Directions for Replacement Pages
2017 CAMH Update 2

To update your print manual, please remove and recycle the pages listed in the following table 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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# Comprehensive Accreditation Manual for Hospitals

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### Rights and Responsibilities of the Individual (RI)
- RI-3–RI-22

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- TS-11–TS-12

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### Performance Measurement and the ORYX Initiative (PM)
- Entire chapter

### Required Written Documentation (RWD)
- Entire chapter

### Early Survey Policy (ESP)
- Entire chapter

### Primary Care Medical Home Certification Option (PCMH)
- Entire chapter

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### Record of Care, Treatment, and Services (RC)
- RC-1–RC-6

### Rights and Responsibilities of the Individual (RI)
- RI-3–RI-20

### Transplant Safety (TS)
- TS-11–TS-12

### Waived Testing (WT)
- No changes

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What’s New

2017 CAMH Update 2

Effective January 1, 2018, or 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 CAMH since its previous update. Revisions to content within this update are highlighted using shaded text within the replacement pages. Major changes to requirements, accreditation policies and procedures, and other important information in this update include the following:

- Completed Phase IV of the EP Review component of Project REFRESH™, resulting in the consolidation and movement of requirements within the “Human Resources” (HR), “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 Centers for Medicare & Medicaid (CMS) requirements and the 2012 Life Safety Code®
- Revised requirements in the “Medication Management” (MM) chapter so that they continue to reflect evidence-based practices and quality and safety issues that have emerged from the field in recent years (also affects requirements in the EC and “Record of Care, Treatment, and Services” [RC] chapters)
- Updated the decision rules for 2018 in the “The Accreditation Process” (ACC) chapter

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

Currently effective

- About the Comprehensive Accreditation Manual for Hospitals:
  - 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 1. Acronyms Used in This Manual: Updated acronyms
Accreditation Process Information: Clarified that the “Patient Safety Systems” (PS) chapter does not contain new standards or requirements
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 regarding frequently asked questions on standards compliance
Updated list of Joint Commission Connect resources and tools specific to hospitals
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

Patient Safety Systems (PS)

Effective January 1, 2018
Sidebar 2. Assessing Staff Accountability: Added two references as sources of information that can help an organization create a process for handling staff accountability
Tools for Conducting a Proactive Risk Assessment: Updated web addresses for the Contingency Diagram and Potential Problem Analysis (PPA)
Appendix. Key Patient Safety Requirements: Updated to align with changes to the requirements
Made minor editorial revisions
Accreditation Requirements

Accreditation Participation Requirements (APR)

- No changes

Environment of Care (EC)

Effective January 1, 2018

- EC.01.01.01, EPs 3–8: Renumbered as EPs 4–9, respectively
- EC.01.01.01, new EP 3: Added requirement for library of information on inspection, testing, and maintenance of equipment and systems
- EC.02.01.03, new EP 4: Added requirement regarding fire safety as it pertains to patients receiving respiratory therapy
- EC.02.03.01, EP 9: Revised to require periodic instruction for staff and licensed independent practitioners (LIPs) on duties under readily available, written fire response plan
- EC.02.03.01, new EP 11: Added requirement for periodic evaluations of (and written procedures regarding) fire hazards that could occur during surgical procedures
- EC.02.03.01, new EP 12: Added EP regarding what is required when flammable germicides or antiseptics are used during surgeries that involve electrosurgery, cautery, or lasers
- EC.02.03.01, new EP 13: Added requirement for meeting all other related Health Care Facilities Code fire protection requirements (NFPA 99-2012, Chapter 15)
- EC.02.03.03, EP 1: Removed cross-references to LS.02.01.70, EP 6 and LS.03.01.70, EP 6
- EC.02.03.03, EP 3: Revised EP to require that all quarterly fire drills are unannounced
- EC.02.03.05, EP 1: Updated NFPA reference in Note 1
- EC.02.03.05, EP 7: Updated NFPA reference in Note
- EC.02.03.05, EP 14: Updated and added NFPA references in Note 2
- EC.02.03.05, EP 17: Updated second NFPA reference in Note
- EC.02.03.05, EP 20: Updated to specify that sliding and rolling fire doors are what is tested in corridor walls and partitions
EC.02.03.05, EP 25: Clarified that written documentation is needed of annual inspection and testing of door assemblies; updated NFPA references

EC.02.03.05, EP 27: Renumbered as EP 28

EC.02.03.05, new EP 27: Added requirement for documented monthly testing of elevators with firefighters’ emergency operations

EC.02.04.03, new EP 8: Added labeling requirements for equipment listed for use in oxygen-enriched atmospheres

EC.02.04.03, new EP 10: Added EP regarding occupancies with hyperbaric facilities and compliance with NFPA requirements

EC.02.04.03, EP 14: Renumbered as EP 27

EC.02.04.03, EPs 15, 17, and 19–24: Renumbered as EPs 16, 18, and 20–25, respectively

EC.02.04.03, new EP 26: Added requirement regarding equipment maintenance and testing of anesthesia apparatus

EC.02.05.01, EP 1: Revised to require that utility systems are designed and installed according to NFPA codes

EC.02.05.01, EPs 2–11: Renumbered as EPs 3–12, respectively

EC.02.05.01, new EP 2: Added EP on designing building systems to meet NFPA Categories 1–4 requirements

EC.02.05.01, EP 15: Revised Note by removing examples of areas designed for control of airborne contaminants

EC.02.05.01, EP 19: Clarified that the emergency power supply system’s equipment and environment must be maintained at ambient temperature not less than 40°F

EC.02.05.01, EP 20: Added requirement that operating rooms are to be considered (and protected as) wet procedure locations unless determined otherwise by an authorized, documented, accessible risk assessment

EC.02.05.01, new EP 21: Added EP describing three room categories and how electrical distribution is handled for each

EC.02.05.01, new EP 22: Added EP on requirements for electrical receptacles in various locations and supplied from various branches

EC.02.05.01, new EP 23: Added EP on requirements for power strips according to where they are located
- EC.02.05.01, new EP 24: Added EP regarding the use and removal of extension cords, noting that they are not a substitute for a building’s fixed wiring
- EC.02.05.01, new EP 25: Added EP with NFPA compliance requirements regarding zone valves and alarm panels for general anesthesia administration areas using medical gases or vacuum
- EC.02.05.01, new EP 26: Added EP with NFPA compliance requirements regarding the essential electrical system’s supply of power to general anesthesia administration areas using medical gases or vacuum
- 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 updated NFPA references
- EC.02.05.03, new EP 4: Added requirement for new buildings with (or requiring) life support systems to have illumination of means of egress, emergency lighting equipment, exit, and directional signs
- EC.02.05.03, EP 5: Renumbered as EP 6 and updated NFPA references
- EC.02.05.03, EP 6: Renumbered as EP 7, removed urgent care areas from list of examples, and revised NFPA references
- EC.02.05.03, EP 10: Renumbered as EP 11
- EC.02.05.03, new EP 12: Added EP requiring equipment that is powered by the emergency power supply to be energized by the hospital’s design
- EC.02.05.03, EP 11: Renumbered as EP 13 and updated NFPA references
- EC.02.05.03, new EP 14: Added requirement for implementation of a policy to provide emergency backup for essential medication dispensing equipment
- EC.02.05.03, new EP 15: Added requirement for implementation of a policy to provide emergency backup for essential refrigeration for medications
- EC.02.05.03, EP 16: Added EP for deemed-status hospitals requiring that battery lamps and flashlights are available in areas not serviced by the emergency supply source
- EC.02.05.05, EP 7: Renumbered as EP 8
- EC.02.05.05, new EP 7: Added EP regarding requirements for testing line isolation monitors and maintaining records of required tests and associated repairs
- EC.02.05.07, EP 1: Clarified that hospitals must perform a monthly (at least) functional test of emergency lighting systems and exit signs and visual inspection of other exit signs; added another NFPA reference
- EC.02.05.07, EP 2: Added requirement for annual testing of battery-powered lighting in general anesthesia and deep sedation areas of new, renovated, or modernized construction; added cross-reference to LS.02.01.20, EP 39; added NFPA references
- EC.02.05.07, EP 5: Specified that an emergency generator test begins with a cold start; added NFPA reference
- EC.02.05.07, EP 6: Added NFPA reference
- EC.02.05.07, EP 7: Added manual transfer switches to list of items tested monthly; added NFPA reference
- EC.02.05.07, EP 9: Removed reference to EC.02.05.03, EPs 5 and 6
- EC.02.05.07, EP 10: Added Note 2 with NFPA reference
- EC.02.05.09, EP 1: Renumbered as EP 7; revised to include waste anesthetic gas disposal and support gas systems, items for inventory of critical components, and engineering certification requirements
- EC.02.05.09, new EP 1: Added EP categorizing medical gas, medical air, surgical vacuum, waste anesthetic gas disposal, and air supply systems for which failure is likely to cause major injury or death
- EC.02.05.09, EPs 2 and 3: Renumbered as EPs 8 and 9, respectively
- EC.02.05.09, new EP 2: Added requirement for all medical gas and vacuum alarm systems to comply with categorized warning system requirements
- EC.02.05.09, new EP 3: Added EP requiring that containers, cylinders, and tanks comply with specified NFPA requirements
- EC.02.05.09, EP 4: Renumbered as EP 10 and added NFPA references
- EC.02.05.09, new EP 4: Added EP specifying how to label doors for locations containing only oxygen or medical air and doors for locations containing other gases
- EC.02.05.09, EP 5: Renumbered as EP 11; specified how to label/identify piping and shutoff valves and added NFPA references
- EC.02.05.09, new EP 5: Added EP on signage for cylinder storage doors/gates, planning cylinder storage, and items permitted in central supply system/cylinder storage rooms
EC.02.05.09, EP 6: Renumbered as EP 12; added components to include in hospital’s cylinder policy (such as prohibiting adaptors or conversion fittings, maintaining proper temperatures, and securing valve protection caps)
EC.02.05.09, new EP 6: Added requirement listing factors for gauging a cylinder’s threshold pressure and volume of stored gases
EC.02.05.09, EP 7: Renumbered as EP 14
EC.02.05.09, new EP 13: Added EP stipulating how and where (never in patient care rooms) to conduct transfilling
EC.02.06.05, EP 3: Revised to include general maintenance when assessing risks
EC.03.01.01, new EP 1: Added EP on competency, education, and training of staff who maintain, inspect, test, and use systems and equipment pertaining to the physical environment
EC.03.01.01, EP 2: Deleted cross-reference to HR.01.04.01, EP 1
Made minor editorial revisions

Emergency Management (EM)

Effective November 12, 2017

Chapter Outline: Added “IV. Integrated Emergency Management Program (EM.04.01.01)”

Added the following requirements in response to the Centers for Medicare & Medicaid Services (CMS) Emergency Management Final Rule for deemed-status hospitals:
- EM.02.01.01, EPs 12–16
- EM.02.02.01, EPs 20–22
- EM.02.02.07, EPs 11, 13, and 14
- EM.02.02.09, EP 9
- EM.02.02.11, EP 12
- New Standard EM.04.01.01, Introduction, and EPs 1–3

EM.01.01.01, EP 2: Clarified that the hazard vulnerability analysis identifies potential emergencies within the organization and the community
EM.02.02.03, EP 3: Added list of examples of nonmedical supplies
EM.02.02.07, EP 2: Added requirement for documentation; clarified that patient evacuation is included in the list of staff roles and responsibilities
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- EM.02.02.09, EP 2: Clarified that Emergency Operations Plan identifies alternative means of providing lighting
- EM.02.02.09, EP 7: Added Note clarifying that essential utility systems include mechanisms for maintaining temperatures to protect patients and stored provisions

Human Resources (HR)

Effective January 1, 2018
- Chapter Outline: Recategorized HR.01.01.01 under “I.A. Qualifications” and HR.01.02.05 under “I.B. Staffing”
- HR.01.01.01, EPs 2 and 28: Renumbered as HR.01.02.05, EPs 2 and 28
- HR.01.02.01, EP 1: Renumbered as HR.01.01.01, EP 1 and updated cross-reference to EP 32
- HR.01.02.01, EPs 12 and 13: Renumbered as HR.01.01.01, EPs 17 and 18
- HR.01.02.05, EPs 1 and 2: Combined and renumbered as HR.01.01.01, EP 2, regarding how and when to verify and document care providers’ credentials
- HR.01.02.05, EP 3: Renumbered as HR.01.01.01, EP 3 and removed cross-reference
- HR.01.02.05, EPs 4, 5, 7, 16, 18, and 20: Renumbered as HR.01.01.01, EPs 4, 5, 7, 30, 31, and 33, respectively
- HR.01.02.05, EP 10: Deleted requirement
- HR.01.02.05, EP 11: Renumbered as HR.01.02.01, EP 1
- HR.01.02.05, EPs 12–15: Combined and renumbered as HR.01.02.01, EP 2, regarding the equivalent process for credentialing and privileging physician assistants and advanced practice registered nurses who practice within the hospital
- HR.01.02.05, EP 19: Renumbered as HR.01.01.01, EP 32 and updated cross-references
- HR.01.02.07, EPs 1 and 2: Updated cross-reference to HR.01.01.01, EP 32
- HR.01.04.01, EPs 1 and 2: Combined and numbered as EP 1, regarding orientation of staff to key safety content identified prior to provision of care, treatment, and services
- HR.01.04.01, EPs 3–6: Combined and numbered as HR.01.04.01, EP 3, regarding orientation of staff on policies and procedures, specific job duties, sensitivity to cultural diversity, and patient rights
HR.01.05.03, EPs 1 and 4: Combined and numbered as EP 1, regarding staff participation in ongoing education and training
Made minor editorial revisions

Infection Prevention and Control (IC)

Effective January 1, 2018
- IC.01.01.01, EP 3: Updated cross-reference to HR.01.01.01, EP 1
- IC.01.03.01, EPs 1–3: Combined and numbered as EP 1, regarding how hospitals identify risks for acquiring and transmitting infections, and deleted cross-reference to TS.03.03.01, EP 2
- IC.01.03.01, EPs 4 and 5: Renumbered as EPs 2 and 3
- IC.01.04.01, EPs 1–5: Combined and numbered as EP 1, regarding what is included in a hospital’s written infection prevention and control goals
- IC.01.05.01, EP 6: Removed cross-reference to HR.01.04.01, EPs 2 and 4
- IC.02.01.01, EP 7: Removed cross-reference to HR.01.04.01, EP 4
- IC.02.03.01, EPs 2 and 3: Combined and numbered as EP 2, on providing staff and LIPs with services to cope with infectious diseases
- IC.02.04.01, EP 2: Deleted cross-reference to HR.01.04.01, EP 4
- IC.02.04.01, EP 6: Deleted cross-reference to IC.02.04.01, EP 1
- IC.03.01.01, EPs 1–4: Combined and numbered as EP 1, on what is included in a hospital’s annual (or whenever risks significantly change) evaluation of the effectiveness of its infection prevention and control plan

Information Management (IM)
- No changes

Leadership (LD)

Effective November 12, 2017
- LD.01.03.01, EP 21: Added Note explaining that deemed-status hospital projects must be conducted with effort comparable to those of a quality improvement organization (QIO) cooperative project if the hospital does not participate in a QIO

Effective January 1, 2018
- Chapter Outline: Added LD.04.03.13 to “IV.C. Meeting Patient Needs”
- LD.01.03.01, EP 3: Deleted cross-reference to PC.01.01.01, EP 7
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- LD.04.03.09, EP 4: Added cross-reference to MS.13.01.01, EP 1
- Standard LD.04.03.13, EPs 1–7: Added new standard and EPs regarding pain management and pain assessment and leadership engagement in their oversight

**Life Safety (LS)**

*Effective January 1, 2018*

- LS.01.01.01, EP 6: Added NFPA reference
- LS.02.01.10, EP 1: Revised to include information on approved automatic sprinkler systems in new and existing construction
- LS.02.01.10, EP 2: Updated NFPA references
- LS.02.01.10, EPs 3, 5, and 8–11: Renumbered as EPs 6, 9, and 12–15, respectively
- LS.02.01.10, new EP 3: Added EP for buildings undergoing change of use/occupancy classification on complying with NFPA requirements
- LS.02.01.10, EP 4: Renumbered as EP 7; clarified that common walls can exist between two health care occupancy buildings or between a health care occupancy and a business occupancy; updated NFPA references
- LS.02.01.10, new EP 4: Added EP on building additions and compliance with NFPA requirements
- LS.02.01.10, new EP 5: Added EP on how non-sprinklered, rehabbed smoke compartments and buildings without automatic sprinkler systems must comply with NFPA requirements
- LS.02.01.10, EP 6: Renumbered as EP 10 and clarified fire rating of exit stairs in existing buildings and new construction
- LS.02.01.10, EP 7: Renumbered as EP 11 and updated NFPA references
- LS.02.01.10, new EP 8: Added EP on multiple occupancies and compliance with NFPA requirements
- LS.02.01.20, EP 1: Added language about when elevator lobby exit access door locking is allowed
- LS.02.01.20, EP 2: Deleted former language; replaced it with former EP 22 on when doors to patient sleeping rooms can be locked
LS.02.01.20, new EP 3: Added requirement for horizontal sliding doors that do not automatically close

LS.02.01.20, new EP 4: Added requirement regarding criteria for horizontal sliding doors serving an occupant load fewer than 10

LS.02.01.20, EP 6: Renumbered as EP 8 and added NFPA reference

LS.02.01.20, EP 7: Renumbered as EP 9 and added NFPA requirements for ramps, exit passageways, fire and slide escapes, alternating tread devices, and areas of refuge

LS.02.01.20, EP 8: Renumbered as EP 10; clarified signage requirements for new and existing stairs as well as for floor level information

LS.02.01.20, EP 9: Renumbered as EP 12; added description of acceptable exit discharge

LS.02.01.20, new EP 11: Added EP regarding NFPA requirements for the capacity of the means of egress

LS.02.01.20, EP 13: Renumbered as EP 16; clarified exit requirements for building floors and smoke compartments

LS.02.01.20, new EP 17: Added EP regarding exit requirements for corridors

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; added allowance regarding room intervening between exit access corridor and sleeping room with fewer than eight beds

LS.02.01.20, new EP 20: Added EP regarding requirements for existing exit access doors and exit doors

LS.02.01.20, new EP 21: Added EP regarding requirements for new exit access doors and exit doors

LS.02.01.20, EP 27: Renumbered as EP 32 and updated NFPA reference

LS.02.01.20, EP 33: Renumbered as EP 39 and added requirement regarding emergency lighting for the means of egress

LS.02.01.20, EP 34: Renumbered as EP 40 and added requirement about the emergency lighting system serving to continuously illuminate exit and directional signs

LS.02.01.20, new EP 37: Added requirement for measuring travel distances to exits

LS.02.01.30, EPs 2 and 3: Added Note for deemed-status hospitals on door latches for rooms containing flammable or combustible materials
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- LS.02.01.30, EP 4: Renumbered as EP 5 and updated NFPA reference
- LS.02.01.30, new EP 4: Added EP regarding NFPA requirements for laboratories using quantities of flammable, combustible, or hazardous materials that are considered a severe hazard
- LS.02.01.30, EP 5: Renumbered as EP 6 and clarified requirements for storage and handling 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, clarified that requirement applies to corridor doors in new buildings, added that positive latching hardware is required, and updated NFPA references
- 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 added requirement that in new buildings, doors in a means of egress swing in the opposite direction
- LS.02.01.30, EP 23: Renumbered as EP 24 and removed NFPA reference
- LS.02.01.30, EP 24: Renumbered as EP 25; specified applicability for new buildings constructed after July 5, 2016; and removed NFPA reference
- LS.02.01.34, EPs 1, 3, and 4: Renumbered as EPs 7, 9, and 10, respectively
- LS.02.01.34, new EPs 1, 3–6, 8: Added six EPs requiring installation and initiation of the fire alarm system, location of manual alarm boxes, occupant notification in new and existing buildings, automatic activation and alternative power supply, and smoke detection systems
- LS.02.01.34, EP 2: Revised to address smoke detectors in areas not continuously occupied and protected, detection in newly designated occupancies, and the monitoring of fire alarm system wiring or other transmission paths
- LS.02.01.35, EPs 7 and 9: Revised NFPA references
- LS.02.01.35, EP 11: Deleted NFPA reference
- LS.02.01.50, EP 1: Renumbered as EP 5 and clarified that requirement addresses direct-vent fireplaces
- LS.02.01.50, new EP 1: Added EP on NFPA requirements for equipment using gas or gas piping and for electrical wiring and equipment
- LS.02.01.50, EP 2: Renumbered as EP 7 and added NFPA reference
LS.02.01.50, new EP 2: Added EP addressing compliance with NFPA requirements and manufacturers’ specifications for heating, ventilation, and air conditioning
LS.02.01.50, EP 3–7: Renumbered as EPs 9–13, respectively
LS.02.01.50, new EP 3: Added requirement addressing the design and installation of heating devices (other than a central heating plant)
LS.02.01.50, new EP 4: Added EP listing criteria that must be met in order to use suspended unit heaters
LS.02.01.50, new EP 6: Added EP listing criteria that must be met in order to use solid fuel–burning fireplaces (in areas other than patient sleeping rooms)
LS.02.01.50, EP 8: Renumbered as EP 14 and updated NFPA reference
LS.02.01.50, new EP 8: Added EP addressing compliance with NFPA and ASME/ANSI requirements for escalators, dumbwaiters, and moving walks
LS.02.01.70, EPs 3, 5, and 6: Renumbered as EPs 5, 8, and 9, respectively
LS.02.01.70, new EP 3: Added EP addressing NFPA requirements for draperies, curtains, and loosely hanging fabric
LS.02.01.70, EP 4: Renumbered as EP 6 and moved NFPA reference from Note text to EP body text
LS.02.01.70, new EP 4: Added EP addressing char length and heat release NFPA criteria for upholstered furniture and mattresses in buildings without sprinkler protection
LS.02.01.70, new EP 7: Added EP addressing NFPA requirements for testing new and existing engineered smoke control systems
LS.03.01.10, EP 1: Revised to address alternative measures for sprinkler protection and automatic sprinkler systems for new and existing buildings; updated NFPA references
LS.03.01.10, EP 2: Renumbered as EP 4 and added Note on classifying outpatient surgical departments as ambulatory health care occupancies, regardless of the number of patients served
LS.03.01.10, new EP 2: Added EP addressing requirements for interior nonbearing walls
LS.03.01.10, EPs 3–5 and 7–9: Renumbered as EPs 5–7 and 9–11, respectively
LS.03.01.10, new EP 3: Added EP addressing building rehabilitation and NFPA compliance
LS.03.01.10, EP 6: Renumbered as EP 8 and deleted NFPA reference
LS.03.01.20, EPs 1, 5, 6, 8–10, and 13–15: Renumbered as EPs 2, 6, 7, 9–11, 14, 15, and 17, respectively
LS.03.01.20, new EP 1: Added EP requiring doors in a means of egress to not be equipped with a latch or lock that requires using a tool or key from the egress side (unless a compliant locking configuration is used)
LS.03.01.20, EP 2: Renumbered as EP 3, added description of acceptable exit discharges, and updated NFPA references
LS.03.01.20, EP 3: Deleted requirement
LS.03.01.20, EP 4: Renumbered as EP 5 and added exception for 34-inch existing door openings
LS.03.01.20, new EP 4: Added EP regarding NFPA requirements for the capacity of the means of egress
LS.03.01.20, EP 7: Renumbered as EP 8; clarified exit requirements for building floors, smoke compartments, and patient care suites larger than 2,500 square feet
LS.03.01.20, EP 11: Renumbered as EP 12 and clarified that means of egress are automatically illuminated at all points
LS.03.01.20, EP 12: Renumbered as EP 13 and added NFPA requirement regarding emergency lighting
LS.03.01.20, new EP 16: Added EP addressing illumination requirements for new buildings equipped with or requiring the use of life support systems
LS.03.01.30, EP 1: Added NFPA reference
LS.03.01.30, EP 4: Renumbered as EP 5 and clarified requirements for storage and handling of alcohol-based hand rubs
LS.03.01.30, new EP 4: Added EP regarding NFPA requirements for laboratories using quantities of flammable, combustible, or hazardous materials that are considered a severe hazard
LS.03.01.30, EPs 5–7, 9, and 12–14: Renumbered as EPs 7–9, 11, and 13–15, respectively
LS.03.01.30, new EP 6: Added requirement regarding the installation of commercial cooking equipment
LS.03.01.30, EP 8: Renumbered as EP 10 and added NFPA reference
LS.03.01.30, EP 10: Renumbered as EP 12 and added conditions under which the presence of two (or more) smoke compartments is not required for every story
LS.03.01.30, EP 11: Deleted requirement
LS.03.01.30, EP 15: Renumbered as EP 16 and added smoke barrier door requirements for new buildings

LS.03.01.30, EP 16: Renumbered as EP 17 and deleted Note

LS.03.01.34, EPs 1 and 6: Renumbered as EPs 7 and 10, respectively

LS.03.01.34, new EPs 1 and 3–6: Added five EPs on installation and initiation of the fire alarm system, location of manual alarm boxes, occupant notification in new and existing buildings, and automatic activation and alternative power supply

LS.03.01.34, EP 2: Revised to address smoke detectors in areas not continuously occupied and protected, detection in new buildings, and the monitoring of fire alarm system wiring or other transmission paths

LS.03.01.34, EPs 3 and 4: Renumbered as EPs 8 and 9, respectively, and deleted NFPA reference

LS.03.01.34, EP 5: Deleted requirement

LS.03.01.40, EP 2: Differentiated between approved automatic sprinkler system requirements for new and existing high-rise buildings


LS.03.01.50, EPs 1–4: Renumbered as EPs 5, 7, 8, and 10, respectively

LS.03.01.50, new EP 1: Added EP on NFPA requirements for equipment using gas or related gas piping and for electrical wiring and equipment

LS.03.01.50, new EP 2: Added EP addressing compliance with NFPA requirements and manufacturers’ specifications for heating, ventilation, and air conditioning

LS.03.01.50, new EP 3: Added requirement addressing the design and installation of heating devices (other than a central heating plant)

LS.03.01.50, new EP 4: Added EP listing criteria that must be met in order to use suspended unit heaters

LS.03.01.50, new EP 6: Added EP addressing compliance with NFPA and ASME/ANSI requirements for escalators, dumbwaiters, and moving walks

LS.03.01.50, new EP 9: Added EP with requirements for installation of waste chutes

LS.03.01.70, EP 1: Updated NFPA reference

LS.03.01.70, EPs 3–5: Renumbered as EP 5, 6, and 8, respectively

LS.03.01.70, new EP 3: Added EP addressing NFPA requirements for draperies, curtains, and loosely hanging fabric
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- LS.03.01.70, new EP 4: Added EP addressing char length and heat release NFPA criteria for upholstered furniture and mattresses in buildings without sprinkler protection
- LS.03.01.70, EP 6: Renumbered as EP 9 and deleted cross-reference
- LS.03.01.70, new EP 7: Added EP addressing NFPA requirements for testing new and existing engineered smoke control systems

Medication Management (MM)

Effective January 1, 2018
- Standard MM.01.01.03: Updated the Rationale by adding new examples of high-alert medications and an example of a hazardous drug
- MM.01.01.03, EP 1: Updated websites in footnote
- MM.03.01.01, EP 4: Added wasting to the list of things required in a hospital’s written policy on the control of medication between receipt by an individual health care provider and administration of the medication
- MM.04.01.01, EP 1: Added signed and held orders (and definition) to examples of medication orders listed in the Note
- MM.08.01.01, EP 6: Added cross-reference to MM.09.01.01, EP 8
- MM.08.01.01, new EP 16: Added requirement for policy that addresses the types of medication overrides that will be reviewed when automatic dispensing cabinets are used
- MM.09.01.01, EP 3: Deleted requirement

Medical Staff (MS)

Effective January 1, 2018
- MS.03.01.03, EP 2: Deleted requirement
- Standard MS.05.01.01: Updated the Rationale, noting that medical staff involvement in establishing protocols and reviewing performance improvement data improves practitioner engagement and the overall safety and quality of care
- MS.05.01.01, new EP 18: Added requirement for the medical staff’s active involvement in pain assessment, pain management, and safe opioid prescribing
- MS.09.01.01, EP 1: Deleted cross-reference to RI.01.07.01, EP 2
National Patient Safety Goals (NPSG)

Effective January 1, 2018

- NPSG.07.01.01, EP 1: Updated cross-reference to IC.01.04.01, EP 1
- NPSG.07.01.01, EP 2: Updated cross-reference to IC.03.01.01, EP 1
- NPSG.07.03.01: Added carbapenem-resistant enterobacteriaceae (CRE) to Note as an example of a multidrug-resistant organism (MDRO) that causes health care-associated infection
- NPSG.07.03.01, EP 1: Deleted cross-references to IC.01.03.01, EPs 4 and 5
- NPSG.07.03.01, EP 2: Revised so that education on MDROs and prevention strategies occurs upon hire, upon granting of initial privileges, and periodically thereafter as determined by the organization
- NPSG.07.04.01, EP 1: Revised so that education on central line–associated bloodstream infections (CLABSIs) and prevention strategies occurs upon hire, upon granting of initial privileges, and periodically thereafter as determined by the organization
- NPSG.07.04.01, Eps 7, 8, and 9: Renumbered as EPs 8, 10, and 7, respectively
- NPSG.07.04.01, EP 10: Renumbered as EP 9 and added requirement for maximum sterile barrier precautions during central venous catheter insertion
- NPSG.07.04.01, EP 11: Revised to require alcoholic chlorhexidine antiseptic to prepare skin for central venous catheter insertion
- NPSG.07.06.01: Made the following changes:
  - In the language of the standard, updated the website for the Guideline for Prevention of Catheter-associated Urinary Tract Infections, 2009
  - In EP 4, deleted cross-reference to PC.02.01.01, EP 1
  - In EP 5, deleted cross-reference to RC.01.01.01, EP 7

Nursing (NR)

- No changes

Provision of Care, Treatment, and Services (PC)

Effective November 12, 2017

- PC.02.01.03, EP 1: Added Note 2 explaining that the diets of patients at deemed-status hospitals must be ordered by the practitioner responsible for the patient’s care or by a qualified, properly authorized dietitian or nutrition professional
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Effective January 1, 2018

- PC.01.01.01, EP 7: Deleted cross-reference to LD.01.03.01, EP 3
- PC.01.02.01, EP 2: Deleted cross-reference to PC.01.02.07, EP 1
- Standard PC.01.02.07: Added Introduction and revised standards language to focus on enhanced pain assessment and pain management requirements
- PC.01.02.07, EP 1: Deleted requirement
- PC.01.02.07, EP 2: Renumbered as EP 1 and revised to require defined criteria for screening, assessing, and reassessing pain
- PC.01.02.07, new EP 2: Added EP on screening for pain during emergency department visits and at admission
- PC.01.02.07, EP 4: Renumbered as EP 3 and revised Note to include combining pharmacologic and nonpharmacologic approaches as a treatment strategy
- PC.01.02.07, new EP 4: Added requirement noting factors to consider when developing a pain treatment plan
- PC.01.02.07, new EP 5: Added EP on how the hospital involves patients in the pain management treatment planning process
- PC.01.02.07, new EP 6: Added requirement on monitoring patients at high risk for adverse opioid treatment outcomes
- PC.01.02.07, new EP 7: Added EP on reassessing and responding to a patient’s pain (language used in former EP 3) by considering certain components
- PC.01.02.07, new EP 8: Added requirement for educating the patient and family on discharge plans related to pain management
- PC.01.02.09, EP 8: Deleted cross-reference to RI.01.06.03, EP 3
- PC.01.03.01, EP 1: Deleted cross-reference to RC.02.01.01, EP 2
- PC.02.01.03, EP 1: Added Note 2 for deemed-status hospitals regarding the ordering of patient diets
- Made minor editorial revisions

Performance Improvement (PI)

Effective January 1, 2018

- PI.01.01.01, new EP 56: Added requirement for collecting data on pain assessment and pain management including types of interventions and effectiveness
- PI.02.01.01, new EP 18: Added requirement for collecting data on pain assessment and pain management to identify areas needing safety and quality improvements
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- PI.02.01.01, new EP 19: Added requirement for monitoring safe usage of opioids
- Standard PI.02.01.03: Deleted entire standard and EP 1
- PI.03.01.01, EP 2: Added cross-reference to MM.08.01.01, EP 6

Record of Care, Treatment, and Services (RC)

*Effective January 1, 2018*
- RC.01.01.01, EP 7: Added cross-reference to PC.01.02.07, EP 7
- RC.02.01.01, EP 1: Added cross-reference to LD.04.05.17, EP 4
- RC.02.01.01, EP 2: Added requirement for documentation and deleted cross-references to PC.01.02.01, EP 1 and PC.01.03.01, EP 1
- RC.02.01.01, EP 4: Deleted cross-references to RI.01.05.01, EP 11 and RI.01.03.01, EP 13

Rights and Responsibilities of the Individual (RI)

*Effective January 1, 2018*
- Chapter Outline: Removed RI.01.03.03 from “I.C. Informed Consent”
- RI.01.01.01, EP 8: Replaced all cross-references with new one to LD.04.03.13, EP 3
- RI.01.01.03, EP 2: Changed first cross-reference to HR.01.01.01, EP 1
- RI.01.02.01, EP 6: Renumbered as EP 2; added cross-reference to PC.01.02.07, EP 5; and revised cross-reference to RI.01.03.01, EP 1
- RI.01.02.01, EP 2 and partial EP 7: Combined and renumbered as RI.01.02.01, EP 3, on providing written information about the right to refuse care, treatment, and services
- RI.01.02.01, EP 3 and partial EP 7: Combined and renumbered as RI.01.02.01, EP 4, on respecting the right to refuse care, treatment, and services
- RI.01.02.01, EP 8: Added cross-reference to PC.01.02.07, EP 5
- RI.01.02.01, EPs 20–22: Combined and numbered as RI.01.02.01, EP 20, on providing information about outcomes of care, treatment, and services as well as unanticipated outcomes that are sentinel events
- RI.01.03.01, EPs 1–6 and 13: Combined and numbered as RI.01.03.01, EP 1, on following a written policy on informed consent that describes certain listed components
RI.01.03.01, EPs 7, 9, and 11: Combined and renumbered as RI.01.03.01, EP 2, on what is included in a discussion about the informed consent process

Standard RI.01.03.03 and EP 1: Renumbered as RI.01.03.01, EP 3, on obtaining/documenting informed consent before making/using recordings, films, or other images for internal use other than patient identification, diagnosis, or treatment

RI.01.03.05, EPs 4–7: Combined and numbered as RI.01.03.05, EP 4, on what to document in the research consent form

RI.01.04.01, EPs 1 and 2: Combined and numbered as RI.01.04.01, EP 1, regarding a hospital’s responsibility to inform patients of the names of those who have primary responsibility for, and those who will provide, their care

RI.01.05.01, EPs 1, 4–6, 8, 11–13, and 19: Combined and numbered as RI.01.05.01, EP 1, on following written policies for advance directives, forgoing or withdrawing life-sustaining treatment, and withholding resuscitative services

RI.01.05.01, EPs 15 and 16: Combined and numbered as RI.01.05.01, EP 15, on documenting and honoring patients’ wishes concerning organ donation

RI.01.05.01, EP 20: Deleted requirement

RI.01.07.01, EPs 1 and 2: Combined and numbered as RI.01.07.01, EP 1, on establishing and informing patients and families about the complaint resolution process

RI.01.07.07, EPs 1 and 2: Combined and numbered as RI.01.07.07, EP 1, on following a written policy that addresses situations in which patients and residents work for/on behalf of the hospital

Transplant Safety (TS)

Effective January 1, 2018

TS.03.03.01, EP 2: Deleted cross-reference to IC.01.03.01, EP 3

Waived Testing (WT)

No changes
Accreditation Process Information

The Accreditation Process (ACC)

Currently effective

- 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
- Inclusion of Physician Practices in Survey: Clarified that an organization may choose to include physician practices in the survey even if they are not included in the Medicare cost report
- Primary Care Medical Home Certification Option: Clarified that certification is awarded at site level
- Patient Blood Management Certification: Clarified that certification is awarded at site level
- 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 Emergency Management (EM) session to align with introduction to EM chapter
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 a hospital provides information to The Joint Commission with the words “in any way”
- Added new rule DA10 regarding individuals 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 hospitals 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 a hospital 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 Grid (SAG)

Effective November 12, 2017

- Added the following requirements with applicability to all five services (Acute, Long Term Acute Care, Psychiatric, Surgical Specialty, and Swing Beds services):
  - EM.02.01.01, EPs 12–16
  - EM.02.02.01, EPs 20–22
  - EM.02.02.07, EPs 11, 13, and 14
  - EM.02.02.09, EP 9
  - EM.02.02.11, EP 12
  - EM.04.01.01, EPs 1–3

- Updated service applicability of the following requirements to reflect that they are applicable only for Swing Beds:
  - HR.01.02.01, EPs 12 and 13
  - LD.04.02.03, EPs 13–16
  - PC.01.02.09, EP 8
  - PC.02.02.01, EPs 8, 9, and 12
  - PC.02.02.09, EPs 1 and 3
  - PC.04.01.03, EPs 5 and 6
  - PC.04.01.07, EP 1
RC.02.04.01, EPs 1 and 2
RI.01.06.05, EPs 4, 8, and 14
RI.01.06.09, EPs 1–3
RI.01.06.11, EP 3
RI.01.07.05, EPs 1, 3, 5, and 6
RI.01.07.13, EP 1

Effective January 1, 2018

- Added the following requirements with applicability to all five services (Acute, Long Term Acute Care, Psychiatric, Surgical Specialty, and Swing Beds services):

  - EC.01.01.01, EP 3
  - EC.02.01.03, EP 4
  - EC.02.03.01, EPs 11–13
  - EC.02.03.05, EP 27
  - EC.02.04.03, EPs 8, 10
  - EC.02.05.01, EPs 2, 21, and 23–25
  - EC.02.05.03, EPs 4, 12, and 14–16
  - EC.02.05.05, EP 7
  - EC.02.05.09, EPs 1–6 and 13
  - EC.03.01.01, EP 1
  - LS.02.01.10, EPs 3–5 and 8
  - LS.02.01.20, EPs 3, 4, 11, 17, 20, 21, and 37
  - LS.02.01.30, EP 4
  - LS.02.01.34, EPs 1, 3–6, and 8
  - LS.02.01.50, EPs 1–4, 6, 8
  - LS.02.01.70, EPs 3, 4, and 7
  - LS.03.01.10, EPs 2 and 3
  - LS.03.01.20, EPs 1, 4, and 16
  - LS.03.01.30, EPs 4 and 6
  - LS.03.01.34, EPs 1, 3–6
  - LS.03.01.40, EP 3
  - LS.03.01.50, EPs 1–4, 6, and 9
  - LS.03.01.70, EPs 3, 4, and 7
  - MM.08.01.01, EP 16
Added the following requirements with applicability to Acute, Long Term Acute Care, Psychiatric, and Surgical Specialty services:
- EC.02.04.03, EP 26
- EC.02.05.01, EPs 20, 22, and 26
- LD.04.03.13, EPs 1–7
- PI.01.01.01, EP 56
- PI.02.01.01, EPs 18 and 19

Renumbered the following requirements:
- EC.01.01.01, EPs 3–8, as EPs 4–9
- EC.02.03.05, EP 27, as EP 28
- EC.02.04.03, EPs 14, 15, 17, and 19–24, as EPs 27, 16, 18, and 20–25
- EC.02.05.01, EPs 2–11, as EPs 3–12
- EC.02.05.03, EPs 4–6, 10, and 11, as EPs 5–7, 11, and 13
- EC.02.05.05, EP 7, as EP 8
- EC.02.05.09, EPs 1–7, as EPs 7–12 and 14
- HR.01.01.01, EPs 2 and 28, as HR.01.02.05, EPs 2 and 28
- HR.01.02.01, EP 1, as HR.01.01.01, EP 1
- HR.01.02.01, EPs 12 and 13, as HR.01.01.01, EPs 17 and 18 (and removed applicability to Acute)
- HR.01.02.05, EPs 1 and 2, as HR.01.01.01, EP 2
- HR.01.02.05, EP 3–5, 7, 16, 18–20, as HR.01.01.01, EP 3–5, 7, 30, 31–33
- HR.01.02.05, EP 11, as HR.01.02.01, EP 1
- HR.01.02.05, EPs 12–15, as HR.01.02.01, EP 2
- HR.01.04.01, EPs 1 and 2, as EP 1
- HR.01.04.01, EPs 3–6, as EP 3
- HR.01.05.03, EPs 1 and 4, as EP 1
- IC.01.03.01, EPs 1–3, as EP 1
- IC.01.03.01, EPs 4 and 5, as EPs 2 and 3
- IC.01.04.01, EPs 1–5, as EP 1
- IC.02.03.01, EPs 2 and 3, as EP 2
- IC.03.01.01, EPs 1–4, as EP 1
- LS.02.01.10, EPs 3–7 and 8–11, as EPs 6, 7, and 9–15
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- LS.02.01.20, EP 22, as EP 2
- LS.02.01.20, EPs 3–21 and 23–36, as EPs 5–10, 12–16, 18, 19, 22–36, and 38–42
- LS.02.01.30, EPs 4–25, as EPs 5–26
- 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
- LS.03.01.10, EPs 2–9, as EPs 4–11
- LS.03.01.20, EPs 1, 2, and 4–15, as EPs 2, 3, 5–15, and 17
- LS.03.01.30, EPs 4–10 and 12–16, as EPs 5 and 7–17
- LS.03.01.34, EPs 1, 3, and 4, as EPs 7, 9, and 10
- LS.03.01.50, EPs 1–8, as EPs 5, 7, and 9–14
- LS.03.01.70, EPs 3–6, as EPs 5, 6, 8, and 9
- PC.01.02.07, EPs 2 and 4, as EPs 1 and 3
- RI.01.02.01, EP 2 and partial EP 7, as EP 3
- RI.01.02.01, EP 3 and partial EP 7, as EP 4
- RI.01.02.01, EP 6, as EP 2
- RI.01.02.01, EPs 20–22, as EP 20
- RI.01.03.01, EPs 1–6 and 13, as RI.01.03.01, EP 1
- RI.01.03.01, EPs 7, 9, and 11, as EP 2
- RI.01.03.03, EP 1, as RI.01.03.01, EP 3
- RI.01.03.05, EPs 4–7, as EP 4
- RI.01.04.01, EPs 1 and 2, as EP 1
- RI.01.05.01, EPs 1, 4–6, 8, 11–13, and 19, as EP 1
- RI.01.05.01, EPs 15 and 16, as EP 15
- RI.01.07.01, EPs 1 and 2, as EP 1
- RI.01.07.07, EPs 1 and 2, as EP 1

- Deleted requirements formerly numbered as follows:
  - HR.01.02.05, EP 10
  - LS.02.01.20, EP 2
  - LS.03.01.20, EP 3
  - LS.03.01.30, EP 11
  - LS.03.01.34, EP 5
  - MM.09.01.01, EP 3
Sentinel Events (SE)

Effective January 1, 2018
- Definition of Sentinel Event: Updated website in footnote to severe temporary harm
- Responding to Sentinel Events: Deleted paragraph referencing RI.01.02.01 and EPs 21 and 22
- Appendix: Deleted RI.01.02.01 and EPs 21 and 22
- Made minor editorial revisions

The Joint Commission Quality Report (QR)

Effective January 1, 2018
- 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

Performance Measurement and the ORYX Initiative (PM)

Effective January 1, 2018
- Current Requirements for Hospitals: Provided additional information about the ORYX program
- Requirements for Small Hospitals: Deleted section
- Requirements for Psychiatric Hospitals: Deleted section
- Requirements for Long Term Acute Care Hospitals and Inpatient Rehabilitation Facilities: Deleted section
- ORYX Performance Measure Report: Deleted Figures 1–4 (example pages from the report)
- Made minor editorial revisions
Required Written Documentation (RWD)

Effective November 12, 2017
- Added the following requirements:
  - EM.02.01.01, EPs 12–16
  - EM.02.02.01, EPs 20–22
  - EM.02.02.07, EPs 2, 13, and 14
  - EM.02.02.11, EP 12
  - EM.04.01.01, EPs 1–3

Effective January 1, 2018
- Renumbered the following existing RWD requirements:
  - EC.01.01.01, EPs 3–8, as EPs 4–9
  - EC.02.03.05, EP 27, as EP 28
  - EC.02.04.03, EPs 15 and 19–23, as EPs 16 and 20–24
  - EC.02.05.01, EPs 2–7 and 9, as EPs 3–8 and 10
  - EC.02.05.09, EPs 1 and 4, as EPs 7 and 10
  - HR.01.02.05, EPs 1 and 2, as HR.01.01.01, EP 2
  - HR.01.02.05, EPs 3–5, 19, and 20, as HR.01.01.01, EPs 3–5, 32, and 33
  - HR.01.02.05, EPs 12–14, as HR.01.02.01, EP 2
  - HR.01.04.01, EP 2, as EP 1
  - HR.01.04.01, EPs 3–6, as EP 3
  - HR.01.05.03, EPs 1 and 4, as EP 1
  - IC.01.03.01, EP 5, as EP 3
  - IC.01.04.01, EPs 1–5, as EP 1
  - RI.01.02.01, EP 2, as EP 3
  - RI.01.03.03, EP 1, as RI.01.03.01, EP 3
  - RI.01.03.05, EPs 4–7, as EP 4
  - RI.01.05.01, EP 6, as EP 1
- Added the following EPs:
  - EC.02.03.05, EP 27
  - EC.02.05.01, EP 20
  - EC.02.05.03, EPs 14 and 15
  - EC.02.05.05, EP 7
  - MM.08.01.01, EP 16
Early Survey Policy (ESP)

Effective November 12, 2017

- Added the following requirements:
  - EM.02.01.01, EPs 12–16
  - EM.02.02.01, EPs 20–22
  - EM.02.02.07, EPs 11 and 14
  - EM.02.02.09, EP 9
  - EM.02.02.11, EP 12
  - EM.04.01.01, EPs 1 and 3

Effective January 1, 2018

- Renumbered the following existing ESP requirements:
  - EC.01.01.01, EPs 3–8, as EPs 4–9
  - EC.02.04.03, EPs 14 and 17, as EPs 27 and 18
  - EC.02.05.01, EP 11, as EP 12
  - EC.02.05.03, EPs 6, 10, and 11, as EPs 7, 11, and 13
  - EC.02.05.05, EP 7, as EP 8
  - EC.02.05.09, EPs 2, 3, 5, 6, and 7, as EPs 8, 9, 11, 12, and 14
  - HR.01.01.01, EP 2, as HR.01.02.05, EP 2
  - HR.01.02.01, EPs 1, 12, 13, as HR.01.01.01, EPs 1, 17, 18
  - HR.01.02.05, EP 11, as HR.01.02.01, EP 1
  - HR.01.02.05, EPs 12–15, as HR.01.02.01, EP 2
  - HR.01.02.05, EPs 18–20, as HR.01.01.01, EPs 31–33
  - IC.01.03.01, EP 5, as EP 3
  - IC.01.04.01, EPs 1–5, as EP 1
  - LS.02.01.10, EPs 8–11, as LS.02.01.10, EPs 12–15
  - LS.02.01.20, EPs 32–36, as 38–42
  - LS.02.01.30, EP 25, as EP 26
  - LS.02.01.34, EPs 1, 3, and 4, as EPs 7, 9, and 10
  - LS.02.01.50, 3–8, as EPs 9–14
  - LS.02.01.70, EPs 5 and 6, as EPs 8 and 9
LS.03.01.10, EPs 4, 8, and 9 as EPs 6, 10, and 11
LS.03.01.20, EP 15, as EP 17
LS.03.01.30, EP 16, as EP 17
LS.03.01.34, EPs 1, 3, 4, and 6, as EPs 7–10
LS.03.01.50, EPs 2–4, as EPs 7, 8, and 10
LS.03.01.70, EPs 5 and 6, as EPs 8 and 9
RI.01.03.01, EPs 1–6, as EP 1
RI.01.03.05, EP 7, as EP 4
RI.01.05.01, EP 4, as EP 1

- Added the following EPs:
  - EC.02.01.03, EP 4
  - EC.02.03.01, EPs 11–13
  - EC.02.03.05, EP 27
  - EC.02.04.03, EPs 8, 10, and 26
  - EC.02.05.01, EPs 20–26
  - EC.02.05.03, EPs 12 and 14–16
  - EC.02.05.09, EPs 1, 4, and 13
  - EC.03.01.01, EP 1
  - LD.04.03.13, EPs 1–7
  - LS.02.01.20, EP 37
  - LS.02.01.34, EPs 6 and 8
  - LS.02.01.70, EP 7
  - LS.03.01.20, EP 16
  - LS.03.01.40, EP 3
  - LS.03.01.50, EPs 6 and 9
  - LS.03.01.70, EP 7
  - MM.08.01.01, EP 16
  - MS.05.01.01, EP 18
  - PC.01.02.07, EPs 3–8
  - PI.01.01.01, EP 56
  - PI.02.01.01, EPs 18 and 19

- Deleted the following EPs:
  - HR.01.02.05, EP 10
Primary Care Medical Home Certification Option (PCMH)

Effective January 1, 2018
- Added the language of each of the requirements and updated applicability to align with revisions to the standards

Appendix A: Medicare Requirements for Hospitals (AXA)

Effective January 1, 2018
- Replaced the “Definition of Hospital” section with updated language to maintain alignment with CMS

Appendix B: Special Conditions of Participation for Psychiatric Hospitals (AXB)
- No changes

Glossary (GL)

Effective January 1, 2018
- Deleted the term *environmental tours*
- Made minor editorial revisions

Index (IX)

Effective January 1, 2018
- Updated Index
Comprehensive Accreditation Manual

2017 Update 2

CAMH for Hospitals
Effective January 1, 2018

Standards
Elements of Performance
Scoring
Accreditation Policies

The Joint Commission
Accreditation
Hospital
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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Permissions Editor
Department of Publications and Education
Joint Commission Resources
1515 W. 22nd Street
Suite 1300W
Oak Brook, Illinois 60523
permissions@jcrinc.com

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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 Hospitals (CAMH) 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 Hospital Accreditation Program, and its certification options.
2. Part II explains the organization and content of the CAMH.
3. Part III explains how you can use the CAMH 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 Hospital Accreditation Program and the structure and content of the CAMH. After you have a better understanding of the value of accreditation in improving and maintaining the quality of care, treatment, and services, maximizing patient safety, 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 patients and the community that your hospital is committed to providing the highest quality services. It also sets you apart from other hospitals offering the same types of care, treatment, and 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, and services.

- **Helps health care organizations become high reliability organizations:** The Joint Commission offers numerous resources and information to help hospitals 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 hospitals 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 hospital 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 hospital move toward highly reliable care, treatment, and services. Through The Joint Commission, your hospital has access to a range of professionals eager to see you succeed. It starts with the assignment of an account executive specializing in hospitals 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 hospitals 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 Hospital Accreditation Program is designed to help hospitals achieve, maintain, and demonstrate consistent excellence in the services they provide to patients. The program has several key components designed to work collectively to better power your overall performance improvement efforts.
The Joint Commission’s Hospital Accreditation Program
The Joint Commission’s Hospital Accreditation Program uses a patient-centered quality framework and collaborative approach to help organizations proactively identify and address vulnerabilities to safeguard patients.

II. About the Comprehensive Accreditation Manual for Hospitals
The CAMH (and its web-based, fully searchable, electronic version called the E-dition) 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, and services a hospital provides (see the “Identifying Applicable Standards” section in this chapter). The CAMH includes all the information a hospital needs to achieve and maintain continuous compliance with the Joint Commission’s accreditation and optional specialty certification standards. The manual also will help hospitals engage in continuous performance improvement and will guide staff in developing processes to provide the highest quality of safe care, treatment, and services.

Upon initial application for accreditation and receipt of a deposit toward accreditation fees, a hospital 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/tjc_requirements.aspx.
The Joint Commission website offers e-Alerts 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/NewsletterSign-Up.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 patient safety or quality of care and/or 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, and 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 CAMH 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 manual, its updates, and its abridged version (Hospital Accreditation Standards) 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 CAMH 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 1 for a list of acronyms used in this manual.

### Table 1. Acronyms Used in This Manual

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<tr>
<th>Acronym</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
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<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>
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<tr>
<td>CAMH</td>
<td>Comprehensive Accreditation Manual for Hospitals</td>
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<tr>
<td>CMS</td>
<td>US Centers for Medicare &amp; Medicaid Services</td>
</tr>
<tr>
<td>CoP</td>
<td>Conditions of Participation (for CMS)</td>
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<tr>
<td>DA</td>
<td>Denial of Accreditation</td>
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<td>E-App</td>
<td>electronic application for accreditation</td>
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<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>FOC</td>
<td>Focused Survey</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>HR</td>
<td>“Human Resources” 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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</tbody>
</table>

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
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<th>“Introduction: How The Joint Commission Can Help You Move Toward High Reliability” chapter</th>
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<td>“Leadership” chapter</td>
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<tr>
<td>LS</td>
<td>“Life Safety” chapter</td>
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<tr>
<td>LTA</td>
<td>Limited, Temporary Accreditation</td>
</tr>
<tr>
<td>MM</td>
<td>“Medication Management” chapter</td>
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<td>MS</td>
<td>“Medical Staff” chapter</td>
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<tr>
<td>NPSG</td>
<td>National Patient Safety Goal (also a chapter in this manual)</td>
</tr>
<tr>
<td>NR</td>
<td>“Nursing” chapter</td>
</tr>
<tr>
<td>OQPS</td>
<td>Office of Quality and Patient Safety</td>
</tr>
<tr>
<td>ORYX</td>
<td>Joint Commission performance measurement initiative (not an acronym)</td>
</tr>
<tr>
<td>OSHA</td>
<td>Occupational Safety and Health Administration</td>
</tr>
<tr>
<td>PC</td>
<td>“Provision of Care, Treatment, and Services” chapter</td>
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<tr>
<td>PCMH</td>
<td>Primary Care Medical Home</td>
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<tr>
<td>PDA</td>
<td>Preliminary Denial of Accreditation</td>
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<tr>
<td>PFI</td>
<td>Plan for Improvement</td>
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<tr>
<td>PI</td>
<td>“Performance Improvement” chapter</td>
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<tr>
<td>PM</td>
<td>“Performance Measurement and the ORYX Initiative” chapter</td>
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<td>POA</td>
<td>Plan of Action</td>
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<td>PS</td>
<td>“Patient Safety Systems” chapter</td>
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<td>QR</td>
<td>“The Joint Commission Quality Report” chapter</td>
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<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>
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<tr>
<td>RI</td>
<td>“Rights and Responsibilities of the Individual” chapter</td>
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</tbody>
</table>

continued on next page
Accreditation Requirements
The first section of this manual contains the accreditation standards for the Hospital Accreditation Program, which consists of Joint Commission standards, EPs, NPSGs, and other requirements applicable to all organizations accredited in the Hospital 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.

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

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

“Human Resources” (HR): 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 hospitals.

“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.

“Medical Staff” (MS): Addresses the structure, role, and processes of the medical staff, including the process for credentialing and privileging and for evaluation of practitioners.

“National Patient Safety Goals” (NPSG): Includes specific actions that organizations are expected to take to prevent medical errors such as those caused by inaccurate patient identification, medication errors, health care–associated infections, harm associated with clinical alarm systems, and safety risks in patient populations.

“Nursing” (NR): Reflects the leadership role of the nurse executive including directing organizationwide nursing services, establishing guidelines for nursing care delivery, and providing nursing care, treatment, and services.

“Provision of Care, Treatment, and Services” (PC): Covers four basic areas: planning care, implementing care, special conditions, and discharge or transfer.

“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 patient record.

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

“Transplant Safety” (TS): Focuses on the development and implementation of policies and procedures for safely acquiring, receiving, storing, and issuing tissues and organs.
“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, “Primary Care Medical Home Certification Option” (PCMH), 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:

“Patient Safety Systems” (PS): Informs and educates leadership about the importance and structure of an integrated patient safety system. This chapter is designed to clarify the relationship between Joint Commission accreditation and patient safety. It does not contain new standards or requirements. Rather, the chapter describes how existing requirements can be applied to continually improve patient safety. It also provides approaches and methods that may be adapted to remove risk of patient harm.

“The Accreditation Process” (ACC): Provides information about the Joint Commission’s 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 Grid” (SAG): Provides a list of the standards that are applicable to five hospital service types: acute, long term acute care, psychiatric, surgical specialty (including orthopedic and cardiac), and swing beds. This user-friendly format allows you to quickly identify the service types, as you identified them in your E-App, and related standards that apply to your hospital.
“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.

“Performance Measurement and the ORYX® Initiative” (PM): Explains the requirements for integrating performance measurement into the accreditation process and for using a composite rate to assess hospital performance on ORYX accountability measures. It also discusses the use of performance measurement data.

“Required Written Documentation” (RWD): Lists the standards that require written documentation beyond that required in the medical 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 hospital 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.

“Primary Care Medical Home Certification Option” (PCMH): Describes the Primary Care Medical Home Model and the operational characteristics that serve as the foundation for the certification requirements. It also lists the standards and elements of performance that relate directly to the Primary Care Medical Home model.

“Appendix A: Medicare Requirements for Hospitals” (AXA): Includes additional explanatory text from the Code of Federal Regulations for hospitals seeking to obtain or maintain Medicare certification.
“Appendix B: Special Conditions of Participation for Psychiatric Hospitals” (AXB): Lists the Medicare Special Conditions of Participation for psychiatric hospitals that are covered in the Joint Commission standards. These conditions are included in this appendix so that your psychiatric hospital makes certain it complies with the specific details of these special Conditions of Participation.

“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 CAMH includes all Joint Commission standards that apply to all organizations accredited under the Hospital Accreditation Program. But not all standards in the print manual apply to the specific care, treatment, and 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 primary care medical home are preceded by the following boldface lead-in phrase: For hospitals that elect The Joint Commission Primary Medical Care Home option. (These standards are also listed in the PCMH chapter.) Alternately, for example, standards that apply only to psychiatric hospitals seeking certification from the US Centers for Medicare & Medicaid Services have this lead-in phrase: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes. If you are unsure about the standards in the print manual that apply to your hospital, please review the SAG chapter.

In contrast, the E-dition on your Joint Commission Connect extranet site displays only the standards applicable to your organization as identified in your E-App. The E-App gives your organization the ability to select the specific settings that describe your hospital 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, hospitals issuing durable medical equipment to patients will be required to maintain compliance with certain standards in the home care accreditation manual as well as the CAMH). 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, peer-based recovery services, prevention and wellness promotion services, corrections-based services, and opioid treatment programs

3. Critical Access Hospital (Comprehensive Accreditation Manual for Critical Access Hospitals): 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 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: 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.
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- **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 hospitals 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 Hospital 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.

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**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 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 R identifies specific risks by accreditation program (not program segment). Risk is assessed by a system’s proximity to the patient, probability of harm, severity of harm, and number of patients 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.
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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.
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 is provided to patients—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 CAMH 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 CAMH or Hospital Accreditation Standards, 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, and Services

Hospitals face a number of complex issues and challenges when caring for their patients. Perspectives publishes the most common and challenging issues in hospitals each year. Hospitals 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 patients and the quality of care, treatment, and services you provide. The following have recently appeared on the list of challenging standards:

- EC.02.06.01 The hospital establishes and maintains a safe, functional environment.
- IC.02.02.01 The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.
- EC.02.05.01 The hospital manages risks associated with its utility systems.
- LS.02.01.35 The hospital provides and maintains systems for extinguishing fires.
- LS.02.01.30 The hospital provides and maintains building features to protect individuals from the hazards of fire and smoke.
- LS.02.01.20 The hospital maintains the integrity of the means of egress.
- LS.02.01.10 Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.
- EC.02.02.01 The hospital manages risks related to hazardous materials and waste.
- PC.02.01.03 The hospital provides care, treatment, and services as ordered or prescribed, and in accordance with law and regulation.
- RC.01.01.01 The hospital maintains complete and accurate medical records for each individual patient.
- EC.02.03.05 The hospital maintains safety equipment and fire safety building features.

**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: Does my hospital follow its written process for accepting a patient for care, treatment, and services (PC.01.01.01, EP 7)? Does my hospital immediately discard any medication or solution found unlabeled (NPSG.03.04.01, EP 6)?
- Monitor closely the general Joint Commission website for free tools and resources provided. For example, in July 2016 The Joint Commission published a “Compliance Checklist for Diagnostic Imaging” at https://www.jointcommission.org/compliance_checklist_for_diagnostic_imaging/.

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 12 months of performance measurement data and performance improvement activity for assessment and discussion during the on-site survey. If your organization does not have 12 months’ worth, gather what data and activity you have available. **Note:** Initial organizations are not subject to the 12-month track record expectation.

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
- On-site 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
- FSA activated for submission (due by month 12)
- FSA activated for submission (due by month 24)
- Full survey is conducted (between months 18 and 36)
- Triennial accreditation cycle begins again

**Accredited Organization Activities**

- Application
- On-site survey is scheduled
- Organization completes and submits E-App and deposit E-dition and ICM FSA tool made available
- Organization submits ESC
- 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
- Organization completes and submits ICM profile (including selected FSA option), develops POA for standards identified as noncompliant, and identifies their date of compliance
- Organization completes and submits ICM profile (including selected FSA option), develops POA for standards identified as noncompliant, and identifies their date of compliance
- Organization updates and submits E-App for resurvey

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

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 your patients 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 (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 hospitals or search by keyword.
  - When an 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:
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- 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, high-level disinfection [HLD] sterilization).
- 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.
- Oro™ 2.0 High Reliability Organizational Assessment: An online application that provides senior leaders with an opportunity to evaluate their readiness for and advancement toward high reliability in specific areas of leadership commitment to moving toward zero patient harm, a fully functional safety culture, and widespread deployment of RPI tools.
- Surveyor Insights: An online resource for standards compliance information in which Life Safety Code® Surveyors provide leadership, day-to-day operational thoughts, and risk areas of consideration with a focus toward survey preparedness and readiness.

*Life Safety Code® is a registered trademark of the National Fire Protection Association, Quincy, MA.
Standards Interpretation: A landing page that allows organizations to submit questions and view FAQs related to the interpretation of standards.

Visit The Joint Commission’s Performance Measurement page at http://jointcommission.org/performance_measurement.aspx for this information:
- Accountability measures
- Core measure information
- Performance measurement initiatives
- Core measure sets
- Specification manuals
- Performance measurement system information

Keep Current With Standards Changes via Perspectives

It is strongly recommended that leadership and staff read Perspectives each month 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 (https://www.jointcommission.org/standards_information/hap_requirements.aspx) regularly for any revisions to hospital 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.joincommission.org/thickbox/NewsletterSignUp.aspx.
IV. Get Extra Help
All hospitals—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 630-792-5817 for information about:
- The benefits of Joint Commission accreditation and optional certification
- Information about obtaining 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 CAMH 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.
Patient Safety Systems (PS)

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

The intent of this “Patient Safety Systems” (PS) chapter is to provide health care organizations with a proactive approach to designing or redesigning a patient-centered system that aims to improve quality of care and patient safety, an approach that aligns with the Joint Commission’s mission and its standards.

The Joint Commission partners with accredited health care organizations to improve health care systems to protect patients. The first obligation of health care is to “do no harm.” Therefore, this chapter is focused on the following three guiding principles:
1. Aligning existing Joint Commission standards with daily work in order to engage patients and staff throughout the health care system, at all times, on reducing harm.
2. Assisting health care organizations with advancing knowledge, skills, and competence of staff and patients by recommending methods that will improve quality and safety processes.
3. Encouraging and recommending proactive quality and patient safety methods that will increase accountability, trust, and knowledge while reducing the impact of fear and blame.

Quality and safety are inextricably linked. Quality in health care is the degree to which its processes and results meet or exceed the needs and desires of the people it serves. Those needs and desires include safety.

The components of a quality management system should include the following:
- Ensuring reliable processes

Patient safety emerges as a central aim of quality. Patient safety, as defined by the World Health Organization, is the prevention of errors and adverse effects to patients that are associated with health care. Safety is what patients, families, staff, and the public expect from Joint Commission–accredited organizations. While patient safety events may not be completely eliminated, harm to patients can be reduced, and the goal is always zero harm. This chapter describes and provides approaches and methods that may be adapted by a health care organization that aims to increase the reliability of its complex systems while making visible and removing the risk of patient harm. Joint Commission–accredited organizations should be continually focused on eliminating systems failures and human errors that may cause harm to patients, families, and staff.1,2

The ultimate purpose of The Joint Commission’s accreditation process is to enhance quality of care and patient safety. 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. Hospitals should have an integrated approach to patient safety so that high levels of safe patient care can be provided for every patient in every care setting and service.

Hospitals are complex environments that depend on strong leadership to support an integrated patient safety system that includes the following:

- Safety culture
- Validated methods to improve processes and systems
- Standardized ways for interdisciplinary teams to communicate and collaborate
- Safely integrated technologies

In an integrated patient safety system, staff and leaders work together to eliminate complacency, promote collective mindfulness, treat each other with respect and compassion, and learn from their patient safety events, including close calls and other system failures that have not yet led to patient harm.

What Does This Chapter Contain?
The “Patient Safety Systems” (PS) chapter is intended to help inform and educate hospitals about the importance and structure of an integrated patient safety system. 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 health care workers understand the relationship between Joint Commission accreditation and patient safety.

This chapter does the following:
- Describes an integrated patient safety system
- Discusses how hospitals can develop into learning organizations
- Explains how hospitals can continually evaluate the status and progress of their patient safety systems
- Describes how hospitals can work to prevent or respond to patient safety events (Sidebar 1, below, defines key terminology)
- Serves as a framework to guide hospital leaders as they work to improve patient safety in their hospitals
- Contains a list of standards and requirements related to patient 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

- Patient safety event: An event, incident, or condition that could have resulted or did result in harm to a patient.
- Adverse event: A patient safety event that resulted in harm to a patient.
- Sentinel event: A subcategory of Adverse Events, a Sentinel Event is a patient safety event (not primarily related to the natural course of the patient’s illness or underlying condition) that reaches a patient and results in any of the following:
  - Death
  - Permanent harm
  - Severe temporary harm

†For a list of specific patient safety events that are also considered sentinel events, see page SE-1 in the “Sentinel Events” (SE) chapter of this manual.
Close call or “near miss,” “no harm,” or “good catch”: A patient safety event that did not cause harm as defined by the term sentinel event.

Hazardous (or “unsafe”) condition(s): A circumstance (other than a patient’s own disease process or condition) that increases the probability of an adverse event.

Note: It is impossible to determine if there are practical prevention or mitigation countermeasures available without first doing an event analysis. An event analysis will identify systems-level vulnerabilities and weaknesses and the possible remedial or corrective actions that can be implemented.

Becoming a Learning Organization

The need for sustainable improvement in patient safety and the quality of care 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, patient 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 patient safety events. In order to become a learning organization, a hospital 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 hospital leaders.

Leaders, staff, licensed independent practitioners, and patients in a learning organization realize that every patient safety event (from close calls to events that cause major harm to patients) must be reported. When patient safety events are continuously reported, experts within the hospital can define the problem, identify solutions, achieve sustainable results, and disseminate the changes or lessons learned to the rest of the hospital. In a learning organization, the hospital provides staff with information regarding improvements based on reported concerns. This helps foster trust that encourages further reporting.
The Role of Hospital Leaders in Patient Safety

Hospital leaders provide the foundation for an effective patient safety system by doing the following:9

- Promoting learning
- Motivating staff to uphold a fair and just safety culture
- Providing a transparent environment in which quality measures and patient harms 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 hospital’s patient safety system appear in the Joint Commission’s Leadership (LD) standards, including Standard LD.04.04.05 (which focuses on having an organizationwide, integrated patient safety program within performance improvement activities).

Without the support of hospital leaders, hospitalwide changes and improvement initiatives are difficult to achieve. Leadership engagement in patient safety and quality initiatives 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.4 Thus, leadership should take on a long-term commitment to transform the hospital.10

Safety Culture

A strong safety culture is an essential component of a successful patient safety system and is a crucial starting point for hospitals striving to become learning organizations. In a strong safety culture, the hospital has an unrelenting commitment to safety and to do no harm. Among the most critical responsibilities of hospital leaders is to establish and maintain a strong safety culture within their hospital. 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 the hospital.

The safety culture of a hospital is the product of individual and group beliefs, values, attitudes, perceptions, competencies, and patterns of behavior that determine the organization’s commitment to quality and patient safety. Hospitals 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.\textsuperscript{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.\textsuperscript{4}
- Safety as everyone’s first priority.\textsuperscript{4}
- Behaviors that undermine a culture of safety are not acceptable, and thus should be reported to organizational leadership by staff, patients, and families for the purpose of fostering risk reduction.\textsuperscript{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 a patient may be harmed.\textsuperscript{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.\textsuperscript{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 patient safety events.\textsuperscript{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 patient safety event.\textsuperscript{6,14}
- By reporting and learning from patient safety events, staff create a learning organization.

A safety culture operates effectively when the hospital fosters a cycle of trust, reporting, and improvement.\textsuperscript{10,15} In hospitals that have a strong safety culture, health care providers trust their coworkers and leaders to support them when they identify and report a patient safety event.\textsuperscript{10} When trust is established, staff are more likely to report patient safety events, and hospitals 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 hospital to improve.\textsuperscript{10} In turn, staff see that their reporting contributes to actual improvement, which bolsters their trust. Thus, the trust-report-improve cycle reinforces itself.\textsuperscript{10} (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 hospital are addressed, so as not to inhibit others 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.

Intimidating and disrespectful behaviors disrupt the culture of safety and prevent collaboration, communication, and teamwork, which is required for safe and highly reliable patient care. Disrespect is not limited to outbursts of anger that humiliate a member of the 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

These issues are still occurring in hospitals nationwide. Of 4,884 respondents to a 2013 survey by the Institute for Safe Medication Practices (ISMP), 73% reported encountering negative comments about colleagues or leaders during the previous year. In addition, 68% reported condescending language or demeaning comments or insults; while 77% of respondents said they had encountered reluctance or refusal to answer questions or return calls. Further, 69% report that they had encountered impatience with questions or the hanging up of the phone.

Nearly 50% of the respondents indicated that intimidating behaviors had affected the way they handle medication order clarifications or questions, including assuming that an order was correct in order to avoid interaction with an intimidating coworker. Moreover, 11% said they were aware of a medication error during the previous year in which behavior that undermines a culture of safety was a contributing factor. The respondents included nurses, physicians, pharmacists, and quality/risk management personnel.

Only 50% of respondents indicated that their organizations had clearly defined an effective process for handling disagreements with the safety of an order. This is down from 60% of respondents to a similar ISMP survey conducted in 2003, which suggests that this problem is worsening. While these data are specific to medication safety, their lessons are broadly applicable: Behaviors that undermine a culture of safety have an adverse effect on quality and patient safety.

A Fair and Just Safety Culture
A fair and just safety culture is needed for staff to trust that they can report patient safety events without being treated punitively. In order to accomplish this, hospitals should provide and encourage the use of a standardized reporting process for staff to report patient safety events. This is also built into the Joint Commission’s standards at Standard L.D.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 patients are harmed, and *reactive risk reduction* attempts to prevent the recurrence of problems that have already caused patient harm.
A fair and just culture takes into account that individuals 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 individuals accountable for their actions but does not punish individuals for issues attributed to flawed systems or processes.\textsuperscript{14,18,19} Refer to Standard \textbf{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 an individual is accountable, the individual should be held culpable and some disciplinary action may then be necessary. (See Sidebar 2, below, for a discussion of tools that can help leaders determine a fair and just response to a patient safety event.) However, staff should never be punished or ostracized for reporting the event, close call, hazardous condition, or concern.

\begin{sidemargin}
\begin{quote}
\textbf{Sidebar 2. Assessing Staff Accountability}
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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 hospital 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.\textsuperscript{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 patient 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.\textsuperscript{5}

\textbf{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 hospitals adopt a transparent, non-punitive approach to reports of patient safety events or other concerns, the hospital begins reporting to learn—and to learn collectively from adverse events, close calls, and hazardous conditions. This section focuses on data from reported patient safety events. Hospitals 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, the hospital can analyze the patient safety events, change the process or system to improve safety, and disseminate the changes or lessons learned to the rest of the organization.²⁰–²⁴

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 PL.01.01.01, which requires hospitals to collect data to monitor their performance, and
Standard \textbf{LD.03.02.01}, which requires hospitals to use data and information to guide decisions and to understand variation in the performance of processes supporting safety and quality.

Hospitals can engage frontline staff in internal reporting in a number of ways, including the following:

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

**Effective Use of Data**

**Collecting Data**
When hospitals collect data or measure staff compliance with evidence-based care processes or patient outcomes, they can manage and improve those processes or outcomes and, ultimately, improve patient safety. The effective use of data enables hospitals to identify problems, prioritize issues, develop solutions, and track to determine success. Objective data can be used to support decisions, influence people to change their behaviors, and to comply with evidence-based care guidelines.

The Joint Commission and the Centers for Medicare & Medicaid Services (CMS) both require hospitals to collect and use data related to certain patient care outcomes and patient harms. Some key Joint Commission standards related to data collection and use require hospitals 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 patient safety program within their performance improvement activities (Standard LD.04.04.05)
- Evaluate the effectiveness of their medication management system (Standard MM.08.01.01)
- Report (if using Joint Commission accreditation for deemed status purposes) deaths associated with the use of restraint and seclusion (Standard PC.03.05.19)
- Collect data to monitor their 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 hospital to “diagnose” problems within its system similar to the way one would diagnose a patient’s illness based on symptoms, health 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 hospital to
monitor the performance of a system, detect variation, and identify opportunities to improve. This can help the hospital not only understand the current performance of hospital systems but also can help it predict its performance going forward.\textsuperscript{23}

Analyzing data with tools such as run charts, statistical process control (SPC) charts, and capability charts helps a hospital determine what has occurred in a system and provides clues as to why the system responded as it did.\textsuperscript{23} Table 1, following, 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>
</thead>
<tbody>
<tr>
<td>Run Chart&lt;sup&gt;1&lt;/sup&gt;</td>
<td>- When the hospital needs to identify variation within a system</td>
<td><img src="image" alt="Run Chart Example" /></td>
</tr>
<tr>
<td></td>
<td>- When the hospital needs a simple and straightforward analysis of a system</td>
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<tr>
<td></td>
<td>- As a precursor to an SPC chart</td>
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<tr>
<td>Statistical Process Control Chart</td>
<td>- When the hospital needs to identify variation within a system and find indicators of why the variation occurred</td>
<td><img src="image" alt="Statistical Process Control Chart Example" /></td>
</tr>
<tr>
<td></td>
<td>- When the hospital needs a more detailed and in-depth analysis of a system</td>
<td></td>
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<tr>
<td>Capability Chart&lt;sup&gt;2&lt;/sup&gt;</td>
<td>- When the hospital needs to determine whether a process will function as expected, according to requirements or specifications</td>
<td><img src="image" alt="Capability Chart Example" /></td>
</tr>
</tbody>
</table>

Shading indicates a change effective July 1, 2017, unless otherwise noted in the What's New.
Sources:

Using Data to Drive Improvement
After data has been turned into information, leadership should ensure the following (per the requirements shown): 27–29
- Information is presented in a clear manner (Standard LD.03.04.01, EP 3)
- Information is shared with the appropriate groups throughout the organization (from the front line to the board) (Standards LD.03.04.01, LD.04.04.05)
- Opportunities for improvement and actions to be taken are clearly articulated (Standards LD.03.05.01, EP 4; LD.04.04.01)
- Improvements are celebrated or recognized

A Proactive Approach to Preventing Harm
Proactive risk reduction prevents harm before it reaches the patient. By engaging in proactive risk reduction, a hospital can correct process problems in order to reduce the likelihood of experiencing adverse events.

In a proactive risk assessment the hospital 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-frequency 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 patient safety includes increased likelihood of the following:
- Identification of actionable common causes
- Avoidance of unintended consequences
- Identification of commonalities across departments/services/units
- Identification of system solutions

Hazardous (or unsafe) conditions provide an opportunity for a hospital to take a proactive approach to reduce harm. Hospitals also benefit from identifying hazardous conditions while designing any new process that could impact patient safety. A hazardous condition is defined as any circumstance that increases the probability of a patient safety event. A hazardous condition may be the result of a human error or
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violation, may be a design flaw in a system or process, or may arise in a system or process in changing circumstances.\(^6\) A proactive approach to such conditions should include an analysis of the systems and processes in which the hazardous condition is found, with a focus on conditions that preceded the hazardous condition. (See Sidebar 3, below.)

A proactive approach to hazardous conditions should include an analysis of the related systems and processes, including the following aspects:\(^6\)

- **Preconditions.** Examples include hazardous (or unsafe) conditions in the environment of care (such as noise, clutter, wet floors and so forth), inadequate staffing levels, an operator who is impaired or inadequately trained.

- **Supervisory influences.** Examples include inadequate supervision, planned inappropriate operations, failure to address a known problem, authorization of activities that are known to be hazardous.

- **Organizational influences.** Examples include inadequate staffing, inadequate policies, lack of strategic risk assessment.

The Joint Commission addresses proactive risk assessments at Standard **LD.04.04.05**, EP 10, which requires hospitals to select one high-risk process and conduct a proactive risk assessment at least every 18 months.

Hospitals should recognize that this standard represents a minimum requirement. Hospitals working to become learning organizations are encouraged to exceed this requirement by constantly working to proactively identify risk.

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**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).

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\(^6\)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 (continued)

- 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 patients 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 patients.
- 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.\(^31\)

Hospitals have other tools they can consider using in their proactive risk assessment. Some examples include the following:

- 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 Patient Activation
To achieve the best outcomes, patients and families must be more actively engaged in decisions about their health care and must have broader access to information and support. Patient activation is inextricably intertwined with patient safety. Activated patients are less likely to experience harm and unnecessary hospital readmissions. Patients who are less activated suffer poorer health outcomes and are less likely to follow their provider’s advice.32,33

A patient-centered approach to care can help hospitals assess and enhance patient activation. Achieving this requires leadership engagement in the effort to establish patient-centered care as a top priority throughout the hospital. This includes adopting the following principles:34

- Patient safety guides all decision making.
- Patients and families are partners at every level of care.
- Patient- and family-centered care is verifiable, rewarded, and celebrated.
- The licensed independent practitioner responsible for the patient’s care, or his or her designee, discloses to the patient and family any unanticipated outcomes of care, treatment, and services.
- Though Joint Commission standards do not require apology, evidence suggests that patients benefit—and are less likely to pursue litigation—when physicians disclose harm, express sympathy, and apologize.
- Staffing levels are sufficient, and staff has the necessary tools and skills.
- The hospital has a focus on measurement, learning, and improvement.
- Staff and licensed independent practitioners must be fully engaged in patient- and family-centered care as demonstrated by their skills, knowledge, and competence in compassionate communication.

Hospitals can adopt a number of strategies to support and improve patient activation, including promoting culture change, adopting transitional care models, and leveraging health information technology capabilities.34
A number of Joint Commission standards address patient rights and provide an excellent starting point for hospitals seeking to improve patient activation. These standards require that hospitals do the following:

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

**Beyond Accreditation: The Joint Commission Is Your Patient Safety Partner**

To assist hospitals on their journey toward creating highly reliable patient safety systems, The Joint Commission provides many resources, including the following:

- *Office of Quality and Patient Safety*: An internal Joint Commission department that offers hospitals guidance and support when they experience a sentinel event. Organizations can call the Sentinel Event Hotline (630-792-3700) to clarify whether a patient 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 hospital’s comprehensive systematic analysis as well as the action plan to help the hospital 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 health care’s most critical safety and quality problems to help hospitals transform into high reliability organizations. For specific quality and patient problems, the Center’s Targeted Solutions Tool® (TST®) guides 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. To date, a TST has been developed for each of the following: hand hygiene, hand-off communications, and wrong-site surgery. For more information, visit 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. 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.

- **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.)

- **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.)

- **Quick Safety**: Quick Safety is a monthly newsletter that outlines an incident, topic, or trend in health care that could compromise patient safety. http://www.jointcommission.org/quick_safety.aspx?archive=y

- **Core Measure Solution Exchange**: Available for accredited or certified organizations through the Joint Commission Connect™ extranet, organizations can search a database of over two hundred success stories from accredited hospitals that have attained excellent performance on core measures, including accountability measures.

