care services respects the rights of the foster family.

Elements of Performance for RI.03.01.05

1. For foster care: The agency respects the foster family’s right to know how it sees the foster family’s role as a team member and how it helps the foster family in serving children, youth, or adults in their charge.

2. For foster care: The agency informs the foster family of the following:
The support and help the foster family will receive, including arrangements for respite, consultation, and support from agency staff and response to crisis situations.

The training they will receive (content and process of training), such as child abuse reporting requirements.

Remuneration rate schedules.

The identified needs and background of the individual in foster care.

How to file and handle complaints.

7. For foster care: Foster care agency staff are trained on how to communicate with the foster families regarding their rights. This training is documented. (See also HRM.01.05.01, EP 1)
Waived Testing (WT)

Overview
Waived testing refers to the least complex laboratory tests as defined in the federal regulation governing laboratory testing, known as the Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88). The Joint Commission first developed standards to address waived testing in 1992, and the standards were essentially unchanged until 2005.

At that time, The Joint Commission approved revisions to its waived testing standards to address the growing number of waived testing methods, risks to individual safety and quality of care when waived testing is performed improperly, and quality problems revealed by the Centers for Medicare & Medicaid Services (CMS).

The Morbidity and Mortality Weekly Report article, “Good Laboratory Practices for Waived Testing Sites” from November 11, 2005, supports the waived testing requirements. This report indicates quality and safety concerns related to waived testing. Although by law waived tests should have insignificant risk of erroneous results, these tests are not completely error proof, and some waived tests have potential for serious health impacts if performed incorrectly. This report draws attention to these pertinent risks:

- Lack of current manufacturers’ instructions, including manufacturers’ updates
- Failure to follow manufacturers’ instructions, including performing quality control
- Reporting of incorrect results
- Lack of adherence to expiration dates
- Inappropriate storage requirements
- Not performing test system function checks or calibration checks
- Lack of documentation, including quality control and tests performed
- Inadequate training
- Lack of understanding about good laboratory practices

These errors could cause inaccurate results that could lead to inaccurate diagnoses, inappropriate or unnecessary medical treatment, and poor individual outcomes.
Not all behavioral health care organizations perform waived testing. When performed, it
involves a few relatively simple procedures such as glucose testing, urine pregnancy
screens, rapid strep screens, and urine drug screens. The current list of methods that are
approved as waived testing can be found at the following websites:

- http://www.cms.hhs.gov/clia

Under CLIA ’88, an organization performing waived tests must be enrolled in the CLIA
program and have obtained a certificate of waiver. The person whose name appears on
the CLIA certificate does not have to have extensive knowledge of the procedures
involved. However, this person is accountable for the waived testing performed under
the CLIA certificate.

The information needed to establish the procedures and train staff is usually found in
the material made available by the manufacturer of the equipment or test kits. Most of
the time, the instructions that come with the equipment or test kits provide the basic
information to meet the requirements. If the organization decides to modify the
manufacturer’s instructions, the test would no longer be classified as a waived test but as
a nonwaived test. In this situation, the organization would have to be in compliance
with the CLIA ’88 requirements for nonwaived testing.

About This Chapter
These standards apply when the staff of the organization perform the testing with
instruments either owned by the organization or by the individual served. These
standards do not apply to waived tests performed by the individual. If staff members are
providing instruction or cueing the individual served, then these standards would also
not apply.

When the organization uses the results of testing done by the individual served for
clinical decisions, the organization needs to ensure that the individual served is doing the
testing properly so the results are accurate. The organization must also ensure that the
appropriate quality control measures have been used on the testing equipment by the
individual. The process is similar to ensuring the competency of a staff member who
performs the test.

* For further information on enrolling in the CLIA program and obtaining a CLIA certificate, see http://
How_to_Apply_for_a_CLIA_Certificate_International_Laboratories.html.
Currently, The Joint Commission allows for an organization to use the individual’s results for treatment decisions. When using an individual’s results from self-testing, health care providers do not have the same types of assurance about quality as they would if they conducted the waived testing themselves. The following processes are not specific Joint Commission requirements but are provided only as examples of how organizations have dealt with these concerns in practice:

- Verification of competency by either confirming that the individual served has been previously trained or observing the individual served perform his or her first test
- Requiring the individual served to perform quality control, if available for the meter, each day results are used
- Correlation of the individual’s first glucose result with testing by a main laboratory
- Confirmation of all critical and nonlinear instrument values with testing by the main laboratory
- Demonstration of proper equipment maintenance

**Note:** The Joint Commission requirements for organizations or sites that perform nonwaived testing are located in the “Quality System Assessment for Nonwaived Testing” (QSA) chapter of the Comprehensive Accreditation Manual for Laboratory and Point-of-Care Testing.
Chapter Outline

I. Policies and Procedures (WT.01.01.01)
II. Identification of Staff Performing and Supervising Waived Testing (WT.02.01.01)
III. Competency of Staff Performing Waived Testing (WT.03.01.01)
IV. Performance of Quality Control Checks (WT.04.01.01)
V. Recordkeeping (WT.05.01.01)
Standards, Rationales, and Elements of Performance

Standard WT.01.01.01

Policies and procedures for waived tests are established, current, approved, and readily available.

Elements of Performance for WT.01.01.01

1. The person from the organization whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88) certificate approves a consistent approach for when waived test results can be used for diagnosis and treatment and when follow-up testing is required. (See also LD.04.01.01, EP 1)

2. The person from the organization whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88) certificate, or a qualified designee, establishes written policies and procedures for waived testing that address the following:
   - Clinical usage and limitations of the test methodology
   - Need for confirmatory testing (for example, recommendations made by the manufacturer for rapid tests) and result follow-up recommendations (for example, a recommendation to repeat the test when results are higher or lower than the reportable range of the test)
   - Specimen type, collection, and identification, and required labeling
   - Specimen preservation, if applicable
   - Instrument maintenance and function checks, such as calibration
   - Storage conditions for test components
   - Reagent use, including not using a reagent after its expiration date
   - Quality control (including frequency and type) and corrective action when quality control is unacceptable
   - Test performance
   - Result reporting, including not reporting individual patient results unless quality control is acceptable
   - Equipment performance evaluation

Note 1: Policies and procedures for waived testing are made available to testing personnel.
Note 2: The designee should be knowledgeable by virtue of training, experience, and competence about the waived testing performed.

3. If manufacturers’ manuals or package inserts are used as the policies or procedures for each waived test, they are enhanced to include specific operational policies (that is, detailed quality control protocols and any other institution-specific procedures regarding the test or instrument).

4. The person from the organization whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88) certificate, or a qualified designee, approves in writing policies and procedures for waived testing at the following times:
   - Before initial use of the test for patient testing
   - Periodically thereafter, as defined by the person whose name appears on the CLIA certificate but at least once every three years
   - When changes in procedures occur (for example, when manufacturers’ updates to package inserts include procedural changes or when a different manufacturer is used)

Standard WT.02.01.01
The person from the organization whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88) certificate identifies the staff responsible for performing and supervising waived testing.

Note 1: Responsible staff may be employees of the organization, contracted staff, or employees of a contracted service.

Note 2: Responsible staff may be identified within job descriptions or by listing job titles or individual names.

Elements of Performance for WT.02.01.01

1. The person from the organization whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88) certificate, or a qualified designee, identifies, in writing, the staff responsible for performing waived testing.

2. The person from the organization whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88) certificate, or a qualified designee, identifies, in writing, the staff responsible for supervising waived testing.
**Standard WT.03.01.01**

Staff performing waived tests are competent.

**Elements of Performance for WT.03.01.01**

1. The person from the organization whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88) certificate, or a qualified designee, provides orientation and training to, and assesses the competency of, staff who perform waived testing.

2. Staff who perform waived testing have received orientation in accordance with the organization’s specific services. The orientation for waived testing is documented.

3. Staff who perform waived testing have been trained for each test that they are authorized to perform. The training for each waived test is documented.

4. Staff who perform waived testing that requires the use of an instrument have been trained on its use and operator maintenance. The training on the use and operator maintenance of an instrument for waived testing is documented.

5. Competency for waived testing is assessed using at least two of the following methods per staff per test:
   - Performance of a test on a blind specimen
   - Periodic observation of routine work by the supervisor or qualified designee
   - Monitoring of each user’s quality control performance
   - Use of a written test specific to the test assessed

6. Competence for waived testing is assessed according to organization policy at defined intervals, but at least at the time of orientation and annually thereafter. This competency is documented.

**Standard WT.04.01.01**

The organization performs quality control checks for waived testing on each procedure.

**Note:** Internal quality controls may include electronic, liquid, or control zone. External quality controls may include electronic or liquid.
Elements of Performance for WT.04.01.01

1. ☐ The person from the organization whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88) certificate establishes a written quality control plan for waived testing that specifies the method(s) for controlling procedures for quality, establishes timetables, and explains the rationale for choice of procedures and timetables. (See also LD.04.01.01, EP 1)

2. The documented quality control rationale for waived testing is based on the following:
   - How the test is used
   - Reagent stability
   - Manufacturers’ recommendations
   - The organization’s experience with the test
   - Currently accepted guidelines

3. For non-instrument-based waived testing, quality control checks are performed at the frequency and number of levels recommended by the manufacturer and as defined by the organization’s policies.

   **Note:** If these elements are not defined by the manufacturer, the organization defines the frequency and number of levels for quality control.

4. For instrument-based waived testing, quality control checks are performed on each instrument used for testing per manufacturers’ instructions.

5. For instrument-based waived testing, quality control checks require two levels of control, if commercially available.

**Standard WT.05.01.01**

The organization maintains records for waived testing.
Elements of Performance for WT.05.01.01

1. Quality control results, including internal and external controls for waived testing, are documented.
   
   **Note 1:** Internal quality controls may include electronic, liquid, or control zone. External quality controls may include electronic or liquid.

   **Note 2:** Quality control results may be located in the clinical/case record.

2. Test results for waived testing are documented in the individual’s clinical/case record.

3. Quantitative test result reports in the individual’s clinical/case record for waived testing are accompanied by reference intervals (normal values) specific to the test method used and the population served.
   
   **Note 1:** Semiquantitative results, such as urine macroscopic and urine dipsticks, are not required to comply with this element of performance.

   **Note 2:** If the reference intervals (normal values) are not documented on the same page as and adjacent to the waived test result, they must be located elsewhere within the individual’s permanent clinical/case record. The result must have a notation directing the reader to the location of the reference intervals (normal values) in the individual’s clinical/case record.

4. Individual test results for waived testing are associated with quality control results and instrument records.
   
   **Note:** A formal log is not required, but a functional audit trail is maintained that allows retrieval of individual test results and their association with quality control and instrument records.

5. Quality control result records, test result records, and instrument records for waived testing are retained for at least two years.
The Accreditation Process
(ACC)

Notices
The Joint Commission Connect™ extranet site is the primary means of communication by The Joint Commission. Any required notices to be given to an organization shall be sent to the organization via the organization’s secure Joint Commission Connect extranet site.

ACC Chapter Contents
This chapter introduces the Joint Commission’s accreditation process, beginning with general information about eligibility for accreditation and the application process, accreditation policies, and types of surveys. Details are then provided on what organizations can expect before, during, after, and between on-site surveys. Finally, the chapter ends by listing the accreditation decision rules and outlining review and appeal procedures. This outline provides a way to easily navigate the chapter and find information quickly.

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Overview

The policies, procedures, and explanations of process described in this chapter apply to any health care organization interested in Joint Commission accreditation, whether it is applying for the first time or seeking continued accreditation. All health care organizations must follow the policies and procedures listed in this chapter to participate in the accreditation process. Failure to follow the policies and procedures described in this chapter can result in denial of accreditation. Because this information is reviewed and revised as necessary on a continuous basis, all accredited organizations are responsible for keeping track of changes to these policies and procedures.

Changes made to accreditation requirements between manual updates can be viewed at “The Joint Commission Requirements” page on The Joint Commission website at http://www.jointcommission.org/standards_information/tjc_requirements.aspx.

The “Accreditation Participation Requirements” (APR) chapter also includes specific requirements for accreditation participation. The APRs are existing policies and are currently effective for accreditation purposes. Cross-references to the APRs are noted in the applicable sections of this chapter.

General Eligibility Requirements

Any health care organization may apply for Joint Commission accreditation if all the following requirements are met:

- The organization is in the United States or its territories or, if outside the United States, is owned or operated by the US government or under a charter of the US Congress.
- If required by law, the organization has a license or registration to conduct its scope of services.

¹Health care includes physical and behavioral health care.
The organization can demonstrate that it continually assesses and improves the quality of its care, treatment, and/or services. This process includes a review by clinicians or other qualified individuals, including those knowledgeable in the type of care, treatment, and/or services provided at the organization.

The organization identifies the services it provides, indicating which care, treatment, and/or services it provides directly, under contract, or through some other arrangement.

The organization provides programs/services that can be evaluated by The Joint Commission’s standards.

The organization meets parameters for the minimum number of individuals served/volume of services required for organizations seeking Joint Commission accreditation; that is, three individuals served, with at least two active at the time of survey; or for foster care/therapeutic foster care programs, three foster homes with at least two providing care for at least one foster child/adult; or for methadone detoxification programs (both inpatient and residential), three patients served within the past 12 months.

The tests, treatments, or interventions provided at the organization are in accordance with state and federal requirements.

Scope of Accreditation Surveys
The Joint Commission evaluates all health care services provided by the organization for which The Joint Commission has standards and makes an accreditation decision for each accreditation program surveyed. The survey results are documented by the surveyor(s) and left on site (with the exception of for-cause surveys) in the preliminary Summary of Survey Findings Report. During a survey, an organization must be prepared to provide evidence of its compliance with each applicable standard. To attain accreditation, an organization must demonstrate compliance with the standards and their elements of performance (EPs).

In addition to using standards and EPs, The Joint Commission also surveys organizations by using APRs and the Joint Commission National Patient Safety Goals (see the APR and “National Patient Safety Goals” [NPSG] chapters, respectively). Used in conjunction with the standards, these requirements help assess an organization’s performance.
Accreditation Policies
This section provides information on the policies that govern the accreditation process for organizations and describes how The Joint Commission shares information about an individual organization.

Tailored Survey Policy
The public expects all of the programs or services delivered under the auspices of an accredited organization to have been evaluated. As such, The Joint Commission applies its Tailored Survey Policy to components (for which there are applicable Joint Commission standards) that are organizationally and functionally integrated with the health care organization applying for accreditation (see the “Organizational and Functional Integration” section).

The Joint Commission will include another service, program, or related entity (that is, component), whether providing programs or services directly or through a contractual arrangement†, in the survey of the applicant organization under the following circumstances:

- There are Joint Commission accreditation/certification requirements applicable to the component.
- There is organizational and functional integration between the component and the applicant organization.

The Joint Commission survey, assuming satisfactory compliance, provides one accreditation award for each accreditation program surveyed (for example, ambulatory physical health care, behavioral health care, home care, nursing care centers, and so forth).

Any service, program, or related entity that is a component of an accreditation-eligible organization may independently seek accreditation if it can meet Joint Commission survey eligibility requirements. The results of such a separate accreditation survey will not affect the overall organization’s decision. If the service, program, or related entity seeks separate accreditation, the Tailored Survey Policy does not require the larger complex organization to be separately accredited.

†Contractual arrangements are evaluated for tailoring applicability on a case-by-case basis.
Complex Organization Survey Process
The complex organization survey process is applied to organizations that are governed by the Tailored Survey Policy. The Joint Commission conducts a complex organization survey based on the services or programs provided by the organization, as reported in its electronic application for accreditation (E-App). After completing its E-App, the organization is able to view which manuals are applicable to the accreditation survey on the “Applicable Manuals” tab. Because a complex organization survey process involves standards in more than one of the accreditation manuals, The Joint Commission provides the organization with access to the electronic editions of the manuals to be used in the survey before it is conducted. The Joint Commission surveys and, assuming satisfactory compliance, provides one accreditation award for each accreditation program under which the organization was surveyed.

Organizational and Functional Integration
Organizational and functional integration refers to the degree to which a component is overseen and managed by the applicant organization that is either seeking accreditation or currently accredited. A component is a service, program, or related entity that delivers care, treatment, or services and is eligible for survey under one of The Joint Commission’s accreditation programs listed in the INTRO chapter.

Organizational integration exists when an applicant organization’s governing body either directly or ultimately controls budgetary and resource allocation decisions for the component or, where individual corporate entities are involved, there is greater than 50% common governing board membership for the applicant organization and on the board of the component.

Functional integration exists when the entity meets at least three of the following eight criteria:

1. The applicant organization assigns duties and responsibilities based on job descriptions and contracted scope of services.
2. The applicant organization’s human resources function hires and assigns staff at the component and has the authority to do the following:

A complex organization refers to an organization that is surveyed under more than one accreditation manual.

For organizations that are accredited under the Comprehensive Accreditation Manual for Behavioral Health Care via a tailored survey, also consider whether the applicant organization and the component may use the same process for credentialing and assigning clinical responsibilities to licensed independent practitioners.
Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.

- Terminate staff at the component
- Transfer or rotate staff between the applicant organization and the component
- Conduct performance appraisals of the staff who work in the component

3. The applicant organization’s policies and procedures are applicable to the component, with few or no exceptions.

4. The applicant organization manages significant operations of the component (that is, the component has little or no management authority or autonomy independent of the applicant organization).

5. The component’s clinical/case records are integrated into the applicant organization’s clinical/case record system.

6. The applicant organization applies its performance improvement program to the component and has authority to implement actions intended to improve performance at the component.

7. The applicant organization bills for care, treatment, or services provided by the component under the name of the applicant organization.

8. The applicant organization and/or the component portrays to the public that the component is part of the organization through the use of common names or logos; references on letterheads, brochures, telephone book listings, or websites; or representations in other published materials.

A checklist to help determine whether organizational and functional integration exists is provided in Figure 1.
**Checklist to Determine Organizational and Functional Integration**

<table>
<thead>
<tr>
<th>Organizational Characteristic</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Budgetary decisions</strong>—Does the governing body of the applicant organization control budget and resource allocation for component?</td>
<td></td>
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<tr>
<td><strong>2. Shared governance</strong>—If separate corporate entities, do the applicant organization and the component share over 50% of governing body membership?</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Functional Characteristic</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Common professional staff</strong>—Is there a unified process for assigning duties and responsibilities based on job description/credentialing?</td>
<td></td>
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</tr>
<tr>
<td><strong>2. Human resources</strong>—Does the applicant organization have hiring/firing/performance appraisal authority over the component’s staff?</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>3. Policies and procedures</strong>—Are there common policies and procedures?</td>
<td></td>
<td></td>
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<tr>
<td><strong>4. Management</strong>—Does the applicant organization manage operations of the component?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>5. Clinical/case records</strong>—Is there an integrated clinical/case record system?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>6. Performance improvement</strong>—Is there an integrated performance improvement program? Does the applicant organization have authority to implement performance improvement actions at component?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>7. Billing</strong>—Are the component’s care, treatment, or services billed by the applicant organization?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>8. Public portrayal</strong>—Is there public portrayal of component as part of a parent organization through names, logos, or such?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:** Applicant organization needs minimum of one “Yes” response for organizational integration and three “Yes” responses for functional integration to include components as “sites” on the electronic application for accreditation (E-App).

**Figure 1.** Checklist to determine organizational and functional integration.
Multiorganization Option

The Joint Commission offers a multiorganization system that owns or leases at least two organizations the option of using a modified survey process. This option has the following three components:

1. A corporate orientation held at the beginning of the year
2. Surveys of participating organizations with the same survey team leader
3. A corporate summation after the last organization in the system is surveyed

A system may choose a corporate orientation, a corporate summation, or both or neither of these options. The orientation session provides an opportunity for corporate staff to orient the surveyor or survey team to the structure and practices of the system. The surveyor or survey team also surveys centralized corporate services, documentation, and policies and procedures applicable to Joint Commission requirements. The corporate summation provides an overall analysis of the system’s strengths and weaknesses. It also provides consultation and education related to accreditation survey findings across the system. There is a separate fee for both the corporate orientation and corporate summation.

Through the multiorganization option, The Joint Commission accredits the individual organizations that are part of a multiorganization system, not the system itself. Therefore, each organization within a system receives its own accreditation decision and Accreditation Survey Findings Report. The findings and decision for one organization within a system have no bearing on those of another organization within the system.

Concurrent and Sequential Survey Options

The Joint Commission offers a concurrent or sequential survey option for behavioral health care systems that operate more than one accredited entity. This option provides a structure across the entire system and has the following components:

- Surveys of participating organizations occur at the same time under the concurrent option.
- Surveys of participating organizations occur in sequence under the sequential survey option.
- Each participating organization must demonstrate compliance with all Joint Commission requirements independent of any other organization within the system.
- Each organization will receive a separate survey report and accreditation decision.
The concurrent survey process works best when conducted in systems where 12 or fewer entities wish to be surveyed concurrently or sequentially.

**Contracted Services**

The Joint Commission evaluates an organization’s management and oversight of the quality of care, treatment, and services (for which there are Joint Commission standards) provided under contractual arrangements, including laboratory services provided under contract. The Joint Commission reserves the right to evaluate, as part of its survey, the care, treatment, and services provided by another organization or provider on behalf of the applicant organization. It may survey performance issues between the contracted organization and the applicant organization, regardless of the accreditation decision of the contracted organization. The Joint Commission also surveys care, treatment, and services provided on site under contract to the applicant organization.

**Initial Surveys**

An organization that is seeking Joint Commission accreditation for the first time or that has not been denied accreditation by The Joint Commission during the previous four months is eligible for an initial survey if it serves the required minimum number of individuals served regardless of how long the organization has been in operation. The full scope of applicable standards is reviewed during the survey. The Joint Commission’s policy for assessing and monitoring organizations new to the accreditation process is as follows:

- If an organization new to the accreditation process demonstrates compliance with applicable Joint Commission accreditation requirements, the organization will receive accreditation.

- All organizations new to the accreditation process that become accredited after their initial survey will be included in a 2% “pool” of organizations undergoing a random unannounced on-site validation survey of their Evidence of Standards Compliance (ESC) (see the “Random Validation of Evidence of Standards Compliance” section for more information).

- The organization meets parameters for the minimum number of individuals served/volume of services required for organizations seeking Joint Commission accreditation for the first time, as defined in the “General Eligibility Requirements” section.
The accreditation effective date for an organization that undergoes an initial survey is the date on which an acceptable ESC was submitted, if the organization has a Requirement for Improvement (RFI). If there are no RFIs, the effective date is the day after the last day of the survey.

**Survey Postponement Policy**

In rare circumstances, it may be appropriate to request a survey postponement. An organization should direct a request for a postponement to its account executive. A request to postpone a survey may be granted if a major unforeseen event has occurred that has totally or substantially disrupted operations, such as the following:

- A natural disaster or major disruption of service due to a facility failure
- The organization’s involvement in an employment strike
- The organization’s cessation of admitting or treating individuals served
- The organization’s inability to treat and care for individuals served and its transfer of these individuals to other facilities or organizations

The Joint Commission may, at its discretion, approve a request to postpone a survey for an organization not meeting any of the criteria described above. The organization may be charged a fee to defray costs.

**Information Accuracy and Truthfulness Policy**

The accuracy and veracity of relevant information, whether actually used in the accreditation or certification processes, are essential to the integrity of the Joint Commission’s accreditation and certification processes. *Falsification*, as the term is used in the Joint Commission’s Information Accuracy and Truthfulness Policy, applies to both commissions and omissions in sharing information with The Joint Commission. Information provided at any time by the organization must be accurate and truthful (see APR.01.02.01 in the APR chapter). Such information may be furnished in any of the following manners:

- Provided verbally or in writing
- Obtained through direct observation or interview by Joint Commission surveyor(s) or reviewer(s)
- Derived from documents supplied by the organization to The Joint Commission, including, but not limited to, an organization’s comprehensive systematic analysis (for example, a root cause analysis) in response to a sentinel event or an organization’s request for accreditation/certification
Electronically transmitted data or documents including, but not limited to, data or
documents provided as part of the E-App process
An attestation that the organization does not currently and knowingly use Joint
Commission full-time, part-time, or intermittent surveyors or reviewers to provide
any accreditation-/certification-related consulting services including, but not
limited to, the following:
- Helping an organization meet Joint Commission accreditation/certification
  requirements
- Helping an organization with any intracycle monitoring process
- Conducting mock surveys for an organization
- Helping an organization in the ESC process

Policy Requirements
The Joint Commission’s Information Accuracy and Truthfulness Policy includes the
following:
1. An organization must never provide The Joint Commission with falsified (as defined
   below) information relevant to the accreditation/certification process. The Joint
   Commission construes any effort to do so as a violation of the organization’s
   obligation to engage in the accreditation/certification process in good faith.
2. *Falsification* is defined for this policy as the fabrication, in whole or in part, and
   through commission or omission, of any information provided by an applicant or
   accredited organization/certified program to The Joint Commission. This includes,
   but is not limited to, any redrafting, reformatting, or content deletion of documents.
3. The organization may submit additional material that summarizes or otherwise
   explains original information submitted to The Joint Commission. These materials
   must be properly identified, dated, and accompanied by the original documents.
4. The Joint Commission conducts an evaluation when it has cause to believe that an
   accredited organization/certified program may have provided falsified information to
   The Joint Commission relevant to the accreditation/certification process. Except as
   otherwise authorized by the president of The Joint Commission, the evaluation may
   include an unannounced on-site survey. This survey uses special protocols designed
   to address the information determined by The Joint Commission to constitute
   possible falsification. It assesses the degree of actual organization compliance with the
   standards and EPs that are the subject of the allegation, if appropriate.
5. The Joint Commission takes action to deny accreditation/certification to an
   organization/program whenever The Joint Commission is reasonably persuaded that
   the organization/program has provided falsified information.
6. The Joint Commission may notify responsible federal and state government agencies of any organization/program subject to such action.

7. If an organization/program is denied accreditation/certification because it provided falsified information, The Joint Commission prohibits it from participating in the accreditation or certification process for a period of one year. The president of The Joint Commission, for good cause only as determined in his/her sole discretion, may waive all or a portion of this waiting period. If an organization requests to participate in the accreditation/certification process prior to the completion of the one-year prohibition period and the president of The Joint Commission does honor the request, executive leadership will be so notified.

**Good Faith Participation in Accreditation/Certification**

The Joint Commission requires each organization seeking (re)accreditation or (re)certification to engage in the process in good faith. The Joint Commission may deny accreditation or certification to any organization that fails to participate in the process in good faith. The following are examples of actions interfering with good faith participation:

- **Deceiving The Joint Commission.** Compliance with the Information Accuracy and Truthfulness Policy requires a commitment on the part of the accredited organization/certified program not to deceive The Joint Commission in any aspect of the accreditation/certification process, such as during the completion of an application for accreditation/certification, during the Intracycle Monitoring (ICM) process, or during a survey/review.

- **Deceiving the public.** An accredited organization/certified program is not acting in good faith if it misleads the public about the meaning and limitations of accreditation/certification. Also, an accredited organization/certified program must not inaccurately suggest to the public that its accreditation/certification award applies to any unaccredited affiliated or otherwise related activities.

- **Retaliation.** The Joint Commission invites open communication from any accredited organization’s/certified program’s staff and recipients of care, treatment, and services about any standards compliance or other issues related to the accreditation/certification process. An organization’s/program’s good faith participation in the accreditation/certification process is questioned if the organization/program does any of the following:
Attempts to discourage such communication—for example, by taking disciplinary steps against an employee solely because that employee provides information to The Joint Commission

- Threatens those who communicate with The Joint Commission with a defamation lawsuit based solely on what was said to The Joint Commission

- Allows the treatment or access to services of any individual or staff member to be adversely affected by his or her or a family member’s communication with The Joint Commission

Standards compliance. If an organization’s/program’s conduct reflects a lack of commitment to standards compliance, issues of good faith may be raised. For example, an intentional refusal to attempt to comply with a standard could suggest a cavalier view of the accreditation/certification process.

The good faith participation requirement applies continuously throughout the accreditation/certification process.

Public Information Policy

Introduction
The Joint Commission is committed to making relevant and accurate information about health care organizations available to interested parties. Information regarding a health care organization’s quality and safety can help organizations improve their services. This information may also help educate consumers and health care purchasers in making informed choices about health care. At the same time, it is important that confidentiality of certain information be maintained to encourage candor in the accreditation and certification processes. The Joint Commission’s primary vehicle for providing public information are Quality Check® and Quality Reports.

Quality Check. Quality Check is The Joint Commission’s website for making available descriptive and performance information about accredited organizations and certified programs.

Quality Reports. The Quality Reports located on Quality Check are publicly available and include relevant and useful information about the quality and safety of care provided in individual Joint Commission–accredited organizations and –certified

This policy meets the requirements of the Health Insurance Portability and Accountability Act of 1996.
programs. Quality Reports are created at the organization level and contain information reflecting an organization’s accreditation and/or certification status, its compliance with National Patient Safety Goals, and performance measurement results, as appropriate.

**Publicly Available Accreditation and Certification Information**

Joint Commission Quality Reports for each accredited organization and/or certified program include the following information:

- The date of an organization’s/program’s most recent full on-site survey/review, and if the organization/program has had any subsequent surveys/reviews since its last full survey/review
- The accreditation/certification decision based on the most recent full on-site survey/review, as well as any subsequent updates to the decision
  - Organizations that are successful in obtaining accreditation following an initial survey will be posted on the Quality Check website.
  - Programs that achieve certification will be posted on the Quality Check website.
- For organizations in the accreditation renewal process, with an accreditation decision of Preliminary Denial of Accreditation or Denial of Accreditation, the standards with Requirements for Improvement leading to the decision
- Services included within the scope of the organization’s accreditation and/or certification decision
- A list of an organization’s previous accreditation and/or program’s certification decisions and the effective date of those decisions for the past seven (7) years
  - If the organization had a previous decision of Preliminary Denial of Accreditation, the standards with Requirements for Improvement
- The receipt of national quality recognition awards, as recognized by the Board of Commissioners
- Compliance with National Patient Safety Goal requirements

Each accredited organization/certified program is afforded the opportunity to prepare a commentary of up to two pages regarding its Quality Report. The commentary will accompany any organization/program Quality Reports distributed by The Joint Commission, whether via hard copy or The Joint Commission’s website.

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*Denial of Accreditation decisions, for organizations that were in the accreditation renewal process, will be posted on the Quality Check website for a duration of one year from the rendering of the accreditation decision.*
When performance measurement data is included in Quality Reports, such data will be accompanied by information regarding its source or derivation; accuracy, reliability, and validity; and appropriate uses of the data.

An organization’s Quality Report may be obtained via the Customer Service Department or through Quality Check. See “The Joint Commission Quality Report” (QR) chapter of this manual for more details.

**Release of Aggregate Data**

The Joint Commission reserves the right to publish or release aggregate data. Protected health information will not be made publicly available. Performance data displayed on Quality Check are available to any interested party at no cost and may be downloaded electronically in a series of predefined report formats through a linked webpage called “Quality Data.”

**Information That Is Publicly Disclosed on Request**

**Release of Accreditation and, if applicable, Certification Information.** In addition to information provided in Quality Reports, the following information may be obtained by writing or calling The Joint Commission:

- For organizations that were previously denied accreditation, are no longer certified, or withdrew from the accreditation/certification process:
  - The organization’s accreditation and, if applicable, certification history
  - Standards for which The Joint Commission had no or insufficient evidence of resolution when an organization withdrew from accreditation and was subsequently denied accreditation

**Sentinel Event Information.** As applicable, confirmation of the occurrence of a sentinel event at an accredited organization for the three-year period prior to the date of the request and The Joint Commission’s intent to apply its Sentinel Event Policy or other applicable procedures to this occurrence.

**Release of Aggregate Complaint-Related Information.** The Joint Commission addresses all incidents that pertain to alleged safety of individuals served or quality of care, treatment, and services issues within the scope of Joint Commission standards. Information about complaints may be forwarded by the Centers for Medicare & Medicaid Services (CMS) or other federal or state agencies having oversight responsibilities for health care organizations, federal or state legislators or legislative committees on behalf of constituents, or may be received directly from individuals served, families,

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**The term complaint refers to an alleged adverse event, unsafe condition, or concern.**
payers, or health care professionals. As used here, the term *complaint* includes potentially relevant reports that are received from federal or state agencies, identified in the media, or otherwise obtained by The Joint Commission. The Joint Commission will only disclose identifiable information if authorized by the individual served, as consistent with its business associate obligations, or otherwise authorized by law. For any party other than the authorizing complainant, The Joint Commission will not disclose name or identifiable information of the individual served, per the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Upon request from any party, The Joint Commission releases the following aggregate information relating to complaints about an accredited organization or a certified program for the three-year period prior to receipt of the request: When an unannounced or unscheduled survey/review is based on information derived from a complaint or public sources, a summary of the standards areas†† for which Requirements for Improvement were issued as a result of The Joint Commission’s evaluation activities.

**Release of Specific Complaint-Related Information**

The Joint Commission also provides the following information as appropriate to complainants regarding their complaints (and those authorized by the complainant), or other individuals who have knowledge regarding a specific complaint:

- Confirmation of the receipt of the complaint and that it will be reviewed to determine what, if any, Joint Commission action is warranted
- Any determination that the complaint is not related to Joint Commission requirements
- If The Joint Commission has decided not to take action regarding an organization’s accreditation/a program’s certification decision, the complainant is to be so advised.
- If the complaint is related to Joint Commission requirements, upon completion of review, the course of action that was taken regarding the complaint, including the standards areas that were evaluated
- If The Joint Commission has decided not to take action regarding an organization’s accreditation/a program’s certification decision as a result of the complaint review, the complainant is to be so advised.

††The term *standard area* refers to the focus area of the complaint review as it relates to The Joint Commission’s standards. Depending on the review status or outcome of the complaint review, the level of information provided may vary.
If The Joint Commission has taken action regarding an organization’s accreditation/a program’s certification decision as a result of an on-site complaint review, the noncompliant standards leading to that decision will be made publicly available on Quality Check.

Data Release to Government Agencies and Organizations with Which The Joint Commission Performs Coordinated Survey Activities
The Joint Commission makes specific accreditation-related and Behavioral Health Home (BHH) certification–related information available to federal, state, local, or other governmental certification or licensing agencies, public health agencies, or any other appropriate enforcement agencies under the following circumstances:

- When The Joint Commission identifies a serious situation in an organization that may jeopardize the health or safety of individuals served or the public and immediately takes action to deny accreditation
- When The Joint Commission identifies a serious situation, or a significant pattern of risk in an organization that may have jeopardized the health or safety of previous individuals served or the public, or that represents risk that extends beyond the organization, such as an incident involving the reuse of contaminated instruments
- If the health care organization or other individual reports the issue to the appropriate authorities, The Joint Commission will evaluate whether it, too, should report the issue.

Additional information is made available when an organization is certified for participation in a federal or state program or licensed to operate by a state agency on the basis of its accreditation. In addition, The Joint Commission may make available information to organizations with which The Joint Commission performs coordinated survey activities. The Joint Commission may advise the organization’s chief executive officer and will provide timely notice to local, state, and federal authorities having jurisdiction. The information available to government agencies and organizations with which The Joint Commission performs coordinated survey activities includes the following:

- Notification of official decision to render Accreditation with Follow-up Survey, Preliminary Denial of Accreditation, or Denial of Accreditation, including the rationale for the decision
- Complaint information requested by the Substance Abuse and Mental Health Services Administration (SAMHSA) in accordance with The Joint Commission’s deeming authority
Complaint information, including the content of the complaint submitted to The Joint Commission, is shared with:

- A state regulatory agency that has entered into a written information-sharing agreement
- An organization with which The Joint Commission conducts coordinated survey activities

Upon request from SAMHSA, the following information is shared:

- All final Requirements for Improvement
- A statement, if any, from the organization regarding its views on the validity of Joint Commission survey findings
- A copy of the corrective action submitted by the organization
- The results of any follow-up survey, if warranted

For governmental agencies, notification of upcoming full surveys and retrospective dates of other surveys conducted, such as random unannounced or for-cause surveys, only if the governmental agency enters into an information-sharing agreement with The Joint Commission and agrees to maintain the confidentiality of the survey dates

- A copy of the Official Accreditation Decision Report and decision letter
  - For SAMHSA upon request respecting deemed status determinations
  - For state agencies that have entered into specific information-sharing agreements that permit provider-authorized release of such reports to the state agency

The Joint Commission will report to SAMHSA, as appropriate, in the event that there is credible evidence of potential identification of fraud and abuse, or other criminal or civil law violation and upon notice to the health care organization.

**Data Release to Cooperative Accrediting Bodies**
The Joint Commission makes available to accrediting bodies with which it has formal cooperative agreements relevant portions of Official Accreditation Decision Reports and complaint-related information pertinent to the accrediting activities of the cooperative partner. Judgments as to pertinence are made solely by The Joint Commission. (For a list of organizations with which The Joint Commission has cooperative agreements, see [http://www.jointcommission.org/facts_about_the_cooperative_accreditation_initiative/](http://www.jointcommission.org/facts_about_the_cooperative_accreditation_initiative/).)
Joint Commission Right to Clarify
The Joint Commission reserves the right to clarify information, even if the information involved would otherwise be considered confidential, when an organization disseminates inaccurate information regarding its accreditation or, if applicable, certification.

Confidential Information
The Joint Commission keeps information received or developed during the accreditation/certification process confidential, such as:

- The Official Accreditation Decision Report, unless its submission is required by a governmental agency (see “Data Release to Government Agencies and Organizations with Which The Joint Commission Performs Coordinated Survey Activities”), is required by organizations with which The Joint Commission performs coordinating surveys, or is requested by an accredited body with which The Joint Commission has a formal agreement (see “Data Release to Cooperative Accrediting Bodies”)
- Information learned from the organization before, during, or following the on-site survey, which is used to determine compliance with specific accreditation standards
- An organization’s comprehensive systematic analysis and related documents prepared in response to a sentinel event or in response to other circumstances specified by The Joint Commission
- All other materials that may contribute to the accreditation or, if applicable, certification decision
- Written staff analyses and executive leadership minutes and agenda materials
- Any data from an organization’s participation in the intracycle monitoring process and related corrective action plan
- The identity of any individual who files a complaint about an accredited organization, except when the complaint is shared by The Joint Commission with a governmental entity, an organization with which The Joint Commission performs coordinated surveys, or accrediting organizations with which The Joint Commission has formal complaint-sharing agreements and the receiving organization has agreed to maintain the confidentiality of the complainant. In instances when the receiving organization cannot assure the confidentiality of the complainant, any complainant-identifying information shall be redacted by The Joint Commission prior to sharing.

This policy applies to all organizations with an accreditation and, if applicable, BHH certification history, subject to any requirements of any applicable laws.
The Accreditation Process

Process for Responding to a Complaint
The Joint Commission’s Office of Quality and Patient Safety (OQPS) triages and reviews complaints, concerns, and inquiries related to accredited organizations, as received from a variety of sources. These complaints may be submitted by individuals served, families, and physical or behavioral health care providers; by state and federal agencies in the form of reports; or through information from the media. The term complaint therefore covers a broad spectrum of information received by the OQPS.

Upon Joint Commission review of a complaint, a number of actions may result. These include recording the information for trending purposes and possible action in the future, obtaining the involved organization’s response to the complaint, and/or conducting an immediate for-cause survey. If The Joint Commission determines that the organization should respond to the complaint, the organization will be so notified. The request for a response will be e-mailed to the organization’s CEO and posted to the organization’s Joint Commission Connect™ extranet site (a secure, password-protected website intended only for Joint Commission–accredited or –certified organizations and key stakeholders). The organization’s response to the complaint also takes place through its extranet site.

The complaint information posted on the Joint Commission Connect site may be either of the following:
- The complaint itself, if the complainant has given permission to do so
- A summary of the complaint, if the complainant requested anonymity

If an accredited organization is required to respond to the complaint, it is usually required to do so within 30 business days of being notified. For more serious issues, the organization may be required to respond to the complaint within 7 business days of being notified, or sooner. When a response in a short time frame is required, the organization will be so notified.

Once a response is received, it is evaluated for compliance with the Joint Commission’s standards, National Patient Safety Goals, and APRs, as applicable. If additional information is required, the organization will be notified.

When the organization’s response is complete and has been accepted, a letter indicating acceptance is e-mailed to the CEO, and the case is considered closed.
Early Survey Policy
An organization seeking Joint Commission accreditation for the first time may choose the Early Survey Policy option. An organization surveyed under the Early Survey Policy will have two surveys. Sidebar 1 lists key features of the Early Survey Policy.

Sidebar 1. Early Survey Policy

First Survey
- Conducted up to two months before opening or operating
- Licensed (according to law and regulation) or in licensing process
- Building identified, constructed, and equipped
- CEO or administrator and clinical director
- Identified opening date
- Announced
- Limited set of standards (physical plant, policies and procedures)
- Outcome: Limited, Temporary Accreditation

Second Survey
- Ready date for survey selected by the organization within six months of the first survey
- Announced
- Full initial survey
- Outcome: Change in Limited, Temporary Accreditation decision to Accredited or Denial of Accreditation. The effective date of the accreditation decision is the day after the second survey if the organization does not receive any Requirements for Improvement (RFIs). If the organization receives at least one RFI and therefore must submit an ESC that resolves all RFIs, the effective date of the accreditation decision is the date the successful ESC is submitted. If at six months the organization is not ready for the second survey, the organization’s Limited, Temporary Accreditation decision will expire.

Note: Limited, Temporary Accreditation may be required for state licensure.

Eligibility for Limited, Temporary Accreditation
The Early Survey Policy is available to any organization that is currently not accredited—except for those that have been denied accreditation. An organization must declare during the application process that it wishes to be surveyed under this policy.
**The First Survey.** When an organization chooses to be surveyed under the Early Survey Policy, The Joint Commission conducts two on-site surveys. The Joint Commission can conduct the first survey as early as two months before the organization begins its operations, provided that the organization meets the following criteria:

- It is licensed (according to law and regulation) or in the licensing process.
- The building in which the services will be offered or from which the services will be coordinated is identified, constructed, and equipped to support such services.
- It has identified its CEO or administrator and its director of clinical or medical services.
- It has identified the date it will begin operations.

Generally, the first survey uses a limited set of standards and assesses only the organization’s physical facilities, policies and procedures, plans, and related structural considerations.

**Limited, Temporary Accreditation Decision.** The Joint Commission grants Limited, Temporary Accreditation to an organization that is in satisfactory compliance with the limited set of standards and EPs assessed in the first of the two surveys conducted under the Early Survey Policy (*see* the “Early Survey Policy Option” [ESP] chapter for a list of these requirements). Since a Limited, Temporary Accreditation decision does not reflect an organization’s compliance with the full set of Joint Commission standards, the organization cannot use the Joint Commission’s Gold Seal of Approval®. An organization that is not in satisfactory compliance must reapply and begin the accreditation process again.

The Limited, Temporary Accreditation decision includes assignment of an additional announced survey against the full set of applicable standards within six months of the first survey. The survey assesses the organization’s compliance with all applicable EPs.

For organizations surveyed under the Early Survey Policy: If an organization does not receive any RFIs during the first survey, the effective date for its Limited, Temporary Accreditation decision is the day after the survey is conducted. If the organization receives at least one RFI during the first survey and therefore must submit an acceptable ESC report that resolves all RFIs, the effective date for Limited, Temporary Accreditation is the date of the acceptable ESC submission.
The Limited, Temporary Accreditation decision remains in effect until the organization has completed the second of the two surveys (which is a full survey) conducted under the Early Survey Policy or until The Joint Commission has withdrawn the Limited, Temporary Accreditation. The Joint Commission may withdraw Limited, Temporary Accreditation in the following situations:

- If an organization that was not providing services at the time of the first survey does not begin providing care, treatment, or services when expected
- If an organization does not meet the survey eligibility criteria
- If an organization fails to accept the second survey
- If an organization is found to be not in satisfactory compliance with the applicable standards and their EPs

In any of these cases, the organization must begin the accreditation process again.

**The Second Survey.** The second survey under the Early Survey Policy is an announced, full, initial accreditation survey. The Joint Commission conducts this survey within six months after the first survey. If at six months the organization is not ready for the second survey, the organization’s Limited, Temporary Accreditation decision will be removed and the organization will not be accredited.

Based on survey results, the organization’s accreditation decision then changes to one of the following:

- Accredited
- Denial of Accreditation

See “Decision Categories for Organizations Seeking Accreditation Renewal” for descriptions of accreditation decisions.

The effective date of the accreditation decision is the day after the second survey if the organization does not receive any RFIs. If the organization receives at least one RFI and therefore must submit an acceptable ESC report that resolves all RFIs, the effective date is then retroactive to the date of the acceptable ESC submission. The organization’s accreditation cycle begins the day after the second survey was conducted, unless The Joint Commission reached a decision to deny accreditation.

**Behavioral Health Home Certification Option**

The Behavioral Health Home (BHH) certification option is available to any organization that has achieved accreditation under the Joint Commission’s Behavioral Health Care (BHC) program. The BHH model and the corresponding requirements

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
emphasize the need for the behavioral health home to coordinate and integrate all health (physical health, mental health, substance use) care. It is through its strong focus on the coordination and integration of care, treatment, or services that the BHH certification program is expected to be effective in decreasing the high rates of morbidity and mortality found in individuals served with serious mental illness and other behavioral health conditions. Because the BHH model is still new to the field and not yet fully defined, this certification product is expected to evolve as the BHH concept matures at the national level. Therefore, the BHH standards are robust enough that compliance demonstrates that an organization is indeed functioning as a behavioral health home, but not so prescriptive that they do not allow innovation.

In addition to demonstrating compliance with all BHC accreditation requirements, organizations choosing to seek BHH certification must comply with BHH certification-specific requirements. The organization may be acting as the health home for all or a subset(s) of the individuals served, as long as there is a minimum of three individuals with no less than two active at the time of the initial on-site certification survey. An organization may apply for BHH certification at the time of the triennial survey or at the points in time described below.

**Initial Application for Accreditation.** An organization may apply for BHH certification at the time of initial accreditation. BHH initial surveys occurring with an initial BHC accreditation survey will be announced (30-day notice), as the evaluation of BHH requirements are integrated as part of the initial, on-site survey process. For organizations that choose the Early Survey Policy option, compliance with the BHH certification requirements would be surveyed during the second of the two on-site surveys. This is because the first survey under the Early Survey Policy uses a limited set of standards, and BHH certification can be awarded only to an organization determined to be in full compliance with all applicable accreditation requirements.

**Between Accreditation Surveys.** BHH certification can be added to an existing BHC accreditation through an extension survey at any time during the three-year accreditation cycle. For the extension survey, the surveyor conducts an on-site survey prior to the 18- to 36-month resurvey.

The Joint Commission expects a BHH–certified organization to be in continuous compliance with all applicable accreditation and certification requirements. Once certified, continued compliance is determined during the organization’s subsequent full,
on-site surveys. In addition, The Joint Commission may perform a for-cause survey when it becomes aware of potentially serious certification requirements compliance or safety issues or when it has other valid reasons.

Organizations that are requesting or that have achieved BHH certification may access the Provider Information Tool via their extranet site. This optional tool enables organizations to identify clinical providers who serve as staff at the health home. Depending on the location of the organization, this information may be used by payers for reimbursement or funding purposes. BHH–certified organizations must identify in the E-App which of their sites are components of its health home.

For more information about the Behavioral Health Home certification program option, please e-mail BHC@jointcommission.org or call 630-792-5771. Program details are also available on the Joint Commission website at http://www.jointcommission.org/accreditation/behavioral_health_home.aspx.

Before the Accreditation Survey

This section provides information on the steps leading to a full on-site survey. These steps include the application process, the role of an account executive, and the Focused Standards Assessment (FSA) process.

An Organization’s Secure Joint Commission Connect™ Site

A key feature of The Joint Commission’s accreditation process is use of technology. The use of technology better enables The Joint Commission and accredited organizations to communicate accreditation- and, if applicable, certification-related information in a more efficient and timely manner.

The Joint Commission provides each organization with a secure, password-protected website on The Joint Commission’s extranet site for accredited organizations, Joint Commission Connect. Joint Commission Connect is the primary means of communication between The Joint Commission and accredited organizations. Full access to this site can only be granted through the use of the organization’s password. This site permits an organization to complete its E-App and FSA electronically. In addition, shortly after an organization’s survey, the organization’s Accreditation Survey Findings Report and its
ESC report are posted on the organization’s secure site. (See the “Stimulate Improvement” section in the INTRO chapter for more details about what is available on Joint Commission Connect.)

While full access to Joint Commission Connect can only be granted via an organization’s password, employees with an e-mail address from their Joint Commission–accredited or –certified health care organization can register themselves for guest access. Guest access enables viewers to see the Leading Practice Library and Standards BoosterPaks™. **Guest access does not include entry to any organization-specific data or reports.**

**Role of the Account Executive**
The Joint Commission assigns an account executive to an organization after receiving its E-App and nonrefundable deposit. This person serves as the primary contact between the organization and The Joint Commission. He or she coordinates survey planning and handles policies, procedures, accreditation and, if applicable, certification issues or services, and inquiries throughout the accreditation cycle. An applicant organization can find contact information for its account executive on its Joint Commission Connect site or by calling 630-792-3007.

**Electronic Application for Accreditation (E-App)**
When an organization notifies The Joint Commission that it wants to become accredited and, if applicable, BHH certified, The Joint Commission provides the organization with information explaining how to access and complete the E-App on the organization’s secure Joint Commission Connect extranet site. (An applicant should contact Business Development at 630-792-5165 for initial access to Joint Commission Connect.) Initial applications are valid for one year. An organization needs to complete and submit its E-App upon initial application for survey and will be asked to verify the information annually. An organization can provide updates to the E-App at any time. (See the “Changes Affecting E-App Information” section for more information on notifying The Joint Commission of significant changes within an organization.)

The application provides essential information about the organization, including ownership, demographics, and types and volume of setting(s) and program(s)/service(s) and sites of care, treatment, or services provided. The E-App does the following:
Describes the organization seeking accreditation and, if applicable, certification in terms of size and scope of programs/services

Requires the organization to have and make available to The Joint Commission during an on-site survey all official records and reports of public or publicly recognized licensing (for example, state licenses), examining, reviewing, or planning bodies (see APR.05.01.01 in the APR chapter)

Authorizes The Joint Commission to obtain any records and reports not possessed by the organization

When accepted, establishes the terms of the relationship between the organization and The Joint Commission

Identifies an organization’s applicable standards based on settings and services provided

Drives the anticipated number of survey days, number and type of surveyors, and survey agenda activities (see the “Survey Agenda” section)

**Accuracy of the Application Information**

The Joint Commission schedules surveys based on information provided in an organization’s E-App. With the information provided, The Joint Commission determines the number of days required for a survey and the number and type of surveyors. Inaccurate or incomplete information in the E-App may necessitate an additional survey, which could delay the processing of survey findings and rendering of an accreditation decision. It may also cause the organization to incur additional survey charges.

**Forfeiture of Survey Deposit**

A nonrefundable, nontransferable deposit toward accreditation fees is required for initial customers. The Joint Commission applies the deposit to the organization’s open invoices until the deposit is exhausted. An organization scheduled for an initial survey forfeits its deposit if its survey is not conducted within one year of submitting its application. The organization must then reapply and submit a new deposit to begin the accreditation process again. **Note:** If it receives approval from The Joint Commission to postpone an initial survey (less than 20 days prior to a scheduled initial survey), the organization will be charged a fee to defray costs.

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Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.

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‡‡The Joint Commission does not charge a deposit for accredited health care organizations that are seeking a new tailored (or certification) program. Also, in instances where an “owner” of multiple health care organizations has at least five accredited entities in good standing, that entity will be eligible for a deposit waiver.
Accreditation Contract and Business Associate Agreement

Organizations seeking Joint Commission accreditation for the first time or reaccreditation with The Joint Commission must submit one signed accreditation contract and a signed Business Associate Agreement. The contract outlines the responsibilities of both the organization and The Joint Commission relative to the accreditation process. This contract is separate from the E-App.

In accordance with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Rules, and modified by the HITECH (Health Information Technology for Economic and Clinical Health) provisions of the American Recovery and Reinvestment Act of 2009, a behavioral health care organization and The Joint Commission must have a signed Business Associate Agreement before the organization’s survey can begin. This Business Associate Agreement outlines the access, use, and disclosure of any individual served–protected health information between The Joint Commission and the health care organization.

An organization will not be scheduled for survey until it signs an accreditation contract and Business Associate Agreement. When this happens, The Joint Commission will proceed with the organization’s survey plans unless the organization notifies The Joint Commission in writing of its intent to withdraw from accreditation and terminate the accreditation contract. Notification in writing is necessary to terminate the accreditation contract, cease survey scheduling, and avoid a final decision of Denial of Accreditation. If an organization fails to notify The Joint Commission in writing of its intent to withdraw from accreditation and terminate its accreditation contract before a survey, The Joint Commission’s decision rules provide for a final decision of Denial of Accreditation.

Annual and Survey Fees

The Joint Commission uses a subscription billing system for all accreditation programs. Fees are determined annually and are based on the need to secure sufficient resources to cover the costs of operation. The Joint Commission generally bases individual organization annual fees on the volume and type of programs/services provided and the sites to be included in the organization’s accreditation survey. Questions about all fees can be directed to the Pricing Unit (pricingunit@jointcommission.org) or by calling 630-792-5115.
The Joint Commission’s fee structure includes a nonrefundable, nontransferable annual fee, which recognizes the provision of substantial accreditation-related services on a continuous basis between on-site surveys. Billed each January, the annual fees are determined by the organization’s size and complexity. The annual fee for organizations applying for accreditation for the first time will be prorated based on the quarter in which the application is submitted.

In addition to the annual fee, organizations are billed an on-site fee within two days after the survey. The on-site fee is designed to cover the direct costs of performing a survey.

For organizations electing the Behavioral Health Home (BHH) certification option, a minimal fee is added to the annual and on-site survey fees to extend the survey an additional day. Another fee will be added if the organization applies for BHH certification at the time of initial or triennial on-site survey. If, however, the organization applies for BHH certification during the accreditation cycle, the extension survey fee is invoiced.

Organizations requiring additional surveys, such as to evaluate a patient safety event, will be assessed a separate survey fee. (The word “patient” in the term patient safety event corresponds to “individuals served” in the behavioral health care setting.)

Electronic invoices will be posted to the organization’s secure Joint Commission Connect site and are due upon receipt. The Joint Commission accepts payment for all fees in any of the following ways:

- Electronic payment using Visa, MasterCard (credit or debit), American Express, Discover, or e-check by logging on the organization’s Joint Commission Connect accreditation home page and clicking on the “What’s Due” tab or by calling Accounts Receivable staff at 630-792-5662
- Check or money order by mail to PO Box 92775, Chicago, IL 60675-2775, or overnight to One Renaissance Boulevard, Oakbrook Terrace, IL 60181
- Wire transfer by calling Accounts Receivable staff at 630-792-5662

Failure to provide timely payment of any Joint Commission fees may result in the loss of accreditation. Letters of nonpayment are posted to the health care organization’s Joint Commission Connect extranet site. Failure to pay overdue amounts will result in a loss of accreditation with no opportunity for appeal or reinstatement. For help in making a payment, please contact Accounts Receivable staff at 630-792-5662.
During the Survey

During an on-site survey, The Joint Commission evaluates an organization’s performance of functions and processes aimed at continuously improving outcomes for individuals served. The survey process focuses on assessing performance of important individual-centered and organization functions that support the safety and quality of care, treatment, and services. This assessment is accomplished through evaluating an organization’s compliance with the applicable requirements in this manual, based on the following activities and information:

- Tracing the care, treatment, and services delivered to individuals served
- Verbal and written information provided to The Joint Commission
- On-site observations and interviews by Joint Commission surveyors
- Review of documents provided by the organization

Under this accreditation process, the full survey is the on-site evaluation piece of a continuous process. The accreditation process encourages organizations to embed the requirements into routine operations to achieve and maintain excellent operational systems on an ongoing basis. Initiatives such as the annual FSA facilitate this and also help identify and manage risk.

A survey is designed to be individualized to each organization, to be consistent, and to support the organization’s efforts to improve performance. The Joint Commission determines the length of a survey based on information supplied in the E-App that describes the organization’s size and scope of services. Although not a routine practice, Joint Commission surveyors may conduct some survey activities during early morning, evening, night, and weekend hours, as necessary. These “off-shift” visits do not occur before the opening conference at the start of the survey.