- **Joint Commission Resources**: A Joint Commission not-for-profit 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 patient safety topics.

- **Speak Up™ program**: The Joint Commission’s campaign to educate patients about 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 patient education resources, go to http://www.jointcommission.org/speakup.)
Standards BoosterPaks™: Available for accredited or certified organizations through 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 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 hospitals 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 Patient Safety Requirements**
A number of Joint Commission standards have been discussed in the “Patient Safety Systems” (PS) chapter. However, many Joint Commission requirements address issues related to the design and management of patient safety systems, including the following examples.

### Accreditation Participation Requirements (APR)

**Standard APR.09.01.01**
The hospital notifies the public it serves about how to contact its hospital management and The Joint Commission to report concerns about patient safety 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 hospital’s website.*

**Elements of Performance for APR.09.01.01**

1. The hospital informs the public it serves about how to contact its management to report concerns about patient safety and quality of care.

2. The hospital informs the public it serves about how to contact The Joint Commission to report concerns about patient safety and quality of care.

**Standard APR.09.02.01**
Any individual who provides care, treatment, and services can report concerns about safety or the quality of care to The Joint Commission without retaliatory action from the hospital.
Elements of Performance for APR.09.02.01

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

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

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

Environment of Care (EC)

Standard EC.04.01.01

The hospital collects information to monitor conditions in the environment.

Elements of Performance for EC.04.01.01

1. The hospital establishes a process(es) for continually monitoring, internally reporting, and investigating the following:  
   - Injuries to patients or others within the hospital’s facilities
   - Occupational illnesses and staff injuries
   - Incidents of damage to its property or the property of others
   - Security incidents involving patients, staff, or others within its facilities
   - Hazardous materials and waste spills and exposures
   - Fire safety management problems, deficiencies, and failures
   - Medical or laboratory equipment management problems, failures, and use errors
   - Utility systems management problems, failures, or use errors

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 hospital reports and investigates the following:

3. Injuries to patients or others in the hospital’s facilities.
4. Occupational illnesses and staff injuries.
5. Incidents of damage to its property or the property of others.
6. Security incidents involving patients, staff, or others within its facilities.
8. Hazardous materials and waste spills and exposures.
10. Medical/laboratory equipment management problems, failures, and use errors.
11. Utility systems management problems, failures, or use errors.
15. Every 12 months, the hospital evaluates each environment of care management plan, including a review of the plan’s objectives, scope, performance, and effectiveness.

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**Infection Prevention and Control (IC)**

**Standard IC.01.03.01**

The hospital identifies risks for acquiring and transmitting infections.

**Elements of Performance for IC.01.03.01**

1. The hospital identifies risks for acquiring and transmitting infections based on the following:
   - Its geographic location, community, and population served
   - The care, treatment, and services it provides
   - The analysis of surveillance activities and other infection control data

*(See also NPSG.07.03.01, EP 1)*
2. The hospital reviews and identifies its risks at least annually and whenever significant changes occur with input from, at a minimum, infection control personnel, medical staff, nursing, and leadership. *(See also NPSG.07.03.01, EP 1)*

3. The hospital prioritizes the identified risks for acquiring and transmitting infections. These prioritized risks are documented. *(See also NPSG.07.03.01, EP 1)*

**Leadership (LD)**

**Standard LD.02.01.01**
The mission, vision, and goals of the hospital support the safety and quality of care, treatment, and services.

**Elements of Performance for LD.02.01.01**

1. The governing body, senior managers, and leaders of the organized medical staff work together to create the hospital’s mission, vision, and goals.

2. The hospital’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 hospital serves.

**Standard LD.02.04.01**
The hospital manages conflict between leadership groups to protect the quality and safety of care.

**Elements of Performance for LD.02.04.01**

1. Senior managers and leaders of the organized medical staff work with the governing body to develop an ongoing process for managing conflict among leadership groups.

5. The hospital implements the process when a conflict arises that, if not managed, could adversely affect patient safety or quality of care.
Standard LD.03.01.01
Leaders create and maintain a culture of safety and quality throughout the hospital.

Elements of Performance for LD.03.01.01

1. Leaders regularly evaluate the culture of safety and quality using valid and reliable tools.
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.

Standard LD.03.02.01
The hospital 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, and services.
3. The hospital 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 hospital uses data and information in decision making that supports the safety and quality of care, treatment, and services. (See also NR.02.01.01, EPs 3 and 6; PI.02.01.01, EP 8)
6. The hospital 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 hospital.
Standard LD.03.03.01
Leaders use hospitalwide planning to establish structures and processes that focus on safety and quality.

Elements of Performance for LD.03.03.01
1. Planning activities focus on improving patient safety and health care quality.
2. Planning is systematic, and it involves designated individuals and information sources.
3. Leaders provide the resources needed to support the safety and quality of care, treatment, and services.
4. Safety and quality planning is hospitalwide.
5. Planning activities adapt to changes in the environment.
6. Leaders evaluate the effectiveness of planning activities.

Standard LD.03.04.01
The hospital communicates information related to safety and quality to those who need it, including staff, licensed independent practitioners, patients, families, and external interested parties.

Elements of Performance for LD.03.04.01
1. Communication processes foster the safety of the patient and the quality of care.
2. Communication is designed to meet the needs of internal and external users.
3. Leaders provide the resources required for communication, based on the needs of patients, the community, physicians, staff, and management.
4. Communication supports safety and quality throughout the hospital. (See also LD.04.04.05, EPs 6 and 12)
5. When changes in the environment occur, the hospital communicates those changes effectively.
6. Leaders evaluate the effectiveness of communication methods.
Standard LD.03.05.01
Leaders implement changes in existing processes to improve the performance of the hospital.

Elements of Performance for LD.03.05.01
1. Structures for managing change and performance improvements exist that foster the safety of the patient and the quality of care, treatment, and services.
3. The hospital 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 hospital.
6. The hospital’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. (See also PI.02.01.01, EP 13)

Standard LD.03.06.01
Those who work in the hospital are focused on improving safety and quality.

Elements of Performance for LD.03.06.01
1. Leaders design work processes to focus individuals on safety and quality issues.
3. Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. (See also IC.01.01.01, EP 3)

   Note: The number and mix of individuals is appropriate to the scope and complexity of the services offered.

4. Those who work in the hospital are competent to complete their assigned responsibilities.
5. Those who work in the hospital adapt to changes in the environment.
6. Leaders evaluate the effectiveness of those who work in the hospital to promote safety and quality.
Standard LD.04.01.01

The hospital complies with law and regulation.

Elements of Performance for LD.04.01.01

1. ☐ The hospital is licensed, is certified, or has a permit, in accordance with law and regulation, to provide the care, treatment, or services for which the hospital is seeking accreditation from The Joint Commission.

   **Note:** Each service location that performs laboratory testing (waived or nonwaived) must have a Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88) certificate\(^5\) as specified by the federal CLIA regulations (42 CFR 493.55 and 493.3) and applicable state law. (See also WT.01.01.01, EP 1; WT.04.01.01, EP 1)

2. The hospital provides care, treatment, and 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.

16. For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes:
   - The psychiatric hospital is primarily engaged in providing, by or under the supervision of a doctor of medicine or osteopathy, psychiatric services for the diagnosis and treatment of mentally ill persons.
   - The psychiatric hospital meets the hospital conditions of participation specified in 42 CFR 482.1 through 482.23, and 42 CFR 482.25 through 482.57.
   - The psychiatric hospital maintains clinical records on all patients to determine the degree and intensity of treatments, as specified in 42 CFR 482.61.
   - The psychiatric hospital meets the staffing requirements specified in 42 CFR 482.62.

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17. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital has a utilization review plan consistent with 42 CFR 482.30 that provides for review of services furnished by the hospital and the medical staff to patients entitled to benefits under the Medicare and Medicaid programs.

**Note 1:** The hospital does not need to have a utilization review plan if either a Quality Improvement Organization (QIO) has assumed binding review for the hospital or the Centers for Medicare & Medicaid Services (CMS) has determined that the utilization review procedures established by the state under title XIX of the Social Security Act are superior to the procedures required in this section, and has required hospitals in that state to meet the utilization review plan requirements under 42 CFR 456.50 through 42 CFR 456.245.

**Note 2:** For guidance regarding the requirements at 42 CFR 482.30, refer to the “Medicare Requirements for Hospitals” appendix.

18. **For hospitals that use Joint Commission accreditation for deemed status purposes:** Utilization review activities are implemented by the hospital in accordance with the plan.

**Note 1:** The hospital does not need to implement utilization review activities itself if either a Quality Improvement Organization (QIO) has assumed binding review for the hospital or the Centers for Medicare & Medicaid Services (CMS) has determined that the utilization review procedures established by the state under title XIX of the Social Security Act are superior to the procedures required in this section, and has required hospitals in that state to meet the utilization review plan requirements under 42 CFR 456.50 through 42 CFR 456.245.

**Note 2:** For guidance regarding the requirements at 42 CFR 482.30, refer to the “Medicare Requirements for Hospitals” appendix.

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**Standard LD.04.01.05**

The hospital effectively manages its programs, services, sites, or departments.

**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. (For more information, refer to the “Performance Improvement” [PI] chapter)

Elements of Performance for LD.04.04.01

1. Leaders set priorities for performance improvement activities and patient 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 4, 6–8, 11, 14, and 15)

3. Leaders reprioritize performance improvement activities in response to changes in the internal or external environment.

4. Performance improvement occurs hospitalwide.

5. For hospitals that elect The Joint Commission Primary Care Medical Home option: Ongoing performance improvement occurs hospitalwide for the purpose of demonstrably improving the quality and safety of care, treatment, or services.

6. For hospitals that elect The Joint Commission Primary Care Medical Home option: The interdisciplinary team actively participates in performance improvement activities.

24. For hospitals that elect The Joint Commission Primary Care Medical Home option: Leaders involve patients in performance improvement activities.

   Note: Patient involvement may include activities such as participating on a quality committee or providing feedback on safety and quality issues.

25. Senior hospital leadership directs implementation of selected hospitalwide improvements in emergency management based on the following:
   - Review of the annual emergency management planning reviews (See also EM.03.01.01, EP 4)
   - Review of the evaluations of all emergency response exercises and all responses to actual emergencies (See also EM.03.01.03, EP 15)
   - Determination of which emergency management improvements will be prioritized for implementation, recognizing that some emergency management improvements might be a lower priority and not taken up in the near term

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
Standard **LD.04.04.05**
The hospital has an organizationwide, integrated patient safety program within its performance improvement activities.

**Elements of Performance for LD.04.04.05**

1. The leaders implement a hospitalwide patient safety program.

2. One or more qualified individuals or an interdisciplinary group manages 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 departments, programs, and services within the hospital participate in the safety program.

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

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

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.03.04.01, EP 5; LD.04.04.03, EP 3; PI.01.01.01, EP 8)*

   **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 a serious adverse outcome or result in an adverse event, often referred to as a close call or near miss.
8. The hospital 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 individuals.

10. At least every 18 months, the hospital selects one high-risk process and conducts a proactive risk assessment. (See also LD.04.04.03, EP 3)

   **Note:** For suggested components, refer to the “Proactive Risk Assessment” section at the beginning of this chapter.

11. To improve safety and to reduce the risk of medical errors, the hospital analyzes and uses information about system or process failures and 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 patients and the families were informed of the event
   - All actions taken to improve safety, both proactively and in response to actual occurrences

   **For hospitals that use Joint Commission accreditation for deemed status purposes:** The determined number of distinct improvement projects to be conducted annually

   - All results of the analyses related to the adequacy of staffing (See also PI.02.01.01, EP 14)
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.07.01.03**

The hospital responds to actual or potential adverse drug events, significant adverse drug reactions, and medication errors.

**Elements of Performance for MM.07.01.03**

3. The hospital complies with internal and external reporting requirements for actual or potential adverse drug events, significant adverse drug reactions, and medication errors.

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

**Standard MM.08.01.01**

The hospital evaluates the effectiveness of its medication management system.

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

**Elements of Performance for MM.08.01.01**

1. The hospital 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. The hospital analyzes data on its medication management system.

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

3. The hospital 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. Based on analysis of its data, as well as review of the literature for new technologies and best practices, the hospital identifies opportunities for improvement in its medication management system.

6. The hospital takes action on improvement opportunities identified as priorities for its medication management system. (See also MM.09.01.01, EP 8; PI.03.01.01, EP 2)

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

7. The hospital evaluates its actions to confirm that they resulted in improvements for its medication management system.

8. The hospital takes additional action when planned improvements for its medication management processes are either not achieved or not sustained.

Medical Staff (MS)

Standard MS.08.01.01

The organized medical staff defines the circumstances requiring monitoring and evaluation of a practitioner’s professional performance.

Elements of Performance for MS.08.01.01

1. A period of focused professional practice evaluation is implemented for all initially requested privileges.

2. The organized medical staff develops criteria to be used for evaluating the performance of practitioners when issues affecting the provision of safe, high quality patient care are identified.

3. The performance monitoring process is clearly defined and includes each of the following elements:
   ◾ Criteria for conducting performance monitoring
   ◾ Method for establishing a monitoring plan specific to the requested privilege
   ◾ Method for determining the duration of performance monitoring
   ◾ Circumstances under which monitoring by an external source is required
4. Focused professional practice evaluation is consistently implemented in accordance with the criteria and requirements defined by the organized medical staff.

5. ⚫ The triggers that indicate the need for performance monitoring are clearly defined.

   **Note:** Triggers can be single incidents or evidence of a clinical practice trend.

6. The decision to assign a period of performance monitoring to further assess current competence is based on the evaluation of a practitioner’s current clinical competence, practice behavior, and ability to perform the requested privilege.

   **Note:** Other existing privileges in good standing should not be affected by this decision.

7. ⚫ Criteria are developed that determine the type of monitoring to be conducted.

8. ⚫ The measures employed to resolve performance issues are clearly defined.

9. The measures employed to resolve performance issues are consistently implemented.

**Standard MS.09.01.01**

The organized medical staff, pursuant to the medical staff bylaws, evaluates and acts on reported concerns regarding a privileged practitioner’s clinical practice and/or competence.

**Elements of Performance for MS.09.01.01**

1. ⚫ The hospital, based on recommendations by the organized medical staff and approval by the governing body, has a clearly defined process for collecting, investigating, and addressing clinical practice concerns. (*See also* RI.01.07.01, EPs 1, 4, 6, and 7)

2. Reported concerns regarding a privileged practitioner’s professional practice are uniformly investigated and addressed, as defined by the hospital and applicable law.
Nursing (NR)

Standard NR.02.01.01
The nurse executive directs the hospital’s nursing services.

Elements of Performance for NR.02.01.01

3. The nurse executive coordinates: The development of an effective, ongoing program to measure, analyze, and improve the quality of nursing care, treatment, and services. *(See also LD.03.02.01, EP 5)*

5. The nurse executive directs: The implementation of hospitalwide programs, policies, and procedures that address how nursing care needs of the patient population are assessed, met, and evaluated.

   **Note:** Examples of patient populations include pediatric, diabetic, and geriatric patients.

6. The nurse executive directs: The implementation of an effective, ongoing program to measure, analyze, and improve the quality of nursing care, treatment, and services. *(See also LD.03.02.01, EP 5)*

Provision of Care, Treatment, and Services (PC)

Standard PC.03.05.19
For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital reports deaths associated with the use of restraint and seclusion.

Elements of Performance for PC.03.05.19

1. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital reports the following information to the Centers for Medicare & Medicaid Services (CMS) regarding deaths related to restraint or seclusion (this requirement does not apply to deaths related to the use of soft wrist restraints; for more information, refer to EP 3 in this standard):
   - Each death that occurs while a patient is in restraint or seclusion
   - Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion
Each death known to the hospital that occurs within one week after restraint or seclusion was used when it is reasonable to assume that the use of the restraint or seclusion contributed directly or indirectly to the patient’s death. The types of restraints included in this reporting requirement are all restraints except soft wrist restraints.

**Note:** In this element of performance “reasonable to assume” includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time or deaths related to chest compression, restriction of breathing, or asphyxiation.

2. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The deaths addressed in PC.03.05.19, EP 1, are reported to the Centers for Medicare & Medicaid Services (CMS) by telephone, by facsimile, or electronically no later than the close of the next business day following knowledge of the patient’s death. The date and time that the patient’s death was reported is documented in the patient’s medical record.

3. **For hospitals that use Joint Commission accreditation for deemed status purposes:** When no seclusion has been used and when the only restraints used on the patient are wrist restraints composed solely of soft, non-rigid, cloth-like material, the hospital does the following:
   - Records in a log or other system any death that occurs while a patient is in restraint. The information is recorded within seven days of the date of death of the patient.
   - Records in a log or other system any death that occurs within 24 hours after a patient has been removed from such restraints. The information is recorded within seven days of the date of death of the patient.
   - Documents in the patient record the date and time that the death was recorded in the log or other system
   - Documents in the log or other system the patient’s name, date of birth, date of death, name of attending physician or other licensed independent practitioner responsible for the care of the patient, medical record number, and primary diagnosis(es)
   - Makes the information in the log or other system available to CMS, either electronically or in writing, immediately upon request

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For law and regulation guidance pertaining to those responsible for the care of the patient, refer to 42 CFR 482.12(c).
Performance Improvement (PI)

Standard PI.01.01.01
The hospital 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 leaders identify the frequency for data collection.

*Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The leaders that specify the frequency and detail of data collection is the governing body.*

The hospital collects data on the following:

3. Performance improvement priorities identified by leaders. *(See also LD.04.04.01, EP 1)*
4. Operative or other procedures that place patients at risk of disability or death. *(See also LD.04.04.01, EP 2; MS.05.01.01, EP 6)*
5. All significant discrepancies between preoperative and postoperative diagnoses, including pathologic diagnoses.
6. Adverse events related to using moderate or deep sedation or anesthesia. *(See also LD.04.04.01, EP 2)*
7. The use of blood and blood components. *(See also LD.04.04.01, EP 2)*
8. All reported and confirmed transfusion reactions. *(See also LD.04.04.01, EP 2; LD.04.04.05, EP 6)*
11. The results of resuscitation. *(See also LD.04.04.01, EP 2)*
14. Significant medication errors. *(See also LD.04.04.01, EP 2; MM.08.01.01, EP 1)*
15. Significant adverse drug reactions. *(See also LD.04.04.01, EP 2; MM.08.01.01, EP 1)*
16. Patient perception of the safety and quality of care, treatment, or services.

*For hospitals that elect The Joint Commission Primary Care Medical Home option:* The primary care medical home collects data on the following:

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
40. Disease management outcomes.

41. Patient access to care within time frames established by the hospital.

42. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home collects data on the following:
   - Patient experience and satisfaction related to access to care, treatment, or services, and communication
   - Patient perception of the comprehensiveness of care, treatment, or services
   - Patient perception of the coordination of care, treatment, or services
   - Patient perception of the continuity of care, treatment, or services

   (Refer to PI.01.01.01, EP 16)

46. The hospital collects data on patient thermal injuries that occur during magnetic resonance imaging exams.

47. The hospital collects data on the following:
   - Incidents where ferromagnetic objects unintentionally entered the magnetic resonance imaging (MRI) scanner room
   - Injuries resulting from the presence of ferromagnetic objects in the MRI scanner room

**Standard PI.02.01.01**

The hospital compiles and analyzes data.

**Elements of Performance for PI.02.01.01**

3. The hospital uses statistical tools and techniques to analyze and display data.

4. The hospital analyzes and compares internal data over time to identify levels of performance, patterns, trends, and variations.

6. The hospital reviews and analyzes incidents where the radiation dose index (computed tomography dose index [CTDIvol], dose length product [DLP], or size-specific dose estimate [SSDE]) from diagnostic CT examinations exceeded expected dose index ranges identified in imaging protocols. These incidents are then compared to external benchmarks.

**Note 1:** While the CTDIvol, DLP, and SSDE are useful indicators for monitoring radiation dose indices from the CT machine, they do not represent the patient’s radiation dose.
Note 2: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.

7. The hospital analyzes its organ procurement conversion rate data as provided by the organ procurement organization (OPO). (See also TS.01.01.01, EP 1)

Note: Conversion rate is defined as the number of actual organ donors over the number of eligible donors defined by the OPO, expressed as a percentage.

8. The hospital uses the results of data analysis to identify improvement opportunities. (See also LD.03.02.01, EP 5)

12. When the hospital identifies undesirable patterns, trends, or variations in its performance related to the safety or quality of care (for example, as identified in the analysis of data or a single undesirable event), it includes the adequacy of staffing, including nurse staffing, in its analysis of possible causes.

Note 1: Adequacy of staffing includes the number, skill mix, and competency of all staff. In their analysis, hospitals may also wish to examine issues such as processes related to work flow; competency assessment; credentialing; supervision of staff; and orientation, training, and education.

Note 2: Hospitals may find value in using the staffing effectiveness indicators (which include National Quality Forum Nursing Sensitive Measures) to help identify potential staffing issues.

13. When analysis reveals a problem with the adequacy of staffing, the leaders responsible for the hospitalwide patient safety program (as addressed at LD.04.04.05, EP 1) are informed, in a manner determined by the safety program, of the results of this analysis and actions taken to resolve the identified problem(s). (See also LD.03.05.01, EP 7)

14. At least once a year, the leaders responsible for the hospitalwide patient safety program review a written report on the results of any analyses related to the adequacy of staffing and any actions taken to resolve identified problems. (See also LD.04.04.05, EP 13)
Standard **Pl.03.01.01**
The hospital improves performance on an ongoing basis.

**Elements of Performance for Pl.03.01.01**

2. The hospital takes action on improvement priorities. *(See also MM.08.01.01, EP 6; MS.05.01.01, EPs 1–11)*

4. The hospital takes action when it does not achieve or sustain planned improvements. *(See also MS.05.01.01, EPs 1–11)*

11. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home uses the data it collects on the patient’s perception of the safety and quality of care, treatment, or services to improve its performance. This data includes the following:
   - Patient experience and satisfaction related to access to care, treatment, or services and communication
   - Patient perception of the comprehensiveness of care, treatment, or services
   - Patient perception of the coordination of care, treatment, or services
   - Patient perception of the continuity of care, treatment, or services

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

Standard **Ri.01.01.01**
The hospital respects, protects, and promotes patient rights.

**Elements of Performance for Ri.01.01.01**

1. ☐ The hospital has written policies on patient rights.

   **Note:** *For hospitals that use Joint Commission accreditation for deemed status purposes:* The hospital’s written policies address procedures regarding patient visitation rights, including any clinically necessary or reasonable restrictions or limitations.

2. The hospital informs the patient of his or her rights. *(See also Ri.01.01.03, EPs 1–3)*
Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital informs the patient (or support person, where appropriate) of his or her visitation rights. Visitation rights include the right to receive the visitors designated by the patient, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend. Also included is the right to withdraw or deny such consent at any time.

Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital makes sure that each patient, or his or her family, is informed of the patient’s rights in advance of furnishing or discontinuing patient care whenever possible.

4. The hospital treats the patient in a dignified and respectful manner that supports his or her dignity.

5. The hospital respects the patient’s right to and need for effective communication. (See also RI.01.01.03, EPs 1–3)

6. The hospital respects the patient’s cultural and personal values, beliefs, and preferences.

7. The hospital respects the patient’s right to privacy. (See also IM.02.01.01, EPs 1–4)

Note 1: This element of performance (EP) addresses a patient’s personal privacy.

Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident’s right to privacy includes privacy and confidentiality of his or her personal records and written communications, including the right to send and receive mail promptly.

8. The hospital respects the patient’s right to pain management. (See also LD.04.03.13, EP 3)

9. The hospital accommodates the patient’s right to religious and other spiritual services.

10. The hospital allows the patient to access, request amendment to, and obtain information on disclosures of his or her health information, in accordance with law and regulation.

28. The hospital allows a family member, friend, or other individual to be present with the patient for emotional support during the course of stay.
**Note:** The hospital allows for the presence of a support individual of the patient’s choice, unless the individual’s presence infringes on others’ rights, safety, or is medically or therapeutically contraindicated. The individual may or may not be the patient’s surrogate decision-maker or legally authorized representative. (For more information on surrogate or family involvement in patient care, treatment, and services, refer to RI.01.02.01, EPs 6–8.)

29. The hospital prohibits discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression.  

**Standard RI.01.01.03**

The hospital respects the patient’s right to receive information in a manner he or she understands.

**Elements of Performance for RI.01.01.03**

1. The hospital provides information in a manner tailored to the patient’s age, language, and ability to understand. (See also PC.02.01.21, EP 2; RI.01.01.01, EPs 2 and 5)

2. The hospital provides language interpreting and translation services. (See also HR.01.01.01, EP 1; PC.02.01.21, EP 2; RI.01.01.01, EPs 2 and 5)

   **Note:** Language interpreting options may include hospital-employed language interpreters, contract interpreting services, or trained bilingual staff. These options may be provided in person or via telephone or video. The hospital determines which translated documents and languages are needed based on its patient population.

3. The hospital provides information to the patient who has vision, speech, hearing, or cognitive impairments in a manner that meets the patient’s needs. (See also PC.02.01.21, EP 2; RI.01.01.01, EPs 2 and 5)

**Standard RI.01.02.01**

The hospital respects the patient’s right to participate in decisions about his or her care, treatment, and services.

**Note:** For hospitals that use Joint Commission accreditation for deemed status purposes: This right is not to be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.
Elements of Performance for RI.01.02.01

1. The hospital involves the patient in making decisions about his or her care, treatment, and services, including the right to have his or her family and physician promptly notified of his or her admission to the hospital.

2. When a patient is unable to make decisions about his or her care, treatment, and services, the hospital involves a surrogate decision maker in making these decisions. (See also PC.01.02.07, EP 5; RI.01.03.01, EP 1)

3. The hospital provides the patient or surrogate decision-maker with written information about the right to refuse care, treatment, and services. (See also PC.01.02.07, EP 5)

4. The hospital respects the patient’s or surrogate decision maker’s right to refuse care, treatment, and services, in accordance with law and regulation. (See also PC.01.02.07, EP 5)

8. The hospital involves the patient’s family in care, treatment, and services decisions to the extent permitted by the patient or surrogate decision-maker, in accordance with law and regulation. (See also PC.01.02.07, EP 5)

20. The hospital provides the patient or surrogate decision-maker with the information about the following:

- Outcomes of care, treatment, and services that the patient needs in order to participate in current and future health care decisions.
- Unanticipated outcomes of the patient’s care, treatment, and services that are sentinel events as defined by The Joint Commission. This information is provided by the licensed independent practitioner responsible for managing the patient’s care, treatment, and services, or his or her designee. (Refer to the Glossary for a definition of sentinel event.)

Note: In settings where there is no licensed independent practitioner, the staff member responsible for managing the care of the patient is responsible for sharing information about such outcomes.

31. For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home respects the patient’s right to make decisions about the management of his or her care.
32. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home respects the patient’s right and provides the patient the opportunity to do the following:
- Obtain care from other clinicians of the patient’s choosing within the primary care medical home
- Seek a second opinion from a clinician of the patient’s choosing
- Seek specialty care

**Note:** *This element of performance does not imply financial responsibility for any activities associated with these rights.*

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**Standard RI.01.03.01**

The hospital honors the patient’s right to give or withhold informed consent.

**Elements of Performance for RI.01.03.01**

1. ☐ The hospital follows a written policy on informed consent that describes the following:
   - The specific care, treatment, and services that require informed consent
   - Circumstances that would allow for exceptions to obtaining informed consent
   - The process used to obtain informed consent
   - How informed consent is documented in the patient record

   **Note:** *Documentation may be recorded in a form, in progress notes, or elsewhere in the record.*
   - When a surrogate decision-maker may give informed consent (*See also PC.01.02.07, EP 5; RI.01.02.01, EP 2*)

2. The informed consent process includes a discussion about the following:
   - The patient’s proposed care, treatment, and services.
   - Potential benefits, risks, and side effects of the patient’s proposed care, treatment, and services; the likelihood of the patient achieving his or her goals; and any potential problems that might occur during recuperation.
   - Reasonable alternatives to the patient’s proposed care, treatment, and services. The discussion encompasses risks, benefits, and side effects related to the alternatives and the risks related to not receiving the proposed care, treatment, and services.
Standard  RI.01.05.01

The hospital addresses patient decisions about care, treatment, and services received at the end of life.

Elements of Performance for RI.01.05.01

1. The hospital follows written policies on advance directives, forgoing or withdrawing life-sustaining treatment, and withholding resuscitative services that address the following:
   - Providing patients with written information about advance directives, forgoing or withdrawing life-sustaining treatment, and withholding resuscitative services.
   - Providing the patient upon admission with information on the extent to which the hospital is able, unable, or unwilling to honor advance directives.
   - For outpatient hospital settings: Communicating its policy on advance directives upon request or when warranted by the care, treatment, and services provided.
   - Whether the hospital will honor advance directives in its outpatient settings.
   - That the hospital will honor the patient’s right to formulate or review and revise his or her advance directives.
   - Informing staff and licensed independent practitioners who are involved in the patient’s care, treatment, and services whether or not the patient has an advance directive.

9. The hospital documents whether or not the patient has an advance directive.

10. Upon request, the hospital refers the patient to resources for assistance in formulating advance directives.

15. When required by policy or upon patient request, the hospital documents the patient’s wishes concerning organ donation and honors the wishes within the limits of its capability, policy, and law and regulation.

17. The existence or lack of an advance directive does not determine the patient’s right to access care, treatment, and services.

21. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital defines how it obtains and documents permission to perform an autopsy.
**Standard RI.02.01.01**
The hospital informs the patient about his or her responsibilities related to his or her care, treatment, and services.

**Elements of Performance for RI.02.01.01**

1. The hospital has a written policy that defines patient responsibilities, including but not limited to the following:
   - Providing information that facilitates their care, treatment, and services
   - Asking questions or acknowledging when he or she does not understand the treatment course or care decision
   - Following instructions, policies, rules, and regulations in place to support quality care for patients and a safe environment for all individuals in the hospital
   - Supporting mutual consideration and respect by maintaining civil language and conduct in interactions with staff and licensed independent practitioners
   - Meeting financial commitments

2. The hospital informs the patient about his or her responsibilities in accordance with its policy.

   **Note:** Information about patient responsibilities can be shared verbally, in writing, or both.
Accreditation Participation Requirements (APR)

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

For a hospital seeking accreditation for the first time, compliance with most of the Accreditation Participation Requirements (APRs) 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 hospital, 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 hospital-specific data and information. Organizations are either compliant or not compliant with the APRs. When a hospital does not comply with an APR, the hospital 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 a preliminary denial of accreditation decision. 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
   A. Selecting and Using Performance Measures (APR.04.01.01)

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 hospital submits information to The Joint Commission as required.

**Element of Performance for APR.01.01.01**

1. The hospital 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 hospital consistently fails to meet the requirements for the timely submission of data and information to The Joint Commission, the hospital 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 hospital’s submissions to The Joint Commission. For example, if information in a hospital’s electronic application for accreditation (E-App) leads to inaccuracies in the appropriate length of the survey and a longer survey is required, the hospital will incur the additional costs of the longer survey. In addition, if there is evidence that the hospital 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 hospital provides accurate information throughout the accreditation process.

**Rationale for APR.01.02.01**
The Joint Commission requires each hospital 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 hospital. Any hospital 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 hospital 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 hospital to The Joint Commission
- Submitted electronically by the hospital 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 hospital 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 hospital notifies The Joint Commission in writing within 30 days of a change in ownership, control, location, capacity, or services offered.

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

**APR.02.01.01**

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

Element of Performance for APR.02.01.01

1. The hospital permits the performance of a survey at The Joint Commission’s discretion.
**APR.03.01.01**
The hospital fulfills requirements for Focused Standards Assessment.

**Rationale for APR.03.01.01**
The Focused Standards Assessment (FSA) helps hospitals incorporate The Joint Commission standards into routine daily operations. When hospitals use the FSA tool to self-assess, monitor, and improve services, their patients are more likely to receive safe, high-quality care on a constant basis.

**Elements of Performance for APR.03.01.01**

1. ☑ The hospital, 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 hospitals 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 hospital’s triennial survey.*

2. The hospital completing the full Focused Standards Assessment (FSA) collaborates with the medical staff in completing the FSA and developing plan(s) of action.

3. ☑ The hospital 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 hospital exercising Option 1 for the Focused Standards Assessment (FSA) completes an FSA and Plan of Action.

   **Note:** *The hospital does not submit this information to The Joint Commission.*

5. The hospital exercising Option 1 for the Focused Standards Assessment (FSA) collaborates with the medical staff in completing the FSA and developing Plan(s) of Action.
6. ☐ The hospital 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 hospital exercising Option 3 for the Focused Standards Assessment agrees to undergo a limited survey.

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

APR.04.01.01
The hospital selects and uses core performance measure sets from among those available through its listed ORYX® vendor.

Note 1: If core measures are not applicable, the hospital identifies clinical measures based on current ORYX® requirements.

Note 2: Hospitals are encouraged to keep up-to-date on any changes in the ORYX® requirements by reviewing recent issues of The Joint Commission Perspectives® or by going to the “Performance Measurement” area on The Joint Commission website at http://www.jointcommission.org.

Elements of Performance for APR.04.01.01

11. The hospital selects a sufficient number of core performance measure sets to meet current ORYX® requirements.

12. The hospital notifies The Joint Commission of its core performance measure set selections by the date requested.

17. The hospital discusses with the surveyor how the data are used to identify, prioritize, and monitor performance improvement activities.

18. The hospital uses each individual core measure set for at least four consecutive quarters before replacing it.

19. Based on The Joint Commission statistical analysis, the hospital continues to use a measure set if the data suggest an unstable pattern of performance or otherwise identify an opportunity for improvement.

21. ☐ The hospital notifies The Joint Commission of any changes in its core measure set selections.

22. The hospital allows the ORYX® vendor to submit hospital clinical data to The Joint Commission at least four times a year.
23. The hospital resolves data quality issues identified by The Joint Commission and determined by the ORYX® vendor to be the hospital’s responsibility.

24. For the most recent 12-month reporting period, the hospital achieves and sustains an acceptable level of performance, as defined by quarterly Joint Commission statistical analysis, for each core measure within a measure set before it discontinues its use of such a measure set.

26. The hospital ensures that hospital-specific data for its selected core measures are submitted by its selected ORYX® vendor to The Joint Commission four times a year, in accordance with timelines established by The Joint Commission.

**APR.05.01.01**

The hospital 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 hospital’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 hospital provides The Joint Commission with all official records and reports of licensing, examining, reviewing, or planning bodies.

**APR.06.01.01**

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

**Element of Performance for APR.06.01.01**

1. The hospital 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 hospital to meet Joint Commission standards
- Helping the hospital to complete its Focused Standards Assessment (FSA)
Comprehensive Accreditation Manual for Hospitals

- Assisting the hospital in remedying areas identified in its FSA as needing improvement
- Conducting mock surveys

APR.07.01.01

The hospital 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 hospital 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 hospital.

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

APR.08.01.01

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

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

APR.09.01.01

The hospital notifies the public it serves about how to contact its hospital management and The Joint Commission to report concerns about patient safety 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 hospital’s website.
Elements of Performance for APR.09.01.01

1. The hospital informs the public it serves about how to contact its management to report concerns about patient safety and quality of care.

2. The hospital informs the public it serves about how to contact The Joint Commission to report concerns about patient safety and quality of care.

APR.09.02.01

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

Rationale for APR.09.02.01

Any individual who provides care, treatment, and services should be free to raise concerns to The Joint Commission when the hospital has not adequately prevented or corrected problems that can have or have had a serious adverse impact on patients. To support this culture of safety, the hospital must communicate to staff that such reporting is permitted. Further, the hospital 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 hospital educates its staff, medical staff, and other individuals who provide care, treatment, and services that concerns about the safety or quality of care provided in the organization may be reported to The Joint Commission.

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

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

APR.09.03.01

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

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

APR.09.04.01

The hospital 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 hospital 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.
Environment of Care (EC)

Overview
The goal of this chapter is to promote a safe, functional, and supportive environment within the hospital 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 patients, visitors, and staff
- Equipment used to support patient care or to safely operate the building or space
- People, including those who work within the hospital, patients, 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, and services. Any hospital, regardless of its size or location, faces risks in the environment, including those associated with safety and security, fire, hazardous materials and waste, medical equipment, 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.

About This Chapter
The standards are organized around the concepts of planning, implementing, and evaluating, and evaluation of results. The chapter calls for written plans for managing risks in each of these areas. Hospitals may choose to address all required components of the environment in a single management plan or in several different plans. If a hospital 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 hospital must address specific risks and the unique conditions at each of its sites.

The standards address the need to identify someone to manage environmental risks. 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:

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
CAMH Update 2, January 2018
Safety and security. This section addresses risks in the physical environment, access to security-sensitive areas, product recalls, and smoking.

Hazardous materials and waste. This section addresses risks associated with hazardous chemicals, radioactive materials, hazardous energy sources, hazardous medications, and hazardous gases and vapors.

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.

Medical equipment. This section addresses selection, testing, and maintenance of medical equipment and contingencies when equipment fails.

Utilities. This section addresses inspection and testing of operating components, control of airborne contaminants, and management of disruptions (refer to Standard IM.01.01.03).

**Note:** Emergency management standards are located in a separate chapter.

### Other Issues for Consideration

1. The hospital that provides care, treatment, and 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, a hospital may need access to the maintenance documents. This hospital and the property owner may want to discuss any building or equipment problems that could adversely affect the safety or health of patients, staff, and other people coming to the hospital, 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
   - 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

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- 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)
   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.02.04.01, EC.02.04.03)
   E. Utilities (EC.02.05.01, EC.02.05.03, EC.02.05.05, EC.02.05.07, EC.02.05.09)
   F. Other Physical Environment Requirements (EC.02.06.01, 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 hospital plans activities to minimize risks in the environment of care.

Note 1: One or more persons can be assigned to manage risks associated with the management plans described in this standard.


Note 3: For further information on waiver and equivalency requests, see https://www.jointcommission.org/life_safety_code_information_resources/ and NFPA 99-2012: 1.4.

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, equipment, and other material; the handling of hazardous materials and waste; the potential for fire; the use of medical equipment; and utility systems. High-level written management plans help the hospital 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; the plans 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 physical environment, collect deficiency information, and disseminate summaries of actions and results.

   Note: Deficiencies include injuries, problems, or use errors.

3. The hospital has a library of information regarding inspection, testing, and maintenance of its equipment and systems.

   Note: This library includes manuals, procedures provided by manufacturers, technical bulletins, and other information.

The hospital has a written plan for managing the following:

4. The environmental safety of patients and everyone else who enters the hospital’s facilities.

5. The security of everyone who enters the hospital’s facilities.

6. Hazardous materials and waste.

7. Fire safety.

8. Medical equipment.

9. Utility systems.

Standard EC.02.01.01

The hospital 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—patients, visitors, and those who work in the hospital. It is important to identify these risks in advance so that the hospital 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, from the performance of everyday tasks, or from situations beyond the hospital’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, infant abduction, and unrestricted access to medications. Security incidents are caused by individuals from either outside or inside the hospital.

**Elements of Performance for EC.02.01.01**

1. © The hospital implements its process to identify safety and security risks associated with the environment of care that could affect patients, staff, and other people coming to the hospital’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 hospital takes action to minimize or eliminate identified safety and security risks in the physical environment.

5. The hospital maintains all grounds and equipment.

7. The hospital identifies individuals entering its facilities.

   **Note:** The hospital determines which of those individuals require identification and how to do so.

8. The hospital controls access to and from areas it identifies as security sensitive.

9. © The hospital has written procedures to follow in the event of a security incident, including an infant or pediatric abduction.

10. When a security incident occurs, the hospital follows its identified procedures.

11. The hospital responds to product notices and recalls. *(See also MM.05.01.17, EPs 1–4)*

14. The hospital manages magnetic resonance imaging (MRI) safety risks associated with the following:
   - Patients who may experience claustrophobia, anxiety, or emotional distress
   - Patients who may require urgent or emergent medical care
   - Patients with medical implants, devices, or imbedded metallic foreign objects (such as shrapnel)
   - Ferromagnetic objects entering the MRI environment
   - Acoustic noise
16. The hospital manages magnetic resonance imaging (MRI) safety risks by doing the following:

- Restricting access of everyone not trained in MRI safety or screened by staff trained in MRI safety from the scanner room and the area that immediately precedes the entrance to the MRI scanner room.
- Making sure that these restricted areas are controlled by and under the direct supervision of staff trained in MRI safety.
- Posting signage at the entrance to the MRI scanner room that conveys that potentially dangerous magnetic fields are present in the room. Signage should also indicate that the magnet is always on except in cases where the MRI system, by its design, can have its magnetic field routinely turned on and off by the operator.

**Standard EC.02.01.03**
The hospital prohibits smoking except in specific circumstances.

**Elements of Performance for EC.02.01.03**

1. The hospital develops a written policy prohibiting smoking in all buildings. Exceptions for patients in specific circumstances are defined.

   **Note:** The scope of this EP is concerned with all smoking types—tobacco, electronic, or other.

4. Smoking materials are removed from patients receiving respiratory therapy. When a nasal cannula is delivering oxygen outside of a patient’s room, no sources of ignition are within the site of intentional expulsion (within 1 foot). When other oxygen delivery equipment is used or oxygen is delivered inside a patient’s room, no sources of ignition are within the area of administration (within 15 feet). Solid fuel–burning appliances are not in the area of administration. Nonmedical appliances with hot surfaces or sparking mechanisms are not within oxygen-delivery equipment or site of intentional expulsion. (For full text, refer to NFPA 99-2012: 11.5.1.1; Tentative Interim Amendment (TIA) 12-6)

6. The hospital takes action to maintain compliance with its smoking policy.

**Standard EC.02.02.01**
The hospital manages risks related to hazardous materials and waste.
Elements of Performance for EC.02.02.01

1. The hospital maintains a written, current inventory of hazardous materials and waste that it uses, stores, or generates. The only materials that need to be included on the inventory are those whose handling, use, and storage are addressed by law and regulation. (See also IC.02.01.01, EP 6; MM.01.01.03, EP 3) 

2. The hospital has written procedures, including the use of precautions and personal protective equipment, to follow in response to hazardous material and waste spills or exposures.

3. The hospital implements its procedures in response to hazardous material and waste spills or exposures. (See also IC.02.01.01, EP 2)

4. The hospital minimizes risks associated with selecting, handling, storing, transporting, using, and disposing of hazardous chemicals. 

5. The hospital minimizes risks associated with selecting, handling, storing, transporting, using, and disposing of radioactive materials.

6. The hospital minimizes risks associated with selecting, handling, storing, transporting, using, and disposing of hazardous gases and vapors.

Note: Hazardous energy is produced by both ionizing equipment (for example, radiation and x-ray equipment) and nonionizing equipment (for example, lasers and MRIs).

7. The hospital minimizes risks associated with selecting and using hazardous energy sources.

Note: Hazardous gases and vapors include, but are not limited to, ethylene oxide and nitrous oxide gases; vapors generated by glutaraldehyde; cauterizing equipment, such as lasers; waste anesthetic gas disposal (WAGD); and laboratory rooftop exhaust. (For full text, refer to NFPA 99-2012: 9.3.8; 9.3.9)

8. The hospital monitors levels of hazardous gases and vapors to determine that they are in safe range.

Note: Law and regulation determine the frequency of monitoring hazardous gases and vapors as well as acceptable ranges.
11. For managing hazardous materials and waste, the hospital has the permits, licenses, manifests, and safety data sheets required by law and regulation. R

12. The hospital labels hazardous materials and waste. Labels identify the contents and hazard warnings.† (See also IC.02.01.01, EP 6) R

17. For hospitals that provide computed tomography (CT), positron emission tomography (PET), or nuclear medicine (NM) services: The results of staff dosimetry monitoring are reviewed at least quarterly by the radiation safety officer, diagnostic medical physicist, or health physicist to assess whether staff radiation exposure levels are “as low as reasonably achievable” (ALARA) and below regulatory limits.

Note 1: For the definition of ALARA, please refer to US Nuclear Regulatory Commission federal regulation 10 CFR 20.1003.

Note 2: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.

18. For hospitals that use Joint Commission accreditation for deemed status purposes: Radiation workers are checked periodically, by the use of exposure meters or badge tests, for the amount of radiation exposure.

19. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has procedures for the proper routine storage and prompt disposal of trash.

Standard EC.02.03.01
The hospital manages fire risks.

Elements of Performance for EC.02.03.01

1. The hospital minimizes the potential for harm from fire, smoke, and other products of combustion. R

4. The hospital 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.

† The Occupational Safety and Health Administration’s (OSHA) Bloodborne Pathogens and Hazard Communications Standards and the National Fire Protection Association (NFPA) provide details on labeling requirements.
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 patients, and how to evacuate to areas of refuge. Staff and licensed independent practitioners are periodically instructed on and kept informed of their duties under the plan. A copy of the plan is readily available with the telephone operator or security.  

**Note:** For full text, refer to NFPA 101-2012: 18/19.7.1; 7.2.

11. Periodic evaluations, as determined by the hospital, are made of potential fire hazards that could be encountered during surgical procedures. Written fire prevention and response procedures, including safety precautions related to the use of flammable germicides or antiseptics, are established.

12. When flammable germicides or antiseptics are used during surgeries utilizing electrosurgery, cautery, or lasers, the following are required:
   - Nonflammable packaging
   - Unit-dose applicators
   - Preoperative “time-out” prior to the initiation of any surgical procedure to verify the following:
     - Application site is dry prior to draping and use of surgical equipment
     - Pooling of solution has not occurred or has been corrected
     - Solution-soaked materials have been removed from the operating room prior to draping and use of surgical devices

   (For full text, refer to NFPA 99-2012: 15.13)

13. The hospital meets all other Health Care Facilities Code fire protection requirements, as related to NFPA 99-2012: Chapter 15.

**Standard EC.02.03.03**
The hospital conducts fire drills.

**Elements of Performance for EC.02.03.03**

1. The hospital conducts fire drills once per shift per quarter in each building defined as a health care occupancy by the *Life Safety Code*. The hospital 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 patients during drills is not required.
Note 2: When drills are conducted between 9:00 p.m. and 6:00 a.m., the hospital 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 hospital occupies.

2. The hospital conducts fire drills every 12 months from the date of the last drill in all freestanding buildings classified as business occupancies and in which patients are seen or treated.

Note: In leased or rented facilities, drills need be conducted only in areas of the building that the hospital 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 hospital 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 patients are housed or treated participate in drills according to the hospital’s fire response plan.

5. The hospital critiques fire drills to evaluate fire safety equipment, fire safety building features, and staff response to fire. The evaluation is documented.

Standard EC.02.03.05
The hospital maintains fire safety equipment and fire safety building features.

Note: This standard does not require hospitals to have the types of fire safety equipment and building features described below. 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 hospital 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. Oval Every 6 months, the hospital 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) should be tested quarterly. The results and completion dates are documented. (For full text, refer to NFPA 25-2011: Table 5.1.1.2)

3. Oval Every 12 months, the hospital 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. Oval Every 12 months, the hospital 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. Oval Every 12 months, the hospital 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. Oval For automatic sprinkler systems: The hospital 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 hospital 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 hospital 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 hospital 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 hospital 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 hospital 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 hospital 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 hospital 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 hospital 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 hospital 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 hospital 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 hospital 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 hospital 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 hospital 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 hospital 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 hospital has written documentation of 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; 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.

27. Elevators with fire fighters’ emergency operations are tested monthly. The test completion dates and results are documented. (For full text, refer to NFPA 101-2012: 9.4.3; 9.4.6)

28. Documentation of maintenance, testing, and inspection activities for Standard EC.02.03.05, EPs 1–20, 25 (including fire alarm and fire protection systems) 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

**Note:** For additional guidance on documenting activities, see NFPA 25-2011: 4.3; 4.4; NFPA 72-2010: 14.2.1; 14.2.2; 14.2.3; 14.2.4.

**Standard EC.02.04.01**

The hospital manages medical equipment risks.

**Elements of Performance for EC.02.04.01**

2. **For hospitals that do not use Joint Commission accreditation for deemed status purposes:** The hospital maintains either a written inventory of all medical equipment or a written inventory of selected equipment categorized by physical risk associated with use (including all life-support equipment) and equipment incident history. The hospital evaluates new types of equipment before initial use to determine whether they should be included in the inventory.

   **For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital maintains a written inventory of all medical equipment.

3. **For hospitals that do not use Joint Commission accreditation for deemed status purposes:** The hospital identifies high-risk medical equipment on the inventory for which there is a risk of serious injury or death to a patient or staff member should the equipment fail.

   **Note:** High-risk medical equipment includes life-support equipment.

4. **For hospitals that do not use Joint Commission accreditation for deemed status purposes:** The hospital identifies the activities and associated frequencies, in writing, for maintaining, inspecting, and testing all medical equipment on the inventory. These activities and associated frequencies are in accordance with manufacturers’ recommendations or with strategies of an alternative equipment maintenance (AEM) program.

   **Note 1:** The strategies of an AEM program must not reduce the safety of equipment and must be based on accepted standards of practice, such as the American National Standards Institute/Association for the Advancement of Medical Instrumentation handbook ANSI/AAMI EQ56: 2013, Recommended Practice for a Medical Equipment Management Program.

   **Note 2:** Medical equipment with activities and associated frequencies in accordance with manufacturers’ recommendations must have a 100% completion rate.
**Note 3:** Scheduled maintenance activities for both high-risk and non-high-risk medical equipment in an alternative equipment maintenance (AEM) program inventory must have a 100% completion rate. AEM frequency is determined by the hospital’s AEM program.

5. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital’s activities and frequencies for inspecting, testing, and maintaining the following items must be in accordance with manufacturers’ recommendations:
   - Equipment subject to federal or state law or Medicare Conditions of Participation in which inspecting, testing, and maintaining must be in accordance with the manufacturers’ recommendations, or otherwise establishes more stringent maintenance requirements
   - Medical laser devices
   - Imaging and radiologic equipment (whether used for diagnostic or therapeutic purposes)
   - New medical equipment with insufficient maintenance history to support the use of alternative maintenance strategies

**Note:** Maintenance history includes any of the following documented evidence:
   - Records provided by the hospital’s contractors
   - Information made public by nationally recognized sources
   - Records of the hospital’s experience over time

6. **For hospitals that use Joint Commission accreditation for deemed status purposes:** A qualified individual(s) uses written criteria to support the determination whether it is safe to permit medical equipment to be maintained in an alternate manner that includes the following:
   - How the equipment is used, including the seriousness and prevalence of harm during normal use
   - Likely consequences of equipment failure or malfunction, including seriousness of and prevalence of harm
   - Availability of alternative or backup equipment in the event the equipment fails or malfunctions
   - Incident history of identical or similar equipment
   - Maintenance requirements of the equipment

(For more information on defining staff qualifications, refer to Standard HR.01.02.01)
7. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital identifies medical equipment on its inventory that is included in an alternative equipment maintenance program.

9. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital has written procedures to follow when medical equipment fails, including using emergency clinical interventions and backup equipment.

10. The hospital identifies quality control and maintenance activities to maintain the quality of the diagnostic computed tomography (CT), positron emission tomography (PET), magnetic resonance imaging (MRI), and nuclear medicine (NM) images produced. The hospital identifies how often these activities should be conducted.

**Standard EC.02.04.03**

The hospital inspects, tests, and maintains medical equipment.

**Elements of Performance for EC.02.04.03**

1. **For hospitals that do not use Joint Commission accreditation for deemed status purposes:** Before initial use of medical equipment on the medical equipment inventory, the hospital performs safety, operational, and functional checks. **For hospitals that use Joint Commission accreditation for deemed status purposes:** Before initial use and after major repairs or upgrades of medical equipment on the medical equipment inventory, the hospital performs safety, operational, and functional checks.

2. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital inspects, tests, and maintains all high-risk equipment. These activities are documented. *(See also PC.02.01.11, EP 2)*

   **Note 1:** High-risk equipment includes medical equipment for which there is a risk of serious injury or even death to a patient or staff member should it fail, which includes life-support equipment.

   **Note 2:** Required activities and associated frequencies for maintaining, inspecting, and testing of medical equipment completed in accordance with manufacturers’ recommendations must have a 100% completion rate.

   **Note 3:** Scheduled maintenance activities for high-risk medical equipment in an alternative equipment maintenance (AEM) program inventory must have a 100% completion rate. AEM frequency is determined by the hospital’s AEM program.
3. The hospital inspects, tests, and maintains non-high-risk equipment identified on the medical equipment inventory. These activities are documented.

Note: Scheduled maintenance activities for non-high-risk medical equipment in an alternative equipment maintenance (AEM) program inventory must have a 100% completion rate. AEM frequency is determined by the hospital’s AEM program.

4. The hospital conducts performance testing of and maintains all sterilizers. These activities are documented. (See also IC.02.02.01, EP 2)

5. The hospital performs equipment maintenance and chemical and biological testing of water used in hemodialysis. These activities are documented.

8. Equipment listed for use in oxygen-enriched atmospheres is clearly and permanently labeled (withstands cleaning/disinfecting) as follows:
   - Oxygen-metering equipment, pressure-reducing regulators, humidifiers, and nebulizers are labeled with name of manufacturer or supplier.
   - Oxygen-metering equipment and pressure reducing regulators are labeled “OXYGEN–USE NO OIL.”
   - Labels on flowmeters, pressure-reducing regulators, and oxygen-dispensing apparatuses designate the gases for which they are intended.
   - Cylinders and containers are labeled in accordance with Compressed Gas Association (CGA) C-7.

   (For full text, refer to NFPA 99-2012: 11.5.3.1)

   Note: Color coding is not utilized as the primary method of determining cylinder or container contents.

10. All occupancies containing hyperbaric facilities comply with construction, equipment, administration, and maintenance requirements of NFPA 99-2012: Chapter 14.

16. For hospitals that use Joint Commission accreditation for deemed status purposes: Qualified hospital staff inspect, test, and calibrate nuclear medicine equipment annually. The results and completion dates are documented.

18. The hospital maintains the quality of the diagnostic computed tomography (CT), positron emission tomography (PET), magnetic resonance imaging (MRI), and nuclear medicine (NM) images produced.

20. For diagnostic computed tomography (CT) services: At least annually, a diagnostic medical physicist does the following:
- Measures the radiation dose (in the form of volume computed tomography dose index [CTDIvol]) produced by each diagnostic CT imaging system for the following four CT protocols: adult brain, adult abdomen, pediatric brain, and pediatric abdomen. If one or more of these protocols is not used by the hospital, other commonly used CT protocols may be substituted.

- Verifies that the radiation dose (in the form of CTDIvol) produced and measured for each protocol tested is within 20 percent of the CTDIvol displayed on the CT console. The dates, results, and verifications of these measurements are documented.

**Note 1:** This element of performance is only applicable for systems capable of calculating and displaying radiation doses.

**Note 2:** This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.

**Note 3:** Medical physicists are accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the physicist. (For more information, refer to HR.01.02.01, EP 1; HR.01.02.05, EP 20; HR.01.02.07, EPs 1 and 2; HR.01.06.01, EP 1; LD.03.06.01, EP 4.)

21. **For diagnostic computed tomography (CT) services:** At least annually, a diagnostic medical physicist conducts a performance evaluation of all CT imaging equipment. The evaluation results, along with recommendations for correcting any problems identified, are documented. The evaluation includes the use of phantoms to assess the following imaging metrics:

- Image uniformity
- Slice thickness accuracy
- Slice position accuracy (when prescribed from a scout image)
- Alignment light accuracy
- Table travel accuracy
- Radiation beam width
- High-contrast resolution
- Low-contrast resolution
- Geometric or distance accuracy
- CT number accuracy and uniformity
- Artifact evaluation
Note 1: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.

Note 2: Medical physicists are accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the physicist. (For more information, refer to HR.01.02.01, EP 1; HR.01.02.05, EP 20; HR.01.02.07, EPs 1 and 2; HR.01.06.01, EP 1; LD.03.06.01, EP 4.)

22. At least annually, a diagnostic medical physicist or magnetic resonance imaging (MRI) scientist conducts a performance evaluation of all MRI imaging equipment. The evaluation results, along with recommendations for correcting any problems identified, are documented. The evaluation includes the use of phantoms to assess the following imaging metrics:
- Image uniformity for all radiofrequency (RF) coils used clinically
- Signal-to-noise ratio (SNR) for all coils used clinically
- Slice thickness accuracy
- Slice position accuracy
- Alignment light accuracy
- High-contrast resolution
- Low-contrast resolution (or contrast-to-noise ratio)
- Geometric or distance accuracy
- Magnetic field homogeneity
- Artifact evaluation

Note: Medical physicists or MRI scientists are accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the medical physicist or MRI scientist. (For more information, refer to HR.01.02.01, EP 1; HR.01.02.05, EP 20; HR.01.02.07, EPs 1 and 2; HR.01.06.01, EP 1; LD.03.06.01, EP 4.)

23. At least annually, a diagnostic medical physicist or nuclear medicine physicist conducts a performance evaluation of all nuclear medicine imaging equipment. The evaluation results, along with recommendations for correcting any problems identified, are documented. The evaluations are conducted for all of the image...
types produced clinically by each NM scanner (for example, planar and/or tomographic) and include the use of phantoms to assess the following imaging metrics:

- Image uniformity/system uniformity
- High-contrast resolution/system spatial resolution
- Sensitivity
- Energy resolution
- Count-rate performance
- Artifact evaluation

**Note 1:** The following test is recommended, but not required: Low-contrast resolution or detectability for non-planar acquisitions.

**Note 2:** The medical physicist or nuclear medicine physicist is accountable for these activities. He or she may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the medical physicist or nuclear medicine physicist. (For more information, refer to HR.01.02.01, EP 1; HR.01.02.05, EP 20; HR.01.02.07, EPs 1 and 2; HR.01.06.01, EP 1; LD.03.06.01, EP 4.)

24. At least annually, a diagnostic medical physicist conducts a performance evaluation of all positron emission tomography (PET) imaging equipment. The evaluation results, along with recommendations for correcting any problems identified, are documented. The evaluations are conducted for all of the image types produced clinically by each PET scanner (for example, planar and/or tomographic) and include the use of phantoms to assess the following imaging metrics:

- Image uniformity/system uniformity
- High-contrast resolution/system spatial resolution
- Low-contrast resolution or detectability (not applicable for planar acquisitions)
- Artifact evaluation

**Note 1:** The following tests are recommended, but not required, for PET scanner testing: sensitivity, energy resolution, and count-rate performance.
Note 2: Medical physicists are accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the medical physicist. (For more information, refer to HR.01.02.01, EP 1; HR.01.02.05, EP 20; HR.01.02.07, EPs 1 and 2; HR.01.06.01, EP 1; LD.03.06.01, EP 4.)

25. For computed tomography (CT), positron emission tomography (PET), nuclear medicine (NM), or magnetic resonance imaging (MRI) services: The annual performance evaluation conducted by the diagnostic medical physicist or MRI scientist (for MRI only) includes testing of image acquisition display monitors for maximum and minimum luminance, luminance uniformity, resolution, and spatial accuracy.

Note 1: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.

Note 2: Medical physicists or MRI scientists are accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the physicist or MRI scientist. (For more information, refer to HR.01.02.01, EP 1; HR.01.02.05, EP 20; HR.01.02.07, EPs 1 and 2; HR.01.06.01, EP 1; LD.03.06.01, EP 4.)

26. The hospital performs equipment maintenance on anesthesia apparatus. The apparatus are tested at the final path to patient after any adjustment, modification, or repair. Before the apparatus is returned to service, each connection is checked to verify proper gas flow and an oxygen analyzer is used to verify oxygen concentration. Areas designated for servicing of oxygen equipment are clean and free of oil, grease, or other flammables. (For full text, refer to NFPA 99-2012: 11.4.1.3; 11.5.1.3; 11.6.2.5; 11.6.2.6)

27. The hospital meets NFPA 99-2012: Health Care Facilities Code requirements related to electrical equipment in the patient care vicinity. (For full text, refer to NFPA 99-2012: Chapter 10)

Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets the applicable provisions of the Health Care Facilities Code Tentative Interim Amendment (TIA) 12-5.

Standard EC.02.05.01
The hospital manages risks associated with its utility systems.
Elements of Performance for EC.02.05.01

1. The hospital designs and installs utility systems according to National Fire Protection Association codes to meet patient care and operational needs.

2. Building systems are designed to meet the National Fire Protection Association’s Categories 1–4 requirements. (For full text, refer to NFPA 99-2012: Chapter 4 for descriptions of the four categories related to gas, vacuum, electrical, and electrical equipment.)

3. For hospitals that do not use Joint Commission accreditation for deemed status purposes: The hospital maintains a written inventory of all operating components of utility systems or maintains a written inventory of selected operating components of utility systems based on risks for infection, occupant needs, and systems critical to patient care (including all life-support systems). The hospital evaluates new types of utility components before initial use to determine whether they should be included in the inventory.

For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital maintains a written inventory of all operating components of utility systems.

4. The hospital identifies high-risk operating components of utility systems on the inventory for which there is a risk of serious harm or death to a patient or staff member should the component fail.

Note: High-risk utility system components include life-support equipment.

5. The hospital identifies the activities and associated frequencies, in writing, for inspecting, testing, and maintaining all operating components of utility systems on the inventory. These activities and associated frequencies are in accordance with manufacturers’ recommendations or with strategies of an alternative equipment maintenance (AEM) program.

Note 1: The strategies of an AEM program must not reduce the safety of equipment and must be based on accepted standards of practice.

Note 2: For guidance on maintenance and testing activities for Essential Electric Systems (Type I), see NFPA 99-2012: 6.4.4.

‡ An example of guidelines for physical plant equipment maintenance is the American Society for Healthcare Engineering (ASHE) book Maintenance Management for Health Care Facilities.
6. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital’s activities and frequencies for inspecting, testing, and maintaining the following items must be in accordance with manufacturers’ recommendations:
   - Equipment subject to federal or state law or Medicare Conditions of Participation in which inspecting, testing, and maintaining be in accordance with the manufacturers’ recommendations, or otherwise establishes more stringent maintenance requirements
   - New operating components with insufficient maintenance history to support the use of alternative maintenance strategies

   **Note:** Maintenance history includes any of the following documented evidence:
   - Records provided by the hospital’s contractors
   - Information made public by nationally recognized sources
   - Records of the hospital’s experience over time

7. **For hospitals that use Joint Commission accreditation for deemed status purposes:** A qualified individual(s) uses written criteria to support the determination of whether it is safe to permit operating components of utility systems to be maintained in an alternate manner that includes the following:
   - How the equipment is used, including the seriousness and prevalence of harm during normal use
   - Likely consequences of equipment failure or malfunction, including seriousness of and prevalence of harm
   - Availability of alternative or backup equipment in the event the equipment fails or malfunctions
   - Incident history of identical or similar equipment
   - Maintenance requirements of the equipment

   (For more information on defining staff qualifications, refer to Standard HR.01.02.01)

8. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital identifies operating components of utility systems on its inventory that are included in an alternative equipment maintenance program.

9. The hospital 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 hospital has written procedures for responding to utility system disruptions. ☐

11. The hospital’s procedures address shutting off the malfunctioning system and notifying staff in affected areas.

12. The hospital’s procedures address performing emergency clinical interventions during utility system disruptions.

13. The hospital responds to utility system disruptions as described in its procedures.

14. The hospital minimizes pathogenic biological agents in cooling towers, domestic hot- and cold-water systems, and other aerosolizing water systems. ☐

15. In critical care areas designed to control airborne contaminants (such as biological agents, gases, fumes, dust), the ventilation system provides appropriate pressure relationships, air-exchange rates, filtration efficiencies, temperature and humidity. ☐

Note: For more information about areas designed for control of airborne contaminants, the basis for design compliance is the Guidelines for Design and Construction of Health Care Facilities, based on the edition used at the time of design (if available).

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.

17. ☐ The hospital maps the distribution of its utility systems.
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)

20. Operating rooms are considered wet procedure locations, unless otherwise determined by a risk assessment authorized by the facility governing body. Operating rooms defined as wet locations are protected by either isolated power or ground-fault circuit interrupters. A written record of the risk assessment is maintained and available for inspection. (For full text, refer to NFPA 99-2012: 6.3.2.2.8.4; 6.3.2.2.8.7; 6.4.4.2)

21. Electrical distribution in the hospital is based on the following categories:
   - Category 1: Critical care rooms served by a Type 1 essential electrical system (EES) in which electrical system failure is likely to cause major injury or death to patients, including all rooms where electric life support equipment is required.
   - Category 2: General care rooms served by a Type 1 or Type 2 EES in which electrical system failure is likely to cause minor injury to patients.
   - Category 3: Basic care rooms in which electrical system failure is not likely to cause injury to patients. Patient care rooms are required to have a Type 3 EES where the life safety branch has an alternate source of power that will be effective for 1½ hours.

   (For full text, refer to NFPA 99-2012: 3.3.138; 6.3.2.2.10; 6.6.2.2.2; 6.6.3.1.1)

22. Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered are tested after initial installation, replacement, or servicing. In pediatric locations, receptacles in patient rooms (other than nurseries), bathrooms, play rooms, and activity rooms are listed tamper-resistant or have a listed cover. Electrical receptacles or cover plates supplied from the life safety and critical branches have a distinctive color or marking. (For full text, refer to NFPA 99-2012: 6.3.2; 6.3.3; 6.3.4; 6.4.2.2.6; 6.5.2.2.4.2; 6.6.2.2.3.2)

23. Power strips in a patient care vicinity are only used for components of movable electrical equipment used for patient care that have been assembled by qualified personnel. These power strips meet UL 1363A or UL 60601-1. Power strips used
outside of a patient care vicinity, but within the patient care room, meet UL
1363. In non–patient care rooms, power strips meet other UL standards. (For
full text, refer to NFPA 99-2012: 10.2.3.6; 10.2.4; NFPA 70-2011: 400-8;
590.3(D); Tentative Interim Amendment (TIA) 12-5)

24. Extension cords are not used as a substitute for fixed wiring in a building.
Extension cords used temporarily are removed immediately upon completion of
the intended purpose. (For full text, refer to NFPA 99-2012: 10.2.3.6; 10.2.4;
NFPA 70-2011: 400-8; 590.3(D); Tentative Interim Amendment (TIA) 12-5)

25. Areas designated for administration of general anesthesia (specifically, inhaled
anesthetics) using medical gases or vacuum are in accordance with NFPA 101-
2012: 8.7 and NFPA 99-2012 as follows:
- Zone valves are located immediately outside each anesthetizing location for
  medical gas or vacuum, readily accessible in an emergency, and arranged so
  shutting off any one anesthetizing location will not affect others.
- Area alarm panels are installed to monitor all medical gas, medical-surgical
  vacuum, and piped waste anesthetic gas disposal (WAGD) systems. Alarm
  panels include visual and audible sensors and are in locations that provide for
  surveillance, including medical gas pressure decreases of 20% and vacuum
  decreases of 12-inch gauge HgV (mercury vacuum).
- Alarm sensors are installed either on the source side of individual room zone
  valve box assemblies or on the patient/use side of each of the individual zone
  valve box assemblies.

(For full text, refer to NFPA 101-2012: 18/19.3.2.3; NFPA 99-2012: 5.1.4.8.7;
5.1.9.3)

26. Areas designated for administration of general anesthesia (specifically, inhaled
anesthetics) using medical gases or vacuum are in accordance with NFPA 101-
2012: 8.7 and NFPA 99-2012 as follows: The essential electrical system’s (EES)
critical branch supplies power for task illumination, fixed equipment, select
receptacles, and select power circuits. The EES equipment system supplies power
to the ventilation system. (For full text, refer to NFPA 101-2012: 18/19.3.2.3;
NFPA 99-2012: 6.4.2.2.4.2)

**Standard EC.02.05.03**
The hospital 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 hospital 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 hospital 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 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).

4. New buildings equipped with or requiring the use of life support systems (electro-mechanical or inhalation anesthetics) have illumination of means of egress, emergency lighting equipment, exit, and directional signs supplied by the life safety branch of the electrical system described in NFPA 99. (For full text, refer to NFPA 101-2012: 18.2.9.2; 18.2.10.5; NFPA 99-2012: 6.4.2.2)

The hospital provides emergency power within 10 seconds for the following:

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).

6. Equipment that could cause patient harm when it fails, including life-support systems; blood, bone, and tissue storage systems; medical air compressors; and medical and surgical vacuum systems.
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).

7. Areas in which loss of power could result in patient harm, including intensive care, emergency rooms, operating rooms, recovery rooms, obstetrical delivery rooms, and nurseries.

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; NFPA 110-2010: 4.1; Table 4.1(b).

11. Emergency lighting at emergency generator locations. The hospital’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.

12. Equipment designated to be powered by emergency power supply is energized by the hospital’s design. Staging of equipment startup is permissible. (For full text, refer to NFPA 99-2012: 6.4.2.2)

13. The hospital provides emergency power for elevators selected to provide service to patients during interruption of normal power (at least one for nonambulatory patients).

Note: For guidance in establishing a reliable emergency power system for the equipment branch (that is, an essential electrical distribution system), refer to NFPA 99-2012: 6.4.2.2.

14. The hospital implements a policy to provide emergency backup for essential medication dispensing equipment identified by the hospital, such as automatic dispensing cabinets, medication carousels, and central medication robots.

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.
15. The hospital implements a policy to provide emergency backup for essential refrigeration for medications identified by the hospital, such as designated refrigerators and freezers.

   **Note:** Examples of emergency backup can include emergency power, battery-based indoor generators, or other actions describing how refrigeration of medications will continue when emergency backup is needed.

16. **For hospitals that use Joint Commission accreditation for deemed status purposes:** Battery lamps and flashlights are available in areas not serviced by the emergency supply source.

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**Standard EC.02.05.05**

The hospital inspects, tests, and maintains utility systems.

**Note:** At times, maintenance is performed by an external service. In these cases, hospitals are not required to possess maintenance documentation but must 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 hospital 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 patients, staff, and visitors.

2. **For hospitals that do not use Joint Commission accreditation for deemed status purposes:** The hospital tests utility system components on the inventory before initial use. The completion dates and test results are documented.

   **For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital tests utility system components on the inventory before initial use and after major repairs or upgrades. The completion date and the results of the tests are documented.

The hospital inspects, tests, and maintains the following:

4. **High-risk utility system components on the inventory.** The completion date and the results of the activities are documented.

   **Note 1:** A high-risk utility system includes components for which there is a risk of serious injury or even death to a patient or staff member should it fail, which includes life-support equipment.
Note 2: Required activities and associated frequencies for maintaining, inspecting, and testing of utility systems components completed in accordance with manufacturers’ recommendations must have a 100% completion rate.

Note 3: Scheduled maintenance activities for high-risk utility systems components in an alternative equipment maintenance (AEM) program inventory must have a 100% completion rate.

5. ☐ Infection control utility system components on the inventory. The completion date and the results of the activities are documented.

Note 1: Required activities and associated frequencies for maintaining, inspecting, and testing of utility systems components completed in accordance with manufacturers’ recommendations must have a 100% completion rate.

Note 2: Scheduled maintenance activities for infection control utility systems components in an alternative equipment maintenance (AEM) program inventory must have a 100% completion rate.

6. ☐ Non-high-risk utility system components on the inventory. The completion date and the results of the activities are documented.

Note: Scheduled maintenance activities for non-high-risk utility systems components in an alternative equipment maintenance (AEM) program inventory must have a 100% completion rate. AEM frequency is determined by the hospital AEM program.

7. ☐ Line isolation monitors (LIM), if installed, are tested at least monthly by actuating the LIM test switch per NFPA 99-2012: 6.3.2.6.3.6, which activates both visual and audible alarms. For LIM circuits with automated self-testing, a manual test is performed at least annually. LIM circuits are tested per NFPA 99-2012: 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. (For full text, refer to NFPA 99-2012: 6.3.2; 6.3.3; 6.3.4)

8. The hospital 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)
Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets the applicable provisions of the Health Care Facilities Code Tentative Interim Amendments (TIAs) 12-2 and 12-3.

**Standard EC.02.05.07**
The hospital inspects, tests, and maintains emergency power systems.

**Note:** This standard does not require hospitals to have the types of emergency power equipment discussed below. However, if these types of equipment exist within the building, then the following maintenance, testing, and inspection requirements apply.

**Rationale for EC.02.05.07**
Emergency electrical power supply systems may fail during a power disruption, leaving the hospital unable to deliver safe care, treatment, and services to patients. 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 hospital 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 hospital performs a functional test of battery-powered lights on the inventory required for egress and exit signs for a duration of 1½ hours. For new construction, renovation, or modernization, battery-powered lighting in locations where deep sedation and general anesthesia are administered is tested annually for 30 minutes. 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 hospital 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 hospital 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 hospital 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 patients, 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 hospital 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 hospital 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 hospital 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 hospital 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)

8. ⬜ At least annually, the hospital tests the fuel quality to ASTM standards. The test results and completion dates are documented.

   **Note:** For additional guidance, see NFPA 110-2010: 8.3.8.

9. ⬜ At least once every 36 months, hospitals with a generator providing emergency power test each emergency generator for a minimum of 4 continuous hours. The test results and completion dates are documented.

   **Note:** For additional guidance, see NFPA 110-2010, Chapter 8.

10. ⬜ The 36-month diesel-powered emergency generator test uses a dynamic or static load that is at least 30% of the nameplate rating of the generator or meets the manufacturer’s recommended prime movers’ exhaust gas temperature.

    **Note 1:** Tests for non-diesel-powered generators need only be conducted with available load.

    **Note 2:** For additional guidance, see NFPA 110-2010, Chapter 8.

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**Standard EC.02.05.09**

The hospital inspects, tests, and maintains medical gas and vacuum systems.

**Note:** This standard does not require hospitals to have the medical gas and vacuum systems discussed below. However, if a hospital has these types of systems, then the following inspection, testing, and maintenance requirements apply.

**Elements of Performance for EC.02.05.09**

1. Medical gas, medical air, surgical vacuum, waste anesthetic gas disposal (WAGD), and air supply systems in which failure is likely to cause major injury or death are designated as follows:
   - Category 1: Systems in which failure is likely to cause minor injury to patients
   - Category 2: Systems in which failure is not likely to cause injury, but can cause discomfort to patients
   - Category 3: Deep sedation and general anesthesia are not administered when using Category 3 medical gas system

(For full text, refer to NFPA 99-2012: 5.1.1.1; 5.2.1; 5.3.1.1; 5.3.1.5; 5.1.14.2)
2. All master, area, and local alarm systems used for medical gas and vacuum systems comply with the category 1–3 warning system requirements. (For full text, refer to NFPA 99-2012: 5.1.9; 5.2.9; 5.3.6.2.2)

3. Containers, cylinders, and tanks are designed, fabricated, tested, and marked in accordance with NFPA 99-2012: 5.1.3.1.1–5.1.3.1.7.

4. Locations containing only oxygen or medical air have doors labeled “Medical Gases: NO Smoking or Open Flame.” Locations containing other gases have doors labeled “Positive Pressure Gases: NO Smoking or Open Flame. Room May Have Insufficient Oxygen. Open Door and Allow Room to Ventilate Before Opening.”

5. A precautionary sign readable from 5 feet away is on each door or gate of a cylinder storage room, where the sign, at a minimum, includes the wording “CAUTION: OXIDIZING GAS(ES) STORED WITHIN. NO SMOKING.” Storage is planned so cylinders are used in the order they are received from the supplier. Only gas cylinders and reusable shipping containers and their accessories are permitted to be stored in rooms containing central supply systems or gas cylinders.

6. When the hospital uses cylinders with an integral pressure gauge, a threshold pressure considered empty is established when the volume of stored gases is as follows:
   - When more than 300 but less than 3,000 cubic feet, the storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum ½-hour fire protection rating.
   - When less than 301 cubic feet in a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in NFPA 99-2012: 11.6.2.

(For full text, refer to NFPA 99-2012: 5.1.3.1; 5.1.3.2.3; 5.2.3.1; 5.3.10; 11.3; 11.6.5.2.1)
7. In time frames defined by the hospital, the hospital inspects, tests, and maintains critical components of piped medical gas and vacuum systems, waste anesthetic gas disposal (WAGD), and support gas systems on the inventory. This inventory of critical components includes at least all source subsystems, control valves, alarms, manufactured assemblies containing patient gases, and inlets and outlets. Activities, dates, and results are documented. Persons maintaining the systems are qualified by training and certification to the requirements of the American Society of Sanitary Engineers (ASSE) 6030 or 6040. (For full text, refer to NFPA 99-2012: 5.1.14.2; 5.1.15; 5.2.14; 5.3.13)

8. When the hospital has bulk oxygen systems above ground, they are in a locked enclosure (such as a fence) at least 10 feet from vehicles and sidewalks. There is permanent signage stating “OXYGEN – NO SMOKING – NO OPEN FLAMES.”

Note: For additional guidance, refer to NFPA 99-2012: 5.1.3.5.12.

9. The hospital’s emergency oxygen supply connection is installed in a manner that allows a temporary auxiliary source to connect to it.

Note: For additional guidance, refer to NFPA 99-2012: 5.1.3.5.13.

10. The hospital tests piped medical gas and vacuum systems for purity, correct gas, and proper pressure when these systems are installed, modified, or repaired. The test results and completion dates are documented. (For full text, refer to NFPA 99-2012: 5.1.2; 5.1.4; 5.1.14.4.1; 5.1.14.4.6; 5.2.13)

11. The hospital makes main supply valves and area shutoff valves for piped medical gas and vacuum systems accessible and clearly identifies what the valves control. Piping is labeled by stencil or adhesive markers identifying the gas or vacuum system, including the name of system or chemical symbol, color code (see NFPA 99-2012: Table 5.1.11), and operating pressure if other than standard. Labels are at intervals of 20 feet or less and are in every room, at both sides of wall penetrations, and on every story traversed by riser. Piping is not painted. Shutoff valves are identified with the name or chemical symbol of the gas or vacuum system, room or area served, and caution to not use the valve except in emergency. (For full text, refer to NFPA 99-2012: 5.1.4; 5.1.11.1; 5.1.11.2; 5.1.14.3; 5.2.11; 5.3.13.3; 5.3.11)

12. The hospital implements a policy on all cylinders within the hospital that includes the following:
- Labeling, handling, and transporting (for example, in carts, attached to equipment, on racks) in accordance with NFPA 99-2012: 11.5.3.1 and 11.6.2
- Physically segregating full and empty cylinders from each other in order to assist staff in selecting the proper cylinder
- Adaptors or conversion fittings are prohibited
- Oxygen cylinders, containers, and associated equipment are protected from contamination, damage, and contact with oil and grease
- Cylinders are kept away from heat and flammable materials and do not exceed a temperature of 130°F
- Nitrous oxide and carbon dioxide cylinders do not reach temperatures lower than manufacturer recommendations or -20°F
- Valve protection caps (if supplied) are secured in place when cylinder is not in use
- Labeling empty cylinders
- Prohibiting transfilling in any compartment with patient care

(For full text, refer to NFPA 99-2012: 11.6.1; 11.6.2; 11.6.5; 11.7.3)

13. At no time is transfilling done in any patient care room. A designated area is used away from any section of the hospital where patients are housed, treated, or examined. The designated area is separated by a barrier of at least 1-hour fire-resistant construction from any patient care areas. Transfilling cylinders is only of the same gas (no mixing of different compressed gases). Transfilling of liquid oxygen is only done in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring. Storage and use of liquid oxygen in base reservoir containers and portable containers comply with sections NFPA 99-2012: 11.7.2–11.7.4. (For full text, refer to NFPA 99-2012: 11.5.2.2; 11.5.2.3.1; 11.5.2.3.2; 11.7.2–11.7.4)

14. The hospital meets all other NFPA 99-2012: Health Care Facilities Code requirements related to gas and vacuum systems and gas equipment. (For full text, refer to NFPA 99-2012: Chapters 5 and 11)

**Note:** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets the applicable provisions of the Health Care Facilities Code Tentative Interim Amendments (TIAs) 12-4 and 12-6.
Introduction to Standard EC.02.06.01
Features of the hospital’s space influence patient outcomes and satisfaction and promote patient 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 patients 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 patient dignity and allow ease of interaction.

The standards do not specifically address all 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 patient satisfaction information, data collected from staff, and evidence-based design guidelines.

Standard EC.02.06.01
The hospital establishes and maintains a safe, functional environment.

Note: The environment is constructed, arranged, and maintained to foster patient safety, provide facilities for diagnosis and treatment, and provide for special services appropriate to the needs of the community.