Survey Notification

The Joint Commission generally conducts unannounced surveys between 18 and 36 months after an organization’s previous full survey, except for situations in which it would not be logical or feasible to conduct an unannounced survey. Table 1 outlines specific exceptions to unannounced surveys and the length of advance notice or threshold, if applicable, for behavioral health care services not offered as part of a hospital.
### Table 1. Exceptions to Unannounced Triennial Surveys

<table>
<thead>
<tr>
<th>Subject</th>
<th>Exception</th>
<th>Threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial surveys</td>
<td>Announced</td>
<td></td>
</tr>
<tr>
<td>Early Survey Policy—1st and 2nd surveys</td>
<td>Announced</td>
<td></td>
</tr>
<tr>
<td>Organizations undergoing ICM Option 2 and Option 3 surveys</td>
<td>Announced (unless organization requests that it be unannounced)</td>
<td></td>
</tr>
<tr>
<td>Department of Defense facilities</td>
<td>7-day notice</td>
<td></td>
</tr>
<tr>
<td>Correction settings</td>
<td>7-day notice</td>
<td></td>
</tr>
<tr>
<td>All foster care programs</td>
<td>7-day notice</td>
<td></td>
</tr>
<tr>
<td>“Small” settings</td>
<td>7-day notice</td>
<td>10 or fewer staff, or a total average daily census of less than 100</td>
</tr>
<tr>
<td>Outpatient programs (including outpatient programs, day programs, and partial hospitalization programs)</td>
<td>7-day notice (unless setting is a component of a hospital, in which case the survey will be unannounced)</td>
<td>10 or fewer staff, or a total average daily census of less than 100</td>
</tr>
<tr>
<td>24-hour services</td>
<td>7-day notice (unless setting is a component of a hospital, in which case the survey will be unannounced)</td>
<td>10 or fewer staff, or a total average daily census of less than 100</td>
</tr>
<tr>
<td>All methadone programs</td>
<td>7-day notice (unless setting is a component of a hospital, in which case the survey will be unannounced)</td>
<td></td>
</tr>
<tr>
<td>All in-home behavioral health, case management, or assertive community treatment (ACT) programs</td>
<td>7-day notice (unless setting is a component of a hospital, in which case the survey will be unannounced)</td>
<td>10 or fewer staff, or a total average daily census of less than 100</td>
</tr>
<tr>
<td>All inpatient freestanding organizations</td>
<td>7-day notice (unless setting is a component of a hospital, in which case the survey will be unannounced)</td>
<td>10 or fewer staff, or a total average daily census of less than 100</td>
</tr>
<tr>
<td>All community-based freestanding organizations</td>
<td>7-day notice (unless setting is a component of a hospital, in which case the survey will be unannounced)</td>
<td>10 or fewer staff, or a total average daily census of less than 100</td>
</tr>
<tr>
<td>All inpatient crisis stabilization programs</td>
<td>7-day notice (unless setting is a component of a hospital, in which case the survey will be unannounced)</td>
<td>10 or fewer staff, or a total average daily census of less than 100</td>
</tr>
<tr>
<td>All residential/group homes</td>
<td>7-day notice (unless setting is a component of a hospital, in which case the survey will be unannounced)</td>
<td>10 or fewer staff, or a total average daily census of less than 100</td>
</tr>
</tbody>
</table>

With an *unannounced survey*, an accredited organization will receive *no notice* of its survey date prior to the start of the survey. In concert with the unannounced survey process, the following procedures will be implemented:

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99In this table, 7 days refers to 7 business days.
Accredited organizations will be able to identify, in their 27-month E-App, up to 15 days in their survey eligibility range (between 18 and 36 months after their last full survey) in which an unannounced survey should be avoided. Once the 27-month E-App has been submitted, these dates cannot be modified. These 15 days should not include federal holidays but may include regional events during which it may be difficult to conduct a survey. The Joint Commission will make every effort to accommodate the organization regarding avoiding these 15 days. However, The Joint Commission reserves the right to conduct a survey during an “avoid period.”

An organization is required to demonstrate how it communicates on an ongoing basis to its public that if members of the public have any quality or safety concerns, they should notify The Joint Commission (see APR.09.01.01 in the APR chapter).

If an organization knows of a surveyor who works or has worked at the organization or a competing organization or has had personal experience with the survey or that represents a potential conflict, the organization is asked to identify the individual(s) in its E-App or notify The Joint Commission via phone or e-mail as soon as possible so that another surveyor may be assigned.

Organizations are notified of upcoming Joint Commission surveys according to which of the following three types of survey they are going to receive:

1. **Unannounced Events.** On the day of the unannounced survey, by 7:30 A.M. in the organization’s local time zone (for organizations within the United States and its territories), The Joint Commission will post on the organization’s secure Joint Commission Connect site the letter of introduction, the survey agenda, and the biography and picture of each surveyor assigned to conduct the event. Once the notification—which serves as the official notice of the upcoming event—has been posted, an e-mail notification will be sent to the individuals listed as chief executive officer, primary accreditation/certification contact, and corporate contact (if applicable) on the organization’s extranet. This e-mail will advise that an event has been scheduled for that day and instruct the contact(s) to log in to the Joint Commission Connect site to view the event details.

2. **Announced Events.** Thirty days prior to the scheduled announced event, The Joint Commission will post on the organization’s secure Joint Commission Connect extranet site the letter of introduction, the survey agenda, and the biography and picture of each surveyor assigned to conduct the event. Once this notification—which serves as the official notice of the upcoming event—has been posted, an e-mail notification will be sent to the individuals listed as chief executive officer and primary accreditation/
certification contact on the organization’s extranet. This e-mail will advise that an event has been scheduled and instruct the contact(s) to log in to the Joint Commission Connect site to view the event details. The organization will also receive a separate e-mail by 7:30 A.M. in the organization’s local time zone (for organizations within the United States and its territories) on the morning of the event with the same information listed above.

3. Short-Notice Events. Seven business days prior to the scheduled event, The Joint Commission will post on the organization’s secure Joint Commission Connect site the letter of introduction, the survey agenda, and the biography and picture of each surveyor assigned to conduct the event. Once the notification—which serves as the official notice of the upcoming event—has been posted, an e-mail notification will be sent to the individuals listed as chief executive officer and primary accreditation/certification contact on the organization’s extranet. This e-mail will advise that an event has been scheduled and instruct the contact(s) to log in to the Joint Commission Connect site to view the event details. The organization will also receive a separate e-mail by 7:30 A.M. in the organization’s local time zone (for organizations within the United States and its territories) on the morning of the event with the same information listed above.

Organizations that are eligible for short notice will no longer receive a phone call from a Joint Commission representative notifying them that the event has been scheduled.

Initial and Full Survey Team Composition

Most behavioral health care accreditation surveys are conducted by a single surveyor; however, based on the size and complexity of the organization being surveyed, an accreditation survey may be conducted by a team of surveyors. The composition of an organization’s survey team is based on the information provided in its E-App.

On surveys with more than one surveyor, one of the surveyors is designated as the team leader. The team leader is responsible for integration, coordination, and communication of on-site survey activities. In addition to being one of the surveyors conducting the survey, the team leader serves as the primary point of on-site contact between the organization and The Joint Commission. Among other responsibilities, the team leader leads the opening conference and the daily and exit briefings.
Survey Agenda

The Joint Commission reviews the data in an organization’s E-App and posts a sample agenda on the organization’s secure Joint Commission Connect site. Also available on the secure site is the Survey Activity Guide, which includes a list of initial materials the surveyor will request to review at the onset of the survey.

The organization’s Joint Commission account executive will contact the organization and provide the anticipated number of days and number of surveyors that will be assigned for the on-site survey. On the first day of an on-site survey, the surveyor(s) will work with the organization to ensure the schedule considers the organization’s operations and needs. During the survey, the surveyor(s) will work to minimize any disruption to the care, treatment, or services of the individuals served when conducting survey activities.

The on-site survey process focuses on continuous operational improvement in support of safe, high-quality care, treatment, and services. The survey agenda will include the elements described in the following paragraphs.

Surveyor Arrival and Preliminary Planning Session. Upon arrival, surveyors will check in with reception, present their identification, and indicate their purpose for visiting. Staff should be prepared with a plan and instructions for how to proceed. The surveyor(s) will want to get settled in and begin reviewing the documentation identified in the Document List as soon as possible.

Opening Conference and Orientation to the Organization. During the opening conference, the surveyor(s) describes the structure and content of the survey to organization staff. Surveyors will take time to introduce your organization to the revised clarification procedures and new Survey Analysis for Evaluating Risk™ (SAFER™) reporting process. During the time designated for the orientation, staff provide the surveyor(s) with information about the organization. At this time, the organization will briefly explain its structures, mission, vision, and relationship with the community. This provides the surveyor(s) with baseline information about the organization that can help focus subsequent survey activities.

Please see the Survey Activity Guide on the Joint Commission Connect site or at https://www.jointcommission.org/2017_survey_activity_guide/ for more detailed information on the survey process.
Surveyor Planning Session. During this session, the surveyor(s) will review data and information about the organization to plan the survey agenda. This will include any information from previously conducted Joint Commission activities and other behavioral health care organization documents that have been gathered for review. The surveyor(s) will select the first individuals served for tracing based on what he or she learns from the review of data and information during this session.

Individual Tracer Activity. During the individual tracer activity, the surveyor(s) will do the following:

- Follow the course of care, treatment, or services provided to the individual served by the organization
- Assess the interrelationships among disciplines and services/programs and the important functions in the care, treatment, or services provided (if care, treatment, or services are provided by multiple disciplines)
- Identify vulnerabilities in the delivery of care, treatment, or services

See the “Tracer Methodology” section for more information.

System Tracers. System tracers are interactive sessions with the surveyor(s) and organization staff that explore the performance of important individual served-related functions that cross the organization. The surveyor(s) will explore critical risk points with organization staff and provide education when indicated during the system tracer sessions. The data management system tracer may also include infection control or medication management, if within the scope of the organization.

As the surveyor(s) performs individual tracers (see section above) to determine standards compliance as it relates to care, treatment, or services delivered to the selected individual served, they also begin to learn about the organization’s overall systems. Information gathered during individual tracers is then considered from a multi-individual served, cross-organizational perspective during system tracers for high-risk processes. See the “Tracer Methodology” section for more information.

Accreditation Program–Specific Tracers. Accreditation program–specific tracers will be conducted if they apply to the organization being surveyed and at the surveyor’s discretion. These focused activities take place during the time noted on the agenda for individual tracer activity. See the “Tracer Methodology” section for more information.

Issue Resolution. This optional session will occur, as necessary, at the surveyor’s discretion to follow up on potential findings that could not be resolved in other survey activities.
Surveyor Team Meeting/Planning Session. This time is reserved for the surveyor(s) to review and analyze the information gathered throughout the day and plan for upcoming survey activities.

Daily Briefings. During the daily briefing session, the surveyor(s) will communicate to organization staff their observations on the previous day’s survey findings, including the placement of findings up to that point on the SAFER Matrix (note that placement of findings on the matrix is subject to change as the survey progresses and there may be additional findings).

If the organization has additional information that would demonstrate compliance with a standard that a surveyor has indicated may be an RFI, the organization should supply that information to the surveyor(s) as soon as possible.

Leadership Session. During the leadership session, surveyors will explore leadership’s responsibility for creating and maintaining the organization’s systems, infrastructure, and key processes that contribute to the quality and safety of care, treatment, or services. The session is intended to be interactive; therefore, surveyors and organization leaders will engage in a discussion, using organization-specific examples, of the following topics:

- Leadership commitment to improvement of quality and safety
- Creating a culture of safety
- Robust Process Improvement®
- Observations that may be indicative of system-level concerns

Environment of Care and Emergency Management. This session is an opportunity for the surveyor(s) and organization to review and evaluate the following:

- The processes in place for managing risk in the physical environment (for example, safety and security, fire safety)
- Emergency management processes, such as identifying risks, interactions with other health care organizations, interactions and communication with the community, and drills, critiques, and performance improvement
- Discuss the four phases of emergency management: mitigation, preparedness, response, and recovery
- Review and discuss organization plans for managing critical areas of their operations so that they can effectively respond regardless of the emergency
Life Safety Code® Building Assessment. This session is conducted for 24-hour settings only. In addition to determining the degree of compliance with relevant Life Safety Code requirements, the surveyor will evaluate the effectiveness of processes for the following:

- Maintaining fire safety equipment and fire safety building features
- Identifying and resolving Life Safety Code problems
- Developing and implementing activities to protect occupants during periods when a building does not meet the Life Safety Code or during construction periods
- Maintaining and testing emergency power systems, if applicable
- Maintaining and testing medical gas and vacuum systems, if applicable

Competence Assessment. This activity will help the organization and the surveyor(s) identify specific issues and do the following:

- Evaluate the process the organization uses to collect relevant data for decisions for determining competence
- Evaluate processes for the assignment of duties and responsibilities based on job descriptions/contracted scope of services
- Determine whether staff practice within the limited scope of job descriptions/contracted scope of services
- Link results of peer review and focused monitoring to this process
- Identify vulnerabilities in job descriptions/contracted scope of services

In addition, the surveyor(s) and the organization will discuss and review topics such as these:

- Processes for verifying required licenses, registrations, and certifications
- Orientation and training process for staff
- Methods for assessing competence of staff
- In-service and other education and training activities for staff

Surveyors will request a sample of personnel records representing a variety of disciplines encountered throughout the survey. With authorized organization staff, the surveyor will review these records to validate through documentation what they have heard from both leaders and staff related to the topic of initial and ongoing competence assessment.

Foster/Respite Family Home Visits. This individual tracer activity will help the organization and the surveyor(s) do the following:

- Assess the interaction among the foster/respite parents/family, the individual served, and the case worker
- Assess the environmental safety issues in the home
**Foster Parents/Caretakers Group Meeting.** A Foster Parents/Caretakers Group Meeting provides a surveyor the opportunity to speak with more foster parents/caretakers than individual home visits will allow. During this meeting, the surveyor(s) will speak with foster parents/caretakers and do the following:

- Learn about the organization’s recruitment, licensing, and training process
- Learn about the preparation of foster parents/caretakers to meet the needs of individuals served
- Learn about the organization’s foster care program from the foster parents’/caretakers’ perspective

**Surveyor Report Preparation.** The surveyor(s) will use this time to compile, analyze, and organize the data he or she has collected throughout the survey into a preliminary Summary of Survey Findings Report reflecting the organization’s compliance with standards (*see* the “Summary of Survey Findings Report” section).

**Exit Briefing and Organization Exit Conference.** The surveyor will offer to meet with the most senior leader, usually the CEO or administrator, or the leadership team to conduct a private Exit Briefing. During the Exit Briefing, the surveyor will present the survey findings and review the preliminary Summary of Survey Findings Report (including the SAFER Matrix results), discuss any concerns senior leaders have with the report, and determine the need for any special arrangements for the Organization Exit Conference.

During the Organization Exit Conference the surveyor(s) will review the survey findings (if desired by senior leaders), review the issues of standards compliance that have been identified during the survey, and review required follow-up actions, as applicable.

**Tracer Methodology**

The tracer methodology is the cornerstone of The Joint Commission on-site survey. The tracer methodology incorporates the use of information the organization supplies in the E-App to follow the experience of care, treatment, or services for a number of individuals through the organization’s entire delivery system of care, treatment, and services. Tracers allow the surveyor(s) to identify performance issues in one or more steps of the process, or in the interfaces between processes. Tracer types are described in the following sections.
Accreditation Program–Specific Tracers
The goal of the accreditation program–specific tracer activity is to identify quality and safety concerns within different levels and types of care, treatment, or services. Accreditation program–specific tracers focus on important issues relevant to the organization (for example, clinical services offered and high-risk, high-volume populations for individuals served).

Topics for the accreditation program–specific tracers were identified through a review of expert literature, research, input from the field, and subject matter expertise. Accreditation program–specific tracers evaluate specific issues and compliance with relevant standards that impact the safety of individuals served. Table 2 contains tracer activity specific to behavioral health care accreditation, including applicability and objectives.

Note: Accreditation program–specific tracers, which occur during the Individual Tracer Activity, are conducted only if they apply to the organization being surveyed.
## Table 2. Behavioral Health Care Accreditation—Specific Tracer Applicability and Objectives

<table>
<thead>
<tr>
<th>Tracer</th>
<th>Applicability</th>
<th>Objectives</th>
</tr>
</thead>
</table>
| Continuity of Foster/Therapeutic Foster Care| Foster/therapeutic foster care (in the presence of multiple placements within the same foster care agency) | - To evaluate the effectiveness of the foster/therapeutic foster care agency processes surrounding placement of children/youth or adults  
- To identify process-level and possibly system-level issues contributing to multiple placements |
| Elopement                                   | Children and youth, addictions, residential treatment, group homes, developmental disabilities, foster care, mental health (in the presence of multiple episodes of elopement), adult day care | - To evaluate the effectiveness of the organization’s processes to prevent elopement, therefore enhancing safety  
- To identify process-level and possibly system-level issues contributing to elopements |
| Suicide prevention                          | 24-hour settings, for example, residential (when organizations have experienced suicide or suicide attempts) | - To evaluate the effectiveness of the organization’s suicide prevention strategy  
- To identify process-level and possibly system-level issues contributing to suicide attempts |
| Violence prevention                         | All settings when surveyors identify concerns related to violent behavior       | - To identify process-level and possibly system-level issues contributing to violent behaviors  
- To evaluate the effectiveness of the organization’s process to control violence and ensure the safety of others |
| Continuity of care, treatment, or services for individuals with eating disorders being discharged or transferred to another level of care, treatment, or services | Organizations providing care, treatment, or services to individuals with eating disorders | - To evaluate the effectiveness of discharge or transfer planning and coordination of care for individuals with eating disorders  
- To identify process-level and, possibly, system-level issues contributing to “gaps” in care, treatment, or services for individuals after discharge from care, treatment, or services or transfer to another level of care, treatment, or services |
Individual Tracer Activity

The individual tracer activity is conducted during an on-site survey and is designed to “trace” the care, treatment, or services experiences that a individual served had while at the organization. The tracer methodology is a way to analyze an organization’s system of providing care, treatment, or services using actual individuals served as the framework for assessing standards compliance. The surveyor(s) will use the following general criteria to select initial individual tracers:

- Individuals served whose tracers would allow for the evaluation of identified accreditation program-specific risk areas/categories (EPs with the R icon).
- Individuals served who cross accreditation programs in organizations surveyed under one or more accreditation manuals
- Individuals served who will contribute greater understanding to system tracer topics (see the “System Tracer Activity” section), such as medication management or individuals with a history of trauma
- Individuals served receiving complex services, such as medication management or participation in an inpatient/residential detox
- Children/youth who are subject to physical holding or any individuals served who are placed in restraints or seclusion
- For organizations providing primary physical health care (directly or indirectly), individuals receiving primary physical health care
- For organizations electing to be certified as a behavioral health home, individuals that the organization is serving as a health home

Individuals served who are selected for initial individual tracer activity will likely be those whose diagnosis/condition, age, or type of services received may enable the best in-depth evaluation of the organization’s processes and practices. In conducting the tracer of an individual served, the surveyor(s) will follow specific individuals served through the organization’s processes. A surveyor will not only examine the individual components of a system but will also evaluate how the components of a system interact with each other. In other words, a surveyor will look at the care, treatment, or services provided by each program or service as well as how programs and services work together. The surveyor(s) usually starts where the individual served is currently located. He or she can then move to where the individual served first entered the organization’s systems; an area of care provided to the individual served that may be a priority for that organization; or to any areas in which the individual served received care, treatment, or

**Please see the Survey Activity Guide on the Joint Commission Connect site for more detailed information on other accreditation program-specific criteria for tracer selection.**
services. The location and order will vary. Along the way, the surveyor(s) will speak with the staff member(s) who actually provided the care, treatment, or services to that individual served—or, if that staff member(s) is not available, will speak with another staff member(s) who provides the same type of care, treatment, or services.

Based on the findings of the surveyor(s), he or she may select similar individuals served to trace. The tracer methodology permits surveyors to further investigate if there is a reason to believe that an issue needs further exploration.

**Risk Areas**
A surveyor conducting any type of tracer at an organization might notice something that requires a more in-depth look. At that point, the surveyor will look at all processes at a system level by asking more detailed questions or spending more time looking at a particular risk area. The focused evaluation includes processes or procedures that, if not planned or implemented correctly, have significant potential for affecting/impacting the safety of individuals served. Topics in organizations that surveyors might need to explore in more detail include, but are not limited to, the following:
- Screening/assessment of suicide and/or risk to self/others
- Restraint/seclusion (including physical holding of children/youth)
- Contracted services
- Flow of individuals served across the continuum of care, treatment, or services

Surveyors will assess and display the risk associated with findings by utilizing the SAFER Matrix. Survey findings will be plotted on the SAFER Matrix according to the likelihood the RFI could cause harm to individuals served, patients, staff, and/or visitors and the scope at which the RFI was observed.

**System Tracer Activity**
System tracers explore one specific system or process across the organization, focusing, when possible, on the experiences of specific individuals served or activities relevant to specific individuals served. This differs from individual tracers in that during individual tracers, the surveyor(s) follows an individual served through his or her course of care, treatment, or services evaluating all aspects of care, treatment, and services as opposed to a “system.” During the system tracer sessions, the surveyor(s) evaluates the system or process, including the integration of related processes and the coordination and communication among disciplines, programs, or services in those processes.
A system tracer includes an interactive session (involving a surveyor and relevant staff members) in tracing a “system” within the organization based on information from individual tracers. Points of discussion in the interactive session include the following:

- The flow of the process across the organization, including identification and management of risk points, integration of key activities, and communication among staff and programs/services involved in the process
- Strengths in the process and possible actions to be taken in areas needing improvement
- Issues requiring further exploration in other survey activities
- A baseline assessment of standards compliance
- Education by the surveyor, as appropriate

The three topics evaluated with system tracers are data management, infection control in 24-hour settings, and medication management. Whether all system tracers are conducted varies based on several factors,*** but the data use system tracer is performed on every organization survey. If a system tracer is not conducted, the relevant given area is assessed through other survey activities.

**Data Management.** The data management system tracer focuses on how the organization collects, analyzes, interprets, and uses or manages data to improve the safety of and care, treatment, or services provided to the individuals served.

**Infection Control.** The infection control individual-based system tracer explores the organization’s infection control processes. The goals of this session are to assess the organization’s compliance with the relevant infection control standards, identify infection control issues that require further exploration, and determine actions that may be necessary to address any identified risks and improve the safety of individuals served.

**Medication Management.** The medication management individual-based system tracer, if applicable, explores the steps in the organization’s medication management processes that apply to the setting while focusing on subprocesses and potential risk points (such as handoff points). This tracer activity helps the surveyor(s) evaluate the continuity of medication management or quality/safety of the organization’s role in the medication management process, which may include some, none, or all the steps in medication management.

***Factors may include survey length, setting, and whether any medication processes are within the scope of the organization.
The Role of Staff in Tracer Methodology
To help the surveyor(s) in the tracer methodology process, staff will be asked to provide the surveyor(s) with a list of individuals being served, including the names of individuals served, their current locations, and diagnoses/conditions, as appropriate. The surveyor(s) may request assistance from staff for selection of appropriate individuals to trace. The surveyor(s) will ask to speak with the staff who have been involved in the tracer individual’s care, treatment, or services if available. If those staff are not available, the surveyor(s) will ask to speak to another staff member who would perform the same function(s). Although it is preferable to speak with the direct staff member, it is not mandatory because the questions that will be asked are questions that any staff member should be able to answer in providing care, treatment, or service to the individual being traced.

Immediate Threat to Health or Safety
The Joint Commission defines Immediate Threat to Health or Safety as “a threat that represents immediate risk and has or may potentially have serious adverse effects on the health or safety of the patient, resident, or individual served.” Such a situation may occur anywhere in an organization. (See Accreditation Participation Requirement [APR].09.04.01.)

If a surveyor identifies any condition that he or she believes poses a serious threat to public or individual served health or safety, he or she will notify the organization’s CEO and Joint Commission headquarters staff immediately. The president of The Joint Commission, or his or her designee, can then issue an expedited Preliminary Denial of Accreditation decision based on the threat. An organization notified of a Preliminary Denial of Accreditation decision†† due to an Immediate Threat to Health or Safety situation does not have a right to “clarify” the survey findings relative to the situation. Since a Preliminary Denial of Accreditation is an official accreditation decision category, the decision is posted on Quality Check.

The organization’s CEO and appropriate governmental authorities are informed of this decision and the findings that led to this action. After notification of the Preliminary Denial of Accreditation decision, an organization has up to 72 hours to do the following:

††After the Preliminary Denial of Accreditation decision has been confirmed by the Joint Commission’s executive leadership, the organization has five days to notify The Joint Commission if it wishes to appeal the decision. If this is the case, The Joint Commission’s Review and Appeal Procedures apply.
Emergency intervention refers to any safety measure implemented to preserve life, whether related to Life Safety Code deficiencies or another Immediate Threat to Health or Safety situation. When referring to specific Life Safety Code issues, these interventions would be called interim life safety measures, which are defined as “a series of 11 administrative actions intended to temporarily compensate for significant hazards posed by existing National Fire Protection Association 101-2012 Life Safety Code deficiencies or construction activities.”

Eliminate the Immediate Threat to Health or Safety situation entirely or

If the situation is such that it will take the organization more time to fully eliminate it (such as situations involving building construction), then the organization must implement emergency interventions‡‡ to abate the risk to individuals served (for example, cease performing a certain procedure, implement additional safety measures) within 72 hours. If the situation is not fully eliminated within 72 hours, the organization will have a maximum of 23 calendar days to do so.

At its next meeting, executive leadership can either confirm or reverse the Preliminary Denial of Accreditation decision by the president or his/her designee. Executive leadership may take into consideration an organization’s corrective actions or responses to a serious threat situation. The organization can provide information to demonstrate that a serious threat to health or safety has been corrected prior to executive leadership’s consideration of the Preliminary Denial of Accreditation decision.

In these situations, the corrective action is considered when a single issue leads to the adverse finding and the organization demonstrates that it did the following:

- Took immediate action to completely remedy the situation
- Adopted systems changes to prevent a future recurrence of the problem

If the organization demonstrates that it has taken corrective action, The Joint Commission will conduct an abatement survey to validate the implementation of the corrective action and that the immediate threat situation is no longer present.

The results of the abatement survey will help The Joint Commission determine whether to remove the Preliminary Denial of Accreditation decision (assuming there are no other reasons for the Preliminary Denial of Accreditation). Therefore, the sooner an organization eliminates the Immediate Threat to Health or Safety situation, the shorter the period of time the organization may be in Preliminary Denial of Accreditation.
Upon resolution of an Immediate Threat to Health or Safety situation, the organization’s accreditation status may change from Preliminary Denial of Accreditation (PDA) to a time-limited PDA and Accreditation with Follow-up Survey and remain as such until an accreditation follow-up survey is conducted to assess the organization’s sustained implementation of appropriate corrective actions.

See Figure 2 for a visual representation of the process flow for Immediate Threat to Health or Safety situations at organizations seeking reaccreditation.

**Immediate Threat to Health or Safety During Initial Survey**

There are only two possible outcomes—Accredited or Denial of Accreditation—for an organization undergoing its first, or initial, Joint Commission survey; therefore, initial organizations that have an Immediate Threat to Health or Safety situation will receive a Denial of Accreditation decision with no opportunity for an appeal. Once the Immediate Threat to Health or Safety situation is identified, the organization will not be able to withdraw from the accreditation process. In addition, The Joint Commission will notify the licensing authority having jurisdiction that the organization was denied accreditation due to the Immediate Threat to Health or Safety. If the organization decides to reapply after the appropriate time interval (a minimum of four months), it will undergo a survey to demonstrate that it has abated the Immediate Threat to Health or Safety. This survey may be conducted before—or in conjunction with—the full survey.
Process Flow for Immediate Threat to Health or Safety (ITHS) Situations

Survey is conducted

During survey, surveyors identify an ITHS situation

Surveyor consults with The Joint Commission’s central office staff

Central office staff discusses the situation with The Joint Commission’s president or his designee

The Joint Commission president agrees with the ITHS and places the organization in Preliminary Denial of Accreditation (PDA)

Organization receives alternative accreditation decision based on survey findings.

PDA decision is presented to executive leadership

The organization is notified of PDA decision and ITHS process is explained

PDA decision is posted on Quality Check and governmental/licensure agencies are notified

Executive leadership confirms PDA decision

Organization is notified of Executive leadership’s decision and its right to appeal provided The Joint Commission is notified within five days

Organization appeals PDA decision

PDA process continues

Organization receives alternative accreditation decision

ITHS situation no longer exists

PDA decision is changed to Accreditation with Follow-up Survey (AFS) decision

Organization appeals PDA decision

YES

AFS process is invoked

NO

Organization receives alternative accreditation decision

Denial of Accreditation becomes final after 5 days

NO

PDA decision is presented to executive leadership

Organization notifies The Joint Commission that it has abated the ITHS situation

The Joint Commission conducts an audit survey

Organization receives alternative accreditation decision based on survey findings.

The organization is notified of executive leadership’s decision and its right to appeal provided The Joint Commission is notified within five days

PDA process continues

The Joint Commission president agrees with the ITHS and places the organization in Preliminary Denial of Accreditation (PDA)

Organization appeals PDA decision

NO

Denial of Accreditation becomes final after 5 days

YES

Organization appeals PDA decision

Executive leadership confirms PDA decision

Organization receives alternative accreditation decision

Denial of Accreditation becomes final after 5 days
The Accreditation Process

The Summary of Survey Findings Report

Following evaluation of an organization’s performance of functions and processes when there are multiple surveyors or a survey team, the survey team reviews the results of integrated individual findings. Then, with the use of laptop-based support software, the surveyor (or survey team) posts the organization’s preliminary Summary of Survey Findings Report to the organization’s extranet site. Included in this preliminary report is the Survey Analysis for Evaluating Risk™ (SAFER™) Matrix, which gives a visual representation of the risk level of each RFI. If requested, the surveyor (or survey team leader) and the organization’s CEO meet prior to the closing conference to determine how the report will be shared (in terms of detailed, summary, or general comments) at the closing conference. The surveyor (or survey team) uses the report contents in making closing conference presentations.

Shortly after a survey, an organization’s report of survey findings is posted on the organization’s secure Joint Commission Connect site. The report includes RFIs, as appropriate. Each RFI will be plotted on the SAFER Matrix according to the risk level of the finding—that is, the likelihood of the finding to cause harm to individuals served, staff, and/or visitors and the scope at which the RFI was observed. If an organization does not receive any RFIs, its accreditation decision is rendered at the same time that the organization’s preliminary Summary of Survey Findings Report is available, and it is effective the day after the completion of the survey. If an organization does receive RFIs, then its accreditation decision is rendered following the submission of an acceptable ESC report. (See the “Accreditation Effective Date” section and the “Evidence of Standards Compliance [ESC] Process” section for more information.)

After the Survey

This section includes information relevant to an organization that has recently participated in an accreditation survey. Material includes information on scoring, the types of accreditation decisions, the ESC and clarification processes, how to request the review of an accreditation decision, how to appeal an accreditation decision, and how to use and display an accreditation award.

The Scoring Process

The performance expectations for determining if a standard is in compliance are included in its Elements of Performance (EPs). If an EP is determined to be out of compliance, then it will be cited as a Requirement for Improvement (RFI). Each RFI is
placed in the SAFER Matrix according to how likely it is that the RFI will harm an individual(s) served, staff, and/or visitor (low, moderate, high) and the scope, or prevalence, at which the RFI was cited (limited, pattern, widespread). As the risk level of a finding or an observation increases, the placement of the standard and EP moves from the bottom left corner (lowest risk level) to the upper right corner (highest risk level). Figure 3 is a representation of the SAFER Matrix.

![SAFER Matrix Diagram]

**Figure 3.** Survey Analysis for Evaluating Risk (SAFER) Matrix.

The SAFER Matrix is the visual representation of risk associated with survey findings. If a standard is not applicable (NA) to the organization, it will be marked “NA” and not placed within the SAFER Matrix.

**How Accreditation Decisions Are Made**

Accreditation decisions are made based on the premise that the immediacy of risk to quality of care and the safety of individuals served—as shown by noncompliance with Joint Commission standards and EPs—varies. All noncompliant EPs will be cited as
RFIs. In addition, all RFIs must be addressed via the ESC submission process. The time frame for completing the ESC submission is within 60 calendar days. However, organizations recommended for Preliminary Denial of Accreditation decision PDA02 (as a result of individuals being placed at risk for a serious adverse outcome due to significant and pervasive patterns, trends, and/or repeat findings) are required to submit a Plan of Correction (POC) within 10 business days instead of an ESC. A validation survey will be required within 60 days to confirm that the organization has implemented the POC and is in full compliance.

The organization’s accreditation decision will be held in abeyance pending submission of ESC within the established time frame. For situations that constitute more immediate risks to quality of care and the safety of individuals served, a more severe accreditation status will be applied. In these scenarios, the two accreditation classifications defined below will be utilized:

- Immediate Threat to Health or Safety
- Decision Rules

### Immediate Threat to Health or Safety
Immediate Threat to Health or Safety situations that are identified on site have or may potentially have serious adverse effects on the health or safety of individuals served. Upon resolution of an Immediate Threat to Health or Safety situation, the organization’s accreditation status may change from Preliminary Denial of Accreditation to Accreditation with Follow-up Survey and remain as such until a follow-up survey is conducted to assess the organization’s sustained implementation of appropriate corrective actions.

Immediate Threat to Health or Safety situations are cited at Accreditation Participation Requirement APR.09.04.01, EP 1.

### Decision Rules
Decision rules determine an accreditation decision that appropriately represents an organization’s overall performance as measured by noncompliance with the applicable standards. Decision rules are applied when a heightened risk to the care and safety of individuals served is determined as a result of on-site survey findings. There are times when situations will automatically trigger a recommendation for Preliminary Denial of Accreditation or Accreditation with Follow-up Survey based on such issues as loss of facility licensure, provision of care by unlicensed individuals who require such a license, and failure to implement corrective action in response to identified Life Safety Code deficiencies. In follow-up to these situations, organizations must demonstrate resolution of the situation through the ESC process. An on-site survey is conducted to validate implementation of corrective action.
For more information regarding decision rules, see the “Decision Rules for Organizations Seeking Reaccreditation” and “Decision Rules for Organizations Seeking Initial Accreditation” sections later in this chapter.

The Accreditation Decision Process
The goal of the accreditation decision and reporting approach is to focus attention on the issues that pose the greatest risk to quality of care, treatment, and services and to the safety of individuals served. Key elements of the accreditation decision process include the following:

- Levels of noncompliance with Joint Commission standards are identified on the SAFER Matrix.
- The surveyor(s) leaves a preliminary Summary of Survey Findings Report on site. (For special surveys, no report is left on site.)
- The Accreditation Survey Findings Report will be posted on the organization’s secure extranet site within 10 business days of the survey’s completion.
- If RFIs are cited, the organization has a 60-day window to submit an ESC report to address correction of the RFIs.
- Organizations that receive a PDA02 decision must submit a POC (instead of an ESC) within 10 business days; a validation survey is conducted within 60 days to confirm that the POC has been implemented and the organization is in full compliance.

The “Joint Commission Findings” section of the Accreditation Survey Findings Report includes RFIs and associated findings cited during the on-site survey. In addition, Joint Commission EPs that are initially identified as less-than-fully compliant but corrected before the conclusion of the survey are designated as Observed but Corrected On-site (OCO). Although the (OCO) indicator recognizes issues as having been “fixed” before the conclusion of the survey, these RFIs remain in the survey report; that is, an ESC still needs to be completed for these findings.

Decision Categories for Organizations Seeking Accreditation Renewal
The Joint Commission’s decision categories are designed to help distinguish organizations with serious patterns and trends in the provision of care, treatment, or services—which require follow-up more quickly—from those with less serious compliance issues. There are four possible decision categories for organizations undergoing a Joint
Commission survey for reaccreditation. Figure 4 illustrates the continuum of accreditation decisions possible following resurvey activity. The Joint Commission’s four accreditation decision categories for organizations seeking renewal of accreditation are as follows:

1. **Accredited.** The organization is in compliance with all applicable requirements at the time of the on-site survey or has successfully addressed all RFIs in an ESC within 60 days following the posting of the Accreditation Survey Findings Report and does not meet any other rules for other accreditation decisions.

2. **Accreditation with Follow-up Survey.** The organization is in compliance with all standards as determined by an acceptable ESC submission. A follow-up survey is required within six months to assess sustained compliance.

3. **Preliminary Denial of Accreditation.** There is justification to deny accreditation to the organization as evidenced by:
   - An Immediate Threat to Health or Safety to patients or the public, and/or
   - Submission of falsified documents or misrepresented information, and/or
   - Lack of a required license or similar issue at the time of survey, and/or
   - Failure to resolve the requirements of Accreditation with Follow-up Survey, and/or
   - Significant noncompliance with Joint Commission standards.

   In some circumstances, a decision of Preliminary Denial of Accreditation is subject to review and appeal prior to the determination to deny accreditation. (See the “Appeal Procedures” section.)

4. **Denial of Accreditation.** The organization has been denied accreditation. All available review and appeal opportunities have been exhausted.

Additional note: There is a fifth decision category for organizations seeking initial accreditation: Limited, Temporary Accreditation. As explained in the “Early Survey Policy” section earlier in this chapter, an organization receives this decision if it demonstrates compliance with the limited set of standards surveyed in the first survey under the Early Survey Policy.
Figure 4. Continuum of survey activity outcomes for organizations seeking renewal of accreditation.

**Decision Outcomes for Organizations Seeking Initial Accreditation**

For organizations undergoing their first, or initial, Joint Commission survey, the decision process may result in only two possible outcomes—Accredited or Denial of Accreditation. Initial organizations receive an Accredited decision when they are in compliance with all applicable requirements at the time of the on-site survey or when they have successfully addressed all RFIs in an ESC within 60 days; if they do not successfully address all RFIs in an ESC within 60 days, they receive a Denial of Accreditation decision.

During the 60-day time frame, the decision is pending and the process is as follows: Organizations found out of compliance with Joint Commission requirements during their initial survey may voluntarily withdraw from the accreditation process with no decision rendered if they have not yet submitted their ESC in the allotted time. If they do not withdraw, initial organizations must submit corrective action through an ESC. Again, a successful ESC will then result in an Accredited decision. If an ESC is unacceptable because it does not demonstrate compliance, a decision of Denial of Accreditation—with no opportunity to appeal—will result.
Accreditation Effective Date
For accredited organizations undergoing a resurvey, the effective date of the accreditation decision varies. (See the “Evidence of Standards Compliance [ESC] Process” section for more information.) For organizations that do not receive any RFIs, the accreditation decision will be effective the day after the last day of survey. Otherwise, an accreditation decision is rendered once all RFIs have been resolved following the submission of an acceptable ESC report, which is retroactive to the day after the last day of the full survey.

The accreditation effective date for an organization that undergoes an initial survey is the date on which the last acceptable ESC was submitted, if the organization has an RFI. If there are no RFIs, the effective date is the day after the last day of the survey.

When an organization’s accreditation decision becomes official, it is publicly disclosable and is posted on Quality Check. In addition, the Requirements for Improvement will be posted for those organizations that receive a Preliminary Denial of Accreditation.

Withdrawing or Closing After Undergoing a Resurvey
An accredited organization’s request to withdraw from the accreditation process after undergoing a resurvey (or that closes after undergoing survey), but before a final decision has been made, does not terminate the decision-making process. The Joint Commission then issues a final accreditation decision.

Withdrawing from Initial Survey
An organization has the opportunity to withdraw from an initial survey up until the time it submits an ESC—which could be on site or shortly thereafter. If the organization requests to withdraw from the survey after it submits an ESC, the request will be denied and the organization will receive a decision of Denial of Accreditation with no opportunity to appeal.

Evidence of Standards Compliance (ESC) Process
An ESC is a report submitted by a surveyed organization that details the action(s) that it took to bring itself into compliance with a standard. The ESC report is available for completion on the organization’s secure Joint Commission Connect site at the same time that the organization’s Summary of Survey Findings report is posted.
After the survey, the surveyor(s) transmits his or her survey findings to the Joint Commission’s Central Office. The organization’s official Accreditation Survey Findings Report will be posted on its secure Joint Commission Connect site within 10 business days of completing a survey.

Every standard found not in compliance at the time of survey will generate an RFI. When an organization receives an RFI, it can choose to go directly to corrective action or to try and clarify the accuracy of the RFI. The organization must submit either a successful clarification or a corrective ESC for every RFI cited in an organization’s Accreditation Survey Findings Report (see the “Standards Clarification” section). Challenging specific surveyor observations will not result in the automatic removal of an RFI. The timeframe for submitting a corrective ESC is 60 days. A corrective ESC must address compliance at the EP level for all applicable corrections.

For those findings of a higher risk level, additional fields will be required within the ESC for the organization to provide a more detailed description of the leadership involvement and preventive analysis that will assist in sustaining the compliance plan. In addition, these higher risk findings will be provided to surveyors for possible review or on-site validation during any on-site surveys up until the next full triennial survey occurs. The SAFER Matrix information in Figure 5 provides a representation of possible ESC follow-up activities for RFIs of varying risk levels.

<table>
<thead>
<tr>
<th>SAFER Matrix™ Placement</th>
<th>Required Follow-Up Activity</th>
</tr>
</thead>
</table>
| **HIGH/LIMITED, HIGH/PATTERN, HIGH/WIDESPREAD** | • 60-day Evidence of Standards Compliance (ESC) that details the action(s) taken to come into compliance with the standards  
  • ESC will also include two additional areas surrounding the following:  
    (1) Leadership Involvement  
    (2) Preventive Analysis  
  • Finding will be highlighted for potential review by surveyors on subsequent on-site surveys up to and including the next full survey. |
| **MODERATE/PATTERN, MODERATE/WIDESPREAD** |  |
| **MODERATE/LIMITED, LOW/PATTERN, LOW/WIDESPREAD** | • 60-day Evidence of Standards Compliance (ESC) that details the action(s) taken to come into compliance with the standards |
| **LOW/LIMITED** |  |

**Figure 5.** SAFER Matrix placement and required follow-up activities.
Standards Clarification
After a survey event, organizations have the opportunity to submit clarifying ESC if they believe that their organization was in compliance with a particular standard at the time of survey. (This process does not include EPs initially identified as noncompliant but corrected before the survey’s conclusion. Also not included in this process is the placement of a finding within the SAFER Matrix; that is, an organization can clarify the finding as a whole but cannot change where the finding is placed within the matrix.)

The “clarification” is part of the ESC process and must be submitted within 10 business days following the posting of the organization’s report on the Joint Commission Connect site. The submission of a clarification does not negate the requirement for submission of a corrective ESC within 60 days if the clarification does not remove the RFI, nor does it provide an organization with additional time to submit its ESC. Therefore, if an organization submits clarification and still has to submit an ESC, the organization will have up to 60 days in total to submit both the clarification and the corrective ESC.

When submitting clarifying ESCs after a survey event, it is important to follow the directions in the submission tool. Address each prompt, detailing why the organization was in compliance at the time of survey. Remember to address the EP as well as the actual surveyor observation. (A finding of “lack of required documentation at the time of survey” is not eligible for clarification because documentation must be available for review at the time of survey—not after the survey.)

Corrective ESC
An acceptable corrective ESC report must detail the following:

- Compliance at the EP level
- Action(s), along with the final date of such action(s), that the organization took to bring itself into compliance with a requirement
- Title of the staff member ultimately responsible for implementing the corrective actions and sustaining compliance
- The plan for sustaining compliance
- Leadership involvement in the corrective action and sustained compliance plan (for those RFIs within the high-risk boxes on the SAFER Matrix, see Figure 5)
- Preventive analysis (for those RFIs within the high-risk boxes on the SAFER Matrix, see Figure 5)
An acceptable ESC report is due within 60 calendar days following the posting of the Accreditation Survey Findings Report (unless the organization is recommended for a PDA02 decision, in which case it must submit a POC within 10 business days and undergo a validation survey within 60 days). The required time frame will be specified in the survey report. Following a successful submission of the ESC report, the organization receives an accreditation decision. However, the organization’s accreditation decision is retroactive to the day after the last day of the survey, unless the organization is undergoing its first Joint Commission survey. The accreditation effective date for an organization that undergoes an initial survey is the date on which an acceptable ESC was submitted, if the organization has any RFIs. If there are no RFIs, the effective date is the day after the last day of the survey.

If the organization implements acceptable actions to address its RFIs, the organization’s accreditation decision is Accredited.

The organization’s ESC submission(s) will be evaluated by Central Office staff using the same scoring guidelines used by the surveyor(s) at the time of survey and by the organizations when they conduct their FSA. The Joint Commission will consider the ESC acceptable when the organization has demonstrated resolution of all RFIs. If the organization has not met a rule for Accreditation with Follow-up Survey or Preliminary Denial of Accreditation, and the ESC submission(s) is determined to be acceptable, its decision will be Accredited.

**On-Site ESC.** Usually the ESC will be an electronic submission to The Joint Commission; however, on occasion, a review of the ESC may also be conducted on site by a surveyor. If an on-site evaluation is required to assess compliance with the relevant standards following electronic submission, a copy of the organization’s electronic ESC is provided to the surveyor conducting the on-site ESC. The on-site ESC process provides the opportunity to evaluate the organization’s success in correcting the issues. It also allows the surveyor to provide coaching and guidance to the organization, supporting its efforts to achieve and maintain compliance with the standards.

A final decision letter will be posted to the organization’s secure, password-protected Joint Commission Connect site when its ESC has been reviewed and an accreditation decision has been rendered. A Quality Report will then be posted on Quality Check on The Joint Commission’s website. For more information, see “The Joint Commission Quality Report” (QR) chapter.
Accreditation Award Display and Use

The Joint Commission provides each accredited organization with one certificate of accreditation per accreditation program. There is no charge for the initial certificate(s). Additional certificates may be purchased. Such requests should be sent to the certificate coordinator in the Division of Accreditation and Certification Operations at The Joint Commission.

The certificate and all copies remain The Joint Commission’s property. They must be returned if either of the following situations occurs:

- The organization is issued a new certificate, reflecting a name change
- The organization’s accreditation decision is changed, withdrawn, or denied for any reason

Accreditation award certificates include language about educating individuals served and their families on how to contact The Joint Commission. An organization accredited by The Joint Commission must be accurate in describing to the public the nature and meaning of its accreditation and its award (see APR.08.01.01 in the APR chapter). When an organization receives an accreditation award, The Joint Commission sends the organization guidelines for characterizing the accreditation award.

An organization may not engage in any false or misleading advertising of an accreditation award. Any such advertising may be grounds for The Joint Commission to deny accreditation. For example, an organization may not represent its accreditation as being awarded by any of The Joint Commission’s corporate members. These include the American College of Physicians, the American College of Surgeons, the American Dental Association, the American Hospital Association, and the American Medical Association. The Joint Commission has permission to reprint the seals of its corporate members on certificates of accreditation. However, these seals must not be reproduced or displayed separately from the certificate.

Any organization that materially misleads the public about any matter relating to its accreditation must undertake corrective advertising to a degree acceptable to The Joint Commission in the same medium in which the misrepresentation occurred. If an organization fails to undertake the required corrective advertising following the communication of false or misleading advertising about its accreditation decision, the organization may be subject to loss of accreditation.

The Joint Commission’s logo is a registered trademark. An accredited organization may use the logo if it follows these guidelines:
The logo must remain in the same proportional relationship as provided and should not be displayed any larger than an organization’s own logo.

- The logo’s format cannot be changed, the name may not be separated from the symbol, and the logo must be printed in the original color.

- Graphic devices such as seals, other words, or slogans cannot be added to the logo, except for the words “Accredited by.”

- These guidelines apply to logo use on all print materials, Internet webpages, and promotional items, such as coffee mugs, T-shirts, and notepads.

Contact The Joint Commission Department of Communications at 630-792-5631 for questions about using The Joint Commission logo or access the Accreditation Publicity Kit online at http://www.jointcommission.org.

**Between Accreditation Surveys**

This section provides information that is relevant to organizations between Joint Commission surveys. Material includes the duration of an accreditation award, the process for continuing accreditation, the FSA process, how to notify The Joint Commission in the event of organization changes, and information on other types of surveys.

**Duration of Accreditation Award**

An accreditation award is continuous until the organization has its next full survey, which will be between 18 and 36 months after its previous full survey, unless accreditation is revoked for cause or as otherwise outlined in this chapter. An organization may request a full accreditation survey more frequently than when it is due to have a survey. The Joint Commission, at its discretion and in accordance with its mission, determines whether to honor the request. An organization should send such a request to its Joint Commission account executive.

An organization’s accreditation cycle is continuous, as long as the organization:

- Has a full survey within approximately 36 months of its last survey; and
- Continues to meet all accreditation-related requirements as required, including, but not limited to, submission of an FSA (see “Focused Standards Assessment [FSA]”, following) and an annual subscription payment.
Continuous Compliance
The Joint Commission expects an accredited organization to be in continuous compliance with all applicable standards and EPs. It may ask an organization to supply, in writing, information about compliance with applicable standards. The Joint Commission may conduct a survey if an organization fails to respond to a request for more information. It may also survey an organization at any time with or without notice in response to complaints, media coverage, or other information that raises questions about the adequacy of individual served health and safety protections (see the “For-Cause Surveys” section for more information).

The Joint Commission may view an organization’s failure to permit a survey as the organization no longer wanting to participate in good faith in the accreditation process. In such a case, The Joint Commission begins proceedings to deny accreditation to the organization (see APR.02.01.01 in the APR chapter).

Intracycle Monitoring
To assist accredited organizations with their continuous compliance efforts, The Joint Commission makes the Intracycle Monitoring (ICM) Profile available on The Joint Commission Connect extranet site. The ICM Profile identifies high-risk areas and related standards for organizations. These standards are displayed within the FSA tool with a special risk icon. The FSA tool enables organizations to conduct their own self-assessment of standards compliance throughout the triennial accreditation cycle.

The Joint Commission identifies critical systems/processes that could lead to adverse effects if they become weak or fail. Risk is assessed by a system’s proximity to the individual served, probability of harm, severity of harm, and number of individuals served at risk. Risk categories in the FSA are related to the following three categories:
1. National Patient Safety Goals
2. Accreditation program–specific risk areas
3. RFIs identified during current accreditation cycle survey events

Focused Standards Assessment (FSA)
The FSA process is designed to help organizations incorporate Joint Commission standards as part of routine operations and ongoing quality improvement efforts, supporting a continuous accreditation process. An organization has access to its FSA tool on a continuous basis throughout its accreditation cycle. The FSA tool becomes available
to an organization seeking accreditation for the first time after submitting its E-App and deposit. The FSA tool permits the organization to evaluate compliance with all applicable Joint Commission standards and EPs. For every noncompliant standard, the organization must identify a Plan of Action (POA) at the EP level, identifying how it plans to come into compliance with the requirement(s). By participating in the FSA, an organization will be better able to incorporate Joint Commission standards into routine operations, which in turn will help to ensure the provision of safe, high-quality care on an ongoing basis.

The FSA must be completed electronically through the Intracyle Monitoring (ICM) application located on the organization’s secure Joint Commission Connect site. The Joint Commission requires submission at the 12th and 24th month for general applications (and at the 12th month for lab applications). An FSA submission is not required the year the organization is scheduled for a full survey. Because full surveys can occur at any time between the 18th and 36th month of the triennial accreditation cycle, should a full survey occur before an organization’s anticipated FSA due date, the FSA due date will be reset accordingly. (Note that leadership of an organization with a PDA02 decision—a decision based on significant and pervasive patterns of noncompliant standards—is required to participate in the ICM process.) These submission intervals are valuable consultative and educational touch points to help organizations remain in continuous compliance with the standards and keep current with accreditation information. The tool and resources available are designed to provide educational support.

Organizations can select from one of the four ICM submission options. To accomplish a full submission, the minimum subset of standards coded with the icon must be scored as well as standards that have been scored as not compliant by the organization. Organizations submitting Option 1 conduct and score their standards self-assessment but elect not to submit the data to The Joint Commission; however, they may still engage in a conference call with the Standards Interpretation Group to discuss topics of concern that are specific to their facility. Next are the on-site Option 2 and 3 surveys. These surveys are conducted by a Joint Commission surveyor for an additional fee. The Option 2 survey results in a written report of findings that the organization follows up with POAs as appropriate. An Option 3 survey provides the organization with a verbal report of survey findings but does not result in any historical written documentation.
The Accreditation Process

Enhancements made to the FSA tool because of the SAFER process include two additional fields: Likelihood to Harm and Scope. These fields will only be displayed if an EP is scored as not compliant. Please note that if an organization scores an EP as not compliant, designating the likelihood to harm and scope is optional.

Sidebar 2 outlines some of the activities in each of these FSA options.

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Sidebar 2. Focused Standards Assessment Options

**Full FSA**
- Organization uses the FSA tool to assess and score compliance with EPs for each applicable standard.
- Organization creates a Plan of Action (POA) addressing each EP scored as not compliant.
- Organization may elect to participate in a conference call with the Standards Interpretation Group (SIG) to discuss POAs or other standards-related issues of its choosing. If a conference call is not requested, the data will be reviewed by SIG. If SIG determines a conference call is needed, the organization will be contacted.
- Organizations submitting the Full FSA with noncompliant standards need to enter their conference call “avoid dates” when they submit their FSA. “Avoid dates” are dates on which the organization prefers that the conference call not be scheduled.
- If standards have been scored compliant and a call has not been requested, once the FSA is submitted, the ICM requirement for that particular year is completed and no further action is required.

**FSA Option 1**
- Organization uses the FSA tool to assess and score compliance with EPs for each applicable standard if it chooses to do so.
- Organization affirms that it has completed an assessment of its compliance with applicable EPs and developed POAs as necessary, but it does not submit data to The Joint Commission.
- Organization can submit standards-related issues in the ICM Profile for telephone discussion with SIG, if desired.

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The Accreditation Process

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.

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Sidebar 2. (continued)

- Organizations that choose an Option 2 on-site survey will be charged a fee.
- The organization requests either an announced or unannounced FSA survey.
- Surveyor conducts the FSA survey using tracer methodology and identified accreditation program–specific risk areas; all standards are subject to review.
- Surveyor leaves a written report of findings with the organization.
- SAFER Matrix is included during on-site visit and embedded within report.
- Within 30 calendar days of the survey, organization submits POAs for each noncompliant standard through the historical FSA tool.
- Organization may elect to participate in a conference call with SIG to discuss the POAs. If a conference call is not requested, the data will be reviewed by SIG. If SIG determines a conference call is needed, the organization will be contacted.
- SIG reviews and approves POAs during conference call.

FSA Option 3

- Organizations that choose an Option 3 on-site survey will be charged a fee.
- The organization requests either an announced or unannounced FSA survey.
- Surveyor conducts the FSA survey using tracer methodology and identified accreditation program–specific risk areas; all standards are subject to review.
- SAFER Matrix is included during on-site visit.
- Surveyor delivers an oral report of findings at the closing conference of the on-site survey. No written report of findings will be left at the organization.

The FSA will affect an organization’s accreditation decision only if the organization fails to participate in the FSA process, whether the Full FSA or one of the three options, or an Immediate Threat to Health or Safety situation is identified through the FSA process and a special survey is conducted. If you need more information while completing the FSA, please contact your account executive at 630-792-3007.

Plan of Action (POA)

A POA is a detailed description of how an organization plans to bring into compliance any standard identified as “not compliant” in the FSA. The POA must include the planned action to be taken and target implementation dates.
Sentinel Event Follow-Up
Accredited organizations are expected to identify and respond appropriately to all sentinel events. The organization is required to conduct a thorough and credible comprehensive systematic analysis and develop a corrective action plan in a manner and time frame acceptable to The Joint Commission as specified in the Sentinel Event Policy and submit them to The Joint Commission or otherwise provide evidence of an acceptable response to the sentinel event. (See the “Sentinel Events” [SE] chapter for more information.)

Notifying The Joint Commission About Organization Changes
Accreditation is neither automatically transferred nor continued if significant changes occur within an organization. Organizations must notify The Joint Commission promptly, in writing, when an additional service is contemplated so any potential impact to accreditation can be determined. Once the change has actually occurred, the E-App must be updated to reflect the change as well.

Changes Affecting E-App Information
At any time during the accreditation process, an organization may undergo a change that modifies the information reported in its E-App (see APR.01.03.01 in the APR chapter). Organizations must notify The Joint Commission promptly, in writing, when an additional service or location is contemplated so any potential impact to accreditation can be determined.

Once the change has actually occurred, the organization must update its E-App within 30 calendar days. Information that must be reported includes any of the following:

- A change in ownership
- A change in location
- A significant increase or decrease in the volume of services or individuals served
- The addition of a new type of physical or behavioral health service, program, or site of care, treatment, or services
- The deletion of an existing physical or behavioral health service, program, or site of care, treatment, or services
- The acquisition of a new component

An organization is considered to have “contemplated” a change when leadership within the organization has approved moving forward with the proposed change and identified a time frame for implementing that change.
The deletion of an existing component

The Joint Commission may conduct an additional survey at a later date if its surveyor or survey team arrives at the organization and discovers that a change was not reported. The Joint Commission may also survey any unreported services and sites addressed by its standards during the survey as appropriate. The Joint Commission makes the final accreditation decision for the organization only after surveying all or an appropriate sample of all services, programs, and sites provided by the organization for which The Joint Commission has standards. Information reported in the E-App is subject to The Joint Commission’s Information Accuracy and Truthfulness Policy.

Changes to the Site of Care, Treatment, or Services

When an organization offers its 24-hour care, treatment, or services at a new location or in a significantly altered physical plant, the organization must evaluate for Life Safety Code deficiencies and document the corrective actions (to be completed within 60 days of notification to The Joint Commission) and Interim Life Safety Measures (ILSM) implemented to protect the building occupants while the deficiencies are being corrected. Failure to provide timely notification to The Joint Commission of these conditions may result in the organization’s loss of accreditation. If the corrective actions cannot be accomplished within 60 days of notification to The Joint Commission, the organization will need to contact its Account Executive. (See the discussion of extension surveys in the “Additional Surveys” section.)

Mergers, Consolidations, and Acquisitions

In the case of a merger, consolidation, or acquisition, The Joint Commission may decide that the organization responsible for services must have a survey. If, after an organization receives an accreditation decision, the organization’s structure changes whereby one or more of its services, programs, or related organizations are no longer part of the organization that was originally surveyed, the service, program, or related organization is no longer included in the organization’s accreditation.

See the “Extension Surveys” section for more information on what The Joint Commission expects to accomplish on these surveys.
Accreditation Status of Organizations That Cease Services After a Disaster

Following a disaster that requires a Joint Commission–accredited organization to cease the provision of services for a period of time, The Joint Commission will work with the affected organization to address the impact that the cessation of services will have on the organization’s accreditation status and to ensure that the organization is prepared to provide safe, quality care upon resumption of services. If after six months the organization cannot resume services, The Joint Commission will discontinue the accreditation of the organization. The impact of the cessation of services for a period of time on the accreditation status of organizations that experience a disaster is described below.

**Cease Services Up to 30 Days.** For organizations that resume services within the first 30 days after a disaster and/or the organization’s decision to cease operations, the organization’s original Joint Commission accreditation status will stay in effect. The time frame for complying with any outstanding Joint Commission requirements (such as the FSA or ESC) will pause until the organization resumes operation. In most cases, The Joint Commission will not need to survey the affected organization to reassess its level of standards compliance. If The Joint Commission decides to conduct a survey, however, the organization’s accreditation decision will be driven by the interim survey findings.

**Cease Services Up to 90 Days.** For organizations that resume services from 31 to 90 days after a disaster, The Joint Commission will conduct an extension survey to determine the organization’s accreditation status. The circumstances surrounding the organization’s closure will determine the survey’s length and scope.

**Cease Services Up to Six Months.** For organizations that resume services from 91 days up to six months after a disaster, The Joint Commission will require an on-site survey to assess the environment of care. This survey will preferably take place one to two weeks after services are resumed. These organizations must receive clearance to operate from the fire marshal, if appropriate, and other local/state authorities before resuming services. In addition, The Joint Commission will conduct a second on-site survey approximately four months after services have been resumed to evaluate sustained compliance with Joint Commission standards and requirements. The track record requirement for demonstrating standards compliance will be four months.