Elements of Performance for EC.02.06.01

1. Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided. R

11. Lighting is suitable for care, treatment, and services.

20. Areas used by patients are clean and free of offensive odors. R

26. The hospital keeps furnishings and equipment safe and in good repair.

Standard EC.02.06.05
The hospital manages its environment during demolition, renovation, or new construction to reduce risk to those in the organization.
Elements of Performance for EC.02.06.05

1. When planning for new, altered, or renovated space, the hospital uses one of the following design criteria:
   - State rules and regulations
   - Guidelines for Design and Construction of Health Care Facilities, 2014 edition, administered by the Facility Guidelines Institute and published by the American Society for Healthcare Engineering (ASHE) When the above rules, regulations, and guidelines do not meet specific design needs, use other reputable standards and guidelines that provide equivalent design criteria.

2. When planning for demolition, construction, renovation, or general maintenance, the hospital 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 hospital takes action based on its assessment to minimize risks during demolition, construction, renovation, or general maintenance.

4. **For computed tomography (CT), positron emission tomography (PET), or nuclear medicine (NM) services:** Prior to installation of new imaging equipment, replacement of existing imaging equipment, or modification to rooms where ionizing radiation will be emitted or radioactive materials will be stored (such as scan rooms or hot labs), a medical physicist or health physicist conducts a structural shielding design assessment to specify required radiation shielding.

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

5. **For computed tomography (CT), positron emission tomography (PET), or nuclear medicine (NM) services:** After installation of imaging equipment or construction in rooms where ionizing radiation will be emitted or radioactive materials will be stored, a medical physicist or health physicist conducts a radiation protection survey to verify the adequacy of installed shielding. This survey is conducted prior to clinical use of the room.

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5 For additional guidance on shielding designs and radiation protection surveys, see National Council on Radiation Protection and Measurements Report No. 147 (NCRP-147).
Note: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.

**Standard EC.03.01.01**

Staff and licensed independent practitioners 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.

**Elements of Performance for EC.03.01.01**

1. Staff responsible for the maintenance, inspection, testing, and use of medical equipment, utility systems and equipment, fire safety systems and equipment, and safe handling of hazardous materials and waste are competent and receive continuing education and training.

2. Staff and licensed independent practitioners can describe or demonstrate actions to take in the event of an environment of care incident.

**Standard EC.04.01.01**

The hospital collects information to monitor conditions in the environment.

**Elements of Performance for EC.04.01.01**

1. The hospital establishes a process(es) for continually monitoring, internally reporting, and investigating the following:
   - Injuries to patients or others within the hospital’s facilities
   - Occupational illnesses and staff injuries
   - Incidents of damage to its property or the property of others
   - Security incidents involving patients, staff, or others within its facilities
   - Hazardous materials and waste spills and exposures
   - Fire safety management problems, deficiencies, and failures
   - Medical or laboratory equipment management problems, failures, and use errors
   - Utility systems management problems, failures, or use errors
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 hospital reports and investigates the following:

3. Injuries to patients or others in the hospital’s facilities.
4. Occupational illnesses and staff injuries.
5. Incidents of damage to its property or the property of others.
6. Security incidents involving patients, staff, or others within its facilities.
8. Hazardous materials and waste spills and exposures.
10. Medical/laboratory equipment management problems, failures, and use errors.
11. Utility systems management problems, failures, or use errors.
15. Every 12 months, the hospital evaluates each environment of care management plan, including a review of the plan’s objectives, scope, performance, and effectiveness.

Standard EC.04.01.03
The hospital analyzes identified environment of care issues.

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

Standard EC.04.01.05
The hospital improves its environment of care.

Element of Performance for EC.04.01.05
1. The hospital takes action on the identified opportunities to resolve environmental safety issues.
Emergency Management (EM)

Overview
Emergencies can be threats to any health care organization. A single emergency can temporarily disrupt services; however, multiple emergencies that occur concurrently or sequentially can adversely impact patient safety and the hospital’s ability to provide care, treatment, and services for an extended length of time. This is particularly true in situations where the community cannot adequately support the hospital. Power failures, water and fuel shortages, flooding, and communication breakdowns are just a few of the hazards that can disrupt patient care and pose risks to staff and the hospital.

About This Chapter
The “Emergency Management” (EM) chapter is organized to allow hospitals to plan to respond to the effects of potential emergencies that fall on a continuum from disruptive to disastrous. Planning involves those activities that must be done in order to put together a comprehensive Emergency Operations Plan (EOP). This planning results in the EOP document. After the EOP is in place, it must be tested through staged emergency response exercises in order to evaluate its effectiveness. Adjustments to the EOP can then be made.

The four phases of emergency management are mitigation, preparedness, response, and recovery. They occur over time; mitigation and preparedness generally occur before an emergency, and response and recovery occur during and after an emergency. 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 the approach to preparedness that will help it to organize and mobilize its essential resources. The organization will use its EOP 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.

Hospitals should identify potential hazards, threats, and adverse events, and assess their impact on the care, treatment, and services they provide for their patients. This assessment is known as a Hazard Vulnerability Analysis (HVA) and is designed to assist hospitals in gaining a realistic understanding of their vulnerabilities in order to help them mitigate and prepare to respond to emergencies and their impact. No hospital can predict the nature of a future emergency, nor can it predict the date of its arrival.
However, hospitals 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:
- Communications
- Resources and assets
- Safety and security
- Staff responsibilities
- Utilities
- Patient clinical and support activities

When hospitals consider their capabilities in these areas, they are taking an “all hazards” approach to emergency management that supports a level of preparedness sufficient to address a range of emergencies, regardless of the cause. This approach lays the foundation for developing an Emergency Operations Plan that is scalable to emergencies that may escalate in complexity, scope, or duration. For the most extreme type of emergencies—disasters—additional human resources may be necessary. Organizations can choose to assign responsibilities to volunteer practitioners or to privilege volunteer licensed independent practitioners when such volunteers are essential for meeting patient care needs. Hospitals should evaluate their planning efforts and test their Plans through exercise scenarios so that they can use the lessons learned to improve the effectiveness of their response strategies.

Additional standards in other chapters are integral to hospitalwide emergency preparedness, including processes for the following:
- Maintaining continuity of information (refer to Standard IM.01.01.03)
- Responding to outbreaks of infectious disease (refer to Standard IC.01.06.01)
- Identifying and mitigating impediments to patient flow (refer to Standard LD.04.03.11)
Chapter Outline

I. Foundation for the Emergency Operations 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. Utilities (EM.02.02.09)
      6. Patients (EM.02.02.11)
      7. Disaster Volunteers
         a. Volunteer Licensed Independent Practitioners (EM.02.02.13)
         b. Volunteer Practitioners (EM.02.02.15)

III. Evaluation (EM.03.01.01, EM.03.01.03)

IV. Integrated Emergency Management Program (EM.04.01.01)
Standards, Rationales, and Elements of Performance

Standard EM.01.01.01
The hospital engages in planning activities prior to developing its written Emergency Operations Plan.

Note: An emergency is an unexpected or sudden event that significantly disrupts the organization’s ability to provide care, 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. 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 patient care, safety, or security functions.

Rationale for EM.01.01.01
An emergency in a health care organization can suddenly and significantly affect demand for its services or its ability to provide these services. Therefore, the organization needs to engage in planning activities that prepare it to form its Emergency Operations Plan. These activities include identifying risks, prioritizing likely emergencies, attempting to mitigate them when possible, and considering its potential emergencies in developing strategies for preparedness. Because some emergencies that impact an organization originate in the community, the organization needs to take advantage of opportunities where possible to collaborate with relevant parties in the community.

Elements of Performance for EM.01.01.01

1. The hospital’s leaders, including leaders of the medical staff, participate in planning activities prior to developing an Emergency Operations Plan.

2. The hospital conducts a hazard vulnerability analysis (HVA) to identify potential emergencies within the organization and the community that could affect demand for the hospital’s services or its ability to provide those services, the likelihood of those events occurring, and the consequences of those events. The findings of this analysis are documented. (See also EM.03.01.01, EP 1; IC.01.06.01, EP 4)
Note 1: Hospitals have flexibility in creating either a single HVA that accurately reflects all sites of the hospital, or multiple HVAs. Some remote sites may be significantly different from the main site (for example, in terms of hazards, location, and population served); in such situations a separate HVA is appropriate.
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Note 2: If the hospital identifies a surge in infectious patients as a potential emergency, this issue is addressed in the “Infection Prevention and Control” (IC) chapter.

3. The hospital, together with its community partners, prioritizes the potential emergencies identified in its hazard vulnerability analysis (HVA) and documents these priorities.

Note: The hospital determines which community partners are critical to helping define priorities in its HVA. Community partners may include other health care organizations, the public health department, vendors, community organizations, public safety and public works officials, representatives of local municipalities, and other government agencies.

4. The hospital communicates its needs and vulnerabilities to community emergency response agencies and identifies the community’s capability to meet its needs. This communication and identification occur at the time of the hospital’s annual review of its Emergency Operations Plan and whenever its needs or vulnerabilities change. (See also EM.03.01.01, EP 1)

5. The hospital uses its hazard vulnerability analysis 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 hospital uses its hazard vulnerability analysis as a basis for defining the preparedness activities that will organize and mobilize essential resources. (See also IM.01.01.03, EPs 1–4)

7. The hospital’s incident command structure is integrated into and consistent with its community’s command structure.*

* The National Incident Management System (NIMS) is one of many models for an incident command structure available to health care organizations. The NIMS provides guidelines for common functions and terminology to support clear communications and effective collaboration in an emergency situation. The NIMS is required of hospitals receiving certain federal funds for emergency preparedness.
Note: The incident command structure used by the hospital should provide for a scalable response to different types of emergencies.

8. The hospital keeps a documented inventory of the resources and assets it has on site that may be needed during an emergency, including, but not limited to, personal protective equipment, water, fuel, and medical, surgical, and medication-related resources and assets. (See also EM.02.02.03, EP 6)

Standard EM.02.01.01
The hospital has an Emergency Operations Plan.

Note: The hospital’s Emergency Operations Plan (EOP) is designed to coordinate its communications, resources and assets, safety and security, staff responsibilities, utilities, and patient 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, EM.02.02.09, 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 Operations Plan that guides decision making at the onset of an emergency and as an emergency evolves. Although the Emergency Operations Plan can be formatted in a variety of ways, it must address response procedures that are both applicable to the hospital’s likely emergencies and adaptable in supporting key areas (such as communications and patient care) that might be affected by emergencies of different causes.

Elements of Performance for EM.02.01.01

1. The hospital’s leaders, including leaders of the medical staff, participate in the development of the Emergency Operations Plan.

2. The hospital develops and maintains a written Emergency Operations Plan that describes the response procedures to follow when emergencies occur. (See also EM.03.01.03, EP 5)

Note: The response procedures address the prioritized emergencies but can also be adapted to other emergencies that the hospital may experience. Response procedures could include the following:
Emergency Operations Plan identifies the hospital’s capabilities and establishes response procedures for when the hospital cannot be supported by the local community in the hospital’s efforts to provide communications, resources and assets, security and safety, staff, utilities, or patient care for at least 96 hours.

**Note:** Hospitals are not required to stockpile supplies to last for 96 hours of operation.

4. The hospital develops and maintains a written Emergency Operations Plan that describes the recovery strategies and actions designed to help restore the systems that are critical to providing care, treatment, and services after an emergency.

5. The Emergency Operations Plan describes the processes for initiating and terminating the hospital’s response and recovery phases of an 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 Operations Plan identifies the individual(s) who has the authority to activate the response and recovery phases of the emergency response.

7. The Emergency Operations Plan identifies alternative sites for care, treatment, and services that meet the needs of the hospital’s patients during emergencies.

8. If the hospital experiences an actual emergency, the hospital implements its response procedures related to care, treatment, and services for its patients.

12. For hospitals that use Joint Commission accreditation for deemed status purposes: The Emergency Operations Plan includes a continuity of operations strategy that covers the following:
A succession plan that lists who replaces key leaders during an emergency if a leader is not available to carry out his or her duties.

A delegation of authority plan that describes the decisions and policies that can be implemented by authorized successors during an emergency and criteria or triggers that initiate this delegation.

**Note:** A continuity of operations strategy is an essential component of emergency management planning. The goal of emergency management planning is to provide care to individuals who are incapacitated by emergencies in the community or in the organization. A continuity of operations strategy focuses on the organization, with the goal of protecting the organization’s physical plant, information technology systems, business and financial operations, and other infrastructure from direct disruption or damage so that it can continue to function throughout or shortly after an emergency. When the organization itself becomes, or is at risk of becoming, a victim of an emergency (power failure, fire, flood, bomb threat, and so forth), it is the continuity of operations strategy that provides the resilience to respond and recover.

13. **For hospitals that use Joint Commission accreditation for deemed status purposes:** If a hospital has one or more transplant centers (see Glossary), the following must occur:

- A representative from each transplant center must be included in the development and maintenance of the hospital’s emergency preparedness program.
- The hospital must develop and maintain mutually agreed upon protocols that address the duties and responsibilities of the hospital, each transplant center, and the organ procurement organization (OPO) for the donation service area where the hospital is situated, unless the hospital has been granted a waiver to work with another OPO, during an emergency.

14. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital has a procedure for requesting an 1135 waiver for care and treatment at an alternative care site.

**Note:** During disasters, organizations may need to request 1135 waivers to address care and treatment at an alternate care site identified by emergency management officials. The 1135 waivers are granted by the federal government during declared public health emergencies; these waivers authorize modification of certain federal...
regulatory requirements (for example, Medicare, Medicaid, Children’s Health Insurance Program, Health Insurance Portability and Accountability Act) for a defined time period during response and recovery.

15. The Emergency Operations Plan describes a means to shelter patients, staff, and volunteers on site who remain in the facility.

16. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has one or more emergency management policies based on the emergency plan, risk assessment, and communication plan. Procedures guiding implementation are defined in the emergency management plan, continuity of operations plan, and other preparedness and response protocols. Policy and procedure documents are reviewed and updated on an annual basis; the format of these documents is at the discretion of the hospital.

**Standard EM.02.02.01**

As part of its Emergency Operations Plan, the hospital prepares for how it will communicate during emergencies.

**Rationale for EM.02.02.01**

The hospital maintains reliable communications capabilities for the purpose of communicating response efforts to staff, patients, and external organizations. The hospital establishes backup communications processes and technologies (for example, cell phones, landlines, bulletin boards, fax machines, satellite phones, Amateur Radio, text messages) to communicate essential information if primary communications systems fail.

**Elements of Performance for EM.02.02.01**

The Emergency Operations Plan describes the following:

1. How staff will be notified that emergency response procedures have been initiated.
2. How the hospital will communicate information and instructions to its staff and licensed independent practitioners during an emergency.
3. How the hospital will notify external authorities that emergency response measures have been initiated.
4. How the hospital will communicate with external authorities during an emergency.
5. How the hospital will communicate with patients and their families, including how it will notify families when patients are relocated to alternative care sites.

6. How the hospital will communicate with the community or the media during an emergency.

7. How the hospital will communicate with suppliers of essential services, equipment, and supplies during an emergency.

8. How the hospital will communicate with other health care organizations in its contiguous geographic area regarding the essential elements of their respective command structures, including the names and roles of individuals in their command structures and their command center telephone numbers.

9. How the hospital will communicate with other health care organizations in its contiguous geographic area regarding the essential elements of their respective command centers for emergency response.

10. How the hospital will communicate with other health care organizations in its contiguous geographic area regarding the resources and assets that could be shared in an emergency response.

11. How and under what circumstances the hospital will communicate the names of patients and the deceased with other health care organizations in its contiguous geographic area.

12. How, and under what circumstances, the hospital will communicate information about patients to third parties (such as other health care organizations, the state health department, police, and the Federal Bureau of Investigation [FBI]).

13. How the hospital will communicate with identified alternative care sites.

14. The hospital establishes backup systems and technologies for the communication activities identified in EM.02.02.01, EPs 1–13.

17. The hospital implements the components of its Emergency Operations Plan that require advance preparation to support communications during an emergency.
20. **For hospitals that use Joint Commission accreditation for deemed status purposes:** As part of its communication plan, the hospital maintains the names and contact information of the following:
- Staff
- Physicians
- Other hospitals and critical access hospitals
- Volunteers
- Entities providing services under arrangement
- Relevant federal, state, tribal, regional, and local emergency preparedness staff
- Other sources of assistance

21. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The Emergency Operations Plan describes the following:
- Process for communicating information about the general condition and location of patients under the organization’s care to public and private entities assisting with disaster relief
- Process, in the event of an evacuation, to release patient information to family, patient representative, or others responsible for the care of the patient

**Note:** These processes are consistent with privacy and disclosure requirements specified under 45 CFR 164.510(b)(1)(ii) and 45 CFR 164.510(b)(4).

22. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The organization maintains documentation of completed and attempted contact with the local, state, tribal, regional, and federal emergency preparedness officials in its service area. This contact is made for the purpose of communication and, where possible, collaboration on coordinated response planning for a disaster or emergency situation.

**Note:** Examples of these contacts may be written or e-mail correspondence; in-person meetings or conference calls; regular participation in health care coalitions, working groups, boards, and committees; or educational events sponsored by a third party (such as a local or state health department).

**Standard EM.02.02.03**
As part of its Emergency Operations Plan, the hospital prepares for how it will manage resources and assets during emergencies.
Rationale for EM.02.02.03
The hospital that continues to provide care, treatment, and services to its patients 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 such as vendors, neighboring health care providers, other community organizations, state affiliates, or a regional parent company. The hospital 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 hospitals are vying for a limited supply from the same vendor.

Elements of Performance for EM.02.02.03
The Emergency Operations Plan describes the following:

1. How the hospital will obtain and replenish medications and related supplies that will be required throughout the response and recovery phases of an emergency, including access to and distribution of caches that may be stockpiled by the hospital, its affiliates, or local, state, or federal sources.

2. How the hospital will obtain and replenish medical supplies that will be required throughout the response and recovery phases of an emergency, including personal protective equipment where required.

3. How the hospital will obtain and replenish nonmedical supplies (including food, bedding, and other provisions consistent with the hospital’s plan for sheltering on site) that will be required throughout the response and recovery phases of an emergency.

4. How the hospital will share resources and assets with other health care organizations within the community, if necessary.

   Note: Examples of resources and assets that might be shared include beds, transportation, linens, fuel, personal protective equipment, medical equipment, and supplies.

5. How the hospital will share resources and assets with other health care organizations outside the community, if necessary, in the event of a regional or prolonged disaster.
Note: Examples of resources and assets that might be shared include beds, transportation, linens, fuel, personal protective equipment, medical equipment, and supplies.

6. How the hospital will monitor quantities of its resources and assets during an emergency. (See also EM.01.01.01, EP 8)

9. The hospital’s arrangements for transporting some or all patients; their medications, supplies, and equipment; and staff to an alternative care site(s) when the environment cannot support care, treatment, and services. (See also EM.02.02.11, EP 3)

10. The hospital’s arrangements for transferring pertinent information, including essential clinical and medication-related information, with patients moving to alternative care sites. (See also EM.02.02.11, EP 3)

12. The hospital implements the components of its Emergency Operations Plan that require advance preparation to provide for resources and assets during an emergency.

Introduction to Standard EM.02.02.05

Controlling the movement of individuals into, throughout, and out of the hospital during an emergency is essential to the preservation of safety (freedom from accidental harm) and the security (freedom from intentional harm) of patients, staff, and critical supplies, equipment, and utilities. The hospital determines the type of access and movement to be allowed by staff, patients, visitors, emergency volunteers, vendors, maintenance and repair workers, utility suppliers, and other individuals when emergency measures are initiated. Factors influencing access and movement vary depending on the type of emergency and local conditions (for example, whether or not the hospital has decided to shelter staff families, the allowance for or prohibition against firearms, any mutual aid agreements with nearby facilities or vendors).

During an emergency, the campus or immediate environment around the hospital may be under the authority of the local police or sheriff serving the larger community. Access to and from the hospital on local roads and interstates could be subject to local, state, or even federal control. As an incident evolves, this responsibility and authority may shift from one agency to another. For this reason, it is important that the Emergency
Operations Plan includes reference to any existing community command structure to provide for ongoing communication and coordination with this structure. In the absence of such a command structure, the hospital maintains direct contact with the agencies charged with community security.

**Standard EM.02.02.05**
As part of its Emergency Operations Plan, the hospital prepares for how it will manage security and safety during an emergency.

**Elements of Performance for EM.02.02.05**
The Emergency Operations Plan describes the following:

1. The hospital’s arrangements for internal security and safety.
2. The roles that community security agencies (for example, police, sheriff, National Guard) will have in the event of an emergency.
3. How the hospital will coordinate security activities with community security agencies (for example, police, sheriff, National Guard).
4. How the hospital will manage hazardous materials and waste.
5. How the hospital will provide for radioactive, biological, and chemical isolation and decontamination.
6. How the hospital will control entrance into and out of the health care facility during an emergency.
7. How the hospital will control the movement of individuals within the health care facility during an emergency.
8. The hospital’s arrangements for controlling vehicles that access the health care facility during an emergency.
9. The hospital implements the components of its Emergency Operations Plan that require advance preparation to support security and safety during an emergency.

**Standard EM.02.02.07**
As part of its Emergency Operations Plan, the hospital prepares for how it will manage staff during an emergency.
Rationale for EM.02.02.07
To provide safe and effective patient care during an emergency, staff roles are well defined in advance, and staff are oriented in their assigned responsibilities. Staff roles and responsibilities may be documented in the Plan using a variety of formats (for example, job action sheets, checklists, flowcharts). Due to the dynamic nature of emergencies, effective training prepares staff to adjust to changes in patient volume or acuity, work procedures or conditions, and response partners within and outside the hospital.

Elements of Performance for EM.02.02.07
The Emergency Operations Plan describes the following:

2. The roles and responsibilities of staff for communications, resources and assets, safety and security, utilities, and patient management and evacuation during an emergency.

3. The process for assigning staff to all essential staff functions.

4. The Emergency Operations Plan identifies the individual(s) to whom staff report in the hospital’s incident command structure.

5. The Emergency Operations Plan describes how the hospital will manage staff support needs (for example, housing, transportation, incident stress debriefing).

6. The Emergency Operations Plan describes how the hospital will manage the family support needs of staff (for example, child care, elder care, pet care, communication).

7. The hospital trains staff for their assigned emergency response roles.

8. The hospital communicates, in writing, with each of its licensed independent practitioners regarding his or her role(s) in emergency response and to whom he or she reports during an emergency.

9. The Emergency Operations Plan describes how the hospital will identify licensed independent practitioners, staff, and authorized volunteers during emergencies. (See also EM.02.02.13, EP 3; EM.02.02.15, EP 3)

Note: This identification could include identification cards, wristbands, vests, hats, or badges.

10. The hospital implements the components of its Emergency Operations Plan that require advance preparation to manage staff during an emergency.
11. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital has a system to track the location of on-duty staff during an emergency.

13. **For hospitals that use Joint Commission accreditation for deemed status purposes:** Initial and ongoing training relevant to their emergency response roles is provided to staff, volunteers, and individuals providing on-site services under arrangement. This training is documented and then reviewed and updated annually and when these roles change. Staff demonstrate knowledge of emergency procedures through participation in drills and exercises, as well as post-training tests, participation in instructor-led feedback (for example, questions and answers), or other methods determined and documented by the organization.

14. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The Emergency Operations Plan describes the use of volunteers in an emergency, including emergency staffing strategies, such as the role and process for integration of state or federally designated health care professionals to address surge needs during an emergency.

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**Standard EM.02.02.09**

As part of its Emergency Operations Plan, the hospital prepares for how it will manage utilities during an emergency.

**Rationale for EM.02.02.09**

Different types of emergencies can have the same detrimental impact on an organization’s utility systems. For example, brush fires, ice storms, and industrial accidents can all result in a loss of utilities required for care, treatment, services, and building operations. Organizations, therefore, must have alternative means of providing for essential utilities (for example, alternative equipment at the hospital; negotiated relationships with the primary suppliers; provision through a parent entity; Memoranda of Understanding (MOU) with other organizations in the community). Hospitals should determine how long they expect to remain open to care for patients and plan for their utilities accordingly. Because some emergencies may be regional in scope or of long duration, organizations should not rely solely on single source providers in the community. Where possible, hospitals should identify other suppliers outside of the local community in case the communities’ infrastructure is severely compromised and unable to support the hospital.
Elements of Performance for EM.02.02.09

As part of its Emergency Operations Plan, the hospital identifies alternative means of providing the following:

2. Electricity and lighting.
3. Water needed for consumption and essential care activities.
4. Water needed for equipment and sanitary purposes.
5. Fuel required for building operations, generators, and essential transport services that the hospital would typically provide.
6. Medical gas/vacuum systems.
7. Utility systems that the hospital defines as essential (for example, vertical and horizontal transport, heating and cooling systems, and steam for sterilization).

Note: The essential utility systems include mechanisms for maintaining temperatures at a level that protect patient health and safety and the safe and sanitary storage of provisions.

8. The hospital implements the components of its Emergency Operations Plan that require advance preparation to provide for utilities during an emergency.

9. For hospitals that use Joint Commission accreditation for deemed status purposes: The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, TIA 12-6); Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, TIA 12-4); and NFPA 110, when a new structure is built or when an existing structure or building is renovated.

Standard EM.02.02.11

As part of its Emergency Operations Plan, the hospital prepares for how it will manage patients during emergencies.

Rationale for EM.02.02.11

The fundamental goal of emergency management planning is to protect life and prevent disability. The manner in which care, treatment, and services are provided may vary by type of emergency. However, certain activities are so fundamental to patient safety (this
can include decisions to modify or discontinue services, make referrals, or transport patients) that the organization should take a proactive approach in considering how they might be accomplished.

The emergency triage process will typically result in patients being quickly treated and discharged, admitted for a longer stay, or transferred to a more appropriate source of care. A disaster may result in the decision to keep all patients on the premises in the interest of safety or, conversely, in the decision to evacuate all patients because the facility is no longer safe. Planning for clinical services must address these situations accordingly, particularly in the face of escalating events or in potentially austere care conditions.

**Elements of Performance for EM.02.02.11**

The Emergency Operations Plan describes the following:

2. How the hospital will manage the activities required as part of patient scheduling, triage, assessment, treatment, admission, transfer, and discharge.

3. How the hospital will evacuate (from one section or floor to another within the building, or, completely outside the building) when the environment cannot support care, treatment, and services. *(See also EM.02.02.03, EPs 9 and 10)*

4. How the hospital will manage a potential increase in demand for clinical services for vulnerable populations served by the hospital, such as patients who are pediatric, geriatric, disabled, or have serious chronic conditions or addictions.

5. How the hospital will manage the personal hygiene and sanitation needs of its patients.

6. How the hospital will manage its patients’ mental health service needs that occur during an emergency.

7. How the hospital will manage mortuary services.

8. How the hospital will document and track patients’ clinical information.

11. The hospital implements the components of its Emergency Operations Plan that require advance preparation to manage patients during an emergency.
12. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital has a system to track the location of patients sheltered on site during an emergency. This system includes documentation of the name and location of the receiving facility or alternate site in the event a patient is relocated during the emergency.

**Note:** The name and location of receiving facilities or alternate sites may be defined in the emergency management plan, formal transfer agreements, or other accessible documents.

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**Introduction to Standards EM.02.02.13 and EM.02.02.15**

When the hospital activates its Emergency Operations Plan in response to a disaster and the immediate needs of its patients cannot be met, the hospital can choose to rely on volunteer practitioners to meet these needs. These practitioners may be volunteer licensed independent practitioners or volunteer practitioners who are not licensed independent practitioners but who are required by law and regulation to have a license, certification, or registration to meet these needs. Under these circumstances, if the usual credentialing and privileging processes cannot be performed because of the disaster, the organization may use a modified credentialing and privileging process on a case-by-case basis for eligible volunteer practitioners. While this standard allows for a method to streamline the process for determining qualifications and competence, safeguards must be in place to assure that the volunteer practitioners are competent to provide safe and adequate care, treatment, or services. Even in a disaster, the integrity of two specific parts of the usual process for determining qualifications and competence must be maintained:

1. Verification of licensure, certification, or registration required to practice a profession
2. Oversight of the care, treatment, and services provided

A number of state and federal systems engaged in pre-event verification of qualifications can help facilitate the assigning of disaster privileges to volunteer licensed independent practitioners at the time of a disaster. Examples of such systems include the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP) and the Medical Reserve Corps (MRC). The ESAR-VHP, created by the Health Resources and Services Administration (HRSA), allows for the advance registration and creden-
tialing of health care professionals needed to augment a hospital or other medical facility to meet increased patient/victim care and increased surge capacity needs. MRC units are comprised of locally based medical and public health volunteers who can assist their communities during emergencies, such as an influenza epidemic, a chemical spill, or an act of terrorism.

**Standard EM.02.02.13**

During disasters, the hospital may grant disaster privileges to volunteer licensed independent practitioners.

**Note:** A disaster is an emergency that, due to its complexity, scope, or duration, threatens the organization’s capabilities and requires outside assistance to sustain patient care, safety, or security functions.

**Elements of Performance for EM.02.02.13**

1. The hospital grants disaster privileges to volunteer licensed independent practitioners only when the Emergency Operations Plan has been activated in response to a disaster and the hospital is unable to meet immediate patient needs.

2. The medical staff identifies, in its bylaws, those individuals responsible for granting disaster privileges to volunteer licensed independent practitioners. *(See also MS.01.01.01, EP 14)*
3. The hospital determines how it will distinguish volunteer licensed independent practitioners from other licensed independent practitioners. (See also EM.02.02.07, EP 9)

4. The medical staff describes, in writing, how it will oversee the performance of volunteer licensed independent practitioners who are granted disaster privileges (for example, by direct observation, mentoring, medical record review).

5. Before a volunteer practitioner is considered eligible to function as a volunteer licensed independent practitioner, the hospital obtains his or her valid government-issued photo identification (for example, a driver’s license or passport) and at least one of the following: R
   - A current picture identification card from a health care organization that clearly identifies professional designation
   - A current license to practice
   - Primary source verification of licensure
   - Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group
   - Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances
   - Confirmation by a licensed independent practitioner currently privileged by the hospital or by a staff member with personal knowledge of the volunteer practitioner’s ability to act as a licensed independent practitioner during a disaster

6. During a disaster, the medical staff oversees the performance of each volunteer licensed independent practitioner.

7. Based on its oversight of each volunteer licensed independent practitioner, the hospital determines within 72 hours of the practitioner’s arrival if granted disaster privileges should continue.

8. Primary source verification of licensure occurs as soon as the disaster is under control or within 72 hours from the time the volunteer licensed independent practitioner presents him- or herself to the hospital, whichever comes first. If
primary source verification of a volunteer licensed independent practitioner’s licensure cannot be completed within 72 hours of the practitioner’s arrival due to extraordinary circumstances, the hospital documents all of the following:

- Reason(s) it could not be performed within 72 hours of the practitioner’s arrival
- Evidence of the licensed independent practitioner’s demonstrated ability to continue to provide adequate care, treatment, and services
- Evidence of the hospital’s attempt to perform primary source verification as soon as possible

9. If, due to extraordinary circumstances, primary source verification of licensure of the volunteer licensed independent practitioner cannot be completed within 72 hours of the practitioner’s arrival, it is performed as soon as possible.

**Note:** Primary source verification of licensure is not required if the volunteer licensed independent practitioner has not provided care, treatment, or services under the disaster privileges.

**Standard EM.02.02.15**

During disasters, the hospital may assign disaster responsibilities to volunteer practitioners who are not licensed independent practitioners, but who are required by law and regulation to have a license, certification, or registration.

**Note:** While this standard allows for a method to streamline the process for verifying identification and licensure, certification, or registration, the elements of performance are intended to safeguard against inadequate care during a disaster.

**Elements of Performance for EM.02.02.15**

1. The hospital assigns disaster responsibilities to volunteer practitioners who are not licensed independent practitioners only when the Emergency Operations Plan has been activated in response to a disaster and the hospital is unable to meet immediate patient needs.

2. The hospital identifies, in writing, those individuals responsible for assigning disaster responsibilities to volunteer practitioners who are not licensed independent practitioners.

3. The hospital determines how it will distinguish volunteer practitioners who are not licensed independent practitioners from its staff. *(See also EM.02.02.07, EP 9)*
4. The hospital describes, in writing, how it will oversee the performance of volunteer practitioners who are not licensed independent practitioners who have been assigned disaster responsibilities. Examples of methods for overseeing their performance include direct observation, mentoring, and medical record review.

5. Before a volunteer practitioner who is not a licensed independent practitioner is considered eligible to function as a practitioner, the hospital obtains his or her valid government-issued photo identification (for example, a driver’s license or passport) and one of the following:
   - A current picture identification card from a health care organization that clearly identifies professional designation
   - A current license, certification, or registration
   - Primary source verification of licensure, certification, or registration (if required by law and regulation in order to practice)
   - Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group
   - Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances
   - Confirmation by hospital staff with personal knowledge of the volunteer practitioner’s ability to act as a qualified practitioner during a disaster

6. During a disaster, the hospital oversees the performance of each volunteer practitioner who is not a licensed independent practitioner.

7. Based on its oversight of each volunteer practitioner who is not a licensed independent practitioner, the hospital determines within 72 hours after the practitioner’s arrival whether assigned disaster responsibilities should continue.

8. Primary source verification of licensure, certification, or registration (if required by law and regulation in order to practice) of volunteer practitioners who are not licensed independent practitioners occurs as soon as the disaster is under control or within 72 hours from the time the volunteer practitioner presents him- or herself to the hospital, whichever comes first. If primary source verification of licensure, certification, or registration (if required by law and
regulation in order to practice) for a volunteer practitioner who is not a licensed independent practitioner cannot be completed within 72 hours due to extraordinary circumstances, the hospital documents all of the following:

- Reason(s) it could not be performed within 72 hours of the practitioner’s arrival
- Evidence of the volunteer practitioner’s demonstrated ability to continue to provide adequate care, treatment, or services
- Evidence of the hospital’s attempt to perform primary source verification as soon as possible

9. If, due to extraordinary circumstances, primary source verification of licensure of the volunteer practitioner cannot be completed within 72 hours of the practitioner’s arrival, it is performed as soon as possible.

**Note:** Primary source verification of licensure, certification, or registration is not required if the volunteer practitioner has not provided care, treatment, or services under his or her assigned disaster responsibilities.

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### Standard EM.03.01.01

The hospital evaluates the effectiveness of its emergency management planning activities.

**Rationale for EM.03.01.01**

The risks and hazards facing an organization or an area of the organization may change over time. The scope or goals of the hospital’s planning activities may evolve in response to changes in the organization, its structure, patient population, community planning partners, or a number of other factors. Such changes can have an impact on the hospital’s response capabilities, including decisions about its inventory of resources and assets needed during an emergency. The hospital conducts an annual review of its planning activities to identify such changes and support decision making regarding how the hospital responds to emergencies.

**Elements of Performance for EM.03.01.01**

1. The hospital conducts an annual review of its risks, hazards, and potential emergencies as defined in its hazard vulnerability analysis (HVA). The findings of this review are documented. (*See also EM.01.01.01, EPs 2 and 4*)

2. The hospital conducts an annual review of the objectives and scope of its Emergency Operations Plan. The findings of this review are documented.
3. The hospital conducts an annual review of its inventory. The findings of this review are documented.

4. The annual emergency management planning reviews are forwarded to senior hospital leadership for review. (See also LD.04.04.01, EP 25)

   Note: Senior hospital leadership refers to those leaders with responsibility for organizationwide strategic planning and budgets (vice presidents and officers). The hospital may determine that all senior hospital leaders participate in reviewing emergency management reviews, or it may designate specific senior hospital leaders to review this information.

Standard EM.03.01.03

The hospital evaluates the effectiveness of its Emergency Operations Plan.

Rationale for EM.03.01.03

The organization conducts exercises to assess the Emergency Operations Plan’s appropriateness; adequacy; and the effectiveness of logistics, human resources, training, policies, procedures, and protocols. Exercises should stress the limits of the plan to support assessment of the organization’s preparedness and performance. The design of the exercise should reflect likely disasters but should test the organization’s ability to respond to the effects of emergencies on its capabilities to provide care, treatment, and services.

Elements of Performance for EM.03.01.03

1. As an emergency response exercise, the hospital activates its Emergency Operations Plan twice a year at each site included in the plan.

   Note 1: If the hospital activates its Emergency Operations Plan in response to one or more actual emergencies, these emergencies can serve in place of emergency response exercises.

   Note 2: Staff in freestanding buildings classified as a business occupancy (as defined by the Life Safety Code†) that do not offer emergency services nor are community designated as disaster-receiving stations need to conduct only one emergency management exercise annually.

† The Life Safety Code® is a registered trademark of the National Fire Protection Association, Quincy, MA. Refer to NFPA 101-2000 for occupancy classifications.
Note 3: Tabletop sessions, though useful, are not acceptable substitutes for these exercises.

Note 4: In order to satisfy the twice-a-year requirement, the hospital must first evaluate the performance of the previous exercise and make any needed modifications to its Emergency Operations Plan before conducting the subsequent exercise in accordance with EPs 13–17.

2. For each site of the hospital that offers emergency services or is a community-designated disaster receiving station, at least one of the hospital’s two emergency response exercises includes an influx of simulated patients.

Note 1: Tabletop sessions, though useful, cannot serve for this portion of the exercise.

Note 2: This portion of the emergency response exercise can be conducted separately or in conjunction with EM.03.01.03, EPs 3 and 4.

3. For each site of the hospital that offers emergency services or is a community-designated disaster receiving station, at least one of the hospital’s two emergency response exercises includes an escalating event in which the local community is unable to support the hospital.

Note 1: This portion of the emergency response exercise can be conducted separately or in conjunction with EM.03.01.03, EPs 2 and 4.

Note 2: Tabletop sessions are acceptable in meeting the community portion of this exercise.

4. For each site of the hospital with a defined role in its community’s response plan, at least one of the two emergency response exercises includes participation in a community-wide exercise.

Note 1: This portion of the emergency response exercise can be conducted separately or in conjunction with EM.03.01.03, EPs 2 and 3.

Note 2: Tabletop sessions are acceptable in meeting the community portion of this exercise.

5. Emergency response exercises incorporate likely disaster scenarios that allow the hospital to evaluate its handling of communications, resources and assets, security, staff, utilities, and patients. (See also EM.02.01.01, EP 2)
6. The hospital designates an individual(s) whose sole responsibility during emergency response exercises is to monitor performance and document opportunities for improvement.

**Note 1:** This person is knowledgeable in the goals and expectations of the exercise and may be a staff member of the hospital.

**Note 2:** If the response to an actual emergency is used as one of the required exercises, it is understood that it may not be possible to have an individual whose sole responsibility is to monitor performance. Hospitals may use observations of those who were involved in the command structure as well as the input of those providing services during the emergency.

7. During emergency response exercises, the hospital monitors the effectiveness of internal communication and the effectiveness of communication with outside entities such as local government leadership, police, fire, public health officials, and other health care organizations.

8. During emergency response exercises, the hospital monitors resource mobilization and asset allocation, including equipment, supplies, personal protective equipment, and transportation.

During emergency response exercises, the hospital monitors its management of the following:


10. Staff roles and responsibilities.

11. Utility systems.

12. Patient clinical and support care activities.

13. Based on all monitoring activities and observations, including relevant input from all levels of staff affected, the hospital evaluates all emergency response exercises and all responses to actual emergencies using a multidisciplinary process (which includes licensed independent practitioners).

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.
15. The deficiencies and opportunities for improvement, identified in the evaluation of all emergency response exercises and all responses to actual emergencies, are communicated to the improvement team responsible for monitoring environment of care issues and to senior hospital leadership. (See also LD.04.04.01, EP 25)


**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 Operations Plan.

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**Introduction to Standard EM.04.01.01**

Each individual health care organization must have an emergency plan that reflects the risks facing the organization and the strategies, resources, and capabilities it can deploy to serve its patients safely during time of disaster. Hospitals in systems with integrated emergency preparedness programs can increase resilience through integrating their plans with the system and leveraging system expertise, resources, and other capabilities. System participation extends the ability of the hospital to serve its patients, protect its facilities, mobilize its staff, and aid its system and/or community by serving more patients.

Depending on the hospital’s risks, services, and capabilities, some aspects of integration with the system may be at an early stage rather than an advanced stage. However, because disasters can occur at any time, the hospital must implement communication procedures immediately in order to stand ready to actively use and align with the system’s emergency response procedures.

In terms of format, the system’s plan can be an annex to the hospital’s plan, the hospital’s individual emergency plan can be integrated into the system’s plan, there can be a single universal system plan that has sections for each organization—no specific format is prescribed. However, the hospital must be able to readily access and use its
individual plan for its preparedness, response, and recovery efforts. The hospital must be able to readily access the system’s plan and use it to carry out its role effectively within the system’s integrated emergency preparedness program.

Standard EM.04.01.01

For hospitals that use Joint Commission accreditation for deemed status purposes: If the hospital is part of a health care system that has an integrated emergency preparedness program, and it chooses to participate in the integrated emergency preparedness program, the hospital participates in planning, preparedness, and response activities with the system.

Elements of Performance for EM.04.01.01

1. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital demonstrates its participation in the development of its system’s integrated emergency preparedness program through the following:
   - Designation of a staff member(s) who will collaborate with the system in developing the program
   - Documentation that the hospital has reviewed the community-based risk assessment developed by the system’s integrated all-hazards emergency management program
   - Documentation that the hospital’s individual risk assessment is incorporated into the system’s integrated program
   - Documentation that the hospital’s patient population, services offered, and any unique circumstances of the hospital are reflected in the system’s integrated program
   - Documentation of an integrated communication plan, including information on key contacts in the system’s integrated program
   - Documentation that the hospital participates in the annual review of the system’s integrated program

2. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital has implemented communication procedures for emergency planning and response activities in coordination with the system’s integrated emergency preparedness program.

3. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital’s integrated emergency management policies, procedures, or plans address the following:
- Identification of the hospital’s emergency preparedness, response, and recovery activities that can be coordinated with the system’s integrated program (for example, acquiring or storing clinical supplies, assigning staff to the local health care coalition to create joint training protocols, and so forth)
- The hospital’s communication and/or collaboration with local, tribal, regional, state, or federal emergency preparedness officials through the system’s integrated program
- Coordination of continuity of operations planning with the system’s integrated program
- Plans and procedures for integrated training and exercise activities with the system’s integrated program
Human Resources (HR)

Overview
The contribution that human resources management makes to a hospital’s ability to provide safe, quality care cannot be overestimated. The quality of the hospital’s staff will, in large part, determine the quality of the care, treatment, and services it provides. The *World Health Report 2000—Health Systems: Improving Performance* states that human resources is the most important contribution to the quality of health care because “the performance of health care systems depends ultimately on the knowledge, skills, and motivation of the people responsible for delivering services.”

This same report describes staff education and training as key investment tools: “Unlike material capital, knowledge does not deteriorate with use. But, like equipment, old skills become obsolete with the advent of new technologies. Continuing education and on-the-job training are required to keep existing skills in line with technological progress and new knowledge.” After staff are hired, even the smallest hospital has a responsibility to see that they receive the education and training they need to provide quality care and to keep patients safe.

About This Chapter
The standards and elements of performance in this chapter address the hospital’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 hospital provides. After staff are on the job, human resources must provide for the assessment of staff competence and performance.

Chapter Outline

I. Staff
   A. Qualifications (HR.01.01.01, HR.01.02.01, HR.01.02.07)
   B. Staffing (HR.01.02.05)
   C. Orientation (HR.01.04.01)
   D. Training and Education (HR.01.05.03)
   E. Competence (HR.01.06.01)
   F. Evaluation of Performance (HR.01.07.01)
Standards, Rationales, and Elements of Performance

Standard HR.01.01.01
The hospital defines and verifies staff qualifications.

Elements of Performance for HR.01.01.01

1. The hospital defines staff qualifications specific to their job responsibilities. (See also HR.01.01.01, EP 32; IC.01.01.01, EP 3; RI.01.01.03, EP 2)

   **Note 1:** Qualifications for infection control may be met through ongoing education, training, experience, and/or certification (such as that offered by the Certification Board for Infection Control).

   **Note 2:** Qualifications for laboratory personnel are described in the Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88), under Subpart M: “Personnel for Nonwaived Testing” §493.1351-$493.1495. A complete description of the requirement is located at http://wwwn.cdc.gov/clia/Regulatory.

   **Note 3:** For hospitals that use Joint Commission accreditation for deemed status purposes: Qualified physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, speech-language pathologists, or audiologists (as defined in 42 CFR 484.4) provide physical therapy, occupational therapy, speech-language pathology, or audiology services, if these services are provided by the hospital. The provision of care and staff qualifications are in accordance with national acceptable standards of practice and also meet the requirements of 409.17. See Appendix A for 409.17 requirements.

   **Note 4:** Qualifications for language interpreters and translators may be met through language proficiency assessment, education, training, and experience. The use of qualified interpreters and translators is supported by the Americans with Disabilities Act, Section 504 of the Rehabilitation Act of 1973, and Title VI of the Civil Rights Act of 1964.

2. The hospital verifies and documents the following:
   - Credentials of care providers using the primary source when licensure, certification, or registration is required by law and regulation to practice their profession. This is done at the time of hire and at the time credentials are renewed.
■ Credentials of care providers (primary source not required) when licensure, certification, or registration is not required by law and regulation. This is done at the time of hire and at the time credentials are renewed.

**Note 1:** It is acceptable to verify current licensure, certification, or registration with the primary source via a secure electronic communication or by telephone, if this verification is documented.

**Note 2:** A primary verification source may designate another agency to communicate credentials information. The designated agency can then be used as a primary source.

**Note 3:** 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.

3. ☐ The hospital verifies and documents that the applicant has the education and experience required by the job responsibilities.

4. ☐ The hospital obtains a criminal background check on the applicant as required by law and regulation or hospital policy. Criminal background checks are documented.

5. ☐ Staff comply with applicable health screening as required by law and regulation or hospital policy. Health screening compliance is documented.

7. Before providing care, treatment, and services, the hospital confirms that nonemployees who are brought into the hospital by a licensed independent practitioner to provide care, treatment, or services have the same qualifications and competencies required of employed individuals performing the same or similar services at the hospital.

**Note 1:** This confirmation can be accomplished either through the hospital’s regular process or with the licensed independent practitioner who brought in the individual.

**Note 2:** When the care, treatment, and services provided by the nonemployee are not currently performed by anyone employed by the hospital, leadership consults the appropriate professional hospital guidelines for the required credentials and competencies.

17. **For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds:** The activities program is directed by a professional who meets one of the following criteria:
- Is a qualified therapeutic recreation specialist or an activities professional who is licensed or registered, if applicable, by the state in which he or she practices and is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990
- Has two years of experience in a social or recreational program within the last five years, one year of which was full time in a patient activities program in a health care setting
- Is a qualified occupational therapist or occupational therapy assistant
- Has completed a training course approved by the state

18. **For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds:** The facility does not employ individuals who have been found guilty by a court of law of abusing, neglecting, or mistreating residents or who have had a finding entered into the state nurse aide registry concerning abuse, neglect, or mistreatment of residents or of misappropriation of their property.

30. **For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes:** The director of psychiatric nursing is a registered nurse who has a master’s degree in psychiatric or mental health nursing, or its equivalent, from a school of nursing accredited by the National League for Nursing, or is qualified by education and experience in the care of the mentally ill. The director of psychiatric nursing demonstrates competence to participate in interdisciplinary formulation of individual treatment plans; to give skilled nursing care and therapy; and to direct, monitor, and evaluate the nursing care furnished.

31. **For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes:** The director of the social work department or service has a master’s degree from an accredited school of social work or is qualified by education and experience in the social services needs of the mentally ill. 

   **Note:** If the director does not hold a master’s degree in social work, at least one staff member has this qualification.

32. **Technologists who perform diagnostic computed tomography (CT) exams have advanced-level certification by the American Registry of Radiologic Technologists (ARRT) or the Nuclear Medicine Technology Certification Board (NMTCB) in computed tomography or have one of the following qualifications:**
State licensure that permits them to perform diagnostic CT exams and documented training on the provision of diagnostic CT exams or
- Registration and certification in radiography by ARRT and documented training on the provision of diagnostic CT exams or
- Certification in nuclear medicine technology by ARRT or NMTCB and documented training on the provision of diagnostic CT exams

(See also HR.01.01.01, EP 1; HR.01.02.07, EPs 1 and 2)

**Note 1**: This element of performance does not apply to CT exams performed for therapeutic radiation treatment planning or delivery, or for calculating attenuation coefficients for nuclear medicine studies.

**Note 2**: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.

33. The hospital verifies and documents that diagnostic medical physicists who support computed tomography (CT) services have board certification in diagnostic radiologic physics or radiologic physics by the American Board of Radiology, or in Diagnostic Imaging Physics by the American Board of Medical Physics, or in Diagnostic Radiological Physics by the Canadian College of Physicists in Medicine, or meet all of the following requirements:

- A graduate degree in physics, medical physics, biophysics, radiologic physics, medical health physics, or a closely related science or engineering discipline from an accredited college or university
- College coursework in the biological sciences with at least one course in biology or radiation biology and one course in anatomy, physiology, or a similar topic related to the practice of medical physics
- Documented experience in a clinical CT environment conducting at least 10 CT performance evaluations under the direct supervision of a board-certified medical physicist

**Note**: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.
Standard HR.01.02.01
Physician assistants and advanced practice registered nurses who practice within the hospital are credentialed, privileged, and reprivileged through the medical staff process or an equivalent process.

Note: Advanced practice registered nurses who are licensed independent practitioners are credentialed and privileged only through the medical staff credentialing and privileging process. (See the “Medical Staff” [MS] chapter)

Elements of Performance for HR.01.02.01

1. The equivalent process for credentialing and privileging physician assistants and advanced practice registered nurses who practice within the hospital is approved by the governing body.

2. The equivalent process for credentialing and privileging physician assistants and advanced practice registered nurses who practice within the hospital includes the following:
   - A documented evaluation of the applicant’s credentials
   - An evaluation of the applicant’s current competence
   - Documented peer recommendations
   - Input from individuals and committees, including the medical staff, to make an informed decision regarding requests for privileges

Standard HR.01.02.05
The hospital has the necessary staff to support the care, treatment, and services it provides.

Elements of Performance for HR.01.02.05

2. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a qualified dietitian on a full-time, part-time, or consultative basis.

28. For hospitals that use Joint Commission accreditation for deemed status purposes: A full-time, part-time, or consulting pharmacist develops, supervises, and coordinates all the activities of the pharmacy department or pharmacy services.

Standard HR.01.02.07
The hospital determines how staff function within the organization.
Elements of Performance for HR.01.02.07

1. All staff who provide patient care, treatment, and services possess a current license, certification, or registration, in accordance with law and regulation. *(See also HR.01.01.01, EP 32)*

2. Staff who provide patient care, treatment, and services practice within the scope of their license, certification, or registration and as required by law and regulation. *(See also HR.01.01.01, EP 32)*

5. Staff supervise students when they provide patient care, treatment, and services as part of their training.

Standard HR.01.04.01

The hospital provides orientation to staff.

Elements of Performance for HR.01.04.01

1. The hospital orients its staff to the key safety content it identifies before staff provides care, treatment, and services. Completion of this orientation is documented.

   **Note:** Key safety content may include specific processes and procedures related to the provision of care, treatment, or services; the environment of care; and infection control.

3. The hospital orients staff on the following:
   - Relevant hospitalwide and unit-specific policies and procedures
   - Their specific job duties, including those related to infection prevention and control and assessing and managing pain
   - Sensitivity to cultural diversity based on their job duties and responsibilities
   - Patient rights, including ethical aspects of care, treatment, or services and the process used to address ethical issues based on their job duties and responsibilities

   Completion of this orientation is documented.

Standard HR.01.05.03

Staff participate in ongoing education and training.
Elements of Performance for HR.01.05.03

1. 🅰️ Staff participate in ongoing education and training to maintain or increase their competency and, as needed, when staff responsibilities change. Staff participation is documented.

14. 🅱️ The hospital verifies and documents that technologists who perform diagnostic computed tomography (CT) examinations participate in ongoing education that includes annual training on the following:
   - Radiation dose optimization techniques and tools for pediatric and adult patients addressed in the Image Gently® and Image Wisely® campaigns
   - Safe procedures for operation of the types of CT equipment they will use

**Note 1:** Information on the Image Gently and Image Wisely initiatives can be found online at http://www.imagegently.org and http://www.imagewisely.org, respectively.

**Note 2:** This element of performance does not apply to CT systems used for therapeutic radiation treatment planning or delivery, or for calculating attenuation coefficients for nuclear medicine studies.

**Note 3:** This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.

25. 🅱️ The hospital verifies and documents that technologists who perform magnetic resonance imaging (MRI) examinations participate in ongoing education that includes annual training on safe MRI practices in the MRI environment, including the following:
   - Patient screening criteria that address ferromagnetic items, electrically conductive items, medical implants and devices, and risk for nephrogenic systemic fibrosis (NSF)
   - Proper patient and equipment positioning activities to avoid thermal injuries
   - Equipment and supplies that have been determined to be acceptable for use in the MRI environment (MR safe or MR conditional)†
   - MRI safety response procedures for patients who require urgent or emergent medical care

† Terminology for defining the safety of items in the magnetic resonance environment is provided in ASTM F2503 Standard Practice for Marking Medical Devices and Other Items for Safety in the Magnetic Resonance Environment (http://www.astm.org).
- MRI system emergency shutdown procedures, such as MRI system quench and cryogen safety procedures
- Patient hearing protection
- Management of patients with claustrophobia, anxiety, or emotional distress

**Introduction to Standards HR.01.06.01 and HR.01.07.01**

A close relationship exists between competence assessment and performance evaluation. Sometimes this relationship can be confusing. Competence assessment lets the hospital know whether its staff have the ability to use specific skills and to employ the knowledge necessary to perform their jobs.

When the hospital defines specific competencies, it should consider the needs of its patient population, the types of procedures conducted, conditions or diseases treated, and the kinds of equipment it uses.

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 hospital, 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. This does not mean, however, that they have to be performed together at the same time. Some hospitals, 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 a hospital 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 HR.01.06.01**

Staff are competent to perform their responsibilities.
Elements of Performance for HR.01.06.01

1. The hospital defines the competencies it requires of its staff who provide patient care, treatment, or services. *(See also NPSG.03.06.01, EP 3)*

3. An individual with the educational background, experience, or knowledge related to the skills being reviewed assesses competence.  

   **Note:** When a suitable individual cannot be found to assess staff competence, the hospital can utilize an outside individual for this task. If a suitable individual inside or outside the hospital cannot be found, the hospital may consult the competency guidelines from an appropriate professional organization to make its assessment.

5. Staff competence is initially assessed and documented as part of orientation.

6. Staff competence is assessed and documented once every three years, or more frequently as required by hospital policy or in accordance with law and regulation.

Standard HR.01.07.01

The hospital evaluates staff performance.

Elements of Performance for HR.01.07.01

1. The hospital evaluates staff based on performance expectations that reflect their job responsibilities.

2. The hospital evaluates staff performance once every three years, or more frequently as required by hospital policy or in accordance with law and regulation. This evaluation is documented.

5. When a licensed independent practitioner brings a nonemployee individual into the hospital to provide care, treatment, and services, the hospital reviews the individual’s competencies and performance at the same frequency as individuals employed by the hospital.

   **Note:** This review can be accomplished either through the hospital’s regular process or with the licensed independent practitioner who brought staff into the hospital.
Infection Prevention and Control (IC)

Overview
The Centers for Disease Prevention and Control (CDC) reports that 1.7 million infections annually are health care related, and as a result, 99,000 people will die each year. Health care practitioners in the hospital environment know all too well about hospital-acquired infections. Modern health care, despite its great strides in preventing and treating disease, has yet to conquer the risk to patients of acquiring an infection in the very place where infection should be least present. However, multidrug-resistant infections can be acquired in almost any setting, including homes, schools, and vacant lots, making the need for effective infection prevention and control in hospitals all the more important.

Certainly, everyone who has clinical contact with patients should wash his or her hands frequently to help prevent the spread of disease. However, effective infection prevention and control plans go well beyond this approach. A strong plan will have the input and support of hospital leadership and will stress communication and collaboration. Everyone involved in the daily operations of the hospital, from practitioners to receptionists to kitchen staff and dock workers, should play a role. For example, physical rehabilitation specialists should take precautions to prevent germs from passing from patient to patient via medical equipment; staff who receive patients at intake should take measures to prevent the spread of disease from staff to paper to patient and back again; everyone should incorporate hand hygiene protocols. Clearly, all hospital staff need to observe proper infection prevention and control techniques at all times.

To help reduce the possibility of acquiring and transmitting an infection, hospitals need to establish a systematic infection prevention and control program. The design and scope of your organization’s program are determined by the specific risks faced by your location, the population(s) you serve, and the types of services you provide. The infection prevention and control activities you adopt should also be practical and reasonable to follow. No organization wants to jeopardize a patient’s health because its

infection control activities are outmoded or too confusing to practice daily. After an
effective program is in place, the hospital takes measures so that the program operates
according to plan and is evaluated appropriately.

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 hospital staff,
practitioners, and administrators might encounter, including a sudden influx of
potentially infectious patients. The standards are designed to assist hospitals, both large
and small, in developing and maintaining an effective program that covers a wide range
of situations.

These standards address activities of planning, implementation, and evaluation and are
based on the following conditions necessary to establish and operate an effective
infection prevention and control program. Every hospital, regardless of its size or the
services it provides, should do the following:

- Recognize that its infection prevention and control program plays a major role in its
efforts to improve patient safety and quality of care
- 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 collaborate with each other when designing and implementing the
infection prevention and control program
- Regularly assess its infection prevention and control program by using an
epidemiological approach that consists of surveillance, data collection, analysis, and
trend identification
- Coordinate its program with the larger community
- Take into account that the potential exists for an infection outbreak so extensive
that it overwhelms the hospital’s resources
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. Influx (IC.01.06.01)

II. Implementation
   A. Activities (IC.02.01.01)
   B. Medical Equipment, Devices, and Supplies (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 any infection prevention and control program to be effective, it needs to be well managed. Toward that end, hospital leadership assigns one or more people to be responsible for development of the program and its management. Depending on the size of the hospital and its resources, this person can be an employee, a contractor, or a consultant. After this person is in place, the work of planning the infection prevention and control program can begin by gathering staff with expertise in infection control, building management, and other key team members who can perform a risk assessment and put in place infection prevention and control activities. The infection prevention and control team may want to consult with community leaders and other outside infection control experts who can provide important information about the hospital’s population and associated health risks.

The results of the hospital’s infection risk assessment should be prioritized, ideally in order of level of probability and potential for harm. The hospital can then set goals for reducing the risks of the infections that pose the greatest threat to patients and the community. These goals should lead to focused activities, based on relevant professional guidelines and sound scientific practices.

Standard IC.01.01.01

The hospital identifies the individual(s) responsible for the infection prevention and control program.

Elements of Performance for IC.01.01.01

1. The hospital identifies the individual(s) with clinical authority over the infection prevention and control program.

2. When the individual(s) with clinical authority over the infection prevention and control program does not have expertise in infection prevention and control, he or she consults with someone who has such expertise in order to make knowledgeable decisions.
3. The hospital assigns responsibility for the daily management of infection prevention and control activities. (*See also* HR.01.01.01, EP 1; LD.03.06.01, EP 3)

**Note:** Number and skill mix of the individual(s) assigned should be determined by the goals and objectives of the infection prevention and control program.

4. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The individual with clinical authority over the infection prevention and control program is responsible for the following:
   - Developing policies governing control of infections and communicable diseases
   - Implementing policies governing control of infections and communicable diseases
   - Developing a system for identifying, reporting, investigating, and controlling infections and communicable diseases

**Standard IC.01.02.01**

Hospital leaders allocate needed resources for the infection prevention and control program.

**Elements of Performance for IC.01.02.01**

1. The hospital provides access to information needed to support the infection prevention and control program. (*See also* IM.02.02.03, EP 2)
2. The hospital provides laboratory resources when needed to support the infection prevention and control program.
3. The hospital provides equipment and supplies to support the infection prevention and control program.

**Standard IC.01.03.01**

The hospital identifies risks for acquiring and transmitting infections.

**Elements of Performance for IC.01.03.01**

1. The hospital identifies risks for acquiring and transmitting infections based on the following:
   - Its geographic location, community, and population served
   - The care, treatment, and services it provides
   - The analysis of surveillance activities and other infection control data
2. The hospital reviews and identifies its risks at least annually and whenever significant changes occur with input from, at a minimum, infection control personnel, medical staff, nursing, and leadership. (See also NPSG.07.03.01, EP 1)

3. The hospital prioritizes the identified risks for acquiring and transmitting infections. These prioritized risks are documented. (See also NPSG.07.03.01, EP 1)

**Standard IC.01.04.01**

Based on the identified risks, the hospital sets goals to minimize the possibility of transmitting infections.

**Note:** See NPSG.07.01.01 for hand hygiene guidelines.

**Element of Performance for IC.01.04.01**

1. The hospital’s written infection prevention and control goals include the following:
   - Addressing its prioritized risks
   - Limiting unprotected exposure to pathogens
   - Limiting the transmission of infections associated with procedures
   - Limiting the transmission of infections associated with the use of medical equipment, devices, and supplies
   - Improving compliance with hand hygiene guidelines (See also NPSG.07.01.01, EP 1)

**Standard IC.01.05.01**

The hospital has an infection prevention and control plan.

**Elements of Performance for IC.01.05.01**

1. When developing infection prevention and control activities, the hospital uses evidence-based national guidelines or, in the absence of such guidelines, expert consensus.

2. The hospital’s infection prevention and control plan includes a written description of the activities, including surveillance, to minimize, reduce, or eliminate the risk of infection.

3. The hospital describes, in writing, the process for investigating outbreaks of infectious disease. (See also IC.02.01.01, EP 5)
Infection Prevention and Control

6. All hospital components and functions are integrated into infection prevention and control activities.

**Standard IC.01.06.01**
The hospital prepares to respond to an influx of potentially infectious patients.

**Elements of Performance for IC.01.06.01**

2. The hospital obtains current clinical and epidemiological information from its resources regarding new infections that could cause an influx of potentially infectious patients.

3. The hospital has a method for communicating critical information to licensed independent practitioners and staff about emerging infections that could cause an influx of potentially infectious patients.

4. The hospital describes, in writing, how it will respond to an influx of potentially infectious patients. (See also EM.01.01.01, EP 2)

   **Note:** One acceptable response is to decide not to accept patients.

**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 between departments and staff. Everyone who works in the hospital should have a role and hold each other accountable. Important infection prevention and control information should be available to both staff and patients. Standard and transmission-based precautions should be used, and any outbreak of infection within the hospital should be investigated.

**Standard IC.02.01.01**
The hospital implements its infection prevention and control plan.

**Elements of Performance for IC.02.01.01**

1. The hospital implements its infection prevention and control activities, including surveillance, to minimize, reduce, or eliminate the risk of infection.
2. The hospital uses standard precautions,† including the use of personal protective equipment, to reduce the risk of infection. (See also EC.02.02.01, EP 4)

**Note:** Standard precautions are infection prevention and control measures to protect against possible exposure to infectious agents. These precautions are general and applicable to all patients.

3. The hospital implements transmission-based precautions‡ in response to the pathogens that are suspected or identified within the hospital’s service setting and community.

**Note:** Transmission-based precautions are 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, or a combination of these precautions.

5. The hospital investigates outbreaks of infectious disease. (See also IC.01.05.01, EP 5)

6. The hospital minimizes the risk of infection when storing and disposing of infectious waste. (See also EC.02.02.01, EPs 1 and 12)

7. The hospital implements its methods to communicate responsibilities for preventing and controlling infection to licensed independent practitioners, staff, visitors, patients, and families. Information for visitors, patients, and families includes hand and respiratory hygiene practices.

**Note:** Information may have different forms of media, such as posters or pamphlets.

8. The hospital reports infection surveillance, prevention, and control information to the appropriate staff within the hospital.

9. The hospital reports infection surveillance, prevention, and control information to local, state, and federal public health authorities in accordance with law and regulation.

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† 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).

‡ 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).
10. When the hospital becomes aware that it transferred a patient who has an infection requiring monitoring, treatment, and/or isolation, it informs the receiving organization.

11. When the hospital becomes aware that it received a patient from another organization who has an infection requiring action, and the infection was not communicated by the referring organization, it informs the referring organization.

Note: Infections requiring action include those that require isolation and/or public health reporting or those that may aid in the referring organization’s surveillance.

Standard **IC.02.02.01**
The hospital reduces the risk of infections associated with medical equipment, devices, and supplies.

**Rationale for IC.02.02.01**
The Centers for Disease Control and Prevention (CDC) estimate that 46.5 million surgical procedures are performed in hospitals and ambulatory settings each year; this includes approximately 5 million gastrointestinal endoscopies. Each of these procedures involves contact with a medical device or surgical instrument. A major risk of all such procedures is the introduction of pathogens that can lead to infection. Additionally, many more people are at risk of developing an infection from contact with medical equipment, devices, or supplies while seeking other health services. Failure to properly clean, disinfect, or sterilize, and use or store medical equipment, devices, and supplies, not only poses risks for the person seeking health services, but also carries the risk for person-to-person transmission of infections.

There are numerous steps involved in the cleaning, disinfecting, and sterilizing of medical equipment, devices, and supplies. It is critical that health care workers follow standardized practices to minimize infection risks related to medical equipment, devices, and supplies. 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 equipment, devices, and supplies
- Levels of staffing and supervision of the health care workers who are processing medical equipment, devices, and supplies
- Standardization of process regardless of whether it is centralized or decentralized

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Footnote:

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 hospital implements infection prevention and control activities when doing the following:

1. Cleaning and performing low-level disinfection of medical equipment, devices, and supplies.\(^{\text{R}}\)

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

2. Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies.\(^{\text{\# (See also EC.02.04.03, EP 4)}}\)\(^{\text{R}}\)

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

3. Disposing of medical equipment, devices, and supplies.\(^{\text{R}}\)

4. Storing medical equipment, devices, and supplies.\(^{\text{R}}\)

5. When reprocessing single-use devices, the hospital implements infection prevention and control activities that are consistent with regulatory and professional standards.

**Standard IC.02.03.01**

The hospital works to prevent the transmission of infectious disease among patients, licensed independent practitioners, and staff.

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\(^{\text{\# For further information regarding cleaning and performing low-level disinfection of medical equipment, devices, and supplies, refer to the website of the Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/hicpac/Disinfection_Sterilization/acknowledg.html.}}\

\(^{\text{\# For further information regarding performing intermediate and high-level disinfection of medical equipment, devices, and supplies, refer to the website of the Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/hicpac/Disinfection_Sterilization/acknowledg.html (Sterilization and Disinfection in Healthcare Settings).}}\)
Elements of Performance for IC.02.03.01

1. The hospital makes screening for exposure and/or immunity to infectious disease available to licensed independent practitioners and staff who may come in contact with infections at the workplace.

2. When licensed independent practitioners or staff have, are suspected of having, or have been occupationally exposed to an infectious disease that puts others at risk, the hospital provides them with or refers them for assessment and potential testing, prophylaxis/treatment, or counseling.

4. When patients have been exposed to an infectious disease, the hospital provides them with or refers them for assessment and potential testing, prophylaxis/treatment, or counseling.

Introduction to Standard IC.02.04.01

Influenza vaccination for staff and licensed independent practitioners 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 to those receiving health care by decreasing their exposure to the influenza virus while receiving this care. One way to improve patient safety is for staff and licensed independent practitioners 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 has been revised and strengthened to better reflect 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 and licensed independent practitioners. However, The Joint Commission does not mandate influenza vaccination for licensed independent practitioners and 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 licensed independent practitioners and staff. The decision on whether to pay for the influenza vaccination for staff and licensed independent practitioners will need to be made independently by each accredited organization.

**Standard IC.02.04.01**

The hospital offers vaccination against influenza to licensed independent practitioners and staff.

**Note:** This standard is applicable to staff and licensed independent practitioners only when care, treatment, or services are provided on site. When care, treatment, or services are provided off site, such as with telemedicine or telephone consultation, this standard is not applicable to off-site staff and licensed independent practitioners.

**Elements of Performance for IC.02.04.01**

1. The hospital establishes an annual influenza vaccination program that is offered to licensed independent practitioners and staff.

2. The hospital educates licensed independent practitioners and staff about, at a minimum, the influenza vaccine; non-vaccine control and prevention measures; and the diagnosis, transmission, and impact of influenza.

3. The hospital provides influenza vaccination at sites and times accessible to licensed independent practitioners and staff.

4. The hospital 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 hospital 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.

6. The hospital 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 Health-
Infection Prevention and Control

Introduction to Standard IC.03.01.01 – Evaluation and Improvement

Evaluation and improvement of the hospital’s infection prevention and control activities are important steps in the hospital’s efforts to control and prevent infection. Infection prevention and control practices need to become a routine part of the care, treatment, and services the hospital provides to patients. They expect and deserve hygienic and safe care, at all times. Continuous review of the goals, activities, and outcomes of the hospital’s program are therefore followed by improvement activities that are both realistic in expectation and effective.

Standard IC.03.01.01

The hospital evaluates the effectiveness of its infection prevention and control plan.
Elements of Performance for IC.03.01.01

1. The hospital evaluates the effectiveness of its infection prevention and control plan annually and whenever risks significantly change. The evaluation includes a review of the following:
   - The infection prevention and control plan’s prioritized risks
   - The infection prevention and control plan’s goals (See also NPSG.07.01.01, EP 2)
   - Implementation of the infection prevention and control plan’s activities

6. Findings from the evaluation are communicated at least annually to the individuals or interdisciplinary group that manages the patient safety program.

7. The hospital uses the findings of its evaluation of the infection prevention and control plan when revising the plan. (See also LD.01.02.01, EP 4)
Information Management (IM)

Overview
Every episode of care generates health information that must be managed systematically by the hospital. All data and information used by the hospital are categorized, filed, and maintained. The system should accurately capture health information generated by the delivery of care, treatment, and services. Health information should be accessed by authorized users who will use health information to provide safe, quality care. 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 hospitals 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 hospital with efficiency and accuracy. Planning also provides for continuity in the event that the hospital’s operations are disrupted or fail. The hospital 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. 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 hospital. The hospital’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 hospital’s needs and its goals. In addition to the hospital’s goals, the hospital’s mission, services, staff, patient safety practices, 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 hospital plans for managing information.

Element of Performance for IM.01.01.01
2. The hospital identifies how data and information enter, flow within, and leave the organization.
Introduction to Standard IM.01.01.03

The primary goal of the information continuity process is to return the hospital to normal operations as soon as possible with minimal downtime and no data loss. The hospital 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 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 hospital plans for interruptions by training staff on alternative procedures, testing the hospital’s Emergency Operations 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. Hospitals that plan for maintaining access to electronic information systems by using various electronic backup and restore procedures can quickly recover from interruptions with minimal downtime and data loss.

Standard IM.01.01.03

The hospital plans for continuity of its information management processes.

Elements of Performance for IM.01.01.03

1. The hospital 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 hospital’s plan for managing interruptions to information processes addresses the following:

2. Scheduled and unscheduled interruptions of electronic information systems. (See also IM.03.01.01, EP 1; EM.01.01.01, EP 6)

3. Training for staff and licensed independent practitioners on alternative procedures to follow when electronic information systems are unavailable. (See also EM.01.01.01, EP 6)

4. Backup of electronic information systems. (See also EM.01.01.01, EP 6)
**Standard IM.02.01.01**
The hospital protects the privacy of health information.

**Elements of Performance for IM.02.01.01**

1. The hospital has a written policy addressing the privacy of health information. *(See also RI.01.01.01, EP 7)*

2. The hospital implements its policy on the privacy of health information. *(See also RI.01.01.01, EP 7)*

3. The hospital 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 hospital discloses health information only as authorized by the patient or as otherwise consistent with law and regulation. *(See also RI.01.01.01, EP 7)*

**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 hospital. 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 hospital’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 hospital 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 hospital maintains the security and integrity of health information.

**Elements of Performance for IM.02.01.03**

1. The hospital has a written policy that addresses the security of health information, including access, use, and disclosure.
2. The hospital has a written policy addressing the integrity of health information against loss, damage, unauthorized alteration, unintentional change, and accidental destruction.
3. The hospital has a written policy addressing the intentional destruction of health information.
4. The hospital 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 hospital’s control.*

5. The hospital protects against unauthorized access, use, and disclosure of health information.
6. The hospital protects health information against loss, damage, unauthorized alteration, unintentional change, and accidental destruction.
7. The hospital controls the intentional destruction of health information.

**Standard IM.02.02.01**
The hospital effectively manages the collection of health information.
Elements of Performance for IM.02.02.01

2. The hospital uses standardized terminology, definitions, abbreviations, acronyms, symbols, and dose designations.

3. The hospital 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.

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 hospital retrieves, disseminates, and transmits health information in useful formats.

Elements of Performance for IM.02.02.03

2. The hospital’s storage and retrieval systems make health information accessible when needed for patient care, treatment, and services. *(See also IC.01.02.01, EP 1)*

   **Note:** For hospitals that use Joint Commission accreditation for deemed status purposes: The medical records system allows for timely retrieval of patient information by diagnosis and procedure.

3. The hospital disseminates data and information in useful formats within time frames that are defined by the hospital and consistent with law and regulation.

13. For hospitals in California that provide computed tomography (CT) services: The hospital complies with radiation event reporting requirements specified in section 115113 of the California Health and Safety Code.

Standard IM.03.01.01
Knowledge-based information resources are available, current, and authoritative.

Element of Performance for IM.03.01.01

1. The hospital provides access to knowledge-based information resources 24 hours a day, 7 days a week. *(See also IM.01.01.03, EP 2)*
Leadership (LD)

Overview
The safety and quality of care, treatment, and services depend on many factors, including the following:

- A culture that fosters safety as a priority for everyone who works in the hospital
- The planning and provision of services that meet the needs of patients
- The availability of resources—human, financial, and physical—for providing care, treatment, and 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 and services that the hospital provides to its patients. In hospitals with a governing body, governance has ultimate responsibility for this oversight. In larger hospitals, different individuals 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 hospital performance. In smaller hospitals, these responsibilities may be handled by just one or two individuals. This chapter addresses the role of leaders in managing these diverse and, at times complex, responsibilities.

Leaders shape the hospital’s culture, and the culture, in turn, affects how the hospital accomplishes its work. A healthy, thriving culture is built around the hospital’s mission and vision, which reflect the core values and principles that the hospital finds important. Leaders must ask some basic questions in order to provide this focus: How does the hospital plan to meet the needs of its population(s)? By what ethical standards will the hospital operate? What does the hospital want to accomplish through its work? Once leaders answer these questions, the culture of the hospital will begin to take shape.

Leaders also have an obligation to set an example of how to work together to fulfill the hospital’s mission. By dedicating themselves to upholding the values and principles of the hospital’s mission, leaders will be modeling to others how to collaborate, communicate, solve problems, manage conflict, and maintain ethical standards, essential practices that contribute to safe health care.
On a more practical level, leaders oversee operations and guide the hospital on a day-to-day basis. They keep operations running smoothly so that the important work of the hospital—serving its population—can continue.

To meet their obligations effectively, leaders must collaborate, which means working together in a spirit of collegiality to achieve a common end. Many hospitals have three leadership groups—the senior managers, governing body, and organized medical staff—who work together to deliver safe, high quality care. The senior managers direct the day-to-day operations of the hospital; the governing body determines what resources the hospitals needs and then secures those resources. The members of the organized medical staff are licensed to make independent decisions about the diagnosis and treatment of their patients and, in doing so, influence the choice and use of many of the hospital’s resources.

**Proactive Risk Assessment**
By undertaking a proactive risk assessment, a hospital can correct process problems and reduce the likelihood of experiencing adverse events. A hospital 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 clinical procedures, such as surgery, as well as processes that are integral to patient care, such as medication administration.

The processes that have the greatest potential for affecting patient safety should be the primary focus for risk assessments. Proactive risk assessments are also 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 patients. A hospital’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 to patients.

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 them.

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 function, which are often referred to as “failure modes.”
3. Identify the possible effects that a breakdown or failure of the process could have on patients 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 patients.
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,” “Hospital Culture and System Performance Expectations,” and “Operations.” The hospital’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 not only relationships, which include the leaders’ combined accountabilities, but also communication among leaders, conflict management and the development of the hospital’s mission, vision, and goals. The standards in the “Hospital Culture and System Performance Expectations” section focus on the framework for the hospital’s culture and systems. These standards also demonstrate how leaders help shape the culture of a hospital and how culture, in turn, affects important systems within the hospital (for example, data use, planning, communication, changing performance, staffing). The standards in the “Operations” section address the functions that are important to patient safety and high-quality care, treatment, and services. Some leaders may not be directly involved in the day-to-day operations of the hospital, 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. Leadership Responsibilities (LD.01.02.01)
   C. Governance Accountabilities (LD.01.03.01)
   D. The Chief Executive Responsibilities (LD.01.04.01)
   E. Medical Staff Accountabilities (LD.01.05.01)

II. Leadership Relationships
   A. Mission, Vision, and Goals (LD.02.01.01)
   B. Conflict of Interest Among Leaders (LD.02.02.01)
   C. Conflict Management (LD.02.04.01)

III. Organization Culture and System Performance Expectations
   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.04.01.06, LD.04.01.07, LD.04.01.11)
   B. Ethical Issues (LD.04.02.01, LD.04.02.03, LD.04.02.05)
   C. Meeting Patient Needs (LD.04.03.01, LD.04.03.07, LD.04.03.09, LD.04.03.11, LD.04.03.13)
   D. Managing Safety and Quality (LD.04.04.01, LD.04.04.03, LD.04.04.05, LD.04.04.07)
Leadership

Standards, Rationales, and Elements of Performance

Introduction to Leadership Structure, Standards LD.01.01.01 Through LD.01.05.01

Each hospital, regardless of its complexity, has a structured leadership. The leadership structure may consist of distinct groups, or leaders may act as a whole. Individual leaders may participate in more than one group and may have several different roles. A leadership group is composed of individuals in senior positions with clearly defined, unique responsibilities. These groups might include governance, management, and medical staff and clinical staff. Not every hospital will have all of these groups, and an individual may be a member of more than one group.

Many leadership responsibilities directly affect the provision of care, treatment, and services, as well as the day-to-day operations of the hospital. In some cases, these responsibilities will be shared among leadership groups, and in other cases, a particular leader or leadership group has primary responsibility. Regardless of the hospital’s structure, it is important that leaders carry out all their responsibilities.

A variety of individuals may work in the hospital, including licensed independent practitioners, staff, volunteers, students, and independent contractors. These standards describe the overall responsibility of the governing body for the safety and quality of care, treatment, and services provided by all of these individuals. In hospitals, the organized medical staff is responsible for overseeing the quality of care provided by individuals with privileges. The structure of the organized medical staff and its responsibilities are covered in the “Medical Staff” (MS) chapter.

How well leaders work together is key to effective hospital performance, and the standards emphasize this. Leaders from different groups—governance, senior management, and the organized medical staff—bring different skills, experiences, and perspectives to the hospital. Working together means that leaders from all groups have the opportunity to participate in discussions and have their opinions heard. Depending on the topic and the hospital, individuals from different leadership groups may participate in decision making, and the governing body may delegate decision making to
certain leadership groups. Final decisions, however, are always the ultimate responsibility of the governing body; this key principle is assumed in any standard that describes how leaders work together.

**Standard LD.01.01.01**
The hospital has a leadership structure.

**Rationale for LD.01.01.01**
Every hospital has a leadership structure to support operations and the provision of care. In many hospitals this structure is formed by three leadership groups: the governing body, senior managers, and the organized medical staff. In some hospitals there may be two leadership groups, and in others only one. Individual leaders may participate in more than one group.

**Elements of Performance for LD.01.01.01**
1. The hospital identifies those responsible for governance.
2. The governing body identifies those responsible for planning, management, and operational activities.
3. The governing body identifies those responsible for the provision of care, treatment, and services. (*See also* NR.01.01.01, EP 3)

**Standard LD.01.02.01**
The hospital identifies the responsibilities of its leaders.

**Rationale for LD.01.02.01**
Many responsibilities may be shared by all leaders. Others are assigned by the governing body to senior managers and the leaders of the organized medical staff. Hospital performance depends on how well the leaders work together to carry out these responsibilities.

**Elements of Performance for LD.01.02.01**
1. Senior managers and leaders of the organized medical staff work with the governing body to define their shared and unique responsibilities and accountabilities. (*See also* NR.01.01.01, EP 3)
4. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The chief executive officer, medical staff, and nurse executive make certain that the hospitalwide quality assessment and performance improvement
and training programs address problems identified by the individual responsible
for infection prevention and control and that corrective action plans are
successfully implemented. (See also IC.03.01.01, EP 7)

**Standard LD.01.03.01**
The governing body is ultimately accountable for the safety and quality of care,
treatment, and services.

**Rationale for LD.01.03.01**
The governing body’s ultimate responsibility for safety and quality derives from its legal
responsibility and operational authority for hospital performance. In this context, the
governing body provides for internal structures and resources, including staff, that
support safety and quality.

**Elements of Performance for LD.01.03.01**

1. The governing body defines in writing its responsibilities.
2. The governing body provides for organization management and planning.
3. The governing body approves the hospital’s written scope of services.

**Note:** For hospitals that use Joint Commission accreditation for deemed status
purposes: If emergency services are provided at the hospital, the hospital complies with
the requirements of 42 CFR 482.55. For more information on 42 CFR 482.55, refer
to the “Medicare Requirements for Hospitals” appendix.

4. The governing body selects the chief executive responsible for managing the hospital.

5. The governing body provides for the resources needed to maintain safe, quality
care, treatment, and services. (See also MM.09.01.01, EP 1; NR.01.01.01, EP 3)

6. The governing body works with the senior managers and leaders of the organized
medical staff to annually evaluate the hospital’s performance in relation to its
mission, vision, and goals.

8. The governing body provides the organized medical staff with the opportunity to
participate in governance.

9. The governing body provides the organized medical staff with the opportunity to
be represented at governing body meetings (through attendance and voice) by
one or more of its members, as selected by the organized medical staff.
10. Organized medical staff members are eligible for full membership in the hospital’s governing body, unless legally prohibited.

12. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital has a governing body that assumes full legal responsibility for the operation of the hospital.

20. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home evaluates the effectiveness of how the primary care clinician and the interdisciplinary team partner with the patient to support continuity of care and comprehensive, coordinated care.

21. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The governing body is responsible for making sure that performance improvement activities reflect the complexity of the hospital’s organization and services, involve all departments and services, and include services provided under contract. (For more information on contracted services, see Standard LD.04.03.09)

    **Note:** **For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital is not required to participate in a quality improvement organization (QIO) cooperative project, but its own projects are required to be of comparable effort.

**Standard LD.01.04.01**
A chief executive manages the hospital.

**Elements of Performance for LD.01.04.01**

The chief executive provides for the following:

1. Information and support systems.
2. Physical and financial assets.
3. The chief executive identifies a nurse leader at the executive level who participates in decision making. (*See also* NR.01.01.01, EP 3 for specific nurse leader responsibilities)

**Standard LD.01.05.01**
The hospital has an organized medical staff that is accountable to the governing body.
Elements of Performance for LD.01.05.01

1. **For hospitals that do not use Joint Commission accreditation for deemed status purposes:** There is a single organized medical staff unless criteria are met for an exception to the single medical staff requirements. (Refer to the introduction to MS.01.01.01)

2. The organized medical staff is self governing. (Refer to the bulleted list describing self governance in the Overview to the “Medical Staff” [MS] chapter.)

4. The governing body approves the structure of the organized medical staff.

6. The organized medical staff is accountable to the governing body for the quality of care provided to patients.

7. **For hospitals that use Joint Commission accreditation for deemed status purposes:** A doctor of medicine or osteopathy, or, if permitted by state law, a doctor of dental surgery or dental medicine, or a doctor of podiatric medicine is responsible for the organization and conduct of the medical staff.

8. **For hospitals that use Joint Commission accreditation for deemed status purposes:** There is a single organized medical staff.

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**Introduction to Leadership Relationships, Standards LD.02.01.01 Through LD.02.04.01**

How well leaders work together and manage conflict affects a hospital’s performance. In fulfilling its role, the governing body involves senior managers and leaders of the organized medical staff in governance and management functions.

Good relationships thrive when leaders work together to develop the mission, vision, and goals of the hospital; encourage honest and open communication; and address conflicts of interest.

**Standard LD.02.01.01**

The mission, vision, and goals of the hospital support the safety and quality of care, treatment, and services.
Rationale for LD.02.01.01
The primary responsibility of leaders is to provide for the safety and quality of care, treatment, and services. The purpose of the hospital’s mission, vision, and goals is to define how the hospital 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 hospital is most likely achieved when it is understood by all who work in or are served by the hospital.

Elements of Performance for LD.02.01.01
1. The governing body, senior managers, and leaders of the organized medical staff work together to create the hospital’s mission, vision, and goals.
2. The hospital’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 hospital serves.

Standard LD.02.02.01
The governing body, senior managers and leaders of the organized medical staff address any conflict of interest involving leaders that affect or could affect the safety or quality of care, treatment and services.

Note: This standard addresses conflict of interest involving individual members of leadership groups. For conflicts of interest among staff and licensed independent practitioners who are not members of leadership groups, see Standard LD.04.02.01.

Rationale for LD.02.02.01
Conflicts of interest can occur in many circumstances and may involve professional or business relationships. Leaders create policies that provide for the oversight and control of these situations. Together, leaders address actual and potential conflicts of interest that could interfere with the hospital’s responsibility to the community it serves.

Elements of Performance for LD.02.02.01
1. The governing body, senior managers, and leaders of the organized medical staff work together to define in writing conflicts of interest involving leaders that could affect safety and quality of care, treatment, and services.
2. The governing body, senior managers, and leaders of the organized medical staff work together to develop a written policy that defines how conflict of interest involving leaders will be addressed.
3. Conflicts of interest involving leaders are disclosed as defined by the hospital.

**Introduction to Standard LD.02.04.01**
Conflict commonly occurs even in well-functioning hospitals and can be a productive means for positive change. However, conflict among leadership groups that is not managed effectively by the hospital with regard to accountabilities, policies, practices, and procedures has the potential to threaten health care safety and quality. Hospitals need to manage such conflict so that health care safety and quality are protected. To do this, hospitals have a conflict management process in place.

To facilitate the management of conflict, it is important that hospitals identify an individual with conflict management skills who can help the hospital implement its conflict management process. Implementation of this process allows hospitals to manage conflict quickly, many times without seeking assistance from outside the hospital. These skilled individuals can also help their hospitals to more easily manage, or even avoid, future conflicts. These people can be the hospital’s own leaders, individuals from other areas of the hospital (for example, Human Resources Management and Administration), or people from outside the hospital.

Conflict management skills can be acquired through various means, including experience, education, and training. If the hospital chooses to train its leaders, it may offer training sessions to key individuals or bring in experts to teach conflict management skills.

Conflict can be successfully managed without being resolved. The goal of this standard is not to resolve conflict, but rather to create the expectation that hospitals will develop and implement a conflict management process so that conflict does not adversely affect patient safety or quality of care.

**Standard LD.02.04.01**
The hospital manages conflict between leadership groups to protect the quality and safety of care.
Elements of Performance for LD.02.04.01

1. Senior managers and leaders of the organized medical staff work with the governing body to develop an ongoing process for managing conflict among leadership groups.

5. The hospital implements the process when a conflict arises that, if not managed, could adversely affect patient safety or quality of care.

Introduction to Hospital Culture and System Performance Expectations, Standards LD.03.01.01 Through LD.03.06.01

A hospital’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 hospitals diverse cultures exist that may or may not share the same values. In fact, diverse cultures can exist even in smaller hospitals. Hospital performance can be effective in either case. Successful hospitals will work to develop a culture of safety and quality.

In a culture of safety and quality, all individuals are focused on maintaining excellence in performance. They accept the safety and quality of patient care, treatment, and services as personal responsibilities and work together to minimize any harm that might result from unsafe or poor quality of care, treatment, and 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 the individual, although reckless behavior and a blatant disregard for safety are not tolerated. Hospitals are committed to ongoing learning and have the flexibility to accommodate changes in technology, science, and the environment.

The leaders provide for the effective functioning of the hospital 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 a hospital:
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 hospitalwide processes (such as medication management) that are important to individual care, treatment, and 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 hospital will facilitate the effective performance of the hospital 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 hospitals demonstrate compliance through performance in standards located in other sections of this manual. These Leadership standards are cited when patterns of performance suggest hospitalwide issues.

The effective performance of these systems results in a culture in which safety and quality are priorities. The hospital 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. They are consistent with and complementary to many existing approaches to improvement, such as the Baldrige criteria and Six Sigma.

**Standard LD.03.01.01**

Leaders create and maintain a culture of safety and quality throughout the hospital.

**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 hospital. Leaders demonstrate their commitment to quality and set expectations for those who work in the hospital. Leaders evaluate the culture on a regular basis.

Leaders encourage teamwork and create structures, processes, and programs that allow this positive culture to flourish. Behavior that intimidates others and affects morale or staff turnover undermines a culture of safety and can be harmful to patient care. Leaders must address such behavior in individuals working at all levels of the hospital, 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 using valid and reliable tools.

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.
Standard LD.03.02.01
The hospital 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 hospitals make the right decisions. When decisions are supported by data, hospitals are more likely to move in directions that help them achieve their goals. Successful hospitals measure and analyze their performance. When data are analyzed and turned into information, this process helps hospitals 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, patient satisfaction, 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, and services.
3. The hospital 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 hospital uses data and information in decision making that supports the safety and quality of care, treatment, and services. *(See also NR.02.01.01, EPs 3 and 6; PI.02.01.01, EP 8)*
6. The hospital 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 hospital.

Standard LD.03.03.01
Leaders use hospitalwide 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
Planning includes contributions from the populations served, from those who work for the hospital, and from other interested groups or individuals.

**Elements of Performance for LD.03.03.01**

1. Planning activities focus on improving patient safety and health care quality.

3. Planning is systematic, and it involves designated individuals and information sources.

4. Leaders provide the resources needed to support the safety and quality of care, treatment, and services.

5. Safety and quality planning is hospitalwide.

6. Planning activities adapt to changes in the environment.

7. Leaders evaluate the effectiveness of planning activities.

**Standard LD.03.04.01**

The hospital communicates information related to safety and quality to those who need it, including staff, licensed independent practitioners, patients, families, and external interested parties.

**Rationale for LD.03.04.01**

Effective communication is essential among individuals and groups within the hospital, and between the hospital and external parties. Poor communication often contributes to adverse events and can compromise safety and quality of care, treatment, and 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 patient and the quality of care.

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 patients, the community, physicians, staff, and management.

5. Communication supports safety and quality throughout the hospital. *(See also LD.04.04.05, EPs 6 and 12)*
6. When changes in the environment occur, the hospital 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 hospital.

**Rationale for LD.03.05.01**
Change is inevitable, and agile hospitals 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 hospital 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 patient and the quality of care, treatment, and services.

3. The hospital 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 hospital.

6. The hospital’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. *(See also PI.02.01.01, EP 13)*

**Standard LD.03.06.01**
Those who work in the hospital are focused on improving safety and quality.

**Rationale for LD.03.06.01**
The safety and quality of care, treatment, and services are highly dependent on the people who work in the hospital. The mission, scope, and complexity of services define the design of work processes and the skills and number of individuals needed. In a
successful hospital, work processes and the environment make safety and quality paramount. This standard, therefore, applies to all those who work in or for the hospital, including staff and licensed independent practitioners.

**Elements of Performance for LD.03.06.01**

1. Leaders design work processes to focus individuals on safety and quality issues.

3. Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, and services. *(See also IC.01.01.01, EP 3)*

   **Note:** The number and mix of individuals is appropriate to the scope and complexity of the services offered.

4. Those who work in the hospital are competent to complete their assigned responsibilities.

5. Those who work in the hospital adapt to changes in the environment.

6. Leaders evaluate the effectiveness of those who work in the hospital to promote safety and quality.

**Introduction to Operations, Standards**

**LD.04.01.01 Through LD.04.04.07**

Although some leaders may not be involved in the day-to-day, hands-on operations of the hospital, their decisions and work affect, either directly or indirectly, every aspect of operations. They are the driving force behind the culture of the hospital. Leaders establish the ethical framework in which the hospital operates, create policies and procedures, and secure resources and services that support patient safety and quality care, treatment, and services.

**Standard LD.04.01.01**

The hospital complies with law and regulation.

**Elements of Performance for LD.04.01.01**

1. The hospital is licensed, is certified, or has a permit, in accordance with law and regulation, to provide the care, treatment, or services for which the hospital is seeking accreditation from The Joint Commission.
2. The hospital provides care, treatment, and 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.

16. For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes:
   ■ The psychiatric hospital is primarily engaged in providing, by or under the supervision of a doctor of medicine or osteopathy, psychiatric services for the diagnosis and treatment of mentally ill persons.
   ■ The psychiatric hospital meets the hospital conditions of participation specified in 42 CFR 482.1 through 482.23, and 42 CFR 482.25 through 482.57.
   ■ The psychiatric hospital maintains clinical records on all patients to determine the degree and intensity of treatments, as specified in 42 CFR 482.61.
   ■ The psychiatric hospital meets the staffing requirements specified in 42 CFR 482.62.

17. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital has a utilization review plan consistent with 42 CFR 482.30 that provides for review of services furnished by the hospital and the medical staff to patients entitled to benefits under the Medicare and Medicaid programs.

**Note 1:** *The hospital does not need to have a utilization review plan if either a Quality Improvement Organization (QIO) has assumed binding review for the hospital or the Centers for Medicare & Medicaid Services (CMS) has determined that the utilization review procedures established by the state under title XIX of the Social

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Security Act are superior to the procedures required in this section, and has required hospitals in that state to meet the utilization review plan requirements under 42 CFR 456.50 through 42 CFR 456.245.

Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to the “Medicare Requirements for Hospitals” appendix.

18. **For hospitals that use Joint Commission accreditation for deemed status purposes:** Utilization review activities are implemented by the hospital in accordance with the plan.

Note 1: The hospital does not need to implement utilization review activities itself if either a Quality Improvement Organization (QIO) has assumed binding review for the hospital or the Centers for Medicare & Medicaid Services (CMS) has determined that the utilization review procedures established by the state under title XIX of the Social Security Act are superior to the procedures required in this section, and has required hospitals in that state to meet the utilization review plan requirements under 42 CFR 456.50 through 42 CFR 456.245.

Note 2: For guidance regarding the requirements at 42 CFR 482.30, refer to the “Medicare Requirements for Hospitals” appendix.

**Standard LD.04.01.03**
The leaders develop 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 hospital when developing the operational and capital budgets. *(See also NR.01.01.01, EP 3)*

3. The operating budget reflects the hospital’s goals and objectives.

4. © The governing body approves an annual operating budget and, when needed, a long-term capital expenditure plan.

**Standard LD.04.01.05**
The hospital effectively manages its programs, services, sites, or departments.
Rationale for LD.04.01.05
Leaders at the program, service, site, or department level create a culture that enables the hospital 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, and services provided in their areas.

Elements of Performance for LD.04.01.05

2. Programs, services, sites, or departments providing patient care are directed by one or more qualified professionals or by a qualified licensed independent practitioner with clinical privileges.

3. The hospital defines, in writing, the responsibility of those with administrative and clinical direction of its programs, services, sites, or departments. (See also NR.01.01.01, EP 5)

   Note: For hospitals that use Joint Commission accreditation for deemed status purposes: This includes the full-time employee who directs and manages dietary services.

4. Staff are held accountable for their responsibilities.

5. Leaders provide for the coordination of care, treatment, and services among the hospital’s different programs, services, sites, or departments. (See also NR.01.01.01, EP 1)

6. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital’s emergency services are directed and supervised by a qualified member of the medical staff.

7. For hospitals that use Joint Commission accreditation for deemed status purposes: A qualified doctor of medicine or osteopathy directs the following services:
   - Anesthesia
   - Nuclear medicine
   - Respiratory care

8. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital assigns one or more individuals who are responsible for outpatient services.
9. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The anesthesia service is responsible for all anesthesia administered in the hospital.

10. **For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital has a director of social work services who monitors and evaluates the social work services furnished.

   **Note:** Social work services are furnished in accordance with accepted standards of practice and established policies and procedures.

12. Leaders identify an individual to be accountable for the following:
   - Staff implementation of the four phases of emergency management (mitigation, preparedness, response, and recovery)
   - Staff implementation of emergency management across the six critical areas (communications, resources and assets, safety and security, staff responsibilities, utilities, and patient clinical and support activities)
   - Collaboration across clinical and operational areas to implement emergency management hospitalwide
   - Identification of and collaboration with community response partners

   **Note:** This role addresses matters of emergency management that are not within the responsibilities of the incident commander role.

### Standard LD.04.01.06

**For hospitals that elect The Joint Commission Primary Care Medical Home option:** Qualified individuals serve in the role of primary care clinician.

### Element of Performance for LD.04.01.06

1. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** Primary care clinicians have the educational background and broad-based knowledge and experience necessary to handle most medical and other health care needs of the patients who selected them. This includes resolving conflicting recommendations for care. *(See also MS.03.01.01, EP 18 and refer to MS.03.01.01, EP 2; MS.06.01.03, EP 2; MS.06.01.03, EP 6; MS.06.01.05, EP 2; MS.06.01.07, EP 2)*

### Standard LD.04.01.07

The hospital has policies and procedures that guide and support patient care, treatment, and services.
Elements of Performance for LD.04.01.07

1. Leaders review and approve policies and procedures that guide and support patient care, treatment, and services. (See also NR.02.03.01, EP 1; RI.01.07.01, EP 1)

2. The hospital manages the implementation of policies and procedures. (See also NR.02.03.01, EP 2)

Standard LD.04.01.11
The hospital makes space and equipment available as needed for the provision of care, treatment, and services.

Rationale for LD.04.01.11
The resources allocated to services provided by the hospital have a direct effect on patient outcomes. Leaders should place highest priority on high-risk or problem-prone processes that can affect patient safety. Examples include infection control, medication management, use of anesthesia, and others defined by the hospital.

Elements of Performance for LD.04.01.11

3. The interior and exterior space provided for care, treatment, and services meets the needs of patients.

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 licensed independent practitioners and/or staff that affects or has the potential to affect the safety or quality of care, treatment, and services.

Elements of Performance for LD.04.02.01

1. The leaders define conflict of interest involving licensed independent practitioners or staff. This definition is in writing.

2. The leaders develop a written policy that defines how the hospital will address conflicts of interest involving licensed independent practitioners and/or staff.

3. Existing or potential conflicts of interest involving licensed independent practitioners and/or staff, as defined by the hospital, are disclosed.
4. The hospital 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, and services and financial incentives are available upon request to all patients and those individuals who work in the hospital, including staff and licensed independent practitioners.

Standard LD.04.02.03

Ethical principles guide the hospital’s business practices.

Elements of Performance for LD.04.02.03

1. The hospital has a process that allows staff, patients, and families to address ethical issues or issues prone to conflict.

2. The hospital uses its process to address ethical issues or issues prone to conflict.

5. Care, treatment, and services are provided based on patient needs, regardless of compensation or financial risk-sharing with those who work in the hospital, including staff and licensed independent practitioners.

13. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Each resident who is entitled to Medicaid benefits is informed in writing, either at the time of admission or when the resident becomes eligible for Medicaid, of the following:
   - The items and services included in the state plan for which the resident may not be charged
   - Those items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services

14. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Residents are informed when changes are made to the services that are specified in LD.04.02.03, EP 13.

15. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: When a resident becomes eligible for Medicaid after admission to the hospital, the hospital charges the resident only the Medicaid-allowable charge.
16. **For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds:** Residents are informed before or at the time of admission, and periodically during the resident’s stay, of services available in the facility and of charges for those services not covered under Medicare or by the facility’s per diem rate.

**Standard LD.04.02.05**
When internal or external review results in the denial of care, treatment, and services, or payment, the hospital makes decisions regarding the ongoing provision of care, treatment, and services, and discharge or transfer, based on the assessed needs of the patient.

**Rationale for LD.04.02.05**
The hospital is professionally and ethically responsible for providing care, treatment, and services within its capability and law and regulation. At times, such care, treatment, and services are denied because of payment limitations. In these situations, the decision to continue providing care, treatment, and services or to discharge the patient is based solely on the patient’s identified needs.

**Element of Performance for LD.04.02.05**
1. Decisions regarding the provision of ongoing care, treatment, and services, discharge, or transfer are based on the assessed needs of the patient, regardless of the recommendations of any internal or external review.

**Standard LD.04.03.01**
The hospital provides services that meet patient needs.

**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.

**Note:** For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: If medical and surgical diagnostic and treatment services are not available within the hospital, the hospital has an agreement with an outside source for these services to make sure that the services are immediately available or an agreement needs to be established for transferring patients to a general hospital that participates in the Medicare program.
2. The hospital provides essential services, including the following:
   - Diagnostic radiology
   - Dietary
   - Emergency
   - Medical records
   - Nuclear medicine
   - Nursing care
   - Pathology and clinical laboratory
   - Pharmaceutical
   - Physical rehabilitation
   - Respiratory care
   - Social work

   **Note:** Hospitals that provide only psychiatric and addiction treatment services are not required to provide nuclear medicine, physical rehabilitation, and respiratory care services.

3. The hospital provides at least one of the following acute-care clinical services:
   - Child, adolescent, or adult psychiatry
   - Medicine
   - Obstetrics and gynecology
   - Pediatrics
   - Treatment for addictions
   - Surgery

   **Note:** When the hospital provides surgical or obstetric services, anesthesia services are also available.

14. **For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes:** The psychiatric hospital provides psychological services, social work services, psychiatric nursing, and therapeutic activities.

   **Note:** The therapeutic activities program is appropriate to the needs and interests of patients and is directed toward restoring and maintaining optimal levels of physical and psychosocial functioning.

26. **For hospitals that use Joint Commission accreditation for deemed status purposes:** Emergency laboratory services are available 24 hours a day, 7 days a week.
Standard LD.04.03.07

Patients with comparable needs receive the same standard of care, treatment, and services throughout the hospital.

Rationale for LD.04.03.07

Comparable standards of care means that the hospital can provide the services that patients need within established time frames and that those providing care, treatment, and services have the required competence. Hospitals may provide different services to patients with similar needs as long as the patient’s outcome is not affected. For example, some patients may receive equipment with enhanced features because of insurance situations. This does not ordinarily lead to different outcomes. Different settings, processes, or payment sources should not result in different standards of care.

Element of Performance for LD.04.03.07

1. Variances in staff, setting, or payment source do not affect outcomes of care, treatment, and services in a negative way.

Introduction to Oversight of Care, Treatment, and Services Provided Through Contractual Agreement, Standard LD.04.03.09

The same level of care should be delivered to patients regardless of whether services are provided directly by the hospital or through contractual agreement. Leaders provide oversight to make sure that care, treatment, and 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, and 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, and services provided to the hospital’s patients. This standard does not apply to contracted services that are not directly related to patient care. 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. The requirements outlined in Standards HR.01.06.01, EC.01.01.01, EC.02.01.01, and PI.01.01.01 can provide ideas for setting expectations related to these topics. Additional ideas for expectations can also come from the elements of performance (EPs) found in specific standards applicable to the contracted service. Although leaders have the same responsibility for oversight of contracted services outside the hospital’s expertise as they do for contracted services within the hospital’s expertise, it is more difficult to determine how to monitor such services. In these cases, information from relevant professional hospitals can provide guidance for setting expectations.

The EPs do not prescribe the methods for evaluating contracted services; leaders are expected to select the best methods for their hospital 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 medical records
- Review of incident reports
- Review of periodic reports submitted by the individual or hospital 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 patients
- Review of patient satisfaction studies
- Review of results of risk management activities
In the event that contracted services do not meet expectations, leaders take steps to improve care, treatment, and 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, and services is not disrupted.

**Credentialing and Privileging**

In most cases, each licensed independent practitioner providing services through a contractual agreement must be credentialed and privileged by the hospital using his or her services following the process described in the “Medical Staff” (MS) chapter. However, there are four special circumstances when this is not required:

- **Direct care through a telemedical link:** Standard MS.13.01.01 describes several options for credentialing and privileging licensed independent practitioners who are responsible for the care, treatment, and services of the patient through a telemedical link.
- **Off-site services provided by a Joint Commission–accredited contractor.**
- **Services provided by a pathologist through a contracted reference laboratory compliant with CLIA (Clinical Laboratory Improvement Amendments) regulations.**
- **For hospitals that do not use Joint Commission accreditation for deemed status purposes interpretive services through a telemedical link:** EP 9 in this standard describes the circumstances under which a hospital can accept the credentialing and privileging decisions of a Joint Commission–accredited ambulatory care organization for licensed independent practitioners providing interpretive services through a telemedical link.

**Standard LD.04.03.09**

Care, treatment, and services provided through contractual agreement are provided safely and effectively.

**Elements of Performance for LD.04.03.09**

1. Clinical leaders and medical staff have an opportunity to provide advice about the sources of clinical services to be provided through contractual agreement.
2. The hospital 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. *(See also MS.13.01.01, EP 1)*

**Note 1:** In most cases, each licensed independent practitioner providing services through a contractual agreement must be credentialed and privileged by the hospital using their services following the process described in the “Medical Staff” *(MS)* chapter.

**Note 2:** For hospitals that do not use Joint Commission accreditation for deemed status purposes: When the hospital contracts with another accredited organization for patient care, treatment, and services to be provided off site, it can do the following:
- Verify that all licensed independent practitioners who will be providing patient care, treatment, and services have appropriate privileges by obtaining, for example, a copy of the list of privileges.
- 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 privileges.

**Note 3:** For hospitals that use Joint Commission accreditation for deemed status purposes: The leaders who monitor the contracted services are the governing body.

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 hospital’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 hospital maintains the continuity of patient care.
9. **For hospitals that do not use Joint Commission accreditation for deemed status purposes:** When using the services of licensed independent practitioners from a Joint Commission–accredited ambulatory care organization through a telemedical link for interpretive services, the hospital accepts the credentialing and privileging decisions of a Joint Commission–accredited ambulatory provider only after confirming that those decisions are made using the process described in Standards MS.06.01.03 through MS.06.01.07, excluding MS.06.01.03, EP 2. *(See also MS.13.01.01, EP 1)*

10. For hospitals that do not use Joint Commission accreditation for deemed status purposes: When using the services of licensed independent practitioners from a Joint Commission–accredited ambulatory care organization through a telemedical link for interpretive services, the hospital accepts the credentialing and privileging decisions of a Joint Commission–accredited ambulatory provider only after confirming that those decisions are made using the process described in Standards MS.06.01.03 through MS.06.01.07, excluding MS.06.01.03, EP 2. *(See also MS.13.01.01, EP 1)*

23. **For hospitals that use Joint Commission accreditation for deemed status purposes:** When telemedicine services are furnished to the hospital’s patients, the originating site has a written agreement with the distant site that specifies the following:

- The distant site is a contractor of services to the hospital.
- The distant site furnishes services in a manner that permits the originating site to be in compliance with the Medicare Conditions of Participation
- The originating site makes certain through the written agreement that all distant-site telemedicine providers’ credentialing and privileging processes meet, at a minimum, the Medicare Conditions of Participation at 42 CFR 482.12(a)(1) through (a)(9) and 482.22(a)(1) through (a)(4). *(See also MS.13.01.01, EP 1)*

**Note:** For the language of the Medicare Conditions of Participation pertaining to telemedicine, see Appendix A.

*If the originating site chooses to use the credentialing and privileging decision of the distant-site telemedicine provider, then the following requirements apply:*

- The governing body of the distant site is responsible for having a process that is consistent with the credentialing and privileging requirements in the “Medical Staff” (MS) chapter (Standards MS.06.01.01 through MS.06.01.13).
- The governing body of the originating site grants privileges to a distant site licensed independent practitioner based on the originating site’s medical staff recommendations, which rely on information provided by the distant site.

† For law and regulation guidance on the Clinical Laboratory Improvement Amendments of 1988, refer to 42 CFR 493.
Introduction to Standard LD.04.03.11

Hospital leaders create the culture, set the expectations, and provide support for effective collaboration on patient flow across units, departments, and functions throughout the hospital. Standard LD.04.03.11 highlights a systematic, hospitalwide approach to patient flow that emphasizes the use of performance measurement to monitor patterns and trends and identify potential improvement opportunities. This approach includes the following:

- Leadership use of data and measures to identify, mitigate, and manage issues affecting patient flow throughout the hospital
- The management of emergency department (ED) throughput as a hospitalwide concern
- Safety risks for boarded patients (that is, patients being held in the emergency department or another temporary location after the decision to admit or transfer has been made)

Staff from throughout the hospital—inpatient units, emergency department, medical staff, nursing, administration, environmental services, risk management—can make a significant contribution to understanding and resolving problems in patient flow. Measures and goals help identify impacts across units, reveal cycles and trends over time, and support accountability at all levels of the organization. The elements of performance (EPs) reflect contemporary thinking about the types of data likely to reveal how well the hospital manages patient flow. The EPs offer guidance without prescribing particular measures or sources of measures, recognizing that many hospitals use measures derived from their systems, regions, associations and collaboratives, and state and federal regulatory requirements, or have specific operational or community drivers.

Hospitals occasionally place patients in overflow locations during peak demand periods, hold patients in temporary bed locations before or after a procedure, or board patients for extended periods while awaiting transport to a bed or transfer to another facility. Patients in overcrowded EDs can experience delays in care and potential deterioration of their conditions as ED staff provide care both to incoming patients and patients who have not yet moved to their rooms. Boarding in particular can result in increased risks due to delays in care, compromised outcomes, and excessive demands on staff, and can be indicative of a systemic problem in patient flow. For these reasons, the EPs address safe care for patients who are waiting in any area of the hospital.
Patients who come to a hospital ED for care of psychiatric emergencies are especially vulnerable to boarding. The expectations here and at Standard PC.01.01.01, EP 4, guide hospitals in providing for a safe location, the orientation and training of staff, and the assessment, reassessment, and care (within its capabilities) of this vulnerable patient population. Community factors related to ongoing barriers in the provision of behavioral health services continue to impact the ability of some hospitals to find placement for patients requiring psychiatric services. It is beneficial for hospital leaders to reach out to behavioral health care providers or authorities in the community to communicate, collaborate, and problem-solve to work toward a more functional continuum of care for individuals who come to EDs for care of psychiatric emergencies.

**Standard LD.04.03.11**
The hospital manages the flow of patients throughout the hospital.

**Rationale for LD.04.03.11**
Managing the flow of patients throughout their care is essential to prevent overcrowding, which can undermine the timeliness of care and, ultimately, patient safety. Effective management of systemwide processes that support patient flow (such as admitting, assessment and treatment, patient transfer, and discharge) can minimize delays in the delivery of care. Monitoring and improving these processes are useful strategies to reduce patient flow problems.

**Elements of Performance for LD.04.03.11**

1. The hospital has processes that support the flow of patients throughout the hospital.
2. The hospital plans for the care of admitted patients who are in temporary bed locations, such as the postanesthesia care unit or the emergency department.
3. The hospital plans for care to patients placed in overflow locations.
4. Criteria guide decisions to initiate ambulance diversion.
5. The hospital measures and sets goals for the components of the patient flow process, including the following:
   - The available supply of patient beds
   - The throughput of areas where patients receive care, treatment, and services (such as inpatient units, laboratory, operating rooms, telemetry, radiology, and the postanesthesia care unit)
   - The safety of areas where patients receive care, treatment and services
The efficiency of the nonclinical services that support patient care and treatment (such as housekeeping and transportation)

Access to support services (such as case management and social work)

6. The hospital measures and sets goals for mitigating and managing the boarding of patients who come through the emergency department. (Refer to NPSG.15.01.01, EPs 1 and 2; PC.01.01.01, EPs 4 and 24; PC.01.02.03, EP 3; PC.02.01.19, EPs 1 and 2)

**Note:** Boarding is the practice of holding patients in the emergency department or another temporary location after the decision to admit or transfer has been made. The hospital should set its goals with attention to patient acuity and best practice; it is recommended that boarding time frames not exceed 4 hours in the interest of patient safety and quality of care.

7. The individuals who manage patient flow processes review measurement results to determine whether goals were achieved. (Refer to NR.02.02.01, EP 4)

8. Leaders take action to improve patient flow processes when goals are not achieved. (Refer to PI.03.01.01, EP 4)

**Note:** At a minimum, leaders include members of the medical staff and governing body, the chief executive officer and other senior managers, the nurse executive, clinical leaders, and staff members in leadership positions within the organization. (See the Glossary for the definition of leader.)

9. When the hospital determines that it has a population at risk for boarding due to behavioral health emergencies, hospital leaders communicate with behavioral health care providers and/or authorities serving the community to foster coordination of care for this population. (Refer to LD.03.04.01, EPs 3 and 6)

**Introduction to Standard LD.04.03.13**

Leadership engagement in the oversight of pain management supports safe and effective practice and sustainable improvements across the various disciplines and departments involved in pain assessment, pain management, and safe opioid prescribing. Monitoring hospital data and performance in opioid prescribing practices is essential for making pain management improvements, and it is important that a leader(s) is responsible for these activities.
It is also important that the hospital provides access to educational materials, resources, and tools for clinicians and staff to support effective pain management services.

- Prescription Drug Monitoring Programs (PDMPs) that aggregate prescribing and dispensing data submitted by pharmacies and dispensing practitioners are an effective tool for reducing prescription drug abuse and diversion. This site (http://www.pdmpassist.org/) provides up-to-date information on state PDMPs, as well as interactive maps.

- In May 2016, the American College of Physicians published a course titled “SAFE Opioid Prescribing: Strategies. Assessment. Fundamentals. Education” that provides guidance for safe and effective pain management when using extended and long-activating opioids.

- Also, when clinicians encounter patients who are addicted to opioids, the US Substance Abuse and Mental Health Services Administration (SAMHSA) has a directory of opioid treatment programs at http://dpt2.samsha.gov/treatment/directory.aspx.

Many patients have complex pain management needs, including the opioid-addicted patient undergoing major surgery, a patient who requires treatment with opioids and is at high risk for adverse events (for example, sleep apnea), or a patient with pain management needs that exceed the expertise of the patient’s attending licensed independent practitioner. Access to pain specialists by consultation or referral reflects best practice in addressing patients with complex pain management needs.

In addition to the availability of pain specialists, this standard requires the hospital to provide nonpharmacologic pain treatment modalities relevant to its patient population. These serve as a complementary approach for pain management and may potentially reduce the need for opioid medications in some circumstances. Nonpharmacologic strategies include, but are not limited to, transcutaneous electrical nerve stimulation, physical modalities (for example, acupuncture therapy, chiropractic therapy, osteopathic manipulative treatment, massage therapy, and physical therapy), relaxation therapy, and cognitive behavioral therapy. The hospital should ensure that patient preferences for pain management are discussed, and, when a patient’s preference for a safe nonpharmacologic therapy cannot be provided, hospitals can educate the patient on where the treatment may be accessed after discharge.

Finally, the most dangerous adverse effect of opioid analgesics is respiratory depression. Pulse oximetry is inadequate for monitoring high-risk patients. However, there are no controlled trials of monitoring respiratory depression to help determine the optimal
strategy for patients deemed high risk. Therefore, decisions on monitoring strategies should be left to the treating clinical team. Hospital leadership commitment is needed to make certain that equipment is available to monitor patients deemed highest risk (that is, patients with sleep apnea, patients receiving continuous intravenous opioids, or patients on supplemental oxygen).

**Standard LD.04.03.13**

Pain assessment and pain management, including safe opioid prescribing, is identified as an organizational priority for the hospital.

**Elements of Performance for LD.04.03.13**

1. The hospital has a leader or leadership team that is responsible for pain management and safe opioid prescribing and develops and monitors performance improvement activities. *(See also PI.02.01.01, EP 19)*

2. The hospital provides nonpharmacologic pain treatment modalities.

3. The hospital provides staff and licensed independent practitioners with educational resources and programs to improve pain assessment, pain management, and the safe use of opioid medications based on the identified needs of its patient population. *(See also RI.01.01.01, EP 8)*

4. The hospital provides information to staff and licensed independent practitioners on available services for consultation and referral of patients with complex pain management needs.

5. The hospital identifies opioid treatment programs that can be used for patient referrals.

6. The hospital facilitates practitioner and pharmacist access to the Prescription Drug Monitoring Program databases.

   **Note:** This element of performance is applicable in any state that has a Prescription Drug Monitoring Program database, whether querying is voluntary or is mandated by state regulations for all patients prescribed opioids.

7. Hospital leadership works with its clinical staff to identify and acquire the equipment needed to monitor patients who are at high risk for adverse outcomes from opioid treatment. *(See also PC.01.02.07, EP 6)*
Standard LD.04.04.01
Leaders establish priorities for performance improvement. (For more information, refer to the “Performance Improvement” [PI] chapter)

Elements of Performance for LD.04.04.01

1. Leaders set priorities for performance improvement activities and patient 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 4, 6–8, 11, 14, and 15)

3. Leaders reprioritize performance improvement activities in response to changes in the internal or external environment.

4. Performance improvement occurs hospitalwide.

5. For hospitals that elect The Joint Commission Primary Care Medical Home option: Ongoing performance improvement occurs hospitalwide for the purpose of demonstrably improving the quality and safety of care, treatment, or services.

6. For hospitals that elect The Joint Commission Primary Care Medical Home option: The interdisciplinary team actively participates in performance improvement activities.

24. For hospitals that elect The Joint Commission Primary Care Medical Home option: Leaders involve patients in performance improvement activities.

Note: Patient involvement may include activities such as participating on a quality committee or providing feedback on safety and quality issues.

25. Senior hospital leadership directs implementation of selected hospitalwide improvements in emergency management based on the following:
   - Review of the annual emergency management planning reviews (See also EM.03.01.01, EP 4)
   - Review of the evaluations of all emergency response exercises and all responses to actual emergencies (See also EM.03.01.03, EP 15)
   - Determination of which emergency management improvements will be prioritized for implementation, recognizing that some emergency management improvements might be a lower priority and not taken up in the near term.
**Standard LD.04.04.03**
New or modified services or processes are well designed.

**Elements of Performance for LD.04.04.03**

1. The hospital’s design of new or modified services or processes incorporates the needs of patients, staff, and others.

2. The hospital’s design of new or modified services or processes incorporates the results of performance improvement activities.

3. The hospital’s design of new or modified services or processes incorporates information about potential risks to patients.  
   (See also LD.04.04.05, EPs 6, 10, and 11)

   **Note:** A proactive risk assessment is one of several ways to assess potential risks to patients. For suggested components, refer to the “Proactive Risk Assessment” section at the beginning of this chapter.

4. The hospital’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 hospital’s design of new or modified services or processes incorporates information about sentinel events.

**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 hospital, including patient care, support, and contract services. It addresses the responsibility of leaders to establish a hospitalwide 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 hospital’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 hospital. It only emphasizes the need to integrate patient-safety activities, both existing and newly created, with the hospital’s leadership, which is ultimately responsible for this integration.

**Standard LD.04.04.05**

The hospital has an organizationwide, integrated patient safety program within its performance improvement activities.

**Elements of Performance for LD.04.04.05**

1. The leaders implement a hospitalwide patient safety program.

2. One or more qualified individuals or an interdisciplinary group manages 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 departments, programs, and services within the hospital participate in the safety program.

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

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

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.03.04.01, EP 5; LD.04.04.03, EP 3; PI.01.01.01, EP 8)*

   **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 a serious adverse outcome or result in an adverse event, often referred to as a close call or near miss.

8. The hospital 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 individuals.

10. At least every 18 months, the hospital selects one high-risk process and conducts a proactive risk assessment. (See also LD.04.04.03, EP 3)

Note: For suggested components, refer to the “Proactive Risk Assessment” section at the beginning of this chapter.

11. To improve safety and to reduce the risk of medical errors, the hospital analyzes and uses information about system or process failures and 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 patients and the families were informed of the event
   ■ All actions taken to improve safety, both proactively and in response to actual occurrences
Leadership

- **For hospitals that use Joint Commission accreditation for deemed status purposes:** The determined number of distinct improvement projects to be conducted annually
- All results of the analyses related to the adequacy of staffing (*See also PI.02.01.01, EP 14*)

14. The leaders encourage external reporting of significant adverse events, including voluntary reporting programs in addition to mandatory programs.
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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.04.04.07**
The hospital considers clinical practice guidelines when designing or improving processes.

**Rationale for LD.04.04.07**
Clinical practice guidelines can improve the quality, utilization, and value of health care services. Clinical practice guidelines help practitioners and patients make decisions about preventing, diagnosing, treating, and managing selected conditions. These guidelines can also be used in designing clinical processes or in checking the design of existing processes. The hospital identifies criteria that guide the selection and implementation of clinical practice guidelines so that they are consistent with its mission and priorities. Sources of clinical practice guidelines include the Agency for Healthcare Research and Quality, the National Guideline Clearinghouse, and professional organizations.

**Elements of Performance for LD.04.04.07**

2. When clinical practice guidelines will be used in the design or modification of processes, the hospital identifies criteria to guide their selection and implementation.

3. The hospital manages and evaluates the implementation of the guidelines used in the design or modification of processes.

4. The leaders of the hospital review and approve the clinical practice guidelines.

5. The organized medical staff reviews the clinical practice guidelines and modifies them as needed.
Life Safety (LS)

Overview

Applicability of the Standards
Life safety risks vary across different health care settings. These differences are due to the types of services provided, whether patients remain overnight, and the existence of specific building features. The standards in this chapter are arranged by types of “occupancies,” as defined in the National Fire Protection Association (NFPA) Life Safety Code® (101-2012). The first two digits of a standard number indicate not only the Roman numeral in the chapter outline, but also the type of building occupancy. The second two digits further define the type of building referred to, and the last two digits correspond to the applicable sections in the applicable chapters of the Life Safety Code.

Inpatient buildings such as hospitals, nursing homes, and limited care facilities need to meet the health care occupancy requirements that begin with Standard LS.02.01.10. Many hospitals also have other settings where outpatients are served, which are considered ambulatory health care occupancies. The Life Safety Code defines an ambulatory health care occupancy as a building or part of a building in which anesthesia or outpatient services are provided to four or more outpatients at the same time, making them incapable of saving themselves in emergencies. These requirements begin with Standard LS.03.01.10. This chapter also applies to all ambulatory surgical centers and outpatient surgical departments seeking accreditation for Medicare certification purposes, regardless of the number of patients incapable of saving themselves in an emergency.

Note: The first two standards, LS.01.01.01 and LS.01.02.01, apply to all occupancy types.

About This Chapter
Fire is a concern for everyone, but it is a special concern in hospitals because patients 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

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the building; and, as a last resort, moving people out of a building. Health care facility design and related features help prevent, detect, and suppress fires. The measures that hospitals 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 hospital are addressed in the “Environment of Care” (EC) chapter.

From time to time, building codes are updated to incorporate new technology that often cannot easily be introduced 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 health care occupancies. Buildings are considered existing health care occupancies if final plans for additions, renovations, or changes in occupancy were approved by the local authority having jurisdiction before July 5, 2016. Existing health care occupancy requirements are found in Chapter 19 of the Life Safety Code (101-2012). 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 health care occupancies. New health care occupancy requirements are found in Chapter 18 of the Life Safety Code. Existing ambulatory health care occupancy requirements are found in Chapter 21 of the Life Safety Code (101-2012). New ambulatory health care occupancy requirements are found in Chapter 20 of the Life Safety Code.

The Joint Commission uses the 2012 edition of the NFPA’s Life Safety Code as the source for the key structural components that help protect people during a fire. Each element of performance (EP) contains a reference to the Life Safety Code. A reference is 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 the following:

- General life safety design and building construction
- The means of egress, including design of space, travel distances, egress illumination, and signage

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
- 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

**Building Maintenance Program**

Typically, deficiencies are identified and corrected using scheduled rounds. A method proven to be effective for tracking and managing these deficiencies is the Building Maintenance Program (BMP). The program involves a scheduled process for inspecting, identifying, and correcting certain *Life Safety Code* deficiencies through maintenance activities. Although organizations are encouraged to use this program, it will not exempt them from receiving RFIs for deficiencies identified during the on-site survey.

The BMP consists of the following:

- Written strategies to manage the items covered in the program
- A documented schedule for the frequency of inspecting the items
- Processes for evaluating the effectiveness of the program

Examples of deficiencies that could be managed using this program include the following:

- Non-functioning positive latching devices, self-closing or automatic-closing devices, and excessive gaps and undercuts on fire-rated doors (LS.02.01.10, EP 6)
- Means of egress with accumulated snow and ice (LS.02.01.20, EP 11)
- Non-functioning egress illumination devices and exit signs (LS.02.01.20, EPs 33 and 34)
- Penetrations in corridor walls and smoke barrier walls and corridor walls (LS.02.01.30, EPs 8–10 and 18)
- Non-functioning latching devices and excessive gaps and undercuts on corridor doors (LS.02.01.30, EP 11)
- Non-functioning self-closing or automatic-closing devices and excessive gaps and undercuts on smoke barrier doors (LS.02.01.30, EP 19)
- Dirty grease-producing devices, including exhaust hoods, exhaust duct systems, and grease removal devices (LS.02.01.35, EP 11)
- Non-functioning positive latching devices and self-closing or automatic-closing devices on inlet and outlet doors in linen or trash chutes (LS.02.01.50, EP 5)
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
   A. All Ambulatory Health Care Occupancy Buildings
      1. General Building Requirements (LS.03.01.10)
      2. Means of Egress Requirements (LS.03.01.20)
      3. Protection (LS.03.01.30)
         a. Fire Alarm (LS.03.01.34)
         b. Extinguishment (LS.03.01.35)
      4. Special Provisions (LS.03.01.40)
      5. Building Services (LS.03.01.50)
      6. Operating Features (LS.03.01.70)
Standards, Rationales, and Elements of Performance

Introduction to Standard LS.01.01.01
Hospitals 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 hospital uses the BBI to identify the life safety features of its building(s). When a hospital 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 hospital may prepare a separate BBI form for each building. In either case, the hospital must address specific risks and the unique conditions at each of its sites and buildings.

The hospital should establish the qualifications of the individuals 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 hospital designs and manages the physical environment to comply with the Life Safety Code.

Elements of Performance for LS.01.01.01

1. The hospital assigns an individual(s) to assess compliance with the Life Safety Code and manage the Statement of Conditions (SOC) when addressing survey-related deficiencies.

   Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital complies with the 2012 Life Safety Code.
2. In time frames defined by the hospital, the hospital performs a building assessment to determine compliance with the "Life Safety" (LS) chapter. 

3. The hospital 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 hospital plans to resolve a deficiency through a Survey-Related Plan for Improvement (SPFI), the hospital meets the 60-day time frame.

   **Note 1:** If the corrective action will exceed the 60-day time frame, the hospital 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 hospital 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.

5. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital maintains documentation of any inspections and approvals made by state or local fire control agencies. 

6. The hospital 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 hospital protects occupants during periods when the *Life Safety Code* is not met or during periods of construction.

**Elements of Performance for LS.01.02.01**

1.  © The hospital has a written interim life safety measure (ILSM) policy that covers situations when *Life Safety Code* deficiencies cannot be immediately corrected or during periods of construction. The policy includes criteria for evaluating when and to what extent the hospital implements LS.01.02.01, EPs 2–15 to compensate for increased life safety risk. The criteria include the assessment process to determine when interim life safety measures are implemented. [R]

2.  © When the hospital identifies *Life Safety Code* deficiencies that cannot be immediately corrected or during periods of construction, the hospital 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) [R]

When the hospital identifies *Life Safety Code* deficiencies that cannot be immediately corrected or during periods of construction, the hospital 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 need for these inspections is based on criteria in the hospital’s interim life safety measure (ILSM) policy. [R]

5.  Provides temporary but equivalent fire alarm and detection systems for use when a fire system is impaired. The need for equivalent systems is based on criteria in the hospital’s interim life safety measure (ILSM) policy. [R]

6.  Provides additional firefighting equipment. The need for this equipment is based on criteria in the hospital’s interim life safety measure (ILSM) policy.
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 need for these partitions is based on criteria in the hospital’s interim life safety measure (ILSM) policy.

8. Increases surveillance of buildings, grounds, and equipment, giving special attention to construction areas and storage, excavation, and field offices. The need for increased surveillance is based on criteria in the hospital’s interim life safety measure (ILSM) policy.

9. Enforces storage, housekeeping, and debris-removal practices that reduce the building’s flammable and combustible fire load to the lowest feasible level. The need for these practices is based on criteria in the hospital’s interim life safety measure (ILSM) policy.

10. Provides additional training to those who work in the hospital on the use of firefighting equipment. The need for additional training is based on criteria in the hospital’s interim life safety measure (ILSM) policy.

11. Conducts one additional fire drill per shift per quarter. The need for additional drills is based on criteria in the hospital’s interim life safety measure (ILSM) policy. (*See also* EC.02.03.03, EP 1)

12. Inspects and tests temporary systems monthly. The completion date of the tests is documented. The need for these inspections and tests is based on criteria in the hospital’s interim life safety measure (ILSM) policy.

13. The hospital conducts education to promote awareness of building deficiencies, construction hazards, and temporary measures implemented to maintain fire safety. The need for education is based on criteria in the hospital’s interim life safety measure (ILSM) policy.

14. The hospital trains those who work in the hospital to compensate for impaired structural or compartmental fire safety features. The need for training is based on criteria in the hospital’s interim life safety measure (ILSM) policy.

**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 hospital’s policy allows the use of other ILSMs not addressed in EPs 2–14.

**Note 1:** The hospital’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 hospital’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.

### 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 hospital 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

1. Buildings meet requirements for construction type and height. In Types I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. All new buildings contain approved automatic sprinkler systems. Existing buildings contain approved automatic sprinkler systems as required by the construction type. (For full text, refer to NFPA 101-2012: 18/19.1.6; 18.3.5.1; 19.3.5.3; 18/19.3.5.4; 18/19.3.5.5; 18.3.5.6)

2. When building rehabilitation occurs, the hospital 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)

3. Any building undergoing change of use or change of occupancy classification complies with NFPA 101-2012: 43.7, unless permitted by NFPA 101-2012:18/19.1.1.4.2.

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
4. When an addition is made to a building, the building is in compliance with NFPA 101-2012: 43.8 and Chapter 18.

5. Buildings without protection from automatic sprinkler systems comply with NFPA 101-2012: 18.4.3.2; 18.4.3.3; and 18.4.3.8. When a nonsprinklered smoke compartment has undergone major rehabilitation, the automatic sprinkler requirements of Chapter 18.3.5 will apply.

Note: Major rehabilitation involves the modification of more than 50 percent, or 4500 square feet, of the area of the smoke compartment. (For full text, refer to NFPA 101-2012: 18/19.1.4.3.3)

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 are fire rated for two hours that are within buildings (occupancy separation), between buildings (two health care occupancy buildings), or the building has a common wall with a nonconforming building (for example, a health care occupancy and a business occupancy). (For full text, refer to NFPA 101-2012: 43.8; 18/19.1.1.4; 18/19.1.3.3; 18/19.1.3.4; 8.2.2.2)

8. When multiple occupancies are identified, they are in accordance with NFPA 101-2012: 18/19.1.3.2 or 18/19.1.3.4, and the most stringent occupancy requirements are followed throughout the building.

Note 1: If a two-hour separation is provided in accordance with NFPA 101-2012: 8.2.1.3, the construction type is determined as follows:

- The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with NFPA 101-2012: 18/19.1.6 and Tables 18/19.1.6.1.

- The construction type of the areas of the building enclosing the other occupancies are based on NFPA 101-2012: 18/19.1.3.5; 8.2.1.3.

Note 2: Outpatient surgical departments must be classified as ambulatory health care occupancy regardless of the number of patients served. (For full text, refer to NFPA 101-2012: 18/19.1.3.4.1)
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 1:** Labels on fire door assemblies must be maintained in legible condition.

   **Note 2:** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets the applicable provisions of the Life Safety Code Tentative Interim Amendment (TIA) 12-1.

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 ⅛ of an inch wide, and undercuts are no larger than ¾ 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 ¾ 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 hospital maintains the integrity of the means of egress.

**Rationale for LS.02.01.20**
Because patients are under medical care and in many cases cannot move on their own to escape the danger of fire, buildings in which patients are cared for must be designed and maintained so patients can be protected in place or moved to safe places in the building (instead of evacuated to a place outside the building). Hospitals 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 patient.

**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)

**Note:** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets the applicable provisions of the Life Safety Code Tentative Interim Amendment (TIA) 12-4.
2. Doors to patient sleeping rooms are not locked unless the clinical needs of patients require specialized security or where patients 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; 18/19.2.2.5.1; 18/19.2.2.5.2)

3. Horizontal sliding doors permitted by NFPA 101-2012: 7.2.1.14 that are not automatic closing are limited to a single leaf and have a latch or other mechanism to prevent the door from rebounding. (For full text, refer to NFPA 101-2012: 18/19.2.2.10.1)

4. Horizontal sliding doors serving an occupant load fewer than 10 are permitted, as long as they comply with NFPA 101-2012: 18/19.2.2.10.2 and meet the following criteria:
   - Area served by the door has no hazards.
   - Door is operable from either side without special knowledge or effort.
   - Force required to operate the door in the direction of travel is less than or equal to 30 pounds-force (lbf) to set the door in motion and less than or equal to 15 lbf to close or open to the required width.
   - Assembly is appropriately fire rated and is self- or automatic-closing by smoke detection per 7.2.1.8; assembly is installed per NFPA 80-2010.
   - Where required to latch, the door has a latch or other mechanism to prevent the door from rebounding.

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; 7.2.2.5.2; 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 patient lift and transport, 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 patient sleeping rooms. 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)
20. Existing exit access doors and exit doors are of the swinging type and are at least 32 inches in clear width. Exceptions are provided for existing 34-inch doors and for existing 28-inch doors where the fire plan does not require evacuation by bed, gurney, or wheelchair. (For full text, refer to NFPA 101-2012: 19.2.3.6, 19.2.3.7)

21. New exit access doors and exit doors are of the swinging type and are at least 41\(\frac{1}{2}\) inches in clear width. In psychiatric hospitals doors are at least 32 inches wide. Doors not subject to patient use, in exit stairway enclosures, or serving newborn nurseries are at least 32 inches in clear width. If using a pair of doors, the doors have a rabbet, bevel, or astragal at the meeting edge, and at least one of the doors provides 32 inches in clear width, while the inactive leaf of the pair is secured with automatic flush bolts. (For full text, refer to NFPA 101-2012: 18.2.3.6; 18.2.3.7)

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 longer than 30 feet 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. Patient sleeping rooms open directly onto an exit access corridor. Patient 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. Patient sleeping rooms that are larger than 1,000 square feet have at least two exit access doors remotely located from each other. Rooms not used as patient sleeping rooms 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 patient sleeping rooms 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 patient sleeping rooms 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 patient sleeping rooms 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; 19.2.5.7.2.1(D)(1)(a); 19.2.5.7.2.3; 19.3.4; 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, patient sleeping suites 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. Patient care suites 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 patient care suites 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 patient care suites 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)

37. Travel distances to exits are measured in accordance with NFPA 101-2012: 7.6.

- From any point in the room or suite to the exit is 150 feet or less (200 feet or less if the building is fully sprinklered)
- From any point in a room to the room door is 50 feet or less

(For full text, refer to NFPA 101-2012: 18/19.2.6)

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 hospital provides and maintains building features to protect individuals from the hazards of fire and smoke.

**Rationale for LS.02.01.30**

Fire and smoke are special concerns in health care organizations because of the inability of some patients to evacuate without assistance from staff. If not properly protected, the building can put patients 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. Hospitals 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)

**Note:** For hospitals that use Joint Commission accreditation for deemed status purposes: Doors to rooms containing flammable or combustible materials are provided with positive latching hardware. Roller latches are prohibited on such doors.

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)
Note: For hospitals that use Joint Commission accreditation for deemed status purposes: Doors to rooms containing flammable or combustible materials are provided with positive latching hardware. Roller latches are prohibited on such doors.

4. Laboratories using quantities of flammable, combustible, or hazardous materials that are considered a severe hazard are in accordance with NFPA 101-2012: 8.7 and NFPA 99 requirements applicable to administration, maintenance, and testing. (For full text refer to NFPA 101-2012: 18/19.3.2.2; NFPA 99-2012: 15.4)

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 permitted to be open to the corridor provided all criteria in NFPA 101-2012: 18/19.3.2.5 are met.

Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets the applicable provisions of the Life Safety Code Tentative Interim Amendment (TIA) 12-2.

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 1/2 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 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). 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 1 3/4-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). 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 patient sleeping rooms) 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 hospitals 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 patient sleeping or treatment rooms 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 patients 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 \( \frac{1}{8} \) of an inch. In new buildings, undercuts are no larger than \( \frac{3}{4} \) 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 smoke barrier doors are 25% or less of the size of the doors 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)

24. Every patient sleeping room has an outside window or outside door except newborn nurseries or rooms intended for less than 24-hour stays (such as obstetrical labor beds, recovery beds, and observation beds in the emergency department).

**Note:** Windows in atrium walls are considered outside windows.

25. In new buildings constructed after July 5, 2016, the window sill height in patient sleeping rooms does not exceed 36 inches from the floor, except in special nursing care areas (for example, intensive care units, coronary care units, hemodialysis units, and neonatal intensive care units), where window sill height does not exceed 60 inches above the floor.


**Standard LS.02.01.34**

The hospital provides and maintains fire alarm systems.

**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 sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of a fire. (For full text, refer to NFPA 101-2012: 19.3.4.3; 9.6.4; 9.7.1.1(1))

6. Activation of the required fire alarm control functions occurs automatically and is provided with an alternative power supply in accordance with NFPA 72-2010. (For full text, refer to NFPA 101-2012: 18/19.3.4.4; 9.6.1; 9.6.5)

7. The fire alarm signal automatically transmits using one of the provisions of NFPA 101-2012: 9.6.4. (For full text, refer to NFPA 101-2012: 18/19.3.4) R

8. Smoke detection systems are provided in spaces open to corridors as required by NFPA 101-2012: Chapter 18/19. (For full text, refer to NFPA 101-2012: 18/19.3.4.5.2; 18/19.3.6.1)
9. The ceiling membrane is installed and maintained in a manner that permits activation of the smoke detection system. (For full text, refer to NFPA 101-2012: 18/19.3.4.1)


**Standard LS.02.01.35**

The hospital provides and maintains systems for extinguishing fires.

**Elements of Performance for LS.02.01.35**

1. 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 patient sleeping rooms 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 patient sleeping rooms. (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 hospital provides and maintains special features to protect individuals from the hazards of fire and smoke.

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
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 hospital provides and maintains building services to protect individuals from the hazards of fire and smoke.

Elements of Performance for LS.02.01.50

1. Equipment using gas or gas piping complies with NFPA 54-2012, National Fuel Gas Code; electrical wiring and equipment complies with NFPA 70-2012, National Electric Code. Existing installations can continue in service provided there are no life-threatening hazards. (For full text, refer to NFPA 101-2012: 18/19.5.1.1; 9.1.1; 9.1.2)

2. Heating, ventilation, and air conditioning comply with NFPA 101-2012: 9.2 and are installed in accordance with manufacturers’ specifications. (For full text, refer to NFPA 101-2012: 18/19.5.2.1)

3. Any heating device (other than a central heating plant) is designed and installed so combustible materials cannot be ignited by the device and safety features stop fuel and shut down equipment if it experiences excessive temperature or ignition failure. (For full text, refer to NFPA 101-2012: 18/19.5.2.2)

   **Note:** If fuel fired, the heating device is designed as follows:
   - Chimney or vent connected
   - Takes air for combustion from outside
   - Combustion system is separate from occupied area atmosphere

4. A suspended unit heater(s) is permitted provided the following conditions are met:
   - Not located in means of egress or in patient rooms
   - Located high enough to be out of reach of people in the area
5. Direct-vent fireplaces in patient sleeping areas must meet the provisions of NFPA 101-2012: 18/19.5.2.2; 18/19.5.2.3.

6. Solid fuel–burning fireplaces are permitted in areas other than patient sleeping rooms when the following occurs:
   - Areas are separated by a one-hour fire-resistant wall
   - Fireplace complies with NFPA 101-2012: 9.2.2
   - Fireplace enclosure resists breakage up to 650°F and has heat-tempered glass
   - Area has supervised carbon monoxide detection per NFPA 101-2012: 9.8
   (For full text, refer to NFPA 101-2012: 18/19.5.2.3(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)

8. Escalators, dumbwaiters, and moving walks comply with NFPA 101-2012: 9.4. In addition, existing escalators, dumbwaiters, and moving walks (including escalator emergency stop buttons and automatic skirt obstruction stop) conform with the requirements of ASME/ANSI A17.1, Safety Code for Elevators and Escalators and ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. (For full text, refer to NFPA 101-2012: 18/19.5.3; 9.4.2; 9.4.6)

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 hospital provides and maintains operating features that conform to fire and smoke prevention requirements.

**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)

3. Draperies, curtains (including cubicle and shower curtains), and loosely hanging fabric comply with NFPA 101-2012: 10.3.1. (For full text, refer to NFPA 101-2012: 18/19.7.5.1; 18/19.3.5.11; 10.3.1)

   **Note:** Exceptions include shower/bath curtains in addition to window coverings in patient sleeping rooms and non-patient sleeping rooms located in sprinklered compartments where individual drapery or curtain panels do not exceed 48 square feet or total area does not exceed 20% of the wall.

4. In buildings without sprinkler protection, upholstered furniture purchased on or after July 5, 2016, meets Class I or char length and heat release criteria in accordance with NFPA 101-2012: 10.3.2.1 and 10.3.3. Mattresses purchased on or after July 5, 2016, meet char length and heat release criteria in accordance with NFPA 101-2012: 10.3.2.2 and 10.3.4. (For full text, refer to NFPA 101-2012: 18/19.7.5.2; 18/19.7.5.4)

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 patient records awaiting destruction) are permitted in an unprotected area. Those containers that are greater than 96 gallons are stored in a hazardous storage area.
7. When installed, new engineered smoke control systems are tested in accordance with NFPA 92-2012, Standard for Smoke Control Systems. Existing engineered smoke control systems are tested in accordance with established engineering principles. (For full text, refer to NFPA 101-2012: 18/19.7.7)

8. Portable space heaters are prohibited in smoke compartments containing sleeping rooms and patient treatment areas. 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.03.01.10**

Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.

**Note 1:** This standard applies to ambulatory health care occupancy (AHCO) classification requirements for hospitals. The application of AHCO in a hospital would need to meet one of the following provisions: multiple occupancies (18/19.1.3), contiguous non–health care occupancy (18/19.1.3.4), separated building occupancies (20/21.1.2).

**Note 2:** For hospitals that use Joint Commission accreditation for deemed status purposes: This standard applies to outpatient surgical departments associated with hospitals, regardless of the number of patients rendered incapable.

**Note 3:** In leased facilities, the elements of performance of this standard apply only to the space in which the accredited organization is located; all exits from the space to the outside at grade level; and any Life Safety Code building systems that support the space (for example, fire alarm system, automatic sprinkler system).

**Elements of Performance for LS.03.01.10**

1. Buildings meet requirements for construction type and height. In Types I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. All new buildings contain approved automatic sprinkler systems.
Existing buildings contain approved automatic sprinkler systems as required by the construction type. (For full text, refer to NFPA 101-2012: 20/21.1.6.1–20/21.1.6.6; 20/21.3.5)

2. Interior nonbearing walls in Types I or II construction are constructed of noncombustible or limited-combustible materials. Interior nonbearing walls that are required to have a minimum of two-hour fire resistance rating are made with fire retardant–treated wood and enclosed within noncombustible or limited-combustible materials, provided they are not used as shaft enclosures. (For full text, refer to NFPA 101-2012: 20.1.6.3; 20.1.6.4; 21.1.6.3; 21.1.6.4)

3. When building rehabilitation occurs, the hospital incorporates NFPA 101-2012: Chapters 20, 21, and 43. (For full text, refer to NFPA 101-2012: Chapter 43; 20/21.1.1.4; 4.6.7)

4. Ambulatory occupancies located in multioccupancy buildings are separated from health care occupancies by two-hour fire-rated walls and from business occupancies by one-hour fire-rated walls. (For full text, refer to NFPA 101-2012: 20/21.1.3; 20/21.1.4; 20/21.3.7.1)

   **Note:** Per Centers for Medicare & Medicaid Services’ regulation, outpatient surgical departments are classified as ambulatory health care occupancies, regardless of the number of patients served. (For full text, refer to NFPA 101-2012: 20/21.1.3.2; 20/21.3.7.1)

5. 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)

6. The fire protection rating for opening protectives in fire barriers, fire-rated smoke barriers, and fire-rated smoke partitions is 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 ½-hour barriers and partitions
Labels on fire door assemblies must be maintained in legible condition. (For full text, refer to NFPA 101-2012: 8.3.4.2; Table 8.3.4.2; 8.3.3.2.3; NFPA 80-2010: 5.2.13.3)

**Note:** For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital meets the applicable provisions of the Life Safety Code Tentative Interim Amendment (TIA) 12-1.

7. Doors within walls and floors that are required to be fire rated have functioning hardware, including positive latching devices and self-closing or automatic-closing devices. Gaps between meeting edges of door pairs are no more than \(\frac{1}{8}\)-inch wide, and undercuts are no larger than \(\frac{3}{4}\) of an inch. Blocking or wedging open fire-rated doors is prohibited. Doors required to be fire rated in the walls do not have unapproved protective plates greater than 16 inches from the bottom of the door. (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)

8. Doors requiring a minimum fire rating of \(\frac{3}{4}\) of an hour are free of coverings, decorations, or other objects applied to the door face. Informational signs, which are applied with adhesive only, are allowed provided that the informational signage does not exceed 5% of the door face area. (For full text, refer to NFPA 80-2010: 4.1.4)

9. Ducts penetrating the walls and floors with a fire-resistance rating of less than three hours are protected by dampers that are fire rated for 1½ hours; penetrations of three hours or greater are protected by fire dampers that are fire rated for three hours. (For full text, refer to NFPA 101-2012: 8.3.5.7; 9.2.1; NFPA 90A-2012: 5.4)

10. 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:** Non-approved 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.03.01.20**

The hospital maintains the integrity of the means of egress.
Note 1: This standard applies to ambulatory health care occupancy (AHCO) classification requirements for hospitals. The application of AHCO in a hospital would need to meet one of the following provisions: multiple occupancies (18/19.1.3), contiguous non–health care occupancy (18/19.1.3.4), separated building occupancies (20/21.1.2).

Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: This standard applies to outpatient surgical departments associated with hospitals, regardless of the number of patients rendered incapable.

Note 3: In leased facilities, the elements of performance of this standard apply only to the space in which the accredited organization is located; all exits from the space to the outside at grade level; and any Life Safety Code building systems that support the space (for example, fire alarm system, automatic sprinkler system).

Rationale for LS.03.01.20
Because patients are ill and in many cases cannot escape the danger of fire on their own, buildings in which patients are cared for must be designed and maintained so that patients can be moved to safe places in the building (instead of evacuated to a place outside the building).

Means of egress are 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. The hospital should make sure that a sufficient number of exits exist and that they are configured to provide protection from fire. It is important that egress doors are not locked in a way that restricts passage to safety.

Elements of Performance for LS.03.01.20

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: 20/21.2.2)

2. Any door required to be self-closing, including those in an exit stair enclosure, may be held open provided there is an automatic release device that closes the door in response to the manual fire alarm system, loss of power, and smoke detectors. (For full text, refer to NFPA 101-2012: 20/21.2.2.4; 20/21.2.2.5; 7.2.1.8.2)
3. 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: 20/21.2.1; 20/21.2.7; 38/39.2.7; 7.1.7; 7.1.10.1; 7.2.6; 7.7)

4. The capacity of the means of egress complies with NFPA 101-2012: 7.3. (For full text, refer to NFPA 101-2012: 20/21.2.3.1)

5. Exit corridors or passageways serving as a means of egress are 44 (or more) inches wide. Doors opening in the means of egress from diagnostic or treatment areas are 32 (or more) inches wide (unless the existing door opening is 34 inches). (For full text, refer to NFPA 101-2012: 20/21.2.3.2; 2.3.4)

6. Exits, exit accesses, and exit discharges 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: 7.1.10.1)

7. 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: 20/21.2.1; 7.5.2.2.1)

8. 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. Patient care suites larger than 2,500 square feet have two exits remotely located from each other. (For full text, refer to NFPA 101-2012: 20/21.2.4.1; 2.4.2; 7.4; 38/39.2.4)

9. In new buildings protected throughout by an approved automatic sprinkler system, dead-end corridors are no longer than 50 feet. In new buildings not provided with automatic sprinklers throughout, dead-end corridors are no longer than 20 feet. In existing buildings, dead-end corridors are no longer than 50 feet. (For full text, refer to NFPA 101-2012: 20/21.2.5; 38/39.2.5.2)

10. The travel distance from any point in a room to an exit is 150 feet or less; the travel distance is 200 feet or less in buildings protected throughout by an approved automatic sprinkler system. (For full text, refer to NFPA 101-2012: 20/21.2.6)
11. Nothing is stored in any exit enclosure. (For full text, refer to NFPA 101-2012: 20/21.2.1; 7.2.2.5) R

12. Means of egress are automatically and 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: 20/21.2.8; 7.8)

13. Illumination in the means of egress, including exit discharge, is arranged so that failure of any single lighting unit will not result in darkness (less than 0.2 foot-candles of illumination). Emergency lighting of at least 1½-hours duration is provided automatically in accordance with NFPA 101-2012: 7.9. (For full text, refer to NFPA 101-2012: 20/21.2.8; 7.8.1.4)

14. Signs reading “NO EXIT” are posted on doors to stairs in areas that are not conforming exits and that may be mistaken for exits. (For full text, refer to NFPA 101-2012: 20/21.2.10; 7.10.8.3)

15. Exit signs are visible when the path to the exit is not readily apparent. Signs are adequately lit and have letters that are 4 or more inches high or 6 inches high if externally lit. (See NFPA 101-2012: 20/21.2.10; 7.10.5)

16. New buildings equipped with or requiring the use of life support systems (electromechanical or inhalation anesthetics) have illumination for the following: means of egress, emergency lighting equipment, exit, and directional signs supplied by the life safety branch of the electrical system described in NFPA 99-2012. (For full text, refer to NFPA 101-2012: 20.2.9.2; NFPA 99-2012: 6.4.2.2.3)


Standard LS.03.01.30
The hospital provides and maintains building features to protect individuals from the hazards of fire and smoke.

Note 1: This standard applies to ambulatory health care occupancy (AHCO) classification requirements for hospitals. The application of AHCO in a hospital would need to meet one of the following provisions: multiple occupancies (18/19.1.3), contiguous non-health care occupancy (18/19.1.3.4), separated building occupancies (20/21.1.2).
Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: This standard applies to outpatient surgical departments associated with hospitals, regardless of the number of patients rendered incapable.

Note 3: In leased facilities, the elements of performance of this standard apply only to the space in which the accredited organization is located; all exits from the space to the outside at grade level; and any Life Safety Code building systems that support the space (for example, fire alarm system, automatic sprinkler system).

Elements of Performance for LS.03.01.30

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. (For full text, refer to NFPA 101-2012: 20/21.3.1; 8.6; 8.6.5; 38/39.3.1)

   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.

2. In buildings, exit stairs connecting three or fewer floors are fire rated for one hour; exit stairs connecting four or more floors are fire rated for two hours. (For full text, refer to NFPA 101-2012: 20/21.3.1; 38/39.3.1; 8.6.5)

3. All hazardous areas are enclosed with one-hour fire-rated walls with ¾-hour fire-rated doors; or hazardous areas have sprinkler systems and are constructed to resist the passage of smoke with doors equipped with self-closing or automatic-closing devices. (For full text, refer to NFPA 101-2012: 20/21.3.2; 38/39.3.2; 8.7; NFPA 80-2010: 4.8.4.1; 6.3.1.7; 6.5)

4. Laboratories using quantities of flammable, combustible, or hazardous materials that are considered as a severe hazard are protected in accordance with NFPA 101-2012: 8.7 and NFPA 99-2012 requirements. (For full text, refer to NFPA 101-2012: 20/21.3.2.2)

5. 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: 20/21.3.2.6(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

6. Commercial cooking equipment is installed per NFPA 96-2011, unless only used for food warming or limited cooking. (For full text, refer to NFPA 101-2012: 20/21.3.2.4; 20/21.3.2.5; 9.2.3)

7. Wall and ceiling interior finishes of exits and enclosed corridors are rated Class A or B for limiting smoke development and the spread of flames. (For full text, refer to NFPA 101-2012: 20/21.3.3; 38/39.3.3.2; 10.2.3)

8. Newly installed interior floor finishes in exits and enclosed corridors have a Class I or II radiant flux rating. (For full text, refer to NFPA 101-2012: 20/21.3.3; 10.2.7)

9. In new construction, openings in vision panels or doors are permitted without protection provided the openings are installed at or below one half the distance from the floor to the room ceiling and do not exceed 20 square inches. In rooms protected throughout by an approved automatic sprinkler system, the aggregate area of openings is limited to 80 square inches. In existing construction, openings are not limited. (For full text, refer to NFPA 101-2012: 20.3.6.2)

**Note:** Openings may include, but are not limited to, mail slots and pass-through windows in areas such as laboratory, pharmacy, and cashier stations.

10. In new construction, corridors that provide access to exits are separated from other areas by one-hour fire-rated barriers unless otherwise permitted by NFPA 101-2012: 38.3.6.1.

**Note:** For existing construction, there are no requirements. (For full text, refer to NFPA 101-2012: 20.3.6.2; 38.3.6.1)
11. Ambulatory health care space must be separated from other tenants with a one-hour fire resistance–rated barrier, constructed from the floor slab below to the floor or roof above. Doors in the barrier are 1¾ inch thick, solid bonded (or equivalent), self-closing, and have positive latching. Doors are kept in the closed position except when in use. Windows in the barrier comply with NFPA 101-2012: 8.3. (For full text, refer to NFPA 101-2012: 20/21.3.7.1; 8.3)

12. At least two smoke compartments are provided for every story unless one of the following conditions are met:
   - Facility is less than 5,000 square feet and protected by an approved smoke detection system
   - Facility is less than 10,000 square feet and protected by an approved, supervised sprinkler system per NFPA 101-2012: 9.7
   - Adjoining occupancy is used as a smoke compartment if all of the following conditions are met:
     - Separating wall has a fire-resistive rating of one hour
     - Doors in the one-hour fire-rated wall are 1¾” thick
     - Doors in the one-hour fire-rated wall are self-closing
     - Windows in the one-hour fire-rated wall are fixed fire window assemblies per NFPA 101-2012: 8.3
     - The ambulatory health care facility is less than 22,500 square feet
     - Access from the ambulatory health care facility is unrestricted to another occupancy
   (For full text, refer to NFPA 101-2012: 20/21.3.7.2)

13. Smoke barriers extend from the floor slab to the upper floor or roof slab above, through any concealed spaces (such as those above suspended ceilings and interstitial spaces), continuously from exterior wall to exterior wall. All penetrations are sealed. New smoke barriers are constructed of one-hour fire-rated materials. (For full text, refer to NFPA 101-2012: 20/21.3.7.5; 20/21.3.7.6)

14. Ducts that penetrate smoke barriers, are protected by approved smoke dampers that close when a local smoke detector is activated. The detector is located either within the duct system or in the corridor.

Note: In buildings with a fully ducted HVAC system and protected throughout by an approved automatic sprinkler system, dampers are not required. (For full text, refer to NFPA 101-2012: 20/21.3.7.6; 8.5.5)
15. Fixed fire window assemblies in smoke barrier walls or doors are fire rated for 20 minutes and are 25% or less of the size of the fire barrier in which they are installed.

**Note:** Existing window installations that have wired glass or fire-rated glazing, are 1,296 square inches in size or smaller, and are set in approved metal frames are acceptable. (For full text, refer to NFPA 101-2012: 20/21.3.7.7, 8.3.3)

16. Doors in smoke barriers are constructed of 1 ¾ inch or thicker solid-bonded wood core (or equivalent) and are self-closing or automatic-closing. For new buildings, doors are required to swing in the direction of egress travel; rabbets, bevels, or astragals are at meeting edges; and stops are at the head and sides of door frames. Center mullions are prohibited in smoke barrier door openings. (For full text, refer to NFPA 101-2012: 20/21.3.7.9; 20/21.2.2.4; 20.3.7.9; 20.3.7.10; 3.7.13; 3.7.14)


**Standard LS.03.01.34**

The hospital provides and maintains fire alarm systems.

**Note 1:** This standard applies to ambulatory health care occupancy (AHCO) classification requirements for hospitals. The application of AHCO in a hospital would need to meet one of the following provisions: multiple occupancies (18/19.1.3), contiguous non–health care occupancy (18/19.1.3.4), separated building occupancies (20/21.1.2).

**Note 2:** For hospitals that use Joint Commission accreditation for deemed status purposes: This standard applies to outpatient surgical departments associated with hospitals, regardless of the number of patients rendered incapable.

**Note 3:** In leased facilities, the elements of performance of this standard apply only to the space in which the accredited organization is located; all exits from the space to the outside at grade level; and any *Life Safety Code* building systems that support the space (for example, fire alarm system, automatic sprinkler system).

**Elements of Performance for LS.03.01.34**

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 new building, 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: 20/21.3.4.1; 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 and 200 feet of travel distance is not exceeded. (For full text, refer to NFPA 101-2012: 20/21.3.4.2.1; 20/21.3.4.2.2; 9.6.2.5)

4. For 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: 20.3.4.3–20.3.4.4; 9.6.4)

5. For 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 sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of a fire. (For full text, refer to NFPA 101-2012: 21.3.4.3; 9.6.4; 9.7.1.1(1))

6. Activation of the required fire alarm control functions occurs automatically and is provided with an alternative power supply in accordance with NFPA 72-2010. (For full text, refer to NFPA 101-2012: 20/21.3.4.4; 9.6.1; 9.6.5)

7. The fire alarm signal automatically transmits to one of the following:
   - An auxiliary fire alarm system
   - Central station fire alarm system

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
A proprietary supervising station fire alarm system
A remote supervising station fire alarm system
(For full text, refer to NFPA 101-2012: 20/21.3.4.3.2; NFPA 101-2012: 9.6.4)

8. The remote ancillary annunciator panel is in a location approved by the local fire department or its equivalent. (For full text, refer to NFPA 101-2012: 20/21.3.4.3, 9.6.3)

9. The fire alarm system contains an audible and visual evacuation signal throughout the building and provides occupant notification without delay. (For full text, refer to NFPA 101-2012: 20/21.3.4.3, 9.6.3)


**Standard LS.03.01.35**

The hospital provides and maintains equipment for extinguishing fires.

**Note 1:** This standard applies to ambulatory health care occupancy (AHCO) classification requirements for hospitals. The application of AHCO in a hospital would need to meet one of the following provisions: multiple occupancies (18/19.1.3), contiguous non–health care occupancy (18/19.1.3.4), separated building occupancies (20/21.1.2).

**Note 2:** For hospitals that use Joint Commission accreditation for deemed status purposes: This standard applies to outpatient surgical departments associated with hospitals, regardless of the number of patients rendered incapable.

**Note 3:** In leased facilities, the elements of performance of this standard apply only to the space in which the accredited organization is located; all exits from the space to the outside at grade level; and any Life Safety Code building systems that support the space (for example, fire alarm system, automatic sprinkler system).