*Can be natural or man-made; any situation that causes cessation of services.
More Than Six Months. For behavioral health care organizations that do not resume services within six months after a disaster or decide to cease operations, The Joint Commission will discontinue its accreditation. If the organization resumes services, it must reapply to become accredited. In such cases, the accreditation process will involve at least two surveys. The first survey will be conducted at the organization’s request and will assess the organization’s ability to provide safe care, treatment, and services to individuals served. The organization may qualify for an accreditation award as a result of this survey. The second survey will be conducted approximately four months later to assess sustained compliance with Joint Commission requirements. The track record requirement for demonstrating standards compliance will be four months.

The Joint Commission will continue to post on Quality Check all affected organizations as Accredited up to six months after a disaster, unless interim survey findings dictate otherwise.

While working with affected organizations in the aftermath of a catastrophic event, The Joint Commission will be sensitive to these organizations’ needs and will work with responsible state and federal agencies to help reestablish the organizations’ operations as well as their qualification for accreditation.

If, following a disaster, an organization provides services at an alternate site, The Joint Commission will determine whether an extension survey or a full survey is required based on the scope of services being provided at the alternate site and the expected period of time that the services will be provided at the site.

If your organization is affected by a natural disaster, please notify your organization’s account executive as soon as possible. Once notified, The Joint Commission can cancel any accreditation-related events and offer assistance, if needed. If you don’t know who serves as your organization’s assigned account executive, please call 630-792-3007.

The above policy outlines a framework that The Joint Commission will generally follow when an organization is required to cease services for a period of time following a disaster. Depending on the unique circumstances of each situation, The Joint Commission may choose to modify this approach accordingly. In addition, The Joint Commission may coordinate its response with local, state, and/or federal officials having jurisdiction over the organization, as appropriate.
Accreditation Status of Organizations That Cease Services or Do Not Provide Care, Treatment, or Services to Individuals Served for a Period of Time

Joint Commission–accredited organizations may stop providing care, treatment, and services to individuals served or may not have any individuals served for a period of time for reasons other than natural or man-made disasters. When an organization ceases to provide care, treatment, and services to individuals served, it is required to notify The Joint Commission. The Joint Commission will work with the affected organization to address the impact that the cessation of services or the lack of individuals served will have on the organization’s accreditation status and to ensure that the organization is prepared to provide safe, quality care upon resumption of services. If after six months the organization cannot resume services, The Joint Commission will terminate the accreditation of the organization.

Up to 60 Days. If an organization does not have any individuals served for up to 60 days, The Joint Commission will continue the organization’s current accreditation status.

Up to Six Months. If an organization does not have any individuals served from 60 days to less than six months, but then resumes care, treatment, or services within six months, The Joint Commission will continue the organization’s current accreditation status only if the organization has an extension survey. This extension survey would generally take place as soon as possible in accordance with the organization’s request. The purpose of this survey is to evaluate the organization’s capability for resuming services and whether it is performing at current accreditation levels. If the organization refuses an extension survey, the accreditation will be terminated.

More Than Six Months. If an organization does not have any individuals served for six months or longer, The Joint Commission will terminate the organization’s accreditation. If the organization resumes services, it will have to reapply for accreditation and have a full survey in order to evaluate its current compliance with Joint Commission standards.

Reentering the Accreditation Process

For a previously accredited organization to be designated as “new,” it must not have participated in the accreditation process during the previous four months. If an organization is reentering the accreditation process before four months have passed, it must demonstrate a continuous 12-month track record of compliance with the standards.
Additional Surveys
This section describes additional surveys that may occur during the accreditation cycle, including extension surveys, for-cause surveys, and other follow-up surveys.

Extension Surveys
The Joint Commission conducts an extension survey when an accredited organization acquires a new service/program/site for which The Joint Commission has standards; significantly alters how it delivers care, treatment, or services; or adds an optional certification to the existing record. Extension surveys are done to ensure that the accreditation decision previously awarded to the organization is still appropriate under the changed conditions. The results of an extension survey may affect the organization’s accreditation status.

An extension survey is conducted at an accredited organization or at a site that is owned and operated by the organization if the accredited organization’s current accreditation is not due to expire for at least 9 months and when at least one of the following conditions is met:

- Changed ownership and has a significant number of changes in the management and clinical staff or operating policies and procedures
- Offered services at a new location or in a significantly altered physical plant
- Expanded capacity to provide services by 50% or more, as measured by volume of individuals served, pieces of equipment, or other relevant measures. This criterion will generate an extension survey only if there are also other changes at the organization.
- Provided a more intensive level of service

An extension survey will be conducted within 6 months to allow the organization time to bring a new service or site up to the accredited organization’s standard of performance. The survey findings resulting from the extension survey are maintained separately from, and are not reflected in, the accreditation decision of the acquiring organization for 12 months following the acquisition. The newly acquired component will be considered accredited during that period. After the extension survey, any outstanding standards compliance problems in the acquired component(s) are reflected in the accreditation decision of the acquiring organization.
The Accreditation Process

For-Cause Surveys
The Joint Commission may perform a for-cause survey when it becomes aware of a potentially serious standards compliance issue and/or issue related to the care, treatment, service, or safety of individuals served or when it has other valid reasons for surveying an accredited organization (see APR.02.01.01 in the APR chapter).

Note: While The Joint Commission may conduct a for-cause survey within a full survey (as these surveys may be referred to the full survey team for investigation), for-cause unannounced surveys should not be confused with the regular unannounced surveys described in the “Survey Notification” section.

Such a survey can either include all the organization’s services or only those areas where a serious concern may exist.

A for-cause survey, which is usually unannounced, can take place at any point in an organization’s accreditation cycle. No on-site summary report is generated after a for-cause survey.

Note: An organization is charged for a for-cause survey. An organization can determine the cost of such a survey by calling the Joint Commission’s Pricing Unit at 630-792-5115.

The Joint Commission may deny an organization accreditation if the organization does not allow The Joint Commission to conduct an unscheduled or unannounced survey (see APR.02.01.01 in the APR chapter).

Random Validation of Evidence of Standards Compliance
On an annual basis, a 2% random sample of all organizations that have been required to submit an ESC will be selected for an unannounced on-site validation survey that will take place soon after the ESC submission. The purpose of this survey is to maintain the credibility of the ESC process by validating statements made in the ESC submission. The surveyor will evaluate areas that were the subject of each RFI to determine whether the corrective actions were implemented as stated.

Decision Rules for Organizations Seeking Initial Accreditation
The Joint Commission makes accreditation decisions by applying decision rules to the scored standards. Decision rules determine an accreditation decision that appropriately represents an organization’s overall performance as measured by evidence of compliance.
with the applicable standards. Decision rules are approved by executive leadership. Executive leadership may exercise reasonable discretion in individual cases to determine whether to vary from applicable decision rules in furtherance of The Joint Commission’s mission to help health care organizations to continuously improve health care for the public.

The decision rules for organizations follow.

**Note:** Accreditation decision rules are numbered sequentially across all Joint Commission accreditation programs. Some accreditation decision rules do not apply to organizations accredited under the behavioral health care manual and are therefore not included in this accreditation manual. Consequently, gaps may appear in the sequence of the decision rules included in this section.

### Accredited

Accreditation will be recommended when one or more of the following conditions are met:

**A01** The organization is in compliance with all standards at the time of the on-site survey or has successfully addressed all RFIs in its first ESC submission and does not meet any rules for other accreditation decisions.

**A02** The organization, as a result of an on-site follow-up survey, is compliant with the original survey RFIs.

**Note:** Should additional RFIs be identified, appropriate decision rules apply.

### Behavioral Health Home Certification

The following rules will be used for Joint Commission–accredited organizations that choose to apply for Behavioral Health Home Certification:

**BHH01** A Joint Commission–accredited organization will be certified for the Behavioral Health Home program if it is in compliance with all Behavioral Health Home Certification standards at the time of the on-site survey.

**BHH02** A Joint Commission–accredited organization will not be certified for the Behavioral Health Home program if it has not successfully addressed all Behavioral Health Home Certification RFIs in its ESC submission.
BHH03  A Joint Commission–accredited organization will not be certified for the Behavioral Health Home program if it does not meet all Joint Commission standards for Behavioral Health Home Certification either at the time of its on-site survey or following submission of an ESC.

**Limited, Temporary Accreditation**
Limited, Temporary Accreditation will be recommended when the following condition is met:

**LTA01**  The organization has demonstrated compliance with the selected standards used in the first survey conducted under the Early Survey Policy.

**Evidence of Standards Compliance (ESC)**
An ESC will be required when one or more of the following conditions are met:

**ESC01**  An organization has one or more noncompliant standards at the time of a survey event.

**ESC02**  An organization that fails to successfully address all RFIs in an ESC may be required to submit a second ESC.

**ESC03**  An on-site evaluation may be scheduled to validate compliance with the relevant standards in a written ESC.

**Denial of Accreditation**
Denial of Accreditation will be recommended when one or more of the following conditions are met:

**DA01**  The organization does not permit the performance of any survey by The Joint Commission. (APR.02.01.01, EP 1)

**DA03**  The organization has failed to submit payment for survey fees or annual fees.

**DA04**  The organization has repeatedly failed to submit an ESC.

**DA05**  An organization undergoing its first Joint Commission survey has placed individuals served at risk for a serious adverse outcome(s) due to significant and pervasive patterns and trends in survey findings.
DA06  An Immediate Threat to Health or Safety exists for individuals served, staff, or the public within the organization undergoing its first Joint Commission survey. (APR.09.04.01, EP 1)

DA07  The Joint Commission is reasonably persuaded that the organization submitted falsified documents or misrepresented information in any way in seeking to achieve accreditation. If accreditation is denied following implementation of this rule, the organization shall be prohibited from participating in the accreditation process for a period of one year unless the president of The Joint Commission, for good cause, waives all or a portion of this waiting period. (APR.01.02.01, EP 1)

DA08  The organization undergoing its first Joint Commission survey fails to successfully address all RFIs in an ESC after two opportunities.

DA10  The organization’s individuals served have been placed at risk for a serious adverse outcome because either a practitioner who does not possess a license, registration, or certification is providing or has provided care, treatment, or services in the organization that would, under applicable law or regulation, require such a license, registration, or certification; or a practitioner is practicing outside the scope of his or her license, registration, or certification. (HRM.01.01.03, EPs 1 and 2)

DA11  The organization does not possess a license, certificate, and/or permit, as or when required by applicable law and regulation, to provide the health care services for which the organization is seeking accreditation. (LD.04.01.01, EP 1)

Decision Rules for Organizations Seeking Reaccreditation

Accredited
Accreditation will be recommended when one or more of the following conditions are met:

A01  The organization is in compliance with all standards at the time of the on-site survey or has successfully addressed all RFIs in its first ESC submission and does not meet any rules for other accreditation decisions.
A02  The organization, as a result of an on-site follow-up survey, is compliant with the original survey RFIs.

Note: Should additional RFIs be identified, appropriate decision rules apply.

Behavioral Health Home Certification
The following rules will be used for Joint Commission–accredited organizations that choose to apply for Behavioral Health Home Certification:

BHH01  A Joint Commission–accredited organization will be certified for the Behavioral Health Home program if it is in compliance with all Behavioral Health Home Certification standards at the time of the on-site survey.

BHH02  A Joint Commission–accredited organization will not be certified for the Behavioral Health Home program if it has not successfully addressed all Behavioral Health Home Certification RFIs in its ESC submission.

BHH03  A Joint Commission–accredited organization will not be certified for the Behavioral Health Home program if it does not meet all Joint Commission standards for Behavioral Health Home Certification either at the time of its on-site survey or following submission of an ESC.

Evidence of Standards Compliance (ESC)
An ESC will be required when one or more of the following conditions are met:

ESC01  An organization has one or more noncompliant standards at the time of a survey event.

ESC02  An organization that fails to successfully address all RFIs in an ESC may be required to submit a second ESC.

Accreditation with Follow-up Survey
Note: The Accreditation with Follow-up Survey could occur within 30 days or up to six months after the decision is rendered.

Accreditation with Follow-up Survey will be recommended when one or more of the following conditions are met:
Comprehensive Accreditation Manual for Behavioral Health Care

AFS01 The organization demonstrates systemic patterns, trends, and repeat findings with standards.

AFS03 The organization fails to successfully address all RFIs in an ESC after two opportunities.

AFS05 The organization, which has failed to resolve one or more of its original RFIs, may be scheduled for a second Accreditation with Follow-up Survey.

AFS06 The organization fails to participate in Intracycle Monitoring requirements.

AFS09 A practitioner who does not possess a license, registration, or certification is providing or has provided care, treatment, or services in the organization that would, under applicable law or regulation, require such a license, registration, or certification; or a practitioner is practicing outside the scope of his or her license, registration, or certification. (HRM.01.01.03, EPs 1 and 2)

Note: Except as provided under rule PDA03.

AFS10 The organization has failed to develop and implement the interim life safety measures (ILSM) policy and its criteria associated with evaluation and compensation for increased safety. (LS.01.02.01)

AFS11 If the Immediate Threat to Health or Safety abatement survey through direct observation or other determining method has demonstrated that the organization has implemented sufficient corrective action of the Immediate Threat, executive leadership may change the decision to Accreditation with Follow-up Survey.

AFS12 There is some evidence that the organization may have engaged in possible fraud or abuse.

AFS13 If an organization that has met the PDA02 decision rule has implemented sufficient corrective action as evidenced through an on-site validation survey, executive leadership may change the decision to Accreditation with Follow-up Survey.

Preliminary Denial of Accreditation

Preliminary Denial of Accreditation will be recommended when one or more of the following conditions are met:
PDA01 An Immediate Threat to Health or Safety exists for individuals served, staff, or the public within the organization. (APR.09.04.01, EP 1)

PDA02 The organization’s individuals served have been placed at risk for a serious adverse outcome(s) due to significant and pervasive patterns, trends, and/or repeat findings.

PDA03 The organization’s individuals served have been placed at risk for a serious adverse outcome because either a practitioner who does not possess a license, registration, or certification is providing or has provided care, treatment, or services in the organization that would, under applicable law or regulation, require such a license, registration, or certification; or a practitioner is practicing outside the scope of his or her license, registration, or certification. (HRM.01.01.03, EPs 1 and 2)

PDA04 The organization does not possess a license, certificate, and/or permit, as or when required by applicable law and regulation, to provide the health care services for which the organization is seeking accreditation. (LD.04.01.01, EP 1)

PDA05 The Joint Commission is reasonably persuaded that the organization submitted falsified documents or misrepresented information in any way in seeking to achieve or retain accreditation. If accreditation is denied following implementation of this rule, the organization shall be prohibited from participating in the accreditation process for a period of one year unless the president of The Joint Commission, for good cause, waives all or a portion of this waiting period. (APR.01.02.01, EP 1)

PDA06 The organization with a decision of Accreditation with Follow-up Survey has failed to resolve all RFIs after two opportunities.

PDA10 The organization’s individuals served have been placed at risk for a serious adverse outcome because there is some evidence that the organization may have engaged in possible fraud or abuse.

PDA11 If the Immediate Threat to Health or Safety abatement survey through direct observation or other determining method has not demonstrated that the organization has implemented sufficient corrective action of the Immediate Threat, executive leadership will continue the decision of Preliminary Denial of Accreditation.
**Denial of Accreditation**

Denial of Accreditation will be recommended when one or more of the following conditions are met:

**DA01** The organization does not permit the performance of any survey by The Joint Commission. (APR.02.01.01, EP 1)

**DA02** The organization has failed to resolve an Accreditation with Follow-up Survey status prior to withdrawing from the accreditation process.

**DA03** The organization has failed to submit payment for survey fees or annual fees.

**DA04** The organization has failed to submit an ESC or a Plan of Correction.

**DA05** An organization in the sustaining improvement program fails to participate in Joint Commission intervention.

**DA06** An organization has received a PDA decision in two sequential surveys.

**Process for Organizations That Meet Decision Rule PDA02 for Individuals Served Placed at Risk for Serious Adverse Outcomes Due to Significant and Pervasive Patterns, Trends, and/or Repeat Findings**

The following process applies for organizations that receive a PDA02 decision:

- If an organization meets decision rule PDA02, the organization will be notified within 10 business days of the completion of its survey when its final report is posted on its extranet site.
- An organization will have the option of clarifying any inaccurate survey findings within 10 business days of the posting of the final report. The organization may waive this clarification option.
- Once the clarification is completed or waived, a Plan of Correction (POC) will be required within 10 business days. The POC must address all RFIs cited in the organization’s survey report.

**Note:** Organizations that fail to submit any timely POC will receive an automatic Denial of Accreditation with no opportunity to appeal.
Following submission of a POC, an unannounced PDA validation survey will occur within approximately two months (60 calendar days) from the posting date of the final survey report. The validation survey will review implementation of the corrective actions identified in the POC.

- If the PDA validation survey is successful, the organization may receive a time-limited PDA and Accreditation with Follow-up Survey thereafter.
- If the validation survey is unsuccessful, the PDA status continues and the organization may appeal the PDA decision to a Review Hearing Panel. If an organization fails to appeal the continued PDA, the PDA decision becomes a final Denial of Accreditation within 5 business days of being notified of the continued PDA.

Following a PDA validation survey that results in a time-limited PDA with an Accreditation with Follow-up Survey decision, The Joint Commission’s Chief Medical Officer or Chief Operating Officer, or their designees, will contact the organization’s leadership to discuss the organization’s accreditation and to offer assistance to the organization in making sustainable improvements.

The organization is required to participate in the Intracycle Monitoring (ICM) process, which means that organizations that were recommended for a PDA at one time will not have the opportunity to merely attest that the organization is in compliance with Joint Commission standards between surveys.

For organizations that had a time-limited PDA, The Joint Commission will schedule the organization’s next unannounced triennial survey early within the 18- to 33-month period.

Should the organization’s next triennial survey result in a repeat Preliminary Denial of Accreditation, the organization will receive a Denial of Accreditation (DA) with the opportunity for an expedited appeal without a hearing.

See Figure 6 for a visual representation of the PDA02 decision process flow.
Preliminary Denial of Accreditation 02 (PDA02*+) Process
Effective for Surveys Beginning January 1, 2017

*Patients are placed at risk for a serious adverse outcome(s) due to significant and pervasive patterns, trends, and/or repeat findings
+Organizations will have the right to appeal this decision

Survey is conducted
Within 10 business days from the end of the survey, the final report is posted on the health care organization’s (HCO’s) extranet site with a recommendation of PDA02
Within 10 business days of posted final report, the HCO will have the option to clarify inaccurate survey findings
Within 10 business days of the completion of the clarification process, the HCO is required to submit a Plan of Correction (POC)
Within approximately two months of the posted final report, the HCO will have a validation survey to confirm implementation of the POC

If the validation survey (VS) is successful, the HCO receives a time-limited PDA decision with a decision of Accreditation with Follow-up Survey (AFS) thereafter
The HCO will have the follow-up survey within 4 months of receiving its AFS decision to assess sustainability
The HCO will be required to participate in mandatory Intracycle Monitoring (ICM) process
The HCO will have its next triennial survey within 18-20 months
If the validation survey is unsuccessful, the HCO will receive a PDA decision.

*Patients are placed at risk for a serious adverse outcome(s) due to significant and pervasive patterns, trends, and/or repeat findings
Organizations will have the right to appeal this decision

Figure 6. PDA02 decision process flow.

Process for Organizations That Meet Decision Rule PDA04
If an organization does not possess a license, certificate, and/or permit, when required by applicable law and regulation, to provide the health care services for which it is seeking accreditation, Joint Commission staff may initiate the Preliminary Denial of Accreditation process under decision rule PDA04.

The process for Preliminary Denial of Accreditation in such circumstances is as follows:
- If at the time of survey the organization does not have a required license, certificate, or permit, the organization will be notified that it meets a rule for Preliminary Denial of Accreditation and The Joint Commission will initiate such action.
- The organization will also be notified that if it obtains the required license, certificate, or permit or is able to provide proof of application during the clarification process, the PDA decision will be removed but the RFI will remain in the survey report.
- The organization will not be presented to executive leadership unless it meets a decision for Preliminary Denial of Accreditation based on another decision rule.
Review and Appeal Procedures

After any Preliminary Denial of Accreditation decision, the organization has the right to ask in writing, within five (5) business days of being notified, for a hearing before a Review Hearing Panel. Failure to appeal results in a Denial of Accreditation.

Organizations that choose to appeal may submit additional materials for the Hearing Panel’s consideration. After the hearing, The Joint Commission reviews the findings of the Review Hearing Panel and either denies accreditation to the organization or selects an appropriate alternative accreditation decision.

The outline in this section details the review and appeal procedures for any accreditation decision.

I. Evaluation by Joint Commission Staff

A. Review and Determination by Joint Commission Staff. Following any survey activity, Joint Commission staff review survey findings, survey documents, and any other relevant materials or information received from any source. Joint Commission staff may take one of the following actions:

- Recommend that the organization be Accredited.
- Recommend that the organization receive Accreditation with Follow-up Survey.
- Recommend that the organization receive Preliminary Denial of Accreditation.
- Defer consideration while additional information regarding the organization’s compliance status is reviewed.
- Determine that the organization be granted Limited, Temporary Accreditation in accordance with the Early Survey Policy.
- Recommend that the organization initially be denied Limited, Temporary Accreditation in accordance with the Early Survey Policy.

B. Determination to Recommend Preliminary Denial of Accreditation. If Joint Commission staff, based on survey findings, survey documents, and any other relevant materials or information received from any source, determine in accordance with approved decision rules to recommend that the organization receive Preliminary Denial of Accreditation, it will outline its findings and determination. The organization may take either of the following actions:

- Accept the findings and determination of the staff through submission of the ESC (or POC, if decision rule PDA02 is applicable).
Submit to The Joint Commission, through the ESC (or POC, if decision rule PDA02 is applicable), any clarification of its compliance with Joint Commission standards at the time of the survey.

Joint Commission staff members review the organization’s submission of any additional information and shall, in accordance with approved decision rules, take one of the following actions:

- Recommend that the organization receive Accreditation with Follow-up Survey.
- Recommend that the organization receive Preliminary Denial of Accreditation.
- Recommend that the organization be Accredited.

C. Immediate Threat to Health or Safety. If the findings of any survey identify a condition that poses a threat to public or patient health or safety, the president of The Joint Commission, or his or her designee, may promptly decide that the organization be immediately placed in Preliminary Denial of Accreditation. This action and the findings that led to this action shall be reported by telephone and in writing to the organization’s chief executive officer and in writing to the authorities having jurisdiction.

II. Accreditation with Follow-up Survey

A. Survey to Determine Implementation of ESC. The Joint Commission conducts a survey of the organization to determine the degree to which deficiencies have been corrected or improvements implemented following a survey any time up to 6 months from the date the organization is notified of its Accreditation with Follow-up Survey decision.

B. Charges to the Organization. The full costs of all surveys shall be borne by the surveyed organization.

III. Review Hearings

A. Right to a Review Hearing. Upon request, an organization that has received a Preliminary Denial of Accreditation (PDA) is entitled to a review hearing. A PDA decision will become a Denial of Accreditation unless the organization makes a timely request for a review hearing to demonstrate why it should not be denied accreditation. If an appeal is requested, the organization remains in PDA status until The Joint Commission renders a final decision.
B. Purpose of the Review Hearing. The review hearing is an opportunity for an organization to present facts and/or arguments to a Review Hearing Panel comprising two outside health care professionals and one member of The Joint Commission’s Board of Commissioners. Presentations are limited to either of the following:
- Facts that were in error during the survey or post-survey processes
- Arguments that The Joint Commission did not follow its policies, procedures, or decision rules

C. Requesting a Review Hearing; Notice of Time and Place. An organization must submit a written request for a review hearing within five (5) business days of The Joint Commission’s notification of the final PDA decision. For the purpose of this section, the date of a notification is the date a notice was posted to the organization’s Joint Commission Connect extranet site. Within a reasonable period of time before the review hearing, The Joint Commission provides notice of the time and date of the review hearing. If the organization intends to submit a written response, or other documents limited to the parameters established above, such response and documents must be submitted at least five (5) business days prior to the review hearing. The Review Hearing Panel is under no obligation to consider late submissions.

D. Charges to the Organization. The organization will be charged a nonrefundable fee for the review hearing, as published in the accreditation and certification pricing schedule found on the Joint Commission Connect extranet site. The fee, along with any other outstanding invoices due to The Joint Commission, must be paid in full at the time an organization requests a review hearing.

E. Procedure for the Conduct of a Review Hearing. Review hearings are limited to three (3) hours. After introductions, Joint Commission staff will summarize the historical facts that led to the PDA decision. The organization will then have an opportunity to make its presentation to the Panel. The organization’s presentation should be limited to factual or procedural errors. The Panel may ask questions of the organization and of Joint Commission staff.

Hearings are not video/audio recorded. The organization may choose to retain a transcriptionist for the hearing at its own expense. The organization shall provide a copy of any transcript to The Joint Commission, at the organization’s expense, at or around the same time the transcript is made available to the organization. Transcripts of Joint Commission proceedings are confidential and shall remain confidential. Any disclosures to a third party require the express written permission of The Joint Commission.
F. Participants at the Review Hearing. A review hearing may proceed with only two of the three panel members present, provided one of the two is a member of the Board. Legal staff from The Joint Commission will be present to address procedural matters and will not ask questions of the organization’s representatives. Organizations are encouraged to limit representatives at the review hearing to individuals who are knowledgeable about the organization in the standards areas found noncompliant. An organization may choose to bring legal counsel and/or consultants; however, this type of representative is permitted to address procedural matters only and is not to speak on matters regarding substantive issues of the organization’s standards compliance or question Joint Commission staff.

G. Report of the Review Hearing. After a review hearing, the Review Hearing Panel will prepare and submit a written report that summarizes its findings on factual matters with a recommendation to The Joint Commission. The panel report may include a recommendation for one of the following accreditation decisions:
1. Denial of Accreditation
2. Time-Limited Preliminary Denial of Accreditation
3. Accreditation with Follow-up Survey
4. Full Accreditation

The Joint Commission shall send the organization a copy of the report approximately ten (10) business days before Joint Commission executive leadership reviews the written report. The organization will have an opportunity to comment on the report within five (5) business days of receipt. The Joint Commission is under no obligation to consider late submissions.

IV. Following a Review Hearing
A. Scope of Review. After the review hearing, The Joint Commission will consider the Review Hearing Panel’s findings and recommendation, the responses of the organization, any newly submitted documents limited to factual and/or procedural errors, and comments of staff, if any, to the Review Hearing Panel’s findings and recommendations.

B. Action by The Joint Commission. After review of the hearing report, The Joint Commission may accept, reject, or modify the Review Hearing Panel’s recommendation.
V. Final Review & Appeal Request

A. Final Review & Appeal Request. An organization that has received Denial of Accreditation or retained a time-limited PDA after having had a hearing is entitled to a Final Review & Appeal to members of The Joint Commission’s Board of Commissioners. The Joint Commission must receive the organization’s request for final review within five (5) business days after the organization receives notice of The Joint Commission’s decision following a hearing.

B. Composition and Participation. No member of the Final Review & Appeal will have participated in the decisions of The Joint Commission to this point but may, when convened for a final review and appeal, ask questions of Joint Commission staff and the Commissioner who served on the Review Hearing Panel, if available. Although the organization does not participate in the final review and appeal proceeding, it may submit a letter to the Board members.

C. Notice of Time and Procedure for Review. The Joint Commission shall provide notice of the date of the Final Review & Appeal meeting prior to the meeting. The organization may submit written comments to the Board members conducting the Final Review & Appeal along with any documents not previously submitted limited to factual or procedural errors made by The Joint Commission. Any documents must be submitted at least five (5) business days prior to the meeting and should specifically identify any relevant documents previously submitted for the purpose of demonstrating its compliance with standards or The Joint Commission’s failure to follow its policies, procedures, or decision rules.

D. Final Action. The Board members conducting the Final Review & Appeal shall review the decision of The Joint Commission, the organization’s responses, any materials specifically identified as relevant by the organization, and other information it deems relevant, and shall take either of the following actions:

- Place the organization in Denial of Accreditation after finding that there is substantial evidence to support The Joint Commission’s decision.
- Make an independent evaluation of The Joint Commission’s decision and then decide to grant Accreditation with Follow-up Survey or full Accreditation to the organization.

The action taken by the Board members conducting the Final Review & Appeal shall be the final accreditation decision of The Joint Commission.
Standards Applicability Process (SAP)

While numerous standards and elements of performance (EPs) apply to all types of organizations accredited under the behavioral health care accreditation program, there are specific standards and EPs listed in this manual that apply only to individual types of setting(s), service(s), and population(s) provided by individual organizations. For example, accredited organizations may serve individuals throughout the life span or specialize in an age or diagnosis/condition/type of care, treatment or service. The settings may also vary from facility based to community-based or a combination of both.

The purpose of this chapter is to help each organization determine which specific standards and EPs apply to its setting(s), service(s), and program(s), and specific population(s). The following pages provide three setting(s), service(s), and program(s) applicability grids to allow organizations to better identify which standards and EPs apply. Setting(s), service(s), and program(s) are listed horizontally along the top of each of the three grids. The standard/requirement and EP numbers are listed vertically. Applicability is indicated with an “X.”

These grids do not identify the standards and EPs that all behavioral health care organizations are expected to comply with. For a comprehensive list of the standards and EPs your organization is required to comply with, visit your organization’s Joint Commission Connect™ extranet site.

The following services are listed in the Foster Care and Shelter Services Applicability Grid (starting on page SAP-4):
- Foster Care
  - Adult
  - Therapeutic child and youth
  - Traditional child and youth
  - Respite Care
- Shelter
- Adoption Services
The following services are listed in the Behavioral Health Care Settings Applicability Grid (starting on page SAP-29):

- Correctional
- Forensic
- In-home
- 24-hour inpatient/crisis stabilization
- Outdoor/wilderness program
- Outpatient/staff office(s) only
- Adult day care
- Day treatment
- Intensive outpatient
- Partial hospitalization
- Therapeutic day school
- Group home
- 24-hour therapeutic school
- Residential
- Technology-based
- Transitional/supportive living
- Community-based home

The following services are listed in the Behavioral Health Care Services Applicability Grid (starting on page SAP-61):

- Addictions Services
  - Opioid treatment program (certified by CSAT*)
  - Adult
  - Child/youth
- Family Preservation Services/Wraparound Services—children/youth
  Note: Organizations that provide family preservation/wraparound services also need to follow the outpatient/staff offices only column for applicable accreditation setting requirements on pages SAP-29–SAP-60.
- Intellectual Disabilities
  - Adult
  - Child/youth
- Mental Health Services
  - Adult services

*CSAT, Center for Substance Abuse Treatment

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
- Child and youth services
- Recovery or Resilience Services
- Care coordination/case management services
  
  **Note:** Organizations that provide care coordination/case management services also need to follow the outpatient/staff offices only column for applicable accreditation setting requirements on pages SAP-29–SAP-60.

- Community integration services
- Family support services
- Employment services
- Peer support services
- Housing services
- Vocational Rehabilitation Services
- Eating Disorders
- Primary Physical Health Care
- Prevention and Wellness Promotion Services

Please refer to the end of the “Medication Management” (MM) chapter for an applicability grid to identify the standards and EPs that apply to behavioral health care organizations based on the type of medication management processes within the organization’s scope of care, treatment, or services.

**Note:** The additional MM standards and EPs that apply only to medication-assisted opioid treatment programs (OTP) subject to the Substance Abuse and Mental Health Services Administration (SAMHSA) regulations are not reflected in the “Medication Management Type” grid in the MM chapter; rather, these additional MM requirements are identified in the MM chapter with the lead-in “For opioid treatment programs” and also identified in the “Behavioral Health Care Services Applicability Grid” beginning on page SAP-61.
# Foster Care and Shelter Services Applicability Grid

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CAMBHC Update 2, January 2018

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## Standards Applicability Process

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.

### CAMBHC Update 2, January 2018

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### Standards Applicability Process

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.

**CAMBHC Update 2, January 2018**

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Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
## Standards Applicability Process

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Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
## Comprehensive Accreditation Manual for Behavioral Health Care

### Behavioral Health Care Settings

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<th>Outpatient</th>
<th>Day treatment</th>
<th>Intensive outpatient</th>
<th>Partial hospitalization</th>
<th>Therapeutic day school</th>
<th>Group home</th>
<th>24-hour therapeutic school</th>
<th>Residential</th>
<th>Technology-based</th>
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<th>Intensive outpatient</th>
<th>Partial hospitalization</th>
<th>Therapeutic day school</th>
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Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
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Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.

SAP – 30

CAMBHC Update 2, January 2018
## Standards Applicability Process

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.

**Behavioral Health Care Settings**

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Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
### Behavioral Health Care Settings

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<th>Outpatient/staff office(s) only</th>
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<th>Day treatment</th>
<th>Intensive outpatient</th>
<th>Partial hospitalization</th>
<th>Therapeutic day school</th>
<th>Group home</th>
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<th>Residential</th>
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<th>EP #</th>
<th>Correctional</th>
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<th>Inpatient crisis stabilization</th>
<th>Outdoor/wilderness program</th>
<th>Outpatient/Staff office(s) only</th>
<th>24-hour therapeutic school</th>
<th>Day treatment</th>
<th>Intensive outpatient</th>
<th>Partial hospitalization</th>
<th>Therapeutic day school</th>
<th>Group home</th>
<th>Residential</th>
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### Standards Applicability Process

**Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.**

**CAMBHC Update 2, January 2018**

| Standard/Requirement Number | EP # | Correctional | Forensic | In-home | Inpatient crisis stabilization | Outdoor/wilderness program | Outpatient/staff office(s) only | Outpatient/day care | Adult day care | Intensive outpatient | Partial hospitalization | Therapeutic day school | Group home | 24-hour therapeutic school | Residential | Technology-based | Transitional/supportive living | Community-based home |
|-----------------------------|------|--------------|----------|---------|------------------------------|----------------------------|-------------------------------|---------------------|--------------|---------------------|------------------------|-----------------------|------------|--------------------------|-------------|-----------------------|--------------------------|
| CTS.05.04.13                | 1    | X            | X        | X       | X                             | X                           | X                             | X                   | X            | X                   | X                      | X                     |            | X                        | X           | X                     | X                        |
|                             | 2    | X            | X        | X       | X                             | X                           | X                             | X                   | X            | X                   | X                      | X                     |            | X                        | X           | X                     | X                        |
|                             | 3    | X            | X        | X       | X                             | X                           | X                             | X                   | X            | X                   | X                      | X                     |            | X                        | X           | X                     | X                        |
| CTS.05.04.15                | 1    | X            | X        | X       | X                             | X                           | X                             | X                   | X            | X                   | X                      | X                     |            | X                        | X           | X                     | X                        |
|                             | 2    | X            | X        | X       | X                             | X                           | X                             | X                   | X            | X                   | X                      | X                     |            | X                        | X           | X                     | X                        |
| CTS.05.04.17                | 1    | X            | X        | X       | X                             | X                           | X                             | X                   | X            | X                   | X                      | X                     | X          | X                        | X           | X                     | X                        |
| CTS.05.06.03                | 1    | X            | X        | X       | X                             | X                           | X                             | X                   | X            | X                   | X                      | X                     | X          | X                        | X           | X                     | X                        |
|                             | 2    | X            | X        | X       | X                             | X                           | X                             | X                   | X            | X                   | X                      | X                     | X          | X                        | X           | X                     | X                        |
| CTS.05.06.01                | 1    | X            | X        | X       | X                             | X                           | X                             | X                   | X            | X                   | X                      | X                     | X          | X                        | X           | X                     | X                        |
|                             | 2    | X            | X        | X       | X                             | X                           | X                             | X                   | X            | X                   | X                      | X                     | X          | X                        | X           | X                     | X                        |
|                             | 3    | X            | X        | X       | X                             | X                           | X                             | X                   | X            | X                   | X                      | X                     | X          | X                        | X           | X                     | X                        |
| CTS.05.06.05                | 1    | X            | X        | X       | X                             | X                           | X                             | X                   | X            | X                   | X                      | X                     | X          | X                        | X           | X                     | X                        |
|                             | 2    | X            | X        | X       | X                             | X                           | X                             | X                   | X            | X                   | X                      | X                     | X          | X                        | X           | X                     | X                        |
|                             | 3    | X            | X        | X       | X                             | X                           | X                             | X                   | X            | X                   | X                      | X                     | X          | X                        | X           | X                     | X                        |
| CTS.06.05.07                | 1    | X            | X        | X       | X                             | X                           | X                             | X                   | X            | X                   | X                      | X                     | X          | X                        | X           | X                     | X                        |
|                             | 2    | X            | X        | X       | X                             | X                           | X                             | X                   | X            | X                   | X                      | X                     | X          | X                        | X           | X                     | X                        |
|                             | 3    | X            | X        | X       | X                             | X                           | X                             | X                   | X            | X                   | X                      | X                     | X          | X                        | X           | X                     | X                        |
|                             | 4    | X            | X        | X       | X                             | X                           | X                             | X                   | X            | X                   | X                      | X                     | X          | X                        | X           | X                     | X                        |
|                             | 5    | X            | X        | X       | X                             | X                           | X                             | X                   | X            | X                   | X                      | X                     | X          | X                        | X           | X                     | X                        |
|                             | 6    | X            | X        | X       | X                             | X                           | X                             | X                   | X            | X                   | X                      | X                     | X          | X                        | X           | X                     | X                        |
|                             | 7    | X            | X        | X       | X                             | X                           | X                             | X                   | X            | X                   | X                      | X                     | X          | X                        | X           | X                     | X                        |
|                             | 8    | X            | X        | X       | X                             | X                           | X                             | X                   | X            | X                   | X                      | X                     | X          | X                        | X           | X                     | X                        |
|                             | 9    | X            | X        | X       | X                             | X                           | X                             | X                   | X            | X                   | X                      | X                     | X          | X                        | X           | X                     | X                        |
|                             | 10   | X            | X        | X       | X                             | X                           | X                             | X                   | X            | X                   | X                      | X                     | X          | X                        | X           | X                     | X                        |
|                             | 11   | X            | X        | X       | X                             | X                           | X                             | X                   | X            | X                   | X                      | X                     | X          | X                        | X           | X                     | X                        |
|                             | 12   | X            | X        | X       | X                             | X                           | X                             | X                   | X            | X                   | X                      | X                     | X          | X                        | X           | X                     | X                        |

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## Standards Applicability Process

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### Comprehensive Accreditation Manual for Behavioral Health Care

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**SAP – 40**

**CAMBHC Update 2, January 2018**

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Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.

SAP – 44
CAMBHC Update 2, January 2018
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Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
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Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.

SAP – 50

CAMBHC Update 2, January 2018
### Standards Applicability Process

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Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
### Comprehensive Accreditation Manual for Behavioral Health Care

#### Behavioral Health Care Settings

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<th>Intensive outpatient</th>
<th>Partial hospitalization</th>
<th>Therapeutic day school</th>
<th>Group Home</th>
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Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
### Standards Applicability Process

#### Behavioral Health Care Settings

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Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.

SAP – 54

CAMBHC Update 2, January 2018
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## Standard/Requirement Number | EP # | Correctional | Forensic | In-home | Inpatient crisis stabilization | Intensive outpatient | Intensive outpatient/Staff office(s) only | Adult day care | Behavioral Health Care Settings
---|---|---|---|---|---|---|---|---|---
| | | | | | | | | | Outdoor/wilderness program
| | | | | | | | | Residential
| | | | | | | | | Partial hospitalization
| | | | | | | | | 24-hour therapeutic school
| | | | | | | | | Transitional/supportive living
| | | | | | | | | Community-based home

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### Standards Applicability Process

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**CAMBHC Update 2, January 2018**

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Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
Behavioral Health Care Services Applicability Grid

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### Comprehensive Accreditation Manual for Behavioral Health Care

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- Opioid
- Adult
- Child/youth
- Wraparound Services — child/youth
- Family Preservation Services — child/youth
- Child/youth services
- Adult services
- Child & youth services
- Care coordination and management
- Community integration services
- Family support services
- Employment services
- Peer support services
- Housing services
- Vocational rehabilitation services
- Eating disorders
- Primary Physical Health Care
- Prevention and Wellness Promotion
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Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
### Comprehensive Accreditation Manual for Behavioral Health Care

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  - Adult
  - Child/Youth

- **Intellectual Disabilities Services**
  - Family Preservation Services
  - Child/Youth

- **Mental Health Services**
  - Adult Services
  - Child & Youth Services

- **Recovery or Resilience Services**
  - Community Integration Services
  - Family Support Services
  - Employment Services
  - Peer Support Services
  - Housing Services
  - Vocational Rehabilitation Services
  - Eating Disorders
  - Primary Physical Health Care
  - Prevention and Wellness Promotion Services
### Standards Applicability Process

Patterns indicate a change effective January 1, 2018, unless otherwise noted in the What's New.

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  - Adult
  - Child/youth

- **Intellectual Disabilities Services**
  - Adult
  - Child/youth

- **Mental Health Services**
  - Adult services
  - Child & youth services

- **Recovery or Resilience Services**
  - Care coordination/case management
  - Community integration services
  - Family support services
  - Employment services
  - Peer support services
  - Housing services
  - Vocational Rehabilitation Services
  - Eating Disorders
  - Primary Physical Health Care
  - Prevention and Wellness Promotion

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
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- Opioid
- Adult
- Child/youth

**Intellectual Disabilities**
- Family Preservation Services/Family Preservation Services
- Child/youth
- Adult services
- Child & Youth Services

**Mental Health Services**
- Care coordination/case management
- Community integration services
- Family support services
- Employment services
- Peer support services
- Housing services

**Recovery or Resilience Services**
- Vocational Rehabilitation Services
- Eating Disorders
- Primary Physical Health Care
- Prevention and Wellness Promotion
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**Addictions Services**
- Opioid
- Adult
- Child/Youth

**Intellectual Disabilities**
- Family Preservation Services

**Mental Health Services**
- Recovery Services

**Recovery of Resilience Services**
- Care coordination/case management
- Community integration services
- Family support services
- Employment services
- Peer support services
- Housing services
- Vocational Rehabilitation Services
- Eating Disorders
- Primary Physical Health Care
- Prevention and Wellness Promotion
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  - Adult
  - Child/youth

- **Intellectual Disabilities Services**
  - Adult
  - Child/youth

- **Mental Health Services**
  - Adult services
  - Child & youth services

- **Recovery or Resilience Services**
  - Care coordination/management
  - Community integration services
  - Family support services
  - Employment services
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  - Vocational Rehabilitation Services
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Legend:
- **Addictions Services**
  - Adult
  - Child/youth

- **Intellectual Disabilities Services**
  - Adult
  - Child/youth

- **Mental Health Services**
  - Adult services
  - Child & youth services

- **Recovery or Resilience Services**
  - Care coordination/case management
    - Community integration services
    - Family support services
    - Employment services
    - Peer support services
    - Housing services
  - Vocational Rehabilitation Services
  - Eating Disorders
  - Primary Physical Health Care
  - Prevention and Wellness Promotion

Note: Shadings indicate a change effective January 1, 2018, unless otherwise noted in the What's New.
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Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
### Comprehensive Accreditation Manual for Behavioral Health Care

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#### Addictions Services

- Opoid
- Adult
- Child/youth

#### Intellectual Disabilities Services

- Adult
- Child/youth

#### Mental Health Services

- Adult services
- Child & youth services

- Care coordination & management
- Community integration services
- Family support services
- Employment services
- Peer support services
- Housing services
- Vocational rehabilitation services
- Eating disorders
- Primary physical health care
- Prevention and wellness promotion

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Sentinel Events (SE)

I. Sentinel Events
The Joint Commission adopted a formal Sentinel Event Policy in 1996 to help behavioral health care organizations that experience serious adverse events improve safety and learn from those sentinel events. Careful investigation and analysis of patient safety events, as well as strong corrective actions that provide effective and sustained system improvement, is essential to reduce risk and prevent harm to individuals served. The Sentinel Event Policy explains how The Joint Commission partners with organizations that have experienced a serious patient safety event to protect the individual served, improve systems, and prevent further harm.

Definition of Sentinel Event
A sentinel event is a patient safety event (not primarily related to the natural course of an illness or underlying condition of an individual served) that reaches an individual served and results in any of the following:

- Death
- Permanent harm
- Severe temporary harm†

An event is also considered sentinel if it is one of the following:

- Suicide of any individual served receiving care, treatment, or services in a staffed around-the-clock care setting or within 72 hours of discharge, including from the organization’s emergency department (ED)
- Unanticipated death of a full-term infant
- Discharge of an infant to the wrong family

† In the term patient safety event, the word “patient” corresponds to “individuals served” in the Behavioral Health Care setting.
Abduction of any individual served receiving care, treatment, or services
Any elopement (that is, unauthorized departure) of an individual served from a staffed around-the-clock care setting (including the ED) leading to the death, permanent harm or severe temporary harm of the individual served
Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (ABO, Rh, other blood groups)
Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of any individual served receiving care, treatment, or services while on site at the organization

Rape, assault (leading to death, permanent harm, or severe temporary harm), or homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the organization
Invasive procedure, including surgery, on the wrong patient, at the wrong site, or that is the wrong (unintended) procedure
Unintended retention of a foreign object in a patient after an invasive procedure, including surgery
Severe neonatal hyperbilirubinemia (bilirubin >30 milligrams/deciliter)

Sexual abuse/assault (including rape) as a sentinel event is defined as nonconsensual sexual contact involving an individual served and another individual served, staff member, or other perpetrator while being treated or on the premises of the organization, including oral, vaginal, or anal penetration or fondling of the patient’s sex organ(s) by another individual’s hand, sex organ, or object. One or more of the following must be present to determine that it is a sentinel event:

Any staff-witnessed sexual contact as described above
Admission by the perpetrator that sexual contact, as described above, occurred on the premises
Sufficient clinical evidence obtained by the organization to support allegations of unconsented sexual contact

Invasive procedures, including surgery, on the wrong patient, or at the wrong site, or that is the wrong procedure are reviewable under the policy, regardless of the type of the procedure or the magnitude of the outcome.

“After surgery” is defined as any time after the completion of final skin closure, even if the patient is still in the procedural area or in the operating room under anesthesia. This definition is based on the premise that a failure to identify and correct an unintended retention of a foreign object prior to that point in the procedure represents a system failure, which requires analysis and redesign. It also places the patient at additional risk by extending the surgical procedure and time under anesthesia. If a foreign object (for example, a needle tip or screw) is left in the patient because of a clinical determination that the relative risk to the patient of searching for and removing the object exceeds the benefit of removal, this would not be considered a sentinel event to be reviewed. However, in such cases, the organization shall (1) disclose to the patient the unintended retention, and (2) keep a record of the retentions to identify trends and patterns (for example, by type of procedure, by type of retained item, by manufacturer, by practitioner) that may identify opportunities for improvement.
Prolonged fluoroscopy with cumulative dose >1,500 rads to a single field or any delivery of radiotherapy to the wrong body region or >25% above the planned radiotherapy dose

Fire, flame, or unanticipated smoke, heat, or flashes occurring during an episode of care

Any intrapartum (related to the birth process) maternal death

Severe maternal morbidity (not primarily related to the condition of an individual served) when it reaches an individual served and results in permanent harm or severe temporary harm

The above list is consistent across all Joint Commission accreditation programs, though some of these events may be unlikely to occur in certain settings. In cases in which the organization is uncertain that a patient safety event is a sentinel event as defined by The Joint Commission, the event will be presumed to be a patient safety event and not a sentinel event unless determined otherwise through further investigation or the presentation of relevant information. Patient safety events require analysis and should be shared with the Office of Quality and Patient Safety through an organization response.

All sentinel events must be reviewed by the organization and are subject to review by The Joint Commission. Accredited organizations are expected to identify and respond appropriately to all sentinel events (as defined by The Joint Commission) occurring in the organization or associated with services that the organization provides. An appropriate response includes all of the following:

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*Fire* is defined as a rapid oxidation process, which is a chemical reaction resulting in the evolution of light and heat in varying intensities. A combustion process that results in smoldering condition (no flame) is still classified as fire. Source: National Fire Protection Association. *NFPA 901: Standard Classifications for Incident Reporting and Fire Protection Data*. Quincy, MA: NFPA, 2011.

**Severe maternal morbidity** is defined, by the American College of Obstetrics and Gynecology, the US Centers for Disease Control and Prevention, and the Society of Maternal and Fetal Medicine, as a patient safety event that occurs from the intrapartum through the immediate postpartum period (24 hours), requiring the transfusion of 4 or more units of packed red blood cells (PRBC) and/or admission to the intensive care unit (ICU). *Admission to the ICU* is defined as admission to a unit that provides 24-hour medical supervision and is able to provide mechanical ventilation or continuous vasoactive drug support. Ongoing vigilance to better identify patients at risk—and timely implementation of clinical interventions consistent with evidence-based guidelines—are important steps in the ongoing provision of safe and reliable care. Appropriate systems improvements can be informed by identifying occurrences of maternal morbidity, reviewing the cases, and analyzing the findings. For additional details, see "Update: Revised Definition of Severe Maternal Morbidity in Sentinel Event Policy," June 2015 Perspectives.
A formalized team response that stabilizes the individual served, discloses the event to the individual served and family, and provides support for the family as well as staff involved in the event

- Notification of organization leadership
- Immediate investigation
- Completion of a comprehensive systematic analysis for identifying the causal and contributory factors
- Strong corrective actions derived from the identified causal and contributing factors that eliminate or control system hazards or vulnerabilities and result in sustainable improvement over time
- Time line for implementation of corrective actions
- Systemic improvement

Sentinel events are one category of patient safety events. A patient safety event is an event, incident, or condition that could have resulted or did result in harm to an individual served. A patient safety event can be, but is not necessarily, the result of a defective system or process design, a system breakdown, equipment failure, or human error. Patient safety events also include adverse events, no-harm events, close calls, and hazardous conditions, which are defined as follows:

- An adverse event is a patient safety event that resulted in harm to an individual served.
- A no-harm event is a patient safety event that reaches the individual served but does not cause harm.
- A close call (or “good catch”) is a patient safety event that did not reach the individual served.
- A hazardous (or “unsafe”) condition(s) is a circumstance (other than an individual’s own disease, process, or condition) that increases the probability of an adverse event.

The organization determines how it will respond to patient safety events that do not meet the Joint Commission’s definition of sentinel event. Adverse events shall prompt notification of organization leaders, investigation, and corrective actions, in accordance with the organization’s process for responding to patient safety events that do not meet the definition of sentinel event. An adverse event may or may not result from an error.

No-harm events, close calls, and hazardous conditions are tracked and used as opportunities to prevent harm, in accordance with the organization’s process for responding to patient safety events that do not meet the definition of sentinel event. (See
also Leadership [LD] Standard LD.04.04.05, element of performance [EP] 3, which states: The scope of the safety program includes the full range of safety issues, from potential or no-harm errors [sometimes referred to as near misses, close calls, or good catches] to hazardous conditions and sentinel events.)

II. Goals of the Sentinel Event Policy
The policy has the following four goals:
1. To have a positive impact in improving care, treatment, or services and in preventing unintended harm
2. To focus the attention of an organization that has experienced a sentinel event on understanding the factors that contributed to the event (such as underlying causes, latent conditions and active failures in defense systems, or organization culture), and on changing the organization’s culture, systems, and processes to reduce the probability of such an event in the future
3. To increase the general knowledge about patient safety events, their contributing factors, and strategies for prevention
4. To maintain the confidence of the public, clinicians, and organizations that the safety of individuals served is a priority in accredited organizations

III. Responding to Sentinel Events

Standards
Each Joint Commission accreditation manual contains standards that relate specifically to the management of sentinel events. (See the Appendix to this chapter for related standards.)

LD.04.04.05, EP 7, requires each accredited organization to define patient safety event for its own purposes and to communicate this definition throughout the organization. This definition must encompass sentinel events as defined by The Joint Commission. An accredited organization is encouraged to include in its definition events, incidents, and conditions in which no or only minor harm occurred to an individual served. The organization determines how it will respond to patient safety events that do not meet the definition of sentinel event.
Comprehensive Systematic Analysis
As indicated above, appropriate response to a sentinel event includes the completion of a comprehensive systematic analysis for identifying the causal and contributory factors. Root cause analysis, which focuses on systems and processes, is the most common form of comprehensive systematic analysis used for identifying the factors that underlie a sentinel event.

An organization may use other tools and methodologies to conduct its comprehensive systematic analysis. The Joint Commission encourages the organization to contact the patient safety specialist assigned to the organization’s event or to call the Office of Quality and Patient Safety at 630-792-3700 if it has questions regarding using the tools discussed above or other tools it is considering. (See the “Review of Comprehensive Systematic Analyses and Corrective Action Plans” section for further discussion of acceptability.)

Corrective Action Plan
The product of the comprehensive systematic analysis is a corrective action plan. The corrective action plan identifies the strategies that the organization intends to implement in order to reduce the risk of similar events occurring in the future. The identified actions should eliminate or control system hazards or vulnerabilities that have been identified by the comprehensive systematic analysis. Analysis teams should identify at least one stronger or intermediate strength action when possible (see Figure 3 on page 17 of the National Patient Safety Foundation [NPSF] RCA2: Improving Root Cause Analyses and Actions to Prevent Harm report at http://c.ymcdn.com/sites/www.npsf.org/resource/resmgr/PDF/RCA2_v2-online-pub_010816.pdf for more information on strength of action). The plan must address the following:

- Identification of corrective actions to eliminate or control system hazards or vulnerabilities directly related to causal and contributory factors
- Responsibility for implementation
- Time lines for completion
- Strategies for evaluating the effectiveness of the actions
- Strategies for sustaining the change
**Reporting a Sentinel Event to The Joint Commission**

Each organization is strongly encouraged, but not required, to report to The Joint Commission any patient safety event that meets the Joint Commission definition of sentinel event. An organization benefits from self-reporting in the following ways:

- The Joint Commission can provide support and expertise to the organization during the review of a sentinel event.
- A review with the Office of Quality and Patient Safety provides the opportunity for the organization to collaborate with a patient safety specialist who is likely to have reviewed similar events.
- Reporting raises the level of transparency in the organization and helps promote a culture of safety.
- Reporting conveys the organization’s message to the public that it is doing everything possible, proactively, to prevent similar patient safety events in the future.

Further, reporting the event enables the addition of the “lessons learned” from the event to be added to The Joint Commission’s Sentinel Event Database, thereby contributing to the general knowledge about sentinel events and to the reduction of risk for such events in many other organizations.

The value of this review is reflected by the fact that more than 75% of sentinel events reported to The Joint Commission are self-reported by the organizations that experienced the events. Alternatively, The Joint Commission may become aware of a sentinel event by some other means such as communication from an individual served, a family member, an employee of the organization, a surveyor, or through the media.

Self-reporting a sentinel event is not required and there is no difference in the expected response, time frames, or review procedures, whether the organization voluntarily reports the event or The Joint Commission becomes aware of the event by some other means. If an organization wishes to report to The Joint Commission an occurrence of a sentinel event, the organization will be asked to complete a form accessible through its Joint Commission Connect™ extranet site. From this site, place the cursor over “Continuous Compliance Tools.” A dropdown list will appear. From this list, select “Self Report Sentinel Event.”

If The Joint Commission becomes aware of a sentinel event that was not reported by the organization to The Joint Commission, the organization’s CEO (or designee) is contacted, and a preliminary assessment of the sentinel event is made. An event that
occurred more than one year before the date The Joint Commission became aware of the event will not, in most cases, be reviewed under the Sentinel Event Policy. In such a case, a written response will be requested from the organization, including a summary of the processes that were designed to prevent similar occurrences.

**Required Response to a Sentinel Event**

All sentinel events must be reviewed by the organization, whether or not they are reported to The Joint Commission. In addition, if The Joint Commission becomes aware (either through voluntary self-reporting or otherwise) of a sentinel event that meets the criteria of this policy and the event has occurred in an accredited organization, the organization is expected to do the following:

- Prepare a thorough and credible comprehensive systematic analysis and corrective action plan within 45 business days of the event or of becoming aware of the event.
- Submit to The Joint Commission its comprehensive systematic analysis and corrective action plan, or otherwise provide for Joint Commission evaluation its response to the sentinel event using an approved methodology within 45 business days of the known occurrence of the event. The Joint Commission will determine whether the comprehensive systematic analysis and corrective action plan are acceptable.

The fact that an organization has experienced a sentinel event will not impact its accreditation decision. However, willful failure to respond appropriately to the sentinel event could have such an impact. For instance, if the organization fails to submit a comprehensive systematic analysis within an additional 45 days following its due date, its accreditation decision may be impacted. In these instances, patient safety specialists in the Office of Quality and Patient Safety, along with the medical director and patient safety officer, would recommend the chief medical officer and the executive leadership of The Joint Commission change the organization’s accreditation status.

**Submission of Comprehensive Systematic Analyses and Corrective Action Plans**

An organization that reports a sentinel event must submit the comprehensive systematic analysis, including the resulting corrective action plan that describes the organization’s risk reduction strategies as well as how the effectiveness of those strategies will be evaluated. This information is submitted electronically and will be reviewed in a
conference call involving Joint Commission staff and organization staff (Alternative–0). Documents shall not include the names of caregivers and individuals served involved in the sentinel event.

If the organization has concerns about waiving confidentiality protections as a result of sending the comprehensive systematic analysis documents to The Joint Commission, the following four optional alternative approaches to a review of the organization’s response to the sentinel event are acceptable:

1. A review of the comprehensive systematic analysis and corrective action plan documents brought to Joint Commission headquarters by organization staff, then taken back to the organization on the same day (Alternative–1). This can also be performed via web-based video conferencing with a patient safety specialist who is located at The Joint Commission (Web-Alternative). When the web-based video conference is used, the organization’s participants remain at the organization.

2. An on-site meeting at the organization with a Joint Commission patient safety specialist to review the comprehensive systematic analysis and corrective action plan (Alternative–2). This can also be performed via web-based video conferencing with a patient safety specialist who is located at The Joint Commission (Web-Alternative).

3. An on-site review with a Joint Commission patient safety specialist to review the corrective action plan and relevant documentation (Alternative–3). The patient safety specialist may ask questions regarding the comprehensive systematic analysis, but will not review that document itself. For purposes of this review activity, relevant documentation includes, at a minimum, any documentation relevant to the organization’s process for responding to sentinel events and the corrective action plan resulting from the analysis of the sentinel event. The corrective action plan serves as the basis for determining appropriate follow-up activity. This can also be performed via web-based video conferencing with a patient safety specialist who is located at The Joint Commission (Web-Alternative).

4. An on-site visit by a specially trained surveyor arranged to conduct the following (Alternative–4):

   a. Interview and review of relevant documentation, including, if applicable, the medical record of the individual served, to evaluate the following:
      • The process the organization uses in responding to sentinel events
      • The relevant policies and procedures preceding and following the organization’s review of the specific event, and the implementation thereof, sufficient to permit inferences about the adequacy of the organization’s response to the sentinel event
b. A standards-based survey that traces care, treatment, or services received by an individual served and the organization management functions relevant to the sentinel event under review

Each of these options will result in a fee to the organization to cover the average direct costs of the option. Inquiries about the fee should be directed to the Joint Commission’s Pricing Unit at 630-792-5115.

The Joint Commission must receive a request for review of an organization’s response to a sentinel event using any of these options within five business days of the self-report of a sentinel event or of the initial communication by The Joint Commission to the organization that it has become aware of a sentinel event.

**Review of Comprehensive Systematic Analyses and Corrective Action Plans**

A comprehensive systematic analysis will be reviewed for thoroughness, credibility, and acceptability. A behavioral health care organization’s comprehensive systematic analysis should identify system vulnerabilities so that they can be eliminated or mitigated. The analysis should not focus on individual health care worker performance, but should seek out underlying systems-level causations that were manifest in personnel-related performance issues. †† To help adhere to these characteristics it is recommended but not required that the following guidelines be considered when developing causative factor statements: ‡‡

- Clearly show the cause-and-effect relationship.
- Use specific and accurate descriptors for what occurred, rather than negative and vague words.
- Human errors must have a preceding cause.
- Violations of procedure are not root causes, but must have a preceding cause.
- Failure to act is only causal when there is a preexisting duty to act.

To be thorough, the comprehensive systematic analysis must include the following:

The analysis repeatedly asks a series of “Why” questions, until it identifies the systemic causal factors associated with each step in the sequence that led to the sentinel event.

The analysis focuses on systems and processes, not solely on individual performance.

A determination of the human and other factors most directly associated with the sentinel event and the process(es) and systems related to its occurrence.

The analysis of the underlying systems and processes through the series of “Why” questions determines where redesign might reduce risk.

An inquiry into all areas appropriate to the specific type of event.

An identification of risk points and their potential contributions to this type of event.

A determination of potential improvement in processes or systems that would tend to decrease the likelihood of such events in the future, or a determination, after analysis, that no such improvement opportunities exist.

To be credible, the comprehensive systematic analysis must do the following:

- Include participation by a process owner, who is not a member of the response team; typically this is a senior leader of the organization or a designee.

- Each action recommended by a review team should be approved or disapproved, preferably by the CEO or alternatively by another relevant member of top management. If an action is disapproved, the reason for its disapproval should be shared with the comprehensive systematic analysis and action team so that the constraint can be understood and another developed by the team to replace it if the system vulnerability is not otherwise effectively addressed in the corrective action plan.

- Include individuals served, family, or representatives of individuals served when appropriate to ensure a thorough understanding of the facts.

- Include individuals most closely involved in the processes and systems under review.

- Be internally consistent (that is, not contradict itself or leave obvious questions unanswered).

- Provide an explanation for all findings of “not applicable” or “no problem”.

- Include a bibliography of any relevant literature.

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55 A senior leader is not necessarily required to be actively involved in the day-to-day work of the comprehensive systematic analysis team. However, the team should report to the senior leader or designee, and he or she should be involved in deciding or approving the actions the organization will take as a result of the comprehensive systematic analysis.

A corrective action plan will be considered **acceptable** if it does the following:

- Identifies and implements actions to eliminate or control systems hazards or vulnerabilities
- It is recommended but not required that review teams should attempt to identify actions that are likely to reduce the risk or prevent the event from recurring and, if that is not possible, reduce the severity or consequences if it should recur.
- It is recommended that the review team use a tool that will assist in identifying stronger actions that provide effective and sustained system improvement. A tool such as the Action Hierarchy can help organizations evaluate the strength of the corrective actions identified in their comprehensive systematic analysis. The US Department of Veterans Affairs National Center for Patient Safety developed this tool in 2001.**
- Identifies, in situations in which improvement actions are planned, who is responsible for implementation, when the action will be implemented, how the effectiveness of the actions will be evaluated, and how the actions will be sustained
- Identifies at least one stronger or intermediate strength action for each comprehensive systematic analysis

All comprehensive systematic analyses and corrective action plans will be considered and treated as confidential by The Joint Commission.

**Follow-up Activities**

After The Joint Commission has determined that an organization has conducted an acceptable comprehensive systematic analysis (for example, root cause analysis) and developed an acceptable corrective action plan, The Joint Commission will notify the organization that the comprehensive systematic analysis and corrective action plan are acceptable and will assign an appropriate follow-up activity. This will be a mutually agreed-upon documentation of sustained improvement and reduction of risk, which may include one or more Sentinel Event Measure(s) of Success (SE MOS).

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**# An example of the Action Hierarchy tool is available at [http://www.patientsafety.va.gov/docs/joe/rca_tools_2_15.pdf](http://www.patientsafety.va.gov/docs/joe/rca_tools_2_15.pdf), page 28.**
IV. The Sentinel Event Database
The third goal of the Sentinel Event Policy is to increase the general knowledge about patient safety events, their contributing factors, and strategies for prevention. To achieve this, The Joint Commission collects and analyzes data from the review of sentinel events, and their comprehensive systematic analyses, corrective action plans, and follow-up activities. These data and information form the content of the Joint Commission’s Sentinel Event Database.

The Sentinel Event Database is also a major component of the evidence base for developing and maintaining the Joint Commission’s National Patient Safety Goals. The database also informs the development prevention advice to organizations through Sentinel Event Alert or other media. For these purposes, The Joint Commission uses de-identified aggregate data relating to root causes, contributing factors, and risk-reduction strategies. The Joint Commission is committed to developing and maintaining this Sentinel Event Database in a fashion that will protect the confidentiality of the organization, the caregiver, and the individual served.

V. Determination That a Sentinel Event Is Subject to Review
Based on available information received about the event, a patient safety specialist from the Office of Quality and Patient Safety (OQPS) will determine whether an event meets the definition in Section I and is, therefore, a sentinel event. Challenges to a determination that an event is a sentinel event will be resolved through discussions between senior Joint Commission staff and senior organization leaders.

VI. Optional On-Site Review of a Sentinel Event
An initial on-site review of a sentinel event will usually not be conducted unless it is determined that a potential ongoing Immediate Threat to Health or Safety exists. An Immediate Threat to Health or Safety is a threat that represents the most immediate risk and has or may potentially have serious adverse effects on the health or safety of individuals served. All potential Immediate Threats to Health or Safety are referred to Joint Commission executive leadership for authorization to conduct an unannounced
on-site for-cause survey. If an on-site survey is conducted, the organization will be billed a sufficient charge, based on an established fee schedule, to cover the costs of conducting such a survey.

VII. Disclosable Information

If The Joint Commission receives an inquiry about the accreditation decision of an organization that has experienced a sentinel event, the organization’s current accreditation status will be reported in the usual manner without making reference to the sentinel event. If the inquirer specifically references the particular sentinel event, The Joint Commission will acknowledge that it is aware of the event and currently is working or has worked with the organization through the sentinel event review process.

VIII. The Joint Commission’s Response

Patient safety specialists from The Joint Commission assess the acceptability of the organization’s response to the sentinel event, including the thoroughness and credibility of any comprehensive systematic analysis information reviewed and the organization’s corrective action plan. (Root cause analysis is the most commonly used method of comprehensive systematic analysis.) If the comprehensive systematic analysis and corrective action plan are found to be thorough and credible, patient safety specialists from The Joint Commission will notify the organization and assign one or more or other mutually agreed-upon documentation of sustained improvement and reduction of risk, such as SE MOS. (See the “Sentinel Event Measures of Success [SE MOS]” section below for more details.)

A patient safety specialist from The Joint Commission will provide consultation to the organization if the response is unacceptable, and will allow an additional 15 business days beyond the original submission period for the organization to resubmit its response. If the response is still unacceptable, the organization’s accreditation decision may be impacted.
IX. Sentinel Event Measures of Success (SE MOS)

The organization’s follow-up activity may be conducted through the SE MOS process. An SE MOS is a numerical or quantifiable measure, ideally with a numerator and denominator, that indicates whether a planned action was effective and sustained. The SE MOS is due on a mutually agreed-upon date.

If an SE MOS is used, the following information would apply:

- If an SE MOS is submitted on time but does not meet pre-established levels of compliance, the patient safety specialist from The Joint Commission will request an additional four months of data. If the second set of data does not meet pre-established levels of compliance, the organization’s accreditation decision may be impacted.

- If submission of an SE MOS is 90 or more days late, the organization’s accreditation status may be impacted.

X. Handling Sentinel Event–Related Documents

Handling of any submitted comprehensive systematic analysis and corrective action plan is restricted to specially trained staff in accordance with procedures designed to protect the confidentiality of the documents.

At the time the review of the de-identified comprehensive systematic analysis is entered into the Sentinel Events Database, the original documents will be destroyed, as well as any copies. However, upon request the original documents may be returned to the organization. The information contained in any electronically submitted comprehensive systematic analysis tool will be de-identified after the review is completed.

The corrective action plan resulting from the analysis of the sentinel event will initially be retained long enough to serve as the basis for appropriate follow-up activities, such as the SE MOS or other mutually agreed-upon documentation of sustained improvement. After the corrective action plan has been implemented and meets the established levels of compliance, The Joint Commission will destroy and delete the corrective action plan. If the SE MOS was submitted electronically, the information will likewise be de-identified upon completion of the review.
XI. Oversight of the Sentinel Event Policy
The executive leadership of The Joint Commission is responsible for approval of this policy and overseeing its implementation. In addition to reviewing and deciding individual cases involving changes in an organization’s accreditation decision, Joint Commission staff will periodically audit the comprehensive systematic analysis and documentation of follow-up activities. For the purpose of these audits, The Joint Commission temporarily retains random de-identified samples of these documents. Upon completion of the audit, these documents are also destroyed.

For more information about the Joint Commission’s Sentinel Event Policy, visit the Joint Commission’s website at http://www.jointcommission.org or call the Office of Quality and Patient Safety at 630-792-3700.

XII. Survey Process
When conducting an accreditation survey, The Joint Commission seeks to evaluate the organization’s compliance with the applicable standards, National Patient Safety Goals, and Accreditation Participation Requirements, and to assess the organization’s performance based on those requirements. Surveyors are instructed not to search for or investigate sentinel events during an accreditation survey or to inquire about sentinel events that have been reported to The Joint Commission. However, surveyors may assess an organization’s performance improvement practices, such as its processes for responding to a sentinel event.

If, during the course of conducting any survey activities, a potential serious patient safety event is newly identified, the surveyor will take the following steps:
- Inform the organization CEO that the event has been identified
- Inform the CEO the event will be reported to The Joint Commission for further review and follow-up under the provisions of the Sentinel Event Policy

Surveyors are not authorized to review the comprehensive systematic analysis documents and determine credibility, thoroughness, or acceptability because they are limited to applying the related standards and elements of performance to assess performance improvement practices, such as processes for responding to safety events, adverse events, hazardous unsafe conditions, close calls, and sentinel events.

The surveyor makes no determination of whether or not the event is a sentinel event and does not focus on or explore the event further, but rather will hand off further discussion to a patient safety specialist in the Office of Quality and Patient Safety. Surveyors are
not authorized to investigate sentinel events. The patient safety specialist will contact the
organization after all survey activity is entirely completed to explore the event and
determine whether or not submission of a comprehensive systematic analysis is required.
If so, the organization will proceed with the steps described after an event is determined
to be a sentinel event. (See the “Required Response to a Sentinel Event” section in this
chapter.)

During the on-site survey, the surveyor(s) will assess the organization’s compliance with
sentinel event–related standards in the following ways (see Standard LD.04.04.05 in the
Appendix):

- Review the organization’s process for responding to a sentinel event
- Interview the organization’s leaders and staff about their expectations and
  responsibilities for identifying, reporting on, and responding to sentinel events

Appendix. Accreditation Requirements
Related to Sentinel Events
The following standard and associated elements of performance (EPs) are related to
sentinel events:

Leadership (LD)

Standard LD.04.04.05
The organization has an organizationwide, integrated safety program for individuals
served.

Elements of Performance for LD.04.04.05

1. The leaders implement an organizationwide safety program for individuals
   served.

2. One or more qualified persons manage the safety program.

3. The scope of the safety program includes the full range of safety issues, from
   potential or no-harm errors (sometimes referred to as close calls [“near misses”]
   or good catches) to hazardous conditions and sentinel events.
4. All programs and services within the organization participate in the safety program.

5. As part of the safety program, the leaders create procedures for responding to system or process failures.

   **Note 1:** Responses might include continuing to provide care, treatment, or services to those affected, containing the risk to others, and preserving factual information for subsequent analysis.

   **Note 2:** For opioid treatment programs: Examples of reportable patient deaths include the following:
   - Drug-related deaths
   - Methadone or buprenorphine deaths
   - Unexpected or suspicious deaths
   - Treatment-context deaths that raise individual, family, community, or public concern

6. The leaders provide and encourage the use of systems for blame-free internal reporting of a system or process failure, or the results of a proactive risk assessment. (*See also* LD.03.01.01, EP 8; LD.03.04.01, EP 5; LD.04.04.03, EP 3)

   **Note:** This EP is intended to minimize staff reluctance to report errors in order to help an organization understand the source and results of system and process failures. The EP does not conflict with holding individuals accountable for their blameworthy errors.

7. The leaders define patient safety event and communicate this definition throughout the organization.

   **Note:** At a minimum, the organization’s definition includes those events subject to review in the “Sentinel Events” (SE) chapter of this manual. The definition may include any process variation that does not affect the outcome or result in an adverse event, but for which a recurrence carries significant chance of resulting in a serious adverse outcome or an adverse event, often referred to as a close call or near miss.

8. The organization conducts thorough and credible comprehensive systematic analyses (for example, root cause analyses) in response to sentinel events as described in the “Sentinel Events” (SE) chapter of this manual.
9. The leaders make support systems available for staff who have been involved in an adverse or sentinel event.

**Note:** Support systems recognize that conscientious health care workers who are involved in sentinel events are themselves victims of the event and require support. Support systems provide staff with additional help and support as well as additional resources through the human resources function or an employee assistance program. Support systems also focus on the process rather than blaming the involved persons.

11. To improve safety, the organization analyzes and uses information about system or process failures and, when conducted, the results of proactive risk assessments. *(See also LD.04.04.03, EP 3)*

12. The leaders disseminate lessons learned from comprehensive systematic analyses (for example, root cause analyses), system or process failures, and the results of proactive risk assessments to all staff who provide services for the specific situation. *(See also LD.03.04.01, EP 5)*

13. At least once a year, the leaders provide governance with written reports on the following:
   - All system or process failures
   - The number and type of sentinel events
   - Whether the individuals served and the families were informed of the event
   - All actions taken to improve safety, both proactively and in response to actual occurrences

14. The leaders encourage external reporting of significant adverse events, including voluntary reporting programs in addition to mandatory programs.

**Note:** Examples of voluntary programs include The Joint Commission Sentinel Event Database and the US Food and Drug Administration (FDA) MedWatch. Mandatory programs are often state initiated.
The Joint Commission Quality Report (QR)

Introduction
The Joint Commission Quality Report differentiates health care organizations based on accreditation decision categories and other related information. While the accreditation decision reflects the process for assessing an organization’s commitment to achieving continuous improvement in key areas of safety and quality, the Quality Report also reflects information about a health care organization’s performance on National Patient Safety Goals, as well as special recognitions and achievements.

This chapter provides an overview of Quality Reports—what they are, how and when they are developed, how organizations can respond to them, and how the public and organizations can access and use them.

For the purpose of readability and ease of use, this chapter is organized in a question-and-answer format. The chapter includes information on the following:

- A description of the Quality Report and the information it contains
- A description of The Joint Commission’s Quality Check® website and its special features
- Guidelines for submitting a commentary
- Marketing and communication guidelines for using Quality Reports

What Is The Joint Commission Quality Report?
The Joint Commission Quality Report provides accreditation information about the health care organization. The Joint Commission provides Quality Reports to surveyed health care organizations and makes them available to the public on The Joint Commission’s Quality Check website.
What Will My Quality Report Contain?
The Quality Report features two major components.

**Summary of Quality Information.** This section provides the following information:
- **Accreditation decision** including the effective date of the decision. This portion also identifies any additional programs in the organization that are accredited by The Joint Commission, if applicable.

**Quality Indicators.** Quality Indicators include National Patient Safety Goals, which are a series of specified actions that accredited organizations are expected to take in order to prevent medical errors. All organizations providing the related relevant services are required to comply with the National Patient Safety Goals. See Figure 1 for the legend of National Patient Safety Goal Quality Indicator symbols.

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<table>
<thead>
<tr>
<th>Symbol Key</th>
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<tbody>
<tr>
<td>☑️  The organization has met the National Patient Safety Goal.</td>
</tr>
<tr>
<td>🔴  The organization has not met the National Patient Safety Goal.</td>
</tr>
<tr>
<td>N/A The Goal is not applicable for this organization.</td>
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**Figure 1. Legend of National Patient Safety Goal Quality Indicator Symbols**

What Is Quality Check?
Quality Check is a directory of the more than 20,000 Joint Commission–accredited and certified health care organizations and programs throughout the United States. You can access Quality Check at http://www.qualitycheck.org.

These features are included on Quality Check:
- Enhanced search functionality that allows the user to search for a health care organization by the following criteria:
  - Joint Commission–assigned organization number (HCO ID)
  - City, state, or zip code

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
- Type of service provided
- Accreditation or Certification program—This includes certified programs, home care providers, hospitals, laboratories, behavioral health care organizations, nursing care centers, office-based surgery practices, and ambulatory care organizations
- Organization name—This includes Legal Business Name, as well as Doing Business As (DBA) Name (the DBA may be what consumers are most likely to know)

A search results page that displays any organization that matched the user’s search criteria. Also included on this page are filter options, which allow the user to narrow search results by state, services, deemed or CMS-recognition programs, accreditation or certification programs.

Is a Quality Report Available for My Accredited Health Care Organization?
Yes. The amount of information available on the report depends on the type of health care organization surveyed. A complete directory of all Joint Commission–accredited organizations is available through Quality Check’s website (http://www.qualitycheck.org).

Historical Quality Reports (when applicable) can also be accessed on Quality Check. The Joint Commission’s Customer Service Department (630-792-5800) can also address queries about Quality Report availability for an organization and can provide lists of all available reports.

Can My Health Care Organization Comment on Its Quality Report?
Yes. The Joint Commission offers each organization the opportunity to provide its perspective on its Quality Report commentary. Your health care organization has the option of submitting a commentary of up to two pages. Submission of the commentary is voluntary.
How Does My Health Care Organization Submit a Commentary?
If your health care organization chooses to submit a commentary, it may do so by completing an online form that is accessed through your organization’s secure Joint Commission Connect™ extranet site. After your organization submits the form, Joint Commission staff will review the submitted commentary for appropriateness, and then “Accept” the document for posting with the Quality Report on Quality Check. If the submitted commentary does not meet appropriateness guidelines, Joint Commission staff will notify your organization and allow you to resubmit a revised and approved copy.

Are There Any Criteria That Must Be Met in a Commentary?
The commentary must meet the following criteria:

- Only one commentary is permitted per health care organization, regardless of the number of the organization’s accredited services evaluated in a survey.
- The commentary is limited to a maximum of two pages.
- The commentary does not mention surveyors by name or use defamatory or libelous language.

The commentary may be updated at any time by submitting a revised commentary through your organization’s Joint Commission Connect site.

What Are the Marketing and Communication Guidelines for Using Quality Reports?
The Joint Commission recognizes your health care organization’s right to communicate your accreditation decision to interested individuals. Indeed, many organizations across the country point with pride to Joint Commission accreditation as a “seal of approval” of their efforts to provide high-quality care, treatment, or services. In fact, The Joint Commission offers a Gold Seal of Approval® for health care organizations to use to publicize their accreditation. Guidelines for use of the Gold Seal are available on The Joint Commission’s website (http://www.jointcommission.org/accreditation/gold-seal_downloads.aspx).
However, your organization must also communicate responsibly. An organization accredited by The Joint Commission must be accurate when describing to the public the nature and meaning of its accreditation including the public use of its Quality Report. An organization may not engage in any false or misleading advertising with respect to the accreditation award. Any such advertising may be grounds for denying or revoking accreditation (see APR.08.01.01 in the “Accreditation Participation Requirements” [APR] chapter).

**Guidelines for Publicizing Joint Commission Accreditation**

The Joint Commission requires that a health care–accredited organization accurately describe to the public the nature and meaning of its accreditation and its decision award. Any accredited organization that materially misleads the public about any matter relating to its accreditation may have to undertake appropriate corrective advertising or risk loss of accreditation.

Guidelines for publicizing accreditation include the following:

- Accreditation does not “endorse” or “guarantee” a organization’s quality or safety of care, treatment, or services, nor does it “prove,” “assure,” or “testify” that a organization provides high-quality, safe care, treatment, or services. Such language should not be used in your materials.
- Correctly state the organization’s accreditation accomplishment. To say that your organization is the “first” or the “only” organization in the area to receive accreditation or a specific accreditation designation may not be true and can be misleading.
- When referring to The Joint Commission, use the name “The Joint Commission.”

For further information on publicizing your accreditation or using the Gold Seal of Approval, organizations may contact The Joint Commission’s Corporate Marketing Department by visiting our website at https://www.jointcommission.org/accreditation/celebrating_your_accreditation.aspx, or see the “Award Display and Use” section in “The Accreditation Process” (ACC) chapter.
Guidelines for Publicizing the National Patient Safety Goals®

The Joint Commission established the National Patient Safety Goals in 2002 to help accredited organizations prevent specific errors from occurring, such as failing to screen individuals served for risk of harm to self or others. All Joint Commission–accredited health care organizations are surveyed for compliance with the requirements of the goals—or acceptable alternatives—as appropriate to the care, treatment, or services the organization provides. The Joint Commission develops accreditation program–specific goals for each of its accreditation and certification programs.

Guidelines for publicizing your organization’s compliance with the National Patient Safety Goals include the following:

- You may state that your organization is in compliance with the goals but you must state when that was validated. For example, “We were last surveyed for compliance with the National Patient Safety Goals in 2016,” or “Our compliance with the National Patient Safety Goals was validated by The Joint Commission in 2017.”

- Your organization must be in compliance with all applicable goals in order to receive a “check mark” on the summary page of your Quality Report. Tell your individuals served to “look for the check mark” when evaluating behavioral health care providers.

- If your organization fails to comply with one or more of the goal requirements and receives a “minus symbol” on its Quality Report summary page, you may still publicize your compliance but only with the goals and requirements with which you comply. In this instance, you may not imply compliance with all applicable goals.

For more information, please visit our website: https://www.jointcommission.org/accreditation/guidelines_for_publicizing_npsg_compliance.aspx.
Required Written Documentation (RWD)

This chapter provides you with a list of elements of performance (EPs) that require written documentation. You may find it useful to use this document as a checklist to maintain continuous compliance with the requirements.

The Joint Commission’s focus is on performance and implementation rather than documentation. The standards, consequently, require documentation only when it is essential. The documentation icon—○— is used to identify data collection and documentation requirements that are in addition to information found in the clinical/case record. For example, the documentation icon is applied to an EP that requires a written procedure, but the icon is not applied to an EP that lists the required components of the clinical/case record. Other examples in which the documentation icon is applied are EPs that require a policy, a written plan, a license, evidence of testing, data, performance improvement reports, medication labels, safety data sheets, and meeting minutes. Documentation can be on paper or in an electronic format.

While documentation is important, the primary emphasis of the survey will be on how your organization carries out the functions described in the Comprehensive Accreditation Manual for Behavioral Health Care (CAMBHC). The surveyors may use a combination of data sources, including interviews with leaders of the organization, staff, individuals served, and the individual’s family members; visits to health care settings; and review of documentation to arrive at an assessment of the organization’s compliance with a standard.

Note: This list is meant to be a guide for you in preparing for the survey. The names and format of specific documents may vary from organization to organization.
List of EPs Requiring Written Documentation for Behavioral Health Care Organizations

### Accreditation Participation Requirements (APR)

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### Emergency Management (EM)

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
Required Written Documentation

Human Resources Management (HRM)
- EM.02.01.01, EPs 2, 4
- EM.02.02.01, EP 16
- EM.03.01.03, EP 14
- EM.02.02.01, EPs 2, 3
- EM.01.05.01, EP 1
- EM.01.06.01, EPs 3-5
- EM.01.07.01, EP 2

Infection Prevention and Control (IC)
- IC.01.03.01, EP 3
- IC.01.04.01, EP 1
- IC.01.05.01, EPs 2, 3, 5
- IC.01.06.01, EP 4
- IC.02.04.01, EPs 4-6, 8

Information Management (IM)
- IM.01.01.03, EP 1
- IM.02.01.01, EP 1
- IM.02.01.03, EPs 1-4
- IM.02.02.01, EP 2

Leadership (LD)
- LD.01.03.01, EPs 1, 3
- LD.02.01.01, EPs 4, 5
- LD.03.01.01, EP 4
- LD.04.01.01, EP 1
- LD.04.01.03, EPs 4, 7
- LD.04.01.05, EP 3
- LD.04.01.09, EPs 2, 3, 10-13
- LD.04.02.01, EPs 1, 2
- LD.04.02.03, EP 4
- LD.04.03.05, EPs 7, 9, 13
- LD.04.03.09, EPs 2, 3, 5, 10
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Life Safety (LS)
- LS.01.01.01, EPs 2, 3
- LS.01.02.01, EPs 2, 12

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### National Patient Safety Goals (NPSG)

| NPSG.03.06.01, EPs 1, 4 | NPSG.15.01.01, EP 1 |

### Record of Care, Treatment, and Services (RC)

| RC.01.03.01, EP 1       | RC.02.01.05, EP 5   |
| RC.01.05.01, EP 1       | RC.02.03.07, EP 1   |
| RC.02.01.01, EP 2       | RC.03.01.01, EP 1   |

### Rights and Responsibilities of the Individual (RI)

| RI.01.01.01, EPs 1, 20, 25 | RI.01.07.03, EP 4 |
| RI.01.03.01, EPs 1, 3     | RI.01.07.07, EP 1 |
| RI.01.03.05, EP 4          | RI.02.01.01, EP 3 |
| RI.01.05.01, EP 1          | RI.03.01.01, EP 1 |
| RI.01.06.05, EPs 13, 29   | RI.03.01.03, EP 1 |
| RI.01.07.01, EP 28         | RI.03.01.05, EP 7 |

### Waived Testing (WT)

| WT.01.01.01, EPs 2-4      | WT.04.01.01, EP 1 |
| WT.02.01.01, EPs 1, 2     | WT.05.01.01, EP 1 |
| WT.03.01.01, EPs 2-4, 6   | WT.04.01.01, EP 1 |
Early Survey Policy (ESP)

A behavioral health care organization wishing to be accredited for the first time by the Joint Commission may choose the Early Survey Policy option. The organization must declare during the application process that it wishes to pursue this option.

Under this option, the behavioral health care organization must undergo two surveys, both of which would be announced. The first survey would cover a limited selection of standards. The second survey would be a full survey. For a detailed explanation of the Early Survey Policy, please see “The Accreditation Process” (ACC) chapter in this manual.

This following table lists the selected elements of performance (EPs) and requirements that are applicable to a first survey when a behavioral health care organization has chosen the Early Survey Policy option.

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### Rights and Responsibilities of the Individual (RI)

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### Waived Testing (WT)

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Opioid Treatment Programs (OTP)

Overview
This chapter includes the additional standards and elements of performance that apply to opioid addiction treatment programs; they reflect the requirements found in the Federal Guidelines for Opioid Treatment and the Federal Regulations for the Certification of Opioid Treatment Programs, 42 CFR Part 8. The standards and elements of performance specific to opioid addiction treatment programs are repeated here to identify additional requirements that will be used in surveying opioid addiction treatment programs’ compliance with the federal regulations at 42 CFR Part 8. The standards and elements of performance listed here apply to opioid addiction treatment programs that provide maintenance and/or withdrawal services. See the “Standards Applicability Process” (SAP) chapter for a detailed guide to identifying all standards applicable to your organization.

Note: Opioid Treatment Programs include programs that provide medication-assisted treatment.

Standards List
The following is a list of standards with elements of performance specific to opioid addiction treatment programs. They are presented here for your convenience without footnotes or other explanatory text. If you have a question about a term used here, please check the Glossary.

Care, Treatment, and Services (CTS)

CTS.01.01.01 The organization accepts for care, treatment, or services only those individuals whose identified care, treatment, or service needs it can meet.

CTS.02.01.01 The organization has a screening procedure for the early detection of risk of imminent harm to self or others.
CTS.02.01.03 The organization performs screenings and assessments as defined by the organization’s policy.

CTS.02.01.07 The organization completes a physical health assessment, including a medical history and physical examination.

CTS.02.01.09 The organization screens all individuals served for physical pain.

CTS.02.02.01 The organization collects assessment data on each individual served.

CTS.02.02.05 The organization identifies individuals served who may have experienced trauma, abuse, neglect, or exploitation.

CTS.02.02.07 The organization reassesses individuals served, as needed.

CTS.02.02.09 For opioid treatment programs: The organization has a process to provide medical histories, physical examinations, and diagnostic and laboratory tests.

CTS.02.03.03 For organizations providing care, treatment, or services to a child or youth: The organization assesses the needs of children or youth.

CTS.03.01.01 The organization bases the planned care, treatment, or services on the needs, strengths, preferences, and goals of the individual served.

CTS.03.01.03 The organization has a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served.

CTS.03.01.05 The plan for care, treatment, or services addresses the family’s involvement.

CTS.03.01.07 When individuals served need additional care, treatment, or services not offered by the organization, referrals are made and documented in the clinical/case record.

CTS.04.01.01 The organization coordinates the care, treatment, or services provided to an individual served as part of the plan for care, treatment, or services and in a manner consistent with the organization’s scope of care, treatment, or services.
Opioid Treatment Programs

**CTS.04.01.03** The individual served receives education and training specific to the individual’s needs and abilities consistent with the care, treatment, or services provided.

**CTS.04.03.35** The organization responds to medical emergencies according to organization policy and procedures.

**CTS.05.01.01** The organization prohibits the use of any procedure that physically harms or is a psychological risk to the individual served.

**CTS.06.02.01** When an individual served is transferred or discharged, the continuity of care, treatment, or services is maintained.

**CTS.06.02.03** When an individual served is discharged or transferred, the organization bases the discharge or transfer on the assessed needs of the individual and the organization’s capabilities.

**CTS.06.02.05** When individuals served are transferred or discharged, pertinent information related to the care, treatment, or services provided is exchanged with other providers.

**Environment of Care (EC)**

**EC.02.01.01** The organization manages safety and security risks.

**EC.02.03.01** The organization manages fire risks.

**EC.02.03.03** The organization conducts fire drills.

**EC.02.03.05** The organization maintains fire safety equipment and fire safety building features.

**EC.02.06.01** The organization establishes and maintains a safe, functional environment.

**Emergency Management (EM)**

**EM.01.01.01** The organization engages in planning activities prior to developing its Emergency Management Plan.
EM.02.02.01 As part of its Emergency Management Plan, the organization prepares for how it will communicate during emergencies.

**Human Resources Management (HR)**

**HRM.01.01.01** The organization develops written job descriptions.

**HRM.01.01.03** The organization determines how staff function within the organization.

**HRM.01.02.01** The organization verifies and evaluates staff qualifications.

**HRM.01.03.01** The organization provides orientation to staff.

**HRM.01.05.01** Staff participate in education and training.

**HRM.01.06.01** Staff are competent to perform their job duties and responsibilities.

**HRM.01.06.03** Staff who assess individuals with substance abuse, dependence, and other addictive behaviors and who plan services for and deliver services to these individuals have specific competencies.

**HRM.01.07.01** The organization evaluates staff performance.

**Infection Prevention and Control (IC)**

**IC.01.03.01** The organization identifies risks for acquiring and spreading infections.

**IC.01.05.01** The organization has an infection prevention and control plan.

**Information Management (IM)**

**IM.01.01.03** The organization plans for continuity of its information management processes.

**IM.02.01.01** The organization protects the privacy of health information.

**IM.02.01.03** The organization maintains the security and integrity of health information.

**IM.02.02.03** The organization retrieves, disseminates, and transmits health information in useful formats.
Leadership (LD)
LD.01.04.01 A chief executive manages the organization.
LD.02.01.01 The mission, vision, and goals of the organization support the safety and quality of care, treatment, or services.
LD.03.06.01 Those who work in the organization are focused on improving safety and quality.
LD.04.01.01 The organization complies with law and regulation.
LD.04.01.09 Policies and procedures guide the provision of program services and define the goals and scope of services offered.
LD.04.01.11 The organization makes space and equipment available as needed for the provision of care, treatment, or services.
LD.04.02.03 Ethical principles guide the organization’s business practices.
LD.04.03.05 Services are defined through the collaboration of the organization’s leaders with leaders of the various communities served by the organization and other external organizations.
LD.04.04.05 The organization has an organizationwide, integrated safety program for individuals served.

Medication Management (MM)
MM.01.01.01 The organization plans its medication management processes.
MM.01.01.03 The organization safely manages high-alert medications.
MM.03.01.01 The organization safely stores medications.
MM.03.01.03 The organization safely manages emergency medications and supplies.
MM.04.01.01 Medication orders are clear and accurate.
MM.05.01.01 The organization reviews the appropriateness of all medication orders for medications to be dispensed in the organization.
MM.05.01.11 The organization safely dispenses medications.
MM.05.01.13 The organization safely obtains medications when the pharmacy is closed.

MM.06.01.01 The organization safely administers medications.

MM.06.01.03 Self-administered medications are administered safely and accurately.

MM.07.01.01 The organization monitors individuals served to determine the effects of their medication(s).

MM.07.01.03 The organization responds to actual or potential adverse medication events, significant adverse medication reactions, and medication errors.

**Performance Improvement (PI)**

Pl.01.01.01 The organization collects data to monitor its performance.

**Record of Care, Treatment, and Services (RC)**

RC.01.01.01 The organization maintains complete and accurate clinical/case records.

RC.01.02.01 Entries in the clinical/case record are authenticated.

RC.01.03.01 Documentation in the clinical/case record is entered in a timely manner.

RC.01.04.01 The organization audits its clinical/case records.

RC.01.05.01 The organization retains its clinical/case records.

RC.02.01.01 The clinical/case record contains information that reflects the care, treatment, or services provided to the individual served.

RC.02.04.01 The organization documents the discharge information of the individual served.

**Rights and Responsibilities of the Individual (RI)**

RI.01.01.01 The organization respects the rights of the individual served.

RI.01.01.03 The organization respects the right of the individual served to receive information in a manner he or she understands.
RI.01.02.01 The organization respects the right of the individual served to collaborate in decisions about his or her care, treatment, or services.

RI.01.03.01 The organization honors the right of the individual served to give or withhold informed consent.

RI.01.03.05 The organization protects the individual served and respects his or her rights during research, investigation, and clinical trials.

RI.01.06.03 The individual served has the right to be free from neglect; exploitation; and verbal, mental, physical, and sexual abuse.

RI.01.07.01 The individual served and his or her family have the right to have complaints reviewed by the organization.

RI.02.01.01 The organization informs the individual served about his or her responsibilities related to his or her care, treatment, or services.

Additional Standards, Rationales, Elements of Performance, and Scoring for Opioid Treatment Programs

Care, Treatment, and Services (CTS)

Standard CTS.01.01.01 The organization accepts for care, treatment, or services only those individuals whose identified care, treatment, or service needs it can meet.

Note 1: For opioid treatment programs: If an individual eligible for treatment applies for admission to a comprehensive maintenance treatment program but cannot be placed within 14 days in a program that is within a reasonable geographic area, an opioid treatment program’s program sponsor may place the individual in interim maintenance treatment.
Note 2: For opioid treatment programs: There may be individuals in special populations who have a history of opioid use but are not currently physiologically dependent. Federal regulations waive the one-year history of addiction for these special populations, because these individuals are susceptible to relapse to opioid addiction, leading to high-risk behaviors with potentially life-threatening consequences. These populations include the following:

- Persons recently released from a penal institution
- Persons recently discharged from a chronic care facility
- Pregnant women
- Previously treated patients

Elements of Performance for CTS.01.01.01

8. For opioid treatment programs: Patients may have access to the program after the program physician documents a diagnosis of addiction or dependence and determines that maintenance or withdrawal treatment is medically necessary.

9. For opioid treatment programs: The treatment program gives priority for admission to pregnant women who seek treatment and documents the reasons for denying admission to any pregnant applicant on an intake log or other accessible program records.

10. For opioid treatment programs: Services are provided during hours that meet the needs of the majority of patients, including before and/or after the traditional 8:00 A.M. to 5:00 P.M. working day, when possible.

11. For opioid treatment programs: Admission procedures use accepted medical criteria, such as those listed in the current Diagnostic and Statistical Manual for Mental Disorders, to determine that the person is currently addicted to or dependent on an opioid drug, and that the person became addicted or dependent at least one year before admission for treatment.

Note 1: In order to determine the one-year history of addiction or dependence, the program may accept arrest records, medical records, information from significant others and relatives, and other information.

Note 2: Patients generally are not admitted to opioid maintenance therapy for pain relief only.

12. For opioid treatment programs: Admission procedures use criteria for determining a diagnosis of addiction or dependence based on behavior.

Note: Behavior indicative of opioid addiction includes the following:
Continuing use of the opiate despite known adverse consequences to self, family, or society
- Obtaining illicit opiates
- Using prescribed opiates inappropriately
- Previous attempts at tapering methadone or other drugs

14. **For opioid treatment programs**: The program physician waives the admission criteria requiring a one-year history of addiction or dependence only in the following circumstances:
   - The patient has been released from a penal institution in the last six months.
   - The patient is pregnant.
   - The patient was treated with an opioid agonist treatment medication within the last two years.

15. **For opioid treatment programs**: Admission procedures do not exclude patients that are not currently physiologically dependent.

16. **For opioid treatment programs**: Admission procedures include use of a central registry system (if applicable) or an alternative mechanism to prevent patients from enrolling in treatment provided by more than one clinic or individual practitioner.

   **Note**: In some cases, the program may, after obtaining the patient's consent, contact other opioid treatment programs within a reasonable geographic distance (100 miles) to verify that the patient is not enrolled in another program.

18. **For opioid treatment programs**: When a physician makes a diagnosis and admits a patient after reviewing by telephone or fax the medical examination performed by another qualified health professional, the physician reviews and countersigns the patient record within 72 hours.

   **Note**: Standing orders for admitting patients are not acceptable.

19. **For opioid treatment programs**: Patients who are diagnosed with physical dependence and a pain disorder are eligible to receive medication-assisted treatment for maintenance or for medically supervised withdrawal in a program setting.

20. **For opioid treatment programs**: Patients in medication-assisted treatment are eligible to receive both medication-assisted treatment and adequate doses of opioid analgesics for pain.
21. **For opioid treatment programs:** If a patient is denied admission based on the results of the initial assessment, the program provides a full explanation to the patient and a referral to another program.

22. **For opioid treatment programs:** If the opioid treatment program provides interim maintenance treatment, it has written authorization to do so both by the Substance Abuse & Mental Health Services Administration (SAMHSA) and by the chief public health officer in the state in which the program operates.

   **Note:** SAMHSA may revoke its authorization if the program does not comply with the federal requirements for interim maintenance treatment. Additionally, SAMHSA will consider revoking the interim maintenance authorization of the program if the state in which the program operates is not in compliance with the requirements of 42 CFR 8.11(g).

23. **For opioid treatment programs:** Interim maintenance treatment, if provided by the program, does not exceed the 120-day maximum allowed by federal regulations for opioid treatment programs.

24. **For opioid treatment programs:** The program establishes and follows written criteria for prioritizing the transfer of patients from interim maintenance treatment to comprehensive maintenance treatment. These transfer criteria include a preference for admitting pregnant women to interim maintenance treatment and transferring them from interim maintenance to comprehensive maintenance treatment.

25. **For opioid treatment programs:** To receive interim maintenance, the patient must be fully eligible for admission to comprehensive maintenance.

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### Standard CTS.02.01.01

The organization has a screening procedure for the early detection of risk of imminent harm to self or others.

### Elements of Performance for CTS.02.01.01

1. The screening procedure determines the need for immediate intervention to protect the individual served or others.
Standard  CTS.02.01.03

The organization performs screenings and assessments as defined by the organization’s policy.

Elements of Performance for CTS.02.01.03

7. **For opioid treatment programs:** Patients receive a comprehensive evaluation that covers the following, based on the patient’s condition and needs: medical, psychosocial, vocational, educational, behavioral, family, financial, legal, health, and self-care needs.

   **Note:** *For patients receiving interim maintenance treatment, the program is not required to provide rehabilitative, education, and other counseling services to the patient.*

8. **For opioid treatment programs:** The comprehensive evaluation is conducted by one or more disciplines within approximately 30 days of admission or earlier when necessary.

Standard  CTS.02.01.07

The organization completes a physical health assessment, including a medical history and physical examination.

**Note:** *This standard does not apply to foster care and therapeutic foster care. (Refer to CTS.02.04.01, EP 1 for more information)*

Elements of Performance for CTS.02.01.07

3. **For opioid treatment programs:** The program completes a medical evaluation within 14 days after treatment is initiated.

4. **For opioid treatment programs:** The physical assessment includes an examination of the following:
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Clinical signs of addiction, such as old and fresh needle marks, constricted or dilated pupils, and/or an eroded or perforated nasal septum

Observable and reported presence of withdrawal signs and symptoms, such as yawning, rhinorrhea, lacrimation, chills, restlessness, irritability, perspiration, piloerection, nausea, and diarrhea

**Note:** On-site “point of collection” devices may be useful in screening a patient’s current physiological dependence.

5. **For opioid treatment programs:** The program documents the patient’s medical and family history to determine current chronic or acute medical conditions, such as diabetes; renal diseases; hepatitis A, B, C, and D; HIV exposure; tuberculosis; sexually transmitted diseases; other infectious diseases; sickle-cell trait or anemia; pregnancy (including past history of pregnancy and current involvement in prenatal care); and chronic cardiopulmonary disease.

6. **For opioid treatment programs:** Based on the patient’s history and physical examination, the program evaluates the possibility of various conditions (such as infectious disease, liver or pulmonary conditions, cardiac abnormalities, psychiatric problems, dermatologic sequelae of addiction, and concurrent surgical problems).

**Note:** This may be accomplished within the program itself, or by referring the patient to a cooperating agency or a consultant clinician.

7. **For opioid treatment programs:** Patients who test positive for viral hepatitis receive a referral for further evaluation and treatment, if necessary.

8. **For opioid treatment programs:** The program immunizes the patient, or refers the patient for immunization, against hepatitis A and B if not already immune, and against other viral hepatitis strains as those vaccines become available.

9. **For opioid treatment programs:** The program does not use telemedicine to substitute for a physical examination when one is needed. Telemedicine may be used to support the decision making of a physician when a provider qualified to conduct physical examinations and make diagnoses is physically located with the patient.
Standard CTS.02.01.09
The organization screens all individuals served for physical pain.

Rationale for CTS.02.01.09
Physical pain can have physiological and psychological consequences. Therefore, organizations should screen for physical pain when individuals served receive behavioral health care, treatment, or services. Further assessment and treatment of the physical pain can be provided by the behavioral health organization, or the individual served may be referred to another organization for assessment and treatment.

Elements of Performance for CTS.02.01.09

1. The organization screens all individuals served to identify those for whom a physical pain assessment is indicated. (Refer to CTS.02.01.03 through CTS.02.01.07 for more information)

2. Individuals for whom a physical pain assessment is indicated are either assessed and treated by the organization or referred for assessment or treatment.  

   **Note:** Treatment strategies for pain may include pharmacologic and nonpharmacologic approaches. Strategies should reflect an approach centered on the individual and consider the individual’s current presentation, the health care practitioner’s clinical judgment, and the risks and benefits associated with the strategies, including potential risk of dependency, addiction, and abuse.

3. **For opioid treatment programs:** The program employs a multidisciplinary approach for treating patients with both chronic pain disorder and addiction, including both addiction medicine specialists and pain medicine specialists.

   **Note:** The site of such treatment may be either a medical clinic or an opioid treatment program, depending on the patient’s needs and the best utilization of available resources.

4. **For opioid treatment programs:** Patients with pain management needs receive their regular opioid medication at adequate doses to treat addiction.
Standard CTS.02.02.01

The organization collects assessment data on each individual served.

Elements of Performance for CTS.02.02.01

1. As relevant to care, treatment, or services, the organization collects the following assessment data about each individual served:
   - Environment and living situation(s)
   - Leisure and recreational interests
   - Religion or spiritual orientation
   - Cultural preferences
   - Childhood history
   - Military service history, if applicable
   - Financial issues
   - Usual social, peer-group, and environmental setting(s)
   - Language preference and language(s) spoken
   - Ability to self-care
   - Family circumstances, including bereavement
   - Current and past trauma
   - Community resources accessed by the individual served

Note 1: Relevance to care, treatment, or services may be determined by the individual's presenting needs and the organization’s scope of care, treatment, or services.

Note 2: For certain populations, early identification of community resources is important to care, treatment, or services. Such populations include individuals with severe mental illness or disabilities and children and youth. Community resources for these groups encompass a wide range of services. These services are supportive (such as community mental health, sheltered living, day treatment, or activity programs) as well as commonly accessed by the general public (such as public transportation, banking, or retail stores). For youth or children in foster care or in-home services, resources might include community mental health centers, teen centers, YMCAs, or Jewish community centers. These sources of community services may be used as informational, discharge planning, supportive, or continuing care resources.

4. When indicated, the following evaluations are conducted:
   - Mental status
   - Psychological
   - Psychiatric
   - Intellectual and cognitive functioning
Standard CTS.02.02.05
The organization identifies individuals served who may have experienced trauma, abuse, neglect, or exploitation.

Rationale for CTS.02.02.05
The effect of trauma, abuse, neglect, or exploitation may be evidenced in the behavior of individuals served immediately or long after the event. The individual’s experience of trauma, abuse, neglect, or exploitation must be considered in the planning and delivery of care, treatment, or services. Although abuse, neglect, and exploitation are traumatic events, trauma includes a much broader array of life events that can adversely impact an individual’s functioning (for example, a child who experiences the death of a parent). Accordingly, only the specific traumas of abuse, neglect, and exploitation are required to be reported to authorities as specified in law and regulation.

Elements of Performance for CTS.02.02.05
2. The organization identifies individuals who may have experienced trauma, abuse, neglect, or exploitation during initial screening and assessment and on an ongoing basis.

Standard CTS.02.02.07
The organization reassesses individuals served, as needed.

Note: The scope and intensity of any further assessments are based on the individual's functioning; the setting; the individual’s preferences for care, treatment, or services; and the individual’s response to care, treatment, or services provided. Each individual may be reassessed for many reasons, including the following:
- To evaluate his or her response to care, treatment, or services
- To respond to a significant change in status and/or diagnosis or condition
- To satisfy legal or regulatory requirements
- To meet time intervals specified by the organization
- To meet time intervals determined by the course of the individual’s care, treatment, or services

Elements of Performance for CTS.02.02.07
1. The organization reassesses each individual served, as needed.
2. **For opioid treatment programs**: Assessments are updated quarterly during the patient’s first year of continuous treatment and semiannually during subsequent years.

**Standard CTS.02.02.09**

*For opioid treatment programs*: The organization has a process to provide medical histories, physical examinations, and diagnostic and laboratory tests.

**Elements of Performance for CTS.02.02.09**

2. **For opioid treatment programs**: The program conducts initial toxicology tests as part of the admission process.

   **Note:** The recommended medical laboratory analysis and diagnostic evaluation may include the following as medically appropriate for the patient:
   - Vital signs, including blood pressure, pulse, respirations, and temperature
   - TB skin test, and chest x-ray if the skin test is positive (including consideration for anergy)
   - Screening test for syphilis
   - Complete blood count (CBC) and lipid panel
   - Liver function tests and viral hepatitis marker tests
   - HIV testing and counseling
   - Tests appropriate for the screening or confirmation of illnesses or conditions based on concerns specific to the patient regarding renal function, electrolyte imbalance, metabolic syndromes, pain, and so forth
   - Pregnancy test
   - Neurological or psychological testing and assessment
   - Chest x-ray
   - Electrocardiogram (EKG)
   - Pap smear
   - Screening test for sickle-cell disease
   - Additional diagnostic testing based on the results of baseline screening tests, especially when those results have the potential to affect treatment decisions

3. **For opioid treatment programs**: The medical assessment addresses symptoms of and risk factors for torsades de pointes and includes any follow-up tests that are indicated, such as an EKG or comprehensive electrophysiological assessment.
4. **For opioid treatment programs:** On admission, the program tests the patient for opiates, methadone, amphetamines, cocaine, marijuana, and benzodiazepines. The need for testing for additional substances is determined by individual patient circumstances and local drug use patterns.

5. **For opioid treatment programs:** The program collects toxicological specimens in a manner that demonstrates trust and respect while taking reasonable steps to prevent falsification of samples.

   **Note:** Direct observation, although necessary for some patients, is neither necessary nor appropriate for all patients.

6. **For opioid treatment programs:** The program uses drug and alcohol screening as aids to monitor and evaluate a patient’s progress in treatment.

7. **For opioid treatment programs:** The program performs drug tests for each patient on an ongoing basis as frequently as required by law and regulation.

8. **For opioid treatment programs:** For patients in interim maintenance treatment, the program performs a urine screen upon admission and performs at least two additional urine screens if the patient is present for the maximum of 120 days permitted for interim treatment.

9. **For opioid treatment programs:** The program’s clinicians determine the ongoing drug-testing regime by analyzing individual circumstances and community drug use patterns.

   **Note:** Testing might include, but is not limited to, opiates, benzodiazepines, barbiturates, cocaine, marijuana, methadone and its metabolites, amphetamines, and alcohol.

10. **For opioid treatment programs:** Program staff discusses results of toxicology testing promptly with patients. The program documents both the results of toxicology tests and the follow-up therapeutic interventions in the patient record.

11. **For opioid treatment programs:** The program establishes and implements procedures for addressing potentially false positive and false negative toxicology test results.*

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* TIP 43 outlines principles for handling potentially false positive and negative test results. See TIP 43, "Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs" (CSAT 2005, chapter 9).
12. **For opioid treatment programs:** The program includes confirmation testing such as gas chromatography-mass spectrometry (GC-MS) or liquid chromatography-mass spectrometry (LC-MS) as part of its established procedures for addressing potentially false-positive and false-negative urine or other toxicology test results.

13. **For opioid treatment programs:** Clinicians determine the frequency of ongoing toxicological testing by evaluating the need for testing in relation to the patient’s stage in treatment.

14. **For opioid treatment programs:** Clinicians intervene when the patient discloses illicit drug use, has a positive drug test, or is suspected of diversion of opioid medication as evidenced by a lack of opioids or related metabolites in drug toxicology tests.

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**Standard CTS.02.03.03**

*For organizations providing care, treatment, or services to a child or youth:* The organization assesses the needs of children or youth.

**Elements of Performance for CTS.02.03.03**

1. **For organizations providing care, treatment, or services to a child or youth:**
   - Assessment information defined by the organization to be collected during the initial assessment of a child or youth includes the following, as relevant to care, treatment, or services:
     - Legal custody status, including the clear identification of the legal guardian(s)
     - The use of a developmental perspective in evaluating all aspects of functioning, including the child’s or youth’s physical, emotional, cognitive, educational, nutritional, and social development
     - Assessment of normative development as related to chronological age
     - The child’s or youth’s leisure and recreational interests
     - The family history and current living situation
     - The family dynamics and their impact on the child’s or youth’s current needs
     - Family factors that should be considered in discharge planning

2. **For organizations providing care, treatment, or services to a child or youth:**
   - When a physical health examination is done for a child or youth, it addresses the following:
     - Motor development and functioning
     - Sensorimotor functioning
Speech, hearing, and language functioning
- Visual functioning
- Immunization status
- Oral health and oral hygiene

(For more information about the physical health assessment, refer to Standard CTS.02.01.07.)

3. **For opioid treatment programs:** The program’s screenings and assessments tailored to adolescents make certain that medication-assisted treatment is the most appropriate treatment for these patients.

### Standard CTS.03.01.01

The organization bases the planned care, treatment, or services on the needs, strengths, preferences, and goals of the individual served.

**Note: For opioid treatment programs:** Methadone has well-documented effects on several systems, including the respiratory, nervous, and cardiac systems, and the liver. Additionally, many medications including methadone can act to increase the QT interval on an electrocardiogram and potentially lead to torsades de pointes, a potentially life-threatening cardiac arrhythmia. Therefore, it is important for the program physician to consider all of the medications the patient is currently taking (including actual versus prescribed doses, illicit drugs, medically active adulterants potentially present in illicit substances, and medically active over-the-counter or natural remedies). Given consideration of this information, the program physician can determine whether the treatment drug will be methadone, buprenorphine, or another medication and whether the treatment indicated for the patient is induction, detoxification, or maintenance.

### Elements of Performance for CTS.03.01.01

1. The needs, strengths, preferences, and goals of the individual served are identified based on the screening and assessment and are used in the plan for care, treatment, or services.

2. Care, treatment, or service decisions are collaborative and interdisciplinary when more than one discipline is involved in the care, treatment, or services of the individual served.

3. Planning for care, treatment, or services includes identifying objectives for the identified goals. *(See also CTS.03.01.03, EP 3)*
4. Planning for care, treatment, or services includes interventions and services necessary to meet the identified goals.

6. **For opioid treatment programs:** The program manages concurrent abuse of other drugs† within the context of the medication-assisted treatment.

7. **For opioid treatment programs:** The program establishes strategies to prevent or limit patients from acquiring and abusing prescriptions for controlled substances or other psychotropics from prescribers with whom the patients have ongoing relationships.

8. **For opioid treatment programs:** For patients with two or more unsuccessful withdrawal episodes within a 12-month period, the program physician assesses the patient to determine what other forms of treatment should be considered.

9. **For opioid treatment programs:** The program includes smoking and tobacco cessation as an integral part of the treatment of patients who use tobacco.

10. **For opioid treatment programs:** Patients diagnosed with diseases that must be reported to the public health department (such as tuberculosis or sexually transmitted diseases) are either treated by the program or are referred for further evaluation and treatment elsewhere.

11. **For opioid treatment programs:** The program provides patients with free or low-cost access to the immunizations recommended by the Centers for Disease Control and Prevention (CDC) either on site or through referral.

12. **For opioid treatment programs:** The program establishes linkages with community HIV/AIDS treatment programs, prevention programs, and social support services to continue opioid medication when AIDS becomes the patient’s primary health concern.

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† Principles for managing concurrent abuse of other drugs are described in TIP 43, “Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs” (CSAT 2005).

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
Standard **CTS.03.01.03**
The organization has a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served.

**Elements of Performance for CTS.03.01.03**

1. The organization develops a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served.

2. The plan for care, treatment, or services includes the following:
   - Goals that are expressed in a manner that captures the individual’s words or ideas
   - Goals that build on the individual’s strengths
   - Factors that support the transition to community integration when identified as a need during assessment
   - The criteria and process for the individual’s expected successful transfer and/or discharge, which the organization discusses with the individual (For more information, refer to Standard CTS.06.02.01)

**Note 1:** Barriers that might need to be considered include co-occurring illnesses, cognitive and communicative disorders, developmental disabilities, vision or hearing disabilities, physical disabilities, and social and environmental factors.

**Note 2:** For opioid treatment programs: For patients receiving interim maintenance treatment, neither an initial treatment plan nor a periodic treatment plan evaluation is required.

3. The objectives of the plan for care, treatment, or services meet the following criteria:
   - They include identified steps to achieve the goal(s) (See also CTS.03.01.01, EP 3)
   - They are sufficiently specific to assess the progress of the individual served
   - They are expressed in terms that provide indices of progress

4. The organization re-evaluates and, when necessary, revises the goals and objectives of the plan for care, treatment, or services based on change(s) in the individual’s needs, preferences, and goals and his or her response to care, treatment, or services. If no change(s) occurs, the goals and objectives are re-evaluated at a specified time interval established by organization policy.
5. Reasons for deferring a goal, or the objectives leading toward or related to a goal, are documented.

6. The organization provides care, treatment, or services for each individual served according to the plan for care, treatment, or services.

7. **For opioid treatment programs:** The program includes recovery support services in patients’ treatment plans according to patients’ needs. Examples of such services include follow-up phone calls; face-to-face meetings; e-mails; and connecting patients to peer-to-peer services, 12-step or faith-based programs, and community groups.

8. **For opioid treatment programs:** Treatment plans are updated when there are changes in the patient’s problems, needs or response to treatment or, if no changes occur, at least quarterly during the patient’s first year of continuous treatment and semiannually during subsequent years.

9. **For opioid treatment programs:** The program offers people living with HIV/AIDS medication-assisted treatment that addresses medication side effects and toxicity.

10. **For opioid treatment programs:** The program supports a patient’s decision to breast-feed during methadone treatment, unless medically contraindicated, such as by the presence of HIV or HTLVI or II infection in the mother.

11. **For opioid treatment programs:** Voluntary withdrawal from medication-assisted treatment is medically supervised and occurs at a rate well tolerated by the patient and in accordance with sound clinical judgment.

**Note:** Voluntary withdrawal can occur when the physician and patient agree to the process or when the patient requests withdrawal against medical advice. Voluntary supervised withdrawal is distinct from involuntary tapering or administrative withdrawal (refer to Standard CTS.06.02.01).

12. **For opioid treatment programs:** The program offers a variety of options to promote successful medically supervised withdrawal, including increased counseling prior to discharge and encouraging attendance at a 12-step or other mutual help program that accepts individuals receiving medication-assisted treatment.