**Elements of Performance for LS.03.01.35**

1. For new construction, the fire alarm system monitors the components of any required approved automatic sprinkler system. (For full text, refer to NFPA 101-2012: 20/21.3.5.2; 9.7.1.1)

2. The fire alarm system is connected to water flow alarms of any required automatic sprinkler system. (For full text, refer to NFPA 101-2012: 20/21.3.4.4; 20/21.3.5; 9.7.1.1)
3. Piping supports for approved automatic sprinkler systems are not damaged or loose. (For full text, refer to NFPA 101-2012: 20/21.3.4.4; NFPA 25-2011: 5.2.1; 5.2.2; 5.2.3)

4. Approved automatic sprinkler systems piping is not used to support any other item. (For full text, refer to NFPA 101-2012: 20/21.3.4.4; NFPA 25-2011: 5.2.2; NFPA 13-2010: 8.5.5.2; 8.5.5.3)

5. Sprinkler heads are not damaged and are free from corrosion, foreign materials, and paint. (For full text, refer to NFPA 101-2012: 20/21.3.4.4; NFPA 25-2011: 5.2.1; 5.2.2; NFPA 13-2010: 6.2.6.2; 6.2.7.1)

6. There is 18 inches or more of open space maintained below a sprinkler deflector to the top of storage.

   **Note:** Perimeter wall shelving may extend up to the ceiling when not located directly below a sprinkler head. (For full text, refer to NFPA 101-2012: 20/21.3.4.4; NFPA 25-2011: 5.2.1; 5.2.2; NFPA 13-2010: 8.5.5; 8.5.6)

7. 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 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: 20/21.3.5.3; 9.7.4.1; NFPA 10-2010: 6.1.3; 6.2.1)


**Standard LS.03.01.40**

The hospital provides and maintains special features to protect individuals from the hazards of fire and smoke.

**Note 1:** This standard applies to ambulatory health care occupancy (AHCO) classification requirements for hospitals. The application of AHCO in a hospital would need to meet one of the following provisions: multiple occupancies (18/19.1.3), contiguous non–health care occupancy (18/19.1.3.4), separated building occupancies (20/21.1.2).

**Note 2:** For hospitals that use Joint Commission accreditation for deemed status purposes: This standard applies to outpatient surgical departments associated with hospitals, regardless of the number of patients rendered incapable.
Note 3: In leased facilities, the elements of performance of this standard apply only to the space in which the accredited organization is located; all exits from the space to the outside at grade level; and any Life Safety Code building systems that support the space (for example, fire alarm system, automatic sprinkler system).

Elements of Performance for LS.03.01.40

1. Windowless buildings or portions of windowless buildings meet the requirements of NFPA 101-2012: 20/21.4; 11.7.

2. Existing high-rise buildings have approved automatic sprinkler systems that meet the requirements of NFPA 101-2012: 20/21.4; 11.8; 9.7.1.1(1), or they have an engineered life safety system complying with NFPA 101-2012: 39.4.2.1(2). New high-rise buildings comply with NFPA 101-2012: 11.8. (For full text, refer to NFPA 101-2012: 20/21.4; 11.8; 39.4.2.1)


Standard LS.03.01.50

The hospital provides and maintains building services to protect individuals from the hazards of fire and smoke.

Note 1: This standard applies to ambulatory health care occupancy (AHCO) classification requirements for hospitals. The application of AHCO in a hospital would need to meet one of the following provisions: multiple occupancies (18/19.1.3), contiguous non–health care occupancy (18/19.1.3.4), separated building occupancies (20/21.1.2).

Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: This standard applies to outpatient surgical departments associated with hospitals, regardless of the number of patients rendered incapable.

Note 3: In leased facilities, the elements of performance of this standard apply only to the space in which the accredited organization is located; all exits from the space to the outside at grade level; and any Life Safety Code building systems that support the space (for example, fire alarm system, automatic sprinkler system).
Elements of Performance for LS.03.01.50

1. Equipment using gas or related gas piping complies with NFPA 54-2012, National Fuel Gas Code; electrical wiring and equipment complies with NFPA 70-2012, National Electric Code. Existing installations can continue in service provided there are no life-threatening hazards. (For full text, refer to NFPA 101-2012: 20/21.5.1; 9.1.1)

2. Heating, ventilation, and air conditioning comply with NFPA 101-2012: 9.2 and are installed in accordance with the manufacturers’ specifications. (For full text, refer to NFPA 101-2012: 20/21.5.2.1; 9.2)

3. Any heating device (other than a central heating plant) is designed and installed so combustible materials cannot be ignited by the device, and safety features stop fuel and shut down equipment if it experiences excessive temperature or ignition failure.

   Note: If fuel fired, the heating device is designed as follows:
   - Chimney or vent connected
   - Takes air for combustion from outside
   - Combustion system that is separate from occupied area atmosphere
   (For full text, refer to NFPA 101-2012: 20/21.5.2.2)

4. A suspended unit heater(s) is permitted provided the following conditions are met:
   - Not located in means of egress or in patient rooms
   - Located high enough to be out of reach of people in the area
   - Has a safety feature to stop fuel and shut down equipment if it experiences excessive temperature or ignition failure
   (For full text, refer to NFPA 101-2012: 20/21.5.2.2)

5. New elevators are equipped with all of the following:
   - Firefighters service key recall and smoke detector automatic recall
   - Firefighters service emergency in-car key operation
   - Machine room smoke detectors
   - Elevator lobby smoke detectors

   Existing elevators meet these requirements when they have a travel distance of 25 feet or more above or below the level that best serves the needs of firefighters.
   (For full text, refer to NFPA 101-2012: 20/21.5.3; 9.4)
6. Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4. All existing escalators, dumbwaiters, and moving walks (including escalator emergency stop buttons and automatic skirt obstruction stop) conform to the requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. (For full text, refer to NFPA 101-2012: 20/21.5.3; 9.4.2)

7. The hospital does not allow unvented fuel-fired heaters. (For full text, refer to NFPA 101-2012: 20/21.5.2.2)

8. All heating appliances are provided with safety features to stop the flow of fuel and turn off the appliance during times of excessive temperatures or ignition failure. (For full text, refer to NFPA 101-2012: 20/21.5.2.2)

9. Waste chutes are installed per NFPA 101-2012: 9.5 and meet the following requirements:
   - Walls, partitions, and inlet openings meet the requirements of NFPA 101-2012: 8.3.
   - Doors of chutes open to a room designed exclusively for accessing the chute opening.
   - Rooms used for accessing the chute opening(s) are separated from other spaces per NFPA 101-2012: 8.7.
   - Chutes are permitted to open into rooms not exceeding 400 cubic feet in size if the room is sprinkler protected and not used for storage.

(For full text, refer to NFPA 101-2012: 20/21.5.4; 9.5; NFPA 82-2009)

**Note:** Existing installations having properly enclosed and maintained chute openings are permitted to have inlets open to a corridor or normally occupied space.


**Standard LS.03.01.70**

The hospital provides and maintains operating features that conform to fire and smoke prevention requirements.

**Note 1:** This standard applies to ambulatory health care occupancy (AHCO) classification requirements for hospitals. The application of AHCO in a hospital would need to meet one of the following provisions: multiple occupancies (18/19.1.3), contiguous non–health care occupancy (18/19.1.3.4), separated building occupancies (20/21.1.2).
Life Safety

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Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: This standard applies to outpatient surgical departments associated with hospitals, regardless of the number of patients rendered incapable.

Note 3: In leased facilities, the elements of performance of this standard apply only to the space in which the accredited organization is located; all exits from the space to the outside at grade level; and any Life Safety Code building systems that support the space (for example, fire alarm system, automatic sprinkler system).

Elements of Performance for LS.03.01.70

1. 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: 20/21.7.4)

2. 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.

3. Draperies, curtains (including cubicle curtains) and loosely hanging fabric comply with NFPA 101-2012: 10.3.1. (For full text, refer to NFPA 101-2012: 18/19.7.5.1; 18/19.3.5.11; 10.3.1)

   Note: Exceptions include shower/bath curtains in addition to window coverings in patient sleeping rooms and in non-patient sleeping rooms located in sprinklered compartments where individual drapery or curtain panels do not exceed 48 square feet or total area does not exceed 20% of the wall.

4. In buildings without sprinkler protection, upholstered furniture purchased on or after July 5, 2016, meets Class I or char length and heat release criteria in accordance with NFPA 101-2012: 10.3.2.1 and 10.3.3. Mattresses purchased on or after July 5, 2016, meet char length and heat release criteria in accordance with NFPA 101-2012: 10.3.2.2 and 10.3.4. (For full text, refer to NFPA 101-2012: 20/21.7.5.2; 20/21.7.5.4)
5. The hospital prohibits all combustible decorations unless they meet the criteria of NFPA 101-2012: 20/21.7.5.4.

6. Soiled linen and trash receptacles larger than 32 gallons (including recycling containers) are located in a room protected as a hazardous area. (For full text, refer to NFPA 101-2012: 20/21.7.5.5)

7. When installed, new engineered smoke control systems are tested in accordance with NFPA 92-2012, Standard for Smoke Control Systems. Existing engineered smoke control systems are tested in accordance with established engineering principles. (For full text, refer to NFPA 101-2012: 20/21.7.7)

8. Portable space heaters are prohibited in smoke compartments containing staff sleeping rooms and patient treatment areas. Non-sleeping rooms occupied by staff and employee areas separated from the corridor are permitted to have portable space heaters that contain heating elements not exceeding 212°F. (For full text, refer to NFPA 101-2012: 20/21.7.8)

Medication Management (MM)

Overview
Medication management is an important component in the palliative, symptomatic, and curative treatment of many diseases and conditions. However, medications are also capable of causing great harm if the incorrect dose or medication is inadvertently administered to a patient. To eliminate any potential harm that could be caused by medications, hospitals need to develop an effective and safe medication management system.

A safe medication management system addresses an organization’s medication processes, which in many organizations includes the following (as applicable):
- 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 hospital and those provided through contracted pharmacy services. However, the specifics of the medication management system used by the hospital can vary depending on the care, treatment, and services it provides. Not all hospitals will implement all of the medication processes. For example, the hospital implements the medication management processes continuously, since services are provided to patients 24 hours a day. If the hospital does not operate a 24-hour pharmacy, it may contract to provide pharmacy services, such as preparing and dispensing medications, during hours when its pharmacy is closed.

Effective and safe medication management also involves multiple services and disciplines working closely together. The medication management standards address activities involving various individuals within an organization’s medication management system, such as licensed independent practitioners and staff.
Additionally, an effective medication management system includes mechanisms for reporting potential and actual medication-related errors and a process to improve medication management processes and patient safety based on this information.

In essence, a well-planned and implemented medication management system supports patient safety 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 hospital
- Standardizing equipment and handling processes, including those for sample medications, across the hospital 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, and services provided by the hospital. 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 hospital by patients, their families, or 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 hospitals that permit their use. Medication Management EPs that do not include this note are not applicable to sample medications. In the rare circumstance of a sample medication being used in an inpatient setting, the sample medication would be subject to the complete Medication Management standards and EPs like any other inpatient medication.
Chapter Outline

I. Planning
   A. Medication Planning (MM.01.01.01, MM.01.01.03)
   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.05.01.17, MM.05.01.19)

VI. Administration (MM.06.01.01, MM.06.01.03, MM.06.01.05)

VII. Monitoring (MM.07.01.03)

VIII. Evaluation (MM.08.01.01)

IX. Antimicrobial Stewardship (MM.09.01.01)
Standards, Rationales, and Elements of Performance

Standard MM.01.01.01
The hospital plans its medication management processes.

Rationale for MM.01.01.01
Medication management is often complicated, involving many people and processes. For this reason, the hospital plans each part of the process with care so that safety and quality are maintained. This planning may involve the coordinated efforts of multiple services and disciplines.

Elements of Performance for MM.01.01.01

1. The organization has a written policy that describes that the following information about the patient is accessible to licensed independent practitioners and staff who participate in the management of the patient’s medications:
   - Age
   - Sex
   - Diagnoses
   - Allergies
   - Sensitivities
   - Current medications
   - Height and weight (when necessary)
   - Pregnancy and lactation information (when necessary)
   - Laboratory results (when necessary)
   - Any additional information required by the organization

   *(See also MM.04.01.01, EP 10; IM.02.01.01, EP 3)*

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

2. The hospital implements its policy to make information about the patient accessible to licensed independent practitioners and staff who participate in the management of the patient’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 hospital safely manages high-alert and hazardous medications.

**Rationale for MM.01.01.03**
High-alert medications are those medications that bear a heightened risk of causing significant patient harm 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 hospital needs to develop its own lists of both high-alert medications and hazardous drugs. These should be based on the hospital’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 hospital to determine whether medications that are new to the market are high alert or hazardous. In addition, the hospital 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**

1. ⑥ The hospital identifies, in writing, its high-alert and hazardous medications.‡ *(See also EC.02.02.01, EP 8)*

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

2. The hospital has a process for managing high-alert and hazardous medications. *(See also EC.02.02.01, EP 8; MM.03.01.01, EP 9)*

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⑥ 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.
‡ 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.
Note: This element of performance is also applicable to sample medications.

3. The hospital implements its process for managing high-alert and hazardous medications. (See also EC.02.02.01, EPs 1 and 8) 

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

5. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital reports abuses and losses of controlled substances, in accordance with law and regulation, to the individual responsible for the pharmacy department or service and, as appropriate, to the chief executive.

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

Standard MM.01.02.01
The hospital addresses the safe use of look-alike/sound-alike medications.

Elements of Performance for MM.01.02.01

1. The hospital develops a list of look-alike/sound-alike medications it stores, dispenses, or administers.


Note 2: This element of performance is also applicable to sample medications.

2. The hospital 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 hospital 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 hospital selects and procures medications.
Elements of Performance for MM.02.01.01

1. Members of the medical staff, licensed independent practitioners, pharmacists, and staff involved in ordering, dispensing, administering, and/or monitoring the effects of medications develop written criteria for determining which medications are available for dispensing or administering to patients.

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

2. The hospital develops and approves criteria for selecting medications, which, at a minimum, include the following:
   - Indications for use
   - Effectiveness
   - Drug interactions
   - Potential for errors and abuse
   - Adverse drug events
   - Sentinel event advisories
   - Population(s) served (for example, pediatrics, geriatrics)
   - Other risks
   - Costs

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

3. Before using a medication new to the hospital, the hospital determines a method to monitor the response of the patient.

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

4. The hospital maintains a formulary, including medication strength and dosage.

   **Note 1:** Sample medications are not required to be on the formulary.

   **Note 2:** In some settings, the term “list of medications available for use” is used instead of “formulary.” The terms are synonymous.

5. The hospital makes its formulary readily available to those involved in medication management.

6. The hospital standardizes and limits the number of drug concentrations available to meet patient care needs.

7. The hospital has a process to select, approve, and procure medications that are not on its formulary.
Note: This element of performance is also applicable to sample medications.

8. The hospital implements the process to select, approve, and procure medications that are not on its formulary.

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

9. Medications designated as available for dispensing or administration are reviewed at least annually based on emerging safety and efficacy information.

10. The hospital has a process to communicate medication shortages and outages to licensed independent practitioners and staff who participate in medication management.

11. The hospital implements its process to communicate medication shortages and outages to licensed independent practitioners and staff who participate in medication management.

12. The hospital develops and approves written medication substitution protocols to be used in the event of a medication shortage or outage.

13. The hospital implements its approved medication substitution protocols.

14. The hospital has a process to communicate to licensed independent practitioners and staff who participate in medication management about the medication substitution protocols for shortages or outages.

15. The hospital implements its process to communicate to licensed independent practitioners and staff who participate in medication management about the medication substitution protocols for shortages and outages.

**Standard MM.03.01.01**
The hospital safely stores medications.

**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 hospital’s approach to medication storage.
Elements of Performance for MM.03.01.01

2. The hospital stores medications according to the manufacturers’ recommendations or, in the absence of such recommendations, according to a pharmacist’s instructions.

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

3. The hospital stores all medications and biologicals, including controlled (scheduled) medications, in a secured area to prevent diversion, and locked when necessary, in accordance with law and regulation.


   Note 2: This element of performance is also applicable to sample medications.

4. The hospital has a written policy addressing the control of medication between receipt by an individual health care provider 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. The hospital implements its policy addressing the control of medication between receipt by an individual health care provider and its administration.

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

6. The hospital prevents unauthorized individuals from obtaining medications in accordance with its policy and law and regulation.

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

7. All stored medications and the components used in their preparation are labeled with the contents, expiration date, and any applicable warnings.

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

8. The hospital removes all expired, damaged, and/or contaminated medications and stores them separately from medications available for administration.

   Note: This element of performance is also applicable to sample medications.
9. The hospital keeps concentrated electrolytes present in patient care areas only when patient safety necessitates their immediate use, and precautions are used to prevent inadvertent administration. (See also MM.01.01.03, EP 2)

18. The hospital periodically inspects all medication storage areas.

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

19. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital has a pharmacy directed by a registered pharmacist or a supervised drug storage area, in accordance with law and regulation.

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

24. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital maintains records of the receipt and disposition of radiopharmaceuticals.

### Standard MM.03.01.03

The hospital safely manages emergency medications.

### Rationale for MM.03.01.03

Patient emergencies occur frequently in health care settings. The hospital, therefore, needs to plan how it will address patient emergencies and what medications and supplies it will need. Although the processes may be different, the hospital 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. Hospital leaders, in conjunction with members of the medical staff and licensed independent practitioners, decide which emergency medications and their associated supplies will be readily accessible in patient care areas based on the population served.

2. Emergency medications and their associated supplies are readily accessible in patient care areas.

3. Whenever possible, emergency medications are available in unit-dose, age-specific, and ready-to-administer forms.

6. When emergency medications or supplies are used, the hospital replaces them as soon as possible to maintain a full stock.
Standard **MM.03.01.05**
The hospital safely controls medications brought into the hospital by patients, their families, or licensed independent practitioners.

**Rationale for MM.03.01.05**
A number of valid reasons exist for allowing the patient to use his or her own medications in an organization. The hospital needs to control the use of these medications in order to protect the safety of the patient and the quality of care provided. Therefore, the hospital needs to define its responsibilities for the safe use of these medications.

**Elements of Performance for MM.03.01.05**

1. The hospital defines when medications brought into the hospital by patients, their families, or licensed independent practitioners can be administered.
   
   **Note:** *This element of performance is also applicable to sample medications.*

2. Before use or administration of a medication brought into the hospital by a patient, his or her family, or a licensed independent practitioner, the hospital 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.*

**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 hospital is responsible for reducing the potential for medication errors and the misinterpretation of these medication orders. As part of this process, the hospital 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 licensed independent practitioners involved in the medication process are essential.

**Standard MM.04.01.01**
Medication orders are clear and accurate.
Elements of Performance for MM.04.01.01

1. The hospital 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 licensed independent practitioner to administer a medication to a person in clearly defined circumstances
   - Automatic stop orders: Orders that include a date or time to discontinue a medication
   - Titrating orders: Orders in which the dose is either progressively increased or decreased in response to the patient’s status
   - 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 patient’s status
   - Signed and held orders: New prewritten (held) medication orders and specific instructions from a licensed independent practitioner to administer medication(s) to a patient in clearly defined circumstances that become active upon the release of the orders on a specific date(s) and time(s)
   - Orders for compounded drugs or drug mixtures not commercially available
   - Orders for medication-related devices (for example, nebulizers, catheters)
   - Orders for investigational medications
   - Orders for herbal products
   - Orders for medications at discharge or transfer

The hospital has a written policy that defines the following:

2. The required elements of a complete medication order.

3. When indication for use is required on a medication order.

4. The precautions for ordering medications with look-alike or sound-alike names.

5. Actions to take when medication orders are incomplete, illegible, or unclear.
6. The hospital minimizes the use of verbal and telephone medication orders.

7. The hospital reviews and updates preprinted order sheets, within time frames it identifies or sooner if necessary, based on current evidence and practice.

8. The hospital prohibits summary (blanket) orders to resume previous medications. ◼

9. A diagnosis, condition, or indication for use exists for each medication ordered.

   **Note:** This information can be anywhere in the medical record and need not be on the order itself. For example, it might be part of the medical history.

10. ◼ The hospital defines, in writing, the circumstances for which weight-based dosing is required for pediatric populations. *(See also MM.01.01.01, EP 1)*

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

13. The hospital implements its policies for medication orders. ◼

14. The hospital requires an order from a doctor of medicine or osteopathy or, as permitted by law and regulation, a hospital-specific protocol(s) approved by a doctor of medicine or osteopathy to administer influenza and pneumococcal vaccines.

15. ◼ **For hospitals that use Joint Commission accreditation for deemed status purposes:** Processes for the use of preprinted and electronic standing orders, order sets, and protocols for medication orders include the following:

   - Review and approval of standing orders and protocols by the medical staff and the hospital’s nursing and pharmacy leadership
   - Evaluation of established standing orders and protocols for consistency with nationally recognized and evidence-based guidelines
   - Regular review of such standing orders and protocols by the medical staff and the hospital’s nursing and pharmacy leadership to determine the continuing usefulness and safety of the standing orders and protocols
   - Dating, timing, and authenticating of standing orders and protocols by the ordering practitioner or another practitioner responsible for the patient’s care in accordance with professional standards of practice; law and regulation; hospital policies; and medical staff bylaws, rules, and regulations.

21. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home uses an electronic prescribing process.
Standard  MM.05.01.01
A pharmacist reviews the appropriateness of all medication orders for medications to be dispensed in the hospital.

Elements of Performance for MM.05.01.01
1. Before dispensing or removing medications from floor stock or from an automated storage and distribution device, a pharmacist reviews all medication orders or prescriptions unless a licensed independent practitioner controls the
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ordering, preparation, and administration of the medication or when a delay would harm the patient in an urgent situation (including sudden changes in a patient’s clinical status), in accordance with law and regulation.

**Note 1:** The Joint Commission permits emergency departments to broadly apply two exceptions in regard to Standard MM.05.01.01, EP 1. These exceptions are intended to minimize treatment delays and patient back-up. The first exception allows medications ordered by a licensed independent practitioner to be administered by staff who are permitted to do so by virtue of education, training, and organization policy (such as a registered nurse) and in accordance with law and regulation. A licensed independent practitioner is not required to remain at the bedside when the medication is administered. However, a licensed independent practitioner must be available to provide immediate intervention should a patient experience an adverse drug event. The second exception allows medications to be administered in urgent situations when a delay in doing so would harm the patient.

**Note 2:** A hospital’s radiology service (including hospital-associated ambulatory radiology) will be expected to define, through protocol or policy, the role of the licensed independent practitioner in the direct supervision of a patient during and after IV contrast media is administered including the licensed independent practitioner’s timely intervention in the event of a patient emergency.

2. When an on-site pharmacy is not open 24 hours a day, 7 days a week, a health care professional determined to be qualified by the hospital reviews the medication order in the pharmacist’s absence.

3. When an on-site pharmacy is not open 24 hours a day, 7 days a week, a pharmacist conducts a retrospective review of all medication orders during this period as soon as a pharmacist is available or the pharmacy opens.

All medication orders are reviewed for the following:

4. Patient allergies or potential sensitivities.

5. Existing or potential interactions between the medication ordered and food and medications the patient is currently taking.

6. The appropriateness of the medication, dose, frequency, and route of administration.

7. Current or potential impact as indicated by laboratory values.

8. Therapeutic duplication.
9. Other contraindications.

11. After the medication order has been reviewed, all concerns, issues, or questions are clarified with the individual prescriber before dispensing. 🠧

**Standard MM.05.01.07**

The hospital safely prepares medications.

**Elements of Performance for MM.05.01.07**

1. A pharmacist, or pharmacy staff under the supervision of a pharmacist, compounds or admixes all compounded sterile preparations except in urgent situations in which a delay could harm the patient or when the product’s stability is short. 🠧

2. Staff use clean or sterile techniques and maintain clean, uncluttered, and functionally separate areas for product preparation to avoid contamination of medications.

3. 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)*

4. The hospital uses a laminar airflow hood or other ISO Class 5 environment in the pharmacy for preparing intravenous (IV) admixture or any sterile product that will not be used within 24 hours.

5. **For hospitals that use Joint Commission accreditation for deemed status purposes:** Medications are prepared and administered in accordance with the orders of a licensed independent practitioner or other practitioner responsible for the patient’s care, and in accordance with hospital policies; medical staff bylaws, rules, and regulations; and law and regulation. † 🠧

6. **For hospitals that use Joint Commission accreditation for deemed status purposes:** In-house preparation of radiopharmaceuticals is done by, or under the supervision of, an appropriately trained registered pharmacist or doctor of medicine or osteopathy.

**Standard MM.05.01.09**

Medications are labeled.

† For law and regulation guidance pertaining to those responsible for the care of patients, refer to 42 CFR 482.12(c).
Rationale for MM.05.01.09
A label on every medication and medication container has long been a standard of practice by the pharmacy profession and is required by law and regulation. A standardized method to label medications and containers promotes medication safety.

Elements of Performance for MM.05.01.09

1. Medication containers are labeled whenever medications are prepared but not immediately administered. R

   Note 1: An immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to a patient, and administers to that patient without any break in the process.

   Note 2: This element of performance is also applicable to sample medications.

2. Information on medication labels is displayed in a standardized format, in accordance with law and regulation and standards of practice.

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

All medications prepared in the hospital are correctly labeled with the following:

3. Medication name, strength, and amount (if not apparent from the container).

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

4. Expiration date when not used within 24 hours.

5. Expiration time when expiration occurs in less than 24 hours.

6. The date prepared and the diluent for all compounded intravenous admixtures and parenteral nutrition formulas.

When preparing individualized medications for multiple patients, the label also includes the following:

7. The patient’s name.

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 a patient identifier during administration of a medication, as indicated by NPSG.01.01.01, EP 1.

9. Directions for use and applicable accessory and cautionary instructions.
When an individualized medication(s) is prepared by someone other than the person administering the medication, the label includes the following:

10. The patient’s name.

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 a patient identifier during administration of a medication, as indicated by NPSG.01.01.01, EP 1.

12. Directions for use and applicable accessory and cautionary instructions.

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**Standard MM.05.01.11**
The hospital safely dispenses medications.

**Elements of Performance for MM.05.01.11**

1. The hospital dispenses quantities of medications that are consistent with patient needs.

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

2. The hospital 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. The hospital dispenses medications within time frames it defines to meet patient needs.

4. 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.

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**Standard MM.05.01.13**
The hospital safely obtains medications when the pharmacy is closed.
Rationale for MM.05.01.13
In today’s health care settings, many organizations that provide 24-hour care do not provide 24-hour pharmacy services. However, patients in these settings may require medications during the times the pharmacy is not in operation. For safe, quality care, the hospital provides for the patient’s urgent or emergent medication needs when the pharmacy is closed.

Elements of Performance for MM.05.01.13

1. The hospital has a process for providing medications to meet patient needs when the pharmacy is closed.

2. When non-pharmacist health care professionals are allowed by law or regulation to obtain medications after the pharmacy is closed, the following occurs: Medications available are limited to those approved by the hospital.

3. When non-pharmacist health care professionals are allowed by law or regulation to obtain medications after the pharmacy is closed, the following occurs: The hospital stores and secures the medications approved for use outside of the pharmacy.

4. When non-pharmacist health care professionals are allowed by law or regulation to obtain medications after the pharmacy is closed, the following occurs: Only trained, designated prescribers and nurses are permitted access to approved medications.

5. When non-pharmacist health care professionals are allowed by law or regulation to obtain medications after the pharmacy is closed, the following occurs: Quality control procedures (such as an independent second check by another individual or a secondary verification built into the system such as bar coding) are in place to prevent medication retrieval errors.

6. When non-pharmacist health care professionals are allowed by law or regulation to obtain medications after the pharmacy is closed, the following occurs: The hospital arranges for a qualified pharmacist to be available either on-call or at another location (for example, at another organization that has 24-hour pharmacy service) to answer questions or provide medications beyond those accessible to non-pharmacy staff.

7. The hospital implements its process for providing medications to meet patient needs when the pharmacy is closed.
Standard **MM.05.01.17**
The hospital follows a process to retrieve recalled or discontinued medications.

**Elements of Performance for MM.05.01.17**

1. The hospital has a written policy describing how it will retrieve and handle medications within the hospital 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. The hospital 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. When a medication is recalled or discontinued for safety reasons by the manufacturer or the US Food and Drug Administration (FDA), the hospital 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. When required by law and regulation or hospital policy, the hospital informs patients 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 hospital safely manages returned medications.

**Rationale for MM.05.01.19**
Medications may be returned to the hospital when allowed by law or regulation and organization policy. Previously dispensed but unused, expired, or returned medications in the hospital must be accounted for, controlled, and disposed of in order to keep patients safe and prevent diversion.
Elements of Performance for MM.05.01.19

1. The hospital determines under what circumstances unused, expired, or returned medications will be managed by the pharmacy or the hospital.

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

2. When the hospital accepts unused, expired, or returned medications, it has a process for returning medications to the pharmacy’s control that includes procedures for preventing diversion.

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

3. The hospital determines if and when outside sources are used for destruction of medications.

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

4. The hospital implements its process for managing unused, expired, or returned medications.

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

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Standard  **MM.06.01.01**

The hospital safely administers medications.

Elements of Performance for MM.06.01.01

1. The hospital defines, in writing, licensed independent practitioners and the clinical staff disciplines that are authorized to administer medication, with or without supervision, in accordance with law and regulation. (*See also* MM.06.01.03, EP 1)

2. Only authorized licensed independent practitioners and clinical staff administer medications.  

   **Note:** *This does not prohibit self-administration of medications by patients, when indicated.* (*See also* MM.06.01.03, EP 1)

Before administration, the individual administering the medication does the following:

3. Verifies that the medication selected matches the medication order and product label.

4. 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)
5. Verifies that the medication has not expired.
6. Verifies that no contraindications exist.
7. Verifies that the medication is being administered at the proper time, in the prescribed dose, and by the correct route.
8. Discusses any unresolved concerns about the medication with the patient’s licensed independent practitioner, prescriber (if different from the licensed independent practitioner), and/or staff involved with the patient’s care, treatment, and services.
9. Before administering a new medication, the patient or family is informed about any potential clinically significant adverse drug reactions or other concerns regarding administration of a new medication. *(See also MM.06.01.03, EPs 3–6; PC.02.03.01, EP 10)*
13. Before administering a radioactive pharmaceutical for diagnostic purposes, staff verify that the dose to be administered is within 20% of the prescribed dose, or, if the dose is prescribed as a range, staff verify that the dose to be administered is within the prescribed range.

**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, written processes that address training, supervision, and documentation guide the safe and accurate self-administration of medications or the administration of medications by a family member. *(See also MM.06.01.01, EPs 1 and 2)*
2. The hospital implements its written processes for medication self-administration or medication administration.
3. The hospital educates patients and families involved in self-administration about the following: Medication name, type, and reason for use. *(See also MM.06.01.01, EP 9; PC.02.03.01, EP 10)*
4. The hospital educates patients and families involved in self-administration about the following: How to administer medication, including process, time, frequency, route, and dose. (See also MM.06.01.01, EP 9; PC.02.03.01, EP 10)

5. The hospital educates patients and families involved in self-administration about the following: Anticipated actions and potential side effects of the medication administered. (See also MM.06.01.01, EP 9; PC.02.03.01, EP 10)

6. The hospital educates patients and families involved in self-administration about the following: Monitoring the effects of the medication. (See also MM.06.01.01, EP 9; PC.02.03.01, EP 10)

7. The hospital determines that the patient or the family member who administers the medication is competent at medication administration before allowing him or her to administer medications.

**Standard MM.06.01.05**

The hospital safely manages investigational medications.

**Rationale for MM.06.01.05**

Investigational medications can be of great help to the patient. In some cases, investigational medications may represent one of a few options in the patient’s care plan. The hospital contributes to the safety of patients participating in investigational or clinical medication studies by controlling and monitoring the use of these medications.

**Note:** For a discussion of patient rights regarding the use of investigational medications, see Standard RI.01.03.05.

**Elements of Performance for MM.06.01.05**

1. The hospital has a written process addressing the use of investigational medications that includes review, approval, supervision, and monitoring.

2. The hospital’s written process for the use of investigational medications specifies that the pharmacy controls the storage, dispensing, labeling, and distribution of investigational medications.

3. The written process for the use of investigational medications specifies that when a patient is involved in an investigational protocol that is independent of the hospital, the hospital evaluates and, if no contraindication exists, accommodates the patient’s continued participation in the protocol.
4. The hospital implements its processes for the use of investigational medications.

**Standard MM.07.01.03**

The hospital responds to actual or potential adverse drug events, significant adverse drug reactions, and medication errors.

**Rationale for MM.07.01.03**

Adverse drug reactions and medication errors place patients at considerable risk. For safe, quality care, hospitals must have systems in place to respond to and monitor a patient in the event of an adverse drug reaction or medication error.

**Elements of Performance for MM.07.01.03**

1. The hospital has a written process to respond to actual or potential adverse drug events, significant adverse drug reactions, and medication errors.
   
   **Note:** *This element of performance is also applicable to sample medications.*

2. The hospital has a written process addressing prescriber notification in the event of an adverse drug event, significant adverse drug reaction, or medication error.
   
   **Note:** *This element of performance is also applicable to sample medications.*

3. The hospital complies with internal and external reporting requirements for actual or potential adverse drug events, significant adverse drug reactions, and medication errors.
   
   **Note:** *This element of performance is also applicable to sample medications.*

5. The hospital implements its process for responding to adverse drug events, significant adverse drug reactions, and medication errors.
   
   **Note:** *This element of performance is also applicable to sample medications.*

6. **For hospitals that use Joint Commission accreditation for deemed status purposes:** Medication administration errors, adverse drug reactions, and medication incompatibilities as defined by the hospital are immediately reported to the attending physician or clinical psychologist and as appropriate to the organizationwide quality assessment and performance improvement program.
   
   **Note:** *The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).*
**Standard MM.08.01.01**
The hospital evaluates the effectiveness of its medication management system.

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

**Elements of Performance for MM.08.01.01**

1. The hospital 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. The hospital analyzes data on its medication management system.
   
   **Note:** *This element of performance is also applicable to sample medications.*

3. The hospital 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. Based on analysis of its data, as well as review of the literature for new technologies and best practices, the hospital identifies opportunities for improvement in its medication management system.

6. The hospital takes action on improvement opportunities identified as priorities for its medication management system. *(See also MM.09.01.01, EP 8; PI.03.01.01, EP 2)*
   
   **Note:** *This element of performance is also applicable to sample medications.*

7. The hospital evaluates its actions to confirm that they resulted in improvements for its medication management system.

8. The hospital 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 hospital 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.
Standard MM.09.01.01
The hospital has an antimicrobial stewardship program based on current scientific literature.

Elements of Performance for MM.09.01.01

1. Leaders establish antimicrobial stewardship as an organizational priority. *(See also LD.01.03.01, EP 5)*
   
   **Note:** Examples of leadership commitment to an antimicrobial stewardship program are as follows:
   - Accountability documents
   - Budget plans
   - Infection prevention plans
   - Performance improvement plans
   - Strategic plans
   - Using the electronic health record to collect antimicrobial stewardship data

2. The hospital educates staff and licensed independent practitioners involved in antimicrobial ordering, dispensing, administration, and monitoring about antimicrobial resistance and antimicrobial stewardship practices. Education occurs upon hire or granting of initial privileges and periodically thereafter, based on organizational need.

4. The hospital has an antimicrobial stewardship multidisciplinary team that includes the following members, when available in the setting:
   - Infectious disease physician
   - Infection preventionist(s)
   - Pharmacist(s)
   - Practitioner

   **Note 1:** Part-time or consultant staff are acceptable as members of the antimicrobial stewardship multidisciplinary team.

   **Note 2:** Telehealth staff are acceptable as members of the antimicrobial stewardship multidisciplinary team.

5. The hospital’s antimicrobial stewardship program includes the following core elements:
   - Leadership commitment: Dedicating necessary human, financial, and information technology resources.
Accountability: Appointing a single leader responsible for program outcomes. Experience with successful programs show that a physician leader is effective.

Drug expertise: Appointing a single pharmacist leader responsible for working to improve antibiotic use.

Action: Implementing recommended actions, such as systemic evaluation of ongoing treatment need, after a set period of initial treatment (for example, “antibiotic time out” after 48 hours).

Tracking: Monitoring the antimicrobial stewardship program, which may include information on antibiotic prescribing and resistance patterns.

Reporting: Regularly reporting information on the antimicrobial stewardship program, which may include information on antibiotic use and resistance, to doctors, nurses, and relevant staff.

Education: Educating practitioners, staff, and patients on the antimicrobial program, which may include information about resistance and optimal prescribing.

(See also IC.02.01.01, EP 1 and NPSG.07.03.01, EP 5)

Note: These core elements were cited from the Centers for Disease Control and Prevention’s Core Elements of Hospital Antibiotic Stewardship Programs (http://www.cdc.gov/getsmart/healthcare/pdfs/core-elements.pdf). The Joint Commission recommends that organizations use this document when designing their antimicrobial stewardship program.

6. The hospital’s antimicrobial stewardship program uses organization-approved multidisciplinary protocols (for example, policies and procedures).

Note: Examples of protocols are as follows:

- Antibiotic Formulary Restrictions
- Assessment of Appropriateness of Antibiotics for Community-Acquired Pneumonia
- Assessment of Appropriateness of Antibiotics for Skin and Soft Tissue infections
- Assessment of Appropriateness of Antibiotics for Urinary Tract Infections
- Care of the Patient with Clostridium difficile (C. diff)
- Guidelines for Antimicrobial Use in Adults
- Guidelines for Antimicrobial Use in Pediatrics
- Plan for Parenteral to Oral Antibiotic Conversion
- Preauthorization Requirements for Specific Antimicrobials
- Use of Prophylactic Antibiotics
7. The hospital collects, analyzes, and reports data on its antimicrobial stewardship program.

**Note:** Examples of topics on which to collect and analyze data may include evaluation of the antimicrobial stewardship program, antimicrobial prescribing patterns, and antimicrobial resistance patterns.

8. The hospital takes action on improvement opportunities identified in its antimicrobial stewardship program. *(See also MM.08.01.01, EP 6)*
Medical Staff (MS)

Overview
The self-governing organized medical staff provides oversight of the quality of care, treatment, and services delivered by practitioners who are credentialed and privileged through the medical staff process. The organized medical staff is also responsible for the ongoing evaluation of the competency of practitioners who are privileged, delineating the scope of privileges that will be granted to practitioners, and providing leadership in performance improvement activities within the organization.

All licensed independent practitioners are credentialed and privileged by the organized medical staff. Physician assistants (PAs) and advanced practice registered nurses (APRNs) who are not licensed independent practitioners may be privileged through either the medical staff process or a procedure that is equivalent to the medical staff process and criteria set forth in the credentialing and privileging standards contained in this chapter. This procedure must be approved by the governing body and assure communication with and input from the Medical Staff Executive Committee regarding those privileges.

The organized medical staff must create and maintain a set of bylaws that define its role within the context of a hospital setting and responsibilities in the oversight of care, treatment, and services. The medical staff bylaws, rules, and regulations create a framework within which medical staff members can act with a reasonable degree of freedom and confidence.

The hospital’s governing body has the ultimate authority and responsibility for the oversight and delivery of health care rendered by licensed independent practitioners, and other practitioners credentialed and privileged through the medical staff process or any equivalent process. The governing body and the medical staff define medical staff membership criteria, which, as deemed necessary by the governing body and the medical staff, may include licensed independent practitioners and other practitioners. Only licensed independent practitioner members of the medical staff oversee the delivery of

* The Joint Commission defines a licensed independent practitioner as “any individual permitted by law and by the organization to provide care, treatment, and services, without direction or supervision.”
care provided. The criteria used to determine which licensed independent practitioners are eligible to participate in the oversight process is developed by the organized medical staff.

Membership on the medical staff is not synonymous with privileges. The medical staff may create categories of membership, as in active member, courtesy member, and so forth. These categories may be helpful in defining the roles and expectations for the various members of the medical staff.

**Organized Medical Staff Structure**

The organized medical staff is structured such that it has the ability to function in guiding and governing its members. The primary function of the organized medical staff is to approve and amend medical staff bylaws and to provide oversight for the quality of care, treatment, and services provided by practitioners with privileges.

The organized medical staff must be structured using the following guiding principles:

- Designated members of the organized medical staff who have independent privileges provide oversight of care, treatment, and services provided by practitioners with privileges.
- The organized medical staff is responsible for structuring itself to provide a uniform standard of quality patient care, treatment, and services.
- The organized medical staff is accountable to the governing body.
- Applicants for privileges need not necessarily be members of the medical staff.

Self-governance of the organized medical staff includes the following and is located in the medical staff’s bylaws:

- Initiating, developing, and approving medical staff bylaws and rules and regulations
- Approving or disapproving amendments to the medical staff bylaws and rules and regulations
- Selecting and removing medical staff officers
- Determining the mechanism for establishing and enforcing criteria and standards for medical staff membership
- Determining the mechanism for establishing and enforcing criteria for delegating oversight responsibilities to practitioners with independent privileges

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1 The term “medical staff” takes on various meanings within different organizations. The standards and elements of performance in this chapter are intended to apply to all practitioners privileged through the medical staff process.

2 The organized medical staff role and responsibility as a component of hospital leadership is further defined in the “Leadership” (LD) chapter.
Determining the mechanism for establishing and maintaining patient care standards and credentialing and delineation of clinical privileges

Engaging in performance improvement activities

An organized medical staff is self-governing and has the responsibility to oversee care, treatment, and services provided by practitioners with privileges. Oversight of care, treatment, and services is provided by a variety of mechanisms, one of which is the development of bylaws that govern the actions of the medical staff. The governing body must approve the medical staff bylaws.

Under most circumstances, the organized medical staff should be a single, organized medical staff. There may be exceptions to the general requirement for a single medical staff (see note below regarding requirements for exception). When more than one organized medical staff exists, it is incumbent upon the medical staffs to have a mechanism to ensure that the same principles that guide a single medical staff are fully integrated into any multiple medical staff structure.

Note: The following bases are used in determining whether a hospital may have more than one organized medical staff.

- A hospital with a single governing body that has multiple inpatient care sites, each of which serves two or more geographically distinct patient populations, may have a separate organized medical staff at each site.
- The patient population consists of those individuals who chose the hospital as their primary source of inpatient care, treatment, and services and for whom the hospital designs and delivers services consistent with its mission.

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5 Please note that The Medicare Conditions of Participation require a single medical staff for each hospital (i.e., provider number).
Chapter Outline

I. Medical Staff Bylaws (MS.01.01.01, MS.01.01.03, MS.01.01.05)
II. Structure and Role of Medical Staff Executive Committee (MS.02.01.01)
III. Medical Staff Role in Oversight of Care, Treatment, and Services (MS.03.01.01, MS.03.01.03)
IV. Medical Staff Role in Graduate Education Programs (MS.04.01.01)
V. Medical Staff Role in Performance Improvement (MS.05.01.01, MS.05.01.03)
VI. Credentialing and Privileging (MS.06.01.01, MS.06.01.03, MS.06.01.05, MS.06.01.07, MS.06.01.09, MS.06.01.11, MS.06.01.13)
VII. Appointment to Medical Staff (MS.07.01.01, MS.07.01.03)
VIII. Evaluation of Practitioners (MS.08.01.01, MS.08.01.03)
IX. Acting on Reported Concerns About a Practitioner (MS.09.01.01)
X. Fair Hearing and Appeal Process (MS.10.01.01)
XI. Licensed Independent Practitioner Health (MS.11.01.01)
XII. Continuing Education for Practitioners (MS.12.01.01)
XIII. Medical Staff Role in Telemedicine (MS.13.01.01, MS.13.01.03)
Standards, Rationales, and Elements of Performance

Introduction to Standard MS.01.01.01

The doctors of medicine and osteopathy and, in accordance with medical staff bylaws, other practitioners are organized into a self-governing medical staff that oversees the quality of care provided by all physicians and by other practitioners who are privileged through a medical staff process. The organized medical staff and the governing body collaborate in a well-functioning relationship, reflecting clearly recognized roles, responsibilities, and accountabilities, to enhance the quality and safety of care, treatment, and services provided to patients. This collaborative relationship is critical to providing safe, high-quality care in the hospital. While the governing body is ultimately responsible for the quality and safety of care at the hospital, the governing body, medical staff, and administration collaborate to provide safe, quality care. (See the “Leadership” [LD] chapter for more discussion of the relationship among the organized medical staff, administration, and governing body.)

To support its work, and its relationship with and accountability to the governing body, the organized medical staff creates a written set of documents that describes its organizational structure and the rules for its self-governance. These documents are called medical staff bylaws, rules and regulations, and policies. These documents create a system of rights, responsibilities, and accountabilities between the organized medical staff and the governing body, and between the organized medical staff and its members. Because of the significance of these documents, the medical staff leaders should strive to ensure that the medical staff members understand the content and purpose of the medical staff bylaws and relevant rules and regulations and policies, and their adoption and amendment processes.

Of the members of the organized medical staff, only those who are identified in the bylaws as having voting rights can vote to adopt and amend the medical staff bylaws. The voting members of the organized medical staff may include within the scope of responsibilities delegated to the medical executive committee the authority to adopt, on the behalf of the voting members of the organized medical staff, any details associated with Elements of Performance 12 through 37 that are placed in rules and regulations, or policies.
The medical executive committee plays a vital role in the relationship between the medical staff and the governing body. Medical staffs and governing bodies often rely on the medical executive committee to act expeditiously on urgent and other delegated matters that arise within the hospital. The medical executive committee serves as a voice for the medical staff to communicate to the governing body and is, therefore, accountable to the organized medical staff, regardless of how the medical executive committee members are selected. Because it plays this vital role, it is incumbent upon the medical executive committee to convey accurately to the governing body the views of the medical staff on all issues, including those relating to quality and safety. In order to fulfill this role, the medical executive committee seeks out the medical staff’s views on all appropriate issues.

If conflict arises within the medical staff regarding medical staff bylaws, rules and regulations, or policies, it implements its process for managing internal conflict (see Element of Performance 10). If conflicts regarding the medical staff bylaws, rules and regulations, or policies arise between the governing body and the organized medical staff, the organization implements its conflict management processes, as set forth in the “Leadership” (LD) chapter.

**Note:** See the Glossary for definitions of terms used in this standard, including medical staff; medical staff bylaws; medical staff, organized; medical staff, voting members of the organized; and rules and regulations and policies of the medical staff.

**Standard MS.01.01.01**

Medical staff bylaws address self-governance and accountability to the governing body.

**Elements of Performance for MS.01.01.01**

1. The organized medical staff develops medical staff bylaws, rules and regulations, and policies.

2. The organized medical staff adopts and amends medical staff bylaws. Adoption or amendment of medical staff bylaws cannot be delegated. After adoption or amendment by the organized medical staff, the proposed bylaws are submitted to the governing body for action. Bylaws become effective only upon governing body approval. (See the “Leadership” [LD] chapter for requirements regarding the governing body’s authority and conflict management processes. See Element of Performance 17 for information on which medical staff members are eligible to vote.)
3. Every requirement set forth in MS.01.01.01, Elements of Performance (EPs) 12–37, is in the medical staff bylaws. These requirements may have associated details, some of which may be extensive; such details may reside in the medical staff bylaws, rules and regulations, or policies. The organized medical staff adopts what constitutes the associated details, where they reside, and whether their adoption can be delegated. Adoption of associated details that reside in medical staff bylaws cannot be delegated. For those EPs 12–37 that require a process, the medical staff bylaws include, at a minimum, the basic steps required for implementation of the requirement, as determined by the organized medical staff and approved by the governing body. The organized medical staff submits its proposals to the governing body for action. Proposals become effective only upon governing body approval. (See the “Leadership” [LD] chapter for requirements regarding the governing body’s authority and conflict management processes.)

Note: If an organization is found to be out of compliance with this EP, the citation will occur at the appropriate element(s) of performance in MS.01.01.01, EPs 12–37.

4. The medical staff bylaws, rules and regulations, and policies, the governing body bylaws, and the hospital policies are compatible with each other and are compliant with law and regulation. (See also MS.01.01.03, EP 1)

5. The medical staff complies with the medical staff bylaws, rules and regulations, and policies.

6. The organized medical staff enforces the medical staff bylaws, rules and regulations, and policies by recommending action to the governing body in certain circumstances and taking action in others.

7. The governing body upholds the medical staff bylaws, rules and regulations, and policies that have been approved by the governing body.

8. The organized medical staff has the ability to adopt medical staff bylaws, rules and regulations, and policies, and amendments thereto, and to propose them directly to the governing body.

9. If the voting members of the organized medical staff propose to adopt a rule, regulation, or policy, or an amendment thereto, they first communicate the proposal to the medical executive committee. If the medical executive committee proposes to adopt a rule or regulation, or an amendment thereto, it first communicates the proposal to the medical staff; when it adopts a policy or an amendment thereto, it communicates this to the medical staff. This element of
performance applies only when the organized medical staff, with the approval of the governing body, has delegated authority over such rules, regulations, or policies to the medical executive committee.

10. The organized medical staff has a process which is implemented to manage conflict between the medical staff and the medical executive committee on issues including, but not limited to, proposals to adopt a rule, regulation, or policy or an amendment thereto. Nothing in the foregoing is intended to prevent medical staff members from communicating with the governing body on a rule, regulation, or policy adopted by the organized medical staff or the medical executive committee. The governing body determines the method of communication.

11. In cases of a documented need for an urgent amendment to rules and regulations necessary to comply with law or regulation, there is a process by which the medical executive committee, if delegated to do so by the voting members of the organized medical staff, may provisionally adopt and the governing body may provisionally approve an urgent amendment without prior notification of the medical staff. In such cases, the medical staff will be immediately notified by the medical executive committee. The medical staff has the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the organized medical staff and the medical executive committee, the provisional amendment stands. If there is conflict over the provisional amendment, the process for resolving conflict between the organized medical staff and the medical executive committee is implemented. If necessary, a revised amendment is then submitted to the governing body for action.

Note: Please see the Introduction to this standard for further discussion of the relationship of the voting members of the organized medical staff to the medical executive committee.

12. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: The structure of the medical staff.

13. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: Qualifications for appointment to the medical staff.

Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The medical staff must be composed of doctors of medicine or osteopathy. In accordance with state law, including scope of practice laws, the medical staff may also
include other categories of physicians as listed at 482.12(c)(1) and nonphysician practitioners who are determined to be eligible for appointment by the governing body.

14. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: The process for privileging and re-privileging licensed independent practitioners, which may include the process for privileging and re-privileging other practitioners. (See also EM.02.02.13, EP 2; MS.06.01.13, EP 1)

15. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: A statement of the duties and privileges related to each category of the medical staff (for example, active, courtesy).

   **Note:** Solely for the purposes of this element of performance, The Joint Commission interprets the word “privileges” to mean the duties and prerogatives of each category, and not the clinical privileges to provide patient care, treatment, and services related to each category. Each member of the medical staff is to have specific clinical privileges to provide care, treatment, and services authorized through the processes specified in Standards MS.06.01.03, MS.06.01.05, and MS.06.01.07.

16. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: The requirements for completing and documenting medical histories and physical examinations. The medical history and physical examination are completed and documented by a physician, an oralmaxillofacial surgeon, or other qualified licensed individual in accordance with state law and hospital policy. (For more information on performing the medical history and physical examination, refer to MS.03.01.01, EPs 6–11.)

   **Note 1:** The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

   **Note 2:** The requirements referred to in this element of performance are, at a minimum, those described in the element of performance and Standard PC.01.02.03, EPs 4 and 5.

17. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: A description of those members of the medical staff who are eligible to vote.
18. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: The process, as determined by the organized medical staff and approved by the governing body, by which the organized medical staff selects and/or elects and removes the medical staff officers.

19. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: A list of all the officer positions for the medical staff.

20. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: The medical executive committee’s function, size, and composition, as determined by the organized medical staff and approved by the governing body; the authority delegated to the medical executive committee by the organized medical staff to act on the medical staff’s behalf; and how such authority is delegated or removed. (For more information on the role of the medical executive committee, refer to Standard MS.02.01.01.)

21. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: The process, as determined by the organized medical staff and approved by the governing body, for selecting and/or electing and removing the medical executive committee members.

22. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: That the medical executive committee includes physicians and may include other practitioners and any other individuals as determined by the organized medical staff.

23. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: That the medical executive committee acts on the behalf of the medical staff between meetings of the organized medical staff, within the scope of its responsibilities as defined by the organized medical staff.

24. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: The process for adopting and amending the medical staff bylaws.

25. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: The process for adopting and amending the medical staff rules and regulations, and policies.
26. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: The process for credentialing and re-credentialing licensed independent practitioners, which may include the process for credentialing and re-credentialing other practitioners.

27. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: The process for appointment and re-appointment to membership on the medical staff.

28. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: Indications for automatic suspension of a practitioner’s medical staff membership or clinical privileges.

29. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: Indications for summary suspension of a practitioner’s medical staff membership or clinical privileges.

30. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: Indications for recommending termination or suspension of medical staff membership, and/or termination, suspension, or reduction of clinical privileges.

31. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: The process for automatic suspension of a practitioner’s medical staff membership or clinical privileges.

32. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: The process for summary suspension of a practitioner’s medical staff membership or clinical privileges.

33. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: The process for recommending termination or suspension of medical staff membership and/or termination, suspension, or reduction of clinical privileges.

34. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: The fair hearing and appeal process (refer to Standard MS.10.01.01), which at a minimum shall include:
   - The process for scheduling hearings and appeals
   - The process for conducting hearings and appeals
35. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: The composition of the fair hearing committee.

36. The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: If departments of the medical staff exist, the qualifications and roles and responsibilities of the department chair, which are defined by the organized medical staff, include the following:

**Qualifications:**
- Certification by an appropriate specialty board or comparable competence affirmatively established through the credentialing process.

**Roles and responsibilities:**
- Clinically related activities of the department
- Administratively related activities of the department, unless otherwise provided by the hospital
- Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges
- Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department
- Recommending clinical privileges for each member of the department
- Assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization
- Integration of the department or service into the primary functions of the organization
- Coordination and integration of interdepartmental and intradepartmental services
- Development and implementation of policies and procedures that guide and support the provision of care, treatment, and services
- Recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services
- Determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services
- Continuous assessment and improvement of the quality of care, treatment, and services
- Maintenance of quality control programs, as appropriate
- Orientation and continuing education of all persons in the department or service
- Recommending space and other resources needed by the department or service

**Note:** For hospitals that use Joint Commission accreditation for deemed status purposes: When departments of the medical staff do not exist, the medical staff is responsible for the development of policies and procedures that minimize medication errors. The medical staff may delegate this responsibility to the organized pharmaceutical service.

37. **For hospitals that use Joint Commission accreditation for deemed status purposes:** When a multihospital system has a unified and integrated medical staff, the bylaws describe the process by which medical staff members at each separately accredited hospital (that is, all medical staff members who hold privileges to practice at that specific hospital) are advised of their right to opt out of the unified and integrated medical staff structure after a majority vote by the members to maintain a separate and distinct medical staff for their respective hospital.

**Standard MS.01.01.03**
Neither the organized medical staff nor the governing body may unilaterally amend the medical staff bylaws or rules and regulations.

**Rationale for MS.01.01.03**
A hospital with an organized medical staff and governing body that cannot agree on amendments to critical documents has evidenced a breakdown in the required collaborative relationship.

**Element of Performance for MS.01.01.03**
1. The medical staff bylaws, rules, and regulations are not unilaterally amended. (*See also* MS.01.01.01, EP 4)

**Standard MS.01.01.05**
For hospitals that use Joint Commission accreditation for deemed status purposes: Multihospital systems can choose to establish a unified and integrated medical staff in accordance with state and local laws.
Elements of Performance for MS.01.01.05

For hospitals that use Joint Commission accreditation for deemed status purposes: If a multihospital system with separately accredited hospitals chooses to establish a unified and integrated medical staff, the following occurs:

1. Each separately accredited hospital within a multihospital system that elects to have a unified and integrated medical staff demonstrates that the medical staff members of each hospital (that is, all medical staff members who hold privileges to practice at that specific hospital) have voted by majority either to accept the unified and integrated medical staff structure or to opt out of such a structure and maintain a separate and distinct medical staff for their hospital.

2. The unified and integrated medical staff takes into account each member hospital’s unique circumstances and any significant differences in patient populations and services offered in each hospital.

3. The unified and integrated medical staff establishes and implements policies and procedures to make certain that the needs and concerns expressed by members of the medical staff at each of its separately accredited hospitals, regardless of practice or location, are given due consideration.

4. The unified and integrated medical staff has mechanisms in place to make certain that issues localized to particular hospitals within the system are duly considered and addressed.

Standard MS.02.01.01

There is a medical staff executive committee.

Rationale for MS.02.01.01

The organized medical staff delegates authority in accordance with law and regulation to the medical staff executive committee to carry out medical staff responsibilities. The medical staff executive committee carries out its work within the context of the organization functions of governance, leadership, and performance improvement. The medical staff executive committee has the primary authority for activities related to self governance of the medical staff and for performance improvement of the professional services provided by licensed independent practitioners and other practitioners privileged through the medical staff process.
Note: The medical staff as a whole may serve as the executive committee. In smaller, less complex hospitals where the entire medical staff functions as the executive committee, it is often designated as a committee of the whole.

Elements of Performance for MS.02.01.01

1. The structure and function of the medical staff executive committee conforms to the medical staff bylaws.

2. The chief executive officer (CEO) of the hospital or his or her designee attends each medical staff executive committee meeting on an ex-officio basis, with or without a vote.

3. All members of the organized medical staff, of any discipline or specialty, are eligible for membership on the medical staff executive committee.

4. The majority of voting medical staff executive committee members are fully licensed doctors of medicine or osteopathy actively practicing in the hospital.

5. The medical staff executive committee acts on behalf of the organized medical staff between medical staff meetings.

6. The medical staff executive committee has a mechanism to recommend medical staff membership termination.

7. The medical staff executive committee requests evaluations of practitioners privileged through the medical staff process in instances where there is doubt about an applicant’s ability to perform the privileges requested.

The medical staff executive committee makes recommendations, as defined in the medical staff bylaws, directly to the governing body on, at least, all of the following:

8. Medical staff membership.

9. The organized medical staff’s structure.

10. The process used to review credentials and delineate privileges.

11. The delineation of privileges for each practitioner privileged through the medical staff process.

12. The executive committee’s review of and actions on reports of medical staff committees, departments, and other assigned activity groups.
Introduction to Standard MS.03.01.01

Management of Patient Care, Treatment, and Services

Caring for patients is the nucleus of activity around which all health care organization functions revolve. The organized medical staff is intricately involved in carrying out, and in providing leadership in, all patient care functions conducted by practitioners privileged through the medical staff process.

Standard MS.03.01.01

The organized medical staff oversees the quality of patient care, treatment, and services provided by practitioners privileged through the medical staff process.

Rationale for MS.03.01.01

The organized medical staff is responsible for establishing and maintaining patient care standards and oversight of the quality of care, treatment, and services rendered by practitioners privileged through the medical staff process. The organized medical staff designates member licensed independent practitioners to provide oversight of care, treatment, and services rendered by practitioners privileged through the medical staff process. The organized medical staff recommends practitioners for privileges to perform medical histories and physical examinations; the governing body approves such privileges. Licensed independent practitioners (that is, physicians, oral and maxillofacial surgeons, dentists, podiatrists, and some APRNs), physician assistants, and some APRNs may perform medical histories and physical examinations if permitted by law, the medical staff bylaws, and the organization to do so.

Elements of Performance for MS.03.01.01

1. Licensed independent practitioner members of the organized medical staff are designated to perform the oversight activities of the organized medical staff.

2. Practitioners practice only within the scope of their privileges as determined through mechanisms defined by the organized medical staff.

3. Licensed independent practitioners are responsible for the oversight activities of the organized medical staff.

4. The organized medical staff through its designated mechanisms provides leadership in activities related to patient safety.

5. The organized medical staff provides oversight in the process of analyzing and improving patient satisfaction.
6. ⑥ The organized medical staff specifies the minimal content of medical histories and physical examinations, which may vary by setting or level of care, treatment, and services. *(See also PC.01.02.03, EP 4)*

7. The organized medical staff monitors the quality of medical histories and physical examinations.

8. The medical staff requires that a practitioner who has been granted privileges by the hospital to do so performs a patient’s medical history and physical examination and required updates. *(See also PC.01.02.03, EP 5)*

9. As permitted by state law and policy, the organized medical staff may choose to allow individuals who are not licensed independent practitioners to perform part or all of a patient’s medical history and physical examination under the supervision of, or through appropriate delegation by, a specific qualified doctor of medicine or osteopathy who is accountable for the patient’s medical history and physical examination.

10. ⑥ The organized medical staff defines when a medical history and physical examination must be validated and countersigned by a licensed independent practitioner with appropriate privileges.

11. ⑥ The organized medical staff defines the scope of the medical history and physical examination when required for non-inpatient services.

13. ⑦ **For hospitals that use Joint Commission accreditation for deemed status purposes:** When emergency services are provided at the hospital but not at one or more off-campus locations, the medical staff has written policies and procedures for appraisal of emergencies, initial treatment, and referral of patients at the off-campus locations.

14. ⑦ **For hospitals that use Joint Commission accreditation for deemed status purposes:** When emergency services are not provided at the hospital, the medical staff has written policies and procedures for appraisal of emergencies, initial treatment of patients, and referral of patients when needed.

16. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The medical staff determines the qualifications of the radiology staff who use equipment and administer procedures.

   **Note:** Technologists who perform diagnostic computed tomography exams will, at a minimum, meet the requirements specified at HR.01.02.05, EP 19.
17. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The medical staff approves the nuclear services director’s specifications for the qualifications, training, functions, and responsibilities of the nuclear medicine staff.

18. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** Through the privileging process, the organized medical staff determines which practitioners are qualified to serve in the role of primary care clinician. *(See also LD.04.01.06, EP 1)*

### Standard MS.03.01.03

The management and coordination of each patient’s care, treatment, and services is the responsibility of a practitioner with appropriate privileges.

### Rationale for MS.03.01.03

Quality of care, treatment, and services is dependent on coordination and communication of the plan of care which is given to all relevant health care providers to optimize resources and provide for patient safety. Practitioners have privileges that correspond to the care, treatment, and services needed by individual patients. Such privileges are specific to each patient’s needs and therefore are “appropriate” for that particular patient. Communication and coordination are key to the safe management of patient care, treatment, and services. Communication among all practitioners and staff involved in a patient’s care, treatment, and services is vital to ensuring coordinated, high-quality care.

### Elements of Performance for MS.03.01.03

1. Physicians and clinical psychologists with appropriate privileges manage and coordinate the patient’s care, treatment, and services.

   **Note:** *The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).*

2. A patient’s general medical condition is managed and coordinated by a doctor of medicine or osteopathy.

   **For hospitals that use Joint Commission accreditation for deemed status purposes:** A doctor of medicine or osteopathy manages and coordinates the care of any Medicare patient’s psychiatric problem that is not
specifically within the scope of practice of a doctor of dental surgery, dental medicine, podiatric medicine, or optometry; a chiropractor, as limited under 42 CFR 482.12(c)(1)(v); or a clinical psychologist.

4. The organized medical staff, through its designated mechanism, determines the circumstances under which consultation or management by a doctor of medicine or osteopathy, or other licensed independent practitioner, is required.

5. Consultation is obtained for the circumstances defined by the organized medical staff.

6. There is coordination of the care, treatment, and services among the practitioners involved in a patient’s care, treatment, and services.

12. **For hospitals that use Joint Commission accreditation for deemed status purposes:** A doctor of medicine or osteopathy is on duty or on call at all times.

13. **For hospitals that use Joint Commission accreditation for deemed status purposes:** Patients are admitted to the hospital only on the decision of a licensed practitioner permitted by the state to admit patients to a hospital.

**Standard MS.04.01.01**

In hospitals participating in a professional graduate education program(s), the organized medical staff has a defined process for supervision by a licensed independent practitioner with appropriate clinical privileges of each member in the program in carrying out his or her patient care responsibilities.

**Rationale for MS.04.01.01**

This standard applies to participants registered in a professional graduate education program when the graduate practitioner will be a licensed independent practitioner. The management of each patient’s care, treatment, and services (including patients under the care of participants in professional graduate education programs) is the responsibility of a licensed independent practitioner with appropriate clinical privileges.

**Elements of Performance for MS.04.01.01**

1. The organized medical staff has a defined process for supervision by a licensed independent practitioner with appropriate clinical privileges of each participant in the program in carrying out patient care responsibilities.
2. Written descriptions of the roles, responsibilities, and patient care activities of the participants of graduate education programs are provided to the organized medical staff and hospital staff.

3. The descriptions include identification of mechanisms by which the supervisor(s) and graduate education program director make decisions about each participant’s progressive involvement and independence in specific patient care activities.

4. Organized medical staff rules and regulations and policies delineate participants in professional education programs who may write patient care orders, the circumstances under which they may do so (without prohibiting licensed independent practitioners from writing orders), and what entries, if any, must be countersigned by a supervising licensed independent practitioner.

5. There is a mechanism for effective communication between the committee(s) responsible for professional graduate education and the organized medical staff and the governing body.

6. There is responsibility for effective communication (whether training occurs at the organization that is responsible for the professional graduate education program or in a participating local or community organization or hospital).
   - The professional graduate medical education committee(s) (GMEC) must communicate with the medical staff and governing body about the safety and quality of patient care, treatment, and services provided by, and the related educational and supervisory needs of, the participants in professional graduate education programs.
   - If the graduate medical education program uses a community or local participating hospital or organization, the person(s) responsible for overseeing the participants from the program communicates to the organized medical staff and its governing body about the patient care, treatment, and services provided by, and the related educational and supervisory needs of, its participants in the professional graduate education programs.

Note: The GMEC can represent one or multiple graduate education programs depending on the number of specialty graduate programs within the organization.

7. There is a mechanism for an appropriate person from the community or local hospital or organization to communicate information to the GMEC about the quality of care, treatment, and services and educational needs of the participants.
8. Information about the quality of care, treatment, and services and educational needs is included in the communication that the GMEC has with the governing board of the sponsoring hospital.

9. The medical staff demonstrates compliance with residency review committee citations.

Note: Graduate medical education programs accredited by the Accreditation Council on Graduate Medical Education (ACGME), the American Osteopathic Association (AOA), or the American Dental Association’s Commission on Dental Accreditation are expected to be in compliance with the above requirements; the hospital should be able to demonstrate compliance with any postgraduate education review committee citations related to this standard.

**Standard MS.05.01.01**

The organized medical staff has a leadership role in organization performance improvement activities to improve quality of care, treatment, and services and patient safety.

**Rationale for MS.05.01.01**

Relevant information developed from the following processes is integrated into performance improvement initiatives and consistent with hospital preservation of confidentiality and privilege of information. Medical staff involvement in establishing protocols and reviewing performance improvement data improves practitioner engagement and the overall safety and quality of care.

**Elements of Performance for MS.05.01.01**

1. The organized medical staff provides leadership for measuring, assessing, and improving processes that primarily depend on the activities of one or more licensed independent practitioners, and other practitioners credentialed and privileged through the medical staff process. *(See also PI.03.01.01, EPs 2 and 4)*

The medical staff is actively involved in the measurement, assessment, and improvement of the following:

2. Medical assessment and treatment of patients. *(See also PI.03.01.01, EPs 2 and 4)*

3. Use of information about adverse privileging decisions for any practitioner privileged through the medical staff process. *(See also PI.03.01.01, EPs 2 and 4)*
4. Use of medications. (See also PI.03.01.01, EPs 2 and 4)
5. Use of blood and blood components. (See also PI.03.01.01, EPs 2 and 4)
6. Operative and other procedure(s) (See also PI.01.01.01, EP 4; PI.03.01.01, EPs 2 and 4)
7. Appropriateness of clinical practice patterns. (See also PI.03.01.01, EPs 2 and 4)
8. Significant departures from established patterns of clinical practice. (See also PI.03.01.01, EPs 2 and 4)
9. The use of developed criteria for autopsies. (See also PI.03.01.01, EPs 2 and 4)

Information used as part of the performance improvement mechanisms, measurement, or assessment includes the following:

10. Sentinel event data. (See also PI.03.01.01, EPs 2 and 4)
11. Patient safety data. (See also PI.03.01.01, EPs 2 and 4)

17. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital attempts to secure autopsies in all cases of unusual deaths and cases of medical, legal, and educational interest, and informs the medical staff (specifically the attending physician or clinical psychologist) of autopsies that the hospital intends to perform.

**Note:** The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

18. The medical staff is actively involved in pain assessment, pain management, and safe opioid prescribing through the following:
   - Participating in the establishment of protocols and quality metrics
   - Reviewing performance improvement data

**Standard MS.05.01.03**

The organized medical staff participates in organizationwide performance improvement activities.

**Elements of Performance for MS.05.01.03**

The organized medical staff participates in the following activities:
1. Education of patients and families.

2. Coordination of care, treatment, and services with other practitioners and hospital personnel, as relevant to the care, treatment, and services of an individual patient.
This page is blank due to revisions through the CAMH update.
3. Accurate, timely, and legible completion of patient’s medical records. (See also RC.01.04.01, EP 1)

4. Review of findings of the assessment process that are relevant to an individual’s performance. The organized medical staff is responsible for determining the use of this information in the ongoing evaluations of a practitioner’s competence.

5. Communication of findings, conclusions, recommendations, and actions to improve performance to appropriate staff members and the governing body.

Introduction to Standard MS.06.01.01

Credentialing and Privileging

Overview

Determining the competency of practitioners to provide high quality, safe patient care is one of the most important and difficult decisions an organization must make. The development and maintenance of a credible process to determine competency requires not only diligent data collection and evaluation, but also the actions by both the governing body and organized medical staff.

The credentialing and privileging process involves a series of activities designed to collect, verify, and evaluate data relevant to a practitioner’s professional performance. These activities serve as the foundation for objective, evidence-based decisions regarding appointment to membership on the medical staff, and recommendations to grant or deny initial and renewed privileges. In the course of the credentialing and privileging process, an overview of each applicant’s licensure, education, training, current competence, and physical ability to discharge patient care responsibilities is established.

Three new concepts are introduced in the revised credentialing and privileging standards. First, the revised credentialing and privileging standards have been informed throughout by the six areas of “General Competencies” developed by the Accreditation
Council for Graduate Medical Education (ACGME)\(^\text{\textregistered}\) and the American Board of Medical Specialties (ABMS) joint initiative. The areas of general competencies include the following:

- Patient care
- Medical/clinical knowledge
- Practice-based learning and improvement
- Interpersonal and communication skills
- Professionalism
- Systems-based practice

Integrating these concepts into the standards allows the organized medical staff to conduct a more comprehensive evaluation of a practitioner’s professional practice.

The second new concept is Focused Professional Practice Evaluation. This concept allows the organized medical staff to focus evaluation on a specific aspect of a practitioner’s performance. This process is used in the following two circumstances:

- When a practitioner has the credentials to suggest competence, but additional information or a period of evaluation is needed to confirm competence in the organization’s setting
- If questions arise regarding a practitioner’s professional practice during the course of the Ongoing Professional Practice Evaluation

The third new concept is the Ongoing Professional Practice Evaluation. Traditionally, the credentialing and privileging process has been a procedural, cyclical process in which practitioners are evaluated when privileges are initially granted, and every two years thereafter. The process outlined in these credentialing and privileging standards is designed to continuously evaluate a practitioner’s performance. The process requires the medical staff to conduct an ongoing evaluation of each practitioner’s professional performance. This process not only allows any potential problems with a practitioner’s performance to be identified and resolved as soon as possible, but also fosters a more efficient, evidence-based privilege renewal process.

\textbf{Note:} While the specific information that will be collected and analyzed to make decisions about granting privileges and medical staff appointment is developed by the organized medical staff and recommended to the governing body, the ultimate authority for granting,

\(^{\text{\textregistered}}\) ACGME launched its Outcome Project in September 1999. Through an extensive review process, six general competencies for resident and fellow development were identified. These six competencies have been incorporated into the Institutional Requirements and all sets of Program Requirements for implementation July 1, 2002.
restricting, and revoking privileges rests with the governing body. The range of information collected to make such decisions is clearly defined in governance documents.

**Standard MS.06.01.01**

Prior to granting a privilege, the resources necessary to support the requested privilege are determined to be currently available, or available within a specified time frame.

**Rationale for MS.06.01.01**

Essential information, such as resources, equipment, and types of personnel necessary to support the requested privilege, is gathered in the process of granting, renewing, or revising clinical privileges.

**Elements of Performance for MS.06.01.01**

1. There is a process to determine whether sufficient space, equipment, staffing, and financial resources are in place or available within a specified time frame to support each requested privilege. 

2. The hospital consistently determines the resources needed for each requested privilege.

**Introduction to Standard MS.06.01.03**

**Credentialing**

Credentialing involves the collection, verification, and assessment of information regarding three critical parameters: current licensure; education and relevant training; and experience, ability, and current competence to perform the requested privilege(s). Verification is sought to minimize the possibility of granting privilege(s) based on the review of fraudulent documents.

The verification of current licensure informs the organization that the applicant is appropriately licensed to practice as a health care provider as required by state and/or federal law. The license verification process is conducted prior to the granting of initial privileges, re-privileging, and at the time of each practitioner’s professional license expiration.
The verification of an applicant’s education and relevant training informs the organization of the applicant’s clinical knowledge and skill set. Whenever feasible, verification should be obtained from the original source of the specific credential. Primary sources include the specialty certifying boards approved by the American Dental Association for a dentist’s board certification, letters from professional schools (for example, medical, dental, and podiatric), and letters from postgraduate education or postdoctoral programs for completion of training. Information from credentials verification organizations (CVOs) may also be used. (See the Glossary for guidelines to evaluate CVOs.) When it is not possible to obtain information from the primary source, reliable secondary sources may be used.

Designated equivalent sources may be used to verify certain credentials in lieu of using the primary source. See the Glossary for the list of designated equivalent sources.

Experience, ability, and current competence in performing the requested privilege(s) is verified by peers knowledgeable about the applicant’s professional performance. This process may include an assessment for proficiency in the following six areas of “General Competencies” adapted from the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS) joint initiative.

For relevance in this chapter, the term “practitioner” replaces “resident” in each competency principle.

**Patient Care**

Practitioners are expected to provide patient care that is compassionate, appropriate, and effective for the promotion of health, prevention of illness, treatment of disease, and care at the end of life.

**Medical/Clinical Knowledge**

Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical, and social sciences, and the application of their knowledge to patient care and the education of others.

**Practice-Based Learning and Improvement**

Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate, and improve patient care practices.
Interpersonal and Communication Skills

Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families, and other members of health care teams.

Professionalism

Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward their patients, their profession, and society.

Systems-Based Practice

Practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided, and the ability to apply this knowledge to improve and optimize health care.

**Note 1:** A reliable secondary source can be another hospital that has documented primary source verification of the applicant’s credentials.

**Note 2:** The Joint Commission considers diversity to include race, culture, gender, religion, ethnic background, sexual preference, language, mental capacity, and physical disability.

**Standard MS.06.01.03**

The hospital collects information regarding each practitioner’s current license status, training, experience, competence, and ability to perform the requested privilege.

**Rationale for MS.06.01.03**

There must be a reliable and consistent process in place to process applications and verify credentials. The organized medical staff then reviews and evaluates the data collected. The resultant privilege recommendations to the governing body are based on the assessment of the data.

**Elements of Performance for MS.06.01.03**

1. The hospital credentials applicants using a clearly defined process.
2. The credentialing process is based on recommendations by the organized medical staff.
3. The credentialing process is approved by the governing body.
4. The credentialing process is outlined in the medical staff bylaws.

5. The hospital verifies that the practitioner requesting approval is the same practitioner identified in the credentialing documents by viewing one of the following:
   - A current picture hospital ID card
   - A valid picture ID issued by a state or federal agency (for example, a driver’s license or passport)

6. The credentialing process requires that the hospital verifies in writing and from the primary source whenever feasible, or from a credentials verification organization (CVO), the following information:
   - The applicant’s current licensure at the time of initial granting, renewal, and revision of privileges, and at the time of license expiration
   - The applicant’s relevant training
   - The applicant’s current competence

7. **For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes:** Inpatient psychiatric services are under the direction of a clinical director, service chief, or equivalent who meets the training and experience requirements for examination by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.

9. **For hospitals that use Joint Commission accreditation for deemed status purposes:** A full-time, part-time, or consulting radiologist who is a doctor of medicine or osteopathy qualified by education and experience in radiology supervises ionizing radiology services.

### Introduction to Standard MS.06.01.05

**Privileging**

The organized medical staff is responsible for planning and implementing a privileging process. This process typically entails the following:

- Developing and approving a procedures list
- Processing the application
- Evaluating applicant-specific information
■ Submitting recommendations to the governing body for applicant-specific delineated privileges
■ Notifying the applicant, relevant personnel, and, as required by law, external entities of the privileging decision
■ Monitoring the use of privileges and quality of care issues

The criteria for granting a new privilege(s) to a practitioner with a record of competent professional performance at the organization (for example, a practitioner seeking an additional privilege[s]) should include information from the practitioner’s professional practice evaluation data, which are collected and assessed on an ongoing basis.

For the applicant who does not have a current professional performance record at the privileging organization, current data should be collected during a time-limited period of privilege-specific professional performance monitoring conducted at the organization.

**Standard MS.06.01.05**

The decision to grant or deny a privilege(s), and/or to renew an existing privilege(s), is an objective, evidence-based process.

**Elements of Performance for MS.06.01.05**

1. All licensed independent practitioners that provide care, treatment, and services possess a current license, certification, or registration, as required by law and regulation.

2. The hospital, based on recommendations by the organized medical staff and approval by the governing body, establishes criteria that determine a practitioner’s ability to provide patient care, treatment, and services within the scope of the privilege(s) requested. Evaluation of all of the following are included in the criteria:
   ■ Current licensure and/or certification, as appropriate, verified with the primary source
   ■ The applicant’s specific relevant training, verified with the primary source
   ■ Evidence of physical ability to perform the requested privilege
   ■ Data from professional practice review by an organization(s) that currently privileges the applicant (if available)
   ■ Peer and/or faculty recommendation
   ■ When renewing privileges, review of the practitioner’s performance within the hospital
3. All of the criteria used are consistently evaluated for all practitioners holding that privilege.

4. The hospital has a clearly defined procedure for processing applications for the granting, renewal, or revision of clinical privileges.

5. The procedure for processing applications for the granting, renewal, or revision of clinical privileges is approved by the organized medical staff.

6. An applicant submits a statement that no health problems exist that could affect his or her ability to perform the privileges requested.

   **Note:** The applicant’s ability to perform privileges requested must be evaluated. This evaluation is documented in the individual’s credentials file. Such documentation may include the applicant’s statement that no health problems exist that could affect his or her practice. Documentation regarding an applicant’s health status and his or her ability to practice should be confirmed. Initial applicants may have their health status confirmed by the director of a training program, the chief of services, or the chief of staff at another hospital at which the applicant holds privileges, or by a currently licensed doctor of medicine or osteopathy approved by the organized medical staff. In instances where there is doubt about an applicant’s ability to perform privileges requested, an evaluation by an external and internal source may be required. The request for an evaluation rests with the organized medical staff.

7. The hospital queries the National Practitioner Data Bank (NPDB) when clinical privileges are initially granted, at the time of renewal of privileges, and when a new privilege(s) is requested.

8. Peer recommendation includes written information regarding the practitioner’s current:
   - Medical/clinical knowledge
   - Technical and clinical skills
   - Clinical judgment
   - Interpersonal skills
   - Communication skills
   - Professionalism

   **Note:** Peer recommendation may be in the form of written documentation reflecting informed opinions on each applicant’s scope and level of performance, or a written peer evaluation of practitioner-specific data collected from various sources for the purpose of validating current competence.
9. Before recommending privileges, the organized medical staff also evaluates the following:
   • Challenges to any licensure or registration
   • Voluntary and involuntary relinquishment of any license or registration
   • Voluntary and involuntary termination of medical staff membership
   • Voluntary and involuntary limitation, reduction, or loss of clinical privileges
   • Any evidence of an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant
   • Documentation as to the applicant’s health status
   • Relevant practitioner-specific data as compared to aggregate data, when available
   • Morbidity and mortality data, when available

10. The hospital has a process to determine whether there is sufficient clinical performance information to make a decision to grant, limit, or deny the requested privilege.

11. Completed applications for privileges are acted on within the time period specified in the medical staff bylaws.

12. Information regarding each practitioner’s scope of privileges is updated as changes in clinical privileges for each practitioner are made.

15. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The surgical service maintains a current roster listing each practitioner’s surgical privileges.

   **Note:** The roster may be in paper or electronic format.

**Standard MS.06.01.07**

The organized medical staff reviews and analyzes all relevant information regarding each requesting practitioner’s current licensure status, training, experience, current competence, and ability to perform the requested privilege.

**Elements of Performance for MS.06.01.07**

1. The information review and analysis process is clearly defined.

2. The hospital, based on recommendations by the organized medical staff and approval by the governing body, develops criteria that will be considered in the decision to grant, limit, or deny a requested privilege.
Note: Medical staff membership and professional privileges are not dependent solely upon certification, fellowship, or membership in a specialty body or society.