13. **For opioid treatment programs:** The program advises patients of the risks of relapse following withdrawal and offers a relapse prevention program that includes counseling, naloxone, and opioid antagonist therapy.
14. **For opioid treatment programs:** The program provides medically supervised withdrawal after pregnancy only when clinically indicated or requested by the patient.

15. **For opioid treatment programs:** For medically supervised withdrawal against medical advice: The program explains the risks of leaving treatment and provides information about or referral to alternate treatment options.

16. **For opioid treatment programs:** For medically supervised withdrawal against medical advice: When a patient leaves the program abruptly, the program allows the patient to be readmitted without repeating the initial assessment procedures if the readmission is within 30 days.

17. **For opioid treatment programs:** For medically supervised withdrawal against medical advice: The program documents the reasons given by the patient for seeking medically supervised withdrawal against medical advice and documents all steps taken to avoid discharging the patient.

18. **For opioid treatment programs:** For medically supervised withdrawal against medical advice: If medically supervised withdrawal fails, the physician evaluates the appropriateness of resuming maintenance treatment.

19. **For opioid treatment programs:** For medically supervised withdrawal against medical advice: For a pregnant patient, the program informs the physician or agency providing prenatal care that the patient is undergoing medically supervised withdrawal, consistent with federal privacy standards.

**Standard CTS.03.01.05**

The plan for care, treatment, or services addresses the family’s involvement.

**Elements of Performance for CTS.03.01.05**

1. The family of the individual served is involved in developing the plan for care, treatment, or services upon consent from the individual (if an adult) or in accordance with law and regulation (if a minor). *(See also CTS.04.02.16, EP 5)*

**Standard CTS.03.01.07**

When individuals served need additional care, treatment, or services not offered by the organization, referrals are made and documented in the clinical/case record. (For more information, refer to Standard CTS.04.01.01.)
Elements of Performance for CTS.03.01.07

1. When the organization does not directly provide care, treatment, or services needed by the individual served, it refers the individual to an outside source.

2. Concurrent care, treatment, or services provided by an outside source that are integral to meeting goals and objectives are addressed in the plan for care, treatment, or services.

3. The organization documents referrals of individuals served to outside sources in the clinical/case record.

4. **For opioid treatment programs:** The program completes referrals and follow-up for other health care needs within three months of admission.

5. **For opioid treatment programs:** The program educates all women of child-bearing age about neonatal abstinence syndrome, its symptoms, its potential effect on their infants, and the need for treatment should it occur.

6. **For opioid treatment programs:** The program helps female patients with infants that may be susceptible to neonatal abstinence syndrome to obtain a comprehensive evaluation and treatment for the infant.

7. **For opioid treatment programs:** The program offers referrals to parenting support groups or other services to patients in medication-assisted treatment who have children.

   **Note:** Children of patients in medication-assisted treatment may also need a referral for services because they may have special mental health and cognitive needs, especially if abuse or neglect has occurred.

8. **For opioid treatment programs:** The program offers or provides referrals for child care services to patients in medication-assisted treatment who have children.

9. **For opioid treatment programs:** If the program refers the patient elsewhere for prenatal care, it seeks reciprocity in the exchange of pertinent clinical information about compliance with the recommended course of medical care, in accordance with federal privacy regulations.

10. **For opioid treatment programs:** If a pregnant woman refuses direct prenatal services or appropriate referral for such care, the program’s treating physician or designee has the patient formally acknowledge in writing that the program offered these services but the patient refused them.
11. **For opioid treatment programs:** The program refers the patient for appropriate treatment if the assessment identifies mental health needs.

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**Standard CTS.04.01.01**

The organization coordinates the care, treatment, or services provided to an individual served as part of the plan for care, treatment, or services and in a manner consistent with the organization’s scope of care, treatment, or services. (For more information, refer to Standard CTS.03.01.07.)

**Rationale for CTS.04.01.01**

Care, treatment, or services should be coordinated among providers and between settings, independent of whether they are provided directly by the organization or by an outside source, so that the individual’s needs are addressed in a seamless, synchronized, and timely manner.

**Elements of Performance for CTS.04.01.01**

5. When external resources are needed, the organization participates in coordinating care, treatment, or services with these resources.

6. The organization has a process to receive or share relevant information about the individual served to facilitate coordination and continuity when individuals are referred to other care, treatment, or service providers.

11. **For opioid treatment programs:** The program works with the criminal justice system to provide continuous treatment to patients who are incarcerated, on probation, or on parole.

12. **For opioid treatment programs:** When possible, the program manages comorbidities on site. When comorbidities cannot be managed on site, the program develops referral and consultative relationships with other agencies and providers that can provide services to treat patients for any psychiatric comorbid conditions, medical complications, and communicable diseases.

13. **For opioid treatment programs:** When a patient is being treated for mental health issues, the program and the mental health provider jointly review the prescribed medications.

14. **For opioid treatment programs:** The program provides medication-assisted treatment for alcohol use disorders, when appropriate, as well as counseling interventions for patients with a need for treatment.
15. **For opioid treatment programs:** When a patient has hepatitis C, the program coordinates its treatment with the agency responsible for medical treatment. Attention is paid to the patient’s adherence to the medication regimen and adverse events.

17. **For opioid treatment programs:** The program’s telemedicine services are conducted via an interactive audio and video telecommunications system that permits real-time communication between the health care provider at the distant site and the patient at the originating site.

18. **For opioid treatment programs:** The program periodically queries the prescription drug monitoring program (PDMP) throughout the course of each patient’s treatment (for example, quarterly) and, in particular, before ordering take-home doses as well as at other important clinical decision points.

**Standard CTS.04.01.03**

The individual served receives education and training specific to the individual’s needs and abilities consistent with the care, treatment, or services provided.

**Note:** *This standard does not apply to academic education.*

**Elements of Performance for CTS.04.01.03**

8. **For opioid treatment programs:** The program provides each patient with an orientation and ongoing education that includes: The nature of addictive disorders.

9. **For opioid treatment programs:** The program provides each patient with an orientation and ongoing education that includes: The benefits of treatment and nature of the recovery process, including the phases of treatment.

10. **For opioid treatment programs:** The program provides each patient with an orientation and ongoing education that includes: Clinic guidelines, rules, and regulations, including the requirement to sign a formal agreement of consent, and fees and billing procedures.

11. **For opioid treatment programs:** The program provides each patient with an orientation and ongoing education that includes: Noncompliance and discharge procedures, including administrative withdrawal from medication.

12. **For opioid treatment programs:** The program provides each patient with an orientation and ongoing education that includes: Toxicology testing procedures.
13. **For opioid treatment programs:** The program provides each patient with an orientation and ongoing education that includes: Dispensing medication.

14. **For opioid treatment programs:** The program provides each patient with an orientation and ongoing education that includes: Potential drug interactions.

15. **For opioid treatment programs:** The program provides each patient with an orientation and ongoing education that includes: Any agreements needed in order to exchange appropriate information within the network of consultants and referral agencies (in accordance with HIPAA regulations).

16. **For opioid treatment programs:** The program provides each patient with an orientation and ongoing education that includes: The availability of any 12-step or other mutual help group that is accepting of medication-assisted treatment and of the benefits of peer support.

17. **For opioid treatment programs:** The program counsels patients known to be using benzodiazepines, even by prescription, as to their risk and provides them with overdose prevention education and naloxone.


18. **For opioid treatment programs:** The program documents that it informed and counseled the pregnant patient about the latest patient information sheets and product inserts for methadone.

19. **For opioid treatment programs:** If prenatal care is not available on site or by referral, or if the pregnant patient refuses prenatal care, the treatment program offers basic prenatal instruction on maternal, physical, and dietary care. Provision of the education is documented in the clinical record.

20. **For opioid treatment programs:** The program offers or refers the patient education and training for all patients who are parents or refers patients to parenting skills.

21. **For opioid treatment programs:** The program offers reproductive health education and referrals for contraceptive services.
22. **For opioid treatment programs:** The program educates patients about HIV/AIDS, including testing procedures, confidentiality, reporting, follow-up care, counseling, safer sex, social responsibilities, universal precautions, and sharing of intravenous injection equipment.

23. **For opioid treatment programs:** The program provides education to patients about viral hepatitis and its effects on physical and mental health, including prevention, treatment, and the effects of treatment on dosage levels of opioid medications.

24. **For opioid treatment programs:** The program provides education to patients about preventing HIV infection and other prevalent infectious diseases, such as hepatitis, sexually transmitted infections, and tuberculosis.

**Standard CTS.04.03.35**

The organization responds to medical emergencies according to organization policy and procedures.

**Elements of Performance for CTS.04.03.35**

1. ☑️ The organization develops a written policy and procedures for responding to medical emergencies such as respiratory arrest and cardiac arrest. 🔴

2. Policy and procedures that address medical emergencies include the following:
   - Availability of first aid and basic life support services
   - Emergency transfer to another organization
   - Placement of a phone call to 911

3. The organization responds to medical emergencies according to organization policy and procedures.

4. ☑️ **For opioid treatment programs:** The program’s offices and waiting areas display the names and telephone numbers of whom to contact in case of emergency or 911 or similar local emergency resources.

5. **For opioid treatment programs:** The program has staff on duty who are trained and proficient in the following:
   - Cardiopulmonary resuscitation (CPR) through an evidence-based training program
   - Management of opiate overdose
   - Management of medical emergencies
Other appropriate techniques

6. **For opioid treatment programs:** The program provides patients with a mechanism to address medical or psychiatric emergencies occurring outside of program hours of operation.

7. **For opioid treatment programs:** The program provides each patient with an identification card that identifies the opioid use disorder pharmacotherapy being administered through the program as well as the emergency contact information so that appropriate clinical information and dosing information can be obtained in an emergency.

**Standard CTS.05.01.01**

The organization prohibits the use of any procedure that physically harms or is a psychological risk to the individual served.

**Elements of Performance for CTS.05.01.01**

At a minimum, the following is prohibited:

2. Corporal punishment.

At a minimum, the following are prohibited:

3. Fear-eliciting procedures.

At a minimum, the following is prohibited:

4. The use of intimidation, force, or threat.

**Standard CTS.06.02.01**

When an individual served is transferred or discharged, the continuity of care, treatment, or services is maintained.

**Elements of Performance for CTS.06.02.01**

2. **For opioid treatment programs:** The discharge planning process addresses relapse prevention.

3. **For opioid treatment programs:** The discharge planning process addresses any physical and mental health problems following medically supervised withdrawal.

**Note:** For example, the program might address the need for counseling or appropriate medication to help with sleep disorders, depression, and other problems.
4. **For opioid treatment programs:** The discharge planning process addresses referrals for continuing outpatient care after the last dose of medication and planning for re-entry to maintenance treatment if relapse occurs.

5. **For opioid treatment programs:** Psychosocial treatment is continued for patients electing to discontinue medication-assisted therapy.

6. **For opioid treatment programs:** The program has a process for tracking patients and reinstituting medication-assisted therapy at the first sign of relapse or impending relapse.

   **Note:** It may not be possible for the program to track each patient, especially patients that leave the program, but it is important for the program to have processes in place in order to reinstitute medication-assisted therapy when possible.

7. **For opioid treatment programs:** The program provides the opportunity for patients receiving only long-term medication-assisted therapy to receive psychosocial services again if the need emerges.

8. **For opioid treatment programs:** The program’s process for administrative withdrawal is implemented on an individual basis and follows the principles involved in medically supervised withdrawal from medication.

   **Note:** Administrative withdrawal is usually involuntary and might be initiated based on nonpayment of fees, disruptive behavior, or incarceration. The principles followed for any medically supervised withdrawal also apply for administrative withdrawal; namely, that sound clinical judgment is followed; the time frame is generally 30 days but is adjusted by the physician depending on clinical factors; and a variety of supportive options are available to the patient.

9. **For opioid treatment programs:** When a pregnant patient is discharged, the program refers her for prenatal care and documents the name, address, and telephone number of the physician who will be caring for the patient after discharge.

10. **For opioid treatment programs:** The program makes decisions about administrative withdrawal on a case-by-case basis.

    **Note:** Ongoing multidrug use is not necessarily a reason for discharge, unless the patient refuses recommended care.
11. **For opioid treatment programs:** If practical under the circumstances and with due regard for patient and staff safety, before administrative discharge, the program conducts a crisis assessment to address suicide risk, danger to self or others, risk of relapse or overdose, urgent or critical medical conditions, and immediate threats.

12. **For opioid treatment programs:** When the program makes an administrative decision to discharge a patient from medication-assisted treatment, the program offers a schedule of medically supervised withdrawal that is well-tolerated by the patient and based on clinical judgment. The offer is documented.

13. **For opioid treatment programs:** During medically supervised administrative withdrawal, the program documents the patient’s condition in the clinical/case record.

14. **For opioid treatment programs:** Upon discharge following medically supervised administrative withdrawal, the program provides the patient with referrals to an alternate treatment program. These referrals are documented.

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**Standard CTS.06.02.03**

When an individual served is discharged or transferred, the organization bases the discharge or transfer on the assessed needs of the individual and the organization’s capabilities.

**Elements of Performance for CTS.06.02.03**

3. Planning for transfer or discharge involves the individual served, his or her family, if applicable, and staff.

   **Note:** Family includes legal guardian and surrogate decision-maker (refer to the Glossary).

4. When the individual served is transferred, information provided to the individual includes the following:
   - The reason he or she is being transferred
   - Alternatives to transfer, if any
Standard  CTS.06.02.05
When individuals served are transferred or discharged, pertinent information related to
the care, treatment, or services provided is exchanged with other providers.

Elements of Performance for CTS.06.02.05
1. The organization communicates pertinent information to any organization or
   provider to which the individual served is transferred or discharged.
2. The information shared includes the following:
   - The reason for transfer or discharge
   - Relevant biopsychosocial status at transfer or discharge
   - A summary of care, treatment, or services provided and progress made toward
goals
   - Community resources or referrals provided to the individual served

Environment of Care (EC)

Standard  EC.02.01.01
The organization manages safety and security risks.

Rationale for EC.02.01.01
Safety and security risks are present in most health care environments. These risks affect
all individuals in the organization—individuals served, visitors, and those who work in
the organization. It is important to identify these risks in advance so that the
organization can prevent or effectively respond to incidents. In some organizations,
safety and security are treated as a single function, although in others they are treated as
separate functions.

Safety risks may arise from the structure of the physical environment or the performance
of everyday tasks, or be related to situations beyond the organization’s control, such as
the weather. Safety incidents are most often accidental. On the other hand, security
incidents are often intentional. Security protects individuals and property against harm
or loss. Examples of security risks include workplace violence, theft, and unrestricted
access to medications. Security incidents are caused by individuals from either outside or
inside the organization.
Elements of Performance for EC.02.01.01

13. **For opioid treatment programs:** The organization establishes procedures for handling physical or verbal threats, acts of violence, inappropriate behavior, or other escalating and potentially dangerous situations. This includes situations in which security guards or police need to be summoned.

Standard EC.02.03.01

The organization manages fire risks.

**Rationale for EC.02.03.01**

The organization’s plan for fire response is an essential part of achieving a fire-safe environment. It is important that this response be evaluated in drill scenarios or actual fire situations in order to assess performance of staff and fire safety equipment. Testing the fire response plan should involve realistic situations, although actual evacuation of individuals served during the drills is not required.

An effective fire plan accounts for the needs of the population served. For example, the plan should address how individuals in restraints will be protected during a fire.

Elements of Performance for EC.02.03.01

9. The written fire response plan describes the specific roles of staff and licensed independent practitioners at and away from a fire’s point of origin, including when and how to sound and report fire alarms, how to contain smoke and fire, how to use a fire extinguisher, how to assist and relocate individuals served, and how to evacuate to areas of refuge.

   **Note:** For full text, refer to NFPA 101-2012: 18/19.7.1; 7.2.

Standard EC.02.03.03

The organization conducts fire drills.

Elements of Performance for EC.02.03.03

2. The organization conducts fire drills every 12 months from the date of the last drill in each area that is defined as a business occupancy by the *Life Safety Code* and in which care, treatment, or services are provided.

   **Note:** In leased or rented facilities, drills need to be conducted only in areas of the building that the organization occupies.
Standard EC.02.03.05
The organization maintains fire safety equipment and fire safety building features.

Note: This standard does not require organizations to have the types of fire safety equipment and building features described in the elements of performance of this standard. However, if these types of equipment or features exist within the building, then the following maintenance, testing, and inspection requirements apply.

Elements of Performance for EC.02.03.05

15. ⬤ At least monthly, the organization inspects portable fire extinguishers. The results and completion dates are documented.
   
   Note 1: There are many ways to document the inspections, such as using bar-coding equipment, using check marks on a tag, or using an inventory.
   
   Note 2: Inspections involve a visual check to determine correct type of and clear and unobstructed access to a fire extinguisher, in addition to a check for broken parts and full charge.
   
   Note 3: For additional guidance on inspection of fire extinguishers, see NFPA 10-2010: 7.2.2; 7.2.4.

16. ⬤ Every 12 months, the organization performs maintenance on portable fire extinguishers, including recharging. Individuals performing annual maintenance on extinguishers are certified. The results and completion dates are documented.
   
   Note 1: There are many ways to document the maintenance, such as using bar-coding equipment, using check marks on a tag, or using an inventory.
   
   Note 2: For additional guidance on maintaining fire extinguishers, see NFPA 10-2010: 7.1.2; 7.2.2; 7.2.4; 7.3.1.

Standard EC.02.06.01
The organization establishes and maintains a safe, functional environment.

Elements of Performance for EC.02.06.01

1. Interior spaces meet the needs of the individuals served for safety and suitability for the care, treatment, or services provided.

10. For opioid treatment programs: The use of physical space, including bathrooms, reflects the special needs of female patients.
20. Areas used by individuals served are safe, clean, and comfortable.

36. **For opioid treatment programs:** The program has private, individual offices available for counseling.

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**Emergency Management (EM)**

**Standard EM.01.01.01**
The organization engages in planning activities prior to developing its Emergency Management Plan.

**Rationale for EM.01.01.01**
An emergency in a behavioral health care organization can suddenly and significantly affect its ability to provide services. Therefore, the organization needs to engage in planning activities that prepare it to form its Emergency Management Plan. These activities include considering likely emergencies and identifying risks when developing strategies for emergency preparedness. During these activities, the organization will consider hazards, such as adverse weather conditions, power outages, fire, or flooding, which could affect the organization’s location.

**Elements of Performance for EM.01.01.01**

4. The organization determines what its role will be, if any, in the community response plan.

   **Note:** *A community response plan is the response plan of the organization’s city, county, region, or state, whichever plan is activated by community leadership.*
Standard EM.02.01.01
The organization has an Emergency Management Plan.

Note: The organization’s Emergency Management Plan (EMP) is designed to coordinate its communications, resources and assets, safety and security, staff responsibilities, utilities, and clinical and support activities during an emergency (refer to Standards EM.02.02.01, EM.02.02.03, EM.02.02.05, EM.02.02.07, and EM.02.02.11). Although emergencies have many causes, the effects on these areas of the organization and the required response effort may be similar. This “all hazards” approach supports a general response capability that is sufficiently nimble to address a range of emergencies of different duration, scale, and cause. For this reason, the plan’s response procedures address the prioritized emergencies but are also adaptable to other emergencies that the organization may experience.

Rationale for EM.02.01.01
A successful response effort relies on a comprehensive and flexible Emergency Management Plan that guides decision making regarding how the behavioral health care organization will respond to emergencies, including plans to continue care, treatment, or services or to close in specified circumstances. The plan also supports decision-making at the onset of an emergency and as an emergency evolves. While the Emergency Management Plan can be designed in a variety of ways, it must address response procedures that are adaptable in supporting key areas that could be affected by different types of emergencies.

Elements of Performance for EM.02.01.01
9. For opioid treatment programs: The program identifies an alternative dosing location to be used in the event of an emergency and registers the location with the US Drug Enforcement Administration (DEA) if it is not already an opioid treatment program.
Standard EM.02.02.01  
As part of its Emergency Management Plan, the organization prepares for how it will communicate during emergencies.

Rationale for EM.02.02.01  
The behavioral health care organization maintains reliable communication capabilities for the purpose of communicating response efforts to staff, individuals served, and external organizations. The organization establishes backup communication processes and technologies (for example, cell phones, text messages, landlines, bulletin boards, fax machines, Amateur Radio, television and radio newscasts) to communicate essential information if primary communication systems fail.

Elements of Performance for EM.02.02.01  

15. **For opioid treatment programs:** The program maintains a 24-hour telephone answering capability to respond to facility emergencies.

16. ☐ **For opioid treatment programs:** A roster of patients and a log of medication dosages are accessible to the staff member on call for verification purposes.

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**Human Resources Management (HRM)**

Standard HRM.01.01.01  
The organization develops written job descriptions.

Elements of Performance for HRM.01.01.01  

1. ☐ Each position has a written job description that identifies the following:

   - The minimum qualifications of the position
   - The competencies of the position, which include the minimum skills, knowledge, and experience required for the position
   - The duties and responsibilities of the position

   **Note:** A written contract may replace a job description. (For more information on contracted services, refer to Standard LD.04.03.09.)

3. **For opioid treatment programs:** The program physician(s) has experience in addiction medicine or psychiatry, including medication-assisted treatment, and has completed an accredited residency training program.
Note: Board certification in his or her primary medical specialty and in addiction psychiatry or addiction medicine is preferred.

5. For opioid treatment programs: In states that permit nonlicensed addictions counselors, programs develop job descriptions in accordance with standards put forward by a formal body such as those published by the National Certification Commission for Addiction Professionals.

Standard HRM.01.01.03
The organization determines how staff function within the organization.

Elements of Performance for HRM.01.01.03

1. All staff who provide care, treatment, or services possess a current license, certification, or registration, in accordance with law and regulation and organization policy.

3. Staff practice within the scope of their job description.

4. For opioid treatment programs: The program’s telemedicine services do not expand the scope of practice of a health care provider or permit practice in a jurisdiction (the location of the patient) where the provider is not licensed.

5. For opioid treatment programs: The program reviews the individual licensing, scope of practice, and supervision requirements of its state with regard to the duties of authorized health care professionals within the program, such as advanced practice nurses, physician assistants, and advanced practice pharmacists.

Standard HRM.01.02.01
The organization verifies and evaluates staff qualifications.

Elements of Performance for HRM.01.02.01

8. For opioid treatment programs: The program maintains individualized personnel files as a record of employment. The personnel files contain the following:

- Employment and credentialing data
- Employment application data
- Date of employment
- Up-to-date licensing and credentialing data
- Detailed job descriptions
Standard HRM.01.03.01

The organization provides orientation to staff.

Elements of Performance for HRM.01.03.01

15. **For opioid treatment programs:** Before providing patient care, staff receive education specific to the medication-assisted treatment used in the program and tailored to the patient population.

Standard HRM.01.05.01

Staff participate in education and training.

Elements of Performance for HRM.01.05.01

1. ☐ Staff participate in education and training as follows:
   - To maintain or increase their competency
   - Whenever changes in their responsibilities require it

   **Note:** Education and training are only required if an assessment of staff skills and competencies indicates a need for their provision.
   - To meet specific needs of the population(s) served by the organization

   *Staff participation is documented.* (See also RI.03.01.05, EP 7)

5. **For opioid treatment programs:** The program implements an individual annual training plan for each staff member.

6. **For opioid treatment programs:** The program provides staff with training in the specific characteristics and needs of women participating in their treatment program.

7. **For opioid treatment programs:** Staff receive education about all forms of viral hepatitis and their effects on the health of the patient.

8. **For opioid treatment programs:** Staff have resources for problem solving and troubleshooting patient care issues (for example, vomiting medication, aggressive or disruptive behavior).
Standard HRM.01.06.01
Staff are competent to perform their job duties and responsibilities.

Elements of Performance for HRM.01.06.01

1. For each of its programs or services, the organization defines the competencies it requires of staff members who provide care, treatment, or services.  
   Note: Competencies may be based on the programs or services provided and the populations served. (See also NPSG.03.06.01, EP 3)

Standard HRM.01.06.03
Staff who assess individuals with substance abuse, dependence, and other addictive behaviors and who plan services for and deliver services to these individuals have specific competencies.

Elements of Performance for HRM.01.06.03

3. For opioid treatment programs: Staff understand the benefits and limitations of toxicological testing procedures.

4. For opioid treatment programs: Staff are knowledgeable about strategies for treating alcohol, cocaine, and other drug abuse.

5. For opioid treatment programs: Staff responsible for coordinating medical and psychiatric care are knowledgeable about medication-assisted therapy.

6. For opioid treatment programs: Trained and qualified substance abuse counselors provide services to meet the needs of patients and are sufficient in number to provide reasonable and prompt access by patients to counseling.

7. For opioid treatment programs: The staff members responsible for establishing referrals with other health care organizations and practitioners are knowledgeable about pharmacotherapy treatment (drug interactions, acute withdrawal, and overdose), actively seek patient consent to talk with other providers, and check their state’s prescription drug monitoring program (PDMP).
Standard HRM.01.07.01

The organization evaluates staff performance.

**Elements of Performance for HRM.01.07.01**

1. The organization evaluates staff based on performance expectations that reflect their job descriptions.

   **Note:** For contracted staff, a written contract may replace a job description. (For more information on contracted services, refer to Standard LD.04.03.09.)

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**Infection Prevention and Control (IC)**

Standard IC.01.03.01

The organization identifies risks for acquiring and spreading infections.

**Rationale for IC.01.03.01**

Before developing its infection prevention and control activities, the behavioral health care organization needs to consider the risks of infections that are most likely to affect the individuals it serves. Understanding the risks will help the organization to better determine the most effective actions it can take to prevent infections. Effective prevention can minimize risks to individuals served and reduce the need to implement infection control activities that may be more resource intensive.

**Elements of Performance for IC.01.03.01**

1. The organization identifies infection risks based on the following:

   - Its setting and population served
   - The care, treatment, or services it provides
   - **For 24-hour care settings:** Its monitoring of infection prevention and control activities and/or tracking and analyzing the occurrence of infections

   **Note 1:** The infections that should be tracked are those that are most relevant to the organization’s setting, services, and population(s). The organization may contact its local health department for statistics and other information on some infections, and track other infections internally. For example, an organization may decide to track conjunctivitis itself but rely on health department statistics related to tuberculosis.
Note 2: *The risk of infection will vary across behavioral health care settings. For example, infection risks in group homes, day treatment programs, and couples counseling will vary by hours of contact, number of individuals served, and location and type of service.*

**Standard IC.01.05.01**
The organization has an infection prevention and control plan.

**Rationale for IC.01.05.01**
The organization has a plan for infection prevention and control to support consistency in the activities that prevent the spread of infection. Such activities help protect individuals served and staff from infectious disease even if the organization is not specifically aware that an infection is present. Furthermore, when the organization is aware of or is notified of the presence of an infection, the organization with a plan will be better prepared to respond quickly to prevent its spread within the organization, and to access external information and assistance (for example, through the local health department) if needed.

The local health department may support organizations by following 10 general steps to investigate an outbreak of infectious disease:
1. Prepare for fieldwork (that is, research the disease, gather supplies and equipment, make administrative arrangements such as travel, and consult with local contacts to define roles and activities)
2. Establish the existence of an outbreak
3. Verify the diagnosis
4. Define and identify cases
5. Describe and orient the data in terms of time, place, and person
6. Develop hypothesis
7. Evaluate hypothesis
8. Refine hypothesis and carry out additional studies
9. Implement control and prevention measures
10. Communicate findings

Source: Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion
Elements of Performance for IC.01.05.01

1. When developing infection prevention and control activities, the organization uses accepted practices in preventing the spread of infections where individuals are served.‡

Information Management (IM)

Standard IM.01.01.03

The organization plans for continuity of its information management processes.

Elements of Performance for IM.01.01.03

The plan for managing interruptions to electronic information systems addresses the following:

2. Scheduled and unscheduled interruptions. (See also IM.03.01.01, EP 1; EM.01.01.01, EP 6)

3. Training for staff on alternative procedures to follow when systems are unavailable. (See also EM.01.01.01, EP 6)

4. Backup of the electronic information systems. (See also EM.01.01.01, EP 6)

Standard IM.02.01.01

The organization protects the privacy of health information.

Elements of Performance for IM.02.01.01

1. The organization has a written policy addressing the privacy of health information. (See also RI.01.01.01, EP 7)

2. The organization implements its policy on the privacy of health information. (See also RI.01.01.01, EP 7)

‡ When considering accepted practices, the organization may find it useful to consult guidelines available from the Centers for Disease Control and Prevention: Healthcare Infection Control Practices Advisory Committee (CDC/HICPAC) at http://www.cdc.gov/hai/. Although portions of these guidelines apply only in acute care settings, much of the information is relevant regardless of the setting of care.
4. The organization discloses health information only as authorized by the individual served or as otherwise consistent with law and regulation. *(See also RI.01.01.01, EP 7)*

**Note:** For opioid treatment programs: Patients in addiction treatment programs and opioid treatment programs have the right to confidentiality in accordance with federal regulations (42 CFR).  

**Standard IM.02.01.03**
The organization maintains the security and integrity of health information.

**Elements of Performance for IM.02.01.03**

5. The organization protects against unauthorized access, use, and disclosure of health information.

6. The organization protects health information against loss, damage, unauthorized alteration, unintentional change, and accidental destruction.

**Standard IM.02.02.03**
The organization retrieves, disseminates, and transmits health information in useful formats.

**Rationale for IM.02.02.03**
Access to accurate information enables the organization to deliver, analyze, and improve care, treatment, or services. In order to be useful, data and information should be disseminated in formats that meet user needs and that facilitate accurate interpretation of the information. The intended use of information should be considered when developing forms, screen displays, and standard or ad hoc reports.

**Elements of Performance for IM.02.02.03**

12. The organization retains data and information for time frames consistent with law and regulation.

**Leadership (LD)**

**Standard LD.01.01.01**
The organization has a leadership structure.
Rationale for LD.01.01.01
Every organization has a leadership structure to support operations. Many functions need to be carried out, including governance, administration, and oversight of care, treatment, or services. In some organizations leaders have distinct roles in carrying out these functions; in others a single person may perform all leadership functions.

Elements of Performance for LD.01.01.01

7. **For opioid treatment programs:** The program’s administrative organization is comprised of, at a minimum, a program sponsor, program director or manager, and medical director.

Standard LD.01.04.01
A chief executive manages the organization.

Elements of Performance for LD.01.04.01
The chief executive provides for the following:

1. Information and support systems.
3. Physical and financial assets.

12. **For opioid treatment programs:** Persons in positions of authority are professionally and culturally competent.

   **Note:** *These people are able to work effectively with the local community and/or receive input from members of minority groups or advisors who are knowledgeable about gender, ethnicity, and language issues.*

14. **For opioid treatment programs:** The medical director is responsible for all medical services performed by the program.

15. **For opioid treatment programs:** All medical care is the responsibility of the program’s physician(s).

16. **For opioid treatment programs:** The program’s medical director is a physician licensed in the jurisdiction where the program is located.
Standard LD.02.01.01
The mission, vision, and goals of the organization support the safety and quality of care, treatment, or services.

Rationale for LD.02.01.01
The primary responsibility of leaders is to provide for the safety and quality of care, treatment, or services. The purpose of the organization’s mission, vision, and goals is to define how the organization will achieve safety and quality. The leaders are more likely to be aligned with the mission, vision, and goals when they create them together. The common purpose of the organization is most likely achieved when it is understood by all who work in or are served by the organization.

Elements of Performance for LD.02.01.01
1. Leaders work together to create the organization’s mission, vision and goals.

Standard LD.03.06.01
Those who work in the organization are focused on improving safety and quality.

Rationale for LD.03.06.01
The safety and quality of care, treatment, or services are highly dependent on the people who work in the organization. The mission, scope, and complexity of services define the design of work processes and the skills and number of persons needed. In a successful organization, work processes and the environment make safety and quality paramount. This standard, therefore, applies to all those who work in or for the organization, including staff and licensed independent practitioners.

Elements of Performance for LD.03.06.01
3. Leaders provide for a sufficient number and mix of staff to support safe, quality care, treatment, or services.
Standard LD.04.01.01

The organization complies with law and regulation.

Elements of Performance for LD.04.01.01

1. The organization is licensed, is certified, or has a permit, in accordance with law and regulation, to provide the care, treatment, or services for which the organization is seeking accreditation from The Joint Commission. (See also WT.01.01.01, EP 1; WT.04.01.01, EP 1)

2. The organization provides care, treatment, or services in accordance with licensure requirements, laws, and rules and regulations.

14. For opioid treatment programs: The program complies with Occupational Safety and Health Administration (OSHA) workplace health and safety standards.

Standard LD.04.01.05

The organization effectively manages its programs or services.

Rationale for LD.04.01.05

Leaders at the program or service level create a culture that enables the organization to fulfill its mission and meet its goals. They support staff and instill in them a sense of ownership of their work processes. Leaders may delegate work to qualified staff, but the leaders are responsible for the care, treatment, or services provided in their areas.

Elements of Performance for LD.04.01.05

16. For opioid treatment programs: Physicians have authority over the medical and nursing aspects of medication-assisted treatment and retain autonomy so as to ensure ongoing medical decisions are individualized according to the needs of each patient, the clinical course of treatment, and the standards of medical practice.

17. For opioid treatment programs: In programs where either could occur, the program clearly distinguishes between patients who are cared for by a physician in accordance with the rules under DATA 2000 and those who are cared for in an OTP facility in accordance with 42 CFR 8.12.
18. **For opioid treatment programs:** The program’s medical director is responsible for assuring all medical, psychiatric, nursing, pharmacy, toxicology, and other services offered by the program are conducted in compliance with federal regulations at all times.

19. **For opioid treatment programs:** The medical director is present at the program a sufficient number of hours to assure regulatory compliance and carry out those duties specifically assigned to the medical director by law and regulation.

20. **For opioid treatment programs:** The medical director either directly provides the required services to the program’s patients or assures that the needed services are provided by appropriately trained and licensed providers in compliance with federal and state regulation.

21. **For opioid treatment programs:** The day-to-day management of the program is assigned to the program director or manager who assumes the duties assigned by the program sponsor.

   **Note:** In some programs, the program sponsor may also serve as the program director or manager.

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**Standard LD.04.01.09**

Policies and procedures guide the provision of program services and define the goals and scope of services offered.

**Elements of Performance for LD.04.01.09**

1. **For opioid treatment programs:** Procedures are in place to ensure continuity of care for patients in the event of the voluntary or involuntary closure of the program. The procedures provide for orderly transfer of patients, records, and assets to other programs or practitioners.

2. **For opioid treatment programs:** The program’s written policies provide for assigning female patients to counselors who are sensitive to and trained to address their individual needs, such as domestic violence or sexual abuse.

3. **For opioid treatment programs:** The program establishes written policies and procedures for follow-up primary care of new mothers and well-baby care for their infants.
4. **For opioid treatment programs:** Written policies and procedures apply equally to women with concurrent HIV infection or HIV diagnosis, regardless of whether they are pregnant. These women receive the same services and treatment opportunities.

5. **For opioid treatment programs:** The program offers treatment for groups organized with their special needs in mind, such as gender, sexual minority, seniors, and language.

6. **For opioid treatment programs:** The option of participation in groups comprised of the same sex is available to all patients.

7. **For opioid treatment programs:** The program does not limit the psychosocial services offered to patients receiving “0” dose levels.

9. **For opioid treatment programs:** Policies and procedures are reviewed and recertified at least annually.

10. **For opioid treatment programs:** Programs providing treatment with multiple medications using both the OTP and office-based opioid treatment (OBOT) models of service delivery develop clear written policies and procedures for assigning patients to a specific model and establish criteria for determining a specific pharmacotherapy.

11. **For opioid treatment programs:** If the program offers inpatient detoxification services, it develops written policies and procedures to provide the service so that treatment can be matched to the individual needs and preferences of the patient. These include careful review of the risks and benefits of detoxification; obtaining thorough informed consent from patients choosing this treatment option; and providing accompanying relapse prevention counseling, overdose prevention education (may include an FDA-approved naloxone kit), and aftercare plans that include a strategy to transition to medication-assisted treatment if needed.

**Standard LD.04.01.11**

The organization makes space and equipment available as needed for the provision of care, treatment, or services.

**Note:** This standard is applicable only to those settings that are under the control of the behavioral health care organization.
Rationale for LD.04.01.11
The resources allocated to services provided by the organization have a direct effect on an individual’s outcomes. Leaders should place highest priority on high-risk or problem-prone processes that can affect an individual’s safety. Examples include infection control, medication management, and others defined by the organization.

Elements of Performance for LD.04.01.11
5. The leaders provide for equipment, supplies, and other resources.

Standard LD.04.02.03
Ethical principles guide the organization’s business practices.

Elements of Performance for LD.04.02.03
7. Individuals served receive information about charges for which they will be responsible.

Standard LD.04.03.05
Services are defined through the collaboration of the organization’s leaders with leaders of the various communities served by the organization and other external organizations.

Rationale for LD.04.03.05
For opioid treatment programs: As part of the planning process, the organization determines which essential services it will provide directly to patients based on their identified needs and in compliance with applicable law and regulation. The organization can decide to provide some services through referral, consultation, or contractual agreement.

Services are provided, or referrals made, for patients who have coexisting health and psychosocial issues. Coexisting health and psychosocial issues or needs can include the following:
- Learning problems
- Medical problems
- Chronic pain disorder
- Mental health and family problems
- Use or abuse of multiple drugs and/or alcohol
- HIV or other sexually transmitted diseases
- Infectious diseases
- Pregnancy and prenatal care
Vocational and employment needs

Legal services needs

When possible, comorbidities are concurrently managed on site. Coexisting conditions, especially in patients from disenfranchised populations, are most effectively treated at a single site.

**Note 1:** Managing chronic pain includes consulting with a specialist in pain medicine, when possible and appropriate.

**Note 2:** Programs should establish a mechanism to evaluate mental health medication jointly with the mental health provider. If possible and indicated, programs may even dispense such medications in conjunction with the daily methadone dose.

**Elements of Performance for LD.04.03.05**

4. **For opioid treatment programs:** The program selects its location based on community need and impact.

5. **For opioid treatment programs:** The program solicits input from the community and uses both solicited and unsolicited input from the community to determine the program’s impact in the neighborhood.

6. **For opioid treatment programs:** The program obtains input from patients related to identified community concerns, and considers both patient and community input when developing or revising its policies and procedures.

7. **For opioid treatment programs:** The program has written policies and procedures that address community problems (such as patient loitering and medication diversion). Program operations do not adversely affect community life.

8. **For opioid treatment programs:** The program establishes a liaison with community leaders in order to foster good relations.

**Note:** Examples of community leaders include publicly elected representatives; local health, substance abuse, and social and/or human service agency directors; business organization leaders; community and health planning agency directors; grassroots community organization leaders; local police and law enforcement officials; and religious and spiritual leaders.
9. ⑤ For opioid treatment programs: The program has a written community relations plan that is specific to the configuration and needs of the program within its community.

10. For opioid treatment programs: The community relations plan includes goals and procedures and identifies the program staff who will function as community relations coordinators.

11. For opioid treatment programs: The community relations plan addresses how the program will establish a liaison with the community representatives to share information about the program, the community, and mutual issues.

12. For opioid treatment programs: The community relations plan addresses how the program will serve as a community resource on substance abuse and related health and social issues as well as how it will promote the benefit of medication-assisted treatment in preserving public health.

13. ⑥ For opioid treatment programs: The program documents its community relations efforts and community contacts.

14. For opioid treatment programs: The program evaluates its community relations efforts over time and addresses any outstanding problems.

15. For opioid treatment programs: The program’s building is clean and orderly, and the physical setting does not impede pedestrian or traffic flow.

16. For opioid treatment programs: The program has a communication mechanism so that interested parties and potential patients can obtain general information about the program outside regular operating hours.

**Standard LD.04.04.05**

The organization has an organizationwide, integrated safety program for individuals served.

**Elements of Performance for LD.04.04.05**

5. As part of the safety program, the leaders create procedures for responding to system or process failures.

   **Note 1:** Responses might include continuing to provide care, treatment, or services to those affected, containing the risk to others, and preserving factual information for subsequent analysis.
Note 2: For opioid treatment programs: Examples of reportable patient deaths include the following:
- Drug-related deaths
- Methadone or buprenorphine deaths
- Unexpected or suspicious deaths
- Treatment-context deaths that raise individual, family, community, or public concern

6. The leaders provide and encourage the use of systems for blame-free internal reporting of a system or process failure, or the results of a proactive risk assessment. (See also LD.03.01.01, EP 8; LD.03.04.01, EP 5; LD.04.04.03, EP 3)

Note: This EP is intended to minimize staff reluctance to report errors in order to help an organization understand the source and results of system and process failures. The EP does not conflict with holding individuals accountable for their blameworthy errors.

7. The leaders define patient safety event and communicate this definition throughout the organization.

Note: At a minimum, the organization’s definition includes those events subject to review in the “Sentinel Events” (SE) chapter of this manual. The definition may include any process variation that does not affect the outcome or result in an adverse event, but for which a recurrence carries significant chance of resulting in a serious adverse outcome or an adverse event, often referred to as a close call or near miss.

8. The organization conducts thorough and credible comprehensive systematic analyses (for example, root cause analyses) in response to sentinel events as described in the “Sentinel Events” (SE) chapter of this manual.

Medication Management (MM)

Standard MM.01.01.01
The organization plans its medication management processes.

Note: This standard is applicable to organizations that engage in any of the medication management processes.
Rationale for MM.01.01.01
Medication management is often complicated, involving many staff and processes. For this reason, the organization plans each part of the process with care so that safety and quality are maintained. This planning may involve the coordinated efforts of multiple staff.

Elements of Performance for MM.01.01.01

1. For organizations that engage in any aspect of the medication management process: The organization has a written policy that describes that the following information about the individual served is accessible to staff who participate in the medication management process: 
   - Age
   - Sex
   - Diagnoses/conditions
   - Allergies
   - Sensitivities
   - Height and weight (when necessary)
   - Drug and alcohol use and abuse
   - Current medications
   - Pregnancy and lactation information (when necessary)
   - Any additional information required by the organization

   (See also IM.02.01.01, EP 3)

   Note: This element of performance is also applicable to sample medications.

2. For organizations that engage in any aspect of the medication management process: The organization implements its policy to make information about the individual served accessible to prescribers and staff who participate in the management of the individual’s medications.

   Note 1: This element of performance does not apply in emergency situations.

   Note 2: This element of performance is also applicable to sample medications.

Standard MM.01.01.03
The organization safely manages high-alert and hazardous medications.

Note: This standard is applicable to organizations that engage in any of the medication management processes.
Rationale for MM.01.01.03

High-alert medications are those medications that bear a heightened risk of causing significant harm to an individual served and/or sentinel events when they are used in error and, as a result, require special safeguards to reduce the risk of errors. Examples of high-alert medications include opioids, insulin, anticoagulants, and neuromuscular blocking agents. Lists of high-alert medications are available from organizations such as the Institute for Safe Medication Practices (ISMP).²

Hazardous drugs and medications are those in which studies in animals or humans indicate that exposure to them has a potential for causing cancer, developmental or reproductive toxicity, genotoxicity, or harm to organs. An example of a hazardous drug is one that contains antineoplastic agents or other ingredients that cause the aforementioned risks. Lists of hazardous drugs are available from the National Institute for Occupational Safety and Health (NIOSH).³

For safe management, the organization needs to develop its own lists of both high-alert medications and hazardous drugs. These should be based on the organization’s unique utilization patterns, its own internal data about medication errors and sentinel events, and known safety issues published in professional literature. It is up to the organization to determine whether medications that are new to the market are high alert or hazardous. In addition, the organization may separately choose to include other drugs that require special precautions such as investigational medications, controlled substances, and psychotherapeutic medications.

Elements of Performance for MM.01.01.03

7. Ⓞ For opioid treatment programs: On a daily basis, the program documents the total number of milligrams of medication dispensed. R

8. Ⓞ For opioid treatment programs: The program creates an ongoing accurate inventory of all medications received, dispensed, and disposed. R

9. Ⓞ For opioid treatment programs: The program has a written diversion control plan. R

10. For opioid treatment programs: The diversion control plan includes a mechanism for periodic monitoring of clinical and administrative activities to reduce the risk of medication diversion. R

² For a list of high-alert medications, see http://www.ismp.org/Tools/highAlertMedicationLists.asp.
³ For a list of hazardous drugs, see https://www.cdc.gov/niosh/docs/2016-161/pdfs/2016-161.pdf.
Note: One mechanism for monitoring might be to have security or staff regularly walk around the clinic’s hallways, alleys, and parking lot to assess whether there is a loitering or diversion problem close to the treatment site. Another example is to examine both dosing and take-home dispensing practices to identify potential weaknesses that could lead to diversion problems. Additionally, the program could periodically consult with law enforcement in the community and in areas where patients live to discuss the perceived and actual problems encountered.

12. For opioid treatment programs: The program obtains patient input on the program’s policies and procedures regarding its diversion control plan (DCP), and how those policies and procedures are implemented.

13. For opioid treatment programs: The program develops written policies and procedures to govern the use of and response to prescription drug monitoring program (PDMP) information for diversion control.

Standard MM.03.01.01
The organization safely stores medications.

Note: This standard is applicable only to organizations that store medications at their sites.

Rationale for MM.03.01.01
Medication storage is designed to assist in maintaining medication integrity, promote the availability of medications when needed, minimize the risk of medication diversion, and reduce potential dispensing errors. Law and regulation and manufacturers’ guidelines further define the organization’s approach to medication storage including guidelines for medications that require refrigeration.

Elements of Performance for MM.03.01.01

2. For organizations that store medications: The organization stores medications according to the manufacturers’ recommendations or a pharmacist’s instructions. R

Note: This element of performance is also applicable to sample medications.

3. For organizations that store medications: The organization stores controlled (scheduled) medications to prevent diversion, in accordance with law and regulation. R

Note: This element of performance is also applicable to sample medications.
4. **For organizations that store medications:** The organization has a written policy addressing the control of medication between receipt by staff and administration of the medication, including safe storage, handling, wasting, security, disposition, and return to storage.

   **Note:** This element of performance is also applicable to sample medications.

5. **For organizations that store medications:** The organization safely handles medications between receipt by staff and administration of the medications.

   **Note:** This element of performance is also applicable to sample medications.

6. **For organizations that store medications:** The organization prevents unauthorized individuals from accessing medications in accordance with its policy and law and regulation.

   **Note:** This element of performance is also applicable to sample medications.

7. **For organizations that store medications:** The organization labels stored medications with the contents, expiration date, and any applicable warnings provided by the pharmacy.

   **Note:** This element of performance is also applicable to sample medications.

8. **For organizations that store medications:** The organization removes all expired, damaged, and/or contaminated medications and stores them separately from medications available for administration. *(See also MM.05.01.19, EP 1)*

   **Note:** This element of performance is also applicable to sample medications.

18. **For organizations that store medications:** The organization inspects all medication storage areas periodically, as defined by the organization, to verify that medications are stored properly.

   **Note:** This element of performance is also applicable to sample medications.

25. **For opioid treatment programs:** The program stores methadone and buprenorphine separately from other medications.

   **Note:** Methadone and buprenorphine may be stored together in the same safe, with each product documented in a separate inventory.
**Standard MM.03.01.03**
The organization safely manages emergency medications and supplies.

**Rationale for MM.03.01.03**
Emergencies involving individuals served occur occasionally in behavioral health care settings. The organization, therefore, needs to plan how it will address such emergencies and what medications and supplies it will need, if any. Although the processes may be different, the organization treats emergency medications with the same care for safety as it does medications in nonemergency settings.

**Elements of Performance for MM.03.01.03**
1. Organization leaders decide which, if any, emergency or first aid medications and their associated supplies will be readily accessible in areas used to provide care, treatment, or services, based on the population(s) served.

**Standard MM.04.01.01**
Medication orders are clear and accurate.

**Note:** This standard is applicable only to organizations that prescribe medications. The elements of performance in this standard do not apply to prescriptions written by a prescriber who is not affiliated with the organization.

**Elements of Performance for MM.04.01.01**
1. For organizations that prescribe medications: The organization has a written policy that identifies the specific types of medication orders that it deems acceptable for use.

**Note:** There are several different types of medication orders. Medication orders commonly used include the following:
- As needed (PRN) orders: Orders acted on based on the occurrence of a specific indication or symptom
- Standing orders: A prewritten medication order and specific instructions from the prescriber to administer a medication to an individual in clearly defined circumstances as specified in the instructions
- Automatic stop orders: Orders that include a date or time to discontinue a medication
- Taper orders: Orders in which the dose is decreased by a particular amount with each dosing interval
- **Range orders**: Orders in which the dose or dosing interval varies over a prescribed range, depending on the situation or status of the individual served.

- **Signed and held orders**: New prewritten (held) medication orders and specific instructions from a licensed independent practitioner to administer medication(s) to an individual served or patient in clearly defined circumstances that become active upon the release of the orders on a specific date(s) and time(s).

- **Orders for medication-related devices** (for example, inhalers, nebulizers, glucometers).

- **Orders for investigational medications**.

- **Orders for herbal products**.

- **Orders for medications at discharge or transfer**.

13. **For organizations that prescribe medications**: The organization implements its policies for medication orders.

16. **For opioid treatment programs**: The program provides therapeutic doses of medications for each individual patient as determined by the program physician. Programwide dosage caps or ceilings are not used.

   **Note**: Opioid maintenance therapy has three desired effects: preventing onset of signs of opioid abstinence for at least 24 hours, reducing or eliminating drug hunger or craving, and blocking effects of illicitly acquired or self-administered opiates.

17. **For opioid treatment programs**: Each dose of opioid medication is individually determined by the physician and based on the package insert. Deviations from the approved labeling are documented by the physician.

18. **For opioid treatment programs**: When the patient requires a medication that is not provided by the program, the program makes a referral that meets the needs and preferences of the patient.

19. **For opioid treatment programs**: The initial methadone dose for a newly admitted pregnant patient and the subsequent induction and maintenance dosing strategy reflect the same dosing protocols used for all other patients.

20. **For opioid treatment programs**: The duration or the dosage level of medication is based only on clinical indications.
23. **For opioid treatment programs:** The initial full-day dose of methadone is based on current guidelines and the physician’s evaluation of the patient’s history and present condition, and on knowledge of local conditions such as the relative purity of available street drugs.

   **Note:** The initial dose needs to be reflective of the patient’s drug use history and should be the lowest dose possible. Current Center for Substance Abuse Treatment guidelines recommend that for each new patient, the initial dose of methadone is not to exceed 30 mg and the total dose for the first day is not to exceed 40 mg, unless the program physician documents in the patient’s clinical/case record that 40 mg did not suppress withdrawal symptoms.

24. **For opioid treatment programs:** A physician assesses the patient and adjusts the medication dosage as needed when the program switches from one generic formulation to another and differences in the effective dose cause clinically relevant complaints.

   **Note:** Caution should also be exercised when a patient has missed several doses of medication because his or her tolerance may have changed.

25. **For opioid treatment programs:** The program prohibits the use of standing orders regarding the dose, schedule, or re-administration of methadone because of the unique pharmacologic properties, the well-established potential for fatalities in the induction period, and the risk of relapse during medically supervised withdrawal.

26. **For opioid treatment programs:** A physician may write a very short cascading order incorporating a clinical opiate withdrawal scale (COWS) score or other objective measure in order to titrate the dose of a specific individual only if appropriately trained and qualified staff (as determined by licensing criteria or credentialing) are available to evaluate the ongoing appropriateness of the physician’s treatment plan and recognize the need for the patient to be re-evaluated prior to completion of the full course of the order.

27. **For opioid treatment programs:** The program’s physicians and other health care providers, as permitted, register to use their state’s prescription drug monitoring program (PDMP) and query it for each newly admitted patient prior to initiating dosing.
Standard MM.05.01.01
The organization reviews the appropriateness of all medication orders for medications to be dispensed in the organization.

Note: This standard is applicable only to organizations that operate a pharmacy.

Elements of Performance for MM.05.01.01

4. **For organizations that operate a pharmacy:** All medication orders are reviewed for the individual’s allergies or potential sensitivities. R

5. **For organizations that operate a pharmacy:** All medication orders are reviewed for existing or potential interactions between the medication ordered, food, alcohol, and medications the individual served is currently taking. R

6. **For organizations that operate a pharmacy:** All medication orders are reviewed for the appropriateness of the medication, dose, frequency, and route of administration. R

7. **For organizations that operate a pharmacy:** When clinically indicated, medication orders are reviewed for current or potential impact as indicated by laboratory values. R

8. **For organizations that operate a pharmacy:** All medication orders are reviewed for therapeutic duplication. R

9. **For organizations that operate a pharmacy:** All medication orders are reviewed for other contraindications (for example, age, medical conditions, body weight). R

11. **For organizations that operate a pharmacy:** After the medication order has been reviewed, all concerns, issues, or questions about the order are clarified with the prescriber before dispensing. R

Standard MM.05.01.11
The organization safely dispenses medications.

Note: This standard is applicable only to organizations that operate a pharmacy.
Elements of Performance for MM.05.01.11

7. **For opioid treatment programs:** Doses of methadone or other approved medications are adjusted as needed if a program switches from one generic formulation to another and differences in effective dose cause clinically relevant complaints. 

8. **For opioid treatment programs:** A procedure is established for calibrating medication dispensing instruments consistent with manufacturers’ recommendations in order to ensure accurate patient dosing and substance tracking.

9. **For opioid treatment programs:** The program authorizes appropriate staff members to dispense methadone and buprenorphine to patients admitted for treatment.

Standard MM.05.01.13

The organization safely obtains medications when the pharmacy is closed.

**Note:** This standard is applicable only to organizations that operate a pharmacy.

Elements of Performance for MM.05.01.13

8. ☐ **For opioid treatment programs:** The program maintains an up-to-date written plan for emergency administration of medications in the event the program must be closed temporarily. The plan describes how patients will be informed of these emergency arrangements.

9. **For opioid treatment programs:** Medication dosages and other pertinent patient information are available on a 24-hour, 7-day-a-week basis in case of patient emergency.

Standard MM.06.01.01

The organization safely administers medications.

**Note:** This standard is applicable only to organizations that administer medications.

Elements of Performance for MM.06.01.01

7. **For organizations that administer medications:** Before administration, the staff member administering the medication verifies that the medication is being administered at the proper time, in the prescribed dose, and by the correct route.
Note: For opioid treatment programs: Medications that are best administered by directly observed therapy (DOT)—such as tuberculosis and psychiatric medications—can be given at the same time as the opioid dose.

11. For opioid treatment programs: Every dose of medication is recorded on an administration sheet at the time the dose is administered or dispensed, and recorded on the patient’s individual medication dose history.

Standard MM.06.01.03
Self-administered medications are administered safely and accurately.

Note: The term “self-administered medication(s)” may refer to medications administered by a family member.

Elements of Performance for MM.06.01.03

5. For organizations that allow self-administration of medications: When the individual’s medications are prescribed or dispensed by the organization, the organization educates the individual and his or her family about the anticipated actions and potential side effects of the medication administered. (See also MM.06.01.01, EP 9)

11. For opioid treatment programs: The program’s medical director authorizes procedures for determining the eligibility of patients in comprehensive maintenance treatment for take-home doses of medication that include consideration of the following:

- Absence of recent use of drugs, including alcohol
- Regularity of clinic attendance
- Absence of serious behavior problems at the clinic
- Absence of recent known criminal activity, such as drug dealing
- Stability of the patient’s home environment and social relationships
- Length of time in maintenance treatment
- Assurance that the take-home medication(s) can be safely stored within the patient’s home
- Whether the benefit the patient will derive from decreasing clinic attendance outweighs the potential risks of diversion

Note: A physical is not required to determine eligibility for take-home medication.
12. **For opioid treatment programs:** A multidisciplinary team provides recommendations and input for the physician’s review for decisions allowing take-home medications.

13. **For opioid treatment programs:** The medical director makes certain that the program’s policies for the approval of take-home medication do not create barriers to patients continuing in treatment.

14. **For opioid treatment programs:** A physician makes the final decision on approval for take-home medications and documents the reasons for the decision in the patient’s record.

15. **For opioid treatment programs:** Decisions regarding take-home medications are reviewed periodically (according to the criteria for take-home eligibility and any other clinically relevant factors) and documented in the patient record.

17. **For opioid treatment programs:** There are written policies that guide decisions about additional occurrences of take-home medication on a temporary basis in exceptional circumstances, such as documented family or medical emergencies. The program obtains approval for the exception from the Center for Substance Abuse Treatment.

19. **For opioid treatment programs:** The program has a written policy regarding random call-backs.

20. **For opioid treatment programs:** Take-home medications are packaged in individual, child-proof containers.

21. **For opioid treatment programs:** The patient is informed of his or her responsibility to keep opioid medications secure.

22. **For opioid treatment programs:** The program educates patients receiving unsupervised (take-home) medication about using a locked container to inconspicuously and safely transport take-home medication and store the medication at home.

23. **For opioid treatment programs:** The program records the chain of custody for transporting methadone when a patient is transferring to a different level of care or a new location and the program provides sufficient medication to cover the time until the patient arrives at the new location.

24. **For opioid treatment programs:** The program establishes procedures to accommodate traveling patients.
25. **For opioid treatment programs:** The program develops a standard process to record chain-of-custody of dispensed take-home doses not dispensed directly to the patient.

26. **For opioid treatment programs:** The program determines whether patients who need to travel but do not meet criteria for take-home medications can receive guest dosing.

27. **For opioid treatment programs:** For alcohol use disorders, the program is able to assess patients’ recent use of alcohol via toxicology tests and Breathalyzer results as a means of establishing safety for dosing and take-homes.

**Standard MM.07.01.01**

The organization monitors individuals served to determine the effects of their medication(s).

**Note:** This standard is applicable only to organizations that prescribe or administer medications.

**Elements of Performance for MM.07.01.01**

7. **For opioid treatment programs:** The maintenance dose is individually determined based on monitoring of the effects of the patient’s treatment.  
   
   **Note:** The medication dose and the interval between doses may require adjustments for patients who have concurrent health conditions or atypical metabolic patterns, or if the patient takes other prescribed medications that alter rates of opioid medication metabolism.

8. **For opioid treatment programs:** The program maintains patients who become pregnant during treatment on the pre-pregnancy dosage, if effective, and applies the same medication dosages as used with any other nonpregnant patient.

9. **For opioid treatment programs:** The methadone dose is carefully monitored for pregnant patients. Monitoring is especially important during the third trimester when biological changes, induced by pregnancy, can alter the rate at which methadone is metabolized or eliminated from the system. In these cases, an increased or a split dose may be necessary.

10. **For opioid treatment programs:** The physician evaluates the patient’s stability and response to take-home medication and adjusts the dosage at regular intervals.
11. **For opioid treatment programs**: For women of childbearing potential, the physician conducts an assessment for pregnancy before initiating medically supervised withdrawal. 

12. **For opioid treatment programs**: If a pregnant patient elects to withdraw from methadone and stays in the program, a physician experienced in addiction medicine supervises the withdrawal process with regular fetal assessments as appropriate for gestational age as part of the withdrawal process. The withdrawal is not initiated before 14 weeks or after 32 weeks of gestation.

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**Standard MM.07.01.03**

The organization responds to actual or potential adverse medication events, significant adverse medication reactions, and medication errors.

**Note 1:** *This standard is applicable only to organizations that prescribe or administer medications.*

**Note 2:** *See the Glossary for definitions of “adverse medication event” and “significant adverse medication reaction.”*

**Rationale for MM.07.01.03**

Adverse medication reactions and medication errors place individuals served at considerable risk. To maintain safe, quality care, organizations must have systems in place to respond to and monitor an individual in the event of an adverse medication reaction or medication error.

**Elements of Performance for MM.07.01.03**

2. **For organizations that prescribe or administer medications:** The organization’s written process addresses prescriber notification in the event of a significant adverse medication event, significant adverse medication reaction, or a significant medication error. 

   **Note:** *This element of performance is also applicable to sample medications.*

3. **For organizations that prescribe or administer medications:** The organization complies with internal and external reporting requirements for significant adverse medication events, significant adverse medication reactions, or significant medication errors.

   **Note:** *This element of performance is also applicable to sample medications.*
7. For opioid treatment programs: Medication blood levels are obtained when clinically indicated.

Performance Improvement (PI)

Standard PI.01.01.01
The organization collects data to monitor its performance.

Elements of Performance for PI.01.01.01

16. The organization collects data on the following:
   - Whether the individual served was asked about treatment goals and needs
   - Whether the individual served was asked if his or her treatment goals and needs were met
   - The view of the individual served regarding how the organization can improve the safety of the care, treatment, or services provided

(See also RI.01.01.01, EP 17, for opioid treatment programs)

37. For opioid treatment programs: The program collects data about treatment outcomes and processes.

Note: Examples of data collected include the following:
- Use of illicit opioids, illegal drugs, and the problematic use of alcohol and prescription medications
- Criminal activities and entry into the criminal justice system
- Behaviors contributing to the spread of infectious diseases
- Restoration of physical and mental health and functional status
- Retention in treatment
- Number of patients who are employed
- Abstinence from drugs of abuse

Record of Care, Treatment, and Services (RC)

Standard RC.01.01.01
The organization maintains complete and accurate clinical/case records.
Elements of Performance for RC.01.01.01

5. The clinical/case record contains the information needed to support the diagnosis or condition of the individual served.

6. The clinical/case record contains the information needed to justify the care, treatment, or services provided to the individual served.

7. The clinical/case record contains information that documents the course and result of the care, treatment, or services provided to the individual served.

8. The clinical/case record contains information about the care, treatment, or services provided to the individual served that promotes continuity of care among providers.

11. All entries in the clinical/case record are dated.

Standard RC.01.02.01

Entries in the clinical/case record are authenticated.

Elements of Performance for RC.01.02.01

1. Only authorized staff make entries in the clinical/case record.

3. The author of each clinical/case record entry is identified in the clinical/case record.

4. Entries in the clinical/case record are authenticated by the author. Information introduced into the clinical/case record through transcription or dictation is authenticated by the author.

Note 1: Authentication can be verified through electronic signatures, written signatures or initials, rubber-stamp signatures, or computer key.

Note 2: For paper-based records, signatures entered for purposes of authentication after transcription or for verbal orders are dated when required by law or regulation or organization policy. For electronic records, electronic signatures will be date-stamped.

5. The staff identified by the signature stamp or method of electronic authentication is the only staff who uses it.
Standard **RC.01.03.01**
Documentation in the clinical/case record is entered in a timely manner.

Elements of Performance for **RC.01.03.01**

1. ☐ The organization has a written policy that requires timely entry of information into the clinical/case record. *(See also CTS.04.01.01, EP 4)*

3. The organization implements its policy requiring timely entry of information into the clinical/case record of the individual served.

Standard **RC.01.04.01**
The organization audits its clinical/case records.

Element of Performance for **RC.01.04.01**

1. According to a time frame it defines, the organization reviews its clinical/case records to confirm that the required information is present, accurate, legible, authenticated, and completed on time.

Standard **RC.01.05.01**
The organization retains its clinical/case records.

Elements of Performance for **RC.01.05.01**

1. ☐ The retention time of the clinical/case record is determined by its use and organization policy, in accordance with law and regulation.

Standard **RC.02.01.01**
The clinical/case record contains information that reflects the care, treatment, or services provided to the individual served.

Elements of Performance for **RC.02.01.01**

1. The clinical/case record contains the following demographic information:
   - The name, address, date of birth, and sex of the individual served
   - The name and contact information for the individual’s family and any legally authorized representative
   - The preferred language and any special communication needs of the individual served

   **Note:** *Special communication needs may include sign language.*
2. The clinical/case record of the individual served contains the following clinical information:
   - The reason(s) for admission for care, treatment, or services
   - The initial diagnosis, diagnostic impression(s), or condition(s)
   - Any findings of assessments and reassessments
   - Any allergies to food
   - Any allergies to medications
   - Any conclusions or impressions drawn from the medical history and physical examination
   - Any diagnoses or conditions established during the course of care, treatment, or services
   - Any consultation reports
   - Any observations relevant to care, treatment, or services
   - The response to care, treatment, or services
   - Any emergency care, treatment, or services provided prior to arrival
   - Any progress notes
   - Any medications ordered or prescribed
   - Any medications administered, including the strength, dose, route, date and time of administration
   - Any access site for medication, administration devices used, and rate of administration (for intravenous therapy)
   - Any adverse drug reactions
   - Treatment goals, plan of care, and revisions to the plan of care, treatment, or services
   - Orders for diagnostic and therapeutic tests and procedures and their results

4. As needed to provide care, treatment, or services, the clinical/case record contains the following additional information:
   - Any advance directives
   - Any informed consent
   - Any documentation of protective services
   - Any documentation of consent by the individual served, family, or guardian for admission; care, treatment, or services; evaluation; continuing care; or research
   - Any records of communication with the individual served, such as telephone calls or e-mail
Any documentation of involvement in care, treatment, or services by the individual served and, when necessary, his or her family

Any information on unusual occurrences, such as complications; accidents or injuries to the individual served; procedures that place the individual served at risk or cause pain; other illnesses or conditions that affect care, treatment, or services; or the death of the individual served

Any indications for and episodes of special procedures

**Standard RC.02.04.01**
The organization documents the discharge information of the individual served.

**Element of Performance for RC.02.04.01**

3. The clinical/case record contains the following:
   - A concise discharge summary that includes the reason for acceptance for care, treatment, or services
   - The care, treatment, or services provided
   - The condition at discharge of the individual served
   - Information provided to the individual served and his or her family (for example, written discharge instructions, medication regimen, follow-up care)

**Note 1:** A discharge summary is not required when individuals served are seen for brief interventions, as defined by the clinical staff. In these instances, a final progress note may be substituted for the discharge summary.

**Note 2:** When individuals served are transferred to a different program within the organization, and staff change, a transfer summary may be substituted for the discharge summary. If the staff do not change, a progress note may be used.

**Rights and Responsibilities of the Individual (RI)**

**Standard RI.01.01.01**
The organization respects the rights of the individual served.
Rationale for RI.01.01.01
This standard focuses on how the organization respects the rights of the individual served during his or her encounter with the organization. This encounter is characterized by viewing the individual as a whole person, not merely as a condition or illness to manage. Because the quality of the relationship between the provider and the individual can have an impact on the individual’s effective participation in care, treatment, or services, this relationship should be respectful and not biased by the individual’s diagnosis or condition. A mere list of rights cannot guarantee the rights of the individual. An organization puts its respect for the individual’s rights into action through its policies and procedures and the ways that staff interact with the individual and involve him or her in care, treatment, or services.

Elements of Performance for RI.01.01.01
1. The organization has written policies on the rights of the individual served.
2. The organization informs the individual served of his or her rights. *(See also RI.01.01.03, EPs 1–3)*
3. The program reviews rights and responsibilities with the patient at admission, at the end of the stabilization period, and when any changes have been made to the list of rights and responsibilities.
4. The organization treats the individual served in a respectful manner that supports his or her dignity.
5. The organization respects the cultural and personal values, beliefs, and preferences of the individual served.
6. The organization respects the right of the individual served to privacy. *(See also IM.02.01.01, EPs 1–4)*

**Note:** This element of performance (EP) addresses the personal privacy of the individual served. For EPs addressing security and safety, please see EC.02.01.01, EP 3 and EC.02.06.01, EP 1. For EPs addressing the privacy of health information, please refer to Standard IM.02.01.01.

10. In accordance with law and regulation, the organization allows the individual served to access and request amendment to his or her health information and to obtain information on disclosures of this information.
14. For opioid treatment programs: The program reviews rights and responsibilities with the patient at admission, at the end of the stabilization period, and when any changes have been made to the list of rights and responsibilities.
15. For opioid treatment programs: The program treats women respectfully and safely.
16. **For opioid treatment programs:** The medication schedule (dosing times/program hours) is the least intrusive and disruptive schedule for the majority of patients.

17. **For opioid treatment programs:** Satisfaction surveys allow patients to provide feedback on program policies and services. *(See also PI.01.01.01, EP 16)*

20. ⑤ **For opioid treatment programs:** The program obtains written acknowledgement from patients that they received a copy of their rights and that these rights were discussed with them.

22. The organization informs the individual served of the program rules.

24. **For opioid treatment programs:** The program informs patients about the financial aspects of treatment, including the consequence of nonpayment of fees.

25. ⑥ **For opioid treatment programs:** The program posts patients’ rights and responsibilities at the treatment site in a manner that makes the posting visible to patients.

26. **For opioid treatment programs:** The program informs patients upon admission about its obligation under state-specific requirements and its own policies and procedures to report suspected child abuse and neglect and other forms of abuse (such as violence against women).

**Standard RI.01.01.03**
The organization respects the right of the individual served to receive information in a manner he or she understands.

**Rationale for RI.01.01.03**
Because communication is a cornerstone of safe and quality care, every individual served has the right to receive information in a manner he or she understands. Effective communication allows individuals to participate more fully in their care, treatment, or services. When an individual understands what is being said about his or her care, treatment, or services, he or she is more likely to participate fully in his or her behavioral health care. Communicating effectively with individuals served is also critical to the informed consent process and helps practitioners and organizations give the best possible care. For communication to be effective, the information provided must be accurate, timely, complete, unambiguous, and understood by the individual served. Restrictions to communication should be based only on therapeutic justification.
The individual served has the right to receive information in a manner that he or she understands. Many individuals of varying circumstances require alternative communication methods: individuals who speak and/or read languages other than English; individuals who have limited literacy in any language; individuals who have visual or hearing impairments; individuals with cognitive impairments; and children. The organization has many options available to assist in communication with these individuals, such as interpreters, translated written materials, pen and paper, communication boards, and speech therapy. It is up to the organization to work with the individual served to determine which method works the best for his or her circumstances.

There are laws, regulations, and a body of literature that are relevant to the use of interpreters. These include Title VI of the Civil Rights Act, 1964; Executive Order 13166; policy guidance from the Office of Civil Rights regarding compliance with Title VI, 2004; Title III of the Americans with Disabilities Act, 1990; and state laws (many states have laws and regulations that require the provision of language assistance). Organizations may wish to reference these sources for additional information on providing interpreting and translation services to the individuals they serve.

**Elements of Performance for RI.01.01.03**

1. The organization provides information to the individual served in a manner tailored to his or her language and ability to understand. *(See also CTS.06.02.03, EP 9; RI.01.01.01, EP 2)*

2. The organization provides interpreting and translation services, as necessary. *(See also RI.01.01.01, EP 2)*

**Note:** For organizations that elect The Joint Commission Behavioral Health Home option: Language interpreting options may include trained bilingual staff, contract interpreting services, or employed language interpreters. These options may be provided in person or via telephone or video. The documents that are translated, and the languages into which they are translated, are dependent on the population(s) served by the organization.

3. The organization communicates with the individual served who has vision, speech, hearing, or cognitive impairments in a manner that meets the needs of that individual. *(See also RI.01.01.01, EP 2)*
Standard RI.01.02.01
The organization respects the right of the individual served to collaborate in decisions about his or her care, treatment, or services.

Rationale for RI.01.02.01
Effective behavioral health care requires the involvement of individuals served, and their families or surrogate decision-makers where necessary. An understanding of the care, treatment, or service goals, of how various activities support these goals, and of unexpected outcomes or issues will enhance decision making and assist in preventing or resolving problems in care, treatment, or services.

Elements of Performance for RI.01.02.01

1. The organization involves the individual served in making decisions about his or her care, treatment, or services.

Note: This involvement goes beyond mere presence at the time of discussion or decision making. Involvement connotes a collaborative process in which the organization actively engages the individual served in decision making regarding his or her care, treatment, or services.

2. When an individual served is unable to make decisions about his or her care, treatment, or services, or chooses to delegate decision making to another, the organization involves the surrogate decision maker in making these decisions. (See also RI.01.03.01, EP 1; RI.01.01.01, EP 18)

8. The individual served has the right to involve his or her family in decisions about care, treatment, or services. When there is a surrogate decision-maker, he or she can exercise the right to involve the family on behalf of the individual served, in accordance with law and regulation. (See also RI.01.07.01, EP 2; CTS.04.02.16, EP 5)

28. For opioid treatment programs: The program allows for patient choice in seeking alternative therapies and provides support to patients who choose to explore these alternatives.

Note: Programs may provide culturally appropriate or popular and nonharmful alternative therapies, such as acupuncture or providing a space for a sweat lodge.

34. For opioid treatment programs: The program provides the patient with information about providers in the community who are able to address any of the patient’s needs that the program cannot meet.
35. **For opioid treatment programs:** The program provides the patient with information about providers in the community should the patient be dissatisfied with the services received from the program.

**Standard RI.01.03.01**
The organization honors the right of the individual served to give or withhold informed consent.

**Rationale for RI.01.03.01**
Obtaining informed consent presents an opportunity to establish a mutual understanding between the individual served and the staff about the care, treatment, or services that the individual will receive. Informed consent is not merely a signed document. It is a process that considers needs and preferences of the individual and is in compliance with law and regulation. Utilizing the informed consent process helps the individual to participate fully in decisions about his or her care, treatment, or services. If an individual refuses to give informed consent, and is posing a threat to himself or herself or others, the organization may be permitted, in accordance with law and regulation, to take an alternative course of action, including providing care, treatment, or services without informed consent.

**Elements of Performance for RI.01.03.01**

2. The informed consent process includes a discussion about the following:
   - The proposed care, treatment, or services for the individual served.
   - The goals and potential benefits and risks of the proposed care, treatment, or services.
   - Reasonable alternatives to the individual’s proposed care, treatment, or services. The discussion encompasses risks and benefits related to the alternatives and the risks related to not receiving the proposed care, treatment, or services.

16. **For opioid treatment programs:** Before administering medication, the program obtains voluntary, written, informed consent from the patient for the prescribed medication-assisted treatment. The program’s informed consent policy makes certain that each patient voluntarily chooses maintenance treatment and that all relevant facts concerning the use of the opioid drug are clearly and adequately explained to the patient. Within 30 days post-admission, an appropriate program staff member reviews all relevant facts concerning the use of the opioid drug with the patient.
17. **For opioid treatment programs:** The program informs patients that the goal of medication-assisted treatment is to stabilize functioning.

18. **For opioid treatment programs:** The program informs patients that the provider will periodically discuss with them their present level of functioning, course of treatment, and future goals.

   **Note:** These discussions are not intended to place pressure on the patient to either withdraw from medication or remain on medication maintenance.

19. **For opioid treatment programs:** Patients are informed about their disease’s natural progression, including statistics about success after withdrawing from methadone.

20. **For opioid treatment programs:** The program informs patients about potential medication interactions with and adverse reactions to other substances, including those related to the use of alcohol, licit and illicit drugs, other prescribed or over-the-counter pharmacological agents, other medical procedures, and food.

   **Note:** The program should provide the patient with information about potential medication interactions throughout the course of care, treatment, or services, such as at the time of the treatment plan review and at the time there are changes to the patient’s medication dose.

21. **For opioid treatment programs:** The program informs all pregnant patients with concurrent HIV infection that HIV medication treatment is currently recommended to reduce perinatal transmission, and it provides pregnant patients with appropriate referrals and case management for this treatment.

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**Standard RI.01.03.05**

The organization protects the individual served and respects his or her rights during research, investigation, and clinical trials.

**Note:** This standard applies when organizations conduct or permit individuals served to participate in research investigations or clinical trials.
Rationale for RI.01.03.05
An organization that conducts (or permits within its organization) research, investiga-
tions, or clinical trials involving human subjects knows that its first responsibility is to
the health and well-being of the research subjects. To protect and respect the research
subjects’ rights, the organization reviews the research protocols. If another institution’s
Institutional Review Board (IRB) reviews the research protocols, the organization does
not need to perform this activity.

Note: The federal human subject protection standards generally assume that (1) all
participation in new interventions is voluntary; (2) confidentiality of client records and
research data is assured; (3) written, informed consent is obtained; (4) the risks/benefits of
participation are explained to participants; (5) participation does not jeopardize ongoing
treatment; and (6) the research does not impose an undue burden on participants. (The full
federal human subject protection standards are published in 45 CFR, Part 46.)

Elements of Performance for RI.01.03.05

2. To help the individual served determine whether or not to participate in research,
investigation, or clinical trials, the organization either provides the individual
with all of the following information or confirms that the individual is provided
with this information by the principal investigator:
• An explanation of the purpose of the research
• The expected duration of the individual’s participation
• A clear description of the procedures to be followed
• A statement of the potential benefits, risks, discomforts, and side effects
• Alternative care, treatment, or services available that might prove advan-
tageous to the individual

3. The organization informs the individual served that refusing to participate in
research, investigation, or clinical trials or discontinuing participation at any time
will not jeopardize his or her access to care, treatment, or services unrelated to the
research.

4. The organization documents the following in the research consent form:
• That the individual served received information to help determine whether or
  not to participate in the research, investigation, or clinical trials
• That the individual served was informed that refusing to participate in
  research, investigation, or clinical trials or discontinuing participation at any
time will not jeopardize his or her access to care, treatment, or services
  unrelated to the research
The individual served has the right to be free from neglect; exploitation; and verbal, mental, physical, and sexual abuse.

**Elements of Performance for RI.01.06.03**

8. **For opioid treatment programs:** The program takes steps to prevent patients from being harassed or exploited by other patients or staff.

**Standard RI.01.07.01**

The individual served and his or her family have the right to have complaints reviewed by the organization.

**Elements of Performance for RI.01.07.01**

1. The organization establishes a complaint resolution process and informs the individual served and his or her family about it.

   **Note:** *If the individual served has a surrogate decision-maker, he or she will be informed of and involved in the complaint resolution process.*

4. The organization reviews and, when possible, resolves complaints from the individual served and his or her family.
7. The organization provides the individual served (and when deemed beneficial, his or her family) with the phone number and address needed to file a complaint with the relevant state authority.

28. ⚫ For opioid treatment programs: The program develops and makes available written policies and procedures addressing patient grievances.

29. ⚫ For opioid treatment programs: The policies and procedures specify the minimum elements of due process applicable based on the program’s setting and resources, and include the following:
   - Providing the patient with a written decision that includes the reason for the decision
   - Maintaining the right of patients to appeal the decision to a final, unbiased source
   - Making every attempt, before a patient is discharged, to accommodate his or her desire to remain in opioid therapy at an alternative treatment program
   - Using involuntary withdrawal only as a last resort and applying it in the most humane manner possible, consistent with the safety and well-being of the patient, staff, and other patients
   - As a result of the patient filing a grievance, not changing the patient’s dose of opioids or other medications without his or her knowledge, unless the patient has signed a document waiving such consent

Standard RI.02.01.01
The organization informs the individual served about his or her responsibilities related to his or her care, treatment, or services.

Rationale for RI.02.01.01
The quality and safety of care, treatment, or services is enhanced when individuals served are partners in the behavioral health care process. In addition, organizations are entitled to reasonable and responsible behavior on the part of individuals (and where necessary, their families). When organizations inform individuals and their families about their responsibilities, the topics that are discussed may include the following:
   - Providing information about present complaints, past and current functioning, hospitalizations, medications, and other matters related to their behavioral and physical health
   - Sharing expectations of and satisfaction with the organization
Asking questions when they do not understand their care, treatment, or services or what they are expected to do

Following instructions for their plan of care, treatment, or services, and expressing concerns about their ability to follow the proposed plan of care, treatment, or services

Accepting consequences for the outcomes of care, treatment, or services if they do not follow the planned care, treatment, or services

Following the organization’s policies and procedures

Showing respect and consideration of organization’s staff and property, as well as other individuals and their property

Meeting financial commitments

Elements of Performance for RI.02.01.01

2. The organization informs the individual served about his or her responsibilities.

   **Note:** Information about the individual’s responsibilities can be shared verbally, in writing, or both.

3. For opioid treatment programs: The program obtains written acknowledgement from the patient that patient responsibilities were explained.
Foster Care (FC)

Overview
This chapter includes the additional standards and elements of performance (EPs) that apply only to foster care, therapeutic foster care and respite care programs. This chapter does not, however, provide a complete list of all the standards and EPs applicable to foster or respite care. The standards and EPs specific to foster or respite care organizations are repeated here to identify additional requirements specific to foster and/or respite care programs. See the “Standards Applicability Process” (SAP) chapter for a detailed guide to identifying all standards applicable to your foster or respite care organization.

The following functions are all part of foster care. The agency may provide one or more of the following functions:
- Removal of the individual from the family or situation (CTS.02.04.09)
- Placement decisions (CTS.02.04.01, CTS.02.04.03, CTS.02.04.11, CTS.02.04.17)
- Working with the individual’s family of origin (RI.03.01.03, CTS.02.04.07)
- Licensing of the foster family (CTS.02.04.05, CTS.02.04.13, CTS.02.04.15, CTS.02.04.19, CTS.02.04.21, EC.02.01.05, RC.03.01.01)
- Foster family recruitment, training, and supervision (RI.03.01.05, CTS.04.02.07, CTS.02.04.13, CTS.02.04.19, CTS.02.04.21, RC.03.01.03)
- Case management (CTS.03.02.03)
- Permanency planning (CTS.03.02.03)
- Respite care (CTS.04.02.09)

These standards apply to all foster care agencies: CTS.03.02.03, LD.02.01.01, LD.03.06.01, LD.04.01.08, LD.04.01.09, PI.01.01.01, RC.03.01.01, RI.03.01.01

These standards apply to respite care meeting the definition in the glossary of this manual: CTS.02.04.03, CTS.02.04.05, CTS.02.04.11, CTS.02.04.13, CTS.02.04.15, CTS.02.04.19, CTS.04.02.09.

The agency surveyed specifies which functions apply to it. The agency is required to meet only the standards applicable to the functions it performs.
Note: These foster care standards apply to traditional foster care as well as to therapeutic or treatment foster care. In traditional foster care, the individual served requires out-of-home placement for protection, shelter or care. Therapeutic or treatment foster care offers comprehensive services to children/youth with serious medical or emotional and behavioral issues or children/youth/adults with intellectual disabilities. Wraparound services may be provided for treatment with foster parents having direct responsibility for implementing selected in-home aspects of the plan of care, treatment, or services.

Standards List
The following is a list of standards with elements of performance specific to foster care. They are presented here for your convenience without footnotes or other explanatory text. If you have a question about a term used here, please check the Glossary.

Care, Treatment, and Services (CTS)

CTS.02.04.01 For foster care: The agency screens and assesses each individual to determine needed services and placement.

CTS.02.04.03 For foster and/or respite care: The agency develops criteria to match a foster or respite home to an individual.

CTS.02.04.05 For foster and/or respite care: The agency assesses each prospective foster parent or respite caregiver to determine whether he or she is eligible to be a foster parent or respite caregiver.

CTS.02.04.07 For foster care of children and youth: The agency assesses the needs of the family of origin.

CTS.02.04.09 For foster care: The agency uses a defined process to determine out-of-home placement decisions.

CTS.02.04.11 For foster and/or respite care: The agency defines and uses criteria to determine the need for foster and/or respite care services.

CTS.02.04.13 For foster and/or respite care: The agency defines and uses criteria to identify prospective foster parents and/or respite caregivers.
**Foster Care**

CTS.02.04.15 **For foster and/or respite care:** The agency develops and uses criteria to determine the number of individuals that can be placed in each foster and/or respite care home.

CTS.02.04.17 **For foster care:** The agency uses guidelines in making placement decisions.

CTS.02.04.19 **For foster and/or respite care:** The agency determines the competence of and how to select foster parents and/or respite caregivers.

CTS.02.04.21 **For foster care for children and youth:** Individuals providing therapeutic foster care services receive ongoing training and supervision to maintain competence.

CTS.03.02.03 **For foster care:** The agency develops and periodically reviews its case plans.

CTS.04.02.07 **For foster care:** The foster parent(s) receives information and education to meet the needs of the individuals placed in his or her care.

CTS.04.02.09 **For foster care:** The respite caregiver receives information needed to meet the needs of the individual placed in his or her care.

**Environment of Care (EC)**

EC.02.01.05 **For foster care:** The agency places individuals in foster care in physically safe environments. Note: This standard applies to foster care agencies that make placement decisions.

**Human Resources Management (HRM)**

HRM.01.05.01 Staff participate in education and training.

HRM.01.06.01 Staff are competent to perform their job duties and responsibilities.

**Leadership (LD)**

LD.02.01.01 The mission, vision, and goals of the organization support the safety and quality of care, treatment, or services.
LD.03.06.01  Those who work in the organization are focused on improving safety and quality.

LD.04.01.08  For foster care: Staff caseloads are consistent with the level of care, treatment, or services provided to recipients of foster care.

LD.04.01.09  Policies and procedures guide the provision of program services and define the goals and scope of services offered.

LD.04.03.01  The organization provides services that meet needs of the individual served.

LD.04.03.07  Individuals with comparable needs receive the same standard of care, treatment, or services throughout the organization.

Performance Improvement (PI)
PI.01.01.01  The organization collects data to monitor its performance.

Record of Care, Treatment, and Services (RC)
RC.03.01.01  For foster care: The agency defines and maintains information specific to the individual served and his or her family for continuity of care and initiation of improvement in its performance.

RC.03.01.03  For foster care: The agency maintains foster family information.

Rights and Responsibilities of the Individual (RI)
RI.03.01.01  For foster care: The foster care agency respects the rights of individuals in foster care.

RI.03.01.03  For foster care: The rights of the family of origin are respected.

RI.03.01.05  For foster care: The agency providing foster care services respects the rights of the foster family.
Additional Standards, Rationales, Elements of Performance, and Scoring for Foster Care

Care, Treatment, and Services (CTS)

Standard CTS.02.04.01

For foster care: The agency screens and assesses each individual to determine needed services and placement.

Elements of Performance for CTS.02.04.01

1. For foster care: Each individual in foster care receives a physical status screening.
2. For foster care: Each individual in foster care receives a developmental status screening.
3. For foster care: Each individual in foster care receives an educational status screening.
4. For foster care: Each individual in foster care receives an emotional status screening.
5. For foster care: Each individual in foster care receives a behavioral status screening.
6. For foster care: Each individual in foster care receives a social status screening.
7. For foster care: Each individual in foster care receives a legal status screening.
8. For foster care: Each individual in foster care receives a spiritual status screening.
9. For foster care: Each individual in foster care receives a cultural and linguistic status screening.
10. For foster care: To the extent possible, the agency collects information about the individual served from the individual in foster care, the foster parents, the child’s or youth’s family of origin, and the guardian.
11. For foster care: The agency provides for a process for rapid assessment (triage) of the child’s or youth’s family resources to determine the appropriateness of foster or kinship care and to develop a preliminary plan.
Note: Family resources can include the family of origin and the extended family.

12. For foster care: The agency develops a preliminary plan based on the triage assessment to meet the needs of the individual in foster care and match the foster home to the individual.

13. For foster care: The agency conducts an assessment to secure stable placement of the individual.

14. For foster care: The agency conducts an assessment within the time frame specified by the needs of the individual in foster care, agency policy, and law and regulation.

15. For foster care: Based on the assessment, the agency determines appropriateness of the match of the individual in foster care to a foster home.

16. For foster care: The agency arranges for the history and physical examination, any laboratory or diagnostic tests, dental examinations, and immunization status confirmation to be performed in a time frame that is in compliance with law and regulation and accommodates the best interest and welfare of the individual in foster care.

17. For foster care: If the state or county agency has done an initial assessment, the foster care agency receives and evaluates this information.

Standard CTS.02.04.03

For foster and/or respite care: The agency develops criteria to match a foster or respite home to an individual.

Elements of Performance for CTS.02.04.03

1. For foster and/or respite care: The agency develops criteria to match a foster or respite home to an individual that is based on an assessment to identify the needs of the individual and an assessment of the qualities of the foster or respite family.

2. For foster and/or respite care: The agency uses the criteria to match a foster or respite home to an individual.

3. For foster and/or respite care: The agency develops criteria to address emergency placements of individuals.

4. For foster and/or respite care: The agency uses the criteria to address emergency placements of individuals.
5. **For foster and/or respite care:** The assessment for emergency placement in foster or respite care contains basic information essential to the safety of the individual and the family.

**Standard CTS.02.04.05**

**For foster and/or respite care:** The agency assesses each prospective foster parent or respite caregiver to determine whether he or she is eligible to be a foster parent or respite caregiver.

**Elements of Performance for CTS.02.04.05**

1. **For foster and/or respite care:** Each prospective foster parent or respite caregiver receives an assessment of his or her capability that includes the following:
   - Physical health.

2. **For foster and/or respite care:** Each prospective foster parent or respite caregiver receives an assessment of his or her capability that includes the following:
   - Emotional capacity.

3. **For foster and/or respite care:** Each prospective foster parent or respite caregiver receives an assessment of his or her capability that includes the following:
   - Interpersonal relationships.

4. **For foster and/or respite care:** Each prospective foster parent or respite caregiver receives an assessment of his or her capability that includes the following:
   - Knowledge of developmental needs.

5. **For foster and/or respite care:** Each prospective foster parent or respite caregiver receives an assessment of his or her capability that includes the following:
   - Financial stability.

6. **For foster and/or respite care:** Each prospective foster parent or respite caregiver receives an assessment of his or her capability that includes the following:
   - Cultural and linguistic evaluations.

7. **For foster and/or respite care:** Each prospective foster parent or respite caregiver receives an assessment of his or her capability that includes the following:
   - A willingness to be educated.
8. **For foster and/or respite care:** Each prospective foster parent or respite caregiver receives an assessment of his or her capability that includes the following:
   Criminal background checks, including background checks on any adult living in the home.

9. **For foster and/or respite care:** The assessment of a prospective foster parent or respite caregiver establishes the following:
   - That the prospective foster parent or respite caregiver is free from any diseases or physical conditions that have been determined to be a detriment to the welfare of the individual in foster or respite care
   - That the prospective foster parent or respite caregiver has the ability to nurture and provide care and supervision to the individual in foster or respite care
   - That the prospective foster parent or respite caregiver demonstrates mental and emotional stability

10. **For foster and/or respite care:** The agency assesses a foster parent or respite caregiver on an ongoing basis, but no less than annually.

   **Note:** This assessment may occur at various times throughout service as a foster parent or respite caregiver, such as at license renewal, when a new individual is placed in the home, when physical arrangements change in the home, or when background checks are necessary for any new adult who moves into the home.

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**Standard CTS.02.04.07**

**For foster care of children and youth:** The agency assesses the needs of the family of origin.

**Elements of Performance for CTS.02.04.07**

1. **For foster care of children and youth:** The agency assesses the family of origin and determines the interventions necessary to keep the children or youth with their families or to reunify children and youth in foster care with their families.

   **Note:** Some of the necessary interventions may include help with communication and problem-solving, parenting skills, behavioral contingencies techniques and skills, daily living skills, housing, child care, health care, mental health care, substance abuse care, family therapy, and employment.
2. **For foster care of children and youth:** Based on the results of the assessment, the family of origin is provided access or referral to care, treatment, or services that would alleviate or mitigate the causes of foster placement.

3. **For foster care of children and youth:** The family-of-origin assessment occurs at intake and regularly thereafter or as directed by the case plan of the placing agency authority.

4. **For foster care of children and youth:** The agency obtains relevant information from the family-of-origin assessment when that assessment is performed by another provider.

5. **For foster care of children and youth:** The family-of-origin assessment is made a part of the child’s or youth’s clinical/case record, and services are coordinated with the agency referring the child or youth.

**Standard CTS.02.04.09**

For foster care: The agency uses a defined process to determine out-of-home placement decisions.

**Elements of Performance for CTS.02.04.09**

1. **For foster care:** The agency clearly delineates the process for making out-of-home placement decisions that may involve protective services, voluntary placement, or court orders.

2. **For foster care:** The agency defines how it plans to carry out the voluntary placement agreement or judicial determination.

**Standard CTS.02.04.11**

For foster and/or respite care: The agency defines and uses criteria to determine the need for foster and/or respite care services.

**Elements of Performance for CTS.02.04.11**

1. **For foster and/or respite care:** The agency defines written criteria to determine the appropriateness of foster and/or respite care for an individual served.

2. **For foster and/or respite care:** The agency uses its criteria to determine the appropriateness of foster and/or respite care for an individual served.
3. For foster and/or respite care: At a minimum, criteria to determine the appropriateness of foster and/or respite care include the following: Safety.

4. For foster and/or respite care: At a minimum, criteria to determine the appropriateness of foster and/or respite care include the following: The need for care for adults and care and protection for children and youth.

5. For foster and/or respite care: At a minimum, criteria to determine the appropriateness of foster and/or respite care include the following: Any need for intensive out-of-home care beyond foster and/or respite care.

6. For foster and/or respite care: At a minimum, criteria to determine the appropriateness of foster and/or respite care include the following: The inability of family or friends to care for the individual.

7. For foster and/or respite care: At a minimum, criteria to determine the appropriateness of foster and/or respite care include the following: The benefits to the individual of family-based care.

8. For foster and/or respite care: Agencies accepting referrals receive and review information from the public or custodial agency as part of intake.

9. For foster and/or respite care: Agencies accepting referrals determine if they can meet the needs of the individual.

**Standard CTS.02.04.13**

**For foster and/or respite care:** The agency defines and uses criteria to identify prospective foster parents and/or respite caregivers.

**Elements of Performance for CTS.02.04.13**

1. For foster and/or respite care: The agency defines written criteria to identify prospective foster parents and/or respite caregivers.

2. For foster and/or respite care: The agency uses its written criteria to identify and select prospective foster parents and/or respite caregivers.

3. For foster and/or respite care: The agency determines a recruitment plan that includes targeting and marketing to attract prospective foster parents or respite caregivers.
Standard CTS.02.04.15

For foster care and/or respite care: The agency develops and uses criteria to determine the number of individuals that can be placed in each foster care and/or respite care home.

Elements of Performance for CTS.02.04.15

1. For foster care and/or respite care: The agency develops written criteria to determine the number of individuals in foster care that can be placed in each foster and/or respite care home.

   Note: Criteria may include the following:
   - The individual’s needs (emotional, developmental, psychological, behavioral, age-related, history of legal involvement, history of mental health needs, special restrictions, special physical care needs)
   - Resources available to the foster parent and/or respite caregiver (education, respite)
   - Support services (for example, extended family support, church support, community support)
   - Anticipated length of placement
   - Special-needs training for foster parents and/or respite caregivers
   - Prior experience as a foster care and/or respite caregiver
   - For children and youth, the number of biological children and number of siblings

2. For foster care: The agency uses its criteria to determine the number of individuals in foster care and/or respite care that can be placed in each home.

3. For foster care: The maximum number of individuals living in each home complies with state and federal law and regulation.

Standard CTS.02.04.17

For foster care: The agency uses guidelines in making placement decisions.

Elements of Performance for CTS.02.04.17

1. For foster care: The agency uses guidelines in making placement decisions.

   Note: Guidelines can either be developed and written by the agency or adopted in accordance with law and regulation.

2. For foster care: Guidelines for making placement decisions include the following:
• Consideration for placing the child or youth with kinship care providers (if an appropriate kinship house can be located) before placing in a non-relative foster care provider
• Consideration for community, schools, visitation, placing siblings together, and the proximity of the child or youth to the family of origin
• Being culturally responsive to the characteristics of both the individual in foster care and the families, to the best of the agency’s ability
• Consideration for any respiratory risks to an individual from passive smoke due to existing health issues, such as asthma
• The utmost consideration for the safety and well-being of the individual in foster care

Note: The individual’s best interest and special needs are paramount when considering placement in close proximity to the parent’s home.

Standard CTS.02.04.19

For foster and/or respite care: The agency determines the competence of and how to select foster parents and/or respite caregivers.

Elements of Performance for CTS.02.04.19

1. For foster and/or respite care: The agency develops a process to determine the competence and selection of foster parents and/or respite caregivers.

2. For foster and/or respite care: The agency follows its process to determine the competence and selection of foster parents and/or respite caregivers.

3. For foster and/or respite care: When determining competence and selection of foster parents and/or respite caregivers, the agency uses the following:
   • The application
   • The applicant’s references
   • Criminal background checks for all adults in the household
   • Child abuse registry checks for children and youth
   • Physical examinations
   • Home inspection reports
   • Language of the family
   • Interviews with foster parents and/or respite caregivers
4. **For foster and/or respite care:** When determining competence and selection of foster parents and/or respite caregivers, the agency uses criteria based on the applicant’s ability to care for individuals with special needs, such as physical or intellectual and developmental disabilities or emotional disturbances.

5. **For foster and/or respite care:** When determining competence and selection of foster parents and/or respite caregivers, the agency uses criteria based on competencies that match the level or type of foster and/or respite care.

6. **For foster and/or respite care:** The agency has a written policy for circumstances under which unlicensed alternative care providers must have a safety check. The policy takes into consideration the level of risk involved with the situation.

### Standard CTS.02.04.21

**For foster care for children and youth:** Individuals providing therapeutic foster care services receive ongoing training and supervision to maintain competence.

#### Elements of Performance for CTS.02.04.21

1. **For foster care for children and youth:** Individuals providing therapeutic foster care services receive ongoing training to maintain competence.

2. **For foster care for children and youth:** Individuals providing therapeutic foster care services receive ongoing supervision to maintain competence.

### Standard CTS.03.02.03

**For foster care:** The agency develops and periodically reviews its case plans.

#### Elements of Performance for CTS.03.02.03

1. **For foster care:** The agency develops a case plan.

2. **For foster care:** The agency evaluates the case plan in a time frame that is in accordance with organization policy and law and regulation.

3. **For foster care:** The agency involves relevant persons in evaluating the case plan.

   **Note:** These persons may include agency staff, the individual served, the foster parent(s), the family of origin (for children and youth only), and the representative of the state authority.
4. **For foster care:** The case plan is individualized based on an assessment of the emotional, behavioral, developmental, educational, spiritual, social, physical, cultural, linguistic, and legal status of the individual in foster care as well as that of the family of origin.

5. **For foster care:** The case plan identifies the permanency goal if the individual in foster care is a child or youth.

6. **For foster care:** The agency reviews and revises the case plan as needed to determine the continuing necessity for placement.

7. **For foster care:** The case planning process includes an assessment of preparation for transitional living when older youth or adults are discharged from foster care. (For more information on young adults preparing for transitional living, see Standard CTS.06.03.01)

**Note:** Services for older youth or adults that help them develop skills necessary for independence include the following:

- Employment career planning assessments
- Financial management
- Daily living skills (for example, cooking, transportation)
- Completing high school or general educational development (GED)
- Job search training
- Vocational training

Other possible services that prepare older youth or adults for independence include developing support systems and exploring educational needs such as GED programs/college, social/relationship skills, and parenting skills, when applicable.

8. **For foster care:** When the agency has custody of the individual in foster care, the agency is responsible for case planning.

9. **For foster care:** If the county or state agency retains custody and is responsible for the case plan, the foster care agency participates in developing and evaluating the plan.
Standard  CTS.04.02.07

For foster care: The foster parent(s) receives information and education to meet the needs of the individuals placed in his or her care.

Elements of Performance for CTS.04.02.07

1. For foster care: Each foster parent receives preservice orientation, in-service training, and ongoing education.

For foster care: Orientation of each foster parent includes information on the following:

2. Philosophy and practices of the agency.
3. The foster parent’s role.
4. The agency’s policies and procedures regarding discipline.
5. The agency’s role in helping the foster parent serve individuals placed in his or her care.

For foster care: Education is provided to each foster parent about the following:

6. The individual’s specific behavioral problems and health conditions.
7. Community resources.
8. First aid.
10. The individual’s medications.
11. Infection prevention and control.
12. The health risks of passive smoking.
13. Provision of emergency medical and mental health services, as needed.
14. The agency’s visitation policies and scheduling of the visits.
15. Sitter policies.

16. For foster care: Each foster parent also participates in agency-approved education as required.
Standard  CTS.04.02.09
For respite care: The respite caregiver receives information needed to meet the needs of the individual placed in his or her care.

Element of Performance for CTS.04.02.09
1.  For respite care: The information provided by the organization to each respite caregiver includes the following:
   - Needs, strengths, and preferences of the individual served
   - Medication(s) for the individual served
   - First aid
   - Safety
   - Provision of emergency medical care
   - Specific health conditions of the individual served

Environment of Care (EC)

Standard  EC.02.01.05
For foster care: The agency places individuals in foster care in physically safe environments.

Note: This standard applies to foster care agencies that make placement decisions.

Elements of Performance for EC.02.01.05
1.  For foster care: The foster care agency defines, in writing, criteria for assessing the safety of the foster care family’s physical environment.

For foster care: The foster care agency uses defined criteria to assess the following aspects of safety in the foster care home:

2.  The adequacy of sanitary conditions.

3.  Minimizing the risk of injury from toxic materials and medications.

4.  Minimizing the risk of injury from pets; this includes verifying that pet vaccinations are current, in accordance with law and regulation.

5.  Minimizing the risk of injury from firearms in the home.

6.  Other issues as identified by national or state organizations and local, state, tribal, and federal law (such as licensing standards).
7. **For foster care:** The foster care agency verifies that fire protection equipment (for example, smoke detectors, portable fire extinguishers) is inspected, tested, and maintained in a time frame determined by the organization.

8. **For foster care:** The foster care agency verifies that emergency procedures for responding to fire are in place.

9. **For foster care:** The foster care agency verifies the existence of a door for the sleeping room of the individual in foster care.

10. **For foster care:** The foster care agency verifies the existence of at least two of the following means of escape from the sleeping room of the individual in foster care:
   - An operable exterior window large enough for emergency escape
   - A door leading directly to the outside
   - Access to a means of escape such as an unenclosed stairway

11. **For foster care:** The foster care agency verifies the existence of a smoke detector on each floor and near the sleeping room of the individual in foster care.

13. **For foster care:** The foster care agency reassesses safety during the periodic evaluation of the case plan, or as required by law and regulation. The safety assessment is documented.

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**Human Resources Management (HRM)**

**Standard HRM.01.05.01**
Staff participate in education and training.

**Elements of Performance for HRM.01.05.01**
9. **For foster care:** Staff involved in foster care participate in training that is specific to their responsibilities.

**Standard HRM.01.06.01**
Staff are competent to perform their job duties and responsibilities.

**Elements of Performance for HRM.01.06.01**
7. **For foster care:** Staff demonstrate cultural and age-specific competence.
Leadership (LD)

Standard  LD.02.01.01
The mission, vision, and goals of the organization support the safety and quality of care, treatment, or services.

Rationale for LD.02.01.01
The primary responsibility of leaders is to provide for the safety and quality of care, treatment, or services. The purpose of the organization’s mission, vision, and goals is to define how the organization will achieve safety and quality. The leaders are more likely to be aligned with the mission, vision, and goals when they create them together. The common purpose of the organization is most likely achieved when it is understood by all who work in or are served by the organization.

Elements of Performance for LD.02.01.01
4.  For foster care: The agency’s mission, vision, and values are defined.
5.  For foster care: The agency develops strategic, operational, and program-related plans and written policies to carry out the vision and to achieve the mission.

Standard  LD.03.06.01
Those who work in the organization are focused on improving safety and quality.

Rationale for LD.03.06.01
The safety and quality of care, treatment, or services are highly dependent on the people who work in the organization. The mission, scope, and complexity of services define the design of work processes and the skills and number of persons needed. In a successful organization, work processes and the environment make safety and quality paramount. This standard, therefore, applies to all those who work in or for the organization, including staff and licensed independent practitioners.

Elements of Performance for LD.03.06.01
7.  For foster care: The agency has the administrators, supervisors, and staff necessary to support its scope and volume of services, in accordance with law and regulation.
8.  For foster care: The agency has qualified and competent staff necessary to provide the type(s) of services it makes available, in accordance with law and regulation.
9. **For foster care:** The agency has a process for determining staffing based on the number and types of foster care recipients and foster families served.

   **Note:** The process considers staff training and experience, time for foster family resource development, foster family recruitment, licensing activities, case complexity, home monitoring, and home study.

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**Standard LD.04.01.08**

**For foster care:** Staff caseloads are consistent with the level of care, treatment, or services provided to recipients of foster care.

**Elements of Performance for LD.04.01.08**

1. **For foster care:** The agency has a process for assigning and adjusting staff caseloads based on the level of care, treatment, or services provided to recipients of foster care.

2. **For foster care:** The agency follows its process for assigning and adjusting caseloads.

3. **For foster care:** The caseload size is in accordance with law and regulation.

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**Standard LD.04.01.09**

Policies and procedures guide the provision of program services and define the goals and scope of services offered.

**Elements of Performance for LD.04.01.09**

12. ☐ **For foster care:** The agency has a written nondiscriminatory policy for selecting foster parents.

13. ☐ **For foster care:** The agency develops specific written policies and procedures on the following:
   - Reporting and handling of physical, mental, and sexual abuse
   - Receiving and responding to comments, questions, or complaints from the family of origin, the individual served, and the foster parents
   - Removing an individual from the foster home if there is suspicion that he or she is in danger
   - Actions to take in the event of the closure of foster homes, whether voluntary or by termination orders
Standard LD.04.03.01
The organization provides services that meet needs of the individual served.

Elements of Performance for LD.04.03.01

19. **For foster care:** The leaders work with policymakers and involve the community in foster care through education and awareness.

20. **For foster care:** Entry into the appropriate level of care is based on the proper assessment.

21. **For foster care:** Services are planned based on the characteristics and identified needs of the individual served.

22. **For foster care:** The agency plans services based on the agency’s commitments, which include collaborative relationships with agencies that are separately funded or contracted with to provide services to the family of origin or with agencies that supplement the operating agency’s services.

23. **For foster care:** The agency plans services with community vendors (for example, medical, dental, educational) to guarantee access for the individual with identified needs that are not provided for by the agency.

24. **For foster care:** The agency plans services with the foster parents’ involvement in making decisions about the foster care (for example, policies and program issues).

Standard LD.04.03.07
Individuals with comparable needs receive the same standard of care, treatment, or services throughout the organization.

Rationale for LD.04.03.07
Comparable standards of care means that the organization can provide the services that individuals need within established time frames and that those providing care, treatment, or services have the required competence. Organizations may provide different services to individuals with similar needs as long as his or her outcome is not affected. Different settings, processes, or payment sources should not result in different standards of care.
Elements of Performance for LD.04.03.07

4. **For foster care:** The agency plans services so that the same level of care or service is offered to every individual served. These services are planned according to each individual’s needs regardless of how the service is provided, such as through family of origin, through kinship care, or through foster care.

Performance Improvement (PI)

Standard PI.01.01.01
The organization collects data to monitor its performance.

Elements of Performance for PI.01.01.01

31. **For foster care:** The agency collects data on its performance, including the safety of the placement and the maintenance or improvement of the individual’s level of functioning.

32. **For foster care:** The agency collects data on the permanency of the placement and the permanency of outcome when they are within the organization’s scope of services.

Record of Care, Treatment, and Services (RC)

Standard RC.03.01.01
**For foster care:** The agency defines and maintains information specific to the individual served and his or her family for continuity of care and initiation of improvement in its performance.

Elements of Performance for RC.03.01.01

1. ☐ **For foster care:** The agency defines in writing, and in accordance with law and regulation, the following:
   - Who has what level of access to information (for example, individuals served, family of origin, guardians, attorneys, foster parents)
   - The circumstances under which information may be released
   - The length of time records are kept
The individual served, family of origin or adoptive family, and foster family
The right of the individual served, family of origin or adoptive family, and the foster family to confidentiality and accessibility of information

2. **For foster care:** The agency has a plan to maintain a current life book for the child, or a similar way of providing such information.

   **Note:** This chronological record of a child’s life is created by the child or the caregivers. Items in this book follow the child and will reflect significant life events, up to and including the present placement. The information may include developmental milestones, school information, placement records and reasons for moves, family history, awards and achievements, relationships, goals, information about and descriptions of birth parents and siblings (for example, family tree, pictures), and information about foster families.

3. **For foster care:** The agency implements its processes for accessing information, maintaining confidentiality of information, and for children/youth, maintaining a current life book.

4. **For foster care:** Information maintained by the agency includes the following:

   - Case records that include social and legal information, family of origin history, school reports, incident reports (for example, behavior problems, illness, injuries), medical and dental records and history, birth and developmental history, immunization records, placement authorization, case plan, progress reports, school information, and family of origin and foster care contacts
   - Contracts, correspondence, incident reports, and placement and other records or reports needed for the continuity of care

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**Standard RC.03.01.03**

**For foster care:** The agency maintains foster family information.

**Elements of Performance for RC.03.01.03**

1. **For foster care:** The foster family record contains copies of licensing certificates and reports.

2. **For foster care:** The foster family record contains the application to provide foster care, references, background checks, and all assessment reports.
3. **For foster care**: The foster family record contains correspondence, including records of compliments and complaints.

4. **For foster care**: The foster family record contains evidence of training.

5. **For foster care**: Foster family records are retained in accordance with law and regulation and organizational policy.

### Rights and Responsibilities of the Individual (RI)

#### Standard RI.03.01.01

**For foster care**: The foster care agency respects the rights of individuals in foster care.

#### Elements of Performance for RI.03.01.01

1. **For foster care**: The foster care agency follows written policies that support the following:
   - The participation of individuals in foster care in developing their case plan.
   - **Note**: Children, youth, and adults can be served in foster care programs. Children can participate in developing their case plan as appropriate to their age and maturity.
   - Allowing individuals to maintain contact with their biological families, including siblings, unless otherwise indicated in the case plan.
   - Allowing individuals to access routine, preventive, and emergency medical, vision, behavioral health, dental, and rehabilitation care.
   - Allowing individuals to access educational services.
   - Allowing individuals to participate in recreational skill building and social opportunities.
   - Allowing individuals to maintain contact with their ethnocultural heritage.
   - Prohibiting individuals in foster care from being harassed or abused.
   - Supporting individuals in developing and expressing their own spirituality.

#### Standard RI.03.01.03

**For foster care**: The rights of the family of origin are respected.

#### Elements of Performance for RI.03.01.03

1. **For foster care**: The foster care agency’s written policies address the following:
The right of the family of origin to participate in the case plan of the individual in foster care, unless otherwise indicated in the case plan. The right of the family of origin to maintain contact with the individual in foster care, unless otherwise indicated in the case plan. The right of the family of origin to services that address the conditions that led to foster placement.

**Note:** These services may be provided by the agency or by referral, with the goal of having the individual returned to the family of origin.

**Standard RI.03.01.05**

**For foster care:** The agency providing foster care services respects the rights of the foster family.

**Elements of Performance for RI.03.01.05**

1. **For foster care:** The agency respects the foster family’s right to know how it sees the foster family’s role as a team member and how it helps the foster family in serving children, youth, or adults in their charge.

2. **For foster care:** The agency informs the foster family of the following:
   - The support and help the foster family will receive, including arrangements for respite, consultation, and support from agency staff and response to crisis situations.
   - The training they will receive (content and process of training), such as child abuse reporting requirements.
   - Remuneration rate schedules.
   - The identified needs and background of the individual in foster care.
   - How to file and handle complaints.

7. **For foster care:** Foster care agency staff are trained on how to communicate with the foster families regarding their rights. This training is documented. *(See also HRM.01.05.01, EP 1)*
Behavioral Health Home Certification Option (BHH)

Introduction to Behavioral Health Home Certification Option

Behavioral Health Home (BHH) certification is an option available to any organization accredited under the Joint Commission Behavioral Health Care (BHC) program. The BHH model and the corresponding requirements emphasize the need for the BHH to coordinate and integrate care. It is through its strong focus on the coordination and integration of care, treatment, or services that the BHH certification program is expected to be effective in decreasing the high rates of morbidity and mortality found in individuals served with serious mental illness and other behavioral health conditions. Because the BHH model is new to the field and not yet fully defined, this certification product is expected to evolve as the BHH concept matures nationally. Therefore, the BHH standards are robust enough that compliance demonstrates that an organization is indeed functioning as a BHH, but not so prescriptive that they do not allow innovation.

Three types of BHH are recognized by the Substance Abuse and Mental Health Services Administration (SAMHSA); for all of these, coordination and integration are essential. The BHH standards have been written to apply to each of these types, which are as follows:

- “Facilitated referral”—the BHC organization has processes to ensure the coordination of primary physical health care provided off site.
- “Co-located partnership”—the BHC organization arranges for health care providers to offer some basic primary physical health care services on site.
- “In-house”—the BHC organization provides both the BHC services and some or all of the primary physical health care services.

In addition to the three types described above, a BHH may function as a combination of several of these types.
In this section, the BHH standards are displayed alphabetically according to chapter. Included also are other BHC accreditation program standards that closely relate to the BHH model. This chapter does not, however, provide a complete list of all the standards and elements of performance that are required for BHH certification, as organizations interested in this optional certification must be accredited under the BHC program.
Care, Treatment, and Services (CTS)

Standard CTS.01.01.01

The organization accepts for care, treatment, or services only those individuals whose identified care, treatment, or service needs it can meet.

Note 1: For opioid treatment programs: If an individual eligible for treatment applies for admission to a comprehensive maintenance treatment program but cannot be placed within 14 days in a program that is within a reasonable geographic area, an opioid treatment program’s program sponsor may place the individual in interim maintenance treatment.

Note 2: For opioid treatment programs: There may be individuals in special populations who have a history of opioid use but are not currently physiologically dependent. Federal regulations waive the one-year history of addiction for these special populations, because these individuals are susceptible to relapse to opioid addiction, leading to high-risk behaviors with potentially life-threatening consequences. These populations include the following:
- Persons recently released from a penal institution
- Persons recently discharged from a chronic care facility
- Pregnant women
- Previously treated patients

Elements of Performance for CTS.01.01.01

1. The organization has a written process for determining eligibility of individuals that includes the following:
   - The criteria to determine eligibility for care, treatment, or services
   - The information to be collected to determine eligibility for care, treatment, or services
   - The populations of individuals accepted or not accepted by the organization (for example, programs designed to treat adults that do not treat young children)
   - The procedures for accepting referrals

2. For organizations that elect The Joint Commission Behavioral Health Home option: The organization defines in writing the population(s) served by the behavioral health home; the population(s) served by the behavioral health home can be a defined subset(s) of the population served by the organization as a whole.

3. The organization screens individuals for eligibility at the point of first contact with the organization, whether by phone, in person, or other.
4. After screening, the organization matches accepted individuals with the care, treatment, or services most appropriate to their needs.

5. The organization accepts individuals for care, treatment, or services according to established processes.

6. The organization provides information about the locations and hours during which care, treatment, or services are available.

7. When warranted, the organization provides information about resources available to the individual for the care of his or her dependents.

**Standard CTS.01.04.01**

For organizations that serve adults with serious mental illness: The organization supports the adult’s decisions (psychiatric advance directive) about how care, treatment, or services are to be delivered during times when he or she is unable to make such decisions. *(See also RI.01.05.01, EPs 1, 4, 5, 8, 10)*

**Elements of Performance for CTS.01.04.01**

1. For organizations that serve adults with serious mental illness: The organization documents whether the adult has a psychiatric advance directive.

2. For organizations that serve adults with serious mental illness: Upon request, the organization shares with the adult sources of help in formulating psychiatric advance directives.

3. For organizations that serve adults with serious mental illness: If the adult has a psychiatric advance directive, clinical staff who are involved in the care, treatment, or services provided to that adult are aware that the psychiatric advance directive exists and know how to access it.

**Standard CTS.02.01.05**

For organizations providing care, treatment, or services in non-24-hour settings: The organization implements a written process requiring a physical health screening to determine the individual’s need for a medical history and physical examination.

**Note 1:** This standard does not apply to foster care and therapeutic foster care. *(See also CTS.02.04.01, EP 1)*
Behavioral Health Home Certification Option

Note 2: *If the organization conducts a physical examination on all individuals served, it is in compliance with this standard.*

Elements of Performance for CTS.02.01.05

2. For organizations that elect The Joint Commission Behavioral Health Home option: If the screening triggers indicate the need for a medical history and physical examination, the behavioral health home arranges for the history and physical to occur in a time frame that meets the physical health care needs of the individual served.

Standard CTS.02.02.01

The organization collects assessment data on each individual served.