3. Gender, race, creed, and national origin are not used in making decisions regarding the granting or denying of clinical privileges.

4. The hospital completes the credentialing and privileging decision process in a timely manner.

5. The hospital’s privilege granting/denial criteria are consistently applied for each requesting practitioner.

6. Decisions on membership and granting of privileges include criteria that are directly related to the quality of health care, treatment, and services.

7. If privileging criteria are used that are unrelated to quality of care, treatment, and services or professional competence, evidence exists that the impact of resulting decisions on the quality of care, treatment, and services is evaluated.

8. The governing body or delegated governing body committee has final authority for granting, renewing, or denying privileges.

9. Privileges are granted for a period not to exceed two years.

Standard MS.06.01.09
The decision to grant, limit, or deny an initially requested privilege or an existing privilege petitioned for renewal is communicated to the requesting practitioner within the time frame specified in the medical staff bylaws.

Elements of Performance for MS.06.01.09
1. Requesting practitioners are notified regarding the granting decision. R

2. In the case of privilege denial, the applicant is informed of the reason for denial.

3. The decision to grant, deny, revise, or revoke privilege(s) is disseminated and made available to all appropriate internal and external persons or entities, as defined by the hospital and applicable law.

4. The process to disseminate all granting, modification, or restriction decisions is approved by the organized medical staff.

5. The hospital makes the practitioner aware of available due process or, when applicable, the option to implement the Fair Hearing and Appeal Process for Adverse Privileging Decisions. (See also MS.10.01.01, EPs 1–5)
Standard MS.06.01.11

An expedited governing body approval process may be used for initial appointment and reappointment to the medical staff and for granting privileges when criteria for that process are met.

Elements of Performance for MS.06.01.11

1. The organized medical staff develops criteria for an expedited process for granting privileges.

   **Note:** To expedite initial appointments to membership and granting of privileges, reappointment to membership, or renewal or modification of privileges, the governing body may delegate the authority to render those decisions to a committee of at least two voting members of the governing body.

2. The criteria provide that an applicant for privileges is ineligible for the expedited process if any of the following has occurred:
   - The applicant submits an incomplete application.
   - The medical staff executive committee makes a final recommendation that is adverse or has limitations.

3. The following situations are evaluated on a case-by-case basis and usually result in ineligibility for the expedited process: There is a current challenge or a previously successful challenge to licensure or registration.

4. The following situations are evaluated on a case-by-case basis and usually result in ineligibility for the expedited process: The applicant has received an involuntary termination of medical staff membership at another hospital.

5. The following situations are evaluated on a case-by-case basis and usually result in ineligibility for the expedited process: The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges.

6. The following situations are evaluated on a case-by-case basis and usually result in ineligibility for the expedited process: The hospital determines that there has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

7. The organized medical staff uses the criteria developed for the expedited process when recommending privileges.
Standard MS.06.01.13

Under certain circumstances, temporary clinical privileges may be granted for a limited period of time.

Rationale for MS.06.01.13

There are two circumstances in which temporary privileges may be granted. Each circumstance has different criteria for granting privileges. The circumstances for which the granting of temporary privileges is acceptable are:

- To fulfill an important patient care, treatment, and service need
- When an applicant for new privileges with a complete application that raises no concerns is awaiting review and approval by the medical staff executive committee and the governing body

Note: “Applicant for new privileges” includes an individual applying for clinical privileges at the hospital for the first time; an individual currently holding clinical privileges who is requesting one or more additional privileges; and an individual who is in the reappointment/reprivileging process and is requesting one or more additional privileges.

Medical staff bylaws or other documents may stipulate that, in an emergency, any medical staff member with clinical privileges is permitted to provide any type of patient care, treatment, and services necessary as a life-saving measure or to prevent serious harm—regardless of his or her medical staff status or clinical privileges—provided that the care, treatment, and services provided are within the scope of the individual’s license.

Elements of Performance for MS.06.01.13

1. Temporary privileges are granted to meet an important patient care need for the time period defined in the medical staff bylaws. (See also MS.01.01.01, EP 14) R

2. When temporary privileges are granted to meet an important care need, the organized medical staff verifies current licensure and current competence.

3. Temporary privileges for applicants for new privileges may be granted while awaiting review and approval by the organized medical staff upon verification of the following: R
   - Current licensure
   - Relevant training or experience
   - Current competence
   - Ability to perform the privileges requested
   - Other criteria required by the medical staff bylaws
- A query and evaluation of the National Practitioner Data Bank (NPDB) information
- A complete application
- No current or previously successful challenge to licensure or registration
- No subjection to involuntary termination of medical staff membership at another organization
- No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges

4. All temporary privileges are granted by the chief executive officer or authorized designee.

5. All temporary privileges are granted on the recommendation of the medical staff president or authorized designee.

6. Temporary privileges for applicants for new privileges are granted for no more than 120 days.

**Standard MS.07.01.01**

The organized medical staff provides oversight for the quality of care, treatment, and services by recommending members for appointment to the medical staff.

**Elements of Performance for MS.07.01.01**

1. The organized medical staff develops criteria for medical staff membership.
   
   **Note:** *Medical staff membership and professional privileges are not dependent solely upon certification, fellowship, or membership in a specialty body or society.*

2. The professional criteria are designed to assure the medical staff and governing body that patients will receive quality care, treatment, and services.

3. The organized medical staff uses the criteria in appointing members to the medical staff and appointment does not exceed a period of two years.

4. Gender, race, creed, and national origin are not used in making decisions regarding the granting or denying of medical staff membership.

5. Membership is recommended by the medical staff and granted by the governing body.
Standard MS.07.01.03
Deliberations by the medical staff in developing recommendations for appointment to or termination from the medical staff and for the initial granting, revision, or revocation of clinical privileges include information provided by peer(s) of the applicant.

Rationale for MS.07.01.03
In circumstances where there are insufficient peer review data available when evaluating an applicant for privileges, the organized medical staff uses peer recommendations. A recommendation(s) from peers (appropriate practitioners in the same professional discipline as the applicant who have personal knowledge of the applicant) reflects a basis for recommending the granting of privileges.

Sources for peer recommendations may include the following:
- An organization performance improvement committee, the majority of whose members are the applicant’s peers
- A reference letter(s), written documentation, or documented telephone conversation(s) about the applicant from a peer(s) who is knowledgeable about the applicant’s professional performance and competence
- A department or major clinical service chairperson who is a peer
- The medical staff executive committee

Elements of Performance for MS.07.01.03
1. Recommendations from peers are obtained and evaluated for all new applicants for privileges.
2. Upon renewal of privileges, when insufficient practitioner-specific data are available, the medical staff obtains and evaluates peer recommendations.
3. Peer recommendations include the following information:
   - Medical/clinical knowledge
   - Technical and clinical skills
   - Clinical judgment
   - Interpersonal skills
   - Communication skills
   - Professionalism
4. Peer recommendations are obtained from a practitioner in the same professional discipline as the applicant with personal knowledge of the applicant’s ability to practice.
Introduction to Standard MS.08.01.01

Focused Professional Practice Evaluation

Focused professional practice evaluation is a process whereby the organization evaluates the privilege-specific competence of the practitioner who does not have documented evidence of competently performing the requested privilege at the organization. This process may also be used when a question arises regarding a currently privileged practitioner’s ability to provide safe, high quality patient care. Focused professional practice evaluation is a time-limited period during which the organization evaluates and determines the practitioner’s professional performance.

The organized medical staff does the following:
- Evaluates practitioners without current performance documentation at the organization
- Evaluates practitioners in response to concerns regarding the provision of safe, high quality patient care
- Develops criteria for extending the evaluation period
- Communicates to the appropriate parties the evaluation results and recommendations based on results
- Implements changes to improve performance

Standard MS.08.01.01

The organized medical staff defines the circumstances requiring monitoring and evaluation of a practitioner’s professional performance.

Rationale for MS.08.01.01

The focused evaluation process is defined by the organized medical staff. The time period of the evaluation can be extended, and/or a different type of evaluation process assigned. Information for focused professional practice evaluation may include chart review, monitoring clinical practice patterns, simulation, proctoring, external peer review, and discussion with other individuals involved in the care of each patient (for example, consulting physicians, assistants at surgery, nursing or administrative personnel).

Relevant information resulting from the focused evaluation process is integrated into performance improvement activities, consistent with the organization’s policies and procedures that are intended to preserve confidentiality and privilege of information.
Elements of Performance for MS.08.01.01

1. A period of focused professional practice evaluation is implemented for all initially requested privileges.

2. The organized medical staff develops criteria to be used for evaluating the performance of practitioners when issues affecting the provision of safe, high quality patient care are identified.

3. The performance monitoring process is clearly defined and includes each of the following elements:
   - Criteria for conducting performance monitoring
   - Method for establishing a monitoring plan specific to the requested privilege
   - Method for determining the duration of performance monitoring
   - Circumstances under which monitoring by an external source is required

4. Focused professional practice evaluation is consistently implemented in accordance with the criteria and requirements defined by the organized medical staff.

5. The triggers that indicate the need for performance monitoring are clearly defined.

   Note: Triggers can be single incidents or evidence of a clinical practice trend.

6. The decision to assign a period of performance monitoring to further assess current competence is based on the evaluation of a practitioner’s current clinical competence, practice behavior, and ability to perform the requested privilege.

   Note: Other existing privileges in good standing should not be affected by this decision.

7. Criteria are developed that determine the type of monitoring to be conducted.

8. The measures employed to resolve performance issues are clearly defined.

9. The measures employed to resolve performance issues are consistently implemented.
Introduction to Standard MS.08.01.03

Ongoing Professional Practice Evaluation
(Maintaining Privileges)

The ongoing professional practice evaluation allows the organization to identify professional practice trends that impact on quality of care and patient safety. Such identification may require intervention by the organized medical staff. The criteria used in the ongoing professional practice evaluation may include the following:

- Review of operative and other clinical procedure(s) performed and their outcomes
- Pattern of blood and pharmaceutical usage
- Requests for tests and procedures
- Length of stay patterns
- Morbidity and mortality data
- Practitioner’s use of consultants
- Other relevant criteria as determined by the organized medical staff

The information used in the ongoing professional practice evaluation may be acquired through the following:

- Periodic chart review
- Direct observation
- Monitoring of diagnostic and treatment techniques
- Discussion with other individuals involved in the care of each patient including consulting physicians, assistants at surgery, and nursing and administrative personnel

Relevant information obtained from the ongoing professional practice evaluation is integrated into performance improvement activities. These activities adhere to the organization’s policies or procedures intended to preserve any confidentiality or legal privilege of information established by applicable law.

If there is uncertainty regarding the practitioner’s professional performance, the organized medical staff should follow the course of action defined in the medical staff bylaws for further evaluation of the practitioner.

Note 1: Privileged practitioners have access to the medical staff fair hearing and appeal process should the intervention result in corrective action. (See Standard MS.10.01.01)
Note 2: Operative and other clinical procedures include operative and other invasive and noninvasive procedures that place the patient at risk. The focus is on procedures, and is not meant to include medications that place the patient at risk.

Standard MS.08.01.03

Ongoing professional practice evaluation information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), or to revoke an existing privilege prior to or at the time of renewal.

Elements of Performance for MS.08.01.03

The process for the ongoing professional practice evaluation includes the following:

1. There is a clearly defined process in place that facilitates the evaluation of each practitioner’s professional practice.

2. The type of data to be collected is determined by individual departments and approved by the organized medical staff.

3. Information resulting from the ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privilege(s).

Standard MS.09.01.01

The organized medical staff, pursuant to the medical staff bylaws, evaluates and acts on reported concerns regarding a privileged practitioner’s clinical practice and/or competence.

Rationale for MS.09.01.01

A well-structured internal reporting process supports the ongoing professional practice evaluation and enhances the quality of care and patient safety.

Elements of Performance for MS.09.01.01

1. The hospital, based on recommendations by the organized medical staff and approval by the governing body, has a clearly defined process for collecting, investigating, and addressing clinical practice concerns. (See also RI.01.07.01, EPs 1, 4, 6, and 7)

2. Reported concerns regarding a privileged practitioner’s professional practice are uniformly investigated and addressed, as defined by the hospital and applicable law.
Standard **MS.10.01.01**

There are mechanisms including a fair hearing and appeal process for addressing adverse decisions regarding reappointment, denial, reduction, suspension, or revocation of privileges that may relate to quality of care, treatment, and services issues.

**Rationale for MS.10.01.01**

Mechanisms for fair hearing and appeal processes are designed to allow the affected individual a fair opportunity to defend herself or himself regarding the adverse decision to an unbiased hearing body of the medical staff, and an opportunity to appeal the decision of the hearing body to the governing body. The purpose of a fair hearing and appeal is to assure full consideration and reconsideration of quality and safety issues and, under the current structure of reporting to the National Practitioner Data Bank (NPDB), allow practitioners an opportunity to defend themselves.

**Elements of Performance for MS.10.01.01**

The organized medical staff has developed a fair hearing and appeal process addressing quality of care issues that has the following characteristics:

1. (☑) Is designed to provide a fair process that may differ for members and nonmembers of the medical staff. *(See also MS.06.01.09, EP 5)*

2. (☑) Has a mechanism to schedule a hearing of such requests. *(See also MS.06.01.09, EP 5)*

3. (☑) Has identified the procedures for the hearing to follow. *(See also MS.06.01.09, EP 5)*

4. (☑) Identifies the composition of the hearing committee as a committee that includes impartial peers. *(See also MS.06.01.09, EP 5)*

5. (☑) With the governing body, provides a mechanism to appeal adverse decisions as provided in the medical staff bylaws. *(See also MS.06.01.09, EP 5)*

**Standard **MS.11.01.01**

The medical staff implements a process to identify and manage matters of individual health for licensed independent practitioners which is separate from actions taken for disciplinary purposes.
Rationale for MS.11.01.01
The organized medical staff and organization leaders have an obligation to protect patients, its members, and other persons present in the hospital from harm. Therefore, the organized medical staff designs a process that provides education about licensed independent practitioner health; addresses prevention of physical, psychiatric, or emotional illness; and facilitates confidential diagnosis, treatment, and rehabilitation of licensed independent practitioners who suffer from a potentially impairing condition.

The purpose of the process is to facilitate the rehabilitation, rather than discipline, by assisting a practitioner to retain and to regain optimal professional functioning that is consistent with protection of patients. If at any time during the diagnosis, treatment, or rehabilitation phase of the process it is determined that a practitioner is unable to safely perform the privileges he or she has been granted, the matter is forwarded for appropriate corrective action that includes strict adherence to any state or federally mandated reporting requirements.

Note: Organizations should consider the applicability of the Americans with Disabilities Act (ADA) to their credentialing and privileging activities, and, if applicable, review their medical staff bylaws, policies, and procedures. Federal entities are required to comply with the Rehabilitation Act of 1974.

Elements of Performance for MS.11.01.01
Process design addresses the following issues:

1. Education of licensed independent practitioners and other organization staff about illness and impairment recognition issues specific to licensed independent practitioners (at-risk criteria).

2. Self referral by a licensed independent practitioner.

3. Referral by others and maintaining informant confidentiality.

4. Referral of the licensed independent practitioner to appropriate professional internal or external resources for evaluation, diagnosis, and treatment of the condition or concern.

5. Maintenance of confidentiality of the licensed independent practitioner seeking referral or referred for assistance, except as limited by applicable law, ethical obligation, or when the health and safety of a patient is threatened.

6. Evaluation of the credibility of a complaint, allegation, or concern.
7. Monitoring the licensed independent practitioner and the safety of patients until the rehabilitation is complete and periodically thereafter, if required.

8. Reporting to the organized medical staff leadership instances in which a licensed independent practitioner is providing unsafe treatment.

9. Initiating appropriate actions when a licensed independent practitioner fails to complete the required rehabilitation program.

10. The medical staff implements its process to identify and manage matters of individual health for licensed independent practitioners.

**Standard MS.12.01.01**

All licensed independent practitioners and other practitioners privileged through the medical staff process participate in continuing education.

**Rationale for MS.12.01.01**

Continuing education is an adjunct to maintaining clinical skills and current competence.

**Elements of Performance for MS.12.01.01**

1. Hospital-sponsored educational activities are prioritized by the organized medical staff.

2. These activities relate, at least in part, to the type and nature of care, treatment, and services offered by the hospital.

3. Education is based on the findings of performance improvement activities.

4. Each individual’s participation in continuing education is documented.

5. Participation in continuing education is considered in decisions about reappointment to membership on the medical staff or renewal or revision of individual clinical privileges.
Introduction to Standard MS.13.01.01

Telemedicine

Introduction

The services covered under these standards are narrowly defined, focusing solely on licensed independent practitioners who have either total or shared responsibility for patient care, treatment, and services (as evidenced by having the authority to write orders and direct care, treatment, and services) through a telemedicine link. For hospitals that do not use Joint Commission accreditation for deemed status purposes, licensed independent practitioners who provide official readings of images, tracings, or specimens (interpretive services) through a telemedicine link are credentialed and privileged under the contracted services (Standard LD.04.03.09). If the organization has a pressing clinical need and a practitioner can supply that service through a telemedicine link, the organization can evaluate the use of temporary privileges (Standard MS.06.01.13) for this clinical situation.

These standards allow for the option of credentialing and privileging by proxy. Under special circumstances, the originating site (the site where the patient is located at the time the service is provided) is allowed to accept the privileging decisions of the distant site (the site where the practitioner providing the professional service is located). As in all other standards, these standards assume that the organization is following applicable law and regulation such as appropriate licensure to practice medicine or telemedicine in the states where the originating sites and distant sites are located.

This approach does the following:
- Reduces the credentialing and privileging burden for the originating site, especially where there are large numbers of licensed independent practitioners who might provide telemedicine services
- Recognizes that the distant site has more relevant information upon which to base its privileging decisions
- Acknowledges that the originating site may have little experience in privileging in certain specialties

*Telemedicine is defined as the use of medical information exchanged from one site to another via electronic communications to improve patients’ health status. Telemedicine is a subcategory of telehealth. Source: American Telemedicine Association.
Other Standards Related to the Delivery of Telemedicine

Clinical privileging decisions encompass consideration of the appropriate use of telemedicine equipment by the telemedicine practitioner. See Standards EC.02.04.01 and EC.02.04.03 for additional standards related to maintaining telemedical equipment.

**Standard MS.13.01.01**

*For originating sites only:* Licensed independent practitioners who are responsible for the care, treatment, and services of the patient via telemedicine link are subject to the credentialing and privileging processes of the originating site.

**Rationale for MS.13.01.01**
The originating site retains responsibility for overseeing the safety and quality of services offered to its patients.

**Element of Performance for MS.13.01.01**

1. All licensed independent practitioners who are responsible for the patient’s care, treatment, and services via telemedicine link are credentialed and privileged to do so at the originating site through one of the following mechanisms:
   - The originating site fully privileges and credentials the practitioner according to Standards MS.06.01.03 through MS.06.01.13.
   - The originating site privileges practitioners using credentialing information from the distant site if the distant site is a Joint Commission–accredited organization. The distant-site practitioner has a license that is issued or recognized by the state in which the patient is receiving telemedicine services.
   - The originating site may choose to use the credentialing and privileging decision from the distant site to make a final privileging decision if all the following requirements are met:
     - The distant site is a Joint Commission–accredited hospital or ambulatory care organization.
     - The practitioner is privileged at the distant site for those services to be provided at the originating site.
     - For hospitals that use Joint Commission accreditation for deemed status purposes: The distant site provides the originating site with a current list of licensed independent practitioners’ privileges.
The originating site has evidence of an internal review of the practitioner’s performance of these privileges and sends to the distant site information that is useful to assess the practitioner’s quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes related to sentinel events considered reviewable by The Joint Commission that result from the telemedicine services provided and complaints about the distant site licensed independent practitioner from patients, licensed independent practitioners, or staff at the originating site. (See also LD.04.03.09, EPs 4, 9, and 23)

Note: This occurs in a way consistent with any hospital policies or procedures intended to preserve any confidentiality or privilege of information established by applicable law.

The distant-site practitioner has a license that is issued or recognized by the state in which the patient is receiving telemedicine services.

Note 1: In the case of an accredited ambulatory care organization, the hospital must verify that the distant site made its decision using the process described in Standards MS.06.01.03 through MS.06.01.07 (excluding EP 2 from MS.06.01.03). This is equivalent to meeting Standard HR.02.01.03 in the Comprehensive Accreditation Manual for Ambulatory Care.

Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: As indicated at LD.04.03.09, EP 23, the originating site makes certain that all distant-site telemedicine providers’ credentialing and privileging processes meet, at a minimum, the Medicare Conditions of Participation at 42 CFR 482.12(a)(1) through (a)(9) and 482.22(a)(1) through (a)(4). For the language of the Medicare Conditions of Participation pertaining to telemedicine, see Appendix A.

Standard MS.13.01.03

For originating and distant sites: The medical staffs at both the originating and distant sites recommend the clinical services to be provided by licensed independent practitioners through a telemedical link at their respective sites.
Rationale for MS.13.01.03
Telemedicine will continue to evolve making novel services and approaches through technology more readily available. Medical staff at the originating site evaluates the organization’s ability to safely provide services on an ongoing basis. Medical staff at the distant site evaluates performance of those services as part of privileging and as part of the reappraisal conducted at the time of reappointment, renewal, or revision of clinical privileges.

Elements of Performance for MS.13.01.03

1. The medical staff recommends which clinical services are appropriately delivered by licensed independent practitioners through this medium.

2. The clinical services offered are consistent with commonly accepted quality standards.
National Patient Safety Goals (NPSG)

Chapter Outline

National Patient Safety Goals

I. Goal 1—Improve the accuracy of patient identification.
   A. Use of Two Patient Identifiers (NPSG.01.01.01)
   B. Eliminating Transfusion Errors (NPSG.01.03.01)

II. Goal 2—Improve the effectiveness of communication among caregivers.
    A. Timely Reporting of Critical Results of Tests (NPSG.02.03.01)

III. Goal 3—Improve the safety of using medications.
     A. Labeling Medications (NPSG.03.04.01)
     B. Reducing Harm from Anticoagulation Therapy (NPSG.03.05.01)
     C. Reconciling Medication Information (NPSG.03.06.01)

IV. Goal 6—Reduce harm associated with clinical alarm systems.
    A. Improve the Safety of Clinical Alarm Systems (NPSG.06.01.01)

V. Goal 7—Reduce the risk of health care–associated infections.
   A. Meeting Hand Hygiene Guidelines (NPSG.07.01.01)
   B. Preventing Multidrug-Resistant Organism Infections (NPSG.07.03.01)
   C. Preventing Central Line–Associated Blood Stream Infections
      (NPSG.07.04.01)
   D. Preventing Surgical Site Infections (NPSG.07.05.01)
   E. Preventing Catheter-Associated Urinary Tract Infections (NPSG.07.06.01)

VI. Goal 15—The organization identifies safety risks inherent in its patient population.
    A. Identifying Individuals at Risk for Suicide (NPSG.15.01.01)

Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery™

I. Universal Protocol
   A. Conducting a Preprocedure Verification Process (UP.01.01.01)
   B. Marking the Procedure Site (UP.01.02.01)
   C. Performing a Time-Out (UP.01.03.01)
Requirements, Rationales, and Elements of Performance

Goal 1
Improve the accuracy of patient identification.

NPSG.01.01.01
Use at least two patient identifiers when providing care, treatment, and services.

Rationale for NPSG.01.01.01
Wrong-patient errors 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 patient identifiers when administering medications, blood, or blood components; when collecting blood samples and other specimens for clinical testing; and when providing treatments or procedures. The patient’s room number or physical location is not used as an identifier. (See also MM.05.01.09, EPs 8 and 11; NPSG.01.03.01, EP 1)
2. Label containers used for blood and other specimens in the presence of the patient. (See also NPSG.01.03.01, EP 1)

NPSG.01.03.01
Eliminate transfusion errors related to patient misidentification.

Elements of Performance for NPSG.01.03.01
1. Before initiating a blood or blood component transfusion:
   - Match the blood or blood component to the order.
   - Match the patient to the blood or blood component.
   - Use a two-person verification process or a one-person verification process accompanied by automated identification technology, such as bar coding. (See also NPSG.01.01.01, EPs 1 and 2)
2. When using a two-person verification process, one individual conducting the identification verification is the qualified transfusionist who will administer the blood or blood component to the patient. 

3. When using a two-person verification process, the second individual conducting the identification verification is qualified to participate in the process, as determined by the hospital.

**Goal 2**
Improve the effectiveness of communication among caregivers.

**NPSG.02.03.01**
Report critical results of tests and diagnostic procedures on a timely basis.

**Rationale for NPSG.02.03.01**
Critical results of tests and diagnostic procedures fall significantly outside the normal range and may indicate a life-threatening situation. The objective is to provide the responsible licensed caregiver these results within an established time frame so that the patient can be promptly treated.

**Elements of Performance for NPSG.02.03.01**

1. Develop written procedures for managing the critical results of tests and diagnostic procedures that address the following:
   - The definition of critical results of tests and diagnostic procedures
   - By whom and to whom critical results of tests and diagnostic procedures are reported
   - The acceptable length of time between the availability and reporting of critical results of tests and diagnostic procedures

2. Implement the procedures for managing the critical results of tests and diagnostic procedures.

3. Evaluate the timeliness of reporting the critical results of tests and diagnostic procedures.
Goal 3
Improve the safety of using medications.

NPSG.03.04.01
Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings.

Note: Medication containers include syringes, medicine cups, and basins.

Rationale for NPSG.03.04.01
Medications or other solutions in unlabeled containers are unidentifiable. Errors, sometimes tragic, have resulted from medications and other solutions removed from their original containers and placed into unlabeled containers. This unsafe practice neglects basic principles of safe medication management, yet it is routine in many organizations.

The labeling of all medications, medication containers, and other solutions is a risk-reduction activity consistent with safe medication management. This practice addresses a recognized risk point in the administration of medications in perioperative and other procedural settings. Labels for medications and medication containers are also addressed at MM.05.01.09.

Elements of Performance for NPSG.03.04.01

1. In perioperative and other procedural settings both on and off the sterile field, label medications and solutions that are not immediately administered. This applies even if there is only one medication being used.  

   Note: An immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to a patient, and administers to that patient without any break in the process. Refer to NPSG.03.04.01, EP 5, for information on timing of labeling.

2. In perioperative and other procedural settings both on and off the sterile field, labeling occurs when any medication or solution is transferred from the original packaging to another container.

3. In perioperative and other procedural settings both on and off the sterile field, medication or solution labels include the following: 
   - Medication or solution name
   - Strength
- Amount of medication or solution containing medication (if not apparent from the container)
- Diluent name and volume (if not apparent from the container)
- Expiration date when not used within 24 hours
- Expiration time when expiration occurs in less than 24 hours

**Note:** The date and time are not necessary for short procedures, as defined by the hospital.

4. Verify all medication or solution labels both verbally and visually. Verification is done by two individuals qualified to participate in the procedure whenever the person preparing the medication or solution is not the person who will be administering it.  

5. Label each medication or solution as soon as it is prepared, unless it is immediately administered.  

**Note:** An immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to a patient, and administers to that patient without any break in the process.

6. Immediately discard any medication or solution found unlabeled.  

7. Remove all labeled containers on the sterile field and discard their contents at the conclusion of the procedure.  

**Note:** This does not apply to multiuse vials that are handled according to infection control practices.

8. All medications and solutions both on and off the sterile field and their labels are reviewed by entering and exiting staff responsible for the management of medications.  

**NPSG.03.05.01**
Reduce the likelihood of patient harm associated with the use of anticoagulant therapy.
Note: This requirement applies only to hospitals that provide anticoagulant therapy and/or long-term anticoagulation prophylaxis (for example, atrial fibrillation) where the clinical expectation is that the patient’s laboratory values for coagulation will remain outside normal values. This requirement does not apply to routine situations in which short-term prophylactic anticoagulation is used for venous thrombo-embolism prevention (for example, related to procedures or hospitalization) and the clinical expectation is that the patient’s laboratory values for coagulation will remain within, or close to, normal values.

Rationale for NPSG.03.05.01
Anticoagulation therapy can be used as therapeutic treatment for a number of conditions, the most common of which are atrial fibrillation, deep vein thrombosis, pulmonary embolism, and mechanical heart valve implant. However, it is important to note that anticoagulation medications are more likely than others to cause harm due to complex dosing, insufficient monitoring, and inconsistent patient compliance. This National Patient Safety Goal has great potential to positively impact the safety of patients on this class of medications and result in better outcomes.

To achieve better patient outcomes, patient education is a vital component of an anticoagulation therapy program. Effective anticoagulation patient education includes face-to-face interaction with a trained professional who works closely with patients to be sure that they understand the risks involved with anticoagulation therapy, the precautions they need to take, and the need for regular International Normalized Ratio (INR) monitoring. The use of standardized practices for anticoagulation therapy that include patient involvement can reduce the risk of adverse drug events associated with heparin (unfractionated), low molecular weight heparin, and warfarin.

Elements of Performance for NPSG.03.05.01

1. Use only oral unit-dose products, prefilled syringes, or premixed infusion bags when these types of products are available.  
   Note: For pediatric patients, prefilled syringe products should be used only if specifically designed for children.

2. Use approved protocols for the initiation and maintenance of anticoagulant therapy.

3. Before starting a patient on warfarin, assess the patient’s baseline coagulation status; for all patients receiving warfarin therapy, use a current International Normalized Ratio (INR) to adjust this therapy. The baseline status and current INR are documented in the medical record.
**Note:** The patient’s baseline coagulation status can be assessed in a number of ways, including through a laboratory test or by identifying risk factors such as age, weight, bleeding tendency, and genetic factors.

4. Use authoritative resources to manage potential food and drug interactions for patients receiving warfarin. 

5. When heparin is administered intravenously and continuously, use programmable pumps in order to provide consistent and accurate dosing.

6. A written policy addresses baseline and ongoing laboratory tests that are required for anticoagulants.

7. Provide education regarding anticoagulant therapy to prescribers, staff, patients, and families. Patient/family education includes the following:
   - The importance of follow-up monitoring
   - Compliance
   - Drug-food interactions
   - The potential for adverse drug reactions and interactions

8. Evaluate anticoagulation safety practices, take action to improve practices, and measure the effectiveness of those actions in a time frame determined by the organization.

**Introduction to Reconciling Medication Information**

The large number of people receiving health care 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 a patient should be using (and is actually using) to the new medications that are ordered for the patient 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 patient was prescribed and what medications the patient is actually taking. It can be difficult to obtain a complete list from every patient in an encounter, and accuracy is dependent on the patient’s ability and willingness to provide this information. A good faith effort to collect this information is recognized as meeting the intent of the requirement. As health care evolves with the adoption of more sophisticated systems (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 patient outcomes associated with medication discrepancies. Some aspects of the care process 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 (PC.02.02.01), patient education on safe medication use (PC.02.03.01), and communications with other providers (PC.04.02.01).

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 to patients. It is often important for clinicians to know what medications the patient is taking when planning care, treatment, and services, even in situations where medications are not used. A new requirement in this NPSG addresses the patient’s role in medication safety: it requires organizations to inform the patient about the importance of maintaining updated medication information.

**NPSG.03.06.01**

Maintain and communicate accurate patient medication information.
Rationale for NPSG.03.06.01
There is evidence that medication discrepancies can affect patient outcomes. Medication reconciliation is intended to identify and resolve discrepancies—it is a process of comparing the medications a patient 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 information on the medications the patient is currently taking when he or she is admitted to the hospital or is seen in an outpatient setting. This information is documented in a list or other format that is useful to those who manage medications.

   Note 1: 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 2: It is often difficult to obtain complete information on current medications from a patient. A good faith effort to obtain this information from the patient and/or other sources will be considered as meeting the intent of the EP.

2. Define the types of medication information to be collected in non-24-hour settings and different patient circumstances.

   Note 1: Examples of non-24-hour settings include the emergency department, primary care, outpatient radiology, ambulatory surgery, and diagnostic settings.

   Note 2: Examples of medication information that may be collected include name, dose, route, frequency, and purpose.

3. Compare the medication information the patient brought to the hospital with the medications ordered for the patient by the hospital in order to identify and resolve discrepancies.

   Note: Discrepancies include omissions, duplications, contraindications, unclear information, and changes. A qualified individual, identified by the hospital, does the comparison. (See also HR.01.06.01, EP 1)
4. Provide the patient (or family as needed) with written information on the medications the patient should be taking when he or she is discharged from the hospital or at the end of an outpatient encounter (for example, name, dose, route, frequency, purpose).

**Note:** When the only additional medications prescribed are for a short duration, the medication information the hospital provides may include only those medications. For more information about communications to other providers of care when the patient is discharged or transferred, refer to Standard PC.04.02.01.

5. Explain the importance of managing medication information to the patient when he or she is discharged from the hospital or at the end of an outpatient encounter.

**Note:** Examples include instructing the patient 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 patient education on medications, refer to Standards MM.06.01.03, PC.02.03.01, and PC.04.01.05.)

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**Goal 6**
Reduce the harm associated with clinical alarm systems.

**NPSG.06.01.01**
Improve the safety of clinical alarm systems.

**Rationale for NPSG.06.01.01**
Clinical alarm systems are intended to alert caregivers of potential patient problems, but if they are not properly managed, they can compromise patient safety. This is a multifaceted problem. In some situations, individual alarm signals are difficult to detect. At the same time, many patient care areas have numerous alarm signals and the resulting noise and displayed information tends to desensitize staff and cause them to miss or ignore alarm signals or even disable them. Other issues associated with effective clinical alarm system management include too many devices with alarms, default settings that are not at an actionable level, and alarm limits that are too narrow. These issues vary greatly among hospitals and even within different units in a single hospital.
There is general agreement that this is an important safety issue. Universal solutions have yet to be identified, but it is important for a hospital to understand its own situation and to develop a systematic, coordinated approach to clinical alarm system management. Standardization contributes to safe alarm system management, but it is recognized that solutions may have to be customized for specific clinical units, groups of patients, or individual patients. This NPSG focuses on managing clinical alarm systems that have the most direct relationship to patient safety. As alarm system management solutions are identified, this NPSG will be updated to reflect best practices.

**Elements of Performance for NPSG.06.01.01**

1. Leaders establish alarm system safety as a hospital priority.

2. Identify the most important alarm signals to manage based on the following:
   - Input from the medical staff and clinical departments
   - Risk to patients if the alarm signal is not attended to or if it malfunctions
   - Whether specific alarm signals are needed or unnecessarily contribute to alarm noise and alarm fatigue
   - Potential for patient harm based on internal incident history
   - Published best practices and guidelines

   (For more information on managing medical equipment risks, refer to Standard EC.02.04.01.)

3. Establish policies and procedures for managing the alarms identified in EP 2 above that, at a minimum, address the following:
   - Clinically appropriate settings for alarm signals
   - When alarm signals can be disabled
   - When alarm parameters can be changed
   - Who in the organization has the authority to set alarm parameters
   - Who in the organization has the authority to change alarm parameters
   - Who in the organization has the authority to set alarm parameters to “off”
   - Monitoring and responding to alarm signals
   - Checking individual alarm signals for accurate settings, proper operation, and detectability

Additional information on alarm safety can be found on the AAMI website http://www.aami.org/htsi/alarms/. Also, the ECRI Institute has identified alarm hazards as one of the top technology hazards for 2013; more information on this hazard list can be found at http://www.ecri.org/Forms/Pages/Alarm_Safety_Resource.aspx.
4. Educate staff and licensed independent practitioners about the purpose and proper operation of alarm systems for which they are responsible. R

**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.

**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, and services in a health care organization. Consequently, health care–associated infections (HAIs) are a patient 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 patients, 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.

**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) R*

2. Set goals for improving compliance with hand hygiene guidelines. *(See also IC.03.01.01, EP 1) R*

3. Improve compliance with hand hygiene guidelines based on established goals. R
NPSG.07.03.01

Implement evidence-based practices to prevent health care–associated infections due to multidrug-resistant organisms in acute care hospitals.

Note: This requirement applies to, but is not limited to, epidemiologically important organisms such as methicillin-resistant Staphylococcus aureus (MRSA), Clostridium difficile (CDI), vancomycin-resistant enterococci (VRE), carbapenem-resistant enterobacteriaceae (CRE), and other multidrug-resistant gram-negative bacteria.

Rationale for NPSG.07.03.01

Patients continue to acquire health care–associated infections at an alarming rate. Risks and patient populations, however, differ between hospitals. Therefore, prevention and control strategies must be tailored to the specific needs of each hospital based on its risk assessment. The elements of performance for this requirement are designed to help reduce or prevent health care–associated infections from epidemiologically important multidrug-resistant organisms (MDROs).

Note: Hand hygiene, contact precautions, as well as cleaning and disinfecting patient care equipment and the patient’s environment are essential strategies for preventing the spread of health care–associated infections. Hand hygiene is addressed in NPSG.07.01.01. Contact precautions for patients with epidemiologically significant multidrug-resistant organisms (MDROs) are covered in IC.02.01.01, EP 3. Cleaning and disinfecting patient care equipment are addressed in IC.02.02.01.

Elements of Performance for NPSG.07.03.01

1. Conduct periodic risk assessments (in time frames defined by the hospital) for multidrug-resistant organism acquisition and transmission. (See also IC.01.03.01, EPs 1–3) R

2. Educate staff and licensed independent practitioners about multidrug-resistant organisms and prevention strategies. Education occurs upon hire or granting of initial privileges and periodically thereafter as determined by the organization. R

   Note: The education provided recognizes the diverse roles of staff and licensed independent practitioners and is consistent with their roles within the organization.

3. Educate patients, and their families as needed, who are infected or colonized with a multidrug-resistant organism about health care–associated infection prevention strategies. R
4. Implement a surveillance program for multidrug-resistant organisms based on the risk assessment.  

**Note:** Surveillance may be targeted rather than hospitalwide.

5. Measure and monitor multidrug-resistant organism prevention processes and outcomes, including the following:  
   - Multidrug-resistant organism infection rates using evidence-based metrics  
   - Compliance with evidence-based guidelines or best practices  
   - Evaluation of the education program provided to staff and licensed independent practitioners  

**Note:** Surveillance may be targeted rather than hospitalwide.

6. Provide multidrug-resistant organism process and outcome data to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians.

7. Implement policies and practices aimed at reducing the risk of transmitting multidrug-resistant organisms. These policies and practices meet regulatory requirements and are aligned with evidence-based standards (for example, the Centers for Disease Control and Prevention (CDC) and/or professional organization guidelines).

8. When indicated by the risk assessment, implement a laboratory-based alert system that identifies new patients with multidrug-resistant organisms.

**Note:** The alert system may use telephones, faxes, pagers, automated and secure electronic alerts, or a combination of these methods.

9. When indicated by the risk assessment, implement an alert system that identifies readmitted or transferred patients who are known to be positive for multidrug-resistant organisms.

**Note 1:** The alert system information may exist in a separate electronic database or may be integrated into the admission system. The alert system may be either manual or electronic or a combination of both.

**Note 2:** Each hospital may define its own parameters in terms of time and clinical manifestation to determine which re-admitted patients require isolation.
NPSG.07.04.01
Implement evidence-based practices to prevent central line–associated bloodstream infections.

Note: This requirement covers short- and long-term central venous catheters and peripherally inserted central catheter (PICC) lines.

Elements of Performance for NPSG.07.04.01

1. Educate staff and licensed independent practitioners who are involved in managing central lines about central line–associated bloodstream infections and the importance of prevention. Education occurs upon hire or granting of initial privileges and periodically thereafter as determined by the organization. [R]

2. Prior to insertion of a central venous catheter, educate patients and, as needed, their families about central line–associated bloodstream infection prevention. [R]

3. Implement policies and practices aimed at reducing the risk of central line–associated bloodstream infections. These policies and practices meet regulatory requirements and are aligned with evidence-based standards (for example, the Centers for Disease Control and Prevention (CDC) and/or professional organization guidelines). [R]

4. Conduct periodic risk assessments for central line–associated bloodstream infections, monitor compliance with evidence-based practices, and evaluate the effectiveness of prevention efforts. The risk assessments are conducted in time frames defined by the hospital, and this infection surveillance activity is hospitalwide, not targeted. [R]

5. Provide central line–associated bloodstream infection rate data and prevention outcome measures to key stakeholders, including leaders, licensed independent practitioners, nursing staff, and other clinicians. [R]

6. Use a catheter checklist and a standardized protocol for central venous catheter insertion. [R]

7. Use a standardized supply cart or kit that contains all necessary components for the insertion of central venous catheters. [R]

8. Perform hand hygiene prior to catheter insertion or manipulation. [R]

9. Use maximum sterile barrier precautions during central venous catheter insertion. [R]
10. For adult patients, do not insert catheters into the femoral vein unless other sites are unavailable. 

11. Use an alcoholic chlorhexidine antiseptic for skin preparation during central venous catheter insertion unless contraindicated. 

12. Use a standardized protocol to disinfect catheter hubs and injection ports before accessing the ports. 

13. Evaluate all central venous catheters routinely and remove nonessential catheters. 

**NPSG.07.05.01**

Implement evidence-based practices for preventing surgical site infections.

**Elements of Performance for NPSG.07.05.01**

1. Educate staff and licensed independent practitioners involved in surgical procedures about surgical site infections and the importance of prevention. Education occurs upon hire, annually thereafter, and when involvement in surgical procedures is added to an individual’s job responsibilities. 

2. Educate patients, and their families as needed, who are undergoing a surgical procedure about surgical site infection prevention. 

3. Implement policies and practices aimed at reducing the risk of surgical site infections. These policies and practices meet regulatory requirements and are aligned with evidence-based guidelines (for example, the Centers for Disease Control and Prevention (CDC) and/or professional organization guidelines). 

4. As part of the effort to reduce surgical site infections: 
   - Conduct periodic risk assessments for surgical site infections in a time frame determined by the hospital.
   - Select surgical site infection measures using best practices or evidence-based guidelines.
   - Monitor compliance with best practices or evidence-based guidelines.
   - Evaluate the effectiveness of prevention efforts.

**Note:** Surveillance may be targeted to certain procedures based on the hospital’s risk assessment.
5. Measure surgical site infection rates for the first 30 or 90 days following surgical procedures based on National Healthcare Safety Network (NHSN) procedural codes. The hospital’s measurement strategies follow evidence-based guidelines.

**Note 1:** Surveillance may be targeted to certain procedures based on the hospital’s risk assessment.

**Note 2:** The NHSN is the Centers for Disease Control and Prevention’s health care–associated infection tracking system. NHSN provides facilities, states, regions, and the nation with data needed to identify problem areas, measure progress of prevention efforts, and ultimately eliminate health care–associated infections. For more information on NHSN procedural codes, see [http://www.cdc.gov/nhsn/CPTcodes/ssi-cpt.html](http://www.cdc.gov/nhsn/CPTcodes/ssi-cpt.html).

6. Provide process and outcome (for example, surgical site infection rate) measure results to key stakeholders.

7. Administer antimicrobial agents for prophylaxis for a particular procedure or disease according to methods cited in scientific literature or endorsed by professional organizations.

8. When hair removal is necessary, use a method that is cited in scientific literature or endorsed by professional organizations.

**NPSG.07.06.01**

Implement evidence-based practices to prevent indwelling catheter-associated urinary tract infections (CAUTI).

**Note:** Evidence-based guidelines for CAUTI are located at:
- Compendium of Strategies to Prevent Healthcare-Associated Infections in Acute Care Hospitals, 2014 at [http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=10312260&fulltextType=RA&fileId=S0899823X00193845](http://journals.cambridge.org/action/displayAbstract?fromPage=online&aid=10312260&fulltextType=RA&fileId=S0899823X00193845)

† A limited number of National Patient Safety Goals contain requirements for practices that reflect current science and medical knowledge. In these cases, the element of performance refers to a practice that is cited in scientific literature or endorsed by professional organizations. This means that the practice used by the hospital must be validated by an authoritative source. The authoritative source may be a study published in a peer-reviewed journal that clearly demonstrates the efficacy of that practice or endorsement of the practice by a professional organization(s) and/or a government agency(ies). It is not acceptable to follow a practice that is not supported by evidence or widespread consensus. During the on-site survey, surveyors will explore the source of the practices the hospital follows.
Elements of Performance for NPSG.07.06.01

1. Educate staff and licensed independent practitioners involved in the use of indwelling urinary catheters about CAUTI and the importance of infection prevention. Education occurs upon hire or granting of initial privileges and when involvement in indwelling catheter care is added to an individual’s job responsibilities. Ongoing education and competence assessment occur at intervals established by the organization.

2. Educate patients who will have an indwelling catheter, and their families as needed, on CAUTI prevention and the symptoms of a urinary tract infection.

   Note: See FAQs about “Catheter-associated Urinary Tract Infection” at http://www.shea-online.org/images/patients/NNL_CA-UTI.pdf

3. Develop written criteria, using established evidence-based guidelines, for placement of an indwelling urinary catheter. Written criteria are revised as scientific evidence changes.

   Note: Examples of criteria for placement of an indwelling urinary catheter include the following:
   - Critically ill patients who need accurate urinary output measurements
   - Patients with acute urinary retention or bladder outlet obstruction
   - Patients who require prolonged immobilization (for example, a potentially unstable thoracic or lumbar spine or multiple traumatic injuries such as pelvic fractures)
   - Incontinent patients with an open sacral wound or perineal wounds
   - Perioperative use for selected surgical procedures, such as patients undergoing urologic surgery or other surgery on contiguous structures of the genitourinary tract; patients who will have a prolonged duration of surgery (catheters inserted for this reason should be removed in a post-anesthesia care unit); patients anticipated to receive large-volume infusions or diuretics during surgery; patients needing intraoperative monitoring of urinary output
   - End-of-life care
Follow written procedures based on established evidence-based guidelines for inserting and maintaining an indwelling urinary catheter. The procedures address the following:

- Limiting use and duration
- Performing hand hygiene prior to catheter insertion or maintenance care
- Using aseptic techniques for site preparation, equipment, and supplies
- Securing catheters for unobstructed urine flow and drainage
- Maintaining the sterility of the urine collection system
- Replacing the urine collection system when required
- Collecting urine samples

Note: There are medical conditions that require a prolonged use of an indwelling urinary catheter in order to avoid adverse events and promote patient safety. Examples can include, but are not limited to, patients with a spinal cord injury, multiple sclerosis, Parkinson’s disease, and spina bifida.

Measure and monitor catheter-associated urinary tract infection prevention processes and outcomes in high-volume areas by doing the following:

- Selecting measures using evidence-based guidelines or best practices
- Having a consistent method for medical record documentation of indwelling urinary catheter use, insertion, and maintenance
- Monitoring compliance with evidence-based guidelines or best practices
- Evaluating the effectiveness of prevention efforts

Note: Surveillance may be targeted to areas with a high volume of patients using indwelling catheters. High-volume areas are identified through the hospital’s risk assessment as required in IC.01.03.01, EP 2.

Goal 15
The hospital identifies safety risks inherent in its patient population.

NPSG.15.01.01
Identify patients at risk for suicide.

Note: This requirement applies only to psychiatric hospitals and patients being treated for emotional or behavioral disorders in general hospitals.
Rationale for NPSG.15.01.01
Suicide of a patient 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 patient characteristics and environmental features that may increase or decrease the risk for suicide. ❍

2. Address the patient’s immediate safety needs and most appropriate setting for treatment. ❍

3. When a patient at risk for suicide leaves the care of the hospital, provide suicide prevention information (such as a crisis hotline) to the patient and his or her family. ❍
Introduction to the Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery™

The Universal Protocol applies to all surgical and nonsurgical invasive procedures. Evidence indicates that procedures that place the patient at the most risk include those that involve general anesthesia or deep sedation, although other procedures may also affect patient safety. Hospitals can enhance safety by correctly identifying the patient, the appropriate procedure, and the correct site of the procedure.

The Universal Protocol is based on the following principles:

- Wrong-person, wrong-site, and wrong-procedure surgery can and must be prevented.
- A robust approach using multiple, complementary strategies is necessary to achieve the goal of always conducting the correct procedure on the correct person, at the correct site.
- Active involvement and use of effective methods to improve communication among all members of the procedure team are important for success.
- To the extent possible, the patient and, as needed, the family are involved in the process.
- Consistent implementation of a standardized protocol is most effective in achieving safety.

The Universal Protocol is implemented most successfully in hospitals with a culture that promotes teamwork and where all individuals feel empowered to protect patient safety. A hospital should consider its culture when designing processes to meet the Universal Protocol. In some hospitals, it may be necessary to be more prescriptive on certain elements of the Universal Protocol or to create processes that are not specifically addressed within these requirements.

Hospitals should identify the timing and location of the preprocedure verification and site marking based on what works best for their own unique circumstances. The frequency and scope of the preprocedure verification will depend on the type and complexity of the procedure. The three components of the Universal Protocol are not necessarily presented in chronological order (although the preprocedure verification and site marking precede the final verification in the time-out). Preprocedure verification, site marking, and the time-out procedures should be as consistent as possible throughout the hospital.
Note: Site marking is not required when the individual doing the procedure is continuously with the patient from the time of the decision to do the procedure through to the performance of the procedure.

UP.01.01.01
Conduct a preprocedure verification process.

Rationale for UP.01.01.01
Hospitals should always make sure that any procedure is what the patient needs and is performed on the right person. The frequency and scope of the verification process will depend on the type and complexity of the procedure.

The preprocedure verification is an ongoing process of information gathering and confirmation. The purpose of the preprocedure verification process is to make sure that all relevant documents and related information or equipment are:
- Available prior to the start of the procedure
- Correctly identified, labeled, and matched to the patient’s identifiers
- Reviewed and are consistent with the patient’s expectations and with the team’s understanding of the intended patient, procedure, and site

Preprocedure verification may occur at more than one time and place before the procedure. It is up to the hospital to decide when this information is collected and by which team member, but it is best to do it when the patient can be involved.
Possibilities include the following:
- When the procedure is scheduled
- At the time of preadmission testing and assessment
- At the time of admission or entry into the facility for a procedure
- Before the patient leaves the preprocedure area or enters the procedure room

Missing information or discrepancies are addressed before starting the procedure.

Elements of Performance for UP.01.01.01
1. Implement a preprocedure process to verify the correct procedure, for the correct patient, at the correct site. R
   Note: The patient is involved in the verification process when possible.

2. Identify the items that must be available for the procedure and use a standardized list to verify their availability. At a minimum, these items include the following: R
- Relevant documentation (for example, history and physical, signed procedure consent form, nursing assessment, and preanesthesia assessment)
- Labeled diagnostic and radiology test results (for example, radiology images and scans, or pathology and biopsy reports) that are properly displayed
- Any required blood products, implants, devices, and/or special equipment for the procedure

Note: The expectation of this element of performance is that the standardized list is available and is used consistently during the preprocedure verification. It is not necessary to document that the standardized list was used for each patient.

3. Match the items that are to be available in the procedure area to the patient.

Introduction to UP.01.02.01

Wrong site surgery should never happen. Yet it is an ongoing problem in health care that compromises patient safety. Marking the procedure site is one way to protect patients; patient safety is enhanced when a consistent marking process is used throughout the hospital. Site marking is done to prevent errors when there is more than one possible location for a procedure. Examples include different limbs, fingers and toes, lesions, level of the spine, and organs. In cases where bilateral structures are removed (such as tonsils or ovaries) the site does not need to be marked.

Responsibility for marking the procedure site is a hotly debated topic. One position is that since the licensed independent practitioner is accountable for the procedure, he or she should mark the site. Another position is that other individuals should be able to mark the site in the interests of work flow and efficiency.

There is no evidence that patient safety is affected by the job function of the individual who marks the site. The incidence of wrong-site surgery is low enough that it is unlikely that valid data on this subject will ever be available. Furthermore, there is no clear consensus in the field on who should mark the site. Rather than remaining silent on the subject of site marking, The Joint Commission sought a solution that supports the purpose of the site mark. The mark is a communication tool about the patient for members of the team. Therefore, the individual who knows the most about the patient should mark the site. In most cases, that will be the person performing the procedure.
Recognizing the complexities of the work processes supporting invasive procedures, The Joint Commission believes that delegation of site marking to another individual is acceptable in limited situations as long as the individual is familiar with the patient and involved in the procedure. These include:

- Individuals who are permitted through a postgraduate education program to participate in the procedure
- A licensed individual who performs duties requiring collaborative or supervisory agreements with a licensed independent practitioner. These individuals include advanced practice registered nurses (APRNs) and physician assistants (PAs).

The licensed independent practitioner remains fully accountable for all aspects of the procedure even when site marking is delegated.

**UP.01.02.01**

Mark the procedure site.

**Elements of Performance for UP.01.02.01**

1. Identify those procedures that require marking of the incision or insertion site. At a minimum, sites are marked when there is more than one possible location for the procedure and when performing the procedure in a different location would negatively affect quality or safety. 

   **Note:** For spinal procedures, in addition to preoperative skin marking of the general spinal region, special intraoperative imaging techniques may be used for locating and marking the exact vertebral level.

2. Mark the procedure site before the procedure is performed and, if possible, with the patient involved.

3. The procedure site is marked by a licensed independent practitioner who is ultimately accountable for the procedure and will be present when the procedure is performed. In limited circumstances, the licensed independent practitioner may delegate site marking to an individual who is permitted by the organization to participate in the procedure and has the following qualifications:

   - An individual in a medical postgraduate education program who is being supervised by the licensed independent practitioner performing the procedure; who is familiar with the patient; and who will be present when the procedure is performed.
A licensed individual who performs duties requiring a collaborative agreement or supervisory agreement with the licensed independent practitioner performing the procedure (that is, an advanced practice registered nurse [APRN] or physician assistant [PA]); who is familiar with the patient; and who will be present when the procedure is performed.

**Note:** The hospital’s leaders define the limited circumstances (if any) in which site marking may be delegated to an individual meeting these qualifications.

4. The method of marking the site and the type of mark is unambiguous and is used consistently throughout the hospital.  

**Note:** The mark is made at or near the procedure site and is sufficiently permanent to be visible after skin preparation and draping. Adhesive markers are not the sole means of marking the site.

5. A written, alternative process is in place for patients who refuse site marking or when it is technically or anatomically impossible or impractical to mark the site (for example, mucosal surfaces or perineum).

**Note:** Examples of other situations that involve alternative processes include:

- Minimal access procedures treating a lateralized internal organ, whether percutaneous or through a natural orifice
- Teeth
- Premature infants, for whom the mark may cause a permanent tattoo

**UP.01.03.01**

A time-out is performed before the procedure.

**Rationale for UP.01.03.01**

The purpose of the time-out is to conduct a final assessment that the correct patient, site, and procedure are identified. This requirement focuses on those minimum features of the time-out. Some believe that it is important to conduct the time-out before anesthesia for several reasons, including involvement of the patient. A hospital may conduct the time-out before anesthesia or may add another time-out at that time. During a time-out, activities are suspended to the extent possible so that team members can focus on active confirmation of the patient, site, and procedure.
A designated member of the team initiates the time-out and it includes active communication among all relevant members of the procedure team. The procedure is not started until all questions or concerns are resolved. The time-out is most effective when it is conducted consistently across the hospital.

**Elements of Performance for UP.01.03.01**

1. Conduct a time-out immediately before starting the invasive procedure or making the incision. [R]

2. The time-out has the following characteristics: [R]
   - It is standardized, as defined by the hospital.
   - It is initiated by a designated member of the team.
   - It involves the immediate members of the procedure team, including the individual performing the procedure, the anesthesia providers, the circulating nurse, the operating room technician, and other active participants who will be participating in the procedure from the beginning.

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

4. During the time-out, the team members agree, at a minimum, on the following: [R]
   - Correct patient identity
   - The correct site
   - The procedure to be done

5. Document the completion of the time-out. [R]

*Note: The hospital determines the amount and type of documentation.*
Nursing (NR)

Overview
The quality of a hospital’s nursing services is built upon the leadership of a nurse executive and the work of a qualified staff. The nurse executive promotes quality by incorporating current nursing research findings, nationally recognized professional standards, and other expert literature into policies and procedures governing the provision of nursing care, treatment, and services.

The role of nursing has evolved significantly in response to marked changes in the health care industry. The nurse executive is largely accountable for the most substantial patient care work force of the hospital. Nurse executives routinely assume oversight responsibility for the provision of safe, effective, high-quality nursing care throughout the hospital; development, presentation, and management of the nursing services’ portion of the hospital’s budget; work team productivity; consumer satisfaction activities; and staff retention efforts.

To effectively fulfill this ever expanding role, today’s nurse executive demonstrates expertise in a range of areas (for example, strategic planning, negotiating, budgeting, marketing, trend variance analysis, information technology) in addition to demonstrating extensive knowledge of the current complexities of the health care industry.

Many of the standards in this chapter are linked to the “Leadership” (LD) chapter to clearly reflect the leadership role of the nurse executive.
Chapter Outline

I. Nurse Executive Role
   A. Authority (NR.01.01.01)
   B. Qualifications (NR.01.02.01)

II. Nursing Services
   A. Directing organizationwide nursing services (NR.02.01.01)
   B. Establishing guidelines for nursing care delivery (NR.02.02.01)
   C. Providing nursing care, treatment, and services (NR.02.03.01)
Standards, Rationales, and Elements of Performance

Standard NR.01.01.01
The nurse executive directs the delivery of nursing care, treatment, and services.

Rationale for NR.01.01.01
Nurses make up the front line of patient care; they are directly and intimately involved in the care, treatment, and services patients receive and are likely to be the most visible face of health care for patients who enter the hospital. As a leader in the health care delivery system, the nurse executive is vital to the establishment of a cohesive and collaborative nursing-care team, and ultimately, to the hospital that wishes to maintain safe, quality patient care. The nurse executive is also vital to the continuity of care each patient receives. In order to improve organizationwide quality in nursing care, treatment, and services, the nurse executive must assume an active leadership role in the hospital.

Elements of Performance for NR.01.01.01
1. The nurse executive functions at the senior leadership level to provide effective leadership and to coordinate leaders to deliver nursing care, treatment, and services. (See also LD.04.01.05, EP 5)

3. An identified nurse leader, at the executive level, assumes an active leadership role with the hospital’s governing body, senior leadership, medical staff, management, and other clinical leaders in the hospital’s decision-making structure and process. (See also LD.01.01.01, EP 3; LD.01.02.01, EP 1; LD.01.03.01, EP 5; LD.01.04.01, EP 5; LD.04.01.03, EP 1)

5. The hospital defines the nurse executive’s authority and responsibility in a written contract, written agreement, letter, memorandum, job or position description, or other document. (See also LD.04.01.05, EP 3)

Standard NR.01.02.01
The nurse executive is a licensed professional registered nurse qualified by advanced education and management experience.

Elements of Performance for NR.01.02.01
2. The nurse executive is currently licensed as a registered professional nurse in the state in which he or she practices, in accordance with law and regulation.
3. The nurse executive possesses a postgraduate degree in nursing or a related field; or the knowledge and skills associated with an advanced degree; or a written plan to obtain these qualifications.

   Note: A related field may include health care administration or business administration.

**Standard NR.02.01.01**
The nurse executive directs the hospital’s nursing services.

**Elements of Performance for NR.02.01.01**

2. The nurse executive coordinates: The development of hospitalwide programs, policies, and procedures that address how nursing care needs of the patient population are assessed, met, and evaluated.

   Note: Examples of patient populations include pediatric, diabetic, and geriatric patients.

3. The nurse executive coordinates: The development of an effective, ongoing program to measure, analyze, and improve the quality of nursing care, treatment, and services. (*See also* LD.03.02.01, EP 5)

4. The nurse executive directs: The implementation of hospitalwide plans to provide nursing care, treatment, and services.

5. The nurse executive directs: The implementation of hospitalwide programs, policies, and procedures that address how nursing care needs of the patient population are assessed, met, and evaluated.

   Note: Examples of patient populations include pediatric, diabetic, and geriatric patients.

6. The nurse executive directs: The implementation of an effective, ongoing program to measure, analyze, and improve the quality of nursing care, treatment, and services. (*See also* LD.03.02.01, EP 5)

**Standard NR.02.02.01**
The nurse executive establishes guidelines for the delivery of nursing care, treatment, and services.
Elements of Performance for NR.02.02.01

1. ☐ The nurse executive, registered nurses, and other designated nursing staff write: Standards of nursing practice for the hospital.

2. ☐ The nurse executive, registered nurses, and other designated nursing staff write: Nursing standards of patient care, treatment, and services.

3. ☐ The nurse executive, registered nurses, and other designated nursing staff write: Nursing policies and procedures.

4. ☐ The nurse executive, registered nurses, and other designated nursing staff write: Nurse staffing plan(s). (Refer to LD.04.03.11, EP 6)

Standard NR.02.03.01

The nurse executive directs the implementation of nursing policies and procedures, nursing standards, and a nurse staffing plan(s).

Elements of Performance for NR.02.03.01

1. The nurse executive or designee approves nursing policies; nursing standards of patient care, treatment, and services; and standards of nursing practice for the hospital before implementation. (See also LD.04.01.07, EP 1)

2. The nurse executive implements nursing policies, procedures, and standards that describe and guide how the staff provide nursing care, treatment, and services. (See also LD.04.01.07, EP 2)

3. The nurse executive provides access to all nursing policies, procedures, and standards to the nursing staff.

4. The nurse executive is responsible for the provision of nursing services 24 hours a day, 7 days a week.

6. The nurse executive or designee exercises final authority over staff who provide nursing care, treatment, and services.

7. A registered nurse provides or supervises the nursing services 24 hours a day, 7 days a week.

8. For hospitals that use Joint Commission accreditation for deemed status purposes: A registered nurse assigns the nursing care for each patient to other nursing personnel in accordance with the patient’s needs and the qualifications and competence of the nursing staff available.
Provision of Care, Treatment, and Services (PC)

Overview
The standards in the “Provision of Care, Treatment, and Services” (PC) chapter center around the integrated and cyclical process that allows care to be delivered according to patient needs and the hospital’s scope of services. This care process may occur between multiple organizations or it may be limited to the organization itself. The complexity of providing care, treatment, and services through this process often demands an interdisciplinary collaborative approach and a mutual effort among those who work in the organization to coordinate care in a manner that is conducive to optimal patient outcomes, quality, and safety.

The provision of care, treatment, and services is composed of four core components of the care process:
1. Assessing patient needs
2. Planning care, treatment, and services
3. Providing care, treatment, and services
4. Coordinating care, treatment, and services

Within these core processes, care activities include the following:
- Providing access to levels of care and/or disciplines necessary to meet the patient’s needs
- Interventions based on the plan of care, including the education or instruction of patients regarding their care, treatment, and services
- Coordinating care to promote continuity when patients are referred, discharged, or transferred

The activities are performed by a wide variety of staff and licensed independent practitioners. Therefore, communication, collaboration, and coordination are among the most important work habits that must be adopted so that care, treatment, and services are provided at the highest level.
About This Chapter
The standards in this chapter are placed within a logical framework that demonstrates the continuum of care as a cyclical process that may occur over short or long periods of time and may be continual or episodic in nature. Therefore, the standards are organized to relate to the patient’s experience from entry into the hospital to discharge or transfer.

This chapter addresses the following:
- Accepting the patient for care, treatment and services
- Assessing and reassessing the patient
- Planning the patient’s care
- Providing the patient with care, treatment, and services
- Coordinating the patient’s care, treatment, and services
- Providing the patient with education
- Planning the patient’s operative or other high-risk procedures, including those that require the administration of moderate or deep sedation
- Caring for the patient who requires the use of restraint for non–behavioral health purposes
- Caring for the patient who requires the use of restraint or seclusion for behavioral health purposes
- Meeting the patient’s need for continuing care, treatment, and services after discharge or transfer
Chapter Outline

I. Plan
   A. Admission to the Organization (PC.01.01.01)
   B. Assessment (Screening) (PC.01.02.01, PC.01.02.03, PC.01.02.05, PC.01.02.07, PC.01.02.08, PC.01.02.09, PC.01.02.11, PC.01.02.13, PC.01.02.15)
   C. Planning Care (PC.01.03.01, PC.01.03.03, PC.01.03.05)

II. Implement
   A. Providing Care (PC.02.01.01, PC.02.01.03, PC.02.01.05, PC.02.01.11, PC.02.01.19, PC.02.01.21)
   B. Coordinating Care (PC.02.02.01, PC.02.02.03, PC.02.02.09, PC.02.02.13)
   C. Patient Education (PC.02.03.01)
   D. Primary Care Medical Home (PC.02.04.01, PC.02.04.03, PC.02.04.05)

III. Special Conditions
   A. Special Procedures (PC.03.01.01, PC.03.01.03, PC.03.01.05, PC.03.01.07, PC.03.01.08, PC.03.01.09)
   B. Restraint and Seclusion (PC.03.05.01, PC.03.05.03, PC.03.05.05, PC.03.05.07, PC.03.05.09, PC.03.05.11, PC.03.05.13, PC.03.05.15, PC.03.05.17, PC.03.05.19)

IV. Discharge and Transfer
   A. Discharge Planning (PC.04.01.01, PC.04.01.03, PC.04.01.05)
   B. Continuity of Care (PC.04.02.01)

V. Blood Safety
   A. Potentially Infectious Blood (PC.05.01.09)
Standards, Rationales, and Elements of Performance

Standard PC.01.01.01
The hospital accepts the patient for care, treatment, and services based on its ability to meet the patient’s needs.

Elements of Performance for PC.01.01.01
The hospital has a written process for accepting a patient that includes the following:

2. Criteria to determine the patient’s eligibility for care, treatment, and services.


4. Hospitals that do not primarily provide psychiatric or substance abuse services have a written plan that defines the care, treatment, and services or the referral process for patients who are emotionally ill or who suffer the effects of alcoholism or substance abuse.

5. The hospital provides or refers patients who are emotionally ill or who suffer from alcoholism or substance abuse for care, treatment, and services, consistent with its written plan.

6. Administrative and clinical decisions are coordinated for patients under legal or correctional restrictions on the following:
   - The use of seclusion and restraint for nonclinical purposes
   - The imposition of disciplinary restrictions
   - The restriction of rights
   - The plan for discharge and continuing care, treatment, and services
   - The length of stay

7. The hospital follows its written process for accepting a patient for care, treatment, and services.

24. If a patient is boarded while awaiting care for emotional illness and/or the effects of alcoholism or substance abuse, the hospital does the following:
   - Provides for a location for the patient that is safe, monitored, and clear of items that the patient could use to harm himself or herself or others. (Refer to LD.04.03.11, EP 6; NPSG.15.01.01, EPs 1 and 2)
- Provides orientation and training to any clinical and nonclinical staff caring for such patients in effective and safe care, treatment, and services (for example, medication protocols, de-escalation techniques). (Refer to HR.01.06.01, EP 1)
- Conducts assessments and reassessments, and provides care consistent with the patient’s identified needs.

**Introduction to Standard PC.01.02.01**

The goal of assessment is to determine the care, treatment, and services that will meet the patient’s initial and continuing needs. Patient needs must be reassessed throughout the course of care, treatment, and services.

Identifying and delivering the right care, treatment, and services depends on the following three processes:

1. Collecting information about the patient’s health history as well as physical, functional, and psychosocial status
2. Analyzing the information in order to understand the patient’s needs for care, treatment, and services
3. Making care, treatment, and services decisions based on the analysis of information collected

The depth and frequency of assessment depends on a number of factors, including the patient’s needs, program goals, and the care, treatment, and services provided. Assessment activities may vary between settings, as defined by the hospital’s leaders.

Information gathered at the patient’s first contact may indicate the need for more data or a more intensive assessment. At a minimum, the need for further assessment is determined by the care, treatment, and services sought; the patient’s presenting condition(s); and whether the patient agrees to the recommended care, treatment, and services.

**Standard PC.01.02.01**

The hospital assesses and reassesses its patients.
Elements of Performance for PC.01.02.01

1. ☐ The hospital defines, in writing, the scope and content of screening, assessment, and reassessment. Patient information is collected according to these requirements.

   **Note 1:** In defining the scope and content of the information it collects, the organization may want to consider information that it can obtain, with the patient’s consent, from the patient’s family and the patient’s other care providers, as well as information conveyed on any medical jewelry.

   **Note 2:** Assessment and reassessment information includes the patient’s perception of the effectiveness of, and any side effects related to, his or her medication(s).

2. ☐ The hospital defines, in writing, criteria that identify when additional, specialized, or more in-depth assessments are performed.

   **Note:** Examples of criteria could include those that identify when a nutritional, functional, or pain assessment should be performed for patients who are at risk.

3. The hospital has defined criteria that identify when nutritional plans are developed.

Standard PC.01.02.03

The hospital assesses and reassesses the patient and his or her condition according to defined time frames.

Elements of Performance for PC.01.02.03

1. ☐ The hospital defines, in writing, the time frame(s) within which it conducts the patient’s initial assessment, in accordance with law and regulation. *(See also RC.01.03.01, EP 1)*

2. The hospital performs initial patient assessments within its defined time frame. *(See also RC.01.03.01, EP 3)*

3. Each patient is reassessed as necessary based on his or her plan for care or changes in his or her condition.

   **Note:** Reassessments may also be based on the patient’s diagnosis; desire for care, treatment, and services; response to previous care, treatment, and services; discharge planning needs; and/or his or her setting requirements.
4. The patient receives a medical history and physical examination no more than 30
days prior to, or within 24 hours after, registration or inpatient admission, but
prior to surgery or a procedure requiring anesthesia services. *(See also
MS.03.01.01, EP 6; RC.02.01.03, EP 3)*

5. For a medical history and physical examination that was completed within 30
days prior to registration or inpatient admission, an update documenting any
changes in the patient’s condition is completed within 24 hours after registration
or inpatient admission, but prior to surgery or a procedure requiring anesthesia
services. *(See also MS.03.01.01, EP 8; RC.02.01.03, EP 3)*

6. A registered nurse completes a nursing assessment within 24 hours after the
patient’s inpatient admission. *(See also RC.02.01.01, EP 2)*

**Standard PC.01.02.05**
Qualified staff or licensed independent practitioners assess and reassess the patient.

**Element of Performance for PC.01.02.05**
1. Based on the initial assessment, a registered nurse determines the patient’s need
for nursing care, as required by hospital policy and law and regulation.

**Introduction to Standard PC.01.02.07**
The identification and management of pain is an important component of patient-
centered care. Patients have the right to pain management *(See Standard RI.01.01.01,
EP 8)* and can expect that their health care providers will involve them in the assessment
and management of pain. It is essential to provide care that meets the patient’s identified
needs while mitigating potential harm.

The misidentification and undertreatment of pain continues to occur in hospitals. When
a patient presents to the hospital for other medical issues, pain may be overlooked or
missed. Screening patients for pain during emergency room visits or at the time of
admission will help to improve pain identification and treatment. Pain causes
physiologic, psychologic, and emotional effects. These effects are variable depending on
the patient’s age, past experience with pain, psychological characteristics, and sociocultu-
ral background. For example, a patient who is very anxious about his or her pain may

overestimate the severity of pain, which if not recognized could lead to overtreatment. Conversely, patient underreporting of pain (for example, due to stoicism or concerns about side effects) may lead to undertreatment.

When a screening for pain is positive, a pain assessment is required for determining a plan for pain management. The hospital is responsible for ensuring that appropriate screening and assessment tools are readily available and used appropriately. The tools required to adequately assess pain may differ depending on a patient’s age, condition, and ability to understand; for example, adult intensive care unit (ICU) patients who are unable to self-report and pediatric patients require the use of alternative assessment tools.

Pain management strategies should consider the patient’s current presentation, past medical history, and input on treatment options, in addition to the health care provider’s clinical judgment and the risks and benefits associated with the strategies, including the risk of dependency, addiction, and abuse. In many clinical situations, complete elimination of pain is not a reasonable expectation or goal. Patient involvement in planning pain management involves information sharing and collaboration between the patient and provider to arrive at realistic expectations and clear goals. Patient involvement also allows the provider to clarify the objectives of the process, listen for and respond to patient questions, and guide patients in a manner that increases the likelihood of treatment adherence.

Complex and high-risk patients may require additional pain management strategies designed to optimize safe, effective care such as the following:

- Referrals for patients with complex pain management needs such as the opioid-addicted patient, patients that require treatment with opioids who are at high risk for adverse events, or a patient with pain management needs that exceed the expertise of the patient’s attending licensed independent practitioner.
- Patients who have been prescribed opioids and deemed high risk by clinical staff must be monitored for adverse events associated with opioid use, using monitoring equipment as determined by organizational policy.

Reassessment should be completed in a timely manner to determine if the intervention is working or if the patient is experiencing adverse effects. Using numerical pain scales alone to monitor patients’ pain is inadequate. It is important to assess how pain affects the patient’s function and ability to make progress toward treatment goals. For example, immediately after major abdominal surgery, the goal of pain control may be the patient’s
ability to take a breath without excessive pain. Over the next few days, the goal of pain control may be the ability to sit up in bed or walk to the bathroom without limitation due to pain.

During the discharge process, patients and families need education on the importance of how to manage the patient’s pain at home. Unmanaged pain may cause a patient to regress in his or her recovery process or have uncontrolled pain at home leading to a readmission to the hospital. A discussion with patients and their families is necessary regarding their home environment and activities of daily living that may increase the need for pain management. When a patient is being discharged with a prescription for an opioid, medication education on safe use, including when and how much pain medication to take, should be included in the discharge plan. Opioid disposal education is also critical in order to both reduce diversion and decrease the risk of accidental exposure to someone other than the person for whom the opioid was prescribed. For more information on disposal of medications, the US Food and Drug Administration (FDA) has disseminated medication disposal guidelines: (http://www.fda.gov/downloads/Drugs/ResourcesForYou/Consumers/BuyingUsingMedicineSafely/UnderstandingOver-the-CounterMedicines/ucm107163.pdf ).

**Standard PC.01.02.07**
The hospital assesses and manages the patient’s pain and minimizes the risks associated with treatment.

**Elements of Performance for PC.01.02.07**

1. ☑️ The hospital has defined criteria to screen, assess, and reassess pain that are consistent with the patient’s age, condition, and ability to understand.  
2. The hospital screens patients for pain during emergency department visits and at the time of admission.  
3. The hospital treats the patient’s pain or refers the patient for treatment.  

   **Note:** Treatment strategies for pain may include nonpharmacologic, pharmacologic, or a combination of approaches.

4. ☑️ The hospital develops a pain treatment plan based on evidence-based practices and the patient’s clinical condition, past medical history, and pain management goals.

5. ☑️ The hospital involves patients in the pain management treatment planning process through the following:
- Developing realistic expectations and measurable goals that are understood by the patient for the degree, duration, and reduction of pain.
- Discussing the objectives used to evaluate treatment progress (for example, relief of pain and improved physical and psychosocial function).
- Providing education on pain management, treatment options, and safe use of opioid and non-opioid medications when prescribed.

(See also RI.01.02.01, EPs 2–4, 8; RI.01.03.01, EP 1)

6. The hospital monitors patients identified as being high risk for adverse outcomes related to opioid treatment. (See also LD.04.03.13, EP 7)

7. The hospital reassesses and responds to the patient’s pain through the following:
   - Evaluation and documentation of response(s) to pain intervention(s) (See also RC.01.01.01, EP 7)
   - Progress toward pain management goals including functional ability (for example, ability to take a deep breath, turn in bed, walk with improved pain control)
   - Side effects of treatment
   - Risk factors for adverse events caused by the treatment

8. The hospital educates the patient and family on discharge plans related to pain management including the following:
   - Pain management plan of care
   - Side effects of pain management treatment
   - Activities of daily living, including the home environment, that might exacerbate pain or reduce effectiveness of the pain management plan of care, as well as strategies to address these issues
   - Safe use, storage, and disposal of opioids when prescribed

**Standard PC.01.02.08**
The hospital assesses and manages the patient’s risks for falls.

**Elements of Performance for PC.01.02.08**

1. The hospital assesses the patient’s risk for falls based on the patient population and setting.  

2. The hospital implements interventions to reduce falls based on the patient’s assessed risk.
Standard **PC.01.02.09**
The hospital assesses the patient who may be a victim of possible abuse and neglect.

**Rationale for PC.01.02.09**
Family violence and child and elder abuse are frequently reported. A study published by the Centers for Disease Control and Prevention (CDC) estimates that “intimate partner abuse” results each year in 2 million injuries to women and 600,000 injuries among men. The National Center on Elder Abuse references a study that estimates that between 1 and 2 million Americans age 65 or older have been injured, exploited, or otherwise mistreated by someone on whom they depended for care or protection.

National Consensus Guidelines produced by The Family Violence Prevention Fund points out that “most Americans are seen at some point by a health care provider, and the health care setting offers a critical opportunity for early identification and even the primary prevention of abuse.” People who are victims of abuse or neglect may come to an organization for a variety of reasons. Sometimes the reason a patient seeks health care is not connected to his or her experience with abuse or neglect. By assessing patients who may be possible victims of abuse or neglect, health care organizations fulfill an important role in helping to protect patients.

**Elements of Performance for PC.01.02.09**

1. ☐ The hospital has written criteria to identify those patients who may be victims of physical assault, sexual assault, sexual molestation, domestic abuse, or elder or child abuse and neglect. *(See also RI.01.06.03, EP 2)*  
   **Note:** Criteria can be based on age, sex, and circumstance.

2. ☐ To assist with referrals of possible victims of abuse and neglect, the hospital maintains a list of private and public community agencies that can provide or arrange for assessment and care.

3. The hospital educates staff about how to recognize signs of possible abuse and neglect and about their roles in follow-up.

4. The hospital uses its criteria to identify possible victims of abuse and neglect upon entry into the hospital and on an ongoing basis.

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6. The hospital internally reports cases of possible abuse and neglect. *(See also RI.01.06.03, EP 3)*

7. The hospital reports cases of possible abuse and neglect to external agencies, in accordance with law and regulation. *(See also RI.01.06.03, EP 3)*

8. **For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds:** The hospital reports to the state nurse aide registry or licensing authorities any knowledge it has of any actions taken by a court of law against an employee that would indicate unfitness for service as a nurse aide or other facility staff.

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### Introduction to Standard PC.01.02.11

The foundation of addiction treatment planning is the patient’s assessment. The following standards and elements of performance (EPs) list essential characteristics of a comprehensive assessment process. The goal of the assessment process is to identify for each patient his or her addictive behavior history; patterns of substance use; the impact of addictive behavior on all life domains, including family relationships; and any coexisting physical or mental illness.

### Standard PC.01.02.11

The hospital assesses the needs of patients who receive psychosocial services to treat alcoholism or other substance use disorders.

### Elements of Performance for PC.01.02.11

1. Patients receiving psychosocial services for the treatment of alcoholism or other substance use disorders receive an assessment that includes: The patient’s history of each substance use, including age of onset, duration, intensity, patterns of use, consequences of use, types of previous treatments, and responses to such treatment.

2. Patients receiving psychosocial services for the treatment of alcoholism or other substance use disorders receive an assessment that includes: A history of the patient’s mental, emotional, and behavioral problems; their co-occurrence with substance use disorders; and their treatment.
3. Patients receiving psychosocial services for the treatment of alcoholism or other substance use disorders receive an assessment that includes: A history of the patient’s biomedical complications associated with his or her substance use disorders and the patient’s level of awareness of the relationships between his or her behavioral conditions and his or her pattern of substance use.

4. Based on the patient’s age and needs, the assessment for patients receiving psychosocial services for the treatment of alcoholism or other substance use disorders includes: The patient’s acceptance of treatment or motivation for change, as well as recovery environment features that serve as resources or obstacles to recovery, including family members’ use of alcohol or other substances.

5. Based on the patient’s age and needs, the assessment for patients receiving psychosocial services for the treatment of alcoholism or other substance use disorders includes the following:
   - The patient’s religion and spiritual beliefs, values, and preferences
   - Living situation
   - Leisure and recreational activities
   - Military service history
   - Peer-group
   - Social factors
   - Ethnic and cultural factors
   - Financial status
   - Vocational or educational background
   - Legal history
   - Communication skills

6. Based on the patient’s age and needs, the assessment for patients receiving psychosocial services for the treatment of alcoholism or other substance use disorders includes the following:
   - The patient’s history of any physical or sexual abuse, as either the abuser or the abused
   - The patient’s sexual history and identification
   - Childhood history
   - Emotional and health issues
   - Visual-motor functioning
   - Self care
7. Based on the patient’s age and needs, the assessment for patients receiving psychosocial services for the treatment of alcoholism or other substance use disorders includes: The patient’s family circumstances, including the composition of the family group and the need for their participation in the patient’s care.