Elements of Performance for CTS.02.02.01

1. As relevant to care, treatment, or services, the organization collects the following assessment data about each individual served:
   - Environment and living situation(s)
   - Leisure and recreational interests
   - Religion or spiritual orientation
   - Cultural preferences
   - Childhood history
   - Military service history, if applicable
   - Financial issues
   - Usual social, peer-group, and environmental setting(s)
   - Language preference and language(s) spoken
   - Ability to self-care
   - Family circumstances, including bereavement
   - Current and past trauma
   - Community resources accessed by the individual served

Note 1: *Relevance to care, treatment, or services may be determined by the individual’s presenting needs and the organization’s scope of care, treatment, or services.*

Note 2: *For certain populations, early identification of community resources is important to care, treatment, or services. Such populations include individuals with severe mental illness or disabilities and children and youth. Community resources for these groups encompass a wide range of services. These services are supportive (such as*
community mental health, sheltered living, day treatment, or activity programs) as well as commonly accessed by the general public (such as public transportation, banking, or retail stores). For youth or children in foster care or in-home services, resources might include community mental health centers, teen centers, YMCAs, or Jewish community centers. These sources of community services may be used as informational, discharge planning, supportive, or continuing care resources.

2. As relevant to care, treatment, or services, the assessment data collected about the individual’s emotional and behavioral functioning include at least the following:
   - History of emotional functioning
   - History of behavioral functioning
   - Addictive behaviors as a primary or a co-occurring condition(s), including the use of alcohol, other drugs, gambling, or other addictive behaviors by the individual served and family members
   - Current emotional functioning
   - Current behavioral functioning

3. The assessment data collected include the individual’s short- and long-term personal goal(s).

4. When indicated, the following evaluations are conducted:
   - Mental status
   - Psychological
   - Psychiatric
   - Intellectual and cognitive functioning

5. Family members are invited to participate in the assessment process as relevant to the care, treatment, or services provided, and the age and preference of the individual served.

6. **For organizations that elect The Joint Commission Behavioral Health Home option:** The assessment data collected include the individual’s short- and long-term physical health care goals.

7. **For organizations that elect The Joint Commission Behavioral Health Home option:** The assessment data collected include screening and/or assessment results for, at a minimum, the following chronic physical health conditions:
   - Diabetes
   - Hypertension
   - Heart disease
- Asthma
- Chronic obstructive pulmonary disease (COPD)
- Hepatitis C
- HIV/AIDS
- Obesity
- Any additional chronic physical health condition(s) the behavioral health home may regularly find in the population(s) it serves
- Metabolic syndrome

**Note:** Refer to [http://www.heart.org](http://www.heart.org) for more information on metabolic syndrome.

8. **For organizations that elect The Joint Commission Behavioral Health Home option:** The assessment data collected include the individual’s ability to self-manage chronic behavioral and physical health conditions.

### Standard CTS.03.01.01

The organization bases the planned care, treatment, or services on the needs, strengths, preferences, and goals of the individual served.

**Note:** **For opioid treatment programs:** Methadone has well-documented effects on several systems, including the respiratory, nervous, and cardiac systems, and the liver. Additionally, many medications including methadone can act to increase the QT interval on an electrocardiogram and potentially lead to torsades de pointes, a potentially life-threatening cardiac arrhythmia. Therefore, it is important for the program physician to consider all of the medications the patient is currently taking (including actual versus prescribed doses, illicit drugs, medically active adulterants potentially present in illicit substances, and medically active over-the-counter or natural remedies). Given consideration of this information, the program physician can determine whether the treatment drug will be methadone, buprenorphine, or another medication and whether the treatment indicated for the patient is induction, detoxification, or maintenance.

### Elements of Performance for CTS.03.01.01

1. The needs, strengths, preferences, and goals of the individual served are identified based on the screening and assessment and are used in the plan for care, treatment, or services.

2. Care, treatment, or service decisions are collaborative and interdisciplinary when more than one discipline is involved in the care, treatment, or services of the individual served.
3. Planning for care, treatment, or services includes identifying objectives for the identified goals. (See also CTS.03.01.03, EP 3)

4. Planning for care, treatment, or services includes interventions and services necessary to meet the identified goals.

13. **For organizations that elect The Joint Commission Behavioral Health Home option:** The physical health goals of the individual served are identified based on the screening and assessment and used in the plan for care, treatment, or services.

14. **For organizations that elect The Joint Commission Behavioral Health Home option:** All physical and behavioral health care, treatment, or service decisions are collaborative and integrated when more than one discipline is involved in the care, treatment, or services provided to the individual served.

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**Standard CTS.03.01.03**

The organization has a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served.

**Elements of Performance for CTS.03.01.03**

1. The organization develops a plan for care, treatment, or services that reflects the assessed needs, strengths, preferences, and goals of the individual served. 

2. The plan for care, treatment, or services includes the following:
   - Goals that are expressed in a manner that captures the individual’s words or ideas
   - Goals that build on the individual’s strengths
   - Factors that support the transition to community integration when identified as a need during assessment
   - The criteria and process for the individual’s expected successful transfer and/or discharge, which the organization discusses with the individual (For more information, refer to Standard CTS.06.02.01)

**Note 1:** Barriers that might need to be considered include co-occurring illnesses, cognitive and communicative disorders, developmental disabilities, vision or hearing disabilities, physical disabilities, and social and environmental factors.
Note 2: For opioid treatment programs: For patients receiving interim maintenance treatment, neither an initial treatment plan nor a periodic treatment plan evaluation is required.

3. The objectives of the plan for care, treatment, or services meet the following criteria:
   - They include identified steps to achieve the goal(s) (See also CTS.03.01.01, EP 3)
   - They are sufficiently specific to assess the progress of the individual served
   - They are expressed in terms that provide indices of progress

4. The organization re-evaluates and, when necessary, revises the goals and objectives of the plan for care, treatment, or services based on change(s) in the individual’s needs, preferences, and goals and his or her response to care, treatment, or services. If no change(s) occurs, the goals and objectives are re-evaluated at a specified time interval established by organization policy.

5. Reasons for deferring a goal, or the objectives leading toward or related to a goal, are documented.

6. The organization provides care, treatment, or services for each individual served according to the plan for care, treatment, or services.

20. For organizations that elect The Joint Commission Behavioral Health Home option: The plan for care, treatment, or services includes the following:
   - The physical health care needs of the individual
   - The physical health care goals of the individual
   - How the organization will meet those needs
   - How the organization will help the individual to work toward achieving his or her goals

21. For organizations that elect The Joint Commission Behavioral Health Home option: The organization identifies the verbal and written communication needs of the individual served, including his or her preferred language for discussing health care.

   Note: Examples of communication needs include the need for personal devices such as hearing aids or glasses, language interpreters, communication boards, and translated or plain language materials.
22. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization communicates with the individual served during the provision of care, treatment, or services in a manner that meets his or her verbal and written communication needs.

23. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization works in partnership with the individual served to achieve planned integrated care outcomes.

24. **For organizations that elect The Joint Commission Behavioral Health Home option:** The individual’s self-management goals related to behavioral and physical health conditions are identified and incorporated into the individual’s plan of care, treatment, or services. (Refer to RI.01.02.01, EP 1)

25. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization involves the individual served in the development of his or her plan of care, treatment, or services.

**Standard CTS.03.01.05**

The plan for care, treatment, or services addresses the family’s involvement.

**Elements of Performance for CTS.03.01.05**

1. The family of the individual served is involved in developing the plan for care, treatment, or services upon consent from the individual (if an adult) or in accordance with law and regulation (if a minor). *(See also CTS.04.02.16, EP 5)*

2. The plan for care, treatment, or services reflects family participation in care, treatment, or services unless such participation is contraindicated. *(See also CTS.04.02.16, EP 5)*

3. The organization documents family participation (if any) in the individual’s record of care, treatment, or services. *(See also CTS.04.02.16, EP 5)*

**Standard CTS.03.01.07**

When individuals served need additional care, treatment, or services not offered by the organization, referrals are made and documented in the clinical/case record. (For more information, refer to Standard CTS.04.01.01.)
Elements of Performance for CTS.03.01.07

1. When the organization does not directly provide care, treatment, or services needed by the individual served, it refers the individual to an outside source.

2. Concurrent care, treatment, or services provided by an outside source that are integral to meeting goals and objectives are addressed in the plan for care, treatment, or services.

3. The organization documents referrals of individuals served to outside sources in the clinical/case record.

Standard CTS.04.01.01

The organization coordinates the care, treatment, or services provided to an individual served as part of the plan for care, treatment, or services and in a manner consistent with the organization’s scope of care, treatment, or services. (For more information, refer to Standard CTS.03.01.07.)

Elements of Performance for CTS.04.01.01

1. The organization coordinates the care, treatment, or services provided through internal resources to an individual served.

2. For acute 24-hour settings, a registered nurse plans, assigns, supervises, provides, and evaluates nursing care to individuals served.

   Note: “Acute 24-hour settings” includes inpatient crisis stabilization or medical detoxification.

3. The organization’s process for hand-off communication provides for the opportunity for discussion between the giver and receiver of information regarding the individual served.

   Note: Such information may include the condition, care, treatment, medications, and services of the individual served, as well as any recent or anticipated changes to any of these.

5. When external resources are needed, the organization participates in coordinating care, treatment, or services with these resources.

6. The organization has a process to receive or share relevant information about the individual served to facilitate coordination and continuity when individuals are referred to other care, treatment, or service providers.
8. The activities detailed in the plan of care, treatment, or services are designed to occur in a time frame that meets the behavioral health needs of the individual served.

9. **For organizations that elect The Joint Commission Behavioral Health Home option:** The activities detailed in the plan of care, treatment, or services are designed to occur in a time frame that meets the physical health care needs of the individual served.

10. Before taking action on a verbal order or verbal report of a test result, staff members use a record and “read back” process to verify the information.

19. **For organizations that elect The Joint Commission Behavioral Health Home option:** If an organization has multiple integrated care teams, each team provides care, treatment, or services for a designated panel of individuals.

20. **For organizations that elect The Joint Commission Behavioral Health Home option:** When an individual is referred to an external organization, the integrated care team does the following:
   - Assists the individual with making the referral appointment, when needed
   - Assists the individual in getting to the appointment, when needed
   - Tracks whether the individual kept the appointment
   - Reviews and tracks the care, treatment, or services provided to the individual

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**Standard CTS.04.01.03**

The individual served receives education and training specific to the individual’s needs and abilities consistent with the care, treatment, or services provided.

**Note:** *This standard does not apply to academic education.*

**Elements of Performance for CTS.04.01.03**

1. Education provided is based on the needs and abilities of the individual served.

2. The assessment of learning needs addresses the individual’s cultural and religious beliefs, emotional barriers, desire and motivation to learn, physical or cognitive limitations, and barriers to communication.

3. Education provided to the individual served is coordinated among the disciplines providing care, treatment, or services.
4. Based on the assessed needs and abilities of the individual served and the organization’s scope of care, treatment, or services, the individual is educated about the following:
   - The plan for care, treatment, or services
   - Basic health practices and safety
   - The safe and effective use of medications
   - Nutrition interventions, modified diets, and oral health, as needed
   - Habilitation or rehabilitation techniques to help him or her reach the maximum level of independence possible

5. The content of the education provided to the individual served is presented in an understandable manner.

6. Teaching methods accommodate various learning styles.

7. The individual’s comprehension of the education provided is evaluated.

25. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization identifies the health literacy needs of the individual served.

   **Note:** Typically this is an interactive process. For example, individuals may be asked to demonstrate their understanding of information provided by explaining it in their own words.

26. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization incorporates the health literacy needs of the individual served into his or her education.

27. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization educates the individual served on self-management support, based on his or her individual needs.

28. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization provides education to the individual served on the benefits of integrating behavioral and physical health care including, at a minimum, how improvements in either behavioral or physical health can positively affect the other.
Standard **CTS.04.01.07**

For organizations that elect The Joint Commission Behavioral Health Home option:
The organization provides excellent access to integrated care, treatment, or services.

**Elements of Performance for CTS.04.01.07**

1. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization provides individuals served with the ability to do the following 24 hours a day, 7 days a week:
   - Contact the behavioral health home to request an appointment
   - Request prescription renewal
   - Request clinical advice for urgent health needs

   **Note:** This ability may be provided through a number of methods, including telephone, e-mail, flexible hours, websites, and portals.

2. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization offers flexible scheduling to accommodate the individual’s care, treatment, or service needs.

   **Note:** This may include open access scheduling, same-day or next available appointments, group visits, expanded hours, and arrangements with other organizations.

3. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization has a process to respond to an individual’s urgent care needs 24 hours a day, 7 days a week.

4. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization facilitates individuals’ online access to their health information within four business days after the information is available to the integrated care team. This information includes diagnostic test results, lab results, summary lists, and medication lists.

5. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization uses a certified electronic health record to provide appointment reminders to individuals.

6. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization provides individuals with contact information for the team coordinator on their integrated care team.
**Standard  CTS.04.02.19**

The organization provides basic prevention, screening, and physical health care services.

**Note:** This standard is applicable only to organizations that directly provide primary physical health care either at their own facility or by contracting with another organization to provide primary physical health care on behalf of the behavioral health care organization. It applies whether the organization provides this service to all the individuals it serves or to only a distinct population of individuals.

**Elements of Performance for CTS.04.02.19**

1. **For organizations that directly provide primary physical health care to individuals served:** The organization provides education to the individual served on the value of prevention, screening, and routine physical health care. (For more information, refer to Standard RI.01.01.03)

2. **For organizations that directly provide primary physical health care to individuals served:** The organization provides prevention, screening, and primary physical health care services that are appropriate to the age, gender, and needs of the individual.

3. **For organizations that directly provide primary physical health care to individuals served:** The organization communicates its role in supporting individuals in receiving primary physical health care to the individual and, as appropriate, his or her family.

4. **For organizations that directly provide primary physical health care to individuals served:** The organization makes available to the primary physical health care provider the individual’s needs, strengths, preferences, and goals and other information needed to facilitate physical health care, with the permission of the individual and in accordance with law and regulation.

5. **For organizations that directly provide primary physical health care to individuals served:** The organization provides for physical health care, treatment, and services not directly provided by the organization through a referral (for example, diagnostic and laboratory tests).
6. **For organizations that directly provide primary physical health care to individuals served:** The organization provides education to the individual on the self-management of a physical illness or condition when indicated by the physical health care needs of the individual. (For more information, refer to Standard RI.01.01.03)

7. **For organizations that directly provide primary physical health care to individuals served:** With the permission of the individual served, the organization supports the individual in receiving primary physical health care which, at a minimum, includes helping the individual to do the following:
   - Follow up on tests, medications, and treatments
   - Manage any fear or reluctance about receiving physical health care
   - Obtain and keep appointments

   **Note:** Helping the individual to obtain and keep appointments may include accompanying the individual to appointments, calling the individual to remind him or her of appointments, providing transportation to and from appointments, and other activities within the scope of the organization’s resources.

8. **For organizations that directly provide primary physical health care to individuals served:** The organization maintains communication between itself and the primary physical health care provider regarding the individual’s care, treatment, or services, with the permission of the individual and in accordance with law and regulation.

9. **For organizations that directly provide primary physical health care to individuals served:** The organization educates its primary physical health care staff on how to interact with the behavioral health population(s) it serves.

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**Standard CTS.04.02.23**

**For organizations that elect The Joint Commission Behavioral Health Home option:**
The organization provides or facilitates the provision of prevention, screening, and primary physical health care, treatment, or services as part of integrated care.

**Elements of Performance for CTS.04.02.23**

1. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization makes available to the integrated care team all information needed to facilitate the delivery of integrated physical and behavioral health care, treatment, or services.
2. **For organizations that elect The Joint Commission Behavioral Health Home option:** The behavioral health home staff have access to a primary physical health care clinician for consultation purposes at all times.

3. **For organizations that elect The Joint Commission Behavioral Health Home option:** The behavioral health home staff have access to a behavioral health care clinician for consultation purposes at all times.

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**Standard  CTS.04.02.25**

**For organizations that elect The Joint Commission Behavioral Health Home option:**

The organization is accountable for facilitating the provision of integrated care to the individual served.

**Elements of Performance for CTS.04.02.25**

1. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization manages transitions in care and facilitates the individual’s access to integrated care, treatment, or services including the following:
   - Acute care
   - Management of chronic care
   - Preventive services that are age- and gender-specific
   - Behavioral health care needs
   - Oral health care
   - Vision care
   - Urgent and emergent care

   **Note:** Some of these services may be obtained through the use of community resources as available, or in collaboration with other organizations.

2. **For organizations that elect The Joint Commission Behavioral Health Home option:** The integrated care, treatment, or services address various phases of the lifespan of the individuals it serves, including end-of-life care when relevant to the population(s) served. (For more information, refer to Standard RI.01.05.01)

3. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization provides disease and chronic care management services to the individuals it serves, as needed or as clinically indicated.
4. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization communicates its role in supporting individuals who require specialty physical health assessment, care, treatment, or services to the individual and, as appropriate, his or her family, with the permission of the individual and in accordance with law and regulation.

5. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization makes certain that the specialty physical health care, treatment, or services provider receives all the information about the individual’s behavioral and physical health that is needed to facilitate the specialty physical health assessment(s) and care, treatment, or services, with the permission of the individual and in accordance with law and regulation.

**Standard CTS.04.02.27**

For organizations that elect The Joint Commission Behavioral Health Home option:
The integrated care team works in partnership with the individual served to support the continuity of care and the provision of comprehensive and coordinated care, treatment, or services.

**Elements of Performance for CTS.04.02.27**

1. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization identifies the composition of the integrated care team.

2. **For organizations that elect The Joint Commission Behavioral Health Home option:** The members of the integrated care team provide comprehensive and coordinated care, treatment, or services and maintain the continuity of care, treatment, or services.

   **Note:** The provision of care, treatment, or services may include making internal and external referrals.

3. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization designates one member of the integrated care team to serve as team coordinator. This team member is accountable for coordinating the provision and continuity of the integrated care, treatment, or services and facilitating the individual’s access to all needed care, treatment, or services, whether behavioral or physical.
Note 1: Coordination of integrated care, treatment, or services may include coordinating internal and external referrals and coordinating the development and evaluation of plans of care, treatment, or services.

Note 2: Portions of these activities may be delegated to other staff members by the team coordinator, with accountability remaining with the team coordinator.

4. For organizations that elect The Joint Commission Behavioral Health Home option: The integrated care team participates in the development of the individual’s plan of care, treatment, or services.

5. For organizations that elect The Joint Commission Behavioral Health Home option: The integrated care team assesses individuals for health risk behaviors.

Standard CTS.06.01.05
For organizations that elect The Joint Commission Behavioral Health Home option: Case management/care coordination services are based on the needs, preferences, and goals of the individual served and on the community resources available.

Elements of Performance for CTS.06.01.05
1. For organizations that elect The Joint Commission Behavioral Health Home option: The individual served and, as appropriate, his or her family are partners with the integrated care team in care, treatment, or service planning.

2. For organizations that elect The Joint Commission Behavioral Health Home option: With the assistance of the integrated care team, the individual served and, as appropriate, his or her family identify needs, preferences, and goals for the following:
   ■ Housing
   ■ Employment
   ■ Education
   ■ Transportation
   ■ Crisis support
   ■ Integrated health services
   ■ Illness self-management (for example, symptom management, medication management), including what to do in case of a health crisis or urgent health problem
   ■ Habilitation and rehabilitation services
   ■ Financial services and benefits
- Assistance with housekeeping
- Assistance with personal hygiene
- Assistance with the retention and improvement of other skills related to activities of daily living
- Social support and adaptive skills
- Support of spirituality
- Schools
- Leisure and recreational activities
- Parental support for children and youth
- Interaction with the criminal or juvenile justice system, if applicable

3. **For organizations that elect The Joint Commission Behavioral Health Home option:** The integrated care team assists the individual served in identifying, using, and accessing family, neighborhood, and community supports and services.

4. **For organizations that elect The Joint Commission Behavioral Health Home option:** The integrated care team supports informed choice by individuals served.

5. **For organizations that elect The Joint Commission Behavioral Health Home option:** The integrated care team assists the individual served in achieving his or her personal goals of independent living.

6. **For organizations that elect The Joint Commission Behavioral Health Home option:** The individual served and the integrated care team evaluate all services provided directly or through referral to the individual served on a periodic basis, as defined by the organization.

**Standard CTS.06.01.07**

**For organizations that elect The Joint Commission Behavioral Health Home option:**
The individual served, with assistance from the organization, determines his or her needs, preferences, and goals regarding training and support to help him or her progress toward independent living and community integration.

**Elements of Performance for CTS.06.01.07**

1. **For organizations that elect The Joint Commission Behavioral Health Home option:** Needs, preferences, and goals of the individual served guide the following:
The type of training and support provided
- The intensity of training and support provided
- The duration of training and support provided

2. **For organizations that elect The Joint Commission Behavioral Health Home option:** Needs, preferences, and goals of the individual served and the organization’s scope of services guide the provision of training and support opportunities regarding the following:
- Personal grooming and hygiene
- Housekeeping
- Shopping for necessities
- Meal preparation and healthy eating
- Money management
- Accessing public transportation
- Use of community resources
- Communication skills
- Social skills
- Leisure and recreational activities for children, youth, and adults
- Volunteer activity
- Illness self-management (for example, symptom management, medication management), including what to do in case of a health crisis or urgent health problem

**Environment of Care (EC)**

**Standard EC.02.04.03**
The organization inspects, tests, and maintains medical equipment.

**Element of Performance for EC.02.04.03**

3. ☑ The organization has a process for inspecting, testing as needed, and maintaining all medical equipment that it owns and operates, which is based on manufacturers’ recommendations, risk levels, or current organization experience. These activities are documented.

**Note:** This process does not encompass medical equipment owned by individuals served or other organizations.
Human Resources Management (HRM)

Standard HRM.01.03.01
The organization provides orientation to staff.

Elements of Performance for HRM.01.03.01

1. The organization determines the key safety content of orientation provided to staff.

   **Note:** Key safety content may include specific processes and procedures related to the provision of care, treatment, or services and the environment of care.

2. The organization orients its staff to the key safety content before staff provides care, treatment, or services. Completion of this orientation is documented.

3. The organization orients staff on the following:
   - Policies and procedures related to job duties and responsibilities.
   - Their specific job duties and responsibilities. *(See also IC.01.05.01, EP 6; IC.02.01.01, EP 7)*
   - Sensitivity to cultural diversity based on their job duties and responsibilities.

   **Note:** Sensitivity to cultural diversity means being aware of and respecting cultural differences. This does not mean that staff have to be conversant with every culture that they may encounter in the organization.

   - The rights of individuals served, including the ethical aspects of care, treatment, or services. *(See also RI.01.07.03, EP 5)*

   **Completion of this orientation is documented.**

16. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization orients staff on the following:
   - Behavioral health conditions most commonly found in the population(s) served
   - Chronic physical health conditions most commonly found in the population(s) served

17. **For organizations that elect The Joint Commission Behavioral Health Home option:** If the organization sponsors or offers peer support services, it orients staff providing peer support services to their roles and responsibilities as members of the integrated care team (for example, participating in activities that promote healthy choices and lifestyles).
Standard HRM.01.05.01
Staff participate in education and training.

Elements of Performance for HRM.01.05.01

1. ☐ Staff participate in education and training as follows:
   - To maintain or increase their competency.
   - Whenever changes in their responsibilities require it.

   **Note:** Education and training are only required if an assessment of staff skills and competencies indicates a need for their provision.
   - To meet specific needs of the population(s) served by the organization. Staff participation is documented. *(See also RI.03.01.05, EP 7)*

   **Staff participation is documented.**

10. **For organizations that elect The Joint Commission Behavioral Health Home option:** Staff providing direct care, treatment, or services participate in additional education and training that is specific to the following:
   - Behavioral health conditions most commonly found in the population(s) served
   - Chronic physical health conditions most commonly found in the population(s) served
   - Care, treatment, or services that are centered on the individual served
   - Strategies for engaging individuals served in participating in their care, treatment, or services
   - How equipment or technology related to the provision of primary physical health care is used

Information Management (IM)

Standard IM.01.01.01
The organization plans for managing information.

Elements of Performance for IM.01.01.01

2. The organization identifies how data and information enter, flow within, and leave the organization.
Note: The flow of data and information within the organization includes how it moves into and out of storage.

6. For organizations that elect The Joint Commission Behavioral Health Home option: The organization uses health information technology to do the following:
   - Support the continuity of care and the provision of integrated care, treatment, or services
   - Document and track care, treatment, or services
   - Support disease management, including educating the individual about disease management
   - Support preventive care, treatment, or services
   - Create reports for internal use and external reporting
   - Facilitate electronic exchange of information among providers
   - Support performance improvement

Leadership (LD)

Standard LD.03.04.01

The organization communicates information related to safety and quality to those who need it, including staff, individuals served, families, and external interested parties.

Elements of Performance for LD.03.04.01

1. Communication processes foster the safety of the individual served and the quality of care.

2. Leaders are able to describe how communication supports a culture of safety and quality.

3. Communication is designed to meet the needs of internal and external users.

4. Leaders provide the resources required for communication, based on the needs of individuals served, staff, and administration.

5. Communication supports safety and quality throughout the organization. (See also LD.04.04.05, EPs 6 and 12)

6. When changes in the environment occur, the organization communicates those changes effectively.

7. Leaders evaluate the effectiveness of communication methods.
Standard LD.04.04.01
Leaders establish priorities for performance improvement. (Refer to the “Performance Improvement” [PI] chapter.)

Elements of Performance for LD.04.04.01

1. Leaders set priorities for performance improvement activities and behavioral health outcomes. (See also PI.01.01.01, EPs 1 and 3)

2. Leaders give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities. (See also PI.01.01.01, EPs 14, 15, and 27)

3. Leaders reprioritize performance improvement activities in response to changes in the internal or external environment.

4. Performance improvement occurs organizationwide.

24. **For organizations that elect The Joint Commission Behavioral Health Home option:** Leaders set priorities for physical health care performance improvement activities and outcomes. (See also PI.01.01.01, EP 40)

   **Note:** As an example, activities and outcomes may be related to individuals with multiple chronic physical health conditions.

25. **For organizations that elect The Joint Commission Behavioral Health Home option:** Leaders involve individuals served in performance improvement activities related to integrated care.

   **Note:** This involvement may include activities such as participating on a quality committee or providing feedback on safety and quality issues.

Standard LD.04.04.03
New or modified services or processes are well designed.

Elements of Performance for LD.04.04.03

1. The organization’s design of new or modified services or processes incorporates the needs of the individuals served, staff, and others.

2. The organization’s design of new or modified services or processes incorporates the results of performance improvement activities.
3. The organization’s design of new or modified services or processes incorporates information about potential risks to the individuals served. (See also LD.04.04.05, EPs 6 and 11)

   **Note:** A proactive risk assessment is one of several ways to assess potential risks to the individuals served. For suggested components, refer to the “Proactive Risk Assessment” section at the beginning of this chapter.

4. The organization’s design of new or modified services or processes incorporates evidence-based information in the decision-making process.

   **Note:** For example, evidence-based information could include practice guidelines, successful practices, information from current literature, and clinical standards.

5. The organization’s design of new or modified services or processes incorporates information about sentinel events.

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**Standard LD.04.04.05**

The organization has an organizationwide, integrated safety program for individuals served.

**Elements of Performance for LD.04.04.05**

1. The leaders implement an organizationwide safety program for individuals served.

2. One or more qualified persons manage the safety program.

3. The scope of the safety program includes the full range of safety issues, from potential or no-harm errors (sometimes referred to as close calls ["near misses"] or good catches) to hazardous conditions and sentinel events.

4. All programs and services within the organization participate in the safety program.

5. As part of the safety program, the leaders create procedures for responding to system or process failures.

   **Note 1:** Responses might include continuing to provide care, treatment, or services to those affected, containing the risk to others, and preserving factual information for subsequent analysis.
Note 2: *For opioid treatment programs:* Examples of reportable patient deaths include the following:

- Drug-related deaths
- Methadone or buprenorphine deaths
- Unexpected or suspicious deaths
- Treatment-context deaths that raise individual, family, community, or public concern

6. The leaders provide and encourage the use of systems for blame-free internal reporting of a system or process failure, or the results of a proactive risk assessment. *(See also LD.03.01.01, EP 8; LD.03.04.01, EP 5; LD.04.04.03, EP 3)*

**Note:** This EP is intended to minimize staff reluctance to report errors in order to help an organization understand the source and results of system and process failures. The EP does not conflict with holding individuals accountable for their blameworthy errors.

7. The leaders define patient safety event and communicate this definition throughout the organization.

**Note:** At a minimum, the organization’s definition includes those events subject to review in the “Sentinel Events” (SE) chapter of this manual. The definition may include any process variation that does not affect the outcome or result in an adverse event, but for which a recurrence carries significant chance of resulting in a serious adverse outcome or an adverse event, often referred to as a close call or near miss.

8. The organization conducts thorough and credible comprehensive systematic analyses (for example, root cause analyses) in response to sentinel events as described in the “Sentinel Events” (SE) chapter of this manual.

9. The leaders make support systems available for staff who have been involved in an adverse or sentinel event.

**Note:** Support systems recognize that conscientious health care workers who are involved in sentinel events are themselves victims of the event and require support. Support systems provide staff with additional help and support as well as additional resources through the human resources function or an employee assistance program. Support systems also focus on the process rather than blaming the involved persons.
11. To improve safety, the organization analyzes and uses information about system or process failures and, when conducted, the results of proactive risk assessments. *(See also LD.04.04.03, EP 3)*

12. The leaders disseminate lessons learned from comprehensive systematic analyses (for example, root cause analyses), system or process failures, and the results of proactive risk assessments to all staff who provide services for the specific situation. *(See also LD.03.04.01, EP 5)*

13. At least once a year, the leaders provide governance with written reports on the following:
- All system or process failures
- The number and type of sentinel events
- Whether the individuals served and the families were informed of the event
- All actions taken to improve safety, both proactively and in response to actual occurrences

14. The leaders encourage external reporting of significant adverse events, including voluntary reporting programs in addition to mandatory programs.

**Note:** Examples of voluntary programs include The Joint Commission Sentinel Event Database and the US Food and Drug Administration (FDA) MedWatch. Mandatory programs are often state initiated.

### Standard LD.04.04.09

**For organizations that elect The Joint Commission Behavioral Health Home option:**
The organization uses clinical practice guidelines and/or evidence-based practices to evaluate and treat specific diagnoses, conditions, or symptoms for both physical and behavioral health care.

**Note:** Clinical practice guidelines and evidence-based practices include both nationally recognized guidelines and practices and guidelines and practices developed by individual organizations to address their particular circumstances.

### Elements of Performance for LD.04.04.09

1. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization identifies clinical practice guidelines and/or evidence-based practices to evaluate and treat specific diagnoses, conditions, or symptoms for both physical and behavioral health care that are relevant to the population(s) served by the behavioral health home.
2. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization uses clinical practice guidelines and/or evidence-based practices to evaluate and treat specific diagnoses, conditions, or symptoms for both physical and behavioral health care.

3. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization manages and evaluates the implementation of clinical practice guidelines and/or evidence-based practices that have been selected to evaluate and treat specific diagnoses, conditions, or symptoms for both physical and behavioral health care.

4. **For organizations that elect The Joint Commission Behavioral Health Home option:** The leaders of the organization review and approve the clinical practice guidelines and/or evidence-based practices that have been selected to evaluate and treat specific diagnoses, conditions, or symptoms for both physical and behavioral health care.

5. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization monitors and reviews, then modifies as necessary, its clinical practice guidelines and/or evidence-based practices for continued applicability and effectiveness.

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**Performance Improvement (PI)**

**Standard PI.01.01.01**
The organization collects data to monitor its performance.

**Elements of Performance for PI.01.01.01**

1. The leaders set priorities for data collection. *(See also LD.04.04.01, EP 1)*

2. The organization identifies the frequency for data collection.

The organization collects data on the following:

3. Performance improvement priorities identified by leaders. *(See also LD.04.04.01, EP 1)*

14. Significant medication errors. *(See also LD.04.04.01, EP 2; MM.08.01.01, EP 1)*
15. Significant adverse medication reactions. *(See also LD.04.04.01, EP 2; MM.08.01.01, EP 1)*

16. The organization collects data on the following:
   - Whether the individual served was asked about treatment goals and needs
   - Whether the individual served was asked if his or her treatment goals and needs were met
   - The view of the individual served regarding how the organization can improve the safety of the care, treatment, or services provided

 *(See also RI.01.01.01, EP 17, for opioid treatment programs)*

27. The organization collects data to measure the performance of high-risk, high-volume, problem-prone processes provided to high-risk or vulnerable populations, as defined by the organization. *(See also LD.04.04.01, EP 2)*

   **Note:** Examples of such processes include the use of restraints, seclusion, suicide watch, and behavior management and treatment.

**For organizations that elect The Joint Commission Behavioral Health Home option:**

The organization collects data on the following:

40. Disease management outcomes. *(See also LD.04.04.01, EP 24)*

41. The individual’s access to care within time frames established by the organization.

42. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization collects data on the following:
   - The individual’s experience and satisfaction related to access to care, treatment, or services and communication
   - The individual’s perception of the comprehensiveness of care, treatment, or services
   - The individual’s perception of the coordination of care, treatment, or services
   - The individual’s perception of the continuity of care, treatment, or services

   *(Refer to PI.01.01.01, EP 16)*

43. **For organizations that elect The Joint Commission Behavioral Health Home option:** All staff who are part of the behavioral health home actively participate in performance improvement activities.
Standard PI.02.01.01
The organization compiles and analyzes data.

**Elements of Performance for PI.02.01.01**

4. The organization analyzes and compares internal data over time to identify levels of performance, patterns, trends, and variations.

8. The organization uses the results of data analysis to identify improvement opportunities. (*See also* HRM.01.06.05, EP 2; HRM.01.07.01, EP 3; LD.03.02.01, EP 5)

9. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization uses patient registries, health information technology (HIT), and/or electronic health records (EHRs) to collect, analyze, and compare data in order to improve the outcomes of the individuals served.

Standard PI.03.01.01
The organization improves performance.

**Elements of Performance for PI.03.01.01**

2. The organization takes action on improvement priorities. (*See also* MM.08.01.01, EP 6)

4. The organization takes action when it does not achieve or sustain planned improvements.

11. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization uses the data it collects on the individual’s perception of the safety and quality of care, treatment, or services to improve its performance. This data includes the following:
   - The individual’s experience and satisfaction related to access to care, treatment, or services and communication
   - The individual’s perception of the comprehensiveness of care, treatment, or services
   - The individual’s perception of the coordination of care, treatment, or services
   - The individual’s perception of the continuity of care, treatment, or services
Record of Care, Treatment, and Services (RC)

Standard RC.01.01.01
The organization maintains complete and accurate clinical/case records.

Elements of Performance for RC.01.01.01
5. The clinical/case record contains the information needed to support the diagnosis or condition of the individual served.
7. The clinical/case record contains information that documents the course and result of the care, treatment, or services provided to the individual served.
8. The clinical/case record contains information about the care, treatment, or services provided to the individual served that promotes continuity of care among providers.
11. All entries in the clinical/case record are dated.

Standard RC.02.01.01
The clinical/case record contains information that reflects the care, treatment, or services provided to the individual served.

Elements of Performance for RC.02.01.01
1. The clinical/case record contains the following demographic information:
   - The name, address, date of birth, and sex of the individual served
   - The name and contact information for the individual’s family and any legally authorized representative
   - The preferred language and any special communication needs of the individual served

   Note: Special communication needs may include sign language.

2. The clinical/case record of the individual served contains the following clinical information:
   - The reason(s) for admission for care, treatment, or services
   - The initial diagnosis, diagnostic impression(s), or condition(s)
   - Any findings of assessments and reassessments
   - Any allergies to food
   - Any allergies to medications

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
4. As needed to provide care, treatment, or services, the clinical/case record contains the following additional information:

- Any advance directives
- Any informed consent
- Any documentation of protective services
- Any documentation of consent by the individual served, family, or guardian for admission; care, treatment, or services; evaluation; continuing care; or research
- Any records of communication with the individual served, such as telephone calls or e-mail
- Any documentation of involvement in care, treatment, or services by the individual served and, when necessary, his or her family
- Any information on unusual occurrences, such as complications; accidents or injuries to the individual served; procedures that place the individual served at risk or cause pain; other illnesses or conditions that affect care, treatment, or services; or the death of the individual served
- Any indications for and episodes of special procedures
28. **For organizations that elect The Joint Commission Behavioral Health Home option:** The clinical/case record of the individual served contains the following behavioral and physical health information:
   - All behavioral and physical health diagnoses and conditions that have required care, treatment, or services
   - All hospital admissions
   - All hospital re-admissions
   - All urgent care and emergency department visits

   (Refer to RC.02.01.01, EP 2)

29. **For organizations that elect The Joint Commission Behavioral Health Home option:** For the purpose of identifying disparities in care, treatment, or services, the clinical/case record contains the individual’s race and ethnicity.

30. **For organizations that elect The Joint Commission Behavioral Health Home option:** The clinical/case record includes the individual’s self-management goals related to integrated care and the individual’s progress toward achieving those goals.

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**Rights and Responsibilities of the Individual (RI)**

**Standard RI.01.01.01**

The organization respects the rights of the individual served.

**Elements of Performance for RI.01.01.01**

1. The organization has written policies on the rights of the individual served.
2. The organization informs the individual served of his or her rights. (*See also* RI.01.01.03, EPs 1–3)
4. The organization treats the individual served in a respectful manner that supports his or her dignity.
6. The organization respects the cultural and personal values, beliefs, and preferences of the individual served.
7. The organization respects the right of the individual served to privacy. (See also IM.02.01.01, EPs 1–4)

**Note:** This element of performance (EP) addresses the personal privacy of the individual served. For EPs addressing security and safety, please see EC.02.01.01, EP 3 and EC.02.06.01, EP 1. For EPs addressing the privacy of health information, please refer to Standard IM.02.01.01.

10. In accordance with law and regulation, the organization allows the individual served to access and request amendment to his or her health information and to obtain information on disclosures of this information.

**Standard RI.01.01.03**

The organization respects the right of the individual served to receive information in a manner he or she understands.

**Elements of Performance for RI.01.01.03**

1. The organization provides information to the individual served in a manner tailored to his or her language and ability to understand. (See also CTS.06.02.03, EP 9; RI.01.01.01, EP 2)

2. The organization provides interpreting and translation services, as necessary. (See also RI.01.01.01, EP 2)

**Note:** For organizations that elect The Joint Commission Behavioral Health Home option: Language interpreting options may include trained bilingual staff, contract interpreting services, or employed language interpreters. These options may be provided in person or via telephone or video. The documents that are translated, and the languages into which they are translated, are dependent on the population(s) served by the organization.

3. The organization communicates with the individual served who has vision, speech, hearing, or cognitive impairments in a manner that meets the needs of that individual. (See also RI.01.01.01, EP 2)
Standard RI.01.02.01
The organization respects the right of the individual served to collaborate in decisions about his or her care, treatment, or services.

Elements of Performance for RI.01.02.01

1. The organization involves the individual served in making decisions about his or her care, treatment, or services.
   
   **Note:** *This involvement goes beyond mere presence at the time of discussion or decision making. Involvement connotes a collaborative process in which the organization actively engages the individual served in decision making regarding his or her care, treatment, or services.*

2. When an individual served is unable to make decisions about his or her care, treatment, or services, or chooses to delegate decision making to another, the organization involves the surrogate decision-maker in making these decisions. *(See also RI.01.03.01, EP 1; RI.01.01.01, EP 18)*

4. The organization respects the right of the individual served or surrogate decision-maker to refuse care, treatment, or services, in accordance with law and regulation.

8. The individual served has the right to involve his or her family in decisions about care, treatment, or services. When there is a surrogate decision-maker, he or she can exercise the right to involve the family on behalf of the individual served, in accordance with law and regulation. *(See also RI.01.07.01, EP 2; CTS.04.02.16, EP 5)*

9. The organization accommodates the right of the individual served to request the opinion of a consultant.
   
   **Note:** *This element of performance does not require the organization to pay for consultant services.*

10. The organization accommodates the right of the individual served to request an internal review of his or her plan of care, treatment, or services.

11. The organization has a process for resolving disagreements about therapeutic issues.

20. The organization provides the individual served or surrogate decision-maker with the information about the following:
Outcomes of care, treatment, or services that the individual needs in order to participate in current and future behavioral health care decisions.

Unanticipated events related to the individual’s care, treatment, or services that are sentinel events as defined by The Joint Commission. (Refer to the Glossary for a definition of sentinel event.)

31. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization provides the individual served or surrogate decision-maker with the information about the outcomes of care, treatment, or services that the individual needs in order to participate in current and future physical health care decisions.

32. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization respects the individual’s right to make decisions about the management of his or her care, treatment, or services.

33. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization respects the individual’s right and provides him or her the opportunity to do the following:
   - Obtain care from other clinicians of the individual’s choosing within the behavioral health home
   - Seek a second opinion from a clinician of the individual’s choosing
   - Seek specialty care

   **Note:** This element of performance does not imply financial responsibility on the part of the organization for any activities associated with these rights.

**Standard RI.01.03.01**

The organization honors the right of the individual served to give or withhold informed consent.

**Elements of Performance for RI.01.03.01**

1. ✅ The organization follows a written policy on informed consent that describes the following:
   - The specific care, treatment, or services that require informed consent.
   - Circumstances that would allow for exceptions to obtaining informed consent, such as situations involving threat of harm to self or others, child abuse, or elder abuse.
When a surrogate decision-maker may give informed consent. (See also RI.01.02.01, EP 2)

2. The informed consent process includes a discussion about the following:
   - The proposed care, treatment, or services for the individual served.
   - The goals and potential benefits and risks of the proposed care, treatment, or services.
   - Reasonable alternatives to the individual’s proposed care, treatment, or services. The discussion encompasses risks and benefits related to the alternatives and the risks related to not receiving the proposed care, treatment, or services.

3. The organization obtains and documents informed consent in advance if it makes and uses recordings, films, or other images of individuals served for internal use other than the identification, diagnosis, or treatment of the individual (for example, performance improvement and education). This informed consent includes an explanation of how the recordings, films, or other images will be used.

   Note 1: The term “recordings, films, or other images” refers to photographic, video, digital, electronic, or audio media.

   Note 2: This element of performance does not apply to the use of security cameras.

**Standard RI.01.03.05**

The organization protects the individual served and respects his or her rights during research, investigation, and clinical trials.

**Note:** This standard applies when organizations conduct or permit individuals served to participate in research investigations or clinical trials.

**Elements of Performance for RI.01.03.05**

2. To help the individual served determine whether or not to participate in research, investigation, or clinical trials, the organization either provides the individual with all of the following information or confirms that the individual is provided with this information by the principal investigator:
   - An explanation of the purpose of the research
   - The expected duration of the individual’s participation
   - A clear description of the procedures to be followed
   - A statement of the potential benefits, risks, discomforts, and side effects
■ Alternative care, treatment, or services available that might prove advantageous to the individual

3. The organization informs the individual served that refusing to participate in research, investigation, or clinical trials or discontinuing participation at any time will not jeopardize his or her access to care, treatment, or services unrelated to the research.

4. The organization documents the following in the research consent form:
   ■ That the individual served received information to help determine whether or not to participate in the research, investigation, or clinical trials.
   ■ That the individual served was informed that refusing to participate in research, investigation, or clinical trials or discontinuing participation at any time will not jeopardize his or her access to care, treatment, or services unrelated to the research.
   ■ The name of the person who provided the information and the date the form was signed.
   ■ The right to privacy, confidentiality, and safety of the individual served.

**Standard RI.01.04.01**

The organization respects the right of the individual served to receive information about the staff responsible for his or her care, treatment, or services.

**Elements of Performance for RI.01.04.01**

1. The organization informs the individual served of the following:
   ■ The name of the staff member who has primary responsibility for his or her care, treatment, or services.
   ■ The name of the staff member(s) who will provide his or her care, treatment, or services.

   **Note:** Staff may be under the supervision of a clinician. This clinician will be identified in accordance with RI.01.04.01, EP 1.

6. **For organizations that elect The Joint Commission Behavioral Health Home option:** The organization informs the individual served of the scope of the license, certification, or registration of each behavioral health home staff member who possesses such a credential.
Standard RI.01.04.03

For organizations that elect The Joint Commission Behavioral Health Home option:
The organization provides individuals served with information about the functions and services of the behavioral health home.

Elements of Performance for RI.01.04.03

1. **For organizations that elect The Joint Commission Behavioral Health Home option: The organization provides information to the individual served about:**
The mission, vision, and goals of the behavioral health home. (Refer to LD.02.01.01, EP 3)

   **Note:** This may include how it provides for integrated care that is centered on the individual served, a systems-based approach to quality and safety, and enhanced access for individuals served.

2. **For organizations that elect The Joint Commission Behavioral Health Home option: The organization provides information to the individual served about:**
The scope of care, treatment, or services and types of services provided by the behavioral health home.

3. **For organizations that elect The Joint Commission Behavioral Health Home option: The organization provides information to the individual served about:**
How the behavioral health home functions, including the following:
   - The process for assigning or selecting clinicians
   - Involving the individual in his or her plan of care, treatment, or services
   - Obtaining and tracking referrals
   - Coordinating the individual’s integrated care
   - Collaborating with clinicians who provide specialty care or second opinions

4. **For organizations that elect The Joint Commission Behavioral Health Home option: The organization provides information to the individual served about:**
How to access the behavioral health home for care or information both during and after regular hours of operation.

5. **For organizations that elect The Joint Commission Behavioral Health Home option: The organization provides information to the individual served and, when needed, his or her family or surrogate decision-maker about:**
The individual’s responsibilities, including providing his or her health history and current medications, and participating in self-management activities. (Refer to RI.01.01.03, EPs 1–3 and RI.02.01.01, EP 2)
Note: Individuals’ responsibilities will vary depending on their abilities and unique circumstances. In some cases, family members or surrogate decision-makers may be able to help individuals meet their responsibilities.

6. For organizations that elect The Joint Commission Behavioral Health Home option: The organization provides information to the individual served about:
The individual’s right to obtain care from other clinicians within the behavioral health home, to seek a second opinion, and to seek specialty care. (Refer to RI.01.02.01, EPs 9, 31, and 32)

Standard RI.01.05.01
For organizations that elect The Joint Commission Behavioral Health Home option: The organization addresses decisions made by the individual served about physical health care, treatment, or services received at the end of life. (For more information, refer to Standard CTS.01.04.01.)

Elements of Performance for RI.01.05.01

1. For organizations that elect The Joint Commission Behavioral Health Home option: The organization follows a written policy on physical health advance directives that address the following:
   - Whether the organization will honor physical health advance directives.
   - Communicating its policy on physical health advance directives to the individuals it serves.

For organizations that elect The Joint Commission Behavioral Health Home option: Informing all members of the integrated care team when an individual served has a physical health advance directive, and how to access it.

10. For organizations that elect The Joint Commission Behavioral Health Home option: Upon request, the organization shares with the individual possible sources of help in formulating physical health advance directives.
Standard  RI.01.06.03
The individual served has the right to be free from neglect; exploitation; and verbal, mental, physical, and sexual abuse.

Elements of Performance for RI.01.06.03
1. The organization determines how it will protect the individual served from neglect, exploitation, and abuse that could occur while he or she is receiving care, treatment, or services. R

2. The organization evaluates all allegations, observations, and suspected cases of neglect, exploitation, and abuse that occur within the organization.

3. The organization reports allegations, observations, and suspected cases of neglect, exploitation, and abuse to appropriate authorities based on its evaluation of the suspected events and in accordance with law and regulation.

7. The organization takes steps to protect the individual served from neglect, exploitation, and abuse that could occur while he or she is receiving care, treatment, or services. R

Standard  RI.01.06.05
The individual served has the right to an environment that preserves dignity and contributes to a positive self-image.

Elements of Performance for RI.01.06.05
1. The organization’s environment of care supports the positive self-image and dignity of the individual served.

Standard  RI.01.07.01
The individual served and his or her family have the right to have complaints reviewed by the organization.

Elements of Performance for RI.01.07.01
1. The organization establishes a complaint resolution process and informs the individual served and his or her family about it.

Note: If the individual served has a surrogate decision-maker, he or she will be informed of and involved in the complaint resolution process.
4. The organization reviews and, when possible, resolves complaints from the individual served and his or her family.

7. The organization provides the individual served (and when deemed beneficial, his or her family) with the phone number and address needed to file a complaint with the relevant state authority.

**Standard RI.01.07.03**

The individual served has the right to access protective and advocacy services.

**Elements of Performance for RI.01.07.03**

1. When the organization serves a population of individuals that need protective services (for example, guardianship or advocacy services, conservatorship, or child or adult protective services), it provides resources to help the family and the courts determine the individual’s needs for such services.

4. The organization has a written process for providing a personal advocate. This written process includes the conditions under which a personal advocate is indicated, and his or her role and responsibilities.

5. The organization informs staff and individuals served about the process for providing information on personal advocates. *(See also HRM.01.03.01, EP 3)*

6. The organization determines what its role will be, if any, in assessing the need for protective services, making recommendations, and providing protective services for individuals served.

7. When the organization does not provide protective services, staff make referrals for individuals determined to need such services.

8. Recommendations about the need for guardianship are based on a separate review process independent of considerations used in planning and providing care, treatment, or services.
Glossary (GL)

**abuse**  Intentional mistreatment that may cause either physical or psychological injury. *See also* mental abuse, neglect, physical abuse, sexual abuse.

**accreditation**  Determination by The Joint Commission that an eligible organization complies with applicable Joint Commission accreditation requirements.

**accreditation contract**  The primary document that establishes the terms of the relationship between the organization and The Joint Commission.

**accreditation decisions**  Categories of accreditation that an organization can achieve based on a Joint Commission survey. These decision categories are as follows:

- **Limited, Temporary Accreditation**  The organization demonstrates compliance with selected standards in surveys conducted under the Early Survey Policy.

- **Accredited**  The organization is in compliance with all applicable standards at the time of the on-site survey or has successfully addressed all Requirements for Improvement (RFIs) in an Evidence of Standards Compliance (ESC) within 60 days following the posting of the Accreditation Survey Findings Report and does not meet any other rules for other accreditation decisions.

- **Accreditation with Follow-up Survey**  The organization is in compliance with all standards, as determined by an acceptable ESC submission. A follow-up survey is required within 6 months to assess sustained compliance.

- **Preliminary Denial of Accreditation**  There is justification to deny accreditation to the organization as evidenced by:
  - An Immediate Threat to Health or Safety to individuals served or the public, and/or
  - Submission of falsified documents or misrepresented information, and/or
  - Lack of a required license or similar issue at the time of survey, and/or
  - Significant noncompliance with Joint Commission standards, and/or
  - Individuals served having been placed at risk for serious adverse outcomes due to significant and pervasive patterns/trends/repeat findings

  The decision is subject to review and appeal by the organization prior to the determination to deny accreditation.

- **Denial of Accreditation**  The organization has been denied accreditation. All review and appeal opportunities have been exhausted.

**accreditation manual**  A Joint Commission publication consisting of policies, procedures, and accreditation requirements relating to ambulatory care, behavioral health care, critical access hospital, home
care, hospital, nursing care center, office-based surgery, and clinical laboratory and point-of-care testing. Organizations should use the manual that contains the set of accreditation requirements that is most appropriate to the primary focus or mission of the organization.

**accreditation process** A continuous process whereby organizations are required to demonstrate to The Joint Commission that they are providing safe, high-quality care, as determined by compliance with Joint Commission standards, National Patient Safety Goals, and performance measurement requirements (as applicable). Key components of this process are an on-site evaluation of the organization by a Joint Commission surveyor(s) and, where applicable, quarterly submission of performance measurement data to The Joint Commission.

**Accreditation Quality Report** See Quality Report.

**accreditation survey** An on-site evaluation of an organization to assess its level of compliance with applicable Joint Commission accreditation requirements and to make determinations regarding its accreditation status. The survey includes evaluation of documentation of compliance provided by organization staff; verbal information concerning the implementation of standards or examples of their implementation that enable a determination of compliance to be made; on-site observations by the surveyor(s); and an opportunity for education and consultation regarding standards compliance and performance improvement.

**accreditation survey findings** Findings from an on-site evaluation conducted by Joint Commission surveyors that result in an organization’s accreditation decision.

**addictions services** Care, treatment, or services provided to individuals with substance use disorders or other addictive behaviors.

**admission** The process by which an individual comes into a service or program, including screening and/or assessment by the organization or the practitioner, in order to determine the capacity of the organization or practitioner to provide the care, treatment, or services required to meet the individual’s needs.

**adoption services** Services provided by an agency whereby an adult(s) assumes the parenting for a child or youth and, in so doing, all rights and responsibilities are permanently transferred from the original parent or parents. Unlike guardianship or other systems designed for the care of the young, adoption is intended to effect a permanent change in status and as such requires societal recognition, either through legal or religious sanction.

**adult** An individual who has reached the age of legal majority.

**adult day care** Health care, recreation and diversion activities, social services, and other health maintenance activities offered to adults during daytime hours. These ser-
services can include health monitoring, occupational therapy, recreational therapy, personal care, meals, and transportation. This care is an ongoing program that typically meets two to five times a week for two to five hours per day.

**advance directive** A document or documentation allowing a person to give directions about future health care or to designate another person(s) to make health care decisions if the individual loses decision-making capacity. Advance directives may include living wills, durable powers of attorney, do-not-resuscitate (DNR) orders, right-to-die documents, or similar documents listed in the Patient Self-Determination Act that express the person’s preferences. See also psychiatric advance directive.

**adverse drug event (ADE)** An injury resulting from a medical intervention related to a medication, including harm from an adverse drug reaction or a medication error. See also medication error.

**adverse drug reaction (ADR)** A response to a medicinal product that is noxious and unintended and that occurs at doses normally used in humans for the prophylaxis, diagnosis, or treatment of disease or for the restoration, correction, or modification of physiological or psychological function. See also significant adverse drug reaction.

**adverse event** A patient safety event that resulted in harm to an individual served.

**adverse medication event** See adverse drug event (ADE).

**adverse medication reaction** See adverse drug reaction (ADR).

**advocate** A person who represents the rights and interests of another individual as though those rights and interests were the person’s own in order to realize the rights to which the individual is entitled, obtain needed services, and remove barriers to meeting the individual’s needs.

**ambulatory health care** Health services provided to individuals who are not confined to institutional beds as inpatients during the time services are rendered. Ambulatory care services are provided in many settings ranging from freestanding ambulatory surgery facilities, to primary care settings, to diagnostic radiology; outpatient behavioral health services are not included.

**animal-assisted therapy** A goal-directed intervention in which an animal meeting specific criteria is an integral part of the treatment process. Animal-assisted therapy is delivered and/or directed by staff working within the scope of his or her profession and training. This type of intervention is designed to promote improvement in the physical, emotional/behavioral, and/or cognitive functioning of the individual served. Animal-assisted therapy is provided in a variety of settings and includes group or individual interventions. This definition does not apply to pets.
annually  One year from the date of the last event, plus or minus 30 days. Synonymous with every 12 months, once a year, or every year.

appeal process  The process afforded to an organization that receives a Preliminary Denial of Accreditation decision, which includes the organization’s right to make a presentation to the Review Hearing Panel before accreditation is denied.

applicant organization  An organization that is seeking either accreditation for the first time or re-accreditation.

application for accreditation  See E-App.

assertive community treatment  Intensive case management services based on a team approach, designed to provide comprehensive community-based support to adult individuals served with the goal of maintaining an individual in a community setting.

assessment  1. The process established by the organization for obtaining clinically relevant information about each individual seeking behavioral health care, treatment, or services. The information is used to match an individual’s need with the appropriate setting, service/program, and intervention. 2. For opioid treatment programs, the process of identifying the precise nature and extent of a patient’s substance use disorder and other medical, mental health, and social problems as a basis for treatment planning.

assistive technology  Describes devices used by individuals with intellectual and/or developmental disabilities or brain injuries or other physical disabilities to help compensate for functional limitations and increase learning, independence, mobility, communication, environmental control, and choice.
aversive contingencies  Procedures in which the individual served is exposed to an unpleasant or noxious stimulus while engaging in the target behavior. Positive punishment is considered to be a type of aversive contingency in which target behavior is followed by the presentation of an unpleasant or noxious stimulus to decrease probability that the behavior will occur again. Negative punishment is not an aversive contingency. Negative punishment is a procedure in which the target behavior is followed by the removal of a desirable stimulus to decrease the probability that the behavior will occur again.

behavioral health advance directive  See psychiatric advance directive.

behavioral health care  A broad array of care, treatment, or services for individuals with mental health issues, foster care needs, addictive behaviors, chemical dependency issues, or intellectual/developmental disabilities. Care, treatment, or services can be provided in a wide variety of settings, such as inpatient/crisis stabilization, residential, day program, outpatient, and community-based settings.

behavioral health home  A model for the coordination and integration of behavioral and primary physical health care, treatment, or services provided to individuals served through an organization accredited under the CAMBHC. The behavioral health home may provide both the behavioral and primary physical health care, treatment, or services itself; work with another organization that will provide the primary physical health care, treatment, or services; or use a facilitated referral process to make certain the individual served receives the physical health care he or she requires. Regardless of which operational model is used by the behavioral health home, it must make certain that all of the behavioral and physical health care, treatment, or services are delivered to the individual served as a coordinated and integrated whole with the goal of improving the individual’s health care outcomes over his or her lifespan.

behaviors that undermine a culture of safety  Conduct by staff working in the organization that intimidates others to the extent that quality and safety could be compromised. These behaviors, as determined by the organization, may be verbal or nonverbal, may involve the use of rude language, may be threatening, or may involve physical contact.

blind specimen  A sample with known value tested by personnel who do not know the expected result.

case management/care coordination services  Assistance provided to individuals or their authorized representatives aimed at assessing needs, linking community resources, coordinating services, and delivering flexible problem solving and crisis response.

case plan  An individualized plan for or provision of services that addresses the needs, safety, and well-being of an individual while in foster care.
chemical dependency services  Services that are designed to address environmental, interpersonal, and intrapersonal factors for individuals with alcohol and/or drug dependencies in a designated program or track. An organization providing these services must have policies and procedures in place, must have trained staff to address the needs of the individual served, and may advertise or present its services to the public.

child  A person between 0 and 12 years of age, or as determined by applicable law and regulation.

child/youth behavioral health  Behavioral health care provided to children or youth for diagnosis and treatment or services for behavioral health problems.

clinical/case record  1. An account compiled by behavioral health care professionals on a variety of health information, such as screening/assessment findings; care, treatment, or service details; and progress notes. 2. Data obtained from records or documentation maintained on an individual served in any behavioral health care setting.

Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88)  Federal legislation that created uniform federal standards for regulating laboratory testing. CLIA ’88 unified the disparate federal and state standards regulating clinical laboratories and extended government oversight to all testing facilities, including physician offices.

clinical leader  A behavioral health care professional with overall responsibility to plan, organize, and operate a clinical service or program (for example, a clinical director or a service or program director).

clinical practice guidelines  Tools that describe a specific procedure or processes found, through clinical trials or consensus opinion of experts, to be the most effective in evaluating and/or treating a patient or individual served who has a specific symptom, condition, or diagnosis. Synonyms include practice parameter, protocol, clinical practice recommendation, preferred practice pattern, and guideline.

clinical responsibilities  Authorization assigned by the appropriate authority to a practitioner to provide specific care, treatment, or services in an organization within well-defined limits, based on the following factors, as applicable: license, education, training, experience, competence, health status, and judgment.

clinical staff  Individuals such as employees, licensed independent practitioners, contractors, volunteers, or temporary agency personnel who provide or have provided clinical services to the organization’s patients or individuals served. See also staff.

close call  A patient safety event that did not reach the individual served or patient; also called near miss or good catch.

community-based home  Housing arranged as a required component of care, treatment, or services provided by the or-
ganization. Housing may include apartments, condominiums, or houses and must have three or fewer individuals served living in each unit. A community-based home may be owned or leased by the organization, and is either staffed up to 24 hours a day, 7 days a week, or not staffed. A community-based home may also be a private residence that is staffed by the organization up to 24 hours a day, 7 days a week.

**community integration services** Services that assist individuals in establishing or maintaining a life in the community.

**community support services** Services provided to meet the identified needs of an individual who requires assistance in the maintenance and management of daily living activities.

**compartmentalization** The concept of using various building components (for example, fire walls and doors, smoke barriers, fire-rated floor slabs) to prevent the spread of fire and combustion and to provide a safe means of egress to an approved exit. The presence of these features varies depending on the building occupancy classification.

**complex organization** An organization accredited by The Joint Commission under more than one accreditation manual.

**comprehensive systematic analysis** A process for identifying basic or causal factors underlying variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis is one type of comprehensive systematic analysis.

**confidentiality** Protection of data or information from being made available or disclosed to any unauthorized person(s) or process(es).

**consultation** 1. Provision of professional advice or services. 2. A review of an individual’s problem by a second practitioner and the rendering of an opinion and advice to the referring practitioner. In most instances, the review involves the independent examination of the individual by the consultant. 3. For purposes of Joint Commission accreditation, advice that is given to staff members of surveyed organizations relating to compliance with standards and requirements that are the subject of the survey.

**continuing care/treatment/services** Care, treatment, or services provided over time in various settings, programs, or services and spanning the illness-to-wellness continuum.

**continuity** The degree to which the care, treatment, or services of individuals is coordinated among health care professionals, among organizations, and over time.

**contract** A formal agreement for care, treatment, or services with an organization, agency, or individual that specifies the services, personnel, products, or space provided by, to, or on behalf of the organization and specifies the consideration to be expended in exchange.
contrasted services  Services provided through a written agreement with another organization, agency, or person. The agreement specifies the services or personnel to be provided on behalf of the applicant organization and the fees to provide these services or personnel.

c contractual agreement  An agreement with any organization, group, agency, or individual for services or personnel to be provided by, to, or on behalf of the organization. Such agreements are defined in written form, such as in a contract, letter of agreement, or memorandum of understanding.

coordination of care, treatment, or services  The process of coordinating care, treatment, or services provided by an organization, including referral to appropriate community resources and liaison with others involved in care, treatment, or services (such as an individual’s physician, primary care provider, or another health care organization/agency) to meet the ongoing identified needs of the individual served, to ensure implementation of the plan of care, treatment, or services, and to avoid unnecessary duplication of services.

corrections services  Behavioral health care services provided in a correctional setting.

c corrective maintenance  See maintenance.

credentials  Documented evidence of licensure, education, training, experience, or other qualifications.

credentials verification organization (CVO)  Any entity that provides information on an individual’s professional credentials. An organization that bases a decision in part on information obtained from a CVO should have confidence in the completeness, accuracy, and timeliness of information. To achieve this level of confidence, the organization should evaluate the entity providing the information initially and then periodically as appropriate. The 10 principles that guide such an evaluation include the following:
1. The entity makes known to the user the data and information it can provide.
2. The entity provides documentation to the user describing how its data collection, information development, and verification process(es) are performed.
3. The user is given sufficient, clear information on database functions, including any limitations of information available from the entity (such as practitioners not included in the database), the timeframe for entity responses to requests for information, and a summary overview of quality control processes related to data integrity, security, transmission accuracy, and technical specifications.
4. The user and entity agree on the format for transmitting credentials information about an individual from the CVO.
5. The user can easily discern what information transmitted by the CVO is from a primary source and what is not.
6. For information transmitted by the agency that can go out of date (for example, licensure, board certification),
the CVO provides the date the information was last updated from the primary source.

7. The CVO certifies that the information transmitted to the user accurately represents the information obtained by it.

8. The user can discern whether the information transmitted by the CVO from a primary source is all the primary source information in the CVO’s possession pertinent to a given item or, if not, where additional information can be obtained.

9. The user can engage the CVO’s quality control processes when necessary to resolve concerns about transmission errors, inconsistencies, or other data issues that may be identified from time to time.

10. The user has a formal arrangement with the CVO for communicating changes in credentialing information.

**crisis stabilization** A highly structured environment for individuals who require 24-hour registered nursing supervision and who may be incapable of self-preservation in case of an emergency. Crisis stabilization is typically characterized by a short length of stay, with discharge or transfer to a hospital or inpatient psychiatric facility.

**data integrity** The accuracy, consistency, and completeness of data that are protected in some way from corruption, misuse, or accidental exposure to unauthorized users.

**data source** A primary source used for data collection (for example, physical health and behavioral health information, personnel records, written agreements, safety incident log).

**day treatment** An environment offering an organized day or evening program that may include screening or assessment, treatment, care, services, and habilitation or rehabilitation for individuals not requiring 24-hour care. For behavioral health, this may be a structured, ongoing program that typically meets two to five times a week for two to five hours per day or evening.

**deemed status of opioid treatment programs** Status conferred by the Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) on a medication-assisted opioid treatment program (detoxification program) when it receives its own accreditation, regardless of whether the program is freestanding or a component of another organization (see also opioid treatment program).

**dentist** An individual who has received either a doctor of dental surgery degree or a doctor of dental medicine degree and who is licensed to practice dentistry.

**designated equivalent source** Selected agencies that have been determined to maintain a specific item(s) of credential(s) information that is identical to the information at the primary source. Designated equivalent sources include but are not limited to the following:
- The American Medical Association (AMA) Physician Masterfile for verification of a physician’s United States and Puerto Rican medical school graduation and postgraduate education completion
- The American Board of Medical Specialties (ABMS) for verification of a physician’s board certification
- The Educational Commission for Foreign Medical Graduates (ECFMG) for verification of a physician’s graduation from a foreign medical school
- The American Osteopathic Association (AOA) Physician Database for pre-doctoral education accredited by the AOA Bureau of Professional Education; post-doctoral education approved by the AOA Council on Postdoctoral Training; postdoctoral education approved by the Accreditation Council for Graduate Medical Education (ACGME); and Osteopathic Specialty Board Certification
- The Federation of State Medical Boards (FSMB) for all actions against a physician’s medical license
- The American Academy of Physician Assistants (AAPA) Profile for physician assistant education, provided through the AMA Physician Profile Service (https://profiles.ama-assn.org/amaprofiles/)

**disaster** A type of emergency that, due to its complexity, scope, or duration, threatens the organization’s capabilities and requires outside assistance to sustain care, safety, or security functions.

**discharge planning** A formalized process in an organization through which the need for a program or services of continuing and follow-up care, treatment, or services is ascertained and, if warranted, initiated for each individual served.

**dispensing** See medication management.

**disruptive and inappropriate behavior** See behaviors that undermine a culture of safety.

**do-not-use abbreviations** See prohibited abbreviations.

**drug** See medication.

**drug allergy** See medication allergy.

**E-App** An electronic form used for collecting information pertaining to the applicant organization. Information collected on this form will be used to determine the accreditation requirements applicable to the organization, the types of surveyors needed, the length of survey, and the survey fee.

**Early Survey Policy** A policy that permits an organization to achieve accreditation in a two-survey process. The first survey is limited in scope, and successful completion results in Preliminary Accreditation. The second survey addresses all accreditation requirements, and successful completion results in full accreditation.
eating disorder  A disorder characterized by eating habits that may involve either insufficient or excessive food intake to the detriment of an individual’s physical and emotional health.

element of performance (EP)  Specific action(s), process(es), or structure(s) that must be implemented to achieve the goal of a standard. The scoring of EP compliance determines an organization’s overall compliance with a standard.

emergency  An unexpected or sudden event that significantly disrupts the organization’s ability to provide care, treatment, or services or the environment of care itself or that results in a sudden, significantly changed or increased demand for the organization’s services. Emergencies can be either human-made or natural (such as an electrical system failure or a tornado), or a combination of both, and they exist on a continuum of severity.

emergency, life-threatening  A situation (for example, cardiac arrest, respiratory arrest) in which an individual may require resuscitation or other support to sustain life.

Emergency Management Plan (EMP)  The organization’s written document that describes the process it would implement for managing the consequences of emergencies, including natural and human-made disasters, that could disrupt the organization’s ability to provide care, treatment, or services.

employment assistance  A formal or an informal process of assisting the individual served in considering or maintaining employment as part of general care, treatment, or services. This term is not synonymous with vocational rehabilitation.

enteral nutrition  Nutrition provided via the gastrointestinal tract. Enteral nutrition encompasses both oral (delivered through the mouth) and tube (provided through a tube or catheter that delivers distal to the mouth) nutrition.

epidemic  A disease, such as influenza, that spreads rapidly, attacks many people in a geographic area, causes a high rate of morbidity or mortality, and then subsides. Epidemic applies especially to infectious diseases, as in an epidemic of cholera, but is also applied to any disease, injury, or other health-related event, such as an epidemic of teenage suicide.

every 36 months  Three years from the date of the last event, plus or minus 3 months.

evidence-based practices  Integrating the best research evidence with practitioner expertise and other resources, and with the characteristics, needs, values, and preferences of the population(s) served, to make decisions about how to promote health or provide care, treatment, or services.

Evidence of Standards Compliance (ESC) report  A report submitted by a surveyed organization, which details the action(s) that it took to bring itself into compliance with an accreditation require-
ment or clarifies why the organization believes that it was in compliance with the accreditation requirement for which it received a Requirement for Improvement. An ESC report must address compliance at the element of performance level.

exclusionary time-out  A procedure in which an individual served is excluded from the immediate environment by staff to help the individual regain behavioral/emotional control. This procedure involves the staff verbally directing the individual to remove herself or himself from the immediate environment and verbally restricting the individual to a quiet area or unlocked quiet room. This definition of time-out does not include instances in which an individual served is restricted to an unlocked room or area consistent with a program’s rules (such as restriction to the individual’s sleeping area for quiet time before bedtime or a room or area for homework time) nor does it include a self-calming strategy that the individual served may learn and use to remove herself or himself from an overly-stimulating environment.

exploitation  Taking unjust advantage of another for one’s own advantage or benefit.

facilitated referral  A process by which a behavioral health home refers individuals served to another organization for the individual’s primary physical health care, treatment, or service needs. This process includes taking the steps necessary to assist the individual in making an appointment and arriving at the scheduled time, accompanying the individual if necessary, following up with the primary physical health care provider to make certain that all relevant information is included in the individual’s clinical/case record, scheduling and keeping additional appointments, and any other activities needed to facilitate the provision of the primary physical health care, treatment, or services.

family  A person or persons who play a significant role in an individual’s life. A family is a group of two or more persons united by blood or adoptive, marital, domestic partnership, or other legal ties. The family may also be a person or persons not legally related to the individual (such as a significant other, friend, or caregiver) whom the individual personally considers to be family. A family member may be the surrogate decision-maker if authorized to make care decisions for the individual should he or she lose decision-making capacity or choose to delegate decision making to another.

family preservation / wraparound services  Organizations providing and/or coordinating services for children, youth, and their families with the goal of maintaining the child or youth in his or her family or community.

family support services  A service in which family members are assigned roles and responsibilities (for example, job coach) on the support team for the patient, resident, or individual served. This term is not synonymous with family therapy/counseling.
family therapy/counseling  A type of therapy/counseling designed to identify and address family patterns that contribute to a behavior disorder or mental illness. Family therapy involves discussion and problem-solving sessions with the family. Some of these sessions may be as a group, in couples, or one on one. In family therapy, the established patterns of interpersonal relationships are examined and, ideally, communication is strengthened within the family.

fear eliciting  Intentionally causing undue fear, fright, panic, or terror in order to obtain compliance by the individual.

fire-rated  Material that has undergone a test and is fire protection rated or fire resistance rated.

Two examples of the concept of fire-rated include the following:

- **fire resistance rating**  The time, in minutes or hours, that materials or assemblies have withstood a fire exposure, as determined by tests, or methods based on tests, prescribed by the National Fire Protection Association (NFPA).

- **fire protection rating**  A designation indicating the duration of fire test exposure to which a fire door assembly or fire window assembly was exposed and for which it met all the acceptance criteria, as determined in accordance with NFPA 252, Standard Methods of Fire Tests of Door Assemblies, or NFPA 257, Standard on Fire Test for Window and Glass Block Assemblies.

fire-safety management  Activities selected and implemented by the organization to assess and control the risks of fire, smoke, and other byproducts of combustion that could occur during the organization’s provision of care, treatment, or services.

fire watch  The assignment of a person or persons to an area for the express purpose of protecting occupants from fire or similar emergencies. Examples of this protection include:

- Notifying the fire department, the building occupants, or both of an emergency
- Preventing a fire from occurring
- Extinguishing small fires

Focused Standards Assessment (FSA)

A requirement of the accreditation process whereby an organization reviews its compliance with a selected subset of applicable Joint Commission accreditation requirements (including the applicable National Patient Safety Goals, a selection of standards that address accreditation program-specific high-risk areas, and the organization’s Requirements for Improvement [RFIs] from its last triennial survey); completes and submits to The Joint Commission a Plan of Action (POA) for any accreditation requirement with which it is not in full compliance; and chooses whether to engage in a telephone discussion with a member of the Standards Interpretation Group staff to determine the acceptability of the POA or discuss any other area of concern. Alternatives for a Full FSA submission include FSA Option 1 (attestation that an FSA was completed, but not submit-
ted to The Joint Commission), Option 2 (on-site survey with documented findings), and Option 3 (on-site survey without documented findings). The FSA encourages organizations to be in continuous compliance with Joint Commission accreditation requirements and helps them to identify and manage risk. The organization retains the option to complete self-assessment with all applicable accreditation standards in the FSA tool, available on the organization’s Joint Commission Connect™ extranet site. See also Intracycle Monitoring (ICM).

**foot pound**  A unit of work done by a force of one pound acting through a distance of one foot in the direction of the force.

**forensic services**  Behavioral health care, treatment, or services provided by an order issued by the criminal or juvenile justice system.

**foster care, adult**  A living arrangement where an adult resides as a means of providing protection, shelter, and care. These living arrangements are in private, single residences.

**foster care, therapeutic child/youth**  Treatment services provided to a child or youth outside his or her own home, in a single, private residence. Services are delivered primarily by treatment foster parents who bear direct responsibility for implementing the select in-home aspects of the treatment plan.

**foster care, traditional child/youth**  A living arrangement where a child or youth resides outside his or her own home as a means of providing protection and care. These living arrangements are private, single residences that include relative, non-relative, or non-finalized adoptive homes.

**full survey**  An on-site survey that assesses an organization’s compliance with all applicable Joint Commission accreditation requirements. See also accreditation survey.

**functional exercise**  An exercise that validates the coordination of the emergency response activities within the organization, including collaboration with planning and response partners. It is an operations-based exercise that is action-oriented and designed to validate plans, policies, agreements, and procedures; clarify roles and responsibilities; and identify resource gaps in an operational environment.

**governance**  The individual(s), group, or agency that has ultimate authority and responsibility for establishing policy; maintaining quality of care, treatment, or services; and providing for organization management and planning. Other names for
this group include the owner(s), board, board of trustees, board of governors, board of commissioners, and partnership.

group home A community-based congregate living arrangement that is staffed when individuals served are present. Group homes may serve children, youth, or adults who are capable of self-preservation in the event of an emergency in the organization.

guardian A parent, a trustee, a conservator, a committee, or another individual or agency empowered by law to act on behalf of or be responsible for the patient, resident, or individual served. See also family, surrogate decision-maker.

hazardous materials and waste Materials whose handling, use, and storage are guided or defined by local, state, or federal regulation, such as the Occupational Safety and Health Administration’s Regulations for Bloodborne Pathogens regarding the disposal of blood and blood-soaked items and the Nuclear Regulatory Commission’s regulations for the handling and disposal of radioactive waste. This also includes hazardous vapors (for example, glutaraldehyde, ethylene oxide, nitrous oxide) and hazardous energy sources (for example, ionizing or nonionizing radiation, lasers, microwave, ultrasound). Although The Joint Commission considers infectious waste as falling into this category of materials, federal regulations do not define infectious or medical waste as hazardous waste.

hazard vulnerability analysis (HVA) A process for identifying potential emergencies and the direct and indirect effects these emergencies may have on the organization’s operations and the demand for its services.

health information Any information, oral or recorded, in any form or medium, that is created by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse that relates to past, present, or future physical or mental health or condition; the provision of health care; or payment for the provision of health care to an individual.

high-risk procedures or processes A procedure or process that, if not planned and/or implemented correctly, has a significant potential for affecting the safety of a patient or an individual served.

history and physical Information gathered about an individual using a holistic approach for the purpose of establishing a diagnosis and developing a plan for care, treatment, or services to address physical health issues. The history may include information about previous illnesses; previous medical or surgical interventions and response to treatment; family health history; and social, cultural, economic, and lifestyle issues that may affect the individual’s health and well-being. The physical involves the physical examination of the individual’s body by the following means: inspection, palpation, percussion, and auscultation. When used in concert with behav-
ioral health care services, the history and physical may be used to rule out physical causes for behavioral health conditions or to assess the impact of a medical diagnosis or treatment on a behavioral health condition.

**housing first** A program model with the goal of placing individuals served who are homeless into private, permanent housing without any requirement to participate in behavioral or physical health care, treatment, or services of any kind, except to meet with the organization’s case management staff on a regular basis. Case management staff then actively work with the individual to engage him or her in other available behavioral or physical health care, treatment, or services in support of his or her goals. See also permanent housing support.

**human subject research** The use of humans in the systematic study, observation, or evaluation of factors for preventing, assessing, treating, and understanding an illness. The term applies to all behavioral and medical experimental research that involves human beings as experimental subjects.

**Immediate Threat to Health or Safety** A threat that represents immediate risk and has or may potentially have serious adverse effects on the health or safety of the patient, resident, or individual served. These threats are identified on site by the surveyor.

**individualized behavioral contingencies** An intervention based on behavioral and learning theory using operant conditioning, social learning, or rarely, classical conditioning. Techniques commonly used in the intervention include:

- Positive reinforcement schedules for replacement behavior (acceptable, appropriate, desirable behavior).
- Extinction techniques to extinguish or significantly reduce the target behaviors (unacceptable, inappropriate, or undesirable behaviors).

Characteristics of an individualized behavioral contingency program include the following:

- It is a written, planned program.
- It is individualized.
- It is distinct from routine interactions with the individual served.
- It is applied at all times the individual served is supervised by staff.
- Staff are trained in the application of the program.

**individual served** An individual who receives care, treatment, or service; the individual can be a child, a youth, or an adult. When required for the well-being or age of the individual served, a legally responsible individual is also involved in the care, treatment, or service of the individual served.

**infection** The transmission of a pathogenic microorganism to a host, with subsequent invasion and multiplication, with or without resulting symptoms of disease.
infection, epidemic  See epidemic.

informed consent  Agreement or permission accompanied by full notice about the care, treatment, or service that is the subject of the consent. An individual served must be apprised of the nature and risks of care, treatment, or services, as well as any alternatives. After receiving this information, the individual served or the guardian of the individual then either consents to or refuses such care, treatment, or services.

in-home behavioral health care services  Behavioral health care services provided in the residence of an individual served. In-home behavioral health care services may include individual and family counseling, mobile crisis evaluation service, parent training, early intervention, or support services.

initial survey  An accreditation survey of an organization that has not been accredited by The Joint Commission for at least four months or an accreditation survey of an organization undergoing its first Joint Commission survey.

inpatient services  A highly structured environment for individuals who require 24-hour registered nursing supervision and who may be incapable of self-preservation in case of an emergency in the organization.

instrument, waived testing  A waived testing device used for recording, measuring, or controlling. The levels of operation vary from manual steps to full automation, and specialized knowledge and skill are required.

instrument-based waived testing  Tests with analysis steps that rely on the use of an instrument to produce a test result of a patient, resident, or individual served.

integrated care  Care, treatment, or services (including helping individuals to make healthy choices and lifestyle changes) provided or facilitated by the behavioral health home that address the behavioral health and physical health needs, strengths, preferences, and goals of the individual served. The care, treatment, or services are planned, delivered, and monitored as a coordinated and integrated whole in order to improve individuals’ behavioral and physical health outcomes. See also integrated care team.

integrated care team  The staff in the behavioral health home who provide or facilitate the provision of integrated care to the individual served. The team members include the behavioral and physical health care, treatment, or service providers. The team members work together and communicate closely with one another in order to provide or facilitate the provision of integrated, comprehensive, and coordinated care, treatment, or services to the individual served. The team members understand the individual’s needs, strengths, preferences, and goals regarding his or her behavioral health and physical health and use that information to plan and deliver the individual’s integrated care.
Depending on the structure of the behavioral health home, the integrated team members may all be members of the behavioral health care organization’s staff, or they may be split between the behavioral health care organization and another organization; regardless of the home’s structure and the location of the team members, they are expected to function as a single integrated team. See also integrated care.

**integrity**  The property that data or information have not been altered or destroyed in an unauthorized manner.

**intellectual/developmental disabilities**  Intellectual and physical limitations affecting major life activities. These limitations arise before adulthood and usually last throughout the individual’s life.

**intensive outpatient services**  An environment offering an organized day or evening program that may include screening or assessment, treatment, care, services, and habilitation or rehabilitation for individuals not requiring 24-hour care. For behavioral health, this may be a structured, ongoing program that typically meets two to five times a week for two to five hours per day or week.

**interdisciplinary**  An approach to care, treatment, or services that involves two or more disciplines or professions (for example, social work, nursing, spiritual support, psychology, psychiatry, music, or art therapy) collaborating to plan, treat, or provide care, treatment, or services to an individual served and/or that person’s family.

**interim life safety measures (ILSM)**  A series of 11 administrative actions intended to temporarily compensate for significant hazards posed by existing National Fire Protection Association 101 - 2012 *Life Safety Code* deficiencies or construction activities.

**interpreting services**  A trans-language rendition of a spoken message in which the interpreter comprehends the source language and can speak comprehensively in the target language to convey the meaning intended in the source language. The interpreter knows health and health-related terminology and provides accurate interpretations by choosing equivalent expressions that convey the best matching and meaning to the source language and captures, to the greatest possible extent, all nuances intended in the source message.

**interval-based maintenance**  See maintenance.

**Intracycle Monitoring (ICM)**  A process to help accredited organizations at various touch points in the triennial accreditation cycle with their continuous compliance efforts. The process involves access to an ICM Profile available on the organization’s *Joint Commission Connect™* extranet site. The ICM Profile identifies high-risk areas and related standards areas and displays them within a Focused Standards Assessment (FSA) tool, which allows organizations to conduct a self-assessment of stan-
standards to identify and manage risk in the organization. See also Focused Standards Assessment (FSA).

**Investigational medication** A medication used as part of a research protocol or clinical trial.

**Knowledge-based information** A collection of stored facts, models, and information that can be used for ongoing staff development, for designing and redesigning processes, and for solving problems. Knowledge-based information is found in the clinical, scientific, and management literature.

**Laboratory** A facility that is equipped to examine material derived from the human body to provide information for use in the diagnosis, prevention, or treatment of disease; also called clinical laboratory or medical laboratory.

**Leader** A staff member who sets expectations, develops plans, and implements procedures to assess and improve the quality of the organization’s governance, management, clinical and support functions, and processes. Leaders include professionals with overall responsibility to plan, organize, and operate a service or program, and may include, but are not limited to, the clinical director and program or service director, the chief executive officer, the executive director, and other staff members in leadership positions within the organization.

**Level systems** A type of behavioral intervention that uses a methodology to group individuals served by their needs and behaviors. An individual served progresses through levels of systems that are associated with privileges and restrictions that are made known to staff, individuals served, and their families.

**Licensed independent practitioner** Any practitioner permitted by law and by the organization to provide care, treatment, or services, without direction or supervision, within the scope of the practitioner license and consistent with assigned clinical responsibilities.

**Licensure** A legal right that is granted by a government agency in compliance with a statute governing an occupation (such as medicine, nursing, psychiatry, psychology, clinical counseling, or clinical social work) or the operation of an activity in a health care occupancy (for example, skilled nursing facility, residential treatment center, hospital).

**Life book** A chronological record of a child’s life, usually in a photo album or binder, created by the child and/or the child’s caregivers, that documents for the child in a concrete way the events and relationships important to the child. It may include photographs, mementos, descriptions, or other elements that help the child understand his or her biological origins and others who played significant roles in his or her life.

**Life Safety Code®** A set of standards for the construction and operation of buildings intended to provide a reasonable degree of safety during fires. These standards are prepared, published, and periodically re-
vised by the National Fire Protection Association and adopted by The Joint Commission to evaluate health care organizations under its life safety management program. See also occupancy.

**look-alike/sound-alike medications**
Similar medication names, either written or spoken, which may lead to potentially harmful medication errors when confused with each other.

**maintenance**
There are five types of maintenance — predictive, metered, corrective, interval-based, and reliability-centered:

1. **Predictive maintenance** - A type of maintenance strategy that provides the means to achieve reliability levels that exceed the performance of a piece of equipment or system. This strategy is designed to measure and track data significant to the piece of equipment or system. It confirms possible faults with the equipment, and specific repairs are completed before the equipment fails. Predictive analysis can be performed using advanced monitoring instruments and predictive software that collects data and performs an analysis. The data collected are analyzed, and corrective maintenance is performed when the equipment is performing outside the desired operating parameters.

2. **Metered maintenance** - Maintenance strategy based on the hours of run time or the number of times the equipment is used (for example, number of images processed).

3. **Corrective maintenance** - Maintenance strategy that restores a piece of equipment to operational status after equipment failure.

4. **Interval-based maintenance** - Maintenance done according to specific intervals (for example, calendar time, running hours). A number of periodic inspections or restoration tasks are completed, based on information/data obtained from the last equipment check.

5. **Reliability-centered maintenance** - A type of maintenance that begins with a failure mode and effects analysis to identify the critical equipment failure modes in a systematic and structured manner. The process then requires the examination of each critical failure mode to determine the optimum maintenance policy to reduce the severity of each failure.

The chosen type of maintenance strategy must take into account cost, safety, and environmental and operational consequences. Some functions are not critical and may be allowed to “run to failure,” while other functions must be preserved at all cost. Reliability-centered maintenance emphasizes the use of predictive maintenance techniques in addition to traditional preventive measures (metered, corrective, and interval based).

**means of egress**
A continuous and unobstructed way of travel from any point in a building or other structure to a public way consisting of three separate and distinct parts: the exit access, the exit, and the exit discharge.
means of escape  A way out of a building that does not conform to criteria for an approved means of egress but does provide an alternative way out (for example, an unenclosed interior stair).

medical device  An instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or another similar or related article, including a component part or accessory that is
(1) recognized in the official National Formulary or the United States Pharmacopeia or any supplement to them;
(2) intended for use in the diagnosis of disease or other conditions or in the cure, mitigation, treatment, or prevention of disease in humans or other animals; or
(3) intended to affect the structure or any function of the body of humans or other animals and that does not achieve any of its primary intended purposes through chemical action within or on the body of humans or other animals and that is not dependent on being metabolized for the achievement of any of its primary intended purposes.

medical director, opioid treatment program  A physician who is licensed to practice medicine in the jurisdiction in which the opioid treatment program is located. The medical director is responsible for administering all medical services provided by the program, either by performing them directly or by delegating specific responsibilities to other professionals.

medical equipment  Fixed and portable equipment used for the diagnosis, treatment, monitoring, and direct care of individuals.

medical history  A record consisting of an account of an individual’s physical health history, obtained whenever possible from the individual, and including at least the following information: chief complaint, details of the present illness or care needs, relevant past history, and relevant inventory by body systems.

medically supervised withdrawal  The gradual reduction of a medication dosage over time under the supervision of a physician to achieve the elimination of tolerance to and physical dependence on opioid medications. One synonym is tapering. Detoxification is sometimes used as a synonym; however, drugs used to treat addiction are not toxic when administered in proper dosages.

medical supplies  Medical items, usually of a disposable nature, such as bandages, sterile drapes, and suture materials. These supplies differ from permanent or durable items, such as medical equipment and devices.

medication  Any prescription medications, sample medications, herbal remedies, vitamins, nutraceuticals, vaccines, or over-the-counter drugs; diagnostic and contrast agents used on or administered to persons
to diagnose, treat, or prevent disease or other abnormal conditions; radioactive medications, respiratory therapy treatments, parenteral nutrition, blood derivatives, and intravenous solutions (plain, with electrolytes and/or drugs); and any product designated by the Food and Drug Administration (FDA) as a drug. This definition of medication does not include enteral nutrition solutions (which are considered food products), oxygen, and other medical gases.

**medication allergy** A state of hypersensitivity induced by exposure to a particular drug antigen resulting in harmful immunologic reactions on subsequent drug exposures, such as a penicillin drug allergy. See also medication.

**medication error** A preventable event that may cause or lead to inappropriate medication use or harm to an individual served while the medication is in the control of a professional or the individual served. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing; order communication; product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use. See also significant medication error.

**medication expiration date** The last date that a medication or product is to be used or administered.

**medication management** The process an organization uses to provide medication therapy to individuals served by the organization. The components of the medication management process include the following:

- **procurement** The task of obtaining selected medications from a source outside the organization. It does not include obtaining a medication from the organization’s own pharmacy, which is considered part of the ordering and dispensing processes.

- **storage** The task of appropriately maintaining a supply of medications on the organization’s premises.

- **secure** In locked containers, in a locked room, or under constant surveillance.

- **prescribing or ordering** The process of a licensed independent practitioner or prescriber transmitting a legal order or prescription to an organization, directing the preparing, dispensing, and administration of a specific medication to a specific individual. It does not include requisitions for medication supplies.

- **transcribing** The process by which an order from a licensed independent practitioner is documented either in writing or electronically.

- **preparing** Compounding, manipulating, or in some way getting a medication ready for administration, exactly as ordered by the licensed independent practitioner.
- **dispensing** Providing, furnishing, or otherwise making available a supply of medications to the individual for whom it was ordered (his or her representative) by a licensed pharmacy according to a specific prescription or medication order, or by a licensed independent practitioner authorized by law to dispense. Dispensing does not involve providing an individual a dose of medication previously dispensed by the pharmacy.

- **administration** The provision of a prescribed and prepared dose of an identified medication to the individual for whom it was ordered to achieve its pharmacological effect. This includes directly introducing the medication into or onto the individual’s body.

- **medication reconciliation** The process of identifying the medications currently being taken by an individual. These medications are compared to newly ordered medications and discrepancies are identified and resolved.

- **medications, high-alert** Medications that bear a heightened risk of causing significant harm to individuals when they are used in error.

- **mental abuse** Intentional mistreatment of an individual that may cause psychological injury. Examples include humiliation, harassment, exploitation, and threats of punishment or deprivation.

- **mental health counselor** A professional who is certified and/or licensed and has the skills and knowledge to provide a range of behavioral health services to individuals. A mental health counselor provides services in areas such as psychotherapy, substance use, crisis management, psychoeducational, and prevention programs.

- **mental health services** Care, treatment, or services provided to individuals with mental health issues, including dual diagnosis.

- **metered maintenance** See maintenance.

- **mitigation, emergency** Those activities an organization undertakes in attempting to reduce the severity and impact of a potential emergency. See also emergency.

- **multidisciplinary team** A group of staff members composed of representatives from a range of professions, disciplines, or service areas.

- **near miss** See close call.

- **neglect** The absence of the minimal services or resources required to meet basic needs. Neglect includes withholding or inadequately providing medical care and, consistent with usual care, treatment, and services, food and hydration (without approval from the individual, physician, or surrogate), clothing, or good hygiene. It may also include placing an individual in unsafe or unsupervised conditions. See also abuse.

- **nursing** The health profession dealing with nursing care and services as defined by the Code of Ethics for Nurses with Interpretive Statements, Nursing’s Social Policy Statement, Nurses’ Bill of Rights,
Scope and Standards of Nursing Practice of the American Nurses Association and specialty nursing organizations and (2) defined by relevant state, commonwealth, or territory nurse practice acts and other applicable laws and regulations.

**occupancy** The purpose for which a building or portion thereof is used or intended to be used. Depending on the organization, occupancies may include ambulatory health care occupancy, business occupancy, health care occupancy, and residential occupancy.

- **business occupancy** An occupancy used to provide outpatient care, treatment, day treatment, or other services that does not meet the criteria in the ambulatory health care occupancy definition (for example, three or fewer individuals at the same time who are either rendered incapable of self-preservation in an emergency or are undergoing general anesthesia).

- **residential occupancy** An occupancy in which sleeping accommodations are provided for normal residential purposes and include all buildings designed to provide sleeping accommodations.

**opioid treatment program** Medication-assisted treatment of opioid dependence as certified by the Center for Substance Abuse Treatment (CSAT); this treatment includes detoxification or maintenance.

**organizational and functional integration** The degree to which a component of an organization is overseen and managed by the applicant organization. Organizational integration exists when the applicant organization’s governing body, either directly or ultimately, controls budgetary and resource allocation decisions for the component or, where separate corporate entities are involved, there is greater than 50% common governing board membership on the board of the applicant organization and the board of the component. Functional integration exists when the entity meets at least three of the following seven criteria:

1. The applicant organization’s human resources function hires and assigns staff at the component and has the authority to terminate staff at the component, to transfer or rotate staff between the applicant organization and the component, and to conduct performance appraisals of the staff who work in the component.

2. The applicant organization’s policies and procedures are applicable to the component with few or no exceptions.

3. The applicant organization manages all operations of the component (that is, the component has little or no management authority or autonomy independent of the applicant organization).

4. The component’s clinical/case records are integrated into the applicant organization’s clinical/case record system.

5. The applicant organization applies its performance improvement program to the component and has authority to implement actions intended to improve the performance at the component.
6. The applicant organization bills for services provided by the component under the name of the applicant organization.

7. The applicant organization and/or the component portrays to the public that the component is part of the organization through the use of common names or logos; references on letterheads, brochures, telephone book listings, or Web sites; or representations in other published materials.

**orientation** A process used to provide initial training and information while assessing the competence of clinical staff relative to job responsibilities and the organization’s mission and goals.

**outbreak** The occurrence of more than the expected number of cases of disease, injury, or other health conditions among a specific group during a specified time frame.

**outcome** A measure(s) that indicates the result of the care, treatment, or services provided.

**outdoor/wilderness experience** A behavioral health care treatment or service that uses an outdoor experience as an alternative to conventional environments and as a clinically focused intervention.

**outpatient services** Behavioral health care, treatment, or services provided on an appointment system for each visit.

**ownership** The entity that has ultimate control of resources and operation of the organization applying for accreditation.

**partial hospitalization program** An environment offering an organized day or evening program that may include screening or assessment, treatment, care, services, and habilitation or rehabilitation for individuals not requiring 24-hour care. For behavioral health, this may be a structured, ongoing program that typically meets two to five times a week for two to five hours per day or week.

**patient** A person who receives care, treatment, or services for opioid addiction.

**patient safety event** An event, incident, or condition that could have resulted or did result in harm to an individual served or a patient. See also adverse event, close call, sentinel event.

**peer recommendation** Information submitted by a practitioner(s) in the same professional discipline as an applicant and/or with the same clinical responsibility, reflecting his or her perception of the applicant’s clinical practice, ability to work as part of a team, and ethical behavior; or the documented peer evaluation of practitioner-specific data collected from various sources for the purpose of evaluating current competence.

**peer support services** A service wherein trained consumers support other consumers in recovery.

**performance improvement** The systematic process of detecting and analyzing performance problems, designing and developing interventions to address the prob-
lems, implementing the interventions, evaluating the results, and sustaining improvement.

**permanent housing support** Case management services based on a housing first program model for individuals served who are homeless. See also housing first.

**pharmacist** An individual who has a degree in pharmacy and is licensed and registered to prepare, preserve, compound, and dispense drugs and other chemicals.

**pharmacy services** Pharmaceutical care and services involving the preparation and dispensing of medications and medication-related devices and supplies by a licensed pharmacy, with or without the provision of clinical or consultant pharmacist services.

**physical abuse** Intentional mistreatment of an individual that may cause physical injury. Examples include hitting, slapping, pinching, or kicking, and may also include attempts to control behavior through corporal punishment.

**physical holding of children or youth** A method of restraint in which a child’s or youth’s freedom of movement or normal access to his or her body is restricted by means of staff physically holding the child or youth for safety reasons.

**physician** A doctor of medicine or doctor of osteopathy who, by virtue of education, training, and demonstrated competence, is assigned clinical responsibilities by the organization to perform a specific diagnostic or therapeutic procedure(s) and who is fully licensed to practice medicine.

**Plan for Improvement (PFI)** For purposes of Joint Commission accreditation, an organization’s written statement that details the procedures to be taken and time frames to correct existing *Life Safety Code*® deficiencies. See also *Life Safety Code*, Statement of Conditions™ (SOC).

**Plan of Action (POA)** A plan detailing the action(s) that an organization will take in order to come into compliance with a Joint Commission accreditation requirement. A POA must be completed for each element of performance associated with a non-compliant accreditation requirement.

**plan of care, treatment, or services** A written plan, based on data gathered during screening or assessment, that identifies care, treatment, or service needs, strengths, preferences, and goals; describes the strategy for meeting those needs, preferences, and goals; builds on the strengths and considers the preferences of the individuals served; and documents progress toward meeting the plan’s objectives. The plan may include care, treatment, habilitation, and rehabilitation.

**point-of-care testing** Analytical testing performed at sites outside the traditional laboratory environment, usually at or near where care is delivered to individuals. Testing may be categorized as waived, moderate, or high complexity under the Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88). Testing may range from
simple waived procedures, such as fecal occult blood, to more sophisticated chemical analyzers. Guided by CLIA requirements this testing may be under the control of the main laboratory, another specialized laboratory (for example, for arterial blood gas), or the nursing service (for example, for glucose meters). Point-of-care testing may also be known as alternative site testing, decentralized laboratory testing, or distributed site testing.

**practice guidelines**  See clinical practice guidelines.

**practitioner**  Any individual who is licensed and qualified to practice a health care profession (for example, physician, nurse, social worker, clinical psychologist, psychiatrist, respiratory therapist) and is engaged in the provision of care, treatment, or services.  See also licensed independent practitioner.

**predictive maintenance**  See maintenance.

**preparedness, emergency**  Activities an organization undertakes to build capacity and identify resources that may be used if an emergency occurs.  See also emergency.

**prescriber**  A practitioner authorized by law and organizational policy to order medications for individuals served.

**prescribing or ordering**  See medication management.

**prevention and wellness promotion services**  Prevention and wellness promotion services provide information and/or experiences that raise an individual’s awareness of, and help to support, healthy choices and life practices. These services are designed to assist individuals in coping with the stresses of life and establishing and maintaining healthy lifestyles. Prevention and wellness promotion services are community-based and therefore do not necessitate the opening of an individual or family clinical/case record, although members of the defined community or population may be receiving care, treatment, or services. Community-based prevention and wellness promotion services do not include similar types of services that are provided to an individual served in conjunction with, or as a result of, his or her needs and are addressed in the plan for care, treatment, or services. Prevention and wellness promotion services can either target the public (services directed toward any individual in the general population) or target a subgroup of the population whose members are at higher-than-average risk of experiencing a mental health or substance abuse issue. An example of community-based services is a program for junior high students on the dangers of alcohol and/or drug use. Such a program could include the use of a routine standardized screening tool which may result in a referral to a provider for follow-up. An example of services targeting a subgroup is a group-based intervention for children of parents with alcoholism, or de-
development of a coalition to address increased alcohol and/or drug abuse in a community.

**primary physical health care**  A basic level of physical health care that includes programs addressing the promotion of physical health, early diagnosis of disease or disability, treatment of acute and chronic illnesses, and prevention of disease. Primary physical health care includes health maintenance and education of the individual served, which can include wellness programs or education on diet, smoking cessation, the benefits of physical activity, and risk factors for cardiovascular disease. Examples of common acute health issues treated through primary physical health care include:

- Flu symptoms
- Sore throats
- Minor lacerations
- Sprains

Examples of common chronic health issues treated through primary physical health care include:

- Hypertension, heart failure, and angina
- Diabetes
- Asthma and COPD
- Arthritis

Examples of other care provided through primary physical health care include:

- Medical history and physical examination
- Screenings and diagnostic tests (such as blood pressure, blood sugar level, cholesterol, tuberculosis, sexually transmitted diseases, and HIV)
- Vaccinations
- Wellness or education programs
- Family planning services

**primary source**  The original source or an approved agent of that source of a specific credential that can verify the accuracy of a qualification reported by an individual practitioner. Examples include medical schools, nursing schools, graduate education, state medical boards, federal and state licensing boards, universities, colleges, and community colleges.

**privacy (of information)**  The right of an individual to limit the disclosure of personal information.

**program sponsor, opioid treatment programs**  The person named in the application for certification of an opioid treatment program who is responsible for the operation of the program and who assumes responsibility for all its employees. These employees include any practitioners, agents, and other persons providing medical, rehabilitative, or counseling services at the program or any of its medication units.

**prohibited abbreviations**  A list of abbreviations, acronyms, symbols, and dose designations that are not to be used throughout the organization. For accreditation purposes, the prohibited list applies, at a minimum, to all orders and all medication-
related documentation that is handwritten (including free-text computer entry) or on preprinted forms.

**protected health information**  Health information that contains information such that an individual person can be identified as the subject of that information.

**protective services**  A range of socio-legal, assistive, and remedial services that facilitate the exercise of individual rights and provide certain supportive and surrogate services to help children and youth, elderly, and developmentally disabled individuals reach the maximum independence possible yet protect them from exploitation, neglect, or abuse. Depending on the nature and extent of individual needs, protective services may range from counseling to full guardianship.

**psychiatric advance directive**  A type of advance directive used to record a competent individual’s specific instructions or preferences regarding future mental health treatment. Psychiatric advance directives can be used to plan for the possibility that the individual may lose capacity to give or withhold informed consent to treatment during acute episodes of psychiatric illness. See also advance directive.

**psychoactive**  See psychotropic medication.

**psychosocial**  Pertaining to the influence of social factors on an individual’s mind or behavior and to the interrelation of behavioral and social factors.

**psychotropic medication**  Any medication that affects the central nervous system and that is prescribed with the intention of affecting psychological processes such as perception, mental status, or behavior. Examples of classes of psychotropic medications include: antipsychotics, antidepressants, anxiolytics, hypnotics, and sedatives.

**Public Information Policy**  A Joint Commission policy which specifies the information that The Joint Commission may release about accredited organizations. By submitting a signed accreditation contract, the organization is acknowledging that The Joint Commission may make available to the public the accreditation-related information in accordance with this policy.

**qualifications**  Knowledge, education, training, experience, competency, licensure, registration, or certification related to specific responsibilities.

**quality control**  A set of activities or techniques whose purpose is to ensure that all quality requirements are being met. The organization monitors processes and solves performance problems to achieve this purpose.

**quality of care, treatment, or services**  The degree to which care, treatment, or services for individuals and populations increases the likelihood of desired health outcomes. Considerations include the appropriateness, efficacy, efficiency, timeliness, accessibility, and continuity of care,
treatment, or services; the safety of the physical environment; and the individual’s personal values, practices, and beliefs.

**Quality Report**  A publicly available report that includes relevant and useful information about the provision of safe quality care, treatment, or services provided in individual Joint Commission–accredited and –certified organizations. Quality Reports are created at the organization level and contain information regarding an organization’s accreditation or certification status. These reports provide detailed information about an organization’s performance and how it compares to that of similar organizations; the organization’s accreditation and/or certification decision and the effective dates of the accreditation/certification award; the last full survey/review date and last on-site survey/review date; programs accredited and/or services certified by The Joint Commission, and programs or services accredited by other accrediting bodies; compliance with The Joint Commission’s National Patient Safety Goals; special quality awards, and for hospitals, performance on National Quality Improvement Goals. If an organization has achieved both Joint Commission certification and accreditation, its Quality Report will contain both certification and accreditation information; the organizations will also have a separate Certification Quality Report.

**quantitative result**  A test result that is measured as a discrete number.

**quarterly**  Every three months, plus or minus 10 days.

**range orders**  Orders in which the dose or dosing interval varies over a prescribed range, depending on the situation or the individual’s status.

**rationale for a standard**  A short paragraph that explains the justification for a standard; that is, why the standard is important or how it contributes to quality and/or safety. A rationale is not scored, and not every standard has a rationale.

**read-back**  A method used to ensure understanding of information being communicated, often used between members of a care, treatment, or service team. The process involves the receiver of a verbal or telephone order writing down the complete order or test result or entering it into a computer and then reading it back and receiving confirmation from the person who gave the order or test result.

**reassessment**  Ongoing data collection, which begins on initial assessment, comparing the most recent data with the data collected at earlier assessments.

**recovery, emergency**  The final phase of emergency management, related to strategies, actions, and individual responsibilities necessary to restore the organization’s services after an emergency. See also emergency.

**recovery or resilience services**  Coordinated clinical and support services focused on an individual’s self development to meet the challenges of daily life and achieve his
or her fullest potential of independence and social integration. Recovery or resilience can refer to any of the following services: peer support, employment services, family support, community integration, and care coordination/case management.

**refeeding syndrome** The potentially fatal shifts in fluids and electrolytes that may occur in malnourished individuals receiving artificial refeeding (whether enterally or parenterally). These shifts result from hormonal and metabolic changes and may cause serious clinical complications.

**registered nurse (RN)** A person who is licensed to practice professional nursing.

**reliability-centered maintenance** See maintenance.

**Requirement for Improvement (RFI)** A recommendation that is required to be addressed in an organization’s Evidence of Standards Compliance in order for the organization to retain its accreditation. Failure to adequately address an RFI after two opportunities may result in a recommendation to place the organization in Accreditation with Follow-up Survey.

**residential program** A program that provides 24-hour care, treatment, or services to individuals who need a less structured environment than that of an inpatient program and who are capable of self-preservation in the event of an emergency in the organization. A residential setting may serve children, youth, or adults.

**respite care** A short term, temporary living arrangement used as a means of providing care while the primary caregiver(s) is unavailable. These living arrangements are provided in private, single residences, which include relative and non-relative respite homes.

**response, emergency** Actions taken and procedures implemented by the organization when an emergency occurs. See also emergency.

**restraint** Any method of restricting an individual’s freedom of movement, including seclusion, physical activity, or normal access to his or her body that (1) is not a usual and customary part of a medical diagnostic or treatment procedure to which the individual or his or her legal representative has consented, (2) is not indicated to treat the individual’s medical condition or symptoms, or (3) does not promote the individual’s independent functioning.

**Review Hearing Panel** A panel of three individuals, including one member of The Joint Commission’s Board of Commissioners, which evaluates the facts of an organization appealing a Preliminary Denial of Accreditation.

**risk assessment, proactive** An assessment that examines a process in detail including sequencing of events, actual and potential risks, and failure or points of vulnerability and that prioritizes, through a logical process, areas for improvement based on the actual or potential impact (that is, criticality) of care, treatment, or services provided.
root cause analysis (RCA)  See comprehensive systematic analysis.

SAFER matrix  The Survey Analysis for Evaluating Risk™ (SAFER™) matrix gives a visual representation of the risk level of each Requirement for Improvement (RFI). Each observation reported by a surveyor is plotted on the SAFER matrix according to the risk level of the finding. The risk level is determined according to two factors: (1) the likelihood of the finding to cause harm to individuals served, staff, and/or visitors, and (2) the scope at which the finding was observed.

safety  Risks that may arise from the performance of tasks, from the structure of the physical environment, or from situations beyond the organization’s control (such as weather). Safety refers to actions that mitigate such risk to individuals served and other persons including staff.

safety management  Activities selected and implemented by the organization to assess and control the impact of environmental risk, and to improve general environmental safety.

sampling  Selecting a subset from a larger group of units or observations that provides information that may be used to decide about the larger quantity.

scope of services  The activities defined by the organization and permitted by relevant licensing authorities as descriptive of the services the organization provides.

screening  Process of determining whether individuals have certain risk factors associated with physical or behavioral health issues requiring assessment.

seclusion  The involuntary confinement of an individual in a room alone, for any period of time, from which the individual is physically prevented from leaving. Seclusion does not include involuntary confinement for legally mandated but nonclinical purposes, such as the confinement of a person who is facing criminal charges or who is serving a criminal sentence.

secure  In a locked container, in a locked room, or under constant surveillance.

security  Protection of people and property against harm or loss (for example, workplace violence, theft, access to medications). Security incidents may be caused by persons from outside or inside the organization.

security, information  Administrative, physical, and technical safeguards to prevent unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

self-administration  Independent use of a medication by a patient or individual served, including medications that may be held by the organization for independent use.

self-management  Activities performed by individuals served with one or more chronic conditions that enable them to take an
active role in the management of their behavioral and physical health care and improve their clinical outcomes.

**semi-quantitative result**  Results of tests that are more precise than qualitative tests (negative/positive results) but less precise than quantitative tests (numerical value), usually scored on a graded scale (for example, 1+, 2+, 3+).

**sentinel event**  A patient safety event (not primarily related to the natural course of an illness or underlying condition of an individual served) that reaches an individual served and results in death, permanent harm, or severe temporary harm. Sentinel events are a subcategory of adverse events.

**sexual abuse**  Intentional mistreatment of a sexual nature of an individual that may cause physical and/or psychological injury. Examples include sexual harassment, sexual coercion, and sexual assault.

**shelter**  A non-treatment setting that provides emergency housing and, where needed, protection to individuals.

**significant adverse drug reaction (ADR)**  An adverse medication reaction experienced by an individual that required intervention to preclude or mitigate harm or that requires monitoring to confirm that it resulted in no harm to the individual.

**significant adverse medication reaction**  See significant adverse drug reaction (ADR).

**significant medication error**  A medication error that reached an individual that required intervention to preclude or mitigate harm and/or that required monitoring to confirm that it resulted in no harm to the individual.

**social worker**  A practitioner who provides a range of counseling, case management, and advocacy services to individuals served in various settings. Social workers may work in or with community-based programs, schools, residential and foster care programs, or independently as private practice psychotherapists. A social worker has at least a bachelor’s degree in social work plus documentation of any additional training, education, or experience commensurate with his or her responsibilities.

**specialty physical health care, treatment, or services**  Any non-primary physical health care, treatment, or services required by an individual served that are not provided by the behavioral health home. Such needs are most often addressed through facilitated referrals.

**staff**  As appropriate to their roles and responsibilities, all people who provide care, treatment, or services for the organization, including those receiving pay (for example, permanent, temporary, and part-time personnel, as well as contract employees), volunteers, and behavioral health profession students. When employed by the organization, licensed independent practitioners are considered staff.
standard A principle of safety of the individual served and quality of care, treatment, or services that a well-run organization meets. A standard defines the performance expectations, structures, or processes that must be substantially in place in an organization to enhance the quality of care, treatment, or services.

Statement of Conditions™ (SOC) A proactive document that helps an organization do a critical self-assessment of its current level of compliance and describe how to resolve any Life Safety Code® deficiencies. The SOC was created to be a “living, ongoing” management tool that should be used in a management process that continually identifies, assesses, and resolves Life Safety Code deficiencies.

sterilization The use of a physical or chemical procedure to destroy all microbial life, including highly resistant bacterial endospores.

stored emergency power supply systems (SEPSS) Systems that automatically supply illumination or power to critical areas and equipment essential for safety to human life. Included are systems that supply emergency power for such functions as illumination for safe exiting, ventilation where it is essential to maintain life, fire detection and alarm systems, public safety communications systems, and processes where the current interruption would produce serious life safety or health hazards to patients, residents, individuals served, the public, or staff. Note: Other non-SEPSS battery back-up emergency power systems that an organization has determined to be critical for operations during a power failure (for example, laboratory equipment, electronic medical records) should be properly tested and maintained in accordance with manufacturer recommendations.

supportive living See transitional/supportive living.

surrogate decision-maker Someone legally appointed to make decisions on behalf of another. This decision-maker can be a family member or someone not related to the individual served or patient. A surrogate decision-maker makes decisions when the individual served or patient is without decision-making capacity or when the individual served or patient has given permission to the surrogate to make decisions. Such a decision-maker is sometimes referred to as a legally responsible representative. See also family.

surveillance A systematic method of collecting, consolidating, and analyzing data concerning the frequency or pattern of, and causes or factors associated with, a given disease, injury, or other health condition. Data analysis is followed by the dissemination of the information yielded to those who can improve outcomes. Examples of surveillance data are data on hand hygiene, vaccinations, and staff immunization.

survey A key component in the accreditation process whereby a surveyor(s) conducts an on-site evaluation of an organization’s compliance with Joint Commission accreditation requirements.
Glossary

surveyor  For purposes of Joint Commission accreditation, a health care professional who meets The Joint Commission’s surveyor selection criteria, evaluates compliance with accreditation requirements, and provides education regarding compliance with accreditation requirements to surveyed organizations or systems. The type of surveyor(s) assigned is determined by the accreditation program and its services. A surveyor may be, but is not limited to, a licensed physician, surgeon, podiatrist, dentist, nurse, physician assistant, pharmacist, medical technologist, respiratory therapist, administrator, social worker, psychologist, or behavioral health care professional.

tabletop exercise  An exercise that involves key personnel discussing simulated scenarios and is used to assess plans, policies, and procedures. It is a discussion-based exercise that familiarizes participants with current plans, policies, agreements, and procedures, or may also be used to develop new plans, policies, agreements, and procedures.

technology-based, behavioral health care  Behavioral health care, treatment, or services provided through interactive, live/real time audio and video-conferencing utilizing internet technology.

The Joint Commission  An independent, not-for-profit organization dedicated to improving the safety and quality of health care through standards development, public policy initiatives, accreditation, and certification. The Joint Commission accredits and certifies more than 20,000 health care organizations and programs in the United States.

therapeutic schools  24-hour residential or day programs that provide an integrated educational milieu with an appropriate level of structure and supervision of physical, emotional, behavioral, familial, social, intellectual, and academic development. Therapeutic schools either grant a diploma or award credit that leads to admission or return to a diploma-granting school. Therapeutic schools serve children and youth who have a history of failing to function at home or in less structured or traditional school settings in terms of academic, social, or emotional behavioral development.

time-out  See exclusionary time-out.

tracer methodology  A process surveyors use during the on-site survey to analyze an organization’s systems or processes for delivering safe, high-quality care, treatment, or services by following an individual served through the organization’s care, treatment, or services in the sequence experienced by each individual. Depending on the setting, this process may require surveyors to visit multiple programs and services within an organization or within a single program or service to “trace” the care, treatment, or services rendered.

transitional/supportive/supervised living  24-hour living arrangements provided to individuals in need of a supervised, supportive living environment. This level of care is typically intermittently staffed and
provided as a community re-entry phase within a continuum of care, treatment, or services serving adults or older youth.

**transition services** Services provided to an older youth or young adult to assist the individual in transitioning to a more independent life.

**translation services** A trans-language rendition of a written document in which the translator comprehends the source language and can write comprehensively in the target language to convey the meaning intended in the source language. The translator knows health and health-related terminology and provides accurate translations by choosing equivalent expressions that convey the best matching and meaning to the source language and captures, to the greatest possible extent, all nuances intended in the source document.

**transmission-based precautions** Infection prevention and control measures to protect against exposure to a suspected or identified pathogen. These precautions are specific and based on the way the pathogen is transmitted. Categories include contact, droplet, airborne, and a combination of these.

**trauma** An experience that creates a sense of fear, helplessness, or horror and overwhelms an individual’s resources for coping. The impact of traumatic stress can be devastating and long-lasting, interfering with an individual’s sense of safety, ability to self-regulate, sense of self, perception of control and self-efficacy, and interpersonal relationships. Common experiences of trauma may include sexual abuse, physical abuse, severe neglect, loss, acts of violence, and/or the witnessing of violence, terrorism, and/or disasters.

**uniform data set** An agreed-on and accepted set of terms and definitions constituting a core of data; a collection of related data items.

**utility systems** Building systems that provide support to the environment of care, including electrical distribution and emergency power; vertical and horizontal transport; heating, ventilating, and air conditioning (HVAC); plumbing, boiler, and steam; piped gases; vacuum systems; and communication systems, including data exchange systems.

**variance** A measure of the difference in a set of observations; statistically, the square of the standard deviation.

**vocational rehabilitation services** Formal services designed to attain, retain, or restore vocational usefulness of persons experiencing limited functioning. Vocational rehabilitation services may include vocational evaluation services, employment skills training, work activities, and supportive employment.

**waived testing** Tests that meet the Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88) requirements for waived tests and are cleared by the Food and Drug Administration for home use. These tests employ methodologies that are so simple and accurate that the likelihood of erroneous results is negligible, or they pose
no risk of harm to the patient, resident, or individual served if the test is performed incorrectly. See also Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88).

**weekly**  Once every seven days, plus or minus two days.

**wilderness/outdoor experience**  See outdoor/wilderness experience.

**wraparound services / family preservation**  See family preservation.

**youth**  A person 13 years of age or older who has not reached age of majority, or as identified by law and regulation.
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