**Introduction to Standard PC.01.02.13**

The assessment of patients who are seeking care, treatment, and services for emotional or behavioral disorders provides the foundation for their individualized care and future care needs. The following standard and EPs address the patient’s current level of functioning in all of his or her life domains. The assessment data and information provide the basis for determining immediate treatment, assessing the patient’s progress, and planning for post-hospitalization support.

**Standard PC.01.02.13**

The hospital assesses the needs of patients who receive treatment for emotional and behavioral disorders.

**Elements of Performance for PC.01.02.13**

1. Patients who receive treatment for emotional and behavioral disorders receive an assessment that includes a history of mental, emotional, behavioral, and substance use problems, their co-occurrence, and their treatment.

2. Patients who receive treatment for emotional and behavioral disorders receive an assessment that includes the following:
   - Current mental, emotional, and behavioral functioning
   - Maladaptive or other behaviors that create a risk to the patient or others
   - Mental status examination
   - **For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes:** Reason for admission as stated by the patient and/or others significantly involved in the patient’s care
   - **For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes:** Onset of the patient’s illness and circumstances leading to admission
3. Based on the patient’s age and needs, the assessment for patients who receive treatment for emotional and behavioral disorders includes the following:
   - The patient’s religion and spiritual beliefs, values, and preferences
   - Living situation
   - Leisure and recreational activities
   - Military service history
   - Peer-group
   - Social factors
   - Ethnic and cultural factors
   - Financial status
   - Vocational or educational background
   - Legal history
   - Communication skills

4. Based on the patient’s age and needs, the assessment for patients who receive treatment for emotional and behavioral disorders includes the following:
   - Any history of physical or sexual abuse as either the abuser or abused
   - The patient’s sexual history
   - Childhood history
   - Emotional and health care issues
   - Visual-motor functioning
   - Self care

5. Based on the patient’s age and needs, the assessment for patients who receive treatment for emotional and behavioral disorders includes the following:
   - The patient’s family circumstances, including the composition of the family group
   - The community resources currently used by the patient
   - The need for the family members’ participation in the patient’s care
   - For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: A social history and reports of interviews with patients, family members, and others
6. Based on the patient’s age and needs, the assessment for patients who receive treatment for emotional and behavioral disorders includes the following:
   - A psychiatric evaluation
   - Psychological assessments, including intellectual, projective, neuropsychological, and personality testing
   - For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Complete neurological examination at the time of the admission physical examination, when indicated (For more information on physical examination, see PC.01.02.03, EP 4)

7. For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Each patient receives a psychiatric evaluation completed within 60 hours of admission.

**Standard PC.01.02.15**
The hospital provides for diagnostic testing.

**Elements of Performance for PC.01.02.15**

2. Diagnostic testing and procedures are performed as ordered within time frames defined by the hospital.

5. The hospital documents the radiation dose index (computed tomography dose index [CTDIvol], dose length product [DLP], or size-specific dose estimate [SSDE]) on every study produced during a diagnostic computed tomography (CT) examination. The radiation dose index must be exam specific, summarized by series or anatomic area, and documented in a retrievable format.

**Note 1:** This element of performance is only applicable for systems capable of calculating and displaying radiation dose indices.

**Note 2:** This element of performance does not apply to systems used for therapeutic radiation treatment planning or delivery, or for calculating attenuation coefficients for nuclear medicine studies.

**Note 3:** This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.

**Note 4:** While the CTDIvol, DLP, and SSDE are useful indicators for monitoring radiation dose indices from the CT machine, they do not represent the patient’s radiation dose.
10. **For hospitals that provide diagnostic computed tomography (CT), magnetic resonance imaging (MRI), positron emission tomography (PET), or nuclear medicine (NM) services:** Prior to conducting a diagnostic imaging study, the hospital verifies the following:
   - Correct patient
   - Correct imaging site
   - Correct patient positioning
   - **For CT only:** Correct imaging protocol
   - **For CT only:** Correct scanner parameters

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

12. **For hospitals that provide diagnostic computed tomography (CT), magnetic resonance imaging (MRI), positron emission tomography (PET), or nuclear medicine (NM) services:** The hospital considers the patient’s age and recent imaging exams when deciding on the most appropriate type of imaging exam.

   **Note 1:** Knowledge of a patient’s recent imaging exams can help to prevent unnecessary duplication of these examinations.

   **Note 2:** This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.

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**Introduction to Standard PC.01.03.01**

Planning for care, treatment, and services is individualized to meet the patient’s unique needs. The first step in the process includes creating an initial plan for care, treatment, and services that is appropriate to the patient’s specific assessed needs. To continue to meet the patient’s unique needs, the plan is maintained and revised based on the patient’s response. The plan may be modified or terminated based on reassessment; the patient’s need for further care, treatment, and services; or the patient’s achievement of goals. The modification of the plan for care, treatment, and services may result in planning for the patient’s transfer to another setting or discharge.
Standard PC.01.03.01

The hospital plans the patient’s care.

Elements of Performance for PC.01.03.01

1. The hospital plans the patient’s care, treatment, and services based on needs identified by the patient’s assessment, reassessment, and results of diagnostic testing. *(See also PC.01.02.13, EP 2)*

5. The written plan of care is based on the patient’s goals and the time frames, settings, and services required to meet those goals.

**Note:** For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The patient’s goals include both short- and long-term goals.

6. For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The written plan of care includes the following:
   - A substantiated diagnosis (The substantiated diagnosis is the diagnosis identified by the treatment team to be the primary focus upon which treatment planning will be based. It evolves from the synthesis of data from various disciplines. The substantiated diagnosis may be the same as the initial diagnosis or it may differ, based on new information and assessment.)
   - Documentation to justify the diagnosis and the treatment and rehabilitation activities carried out
   - Documentation that demonstrates all active therapeutic efforts are included
   - The specific treatment modalities used to treat the patient

22. Based on the goals established in the patient’s plan of care, staff evaluate the patient’s progress.

23. The hospital revises plans and goals for care, treatment, and services based on the patient’s needs. *(See also RC.02.01.01, EP 2)*

25. The hospital establishes or adopts diagnostic computed tomography (CT) imaging protocols based on current standards of practice, which address key criteria including clinical indication, contrast administration, age (to indicate whether the patient is pediatric or an adult), patient size and body habitus, and the expected radiation dose index range.

**Note:** This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.
26. Diagnostic computed tomography (CT) imaging protocols are reviewed and kept current with input from an interpreting physician, medical physicist, and lead imaging technologist to make certain that they adhere to current standards of practice and account for changes in CT imaging equipment. These reviews are conducted at time frames identified by the hospital. (For hospitals that use Joint Commission accreditation for deemed status purposes, refer to MS.06.01.03, EP 9 for supervision of radiologic services)

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

43. **For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes:** The plan of care includes the responsibilities of each member of the treatment team.

44. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** Patient self-management goals are identified, agreed upon with the patient, and incorporated into the patient’s treatment plan. (Refer to RI.01.02.01, EP 1)

45. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home uses clinical decision support tools to guide decision making. (Refer to LD.04.04.07, EPs 2–5)

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**Introduction to Standard PC.01.03.03 and Standard PC.01.03.05**

Behavior management and treatment interventions should be therapeutic interventions that foster adaptive behaviors. They should not be used exclusively for behavior control. Policies and procedures should require that the selection of interventions consider both appropriateness and minimizing restrictiveness of interventions.

**Standard PC.01.03.03**

The hospital defines its patient behavior management policies.
Elements of Performance for PC.01.03.03

1. The hospital’s written behavior management policies describe the conditions under which specific behavior management procedures can and cannot be used.

2. The hospital’s written behavior management policies disallow the use of any procedure that could physically harm the patient or place him or her at psychological risk.

3. The hospital’s written behavior management policies include the following:
   - Limit patient time-outs to no more than 30 minutes in an unlocked room.
   - Prohibit the use of intimidation, force, or threat.
   - Require that the patient receive education about the conditions under which time-outs are used.

4. The hospital prohibits the following:
   - The denial of the patient’s basic needs, such as the denial of a nutritious diet and water
   - The denial of shelter
   - The denial of essential, safe clothing
   - The use of corporal punishment
   - The use of fear-eliciting techniques
   - The use of mechanical restraint and seclusion
   - Any procedures that allow another patient to implement behavior management and treatment techniques on other patients

Note 1: The use of mechanical restraint and seclusion as treatment interventions is prohibited except for patients who exhibit intractable behavior that is severely self-injurious or injurious to others, who have not responded to traditional interventions, and who are unable to contract with staff for safety (that is, understand the concept of, and act on, criteria for the discontinuation of restraint or seclusion).

Note 2: When restraint or seclusion is used in an emergency situation, its use needs to be in compliance with Standards PC.03.05.01 through PC.03.05.17.

5. The hospital’s written behavior management policies on the use of aversive procedures are reviewed and approved by clinical leaders and a person(s) external to the hospital, such as an expert in the use of aversive procedures, a patient advocate, or a human rights committee. (See also PC.01.03.05, EP 6)
Standard PC.01.03.05
The hospital’s use of behavior management procedures adhere to the patient’s plan for care, treatment, and services and organization policy.

Elements of Performance for PC.01.03.05
1. Behavior management procedures, when used, are part of the patient’s plan of care.

2. The hospital includes in the patient plan of care for behavior management the following:
   - Target behavior(s)
   - Adaptive or replacement behavior(s)
   - Interventions
   - Criteria for discontinuation of behavior management procedures
   - Behavior management techniques used

3. The patient and, based on his or her plan of care, the family participate in selecting behavior management and treatment interventions.

4. Qualified staff review, evaluate, and approve the use of all behavior management procedures.

6. Time-outs and procedures using restraining devices or aversive techniques are used only in a manner consistent with the patient’s plan of care, policies and procedures, and state and federal laws. (See also PC.01.03.03, EP 5) R

8. When restrictive behavior management techniques are necessary, the hospital chooses the least restrictive technique from among those that are approved for use before progressing to more restrictive behavior management techniques.

Standard PC.02.01.01
The hospital provides care, treatment, and services for each patient.

Elements of Performance for PC.02.01.01
1. The hospital provides the patient with care, treatment, and services according to his or her individualized plan of care. R

5. For hospitals that use Joint Commission accreditation for deemed status purposes: A registered nurse supervises and evaluates the nursing care for each patient.
15. **For hospitals that use Joint Commission accreditation for deemed status purposes:** Blood transfusions and intravenous medications are administered in accordance with state law and approved medical staff policies and procedures.

16. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** Each patient has a designated primary care clinician.

**Standard PC.02.01.03**

The hospital provides care, treatment, and services as ordered or prescribed, and in accordance with law and regulation.

**Elements of Performance for PC.02.01.03**

1. **For hospitals that use Joint Commission accreditation for deemed status purposes:** Prior to providing care, treatment, and services, the hospital obtains or renews orders (verbal or written) from a licensed independent practitioner or other practitioner in accordance with professional standards of practice; law and regulation; hospital policies; and medical staff bylaws, rules, and regulations.‡

   **Note 1:** Outpatient services may be ordered by a practitioner not appointed to the medical staff as long as he or she meets the following:

   - Responsible for the care of the patient
   - Licensed to practice in the state where he or she provides care to the patient or in accordance with Veterans Administration and Department of Defense licensure requirements
   - Acting within his or her scope of practice under state law
   - Authorized in accordance with state law and policies adopted by the medical staff and approved by the governing body to order the applicable outpatient services

   **Note 2:** For hospitals that use Joint Commission accreditation for deemed status purposes: Patient diets, including therapeutic diets, are ordered by the practitioner responsible for the patient’s care, or by a qualified dietitian or qualified nutrition professional who is authorized by the medical staff and acting in accordance with state law governing dietitians and nutrition professionals.

7. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital provides care, treatment, and services using the most recent patient order(s).

‡ For law and regulation guidance pertaining to those responsible for the care of the patient, refer to 42 CFR 482.12(c).
20. Before taking action on a verbal order or verbal report of a critical test result, staff uses a record and “read back” process to verify the information.

**Standard PC.02.01.05**
The hospital provides interdisciplinary, collaborative care, treatment, and services.

**Element of Performance for PC.02.01.05**
1. Care, treatment, and services are provided to the patient in an interdisciplinary, collaborative manner.

**Standard PC.02.01.11**
Resuscitation services are available throughout the hospital.

**Elements of Performance for PC.02.01.11**
1. Resuscitation services are provided to the patient according to the hospital’s policies, procedures, or protocols.
2. Resuscitation equipment is available for use based on the needs of the population served.
   
   **Note:** For example, if the hospital has a pediatric population, pediatric resuscitation equipment should be available. (See also EC.02.04.03, EP 2)
3. An evidence-based training program(s) is used to train staff to recognize the need for and use of resuscitation equipment and techniques.

**Standard PC.02.01.19**
The hospital recognizes and responds to changes in a patient’s condition.

**Note:** Hospitals are not required to create “rapid response teams” or “medical emergency teams” in order to meet this standard. The existence of these types of teams does not mean that all of the elements of performance are automatically achieved.

**Rationale for PC.02.01.19**
A significant number of critical inpatient events are preceded by warning signs prior to the event. A majority of patients who have cardiopulmonary or respiratory arrest demonstrate clinical deterioration in advance. Early response to changes in a patient’s condition by a specially trained individual(s) may reduce cardiopulmonary arrests and patient mortality.
Elements of Performance for PC.02.01.19

1. The hospital has a process for recognizing and responding as soon as a patient’s condition appears to be worsening.

2. The hospital develops written criteria describing early warning signs of a change or deterioration in a patient’s condition and when to seek further assistance.

Standard PC.02.01.21
The hospital effectively communicates with patients when providing care, treatment, and services.

Rationale for PC.02.01.21
This standard emphasizes the importance of effective communication between patients and their providers of care, treatment, and services. Effective patient-provider communication is necessary for patient safety. Research shows that patients with communication problems are at an increased risk of experiencing preventable adverse events, and that patients with limited English proficiency are more likely to experience adverse events than English speaking patients.

Identifying the patient’s oral and written communication needs is an essential step in determining how to facilitate the exchange of information with the patient during the care process. Patients may have hearing or visual needs, speak or read a language other than English, experience difficulty understanding health information, or be unable to speak due to their medical condition or treatment. Additionally, some communication needs may change during the course of care. Once the patient’s communication needs are identified, the hospital can determine the best way to promote two-way communication between the patient and his or her providers in a manner that meets the patient’s needs. This standard complements RI.01.01.01, EP 5 (patient right to and need for effective communication); RI.01.01.03, EP 2 (provision of language interpreting and translation services); and RI.01.01.03, EP 3 (meeting needs of patients with vision, speech, hearing, or cognitive impairments).

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Elements of Performance for PC.02.01.21

1. The hospital identifies the patient’s oral and written communication needs, including the patient’s preferred language for discussing health care. *(See also RC.02.01.01, EP 1)*

   **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.

2. The hospital communicates with the patient during the provision of care, treatment, and services in a manner that meets the patient’s oral and written communication needs. *(See also RI.01.01.03, EPs 1–3)*
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Introduction to Standard PC.02.02.01
Coordination of care is recognized as a major challenge in the safe delivery of care. The rise of chronic illness means that a patient’s care, treatment, and services likely includes an array of providers in a variety of health care settings, including the patient’s home.

The Institute of Medicine’s report “Crossing the Quality Chasm—A New Health System for the 21st Century” notes that “because of the special vulnerability that accompanies illness or injury, coordination of care takes on special importance. Many patients depend on those who provide care to coordinate services—whether tests, consultations, or procedures—to ensure that accurate and timely information reaches those who need it at the appropriate time.” Health care providers and organizations need to work together to coordinate their efforts in order to provide safe, quality care.

Standard PC.02.02.01
The hospital coordinates the patient’s care, treatment, and services based on the patient’s needs.

Elements of Performance for PC.02.02.01
1. The hospital has a process to receive or share patient information when the patient is referred to other internal or external providers of care, treatment, and services. (See also PC.04.02.01, EP 1) 

2. The hospital’s process for hand-off communication provides for the opportunity for discussion between the giver and receiver of patient information.

   Note: Such information may include the patient’s condition, care, treatment, medications, services, and any recent or anticipated changes to any of these.

3. The hospital coordinates the patient’s care, treatment, and services.

   Note: Coordination involves resolving scheduling conflicts and duplication of care, treatment, and services.

8. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides activity services directly or through referral for ambulatory and nonambulatory residents at various functional levels.

9. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides services (directly or through referral) to facilitate family support, social work, nursing care, dental care, rehabilitation, primary physician care, or discharge.
Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital promptly refers residents with lost or damaged dentures to a dentist.

10. When the hospital uses external resources to meet the patient’s needs, it coordinates the patient’s care, treatment, and services.

12. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides 24-hour emergency dental services directly or through arrangement with an external provider.

Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital may charge a Medicare resident an additional amount for routine and emergency dental services.

17. The hospital coordinates care, treatment, and services within a time frame that meets the patient’s needs.

Standard PC.02.02.03
The hospital makes food and nutrition products available to its patients.

Elements of Performance for PC.02.02.03

6. The hospital prepares food and nutrition products using proper sanitation, temperature, light, moisture, ventilation, and security.

7. Food and nutrition products are consistent with each patient’s care, treatment, and services.

9. When possible, the hospital accommodates the patient’s cultural, religious, or ethnic food and nutrition preferences, unless contraindicated.

11. The hospital stores food and nutrition products, including those brought in by patients or their families, using proper sanitation, temperature, light, moisture, ventilation, and security.

22. For hospitals that use Joint Commission accreditation for deemed status purposes: A current therapeutic diet manual approved by the dietitian and medical staff is available to all medical, nursing, and food service staff.
Standard PC.02.02.09
For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Residents participate in social and recreational activities according to their abilities and interests.

Elements of Performance for PC.02.02.09

1. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital offers residents a variety of social and recreational activities according to their abilities and interests.

3. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital helps residents to participate in social and recreational activities according to their abilities and interests.

Introduction to Standard PC.02.02.13
Patients who are near or at the end of their lives need to receive care that addresses their psychosocial, emotional, and spiritual needs. To provide care that meets these needs, staff involved in patient care require education about the unique needs of dying patients and their families.

Standard PC.02.02.13
The patient’s comfort and dignity receive priority during end-of-life care.

Elements of Performance for PC.02.02.13

1. To the extent possible, the hospital provides care and services that accommodate the patient’s and his or her family’s comfort, dignity, psychosocial, emotional, and spiritual end-of-life needs.

2. The hospital provides staff with education about the unique needs of dying patients and their families.
Introduction to Standard PC.02.03.01
Chronic disease is on the rise, and patients are becoming increasingly responsible for managing their own health at home. Acute care patients are often discharged or released from health care settings with instructions for self-care that can range from changing bandages to caring for drains to home infusion. As a consequence, patient education continues to take on greater importance in influencing the patient’s outcome and in promoting healthy behaviors. To equip the patient to provide for his or her health care needs, the organization needs to assess the patient’s learning needs and use methods of education and instruction that are matched to the patient’s level of understanding.

Standard PC.02.03.01
The hospital provides patient education and training based on each patient’s needs and abilities.

Elements of Performance for PC.02.03.01

1. The hospital performs a learning needs assessment for each patient, which includes the patient’s cultural and religious beliefs, emotional barriers, desire and motivation to learn, physical or cognitive limitations, and barriers to communication.

5. The hospital coordinates the patient education and training provided by all disciplines involved in the patient’s care, treatment, and services.

10. Based on the patient’s condition and assessed needs, the education and training provided to the patient by the hospital include any of the following:
- An explanation of the plan for care, treatment, and services
- Basic health practices and safety
- Information on the safe and effective use of medications (See also MM.06.01.01, EP 9; MM.06.01.03, EPs 3–6)
- Nutrition interventions (for example, supplements) and modified diets
- Discussion of pain, the risk for pain, the importance of effective pain management, the pain assessment process, and methods for pain management
- Information on oral health
- Information on the safe and effective use of medical equipment or supplies provided by the hospital
- Habilitation or rehabilitation techniques to help the patient reach maximum independence
- Fall reduction strategies
25. The hospital evaluates the patient’s understanding of the education and training it provided.

27. The hospital provides the patient education on how to communicate concerns about patient safety issues that occur before, during, and after care is received.

28. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The primary care clinician and the interdisciplinary team educate the patient on self-management tools and techniques based on the patient’s individual needs.

30. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The interdisciplinary team identifies the patient’s health literacy needs.

   **Note:** Typically this is an interactive process. For example, patients may be asked to demonstrate their understanding of information provided by explaining it in their own words.

31. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The primary care clinician and the interdisciplinary team incorporate the patient’s health literacy needs into the patient’s education.

**Standard PC.02.04.01**

**For hospitals that elect The Joint Commission Primary Care Medical Home option:** The patient has access to the primary care medical home 24 hours a day, 7 days a week.

**Note:** Access may be provided through a number of methods, including telephone, e-mail, websites, portals, and flexible hours.

**Elements of Performance for PC.02.04.01**

1. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home provides patients with access to the following 24 hours a day, 7 days a week:
   - Appointment availability/scheduling
   - Requests for prescription renewal
   - Test results
   - Clinical advice for urgent health needs

2. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home offers flexible scheduling to accommodate patient care needs.
Note: This may include open scheduling, same-day appointments, group visits, expanded hours, and arrangements with other organizations.

3. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home has a process to address patient urgent care needs 24 hours a day, 7 days a week.

**Standard PC.02.04.03**

For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home is accountable for providing patient care. (Refer to Standard PC.02.04.05)

**Elements of Performance for PC.02.04.03**

1. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home manages transitions in care and provides or facilitates patient access to care, treatment, or services including the following:
   - Acute care
   - Management of chronic care
   - Preventive services that are age- and gender-specific
   - Behavioral health needs
   - Oral health care
   - Urgent and emergent care
   - Substance abuse treatment

   Note: Some of these services may be obtained through the use of community resources as available, or in collaboration with other organizations.

2. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home provides care that addresses various phases of a patient’s lifespan, including end-of-life care.

3. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home provides disease and chronic care management services to its patients.

4. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home provides population-based care.

5. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home uses health information technology to do the following:
Support the continuity of care, and the provision of comprehensive and coordinated care, treatment, or services
- Document and track care, treatment, or services
- Support disease management, including providing patient education
- Support preventive care, treatment, or services
- Create reports for internal use and external reporting
- Facilitate electronic exchange of information among providers
- Support performance improvement

**Standard PC.02.04.05**

For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care clinician and the interdisciplinary team work in partnership with the patient to support the continuity of care and the provision of comprehensive and coordinated care, treatment, or services.

**Elements of Performance for PC.02.04.05**

1. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home identifies the composition of the interdisciplinary team, based on individual patient needs.

2. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The members of the interdisciplinary team provide comprehensive and coordinated care, treatment, or services and maintain the continuity of care.

   **Note:** The provision of care may include making internal and external referrals.

4. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The primary care clinician and the interdisciplinary team provide care for a designated group of patients.

5. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The primary care clinician is responsible for making certain that the interdisciplinary team provides comprehensive and coordinated care, treatment, or services and maintains the continuity of care as described in EPs 6–12.

   **Note:** Coordination of care may include making internal and external referrals, developing and evaluating treatment plans, and resolving conflicts in the provision of care.
6. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** When a patient is referred internally or externally, the interdisciplinary team reviews and tracks the care provided to the patient.

7. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The interdisciplinary team acts on recommendations from internal and external referrals for additional care, treatment, or services.

8. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The interdisciplinary team participates in the development of the patient’s treatment plan.

9. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The interdisciplinary team works in partnership with the patient to achieve planned outcomes.

10. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The interdisciplinary team monitors the patient’s progress toward achieving treatment goals.

11. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The interdisciplinary team involves the patient in the development of his or her treatment plan.

12. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The interdisciplinary team assesses patients for health risk behaviors.

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**Introduction to Standards PC.03.01.01 Through PC.03.01.07**

The standards for sedation and anesthesia care apply when patients in any setting receive, for any purpose, by any route:

- General, spinal, or other major regional anesthesia
- Moderate or deep sedation (with or without analgesia) that, in the manner used, may be expected to result in the loss of protective reflexes

**Standard PC.03.01.01**

The hospital plans operative or other high-risk procedures, including those that require the administration of moderate or deep sedation or anesthesia.
Note: Equipment identified in the elements of performance is available to the operating room suites.

Elements of Performance for PC.03.01.01

5. A registered nurse supervises perioperative nursing care. 

6. For operative or other high-risk procedures, including those that require the administration of moderate or deep sedation or anesthesia: The hospital has equipment available to monitor the patient’s physiological status.

7. For operative or other high-risk procedures, including those that require the administration of moderate or deep sedation or anesthesia: The hospital has equipment available to administer intravenous fluids and medications, and blood and blood components.

10. For hospitals that use Joint Commission accreditation for deemed status purposes: In accordance with the hospital’s policy and state scope-of-practice laws, anesthesia is administered only by the following individuals:

   - An anesthesiologist
   - A doctor of medicine or osteopathy other than an anesthesiologist
   - A doctor of dental surgery or dental medicine
   - A doctor of podiatric medicine
   - A certified registered nurse anesthetist (CRNA) supervised by the operating practitioner except as provided in 42 CFR 482.52(c) regarding the state exemption for this supervision
   - An anesthesiologist’s assistant supervised by an anesthesiologist who is immediately available if needed
   - A supervised trainee in an approved educational program

** The CoP at 42 CFR 482.52(c) for state exemption states: A hospital may be exempt from the requirement for doctors of medicine or osteopathy to supervise CRNAs if the state in which the hospital is located submits a letter to the Centers for Medicare & Medicaid Services (CMS) signed by the governor, following consultation with the state’s Boards of Medicine and Nursing, requesting exemption from doctor of medicine or osteopathy supervision for CRNAs. The letter from the governor attests that he or she has consulted with the state Boards of Medicine and Nursing about issues related to access to and the quality of anesthesia services in the state and has concluded that it is in the best interests of the state’s citizens to opt out of the current doctor of medicine or osteopathy supervision requirement, and that the opt-out is consistent with state law. The request for exemption and recognition of state laws and the withdrawal of the request may be submitted at any time and are effective upon submission.
Note 1: In accordance with 42 CFR 413.85(e), an approved nursing and allied health education program is a planned program of study that is licensed by state law or, if licensing is not required, is accredited by a recognized national professional organization. Such national accrediting bodies include, but are not limited to, the Commission on Accreditation of Allied Health Education Programs and the National League of Nursing Accrediting Commission.

Note 2: “Anesthesiologist assistant” is defined in 42 CFR 410.69(b).

Standard PC.03.01.03
The hospital provides the patient with care before initiating operative or other high-risk procedures, including those that require the administration of moderate or deep sedation or anesthesia.

Elements of Performance for PC.03.01.03

1. Before operative or other high-risk procedures are initiated, or before moderate or deep sedation or anesthesia is administered: The hospital conducts a presedation or preanesthesia patient assessment. (See also RC.02.01.01, EP 2)  

4. Before operative or other high-risk procedures are initiated, or before moderate or deep sedation or anesthesia is administered: The hospital provides the patient with preprocedural education, according to his or her plan for care.

8. The hospital reevaluates the patient immediately before administering moderate or deep sedation or anesthesia. (See also RC.02.01.01, EP 2)  

18. For hospitals that use Joint Commission accreditation for deemed status purposes: A preanesthesia evaluation is completed and documented by an individual qualified to administer anesthesia within 48 hours prior to surgery or a procedure requiring anesthesia services.

Standard PC.03.01.05
The hospital monitors the patient during operative or other high-risk procedures and/or during the administration of moderate or deep sedation or anesthesia.

Element of Performance for PC.03.01.05

1. During operative or other high risk procedures, including those that require the administration of moderate or deep sedation or anesthesia, the patient’s oxygenation, ventilation, and circulation are monitored continuously. (See also RC.02.01.03, EP 8)
Standard PC.03.01.07

The hospital provides care to the patient after operative or other high-risk procedures and/or the administration of moderate or deep sedation or anesthesia.

Elements of Performance for PC.03.01.07

1. The hospital assesses the patient’s physiological status immediately after the operative or other high risk procedure and/or as the patient recovers from moderate or deep sedation or anesthesia. *(See also RC.02.01.03, EP 8)* R

2. The hospital monitors the patient’s physiological status, mental status, and pain level at a frequency and intensity consistent with the potential effect of the operative or other high risk procedure and/or the sedation or anesthesia administered. R

4. A qualified licensed independent practitioner discharges the patient from the recovery area or from the hospital. In the absence of a qualified licensed independent practitioner, patients are discharged according to criteria approved by clinical leaders. *(See also RC.02.01.03, EPs 9 and 10)* R

7. **For hospitals that use Joint Commission accreditation for deemed status purposes:** A postanesthesia evaluation is completed and documented by an individual qualified to administer anesthesia no later than 48 hours after surgery or a procedure requiring anesthesia services. R

8. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The postanesthesia evaluation for anesthesia recovery is completed in accordance with law and regulation and policies and procedures that have been approved by the medical staff. R

Standard PC.03.01.08

**For hospitals that use Joint Commission accreditation for deemed status purposes:** The laboratory has written policies and procedures for the handling of tissue specimens removed during a surgical procedure.

Elements of Performance for PC.03.01.08

1. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The laboratory has a written policy, approved by the medical staff and a pathologist, that establishes which tissue specimens require only a macroscopic examination, and which require both a macroscopic and microscopic examination.
2. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The laboratory has written policies and procedures for collecting, preserving, transporting, receiving, and reporting examination results for tissue specimens.

3. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The laboratory follows its policies and procedures for the handling of tissue specimens removed during a surgical procedure.

### Standard PC.03.01.09

The hospital provides electroconvulsive therapy safely.

#### Elements of Performance for PC.03.01.09

1. **R** The hospital has a written policy that addresses the use of electroconvulsive therapy.

2. The hospital obtains written consent for electroconvulsive therapy from the patient and documents it in the medical record.

3. Before initiating electroconvulsive therapy for a child or youth, two qualified, experienced child psychiatrists who are not directly involved in treating the child or youth examine the child or youth; consult with the child’s or youth’s psychiatrist; and document in the medical record their concurrence with the decision to use electroconvulsive therapy.

4. The hospital justifies the use of electroconvulsive therapy in the patient’s medical record.

5. The hospital implements its policy on the use of electroconvulsive therapy.

### Standard PC.03.05.01

The hospital uses restraint or seclusion only when it can be clinically justified or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others.

#### Elements of Performance for PC.03.05.01

1. The hospital uses restraint or seclusion only to protect the immediate physical safety of the patient, staff, or others. R

2. The hospital does not use restraint or seclusion as a means of coercion, discipline, convenience, or staff retaliation.
3. The hospital uses restraint or seclusion only when less restrictive interventions are ineffective.

4. The hospital uses the least restrictive form of restraint or seclusion that protects the physical safety of the patient, staff, or others.

5. The hospital discontinues restraint or seclusion at the earliest possible time, regardless of the scheduled expiration of the order.

**Standard PC.03.05.03**
The hospital uses restraint or seclusion safely.

**Elements of Performance for PC.03.05.03**

1. The hospital implements restraint or seclusion using safe techniques identified by the hospital’s policies and procedures in accordance with law and regulation.

2. The use of restraint and seclusion is in accordance with a written modification to the patient’s plan of care.

**Standard PC.03.05.05**
The hospital initiates restraint or seclusion based on an individual order.

**Elements of Performance for PC.03.05.05**

1. A physician, clinical psychologist, or other authorized licensed independent practitioner primarily responsible for the patient’s ongoing care orders the use of restraint or seclusion in accordance with hospital policy and law and regulation.

   **Note:** The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

2. The hospital does not use standing orders or PRN (also known as “as needed”) orders for restraint or seclusion.

3. The attending physician or clinical psychologist is consulted as soon as possible, in accordance with hospital policy, if he or she did not order the restraint or seclusion.

   **Note:** The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).
4. Unless state law is more restrictive, orders for the use of restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others may be renewed within the following limits:
- 4 hours for adults 18 years of age or older
- 2 hours for children and adolescents 9 to 17 years of age
- 1 hour for children under 9 years of age

Orders may be renewed according to the time limits for a maximum of 24 consecutive hours.

5. Unless state law is more restrictive, every 24 hours, a physician, clinical psychologist, or other authorized licensed independent practitioner primarily responsible for the patient’s ongoing care sees and evaluates the patient before writing a new order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, staff, or others in accordance with hospital policy and law and regulation.

Note: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

6. Orders for restraint used to protect the physical safety of the nonviolent or non-self-destructive patient are renewed in accordance with hospital policy.

Standard PC.03.05.07
The hospital monitors patients who are restrained or secluded.

Element of Performance for PC.03.05.07

1. Trained physicians, clinical psychologists, or other licensed independent practitioners or staff monitor the condition of patients in restraint or seclusion. (See PC.03.05.17, EPs 2–5 for training requirements)

Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The training requirements in PC.03.05.17, EPs 2–5, are in accordance with 42 CFR 482.13(f).

Standard PC.03.05.09
The hospital has written policies and procedures that guide the use of restraint or seclusion.
Elements of Performance for PC.03.05.09

1. The hospital's policies and procedures regarding restraint or seclusion include the following:
   - Physician, clinical psychologist, and other authorized licensed independent practitioner training requirements
   - Staff training requirements
   - The determination of who has authority to order restraint and seclusion
   - The determination of who has authority to discontinue the use of restraint or seclusion
   - The determination of who can initiate the use of restraint or seclusion
   - The circumstances under which restraint or seclusion is discontinued
   - The requirement that restraint or seclusion is discontinued as soon as is safely possible
   - A determination of who can assess and monitor patients in restraint or seclusion
   - Time frames for assessing and monitoring patients in restraint or seclusion
   - A definition of restraint
   - A definition of seclusion
   - A definition or description of what constitutes the use of medications as a restraint

Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital’s definition of restraint or the use of medications as a restraint is in accordance with 42 CFR 482.13(e)(1)(i)(A–C):

42 CFR 482.13(e)(1) Definitions. (i) A restraint is— (A) Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or 42 CFR 482.13(e)(1)(i)(B) (A restraint is— ) A drug or medication when it is used as a restriction to manage the patient’s behavior or restrict the patient’s freedom of movement and is not a standard treatment or dosage for the patient’s condition.

42 CFR 482.13(e)(1)(i)(C) A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).
Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital’s definition of seclusion is in accordance with 42 CFR 482.13(e)(1)(ii):

Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may be used only for the management of violent or self-destructive behavior.

2. Physicians, clinical psychologists, and other licensed independent practitioners authorized to order restraint or seclusion (through hospital policy in accordance with law and regulation) have a working knowledge of the hospital policy regarding the use of restraint and seclusion.

Note: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

Standard PC.03.05.11
The hospital evaluates and reevaluates the patient who is restrained or secluded.

Elements of Performance for PC.03.05.11

1. A physician, clinical psychologist, or other licensed independent practitioner responsible for the care of the patient evaluates the patient in-person within one hour of the initiation of restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff, or others. A registered nurse or a physician assistant may conduct the in-person evaluation within one hour of the initiation of restraint or seclusion; this individual is trained in accordance with the requirements in PC.03.05.17, EP 3.

Note 1: States may have statute or regulation requirements that are more restrictive than the requirements in this element of performance.

Note 2: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).
2. When the in-person evaluation (performed within one hour of the initiation of restraint or seclusion) is done by a trained registered nurse or trained physician assistant, he or she consults with the attending physician, clinical psychologist, or other licensed independent practitioner responsible for the care of the patient as soon as possible after the evaluation, as determined by hospital policy.  

**Note:** The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

3. The in-person evaluation, conducted within one hour of the initiation of restraint or seclusion for the management of violent or self-destructive behavior that jeopardizes the physical safety of the patient, staff, or others, includes the following:

   - An evaluation of the patient’s immediate situation
   - The patient’s reaction to the intervention
   - The patient’s medical and behavioral condition
   - The need to continue or terminate the restraint or seclusion

**Standard PC.03.05.13**

The hospital continually monitors patients who are simultaneously restrained and secluded.

**Element of Performance for PC.03.05.13**

1. The patient who is simultaneously restrained and secluded is continually monitored by trained staff either in-person or through the use of both video and audio equipment that is in close proximity to the patient.

   **Note:** In this element of performance “continually” means ongoing without interruption.

**Standard PC.03.05.15**

The hospital documents the use of restraint or seclusion.

**Element of Performance for PC.03.05.15**

1. Documentation of restraint and seclusion in the medical record includes the following:
   - Any in-person medical and behavioral evaluation for restraint or seclusion used to manage violent or self-destructive behavior
   - A description of the patient’s behavior and the intervention used
Any alternatives or other less restrictive interventions attempted
The patient’s condition or symptom(s) that warranted the use of the restraint or seclusion
The patient’s response to the intervention(s) used, including the rationale for continued use of the intervention
Individual patient assessments and reassessments
The intervals for monitoring
Revisions to the plan of care
The patient’s behavior and staff concerns regarding safety risks to the patient, staff, and others that necessitated the use of restraint or seclusion
Injuries to the patient
Death associated with the use of restraint or seclusion
The identity of the physician, clinical psychologist, or other licensed independent practitioner who ordered the restraint or seclusion
Orders for restraint or seclusion
Notification of the use of restraint or seclusion to the attending physician
Consultations

**Note:** The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

**Standard PC.03.05.17**
The hospital trains staff to safely implement the use of restraint or seclusion.

**Elements of Performance for PC.03.05.17**

2. The hospital trains staff on the use of restraint and seclusion, and assesses their competence, at the following intervals:
   - At orientation
   - Before participating in the use of restraint and seclusion
   - On a periodic basis thereafter

3. Based on the population served, staff education, training, and demonstrated knowledge focus on the following:
   - Strategies to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of restraint or seclusion
   - Use of nonphysical intervention skills
Methods for choosing the least restrictive intervention based on an assessment of the patient’s medical or behavioral status or condition

Safe application and use of all types of restraint or seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia)

Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary

Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including, but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the in-person evaluation conducted within one hour of initiation of restraint or seclusion

Use of first-aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification

*(See also PC.03.05.07, EP 1)*

4. Individuals providing staff training in restraint or seclusion have education, training, and experience in the techniques used to address patient behaviors that necessitate the use of restraint or seclusion.

5. The hospital documents in staff records that restraint and seclusion training and demonstration of competence were completed.

**Standard PC.03.05.19**

**For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital reports deaths associated with the use of restraint and seclusion.

**Elements of Performance for PC.03.05.19**

1. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital reports the following information to the Centers for Medicare & Medicaid Services (CMS) regarding deaths related to restraint or seclusion (this requirement does not apply to deaths related to the use of soft wrist restraints; for more information, refer to EP 3 in this standard):

- Each death that occurs while a patient is in restraint or seclusion
- Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion
Each death known to the hospital that occurs within one week after restraint or seclusion was used when it is reasonable to assume that the use of the restraint or seclusion contributed directly or indirectly to the patient’s death. The types of restraints included in this reporting requirement are all restraints except soft wrist restraints.

Note: In this element of performance “reasonable to assume” includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time or deaths related to chest compression, restriction of breathing, or asphyxiation.

2. For hospitals that use Joint Commission accreditation for deemed status purposes: The deaths addressed in PC.03.05.19, EP 1, are reported to the Centers for Medicare & Medicaid Services (CMS) by telephone, by facsimile, or electronically no later than the close of the next business day following knowledge of the patient’s death. The date and time that the patient’s death was reported is documented in the patient’s medical record.

3. For hospitals that use Joint Commission accreditation for deemed status purposes: When no seclusion has been used and when the only restraints used on the patient are wrist restraints composed solely of soft, non-rigid, cloth-like material, the hospital does the following:

- Records in a log or other system any death that occurs while a patient is in restraint. The information is recorded within seven days of the date of death of the patient.
- Records in a log or other system any death that occurs within 24 hours after a patient has been removed from such restraints. The information is recorded within seven days of the date of death of the patient.
- Documents in the patient record the date and time that the death was recorded in the log or other system
- Documents in the log or other system the patient’s name, date of birth, date of death, name of attending physician or other licensed independent practitioner responsible for the care of the patient, medical record number, and primary diagnosis(es)††
- Makes the information in the log or other system available to CMS, either electronically or in writing, immediately upon request

†† For law and regulation guidance pertaining to those responsible for the care of the patient, refer to 42 CFR 482.12(c).
Standard PC.04.01.01

The hospital has a process that addresses the patient’s need for continuing care, treatment, and services after discharge or transfer.

Elements of Performance for PC.04.01.01

1. The hospital describes the reason(s) for and conditions under which the patient is discharged or transferred.

2. The hospital describes the method for shifting responsibility for a patient’s care from one clinician, hospital, program, or service to another.

22. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital informs the patient or the patient’s family of his or her freedom to choose among participating Medicare providers and, when possible, respects the patient’s and family’s preferences when they are expressed. The hospital does not limit the qualified providers that are available to the patient.

23. **For hospitals that use Joint Commission accreditation for deemed status purposes:** When the discharge planning evaluation indicates a need for home health care, the hospital includes in the discharge plan a list of participating Medicare home health agencies (which have requested to be on the list) that are available and serve the patient’s geographic area. For patients enrolled in managed care organizations, the hospital lists home health agencies that have a contract with the managed care organization.

24. **For hospitals that use Joint Commission accreditation for deemed status purposes:** When the discharge planning evaluation indicates a need for posthospital extended care services, the hospital includes in the discharge plan a list of participating Medicare skilled nursing facilities that are available and in the geographic area requested by the patient. For patients enrolled in managed care organizations, the hospital lists skilled nursing facilities that have a contract with the managed care organization.

25. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital documents in the patient’s medical record that the list of home health agencies or skilled nursing facilities was presented to the patient or to the individual acting on the patient’s behalf. The discharge plan identifies disclosable financial interests between the hospital and any home health agency or skilled nursing facility on the list.
Note: Disclosure of financial interest is determined in accordance with the provisions in 42 CFR 420.206.

26. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has written discharge planning policies and procedures applicable to all patients.

Standard PC.04.01.03
The hospital discharges or transfers the patient based on his or her assessed needs and the organization’s ability to meet those needs.

Elements of Performance for PC.04.01.03

1. The hospital begins the discharge planning process early in the patient’s episode of care, treatment, and services.

2. The hospital identifies any needs the patient may have for psychosocial or physical care, treatment, and services after discharge or transfer.

3. The patient, the patient’s family, licensed independent practitioners, physicians, clinical psychologists, and staff involved in the patient’s care, treatment, and services participate in planning the patient’s discharge or transfer.

Note 1: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

Note 2: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Social service staff responsibilities include, but are not limited to, participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of information with sources outside the hospital.

Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital notifies the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and reasons for the move in writing. The hospital also provides sufficient preparation and orientation to residents to make sure that transfer or discharge from the hospital is safe and orderly.

4. Prior to discharge, the hospital arranges or assists in arranging the services required by the patient after discharge in order to meet his or her ongoing needs for care and services.
5. **For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds:** Except when specified in the CoP from 42 CFR 483.12(a)(5)(ii), the written notice of transfer or discharge required under paragraph 42 CFR 483.12(a)(4) must be made by the hospital at least 30 days before the resident is transferred or discharged.

**Note:** Notice may be made as soon as is practical before transfer or discharge when the safety of the individuals in the facility would be endangered; the health of the individuals in the facility would be endangered; the resident’s health improves sufficiently to allow a more immediate transfer or discharge, and immediate transfer or discharge is required by the resident’s urgent medical needs; or a resident has not resided in the facility for 30 days.

6. **For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds:** The written notice before transfer or discharge specified in the CoP from 42 CFR 483.12(a)(4) includes the following:
   - The reason for transfer or discharge
   - The effective date of transfer or discharge
   - The location to which the resident is transferred or discharged
   - A statement that the resident has the right to appeal the action to the state
   - The name, address, and telephone number of the state’s long term care ombudsman
   - For a resident who is developmentally disabled, the mailing address and telephone number of the agency responsible for the protection and advocacy, established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act
   - For a resident who is mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy, established under the Protection and Advocacy for Mentally Ill Individuals Act

10. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital conducts reassessments of its discharge planning process within its established time frames for reassessment.

11. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The reassessment of the discharge planning process includes a review of discharge plans to determine if the discharge plans meet the needs of patients.
Standard PC.04.01.05

Before the hospital discharges or transfers a patient, it informs and educates the patient about his or her follow-up care, treatment, and services.

Elements of Performance for PC.04.01.05

1. When the hospital determines the patient’s discharge or transfer needs, it promptly shares this information with the patient, and also with the patient’s family when it is involved in decision making or ongoing care.

2. Before the patient is discharged, the hospital informs the patient, and also the patient’s family when it is involved in decision making or ongoing care, of the kinds of continuing care, treatment, and services the patient will need.

7. The hospital educates the patient, and also the patient’s family when it is involved in decision making or ongoing care, about how to obtain any continuing care, treatment, and services that the patient will need.

Standard PC.04.01.07

For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Residents are not transferred or discharged from the hospital unless they meet specific criteria, in accordance with law and regulation.

Element of Performance for PC.04.01.07

1. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital transfers or discharges residents only when at least one of the following conditions is met:
   - The resident’s health has improved to the point where he or she no longer needs the hospital’s services.
   - The transfer or discharge is necessary for the resident’s benefit or if the hospital cannot meet the resident’s needs.
   - The health or safety of the resident is endangered by remaining in the hospital.
   - The health or safety of individuals in the facility is endangered.
   - The hospital has provided the resident, who has not paid for his or her stay, with reasonable notice of transfer or discharge, as defined by the hospital and in accordance with law and regulation.
   - The hospital ceases operation.
   - The resident leaves against medical advice and signs a form stating that his or her action runs contrary to medical advice.
Standard PC.04.02.01

When a patient is discharged or transferred, the hospital gives information about the care, treatment, and services provided to the patient to other service providers who will provide the patient with care, treatment, or services.

Element of Performance for PC.04.02.01

1. At the time of the patient’s discharge or transfer, the hospital informs other service providers who will provide care, treatment, or services to the patient about the following:
   - The reason for the patient’s discharge or transfer
   - The patient’s physical and psychosocial status
   - A summary of care, treatment, and services it provided to the patient
   - The patient’s progress toward goals
   - A list of community resources or referrals made or provided to the patient

(See also PC.02.02.01, EP 1)

Standard PC.05.01.09

For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital safely provides blood and blood components.

Elements of Performance for PC.05.01.09

1. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a written policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27.

   Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the “Medicare Requirements for Hospitals” appendix.

2. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital implements its policy(s) and procedure(s) addressing potentially infectious blood, consistent with CMS requirements at 42 CFR 482.27.

   Note: For guidance regarding the requirements at 42 CFR 482.27, refer to the “Medicare Requirements for Hospitals” appendix.
Performance Improvement (PI)

Overview
All hospitals want better patient outcomes and, therefore, are concerned about improving the safety and quality of the care, treatment, and services they provide. The best way to achieve better care 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 inform 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, addressing the planning of managing information, and Standard IM.02.02.03, regarding retrieving, disseminating, and transmitting health information in usable formats). Based on its setting, scope, and services, the hospital selects measures that are meaningful to the organization and that address the needs of the patients it serves. 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 patients.

Regardless of how much data the hospital collects, data are not useful if they are not analyzed. Analysis identifies trends, patterns, and performance levels that suggest opportunities for improvement. The hospital 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 patient care 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 hospitals with important information that can be used in a variety of ways. Collecting and analyzing data on performance, outcomes, and other activities can help the hospital improve its ability to provide quality care, treatment, and services. The hospital can collect data from many areas, including internal data obtained from staff, patients, 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, insurers, the community. The Joint Commission has identified important areas that should be measured regularly. In addition, the hospital should establish data priorities particular to its needs.

Note: The hospital also collects data on evaluation and improvement of conditions in the environment, infection control, the use of restraint and seclusion, and the medication management system. Standards addressing this data collection are located in the “Environment of Care” (EC), “Infection Prevention and Control” (IC), “Provision of Care, Treatment, and Services” (PC), and “Medication Management” (MM) chapters.

Standard PI.01.01.01
The hospital 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 leaders identify the frequency for data collection.

   Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The leaders that specify the frequency and detail of data collection is the governing body.

The hospital collects data on the following:

3. Performance improvement priorities identified by leaders. (See also LD.04.04.01, EP 1)
4. Operative or other procedures that place patients at risk of disability or death. (*See also* LD.04.04.01, EP 2; MS.05.01.01, EP 6)

5. All significant discrepancies between preoperative and postoperative diagnoses, including pathologic diagnoses.

6. Adverse events related to using moderate or deep sedation or anesthesia. (*See also* LD.04.04.01, EP 2)

7. The use of blood and blood components. (*See also* LD.04.04.01, EP 2)

8. All reported and confirmed transfusion reactions. (*See also* LD.04.04.01, EP 2; LD.04.04.05, EP 6)

11. The results of resuscitation. (*See also* LD.04.04.01, EP 2)

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

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

16. Patient perception of the safety and quality of care, treatment, or services.

**For hospitals that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home collects data on the following:

40. Disease management outcomes.

41. Patient access to care within time frames established by the hospital.

42. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home collects data on the following:

- Patient experience and satisfaction related to access to care, treatment, or services, and communication
- Patient perception of the comprehensiveness of care, treatment, or services
- Patient perception of the coordination of care, treatment, or services
- Patient perception of the continuity of care, treatment, or services

(Refer to PI.01.01.01, EP 16)

46. The hospital collects data on patient thermal injuries that occur during magnetic resonance imaging exams.

47. The hospital collects data on the following:
Incidents where ferromagnetic objects unintentionally entered the magnetic resonance imaging (MRI) scanner room

Injuries resulting from the presence of ferromagnetic objects in the MRI scanner room

56. The hospital collects data on pain assessment and pain management including types of interventions and effectiveness.

Introduction to Standard PI.02.01.01

When data are collected, they are analyzed using statistical tools and techniques. When the hospital analyzes data over time, it transforms raw data into useful information. Analysis of data from internal sources allows the hospital to identify patterns and trends and to monitor its performance. The hospital may also have access to external databases that allow it to compare its performance with other organizations on a specific topic, such as a procedure or outcome.

Standard PI.02.01.01

The hospital compiles and analyzes data.

Elements of Performance for PI.02.01.01

3. The hospital uses statistical tools and techniques to analyze and display data.

4. The hospital analyzes and compares internal data over time to identify levels of performance, patterns, trends, and variations.

6. The hospital reviews and analyzes incidents where the radiation dose index (computed tomography dose index [CTDIvol], dose length product [DLP], or size-specific dose estimate [SSDE]) from diagnostic CT examinations exceeded expected dose index ranges identified in imaging protocols. These incidents are then compared to external benchmarks.

Note 1: While the CTDIvol, DLP, and SSDE are useful indicators for monitoring radiation dose indices from the CT machine, they do not represent the patient’s radiation dose.

Note 2: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.
7. The hospital analyzes its organ procurement conversion rate data as provided by the organ procurement organization (OPO). *(See also TS.01.01.01, EP 1)*

**Note:** Conversion rate is defined as the number of actual organ donors over the number of eligible donors defined by the OPO, expressed as a percentage.

8. The hospital uses the results of data analysis to identify improvement opportunities. *(See also LD.03.02.01, EP 5)*

12. When the hospital identifies undesirable patterns, trends, or variations in its performance related to the safety or quality of care (for example, as identified in the analysis of data or a single undesirable event), it includes the adequacy of staffing, including nurse staffing, in its analysis of possible causes.

**Note 1:** Adequacy of staffing includes the number, skill mix, and competency of all staff. In their analysis, hospitals may also wish to examine issues such as processes related to work flow; competency assessment; credentialing; supervision of staff; and orientation, training, and education.

**Note 2:** Hospitals may find value in using the staffing effectiveness indicators (which include National Quality Forum Nursing Sensitive Measures) to help identify potential staffing issues.

13. When analysis reveals a problem with the adequacy of staffing, the leaders responsible for the hospitalwide patient safety program (as addressed at LD.04.04.05, EP 1) are informed, in a manner determined by the safety program, of the results of this analysis and actions taken to resolve the identified problem(s). *(See also LD.03.05.01, EP 7)*

14. At least once a year, the leaders responsible for the hospitalwide patient safety program review a written report on the results of any analyses related to the adequacy of staffing and any actions taken to resolve identified problems. *(See also LD.04.04.05, EP 13)*

18. The hospital analyzes data collected on pain assessment and pain management to identify areas that need change to increase safety and quality for patients.

19. The hospital monitors the use of opioids to determine if they are being used safely (for example, the tracking of adverse events such as respiratory depression, naloxone use, and the duration and dose of opioid prescriptions). *(See also LD.04.03.13, EP 1)*

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Standard PI.03.01.01
The hospital improves performance on an ongoing basis.

Elements of Performance for PI.03.01.01

2. The hospital takes action on improvement priorities. *(See also MM.08.01.01, EP 6; MS.05.01.01, EPs 1–11)*

4. The hospital takes action when it does not achieve or sustain planned improvements. *(See also MS.05.01.01, EPs 1–11)*

11. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home uses the data it collects on the patient’s perception of the safety and quality of care, treatment, or services to improve its performance. This data includes the following:
   - Patient experience and satisfaction related to access to care, treatment, or services and communication
   - Patient perception of the comprehensiveness of care, treatment, or services
   - Patient perception of the coordination of care, treatment, or services
   - Patient 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 a wealth of information about the components of a complete medical record. A highly detailed document when seen in its entirety, the record of care comprises all data and information gathered about a patient from the moment he or she enters the hospital to the moment of discharge or transfer. As such, the record of care functions not only as a historical record of a patient’s episode(s) of care, but also as a method of communication between practitioners and staff that can facilitate the continuity of care and aid in clinical decision making.

Whether the hospital keeps paper records, electronic records, or both, the contents of the record remain the same. Special care should be taken, however, by hospitals 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, those responsible for compiling the medical record can find a comprehensive set of requirements for its contents. The separate components of a complete medical record are listed and arranged within common groups (demographic, clinical, and additional information). This chapter also contains documentation requirements for screenings, assessments, and reassessments; pre- and postoperative procedures; the administration of moderate or deep sedation or anesthesia, restraint and seclusion, the clinical procedures themselves, and discharge. Standards provide policies and procedures that guide the compilation, completion, authentication, retention, and release of records.
Chapter Outline

I. Plan
   A. Clinical 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, and Services (RC.02.01.01, RC.02.01.03)
   B. Verbal Orders (RC.02.03.07)
   C. Discharge Information (RC.02.04.01)
Standards, Rationales, and Elements of Performance

Standard RC.01.01.01
The hospital maintains complete and accurate medical records for each individual patient.

Elements of Performance for RC.01.01.01

1. The hospital defines the components of a complete medical record.
5. The medical record contains the information needed to support the patient’s diagnosis and condition.
6. The medical record contains the information needed to justify the patient’s care, treatment, and services.
7. The medical record contains information that documents the course and result of the patient’s care, treatment, and services. (See also PC.01.02.07, EP 7)
8. The medical record contains information about the patient’s care, treatment, or services that promotes continuity of care among providers.

Note: For hospitals that elect The Joint Commission Primary Care Medical Home option: This requirement refers to care provided by both internal and external providers.

11. All entries in the medical record are dated.
19. For hospitals that use Joint Commission accreditation for deemed status purposes: All entries in the medical record, including all orders, are timed.

Standard RC.01.02.01
Entries in the medical record are authenticated.

Elements of Performance for RC.01.02.01

1. Only authorized individuals make entries in the medical record. R
2. The hospital defines the types of entries in the medical record made by nonindependent practitioners that require countersigning, in accordance with law and regulation. R
3. The author of each medical record entry is identified in the medical record. R
4. Entries in the medical record are authenticated by the author. Information introduced into the medical 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 hospital policy. For electronic records, electronic signatures will be date-stamped.

Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes: All orders, including verbal orders, are dated and authenticated by the ordering practitioner or another practitioner who is responsible for the care of the patient, and who, in accordance with hospital policy; law and regulation; and medical staff bylaws, rules, and regulations, is authorized to write orders.

5. The individual identified by the signature stamp or method of electronic authentication is the only individual who uses it.

Standard RC.01.03.01
Documentation in the medical record is entered in a timely manner.

Elements of Performance for RC.01.03.01

1. The hospital has a written policy that requires timely entry of information into the medical record. (See also PC.01.02.03, EP 1)

2. The hospital defines the time frame for completion of the medical record, which does not exceed 30 days after the patient’s discharge.

3. The hospital implements its policy requiring timely entry of information into the patient’s medical record. (See also PC.01.02.03, EP 2)

4. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital records the patient’s medical history and physical examination, including updates, in the medical record within 24 hours after registration or inpatient admission but prior to surgery or a procedure requiring anesthesia services.

Standard RC.01.04.01
The hospital audits its medical records.
Element of Performance for RC.01.04.01

1. The hospital conducts an ongoing review of medical records at the point of care, based on the following indicators: presence, timeliness, legibility (whether handwritten or printed), accuracy, authentication, and completeness of data and information. (*See also* MS.05.01.03, EP 3)

Standard RC.01.05.01

The hospital retains its medical records.

Elements of Performance for RC.01.05.01

1. The retention time of the original or legally reproduced medical record is determined by its use and hospital policy, in accordance with law and regulation.
8. Original medical records are not released unless the hospital is responding to law and regulation.

Standard RC.02.01.01

The medical record contains information that reflects the patient’s care, treatment, and services.

Elements of Performance for RC.02.01.01

1. The medical record contains the following demographic information:
   - The patient’s name, address, and date of birth and the name of any legally authorized representative
   - The patient’s sex
   - The legal status of any patient receiving behavioral health care services
   - The patient’s communication needs, including preferred language for discussing health care (*See also* PC.02.01.21, EP 1; LD.04.05.17, EP 4)

   **Note:** If the patient is a minor, is incapacitated, or has a designated advocate, the communication needs of the parent or legal guardian, surrogate decision-maker, or legally authorized representative is documented in the medical record.

2. The medical record contains the following clinical information:
   - The reason(s) for admission for care, treatment, and services
   - The patient’s initial diagnosis, diagnostic impression(s), or condition(s)
   - Any findings of assessments and reassessments (*See also* PC.03.01.03, EPs 1 and 8)
   - Any allergies to food

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
Any allergies to medications

Any conclusions or impressions drawn from the patient’s medical history and physical examination

Any diagnoses or conditions established during the patient’s course of care, treatment, and services (including complications and hospital-acquired infections). **For psychiatric hospitals using Joint Commission accreditation for deemed status purposes:** The diagnosis includes intercurrent diseases (diseases that occur during the course of another disease; for example, a patient with AIDS may develop an intercurrent bout of pneumonia) and the psychiatric diagnoses.

Any consultation reports

Any observations relevant to care, treatment, and services

The patient’s response to care, treatment, and services

Any emergency care, treatment, and services provided to the patient before his or her arrival

Any progress notes

All orders

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

Any adverse drug reactions

Treatment goals, plan of care, and revisions to the plan of care (**See also PC.01.03.01, EP 23**)

Results of diagnostic and therapeutic tests and procedures

Any medications dispensed or prescribed on discharge

Discharge diagnosis

Discharge plan and discharge planning evaluation (**See also** PC.01.02.03, EP 6)

4. As needed to provide care, treatment, and services, the medical record contains the following additional information: R

- Any advance directives
- Any informed consent, when required by hospital policy
**Note:** The properly executed informed consent is placed in the patient’s medical record prior to surgery, except in emergencies. A properly executed informed consent contains documentation of a patient’s mutual understanding of and agreement for care, treatment, and services through written signature; electronic signature; or, when a patient is unable to provide a signature, documentation of the verbal agreement by the patient or surrogate decision-maker.

- Any records of communication with the patient, such as telephone calls or e-mail
- Any patient-generated information

10. **For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes:** Progress notes are recorded by the following individuals involved in the active treatment of the patient:

- The doctor of medicine or osteopathy responsible for the care of the inpatient
- A nurse
- A social worker
- Others involved in active treatment modalities

The above individuals record progress notes at least weekly for the first two months of a patient’s stay and at least monthly thereafter. The progress notes include recommendations for revisions in the plan of care as indicated, as well as a precise assessment of the patient’s progress in accordance with the original or revised plan of care.

21. The medical record of a patient who receives urgent or immediate care, treatment, and services contains all of the following:

- The time and means of arrival
- Indication that the patient left against medical advice, when applicable
- Conclusions reached at the termination of care, treatment, and services, including the patient’s final disposition, condition, and instructions given for follow-up care, treatment, and services
- A copy of any information made available to the practitioner or medical organization providing follow-up care, treatment, or services

28. The medical record contains the patient’s race and ethnicity.

29. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The medical record includes the patient’s self-management goals and the patient’s progress toward achieving those goals.
Standard RC.02.01.03
The patient’s medical record documents operative or other high-risk procedures and the use of moderate or deep sedation or anesthesia.

Elements of Performance for RC.02.01.03

1. The hospital documents in the patient’s medical record any operative or other high-risk procedure and/or the administration of moderate or deep sedation or anesthesia. 

2. A licensed independent practitioner involved in the patient’s care documents the provisional diagnosis in the medical record before an operative or other high-risk procedure is performed.

3. The patient’s medical history and physical examination are recorded in the medical record before an operative or other high-risk procedure is performed. (See also PC.01.02.03, EPs 4 and 5)

5. An operative or other high-risk procedure report is written or dictated upon completion of the operative or other high-risk procedure and before the patient is transferred to the next level of care.

   Note 1: The exception to this requirement occurs when an operative or other high-risk procedure progress note is written immediately after the procedure, in which case the full report can be written or dictated within a time frame defined by the hospital.

   Note 2: If the practitioner performing the operation or high-risk procedure accompanies the patient from the operating room to the next unit or area of care, the report can be written or dictated in the new unit or area of care.

6. The operative or other high-risk procedure report includes the following information:
   - The name(s) of the licensed independent practitioner(s) who performed the procedure and his or her assistant(s)
   - The name of the procedure performed
   - A description of the procedure
   - Findings of the procedure
   - Any estimated blood loss
   - Any specimen(s) removed
   - The postoperative diagnosis
7. When a full operative or other high-risk procedure report cannot be entered immediately into the patient’s medical record after the operation or procedure, a progress note is entered in the medical record before the patient is transferred to the next level of care. This progress note includes the name(s) of the primary surgeon(s) and his or her assistant(s), procedure performed and a description of each procedure finding, estimated blood loss, specimens removed, and postoperative diagnosis.

8. The medical record contains the following postoperative information:
   - The patient’s vital signs and level of consciousness (See also PC.03.01.05, EP 1; PC.03.01.07, EP 1)
   - Any medications, including intravenous fluids and any administered blood, blood products, and blood components
   - Any unanticipated events or complications (including blood transfusion reactions) and the management of those events

9. The medical record contains documentation that the patient was discharged from the post-sedation or postanesthesia care area either by the licensed independent practitioner responsible for his or her care or according to discharge criteria. (See also PC.03.01.07, EP 4)

10. The medical record contains documentation of the use of approved discharge criteria that determine the patient’s readiness for discharge. (See also PC.03.01.07, EP 4)

11. The postoperative documentation contains the name of the licensed independent practitioner responsible for discharge.

15. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital has a complete and up-to-date operating room register that includes the following:
   - Patient’s name
   - Patient’s hospital identification number
   - Date of operation
   - Inclusive or total time of operation
   - Name of surgeon and any assistants
   - Name of nursing personnel
   - Type of anesthesia used and name of person administering it
   - Operation performed
   - Pre- and postoperative diagnosis
Age of patient

**Note:** A postoperative summary may be considered equivalent if all items listed in this element of performance are included.

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**Standard RC.02.03.07**

Qualified staff receive and record verbal orders.

**Elements of Performance for RC.02.03.07**

1. The hospital 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 individuals who gave, received, recorded, and implemented the orders.
4. Verbal orders are authenticated within the time frame specified by law and regulation.
6. **For hospitals that use Joint Commission accreditation for deemed status purposes:** Documentation of verbal orders includes the time the verbal order was received.

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**Standard RC.02.04.01**

The hospital documents the patient’s discharge information.

**Elements of Performance for RC.02.04.01**

1. **For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds:** Documentation in the medical record includes discharge information provided to the resident and/or to the receiving organization. There is documentation in the resident’s medical record by the resident’s physician when the resident is transferred or discharged, either when the transfer is due to the resident improving and no longer needing long term care services or when the resident’s needs cannot be met in the hospital’s swing bed. There is documentation in the resident’s medical record by a physician when the resident is being transferred or discharged because the safety of other residents would otherwise be endangered.
2. **For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds**: The resident’s discharge information includes the following:
   - The reason for transfer, discharge, or referral
   - Treatment provided, diet, medication orders, and orders for the resident’s immediate care
   - Referrals provided to the resident, the referring licensed independent practitioner’s name, and the name of the licensed independent practitioner who has agreed to be responsible for the resident’s medical care and treatment, if this person is someone other than the referring licensed independent practitioner
   - Medical findings and diagnoses; a summary of the care, treatment, and services provided; and progress reached toward goals
   - Information about the resident’s behavior, ambulation, nutrition, physical status, psychosocial status, and potential for rehabilitation
   - Nursing information that is useful in the resident’s care
   - Any advance directives
   - Instructions given to the resident before discharge

3. In order to provide information to other caregivers and facilitate the patient’s continuity of care, the medical record contains a concise discharge summary that includes the following:
   - The reason for hospitalization
   - The procedures performed
   - The care, treatment, and services provided
   - The patient’s condition and disposition at discharge
   - Information provided to the patient and family
   - Provisions for follow-up care

**Note 1:** A discharge summary is not required when a patient is seen for minor problems or interventions, as defined by the medical staff. In this instance, a final progress note may be substituted for the discharge summary provided the note contains the outcome of hospitalization, disposition of the case, and provisions for follow-up care.

**Note 2:** When a patient is transferred to a different level of care within the hospital, and caregivers change, a transfer summary may be substituted for the discharge summary. If the caregivers do not change, a progress note may be used.
Note 3: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The record of each patient discharged needs to include a discharge summary with the above information. The exceptions in Notes 1 and 2 are not applicable. All patients discharged need to have a discharge summary.
Rights and Responsibilities of the Individual (RI)

Overview

When the hospital recognizes and respects patient rights, it is providing an important aspect of care that has been shown to encourage patients to become more informed and involved in their care. These empowered patients ask questions and develop better relationships with their caregivers. This acknowledgement of patient rights also helps patients feel supported by the hospital and those people directly involved in their care, treatment, and services.

Recognizing and respecting patient rights directly affects the provision of care. Care, treatment, and services should be provided in a way that respects and fosters the patient’s dignity, autonomy, positive self-regard, civil rights, and involvement in his or her care. Care, treatment, and services should also be carefully planned and provided with regard to the patient’s personal values, beliefs, and preferences.

Recognizing and respecting patient rights are, however, only part of the story. Patients also have the obligation to take on certain responsibilities. The hospital defines these responsibilities and then relays them to the patient. When patients understand and accept their responsibilities, the concept of the patient as a partner in care becomes a dynamic component of the patient’s episode of care.

A mere list of patient rights cannot by itself guarantee those rights. The hospital shows its support of patient rights through its interactions with patients and by involving them in decisions about their care, treatment, and services. The standards in this chapter address the following processes and activities as they relate to patient rights:

- Informing patients of their rights
- Helping patients understand and exercise their rights
- Respecting patients’ values, beliefs, and preferences
- Informing patients of their responsibilities regarding their care, treatment, and services
About This Chapter
This chapter presents a series of requirements that help hospitals to recognize and respect patient rights. These requirements address the following:

- Identification of fundamental, overarching patient rights
- The right to effective communication
- The right to participate in care decisions
- The right to informed consent
- The right to know care providers
- The right to participate in end-of-life decisions
- Individual rights of patients
- Patient responsibilities

Note: This chapter talks about the role of a surrogate decision-maker who may participate in circumstances in which the patient cannot or chooses not to make decisions. Instead of stating “patient or surrogate decision-maker” in each occurrence where the surrogate decision-maker may need to play a role, “patient” is used with the understanding that if the patient is unable to make decisions, the surrogate decision-maker will do so.
Chapter Outline

I. Patient Rights
   A. Developing and Communicating Patient Rights
      1. Charge to Organizations (RI.01.01.01)
      2. Effective Communication (RI.01.01.03)
   B. Participation in Care Decisions (RI.01.02.01)
   C. Informed Consent (RI.01.03.01, RI.01.03.05)
   D. Right to Know Care Providers (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.01.06.09, RI.01.06.11)
   G. Services Provided by Organizations to Respect Patient Rights (RI.01.07.01, RI.01.07.03, RI.01.07.05, RI.01.07.07, RI.01.07.13)

II. Patient Responsibilities (RI.02.01.01)
Standards, Rationales, and Elements of Performance

Introduction to Standard RI.01.01.01
This standard focuses on how the hospital respects the rights of the patient during his or her encounter with the hospital. However, a mere list of rights cannot guarantee the patient’s rights. A hospital puts its respect for the patient’s rights into action by showing its support of these rights through the ways that staff and caregivers interact with the patient and involve him or her in care, treatment, and services.

Standard RI.01.01.01
The hospital respects, protects, and promotes patient rights.

Elements of Performance for RI.01.01.01

1. ☐ The hospital has written policies on patient rights.

   Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital’s written policies address procedures regarding patient visitation rights, including any clinically necessary or reasonable restrictions or limitations.

2. The hospital informs the patient of his or her rights. (See also RI.01.01.03, EPs 1–3)

   Note 1: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital informs the patient (or support person, where appropriate) of his or her visitation rights. Visitation rights include the right to receive the visitors designated by the patient, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend. Also included is the right to withdraw or deny such consent at any time.

   Note 2: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital makes sure that each patient, or his or her family, is informed of the patient’s rights in advance of furnishing or discontinuing patient care whenever possible.
4. The hospital treats the patient in a dignified and respectful manner that supports his or her dignity.

5. The hospital respects the patient’s right to and need for effective communication. *(See also RI.01.01.03, EPs 1–3)*

6. The hospital respects the patient’s cultural and personal values, beliefs, and preferences.

7. The hospital respects the patient’s right to privacy. *(See also IM.02.01.01, EPs 1–4)*

   **Note 1:** This element of performance (EP) addresses a patient’s personal privacy.

   **Note 2:** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident’s right to privacy includes privacy and confidentiality of his or her personal records and written communications, including the right to send and receive mail promptly.

8. The hospital respects the patient’s right to pain management. *(See also LD.04.03.13, EP 3)*

9. The hospital accommodates the patient’s right to religious and other spiritual services.

10. The hospital allows the patient to access, request amendment to, and obtain information on disclosures of his or her health information, in accordance with law and regulation.

28. The hospital allows a family member, friend, or other individual to be present with the patient for emotional support during the course of stay.

   **Note:** The hospital allows for the presence of a support individual of the patient’s choice, unless the individual’s presence infringes on others’ rights, safety, or is medically or therapeutically contraindicated. The individual may or may not be the patient’s surrogate decision-maker or legally authorized representative. *(For more information on surrogate or family involvement in patient care, treatment, and services, refer to RI.01.02.01, EPs 6–8.)*

29. The hospital prohibits discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression.
Introduction to Standard RI.01.01.03

Because communication is a cornerstone of patient safety and quality care, every patient has the right to receive information in a manner he or she understands. Effective communication allows patients to participate more fully in their care. When a patient understands what is being said about his or her care, treatment, and services, that patient is more likely to fulfill critical health care responsibilities. Communicating effectively with patients is also critical to the informed consent process and helps practitioners and hospitals give the best possible care. For communication to be effective, the information provided must be complete, accurate, timely, unambiguous, and understood by the patient.

Many patients of varying circumstances require alternative communication methods: patients who speak and/or read languages other than English; patients who have limited literacy in any language; patients who have visual or hearing impairments; patients on ventilators; patients with cognitive impairments; and children. The hospital 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 hospital to determine which method is the best for each patient.

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; state laws (many states have laws and regulations that require the provision of language assistance); and the American Medical Association Office Guide to Limited English Proficiency (LEP) Patient Care. Hospitals may wish to reference these sources for additional information on providing interpreting and translation services to their patients.

Standard RI.01.01.03

The hospital respects the patient’s right to receive information in a manner he or she understands.

Elements of Performance for RI.01.01.03

1. The hospital provides information in a manner tailored to the patient’s age, language, and ability to understand. (See also PC.02.01.21, EP 2; RI.01.01.01, EPs 2 and 5) R

2. The hospital provides language interpreting and translation services. (See also HR.01.01.01, EP 1; PC.02.01.21, EP 2; RI.01.01.01, EPs 2 and 5) R

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Note: Language interpreting options may include hospital-employed language interpreters, contract interpreting services, or trained bilingual staff. These options may be provided in person or via telephone or video. The hospital determines which translated documents and languages are needed based on its patient population.

3. The hospital provides information to the patient who has vision, speech, hearing, or cognitive impairments in a manner that meets the patient’s needs. (See also PC.02.01.21, EP 2; RI.01.01, EPs 2 and 5)

Standard RI.01.02.01
The hospital respects the patient’s right to participate in decisions about his or her care, treatment, and services.

Note: For hospitals that use Joint Commission accreditation for deemed status purposes: This right is not to be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.

Elements of Performance for RI.01.02.01

1. The hospital involves the patient in making decisions about his or her care, treatment, and services, including the right to have his or her family and physician promptly notified of his or her admission to the hospital.

2. When a patient is unable to make decisions about his or her care, treatment, and services, the hospital involves a surrogate decision maker in making these decisions. (See also PC.01.02.07, EP 5; RI.01.03.01, EP 1)

3. The hospital provides the patient or surrogate decision-maker with written information about the right to refuse care, treatment, and services. (See also PC.01.02.07, EP 5)

4. The hospital respects the patient’s or surrogate decision maker’s right to refuse care, treatment, and services, in accordance with law and regulation. (See also PC.01.02.07, EP 5)

8. The hospital involves the patient’s family in care, treatment, and services decisions to the extent permitted by the patient or surrogate decision-maker, in accordance with law and regulation. (See also PC.01.02.07, EP 5)

20. The hospital provides the patient or surrogate decision-maker with the information about the following:
- Outcomes of care, treatment, and services that the patient needs in order to participate in current and future health care decisions.
- Unanticipated outcomes of the patient's care, treatment, and services that are sentinel events as defined by The Joint Commission. This information is provided by the licensed independent practitioner responsible for managing the patient’s care, treatment, and services, or his or her designee. (Refer to the Glossary for a definition of sentinel event.)

**Note:** In settings where there is no licensed independent practitioner, the staff member responsible for managing the care of the patient is responsible for sharing information about such outcomes.

31. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home respects the patient’s right to make decisions about the management of his or her care.

32. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home respects the patient’s right and provides the patient the opportunity to do the following:
   - Obtain care from other clinicians of the patient’s choosing within the primary care medical home
   - Seek a second opinion from a clinician of the patient’s choosing
   - Seek specialty care

**Note:** This element of performance does not imply financial responsibility for any activities associated with these rights.

**Standard RI.01.03.01**
The hospital honors the patient’s right 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 patient and the licensed independent practitioner or other licensed practitioners with privileges about the care, treatment, and services that the patient will receive. Informed consent is not merely a signed document. It is a process that considers patient needs and preferences, compliance with law and regulation, and patient education. Utilizing the informed consent process helps the patient to participate fully in decisions about his or her care, treatment, and services.
Elements of Performance for RI.01.03.01

1. The hospital follows a written policy on informed consent that describes the following:
   - The specific care, treatment, and services that require informed consent
   - Circumstances that would allow for exceptions to obtaining informed consent
   - The process used to obtain informed consent
   - How informed consent is documented in the patient record

   **Note:** Documentation may be recorded in a form, in progress notes, or elsewhere in the record.
   - When a surrogate decision-maker may give informed consent (See also PC.01.02.07, EP 5; RI.01.02.01, EP 2)

2. The informed consent process includes a discussion about the following:
   - The patient’s proposed care, treatment, and services.
   - Potential benefits, risks, and side effects of the patient’s proposed care, treatment, and services; the likelihood of the patient achieving his or her goals; and any potential problems that might occur during recuperation.
   - Reasonable alternatives to the patient’s proposed care, treatment, and services.
     - The discussion encompasses risks, benefits, and side effects related to the alternatives and the risks related to not receiving the proposed care, treatment, and services.

3. The hospital obtains and documents informed consent in advance when it makes and uses recordings, films, or other images of patients for internal use other than the identification, diagnosis, or treatment of the patient (for example, performance improvement and education).

   **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 hospital protects the patient and respects his or her rights during research, investigation, and clinical trials.
Elements of Performance for RI.01.03.05

2. To help the patient determine whether or not to participate in research, investigation, or clinical trials, the hospital provides the patient with all of the following information:
   - An explanation of the purpose of the research
   - The expected duration of the patient’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, and services available to the patient that might prove advantageous to the patient

3. The hospital informs the patient 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, and services unrelated to the research.

4. The hospital documents the following in the research consent form:
   - That the patient received information to help determine whether or not to participate in the research, investigation, or clinical trials
   - That the patient 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, and services unrelated to the research
   - The name of the person who provided the information and the date the form was signed
   - The patient’s right to privacy, confidentiality, and safety

Standard RI.01.04.01

The hospital respects the patient’s right to receive information about the individual(s) responsible for, as well as those providing, his or her care, treatment, and services.

Elements of Performance for RI.01.04.01

1. The hospital informs the patient of the following:
   - The name of the physician, clinical psychologist, or other practitioner who has primary responsibility for his or her care, treatment, or services
   - The name of the physician(s), clinical psychologist(s), or other practitioner(s) who will provide his or her care, treatment, and services

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
Rights and Responsibilities of the Individual

Note: The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

7. For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home allows the patient to select his or her primary care clinician.

Standard RI.01.04.03

For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home provides patients with information about its functions and services.

Elements of Performance for RI.01.04.03

1. For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home provides information to the patient about: Its mission, vision, and goals. (Refer to LD.02.01.01, EP 3)

Note: This may include how it provides for patient-centered and team-based comprehensive care, a systems-based approach to quality and safety, and enhanced patient access.

2. For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home provides information to the patient about: The scope of care and types of services it provides. (Refer to PC.01.01.01, EP 7; LD.01.03.01, EP 3)

3. For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home provides information to the patient about: How it functions, including the following:
   - Processes supporting patient selection of a primary care clinician
   - Involving the patient in his or her treatment plan
   - Obtaining and tracking referrals
   - Coordinating care
   - Collaborating with patient-selected clinicians who provide specialty care or second opinions

Note: Supporting patients in selecting a primary care clinician may include providing patients with information regarding the clinician’s credentials, area(s) of specialty, interests, languages spoken, and gender.
4. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home provides information to the patient about: How to access the organization for care or information.

5. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home provides information to the patient about: Patient responsibilities, including providing health history and current medications, and participating in self-management activities. (Refer to RI.02.01.01, EP 2)

6. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home provides information to the patient about: The patient’s right to obtain care from other clinicians within the primary care medical home, to seek a second opinion, and to seek specialty care. (Refer to PC.02.03.01, EP 4; RI.01.01.03, EPs 1 and 3)

**Standard RI.01.05.01**

The hospital addresses patient decisions about care, treatment, and services received at the end of life.

**Elements of Performance for RI.01.05.01**

1. **The hospital follows written policies on advance directives, forgoing or withdrawing life-sustaining treatment, and withholding resuscitative services that address the following:**

   - Providing patients with written information about advance directives, forgoing or withdrawing life-sustaining treatment, and withholding resuscitative services.
   - Providing the patient upon admission with information on the extent to which the hospital is able, unable, or unwilling to honor advance directives.
   - **For outpatient hospital settings:** Communicating its policy on advance directives upon request or when warranted by the care, treatment, and services provided.
   - Whether the hospital will honor advance directives in its outpatient settings.
   - That the hospital will honor the patient’s right to formulate or review and revise his or her advance directives.
   - Informing staff and licensed independent practitioners who are involved in the patient’s care, treatment, and services whether or not the patient has an advance directive.
9. The hospital documents whether or not the patient has an advance directive.

10. Upon request, the hospital refers the patient to resources for assistance in formulating advance directives.

15. When required by policy or upon patient request, the hospital documents the patient’s wishes concerning organ donation and honors the wishes within the limits of its capability, policy, and law and regulation.

17. The existence or lack of an advance directive does not determine the patient’s right to access care, treatment, and services.

21. For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital defines how it obtains and documents permission to perform an autopsy.

**Standard RI.01.06.03**

The patient 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 hospital determines how it will protect the patient from neglect, exploitation, and abuse that could occur while the patient is receiving care, treatment, and services.

   **Note:** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital also determines how it will protect residents from corporal punishment and involuntary seclusion.

2. The hospital evaluates all allegations, observations, and suspected cases of neglect, exploitation, and abuse that occur within the hospital. (See also PC.01.02.09, EP 1)

3. The hospital reports allegations, observations, and suspected cases of neglect, exploitation, and abuse to appropriate authorities based on its evaluation of the suspected events, or as required by law. (See also PC.01.02.09, EPs 6 and 7)

   **Note:** For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Alleged violations of mistreatment, neglect, or abuse and misappropriation of resident property are reported immediately to the administrator of the hospital.
4. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital develops and implements written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

5. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital has evidence that all alleged violations are thoroughly investigated and that it prevents further abuse while the investigation is in progress. The results of all investigations are reported to the administrator or his or her designated representative within five working days of the incident.

Standard RI.01.06.05
The patient has the right to an environment that preserves dignity and contributes to a positive self-image.

Elements of Performance for RI.01.06.05

4. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital allows the patient to keep and use personal clothing and possessions, unless this infringes on others’ rights or is medically or therapeutically contraindicated, based on the setting or service.

8. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides accommodations for residents with significant others living in the same facility when both individuals consent to the arrangement.

14. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident has the right to have access to stationery, postage, and writing implements at the resident’s own expense.

Standard RI.01.06.09
For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident has the right to choose his or her medical, dental, and other licensed independent practitioner care providers.
Rights and Responsibilities of the Individual

Elements of Performance for RI.01.06.09

1. **For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds:** The hospital supports the resident’s right to choose an attending physician, dentist, and other licensed independent practitioner.

2. **For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds:** The hospital supports the resident’s right to request a different licensed independent practitioner upon admission and throughout the course of care.

3. **For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds:** The hospital makes reasonable attempts to respond to requests from residents to choose a different licensed independent practitioner upon admission and throughout the course of care.

Standard RI.01.06.11

**For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds:** The resident has the right to communicate with his or her medical, dental, and other licensed independent practitioner care providers.

Element of Performance for RI.01.06.11

3. **For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds:** The hospital helps the resident make and keep appointments with medical, dental, and other licensed independent practitioners.

Standard RI.01.07.01

The patient and his or her family have the right to have complaints reviewed by the hospital.

Rationale for RI.01.07.01

A business is often judged by how it handles dissatisfied customers; the same is true for health care organizations. Addressing complaints promptly helps to satisfy the needs of patients and their families during a vulnerable time in their lives, and may also prevent adverse events from occurring in the organization. Complaints can range from the straightforward, such as the temperature of a patient’s room, to the complex, such as the patient’s care being adversely impacted by practitioners’ failure to effectively communicate. Regardless of the complexity of the complaint, patients and their families expect the organization to work toward a resolution as quickly as possible.
Elements of Performance for RI.01.07.01

1. The hospital establishes a complaint resolution process and informs the patient and his or her family about it. (See also LD.04.01.07, EP 1; MS.09.01.01, EP 1)

   **Note:** The governing body is responsible for the effective operation of the complaint resolution process unless it delegates this responsibility in writing to a complaint resolution committee.

4. The hospital reviews and, when possible, resolves complaints from the patient and his or her family. (See also MS.09.01.01, EP 1)

6. The hospital acknowledges receipt of a complaint that the hospital cannot resolve immediately and notifies the patient of follow-up to the complaint. (See also MS.09.01.01, EP 1)

7. The hospital provides the patient with the phone number and address needed to file a complaint with the relevant state authority. (See also MS.09.01.01, EP 1)

18. **For hospitals that use Joint Commission accreditation for deemed status purposes:** In its resolution of complaints, the hospital provides the individual with a written notice of its decision, which contains the following:
   - The name of the hospital contact person
   - The steps taken on behalf of the individual to investigate the complaint
   - The results of the process
   - The date of completion of the complaint process

19. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The hospital determines time frames for complaint review and response.

20. **For hospitals that use Joint Commission accreditation for deemed status purposes:** The process for resolving complaints includes a mechanism for timely referral of patient concerns regarding quality of care or premature discharge to the quality improvement organization (QIO).

**Standard RI.01.07.03**

The patient has the right to access protective and advocacy services.
Element of Performance for RI.01.07.03

1. When the hospital serves a population of patients 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 patient’s needs for such services.

Standard RI.01.07.05
For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident has the right to receive and restrict visitors.

Elements of Performance for RI.01.07.05

1. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital establishes liberal visiting hours that are limited only by the resident’s personal preferences.

3. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital provides space for the resident to receive visitors in comfort and privacy.

5. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital supports the resident’s right to choose with whom he or she communicates.

6. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital complies with law and regulation regarding individuals who are exempted from visiting hour restrictions in order to gain immediate access to the resident.

Standard RI.01.07.07
For psychiatric hospital settings that provide longer term care (more than 30 days) and for hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital protects the rights of patients and residents who work for or on behalf of the hospital.
Elements of Performance for RI.01.07.07

1. ☐ For psychiatric hospital settings that provide longer term care (more than 30 days) and for hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital follows a written policy that addresses situations in which patients and residents work for or on behalf of the hospital.

3. For psychiatric hospital settings that provide longer term care (more than 30 days) and for hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Wages paid to patients and residents who work for or on behalf of the hospital are in accordance with law and regulation.

Note: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The plan of care specifies whether the work performed is voluntary or paid.

4. For psychiatric hospital settings that provide longer term care (more than 30 days) and for hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital incorporates work performed by the patient or resident for or on behalf of the hospital into the plan of care.

5. For psychiatric hospital settings that provide longer term care (more than 30 days) and for hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: Patients and residents have the right to refuse to work for or on behalf of the hospital.

Standard RI.01.07.13

For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The resident has the right to transportation services, as appropriate to his or her care or service plan.

Element of Performance for RI.01.07.13

1. For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital arranges transportation for the resident to and from physician or dentist appointments and other activities identified in the resident’s care or service plan.

Standard RI.02.01.01

The hospital informs the patient about his or her responsibilities related to his or her care, treatment, and services.
Rationale for RI.02.01.01

When the hospital communicates with patients about their responsibilities, it is treating patients as active partners in care and not merely as passive recipients of services. These responsibilities are defined in policy to support consistent expectations about patient responsibilities among staff and licensed independent practitioners, and to support consistent communication with patients. Such consistency is particularly important when addressing patient responsibilities concerning rules, instructions, and financial commitments.

The patient-provider partnership is enhanced when patients understand the importance of providing the information needed to facilitate care and of asking for clarification if something is unclear. Patients have a responsibility to interact with staff and licensed independent practitioners in a civil manner, consistent with the hospital’s obligation to maintain a respectful and considerate relationship with all patients. Mutual respect supports communication and collaboration in a manner that contributes to the safety and quality of care, treatment, and services.

Elements of Performance for RI.02.01.01

1. The hospital has a written policy that defines patient responsibilities, including but not limited to the following:
   - Providing information that facilitates their care, treatment, and services
   - Asking questions or acknowledging when he or she does not understand the treatment course or care decision
   - Following instructions, policies, rules, and regulations in place to support quality care for patients and a safe environment for all individuals in the hospital
   - Supporting mutual consideration and respect by maintaining civil language and conduct in interactions with staff and licensed independent practitioners
   - Meeting financial commitments

2. The hospital informs the patient about his or her responsibilities in accordance with its policy.

Note: Information about patient responsibilities can be shared verbally, in writing, or both.
Transplant Safety (TS)

Overview

Transplantation of organs and tissues is sometimes the only option for treatment of a wide range of diseases. In the past 10 years, advances in transplantation have led to a greater success rate for transplanted organs and tissues. More and more people receive transplants every year and more people are living longer after transplants.

Organ transplants are often life-saving procedures. They involve replacing an individual’s (the recipient) damaged or failing organ, such as a heart, kidney, liver, lung, pancreas, or intestine, with a working organ from another individual (the donor). While tissue transplants are used most often to enhance the lives of recipients, they are also used at times to save lives. Tissues that are transplanted include bones, tendons, corneas, heart valves, veins, and skin. A single donor can save many lives, as well as improve the quality of life for many more.

Transplantation is not free from risk. Transmission of infections from the donor to the recipient is a significant safety concern. With the increased numbers of organ and tissue transplants, the number of opportunities for transmission of infectious pathogens has also increased. Instances of organ- or tissue-borne infection in recipients of donor organs or tissues are well documented. Diseases with documented transmission from infected donors subsequent to transplant include, to name a few, HIV, hepatitis B and C, and Creutzfeldt-Jakob disease (CJD). Recipients may also contract bacterial or fungal infections through contamination during transportation, storage, or handling. The opportunity for transmission of infectious disease will continue to increase as the number of transplants continues to rise.

Effective communication of an adverse event directly related to organ or tissue use is critical to patient safety. The hospital may become aware of an adverse event directly related to organ or tissue use through external notification or internal detection. Prompt investigation of each adverse event provides response and treatment to recipients affected by the infected organ or tissue and could prevent further transplantation from an infected donor.
About This Chapter
The standards in this chapter focus on the development and implementation of policies and procedures for safe organ and tissue donation, procurement, and transplantation.
Chapter Outline

I. Donating and Procuring Organs and Tissues (TS.01.01.01)

II. Transplanting Organs (TS.02.01.01)

III. Transplanting Tissues
   A. Standardized Procedures to Acquire, Receive, Store, and Issue Tissue (TS.03.01.01)
   B. Bi-directional Tracing of Tissues (TS.03.02.01)
   C. Tissue Adverse Events Investigation (TS.03.03.01)
Standards, Rationales, and Elements of Performance

Introduction to Standard TS.01.01.01

Leadership’s commitment to creating a culture conducive to organ and tissue donation can have significant impact on the overall success of the hospital’s organ and tissue procurement efforts. This standard addresses the hospital’s responsibilities for organ and tissue donation and procurement. This includes any individual who has been determined medically suitable for donation by the organ procurement organization (OPO). If the hospital has the necessary resources to support the recovery of organs and tissues after cardiac death, non-heart-beating donors are included in the organ procurement effort.

Standard TS.01.01.01

The hospital, with the medical staff’s participation, develops and implements written policies and procedures for donating and procuring organs and tissues.

Elements of Performance for TS.01.01.01

1.  The hospital has a written agreement with an organ procurement organization (OPO) and follows its rules and regulations. (See also PI.02.01.01, EP 7)

3.  The hospital has a written agreement with at least one tissue bank and at least one eye bank to cooperate in retrieving, processing, preserving, storing, and distributing tissues and eyes.

   Note 1: This process should not interfere with organ procurement.

   Note 2: It is not necessary for a hospital to have a separate agreement with a tissue bank if it has an agreement with its organ procurement organization (OPO) to provide tissue procurement services, nor is it necessary for a hospital to have a separate agreement with an eye bank if its OPO provides eye procurement services. The hospital is not required to use the OPO for tissue or eye procurement, and is free to have an agreement with the tissue bank or eye bank of its choice.

4.  The hospital works with the organ procurement organization (OPO) and tissue and eye banks to do the following:
   - Review death records in order to improve identification of potential donors.
- Maintain potential donors while the necessary testing and placement of potential donated organs, tissues, and eyes takes place in order to maximize the viability of donor organs for transplant.
- Educate staff about issues surrounding donation.
- Develop a written donation policy that addresses opportunities for asystolic recovery that is mutually agreed upon by the hospital, its medical staff, and the designated OPO. When the hospital and its medical staff agree not to provide for asystolic recovery and cannot achieve agreement with the designated OPO, the hospital documents its efforts to reach an agreement with its OPO, and the donation policy addresses the hospital’s justification for not providing for asystolic recovery.

5. Staff education includes training in the use of discretion and sensitivity to the circumstances, beliefs, and desires of the families of potential organ, tissue, or eye donors.

6. The hospital develops, in collaboration with the designated organ procurement organization, written procedures for notifying the family of each potential donor about the option to donate or decline to donate organs, tissues, or eyes.

7. The individual designated by the hospital to notify the family regarding the option to donate or decline to donate organs, tissues, or eyes is an organ procurement representative, an organizational representative of a tissue or eye bank, or a designated requestor.

**Note:** A designated requestor is an individual who has completed a course offered or approved by the organ procurement organization. This course is designed in conjunction with the tissue and eye bank community to provide a methodology for approaching potential donor families and requesting organ and tissue donation.

8. The individual designated by the hospital documents that the patient or family accepts or declines the opportunity for the patient to become an organ, tissue, or eye donor.

9. The hospital notifies the organ procurement organization (OPO) of patients who have died and of mechanically ventilated patients whose death is imminent, according to the following:
   - Clinical triggers defined jointly with its medical staff and the designated OPO
   - Within the time frames (ideally, within one hour of death for patients who have expired) jointly agreed on by the hospital and the designated OPO
For mechanically ventilated patients, prior to the withdrawal of life-sustaining therapies including medical or pharmacological support

**Note:** For additional information about criteria for the determination of brain death, please see the American Academy of Neurology guidelines available at http://www.neurology.org/content/74/23/1911 and the American Academy of Pediatrics guidelines available at http://pediatrics.aappublications.org/content/early/2011/08/24/peds.2011-1511.

10. In Department of Defense hospitals, Veterans Affairs medical centers, and other federally administered health care agencies, notification to the organ procurement organization of patients who have died or whose death is imminent is done according to procedures approved by the respective agency.

11. The organ procurement organization determines medical suitability of organs for organ donation and, in the absence of alternative arrangements by the hospital, it determines the medical suitability of tissue and eyes for donation.

12. The hospital maintains records of potential organ, tissue, or eye donors whose names have been sent to the organ procurement organization and tissue and eye banks.

**Standard TS.02.01.01**

The hospital complies with organ transplantation responsibilities.

**Elements of Performance for TS.02.01.01**

1. The hospital performing organ transplants belongs to and abides by the rules of the Organ Procurement and Transplantation Network (OPTN) established under section 372 of the Public Health Service (PHS) Act.

2. If requested, the hospital provides all data related to organ transplant to the Organ Procurement and Transplantation Network (OPTN), the Scientific Registry, or the hospital’s designated organ procurement organization (OPO), and when requested by the Office of the Secretary, directly to the US Department of Health & Human Services.

The term “rules of the OPTN” means those rules provided for in regulations issued by the Secretary in accordance with section 372 of the PHS Act which are enforceable under 42 CFR 121.10. No hospital is considered to be out of compliance with section 1138(a)(1)(B) of the Act, or with the requirements of this paragraph, unless the Secretary has given the OPTN formal notice that he or she approves the decision to exclude the hospital from the OPTN and has notified the hospital in writing.
Introduction to Standards TS.03.01.01, TS.03.02.01, and TS.03.03.01

The following standards apply to hospitals that store or issue tissue. This includes any areas outside of the clinical laboratory that store or issue tissue; for example, surgery and outpatient centers or tissue banks. They apply to human and nonhuman cellular-based transplantable and implantable products whether classified by the US Food and Drug Administration (FDA) as a tissue or a medical device. Collagen and tissue products derived from plastics and polymers are not considered cellular-based products and are not evaluated under these standards.

Specific tissue transplant requirements apply to autologous tissue. This includes policies and procedures for identifying, tracking, storing, and handling autologous tissue, in addition to investigating tissue adverse events. Also, if the state in which an organization resides classifies something as tissue that falls outside the scope of The Joint Commission definition, the standards would apply.

Examples of Tissue and Cell Products

- Amnion/Amniotic Membrane
- Arteries
- Autologous Cells
- Autologous Tissue
- Bone
- Bone Marrow
- Bone Paste
- Bone Powder
- Bone Putty
- Cancellous Chips
- Cardiac (Heart) Valves (Aortic, Pulmonary)
- Cartilage
- Chondrocytes
- Cornea
- Demineralized Bone Matrix
- Dendritic Cells
- Dermal Matrix
- Dermis
- Dura Mater
- Embryo
- Fascia/Fascia Lata
- Hematopoietic Stem Cells
- Leukocytes
- Ligaments
- Limbal Graft
- Limbal Stem Cells
- Lymphocytes
- Marrow
- Membrane
- Meniscus
- Nerves
- Non-valved Conduits
- Oocyte/Ovarian Cells
- Ovarian Tissue
- Pancreatic Islet Cells
- Parathyroid
- Pericardium
- Peripheral Blood Stem Cells
- Progenitor Cells
- Sclera
- Semen, Sperm
- Skin
- Somatic Cells
- Tendons
- Testicular Tissue
- Therapeutic Cells (T-Cell Pheresis)/T-Cells
- Tissue (also Synthetic Tissue)
- Trachea
- Umbilical Cord Blood Stem Cells
- Vascular Graft
- Veins (Saphenous, Femoral, Iliac)
- Other cellular- and tissue-based transplant or implant products whether classified by the FDA as a tissue or a medical device
- Other tissues that are classified as tissues by state law and regulation

**Standard TS.03.01.01**

The hospital uses standardized procedures for managing tissues.


**Elements of Performance for TS.03.01.01**

1. The hospital assigns responsibility to one or more individuals for overseeing the acquisition, receipt, storage, and issuance of tissues throughout the hospital.

   **Note:** *Responsibility for this oversight involves coordinating efforts to provide standardized practices throughout the hospital. A hospital may have a centralized process (one department responsible for the ordering, receipt, storage, and issuance of tissue throughout the hospital) or a decentralized process (multiple departments responsible for the ordering, receipt, storage, and issuance of tissue throughout the hospital).*

2. The hospital develops and maintains standardized written procedures for the acquisition, receipt, storage, and issuance of tissues. (*See also* TS.03.02.01, EP 5)

3. The hospital confirms that tissue suppliers are registered with the US Food and Drug Administration (FDA) as a tissue establishment and maintain a state license when required.†

   **Note:** *This element of performance does not apply to autologous tissue- or cellular-based products considered tissue for the purposes of these standards but classified as medical devices by the FDA.*

4. The hospital follows the tissue suppliers’ or manufacturers’ written directions for transporting, handling, storing, and using tissue.

5. The hospital documents the receipt of all tissues. (*See also* TS.03.02.01, EPs 3 and 6)

6. The hospital verifies at the time of receipt that package integrity is met and transport temperature range was controlled and acceptable for tissues requiring a controlled environment. This verification is documented. (*See also* TS.03.02.01, EP 6)

   **Note 1:** *If the distributor uses validated shipping containers, then the receiver may document that the shipping container was received undamaged and within the stated time frame.*

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† For US Food and Drug Administration (FDA) registration, the supplier registration status may also be checked annually by using the FDA’s online database: http://www.fda.gov/cber/tissue/tissregdata.htm.
Note 2: Tissues requiring no greater control than “ambient temperature” (generally defined as the temperature of the immediate environment) for transport and storage would not need to have the temperature verified on receipt.

8.  The hospital maintains daily records to demonstrate that tissues requiring a controlled environment are stored at the required temperatures. (See also TS.03.02.01, EP 5)

Note 1: Types of tissue storage include room temperature, refrigerated, frozen (for example, deep freezing colder than -40°C), and liquid nitrogen storage.

Note 2: Tissues requiring no greater control than “ambient temperature” (defined as the temperature of the immediate environment) for storage would not require temperature monitoring.

9.  The hospital continuously monitors the temperature of refrigerators, freezers, nitrogen tanks, and other storage equipment used to store tissues.

Note 1: Continuous temperature recording is not required but may be available with some continuous temperature monitoring systems.

Note 2: For tissue stored at room temperature, continuous temperature monitoring is not required.

10. Refrigerators, freezers, nitrogen tanks, and other storage equipment used to store tissues at a controlled temperature have functional alarms and an emergency back-up plan.

Note: For tissue stored at room temperature, alarm systems are not required.

Standard TS.03.02.01
The hospital traces all tissues bi-directionally.

Elements of Performance for TS.03.02.01

1.  The hospital’s records allow any tissue to be traced from the donor or tissue supplier to the recipient(s) or other final disposition, including discard, and from the recipient(s) or other final disposition back to the donor or tissue supplier.

2.  The hospital identifies, in writing, the materials and related instructions used to prepare or process tissues.

3.  The hospital documents the dates, times, and staff involved when tissue is accepted, prepared, and issued. (See also TS.03.01.01, EP 6)
4. The hospital documents in the recipient’s medical record the tissue type and its unique identifier.

5. The hospital retains tissue records on storage temperatures, outdated procedures, manuals, and publications for a minimum of 10 years. If required by state and/or federal laws, hospitals may have to retain tissue records longer than 10 years. *(See also TS.03.01.01, EPs 2 and 8)*

6. The hospital retains tissue records for a minimum of 10 years beyond the date of distribution, transplantation, disposition, or expiration of tissue (whichever is latest). If required by state and/or federal laws, hospitals may have to retain tissue records longer than 10 years. Records are kept on all of the following:
   - The tissue supplier

   **Note:** *For medical devices, the manufacturer may be the tissue supplier.*
   - The original numeric or alphanumeric donor and lot identification
   - The name(s) of the recipient(s) or the final disposition of each tissue
   - The expiration dates of all tissues

   *(See also TS.03.01.01, EPs 6 and 7)*

7. The hospital completes and returns tissue usage information cards requested by the tissue supplier.

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**Standard TS.03.03.01**

The hospital investigates adverse events related to tissue use or donor infections.

**Elements of Performance for TS.03.03.01**

1. ❋ The hospital has a written procedure to investigate tissue adverse events, including disease transmission or other complications that are suspected of being directly related to the use of tissue.

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❋ According to the Health Insurance Portability and Accountability Act (HIPAA) regulations regarding protected health information, “A covered entity may disclose protected health information for public health activities or other purposes to a person subject to the jurisdiction of the Food and Drug Administration (FDA) for the following purposes:

   - To track products if the disclosure is made to a person required or directed by the FDA to track the product
   - To enable product recalls, repairs or replacement (including locating and notifying individuals who have received products of product recalls, withdrawals, or other problems) *(Refer to 45 CFR 164.512(b)(1)(iii)(B) and (C))*
2. The hospital investigates tissue adverse events, including disease transmission or other complications that are suspected of being directly related to the use of tissue.

3. As soon as the hospital becomes aware of a post-transplant infection or other adverse event related to the use of tissue, it reports the infection or adverse event to the tissue supplier.

4. The hospital sequesters tissue whose integrity may have been compromised or that is reported by the tissue supplier as a suspected cause of infection.

5. The hospital identifies and informs tissue recipients of infection risk when donors are subsequently found to have human immunodeficiency virus (HIV), human T-lymphotropic virus-I/II (HTLV-I/II), viral hepatitis, or other infectious agents known to be transmitted through tissue.
Waived Testing (WT)

Overview
A laboratory test is an activity that evaluates a substance(s) removed from a human body and translates the evaluation into a result. A result can be stated as a number, presence or absence of a cell or reaction, or an interpretation. Tests that produce a result measured as a discrete number are termed “quantitative.” Tests that produce a negative or positive result, such as occult bloods and urine pregnancy screens, are termed “qualitative.” A test that is more precise than a qualitative test (pos/neg), but less precise than a quantitative test (numerical), is usually scored on a graded scale (1+, 2+, 3+) and is termed “semiquantitative.” Tests with analysis steps that rely on the use of an instrument to produce a result are instrument-based tests. These can be qualitative, semiquantitative, or quantitative.

Test results that are used to assess a patient condition or make a clinical decision about a patient are governed by the federal regulations known as the Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88). CLIA ’88 classifies testing into four complexity levels: high complexity, moderate complexity, provider-performed microscopy (PPM procedures, a subset of moderate complexity), and waived testing. The high, moderate, and PPM levels, otherwise called non-waived testing, have specific and detailed requirements regarding personnel qualifications, quality assurance, quality control, and other systems. Waived testing, on the other hand, has few requirements and is less stringent than the requirements for nonwaived testing.

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, the risk to patient safety and quality of care when waived testing is performed improperly, and as quality problems revealed by the Centers for Medicare & Medicaid Services (CMS).

The waived testing requirements are supported by the *Morbidity and Mortality Weekly Report* (November 11, 2005, on “Good Laboratory Practices for Waived Testing Sites”). 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 patient outcomes.

Waived testing is the most common complexity level performed by caregivers at the patient bedside or point of care. The list of methods that are approved as waived is under constant revision, so it is advisable to check the US Food and Drug Administration (FDA), Centers for Disease Control and Prevention (CDC), or CMS websites for the most up-to-date information regarding test categorization and complete CLIA ‘88 requirements such as the following:

- http://www.cdc.gov/clia/Resources/WaivedTests/
- http://www.cms.hhs.gov/clia

**About This Chapter**

When a patient performs a test on him- or herself (for example, whole blood glucose testing by a patient on his or her own meter cleared by the FDA for home use), the action is not regulated. Only testing performed by staff on patients is an activity regulated by CLIA ’88. The Joint Commission standards apply to staff using instruments owned by staff, owned by the organization, or owned by the patient in performing waived laboratory tests. If staff are providing only instruction or cueing the patient, then these standards do not apply. This distinction is important when caring for patients who monitor their own health care (for example, testing of glucose or prothrombin times with home devices).

Currently, The Joint Commission allows for an organization to use the patient’s results for treatment decisions. When using a patient’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 testing themselves. The following processes are not specific Joint Commission requirements and are provided only as examples of how organizations have dealt with these concerns in practice:

- Verification of competency by either confirming the patient has been previously trained or observing the patient perform his or her first test
- Requiring the patient to perform quality control, if available for the meter, each day results are used
- Correlation of the patient’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 laboratories 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 director named 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 hospital 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 hospital 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 hospital 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 hospital, 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 hospital 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 hospital 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 and licensed independent practitioners performing waived tests are competent.

**Elements of Performance for WT.03.01.01**

1. The person from the hospital 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 and licensed independent practitioners who perform waived testing.

2. Staff and licensed independent practitioners who perform waived testing have received orientation in accordance with the hospital’s specific services. The orientation for waived testing is documented.

3. Staff and licensed independent practitioners 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 and licensed independent practitioners who perform waived testing that requires the use of an instrument have been trained on its use and maintenance. The training on the use and 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 person 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 hospital policy at defined intervals, but at least at the time of orientation and annually thereafter. This competency is documented.

**Note 1:** When a licensed independent practitioner performs waived testing that does not involve an instrument and the test falls within his or her specialty, the hospital may use the medical staff credentialing and privileging process to document evidence of training and competency in lieu of annual competency assessment. In this circumstance, individual practitioner privileges include the specific waived tests appropriate to the scope of practice that he or she is authorized to perform. At the...
discretion of the person from the hospital whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88) certificate or according to hospital policy, more stringent competency requirements may be implemented.

Note 2: Provider-performed microscopy (PPM) procedures are not waived tests.

Standard WT.04.01.01
The hospital 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 hospital 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 hospital’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 hospital’s policies.

   Note: If these elements are not defined by the manufacturer, the hospital 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 patient 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 hospital 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 medical record.

2. Test results for waived testing are documented in the patient’s medical record.

3. Quantitative test result reports in the medical 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 permanent medical record. The result must have a notation directing the reader to the location of the reference intervals (normal values) in the medical 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 accreditation 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. This list contains a [CMS] icon next to sections that have content of special interest to hospitals that use Joint Commission accreditation for deeming purposes.

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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 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 hospitals 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 (for all programs), the organization has a facility license or registration to conduct its scope of services.

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 services that can be evaluated by The Joint Commission’s standards.

If the organization uses its Joint Commission accreditation for deemed status purposes, the organization meets the Centers for Medicare & Medicaid Services (CMS) definition of a hospital as set forth in “Appendix A: Medicare Requirements for Hospitals” (AXA); see “Appendix B: Special Conditions of Participation for Psychiatric Hospitals” (AXB) for information about psychiatric hospitals that use accreditation for deemed status purposes.

The organization meets parameters for the minimum number of inpatients/volume of services required for organizations seeking initial or continued Joint Commission accreditation; that is, 10 inpatients served, with one active at the time of survey. A hospital that is seeking Medicare Certification must have one active inpatient case at the time of survey.

- If the hospital’s average daily census (ADC) is 21 or more, or if the hospital is a specialty hospital (cardiac, orthopedic, or surgical), the hospital must be able to provide inpatient records for at least 10% of the ADC, but not less than 30 inpatient records at the time of survey.
- If the hospital’s ADC is less than 21 (1–20), the hospital must be able to provide 20 inpatient records.

The tests, treatments, or interventions provided at the organization are prescribed or ordered by a licensed practitioner in accordance with state and federal requirements.
Eligibility Requirements for Initial Surveys

An organization that is seeking Joint Commission accreditation for the first time, is undergoing an initial survey for deemed status purposes, or has not been denied accreditation by The Joint Commission during the previous four months is eligible for an initial unannounced survey if it serves the required minimum number (defined below) of patients 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 has a sufficient number of inpatient records to review to adequately determine compliance equal to 10% of the average daily census but not fewer than 30 inpatient records, or for small general hospitals (with an average daily census of 20 patients or less) not fewer than 20 inpatient records. Specialty hospitals (such as cardiac, orthopedic, or surgical hospitals) have a minimum of 30 inpatient records regardless of average daily census.
- The organization meets parameters for the minimum number of patients/volume of services required for organizations seeking Joint Commission accreditation for the first time, that is, 10 inpatients served, with one active at the time of survey, if the hospital is not using Joint Commission accreditation to meet deemed status requirements.

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.
**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, performance measurement data (when applicable), and the Joint Commission National Patient Safety Goals (see the APR, “Performance Measurement and the ORYX Initiative” [PM], 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 hospitals 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), including laboratory services, 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:

*Contractual arrangements are evaluated for tailoring applicability on a case-by-case basis.
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.†

**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 program surveyed.

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†The laboratory must meet the requirements of decision rule FOC01 for the organization to be successfully accredited. See the “One-Month Survey” section in the “Accreditation Decision Rules” for the full requirement.

‡A complex organization refers to an organization that is surveyed under more than one accreditation manual.
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 and the component do the following:
   - Use the same process for determining membership of licensed independent practitioners in practitioner panels or medical or professional staff and/or
   - Use the same process for credentialing and assigning of privileges or clinical responsibilities to licensed independent practitioners and/or
   - Share a common organized medical or professional staff between the applicant organization and the component
2. The applicant organization’s human resources function hires and assigns staff at the component and has the authority to do the following:
   - 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 medical records are integrated into the applicant organization’s medical 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 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.
### 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>1. Budgetary decisions—Does the governing body of the applicant organization control budget and resource allocation for component?</td>
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<tr>
<td>2. Shared governance—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>1. Common medical staff—Is there a unified process for credentialing staff and/or licensed independent practitioner membership?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>2. Human resources—Does the applicant organization have hiring/firing/performance appraisal authority over the component’s staff?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3. Policies and procedures—Are there common policies and procedures?</td>
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<tr>
<td>4. Management—Does the applicant organization manage operations of the component?</td>
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<td></td>
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<tr>
<td>5. Patient records—Is there an integrated patient record system?</td>
<td></td>
<td></td>
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<tr>
<td>6. Performance improvement—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>7. Billing—Are the component’s services billed by the applicant organization?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>8. Public portrayal—Is there public portrayal of component as part of a parent organization through names, logos, or such?</td>
<td></td>
<td></td>
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</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).
Inclusion of Physician Practices in Survey
Physician practices are included in an accreditation survey only if the physician practice is included in the hospital’s Medicare cost report as a provider-based practice.

Note: For those physician practices not included in the Medicare cost report, The Joint Commission does not necessarily require the inclusion of physician practices in survey; however, organizations may choose to include them.

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 health care 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 Survey Option
The Joint Commission offers a concurrent survey option for health care systems with more than one accredited entity included in a single system even if the organizations maintain distinct CMS Certification Numbers (CCNs). This option provides a structure across the entire system and has the following components:
- Unannounced surveys of participating organizations occur at the same time.
- Each participating organization must demonstrate compliance with all Joint Commission requirements independent of any other organization within the system.
- Each organization with a distinct CCN 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 at the same time.

**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.

**Integrated Care Certification Option**

Integrated Care Certification evaluates how well an organization integrates key processes and coordinates care as a patient moves across the continuum of care. The certification program is an optional process open to entities that are integrating patient care across the continuum:

- A hospital or health system that is integrating with a physician practice (freestanding or hospital based) or an ambulatory organization
- A physician practice (freestanding or hospital based) or an ambulatory organization integrating with a hospital
- Home care providers and/or nursing care centers that are integrating with any of the above entities or with other home care and/or nursing care centers

At least one of these entities must be accredited by The Joint Commission at the time that an integrated program applies for certification. The organization(s) must be working toward improving outcomes through integration and coordination of care.
The certification review will evaluate compliance with the Integrated Care Certification standards, which are designed to be flexible to accommodate different models and sizes of organizations. The requirements will help organizations develop a foundation for using data to identify their risk points and then determine ways to manage those risks. The review will also utilize the tracer methodology, which will follow the experiences of a select number of patients as they move between the integrated care organization’s care providers.

When ready to apply for Integrated Care Certification, an organization can use the application to describe the integrated programs and also the specific sites to be reviewed.

The results of Integrated Care Certification, which is valid for three years, will have no effect on an organization’s accreditation status.

For further information, please e-mail integratedcare@jointcommission.org or visit The Joint Commission website at https://www.jointcommission.org/certification/integrated_care_certification.aspx.

**Primary Care Medical Home Certification Option**

The Joint Commission’s Primary Care Medical Home (PCMH) certification option helps hospitals provide patient-centered, comprehensive, accessible, and coordinated care delivered by a primary care clinician working with an interdisciplinary care team. This voluntary certification is achieved by demonstrating compliance with all hospital standards, plus an additional set of PCMH-only requirements that support the five operational characteristics of the PCMH model (see the “Primary Care Medical Home Certification Option” [PCMH] chapter). PCMH certification is an optional selection available as part of the application for accreditation; that is, hospital accreditation is required for an organization to be eligible for PCMH certification.

Certification is awarded at the individual site level for those clinics/practices seeking PCMH certification and not for all clinics associated with the applicant organization. A hospital may elect to have the PCMH certification for all or only some of its eligible clinics/practices. As with an initial hospital accreditation survey, all PCMH initial surveys are unannounced, with the evaluation of PCMH requirements being integrated as part of the on-site survey process. PCMH certification can also be added to an already existing hospital accreditation through an extension survey. In an extension survey, the surveyor will conduct an unannounced on-site survey prior to the hospital’s next resurvey.
Additional information about the PCMH certification option for hospitals is available on The Joint Commission website at http://www.jointcommission.org/accreditation/primary_care_medical_home_certification_option_for_hospitals.aspx. The Joint Commission also offers similar certification for ambulatory care organizations, behavioral health care organizations, and critical access hospitals.

Organizations that are requesting or that have achieved PCMH certification may access the Provider Information Tool via their E-App or Joint Commission Connect™ extranet site. This optional tool enables organizations to identify clinical providers who serve as staff at eligible PCMH sites. Depending on the location of the organization, this information may be used by payers for reimbursement or funding purposes.

**Patient Blood Management Certification Option**

The Patient Blood Management certification program is a collaborative effort between AABB and The Joint Commission. The AABB–Joint Commission Patient Blood Management Certification is designed to promote patient safety and quality and to help hospitals realize the maximum benefits of establishing a comprehensive patient blood management program. This voluntary hospital certification, which is based on the AABB Standards for a Patient Blood Management Program, is new; hospitals already accredited by AABB are not automatically certified.

Joint Commission accreditation is required for an organization to be eligible for Patient Blood Management certification, which is awarded at a site level. Organizations with multiple sites under the same health care organization number may choose to apply for Patient Blood Management certification for selected sites. To be certified, sites must be able to meet all of the certification program’s requirements.

A Patient Blood Management certification review is scheduled to last one day. If the hospital is accredited by AABB for blood banking and/or transfusion services, a Joint Commission surveyor will conduct the review. If the hospital is not AABB accredited, the review will be conducted by both a Joint Commission surveyor and an AABB assessor. Certification is valid for two years.

For further information, or to access a complimentary trial edition of the standards for Patient Blood Management Certification, please contact qualityhospitals@jointcommission.org or visit The Joint Commission website at https://www.jointcommission.org/certification/patient_blood_management_certification.aspx.
Accrediting in Accordance with CMS Certification Numbers

Under Medicare rules for The Joint Commission’s deeming authority, The Joint Commission accredits a hospital in accordance with its CCN. Each hospital must meet all requirements as specified in the CMS definition of a hospital (as set forth in “Appendix A: Medicare Requirements for Hospitals” [AXA] of this manual; see also “Appendix B: Special Conditions of Participation for Psychiatric Hospitals” [AXB] of this manual). According to CMS, each hospital with its own CCN must demonstrate full compliance with all applicable Joint Commission standards separately and independently of any relationship or affiliation with any other hospital or health care organization.

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 patients
- The organization’s inability to treat and care for patients and its transfer of patients 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.

This policy meets the requirements of the Health Insurance Portability and Accountability Act of 1996.
**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 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

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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.
Attainment of Top Performer® on Key Quality Measures designation from The Joint Commission, if the program is active

Compliance with National Patient Safety Goal requirements

Performance against National Quality Improvement Goals (core measures)

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.

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 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/or 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 patient safety or quality of care 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 patients, families, 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 patient-identifiable information if authorized by the patient, 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 patient name or identifiable information, 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.

The term complaint refers to an alleged adverse event, unsafe condition, or concern. 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 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.

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 available to federal, state, local, or other governmental certification or licensing agencies or public health agencies, or any other appropriate enforcement agency, specific accreditation-related information under the following circumstances:

- When The Joint Commission identifies a serious situation in an organization that may jeopardize the health or safety of patients 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 patients 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.

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**Section 92, PL 96-499, the Omnibus Budget Reconciliation Act of 1980, requires that Medicare providers include, in all their contracts for services costing $10,000 or more in any 12-month period, a clause allowing the Secretary of the US Department of Health and Human Services (DHHS), the US Comptroller General, or their representatives to examine the contract and the contractor’s books and records. The Joint Commission herein stipulates that if its charges to any such organization amount to $10,000 or more in any 12-month period, the contract or any agreement on which such charges are based and any of the Joint Commission’s books, documents, and records that may be necessary to verify the extent and nature of Joint Commission costs will be available to the Secretary of DHHS, the Comptroller General, or any of their duly authorized representatives for four years after the survey. The same conditions will apply to any subcontracts The Joint Commission has with related organizations if the payments under such contracts amount to $10,000 or more in any 12-month period.**
The Accreditation Process

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 CMS in accordance with The Joint Commission’s deeming authority, including the content of the complaint submitted to The Joint Commission
- Complaint information, including the content of the complaint submitted to The Joint Commission, is shared with:
  - CMS in accordance with The Joint Commission’s deeming authority
  - 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 CMS, 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 CMS 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
This page is blank due to revisions through the CAMH update.
Upon request from state agencies that are acting on behalf of CMS as contractors

The Joint Commission will report to CMS or the Office of the Inspector General, 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/.)

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/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 accreditation 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/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/or certification history, subject to any requirements of any applicable laws.

**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 health care organizations, as received from a variety of sources. These complaints may be submitted by patients, families, and 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 health care 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.

<table>
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<th><strong>Sidebar 1. Early Survey Policy</strong></th>
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**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, director of clinical or medical services (medical director), and nurse executive identified
- 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
- Unannounced
- Full initial survey

*continued on next page*
Sidebar 1. Early Survey Policy (continued)

- 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 is not recognized by CMS for Medicare certification purposes (but it 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, its director of clinical or medical services, and its nurse executive, if applicable.
- 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. For this reason, organizations surveyed under this policy are not recognized by CMS as meeting the requirements for Medicare certification until the second (full) survey has been conducted and a decision of Accredited has been achieved.

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.
The Accreditation Process

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 unannounced 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 conducted under the Early Survey Policy (which is an unannounced full survey) 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 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 unannounced, 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.

Before the Survey

This section provides information on the steps leading to a full accreditation 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-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 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, the Core Measure Solution Exchange®, 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 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, 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 630-792-5145 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 services provided. The E-App does the following:

- Describes the organization seeking accreditation in terms of size and scope of services
- Requires the organization to make available to The Joint Commission all official records and reports of public or publicly recognized licensing (for example, state licenses), examining, reviewing, or planning bodies during the initial on-site survey (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 programs/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.

**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

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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.

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Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
American Recovery and Reinvestment Act of 2009, a 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 patient-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 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. The annual fees, billed each January, 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 annual fees, organizations are also billed an on-site fee within two days after the survey has been conducted. The on-site fee is designed to cover the direct costs of performing a survey.

Organizations requiring additional surveys, such as to evaluate a patient safety event, will be assessed a separate survey fee.
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 accreditation survey, The Joint Commission evaluates an organization’s performance of functions and processes aimed at continuously improving patient outcomes. The survey process focuses on assessing performance of important patient-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 patients
- 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. In addition, 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.

<table>
<thead>
<tr>
<th>Subject</th>
<th>Exception</th>
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<tbody>
<tr>
<td>Early Survey Policy—1st survey</td>
<td>Announced</td>
</tr>
<tr>
<td>Organizations undergoing ICM Option 2 and Option 3 surveys</td>
<td>Announced (unless the organization requests the survey to be unannounced)</td>
</tr>
<tr>
<td>Department of Defense facilities</td>
<td>Announced (with 7 business days’ notice)</td>
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</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:

- 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-of-care 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.

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58 These include all events conducted for Medicare certification purposes through The Joint Commission’s available deemed status or Medicare recognition options.
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
Based on the size and complexity of the organization being surveyed, an accreditation survey may be conducted by one surveyor or a team of surveyors, with a minimum of at least one clinical surveyor assigned to the event. 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.

Life Safety Code® Surveyor Scope of Service
A Life Safety Code® Surveyor will be part of every hospital survey. The Life Safety Code Surveyor is responsible for evaluating specific environment of care and Life Safety Code accreditation criteria and educating the organization during the survey about related compliant and not compliant areas, opportunities for improvement, and remedial action that may be required. The Life Safety Code Surveyor is always accompanied by at least one clinical surveyor during the initial and full survey events.
Survey Agenda

The Joint Commission reviews the data in a hospital’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 that the surveyor will request to review at the onset of the survey.

The organization’s Joint Commission account executive will contact the hospital 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 hospital to ensure the schedule considers the organization’s operations and needs. During the survey, the surveyor(s) will work to minimize any disruption to patient care 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 hospital 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.

Surveyor Planning Session. During this session, the surveyor(s) will review data and information about the hospital to plan the survey agenda. This will include any information from previously conducted Joint Commission activities and other hospital

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.
documents that have been gathered for review. The surveyor(s) will select the first patients 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 patient by the hospital from preadmission through post-discharge
- Assess the interrelationships among disciplines and services/programs and the important functions in the care, treatment, or services provided
- Evaluate the performance of processes relevant to the care, treatment, or service needs of the patient, with particular focus on the integration and coordination of distinct but related processes
- Identify vulnerabilities in the care processes

See the “Tracer Methodology” section for more information about individual tracer activity.

**System Tracers.** System tracers are interactive sessions with the surveyor(s) and organization staff that explore the performance of important patient-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. System tracers may include the following:

- Data management
- Infection control
- Medication management, if within the scope of the organization
- Program-specific areas (see the “Accreditation Program–Specific Tracers” section)

As surveyors perform individual tracers (see section above) to determine standards compliance as it relates to care delivered to the selected patient, they also begin to learn about the organization’s overall systems. Information gathered during individual tracers is then considered from a multi-patient, cross-organizational perspective during system tracers for high-risk processes. See the “Tracer Methodology” section for more information.

**Program-Specific Tracers.** Program-specific tracers will be conducted if they apply to the organization being surveyed and at the surveyor’s discretion. These program-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 session provides an opportunity for the surveyor(s) 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, surveyors will communicate to organization staff their observations on the previous day’s survey findings and any significant patterns or trends that are becoming evident in the survey, if requested to do so. During the daily briefing, the surveyor(s) will do the following:

- Facilitate leaders’ understanding of the survey process and the findings
- Report on findings from the previous day’s survey activities, 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)
- Emphasize patterns or trends of significant concern that could lead to noncompliance determinations
- Highlight any positive findings or exemplary performance
- Allow the organization to supply additional information that would demonstrate compliance with a standard that a surveyor has indicated may be an RFI
- Review the agenda for the survey day ahead and make any necessary adjustments based on hospital needs or the need for more intensive assessment of an issue

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.

Medical Staff Credentialing and Privileging. This activity will help the hospital and the surveyor(s) identify specific issues and do the following:

- Evaluate the process the hospital uses to collect relevant data for decisions for credentialing and privileging
- Evaluate the consistent implementation of the credentialing and privileging process
- Evaluate processes for the granting of and the appropriate delineation of privileges
- Determine whether practitioners practice within the limited scope of delineated privileges
- Link results of peer review and focused monitoring to the credentialing and privileging process
- Identify vulnerabilities in the credentialing, privileging, and appointment process
■ Evaluate ongoing professional practice evaluation (OPPE) and focused professional practice evaluation (FPPE) processes

**Competence Assessment.** This review activity focuses on the hospital’s processes for ensuring the appropriate knowledge and competence of staff providing patient care, treatment, and services. The surveyor(s) and the organization will discuss and review topics such as these:

■ Processes for verifying required professional 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.

**Environment of Care.** This session is an opportunity for the surveyor and hospital to review and evaluate the following:

■ The processes in place for managing risk in the physical environment (for example, safety and security, fire safety, hazardous materials and wastes, medical equipment)

**Emergency Management.** This survey activity will allow the organization and the surveyor(s) to do the following:

■ 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
■ Review 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

**Facility Orientation—Life Safety Code Surveyor.** This survey activity is performed by a Life Safety Code Surveyor. In addition to assessing the main fire alarm panel and becoming familiar with the building layout, the surveyor will evaluate the effectiveness of processes for the following:

■ 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 fire safety equipment and fire safety building features
- Maintaining and testing emergency power systems
- Maintaining and testing medical gas and vacuum systems

**Life Safety Code Building Assessment.** This session includes a building tour that will help the Life Safety Code Surveyor determine the degree of compliance with relevant Life Safety Code requirements. The surveyor will assess the following:
- Pressure relationships in operating rooms
- Required fire separations
- Required smoke separations
- Hazardous areas (and spaces above their ceilings) such as soiled linen rooms, trash collection rooms, and oxygen storage rooms
- Fire exits
- Kitchen grease–producing cooking devices and laundry and trash chutes
- Emergency power systems and equipment
- Medical gas and vacuum system components

**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 patient 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

**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 health care delivery process. 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 program-specific tracer activity is to identify safety concerns within different levels and types of care, treatment, or services. Program-specific tracers focus on important issues relevant to the organization (for example, clinical services offered and high-risk, high-volume patient populations).

Topics for the 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 program-specific issues and compliance with relevant standards that impact patient safety. Table 2 contains hospital-specific tracer activities, including applicability and objectives.

**Note:** Program-specific tracers, which occur during the Individual Tracer Activity, are conducted only if they apply to the organization being surveyed.

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<th>Table 2. Hospital-Specific Tracer Applicability and Objectives</th>
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<th>Tracer</th>
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| Laboratory Integration | All hospitals | ■ To evaluate the consistent application of processes related to laboratory testing throughout the hospital  
                          ■ To evaluate the exchange of information and integration of the laboratory process in the hospital setting (for example, specimen collection and handling, specimen identification)  
                          ■ To evaluate the involvement of laboratory personnel in important processes within the hospital, such as point-of-care testing |
| Patient Flow         | All hospitals | ■ To look for organization awareness and improvements in patient flow  
                          ■ To evaluate process issues throughout the hospital contributing to patient flow concerns |
| Suicide Prevention   | All hospitals | ■ To evaluate the effectiveness of the organization's suicide prevention strategy  
                          ■ To identify processes and system-level issues contributing to suicide attempts |

**Individual Tracer Activity**

The individual tracer activity is conducted during an on-site survey and is designed to “trace” the care experiences that a patient had while at the hospital. The tracer methodology is a way to analyze a hospital’s system of providing care, treatment, or services using actual patients as the framework for assessing standards compliance. The surveyor(s) will use the following general criteria to select initial individual tracers:

- Patients whose tracers would allow for the evaluation of identified program-specific risk areas/categories (EPs with the $\mathbb{R}$ icon).
- Patients who cross programs (for example, home care patients discharged from a hospital or individuals served by behavioral health care organizations who present at an ambulatory care facility in complex organizations)
Patients who will contribute greater understanding to system tracer topics (see the “System Tracer Activity” section), such as infection control or medication management

■ Patients receiving complex services, such as surgery or treatment in an intensive care unit

Patients selected for initial individual tracer activity will likely be those whose diagnosis, age, or type of services received may enable the best in-depth evaluation of the hospital’s processes and practices. In conducting a patient’s tracer, the surveyor(s) will follow specific patients through the hospital’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 department/unit/program and service, as well as how departments/units/programs and services work together. The surveyor(s) usually starts where the patient is currently located. He or she can then move to where the patient first entered the organization’s systems; an area of care provided to the patient that may be a priority for that organization; or to any areas in which the patient received care, treatment, or services. The location and order will vary. Along the way, the surveyor(s) will speak with the health care staff member(s) who actually provided the care to that individual tracer patient—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.

Surveyors use individual patient tracers and systems tracers to review patient medical records. For hospitals seeking deemed status, surveyors will review inpatient records for 10% of the average daily census but not fewer than 30 inpatient records, or for small general hospitals (with an average daily census of 20 patients or less) not fewer than 20 inpatient records. For specialty hospitals (such as cardiac, orthopedic, or surgical hospitals), the minimum is 30 inpatient records regardless of average daily census.

Based on the findings of the surveyor(s), he or she may select similar patients to trace. The tracer methodology permits surveyors to further investigate if there is a reason to believe that an issue needs further exploration.

Please see the Survey Activity Guide on the Joint Commission Connect site for more detailed information on other program-specific criteria for tracer selection.
Risk Areas
A surveyor conducting any type of tracer at a hospital 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 patient safety.

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 patients, staff, and/or visitors and the scope at which the RFI was observed.

Topics in hospitals that surveyors might need to explore in more detail include, but are not limited to, the following:
- Assessing, planning, and coordinating care
- Emergency management
- Environment of care
- Infection control
- Life safety
- Medical staff
- Medication management
- Operative and invasive procedures
- Restraints

System Tracer Activity
System tracers explore one specific system or process across the organization, focusing, when possible, on the experiences of specific patients or activities relevant to specific patients. This differs from individual tracers in that during individual tracers, the surveyor(s) follows a patient through his or her course of care, evaluating all aspects of care 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 and departments 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 Accreditation Process

The flow of the process across the hospital, including identification and management of risk points, integration of key activities, and communication among staff/units 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, and medication management. Whether all system tracers are conducted varies based on survey length, but the data use system tracer is performed on every hospital survey. If survey length does not permit the conduct of an infection control or medication management system tracer, the given area is assessed through other survey activities.

**Data Management.** The data management system tracer focuses on how the hospital collects, analyzes, interprets, and uses or manages data to improve patient safety and care.

**Infection Control.** The infection control individual-based system tracer explores the hospital’s infection control processes. The goals of this session are to assess the hospital’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 patients.

**Medication Management.** The medication management individual-based system tracer explores the hospital’s medication management processes 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 from procurement of medications through the monitoring of their effects on patients.

**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 active patients, including the patients’ names, current locations in the hospital, and diagnoses/conditions, as appropriate. The surveyor(s) may request assistance from hospital staff for selection of appropriate tracer patients. As the surveyor(s) moves around a hospital, he or she will ask to speak with the staff members who have been involved in the tracer patient’s care, treatment, or services if available. If those staff members are not available, the surveyor(s) will ask to speak to another staff member who would perform the same function(s) as the member who has cared for or is
caring for the tracer patient. 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 patient 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.)* For organizations using the deemed status option, the finding(s) that contributes to the Immediate Threat situation will be documented as a Medicare Condition-level deficiency.

If a surveyor identifies any condition that he or she believes poses a serious threat to public or patient 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. *In deemed status scenarios where the survey is utilized to demonstrate compliance with the Medicare Conditions of Participation, The Joint Commission will provide written notification of the immediate threat to CMS within 2 business days of confirming the immediate threat and subsequently within 10 calendar days with additional information concerning the immediate threat.* After notification of the Preliminary Denial of Accreditation decision, an organization has **up to 72 hours** to do the following:

- Eliminate the Immediate Threat to Health or Safety situation *entirely*

or

***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.***
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 patients (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.

†† 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.”
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 CMS (if the organization had planned on using its Joint Commission accreditation for meeting deemed status requirements) or other 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.
Figure 2. Process flow for Immediate Threat to Health or Safety (ITHS) situations at organizations seeking reaccreditation.
The Summary of Survey Findings Report

Following evaluation of an organization’s performance of functions and processes, the surveyor (or 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 patients, staff, and/or visitors and the scope at which the RFI was observed. If a hospital does not receive any RFIs, its accreditation decision is rendered at the same time that the hospital’s preliminary Summary of Survey Findings Report is available, and it is effective the day after the completion of the survey. If a hospital 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 a patient(s), 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.

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 patient safety—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 patients 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 patient safety, 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 patients. 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 patient care and safety 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 patient safety. 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 is posted on the hospital’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 (OBCO). Although the OBCO 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.

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.
Decision Outcomes for Organizations Seeking Initial Accreditation

For organizations undergoing their full 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. 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.
Organizations found with *Condition-level deficiencies* during their initial survey are required by CMS to undergo a second initial Medicare survey. If no deficiencies—whether related to Joint Commission requirements or Medicare Conditions of Participation—are found during this second initial Medicare survey, the organization receives an Accredited decision.

If *Condition-level deficiencies* are found during the second initial Medicare survey, the organization receives a Denial of Accreditation decision. However, if the second Medicare survey results in findings of deficiencies with *Joint Commission requirements only*, the organization’s decision is again pending the submission of corrective action through an ESC. A successful ESC will then result in an Accredited decision; an unsuccessful ESC at this point will result in a decision of Denial of Accreditation with no opportunity to appeal.

**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 and evidence of a successful Medicare deficiency follow-up survey if Medicare Condition-level deficiencies are identified, 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 hospital 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 hospital’s secure Joint Commission Connect site at the same time that the hospital’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 a hospital receives an RFI, it can choose to go directly to corrective action or to try and clarify the accuracy of the RFI. The hospital must submit either a successful clarification or a corrective ESC for every RFI cited in a hospital’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 time frame 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.
### 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

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<table>
<thead>
<tr>
<th>SAFER Matrix Placement</th>
<th>Required Follow-Up Activity</th>
</tr>
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<tbody>
<tr>
<td><strong>HIGH/LIMITED</strong>&lt;br&gt;<strong>HIGH/PATTERN</strong>&lt;br&gt;<strong>HIGH/WIDESPREAD</strong></td>
<td>- 60-day Evidence of Standards Compliance (ESC) that details the action(s) taken to come into compliance with the standards</td>
</tr>
</tbody>
</table>
| **MIXED/PATTERN**<br>**MIXED/WIDESPREAD** | - ESC will also include two additional areas surrounding the following:  
  1. Leadership Involvement  
  2. Preventive Analysis |
| **MIXED/LIMITED**<br>**LOW/PATTERN**<br>**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.*
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 hospital 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 surveyors at the time of survey and by health care organizations when they conduct their FSA. The Joint Commission will consider the ESC acceptable when the hospital has demonstrated resolution of all RFIs. If the hospital
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 hospital’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 hospital’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 patients 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.

Medicare Certification Recommendation Letter

For hospitals that use Joint Commission accreditation for deemed status purposes, in addition to the official accreditation award letter, The Joint Commission will issue a Medicare recommendation letter to inform CMS that a new or existing Medicare provider has participated in a deemed status survey and that The Joint Commission is making a recommendation regarding Medicare certification as a result. The letter includes information on the dates of the survey, the outcome of the survey, the effective date of accreditation, and the locations included in the scope of the accreditation survey. The Joint Commission provides a copy of the letter to the CMS central office and appropriate regional office. The regional office then makes the final determination...
regarding the Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13. Hospitals new to accreditation are encouraged to share the Medicare recommendation letter with their state survey agency.

**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, unannounced 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 in response to complaints, media coverage, or other information that raises questions about the
adequacy of patient health and safety protections. For organizations using The Joint Commission for deeming purposes, the survey will be unannounced. (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 hospitals. 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 patient, probability of harm, severity of harm, and number of patients 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 hospitals incorporate Joint Commission standards as part of routine operations and ongoing quality improvement efforts, supporting a continuous accreditation process. A hospital has access to its FSA tool on a continuous basis throughout its accreditation cycle. The FSA tool becomes available to a hospital seeking accreditation for the first time after submitting its E-App and deposit. The FSA tool permits the hospital to evaluate compliance with all applicable Joint Commission standards and EPs. For every noncompliant standard, the hospital 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, a hospital 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 hospital’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 hospital 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 a hospital’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 R 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.

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.
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.

FSA Option 2
- 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.

A Plan of Action details the action(s) an organization will take to come into compliance with each standard identified as not compliant.

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
Sidebar 2. (continued)

- 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 a hospital's accreditation decision only if the hospital 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 a hospital 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 hospitals are expected to identify and respond appropriately to all sentinel events. The hospital 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 a hospital. Hospitals must notify The Joint Commission promptly, in writing, when an additional service is contemplated so any potential impact to accreditation can be determined. Medicare-certified organizations must also notify the Medicare Administrator Contractor promptly, in writing, when an additional service is contemplated. 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, a hospital may undergo a change that modifies the information reported in its E-App (see APR.01.03.01 in the APR chapter). Hospitals 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. Medicare-certified organizations must notify the Medicare Administrator Contractor promptly, in writing, when an additional service is contemplated.

Once the change has actually occurred, the hospital 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 health service, program, or site of care
- The deletion of an existing health service, program, or site of care
- The acquisition of a new component
- 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 hospital 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 hospital only after surveying all or an appropriate sample of

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.
all services, programs, and sites provided by the hospital 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 a hospital offers its services or programs at a new location or in a significantly altered physical plant, the hospital 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 hospital’s loss of accreditation. If the corrective actions cannot be accomplished within 60 days of notification to The Joint Commission, the hospital will need to contact its Account Executive.

**Mergers, Consolidations, and Acquisitions**

In the case of a merger, consolidation, or acquisition, The Joint Commission may decide that the hospital responsible for services must have a survey. If, after a hospital receives an accreditation decision, the hospital’s structure changes whereby one or more of its services, programs, or related hospitals are no longer part of the hospital that was originally surveyed, the service, program, or related hospital is no longer included in the hospital’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 hospital to cease the provision of services for a period of time, The Joint Commission will work with the affected hospital to address the impact that the cessation of services will have on the hospital’s accreditation status and to ensure that the hospital is prepared to provide safe, quality care upon resumption of services. If after six months the hospital cannot resume

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555 Can be natural or man-made; any situation that causes cessation of services.
services, The Joint Commission will discontinue the accreditation of the hospital. 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 hospitals that resume services within the first 30 days after a disaster and/or the hospital’s decision to cease operations, the hospital’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 hospital resumes operation. In most cases, The Joint Commission will not need to survey the affected hospital to reassess its level of standards compliance. If The Joint Commission decides to conduct a survey, however, the hospital’s accreditation decision will be driven by the interim survey findings.

**Cease Services Up to 90 Days.** For hospitals that resume services from 31 to 90 days after a disaster, The Joint Commission will conduct an extension survey to determine the hospital’s accreditation status. The circumstances surrounding the hospital’s closure will determine the survey’s length and scope.

**Cease Services Up to Six Months.** For hospitals 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 hospitals 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.

**More Than Six Months.** For hospitals 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 hospital 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 hospital’s request and will assess the hospital’s ability to provide safe patient care. The hospital may qualify for an accreditation award as a result of this survey. However, at this point, the hospital will not be recognized by CMS as meeting the requirements for Medicare certification. 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 hospitals as Accredited up to six months after a disaster, unless interim survey findings dictate otherwise.

While working with affected hospitals in the aftermath of a catastrophic event, The Joint Commission will be sensitive to these hospitals’ needs and will work with responsible state and federal agencies to help reestablish the hospitals’ operations as well as their qualification for accreditation.

If, following a disaster, a hospital 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 hospital is affected by a natural disaster, please notify your hospital’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 hospital’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 Have Patients for a Period of Time**

Joint Commission–accredited hospitals may stop providing care, treatment, and services to patients or may not have any patients for a period of time for reasons other than natural or man-made disasters. When a hospital ceases to provide patient care services, it is required to notify The Joint Commission. The Joint Commission will work with the affected hospital to address the impact that the cessation of services or the lack of patients will have on the hospital’s accreditation status and to ensure that the hospital is prepared to provide safe, quality care upon resumption of services. If after six months the hospital cannot resume services, The Joint Commission will terminate the accreditation of the hospital.
**Up to 60 Days.** If a hospital does not have any patients for up to 60 days, The Joint Commission will continue the hospital’s current accreditation status.

**Up to Six Months.** If a hospital does not have any patients from 60 days to less than six months, but then resumes patient services within six months, The Joint Commission will continue the hospital’s current accreditation status only if the hospital has an extension survey. This extension survey would generally take place as soon as possible in accordance with the hospital’s request. The purpose of this survey is to evaluate the hospital’s capability for resuming services and whether it is performing at current accreditation levels. If the hospital refuses an extension survey, the accreditation will be terminated.

**More Than Six Months.** If a hospital does not have any patients for six months or longer, The Joint Commission will terminate the hospital’s accreditation. If the hospital 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 hospital to be designated as “new,” it must not have participated in the accreditation process during the previous four months. If a hospital 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. A new service includes the request for the Primary Care Medical Home certification option.

**Extension Surveys**

The Joint Commission conducts an extension survey when an accredited hospital 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 hospital is still appropriate under the changed conditions. The results of an extension survey may affect the hospital’s accreditation status.
An extension survey is conducted at an accredited hospital or at a site that is owned and operated by the hospital if the accredited hospital’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 patient volume, 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 hospital time to bring a new service or site up to the accredited hospital’s standard of performance. If the hospital uses Joint Commission accreditation for deemed status purposes, the results of the extension survey will immediately affect its accreditation status. If the hospital does not use accreditation for deemed status, the survey findings resulting from the extension survey are maintained separately from, and are not reflected in, the accreditation decision of the acquiring hospital 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 hospital.

**For-Cause Surveys**

The Joint Commission may perform a for-cause survey when it becomes aware of potentially serious standards compliance or patient care, treatment, service, or safety issues or when it has other valid reasons for surveying an accredited hospital (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 hospital’s services or only those areas where a serious concern may exist.

A for-cause survey can take place at any point in an organization’s accreditation cycle. For organizations using The Joint Commission for deeming purposes, the survey will be unannounced. No on-site summary report is generated after a for-cause survey.
**Note:** A hospital is charged for a for-cause survey. A hospital 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 a hospital accreditation if the hospital 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 hospitals 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.

**On-site Follow-up Survey for a Condition-level Deficiency**

According to CMS regulations, The Joint Commission must conduct an on-site follow-up survey whenever a Medicare Condition of Participation is found not to be in compliance at the time of a Joint Commission survey.

If a Condition-level deficiency is found in a “new” (or initial) hospital or a hospital that is seeking a new CCN, then The Joint Commission cannot make a recommendation to CMS that the hospital be Medicare certified. The hospital will have to undergo an additional unannounced initial Medicare survey to evaluate whether it meets Medicare requirements. For existing deemed status hospitals: When a Condition-level deficiency is found, The Joint Commission must conduct a follow-up Medicare Deficiency survey within 45 calendar days to evaluate the hospital’s implementation of corrective action to demonstrate compliance with the Condition(s) of Participation in question. If this survey is unsuccessful, the hospital will have a second Medicare Deficiency survey within 30 calendar days. If the second survey is unsuccessful, CMS must be notified that the organization is no longer recommended for continued Medicare certification, and the organization receives a Preliminary Denial of Accreditation decision.
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 hospitals follow.

**Note:** Accreditation decision rules are numbered sequentially across all Joint Commission accreditation programs. Some accreditation decision rules do not apply to hospitals 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 hospital 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 hospital, 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.

### Primary Care Medical Home Certification

The following rules will be used for Joint Commission–accredited hospitals that choose to apply for Primary Care Medical Home Certification:
PCMH01 A Joint Commission–accredited hospital will be certified for the Primary Care Medical Home program if it is in compliance with all Primary Care Medical Home Certification standards at the time of the on-site survey.

PCMH02 A Joint Commission–accredited hospital will not be certified for the Primary Care Medical Home program if it has not successfully addressed all Primary Care Medical Home Certification RFIs in its ESC submission.

PCMH03 A Joint Commission–accredited hospital will not be certified for the Primary Care Medical Home program if it does not meet all Joint Commission standards for Primary Care Medical 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 hospital 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 A hospital has one or more noncompliant standards at the time of a survey event.

ESC02 A hospital 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.
One-Month Survey
A one-month survey will be performed when the following condition is met:

FOC01  A full laboratory survey will be conducted when a hospital providing laboratory services cannot demonstrate to The Joint Commission that its laboratory accreditation decision is in good standing with a Joint Commission–recognized accreditor or the accreditation is more than 24 months old.

Medicare Survey
A Medicare survey will be performed when the following condition is met:

CLD01  The hospital has one or more Conditions of Participation scored as a Condition-level deficiency.

Note: This rule applies only to hospitals that use accreditation for deemed status purposes. Hospitals currently not Medicare certified that receive one or more Condition-level deficiencies as a result of a survey event will be required to have a new initial unannounced Medicare survey to demonstrate full compliance with all Medicare requirements. Hospitals currently Medicare certified that receive one or more Condition-level deficiencies as a result of a survey event will be required to have an unannounced Medicare Deficiency follow-up survey to demonstrate full compliance with Medicare requirements.

Denial of Accreditation
Denial of Accreditation will be recommended when one or more of the following conditions are met:

DA01  The hospital does not permit the performance of any survey by The Joint Commission. (APR.02.01.01, EP 1)

DA03  The hospital has failed to submit payment for survey fees or annual fees.

DA04  The hospital has repeatedly failed to submit an ESC.

DA05  A hospital undergoing its first Joint Commission survey has placed patients 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 patients, staff, or the public within the hospital undergoing its first Joint Commission survey. (APR.09.04.01, EP 1)

DA07  The Joint Commission is reasonably persuaded that the hospital submitted falsified documents or misrepresented information in any way in seeking to achieve accreditation. If accreditation is denied following implementation of this rule, the hospital 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 hospital undergoing its first Joint Commission survey fails to successfully address all RFIs in an ESC after two opportunities.

DA09  The hospital fails its Medicare follow-up survey as a result of one or more Conditions of Participation scored as a Condition-level deficiency.

Note: This rule applies only to hospitals that use accreditation for deemed status purposes.

DA10  The hospital’s patients have been placed at risk for a serious adverse outcome because either an individual who does not possess a license, registration, or certification is providing or has provided health care services in the hospital that would, under applicable law or regulation, require such a license, registration, or certification; or an individual is practicing outside the scope of his or her license, registration, or certification. (HR.01.02.07, EPs 1 and 2; MS.06.01.05, EP 1)

DA11  The hospital 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 hospital 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 hospital 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 hospital, 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.

Primary Care Medical Home Certification
The following rules will be used for Joint Commission–accredited hospitals that choose to apply for Primary Care Medical Home Certification:

PCMH01 A Joint Commission–accredited hospital will be certified for the Primary Care Medical Home program if it is in compliance with all Primary Care Medical Home Certification standards at the time of the on-site survey.

PCMH02 A Joint Commission–accredited hospital will not be certified for the Primary Care Medical Home program if it has not successfully addressed all Primary Care Medical Home Certification RFIs in its ESC submission.

PCMH03 A Joint Commission–accredited hospital will not be certified for the Primary Care Medical Home program if it does not meet all Joint Commission standards for Primary Care Medical 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 A hospital has one or more noncompliant standards at the time of a survey event.

ESC02 A hospital that fails to successfully address all RFIs in an ESC may be required to submit a second ESC.
One-Month Survey
A one-month survey will be performed when the following condition is met:

**FOC01** A full laboratory survey will be conducted when a hospital providing laboratory services cannot demonstrate to The Joint Commission that its laboratory accreditation decision is in good standing with a Joint Commission–recognized accreditor or the accreditation is more than 24 months old.

Medicare Survey
A Medicare survey will be performed when the following condition is met:

**CLD01** The hospital has one or more Conditions of Participation scored as a Condition-level deficiency.

**Note:** This rule applies only to hospitals that use accreditation for deemed status purposes. Hospitals currently not Medicare certified that receive one or more Condition-level deficiencies as a result of a survey event will be required to have a new initial unannounced Medicare survey to demonstrate full compliance with all Medicare requirements. Hospitals currently Medicare certified that receive one or more Condition-level deficiencies as a result of a survey event will be required to have an unannounced Medicare Deficiency follow-up survey to demonstrate full compliance with Medicare requirements.

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:

**AFS01** The hospital demonstrates systemic patterns, trends, and repeat findings with standards.

**AFS03** The hospital fails to successfully address all RFIs in an ESC after two opportunities.

**AFS05** The hospital, which has failed to resolve one or more of its original RFIs, may be scheduled for a second Accreditation with Follow-up Survey.
The Accreditation Process

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.

**AFS06** The hospital fails to participate in Intracycle Monitoring requirements.

**AFS08** The hospital fails its Medicare follow-up survey as a result of one or more Conditions of Participation scored as a Condition-level deficiency.

*Note: This rule applies only to hospitals that use accreditation for deemed status purposes.*

**AFS09** An individual who does not possess a license, registration, or certification is providing or has provided health care services in the hospital that would, under applicable law or regulation, require such a license, registration, or certification; or an individual is practicing outside the scope of his or her license, registration, or certification. (HR.01.02.07, EPs 1 and 2; MS.06.01.05, EP 1)

*Note: Except as provided under rule PDA03.*

**AFS10** The hospital 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, EP 1)

**AFS11** If the Immediate Threat to Health or Safety abatement survey through direct observation or other determining method has demonstrated that the hospital 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 hospital may have engaged in possible fraud or abuse.

**AFS13** If a hospital 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 patients, staff, or the public within the hospital. (APR.09.04.01, EP 1)
PDA02 The hospital’s patients have been placed at risk for a serious adverse outcome(s) due to significant and pervasive patterns, trends, and/or repeat findings.

PDA03 The hospital’s patients have been placed at risk for a serious adverse outcome because either an individual who does not possess a license, registration, or certification is providing or has provided health care services in the hospital that would, under applicable law or regulation, require such a license, registration, or certification; or an individual is practicing outside the scope of his or her license, registration, or certification. (HR.01.02.07, EPs 1 and 2; MS.06.01.05, EP 1)

PDA04 The hospital 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 hospital is seeking accreditation. (LD.04.01.01, EP 1)

PDA05 The Joint Commission is reasonably persuaded that the hospital 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 hospital 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 hospital with a decision of Accreditation with Follow-up Survey has failed to resolve all RFIs after two opportunities.

PDA09 The hospital fails its second Medicare follow-up survey as a result of a one or more Conditions of Participation scored as a Condition-level deficiency.

Note: This rule applies only to hospitals that use accreditation for deemed status purposes.

PDA10 The hospital’s patients have been placed at risk for a serious adverse outcome because there is some evidence that the hospital 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 hospital 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 hospital does not permit the performance of any survey by The Joint Commission. (APR.02.01.01, EP 1)

DA02  The hospital has failed to resolve an Accreditation with Follow-up Survey status prior to withdrawing from the accreditation process.

DA03  The hospital has failed to submit payment for survey fees or annual fees.

DA04  The hospital has failed to submit an ESC or a Plan of Correction.

DA05  A hospital in the sustaining improvement program fails to participate in Joint Commission intervention.

DA06  A hospital has received a PDA decision in two sequential surveys.

Process for Organizations That Meet Decision Rule PDA02 for Patients 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**

- **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 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 10 business days of posted final report, the HCO will have the option to clarify inaccurate survey findings**

*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.**

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**Process for Organizations That Meet Decision Rule PDA04**

If a hospital 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 hospital does not have a required license, certificate, or permit, the hospital will be notified that it meets a rule for Preliminary Denial of Accreditation and The Joint Commission will initiate such action.**
- **The hospital 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 hospital 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. For existing Medicare-certified organizations using the deemed status option, any Medicare Condition-level deficiencies identified during the unannounced, on-site survey will require an unannounced Medicare Deficiency Follow-up Survey within 45 calendar days from the survey where the deficiency was identified.

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 Grid (SAG)

Not all of the standards/requirements in the CAMH apply to all hospitals. Based on the particular services provided by your hospital, you should use this grid to identify which standards/requirements are applicable.

Services are listed horizontally along the top of this grid. The standard/requirement and element of performance (EP) numbers are listed vertically. Applicability is indicated with an X.

The following services are listed in the grid:
- Acute
- Long Term Acute Care
- Psychiatric
- Surgical Specialty
- Swing Beds
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<th>EP #</th>
<th>Acute</th>
<th>Long Term Acute Care</th>
<th>Psychiatric</th>
<th>Surgical Specialty</th>
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## Standards Applicability Grid

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.

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| 4 | X | X | X | X | X
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| 7 | X | X | X | X | X
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| 16 | X | X | X | X | X
| 17 | X | X | X | X | X
| 18 | X | X | X | X | X
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Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
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## Standards Applicability Grid

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.

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## Standards Applicability Grid

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Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.

CAMH Update 2, January 2018
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Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.

**SAG – 40**  
**CAMH Update 2, January 2018**
Sentinel Events (SE)

I. Sentinel Events
The Joint Commission adopted a formal Sentinel Event Policy in 1996 to help hospitals 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 patient harm. The Sentinel Event Policy explains how The Joint Commission partners with hospitals that have experienced a serious patient safety event to protect the patient, 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 the patient’s illness or underlying condition) that reaches a patient 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 patient receiving care, treatment, and services in a staffed around-the-clock care setting or within 72 hours of discharge, including from the hospital’s emergency department (ED)
- Unanticipated death of a full-term infant
- Discharge of an infant to the wrong family
- Abduction of any patient receiving care, treatment, and services

Sexual abuse/assault (including rape) as a sentinel event is defined as nonconsensual sexual contact involving a patient and another patient, staff member, or other perpetrator while being treated or on the premises of the hospital, 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 hospital to support allegations of unconsented sexual contact

Invasive procedures, 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)

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Invasive procedures, 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)
- 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 patient care
- Any intrapartum (related to the birth process) maternal death
- Severe maternal morbidity (not primarily related to the natural course of the patient’s illness or underlying condition) when it reaches a patient 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 hospital 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 (see the “Patient Safety Systems” [PS] chapter).

All sentinel events must be reviewed by the hospital and are subject to review by The Joint Commission. Accredited hospitals are expected to identify and respond appropriately to all sentinel events (as defined by The Joint Commission) occurring in the hospital or associated with services that the hospital 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-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 patient, discloses the event to the patient and family, and provides support for the family as well as staff involved in the event
- Notification of hospital 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 a patient. 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 a patient.
- A no-harm event is a patient safety event that reaches the patient but does not cause harm.
- A close call (or “good catch”) is a patient safety event that did not reach the patient.
- A hazardous (or “unsafe”) condition(s) is a circumstance (other than a patient’s own disease process or condition) that increases the probability of an adverse event.

The hospital 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 hospital leaders, investigation, and corrective actions, in accordance with the hospital’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 hospital’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 patient care, treatment, and services and in preventing unintended harm
2. To focus the attention of a hospital 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 hospital culture), and on changing the hospital’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 hospitals that patient safety is a priority in accredited hospitals

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.)

Standard **LD.04.04.05**, EP 7, requires each accredited hospital to define patient safety event for its own purposes and to communicate this definition throughout the hospital. This definition must encompass sentinel events as defined by The Joint Commission. An accredited hospital is encouraged to include in its definition events, incidents, and conditions in which no or only minor harm occurred to a patient. The hospital determines how it will respond to patient safety events that do not meet the definition of sentinel event.

The Medical Staff (MS) Standard **MS.05.01.01**, EP 10, requires hospitals to include sentinel event data among the information used as a part of performance improvement activities to improve the quality of care, treatment, and services and patient safety. EP 11 of that standard requires that patient safety data is also used in those activities.
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.

A hospital may use other tools and methodologies to conduct its comprehensive systematic analysis. The Joint Commission encourages the hospital to contact the patient safety specialist assigned to the hospital’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 hospital 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/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 hospital 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. A hospital benefits from self-reporting in the following ways:

- The Joint Commission can provide support and expertise to the hospital during the review of a sentinel event.
- A review with the Office of Quality and Patient Safety provides the opportunity for the hospital to collaborate with a patient safety specialist who is likely to have reviewed similar events.
- Reporting raises the level of transparency in the hospital and helps promote a culture of safety.
- Reporting conveys the hospital’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 hospitals.

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 a patient, a family member, an employee of the hospital, 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 hospital voluntarily reports the event or The Joint Commission becomes aware of the event by some other means. If a hospital wishes to report to The Joint Commission an occurrence of a sentinel event, the hospital 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 hospital to The Joint Commission, the hospital’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 hospital, 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 hospital, 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 hospital, the hospital 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 a hospital 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 hospital 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 hospital’s accreditation status.

**Submission of Comprehensive Systematic Analyses and Corrective Action Plans**

A hospital that reports a sentinel event must submit the comprehensive systematic analysis, including the resulting corrective action plan that describes the hospital’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 hospital staff (Alternative–0). Documents shall not include the names of caregivers and patients involved in the sentinel event.
If the hospital 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 hospital’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 hospital staff, then taken back to the hospital 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 hospital’s participants remain at the hospital.

2. An on-site meeting at the hospital 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 hospital’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 patient’s medical record, to evaluate the following:
      - The process the hospital uses in responding to sentinel events
      - The relevant policies and procedures preceding and following the hospital’s review of the specific event, and the implementation thereof, sufficient to permit inferences about the adequacy of the hospital’s response to the sentinel event
   b. A standards-based survey that traces a patient’s care, treatment, and services and the hospital management functions relevant to the sentinel event under review
Each of these options will result in a fee to the hospital 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 a hospital’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 hospital 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 hospital’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

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- 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 hospital 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 patients, family, or patient representatives 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

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

‡‡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 hospital will take as a result of the comprehensive systematic analysis.

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 a hospital 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 hospital 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).

**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,

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and their comprehensive systematic analyses, corrective action plans, and follow-up activities. These data and information comprise the content of the Joint Commission’s Sentinel Event Database.

The Sentinel Event Database is 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 hospitals 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 hospital, the caregiver, and the patient.

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 hospital 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 patients. 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 hospital 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 a hospital that has experienced a sentinel event, the hospital’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 hospital through the sentinel event review process.

VIII. The Joint Commission’s Response
Patient safety specialists from The Joint Commission assess the acceptability of the hospital’s response to the sentinel event, including the thoroughness and credibility of any comprehensive systematic analysis information reviewed and the hospital’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 hospital 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 hospital if the response is unacceptable, and will allow an additional 15 business days beyond the original submission period for the hospital to resubmit its response. If the response is still unacceptable, the hospital’s accreditation decision may be impacted.

IX. Sentinel Event Measures of Success (SE MOS)
The hospital’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 hospital’s accreditation decision may be impacted.

If submission of an SE MOS is 90 or more days late, the hospital’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 hospital. 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 a hospital’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 hospital’s compliance with the applicable standards, National Patient Safety Goals, and Accreditation Participation Requirements, and to assess the hospital’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 a hospital’s performance improvement practices, such as its processes for responding to a sentinel event.

If during the course of conducting survey activities, a potential serious patient safety event is newly identified, the surveyor will take the following steps:

- Inform the hospital 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 hospital 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 hospital 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 hospital’s compliance with sentinel event-related standards in the following ways (see Standards LD.04.04.05 and MS.05.01.01 in the Appendix):
Review the hospital’s process for responding to a sentinel event
Interview the hospital’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 standards and associated elements of performance (EPs) are related to sentinel events:

Leadership (LD)

Standard LD.04.04.05
The hospital has an organizationwide, integrated patient safety program within its performance improvement activities.

Elements of Performance for LD.04.04.05

1. The leaders implement a hospitalwide patient safety program.
2. One or more qualified individuals or an interdisciplinary group manages 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 departments, programs, and services within the hospital participate in the safety program.
5. As part of the safety program, the leaders create procedures for responding to system or process failures.

Note: Responses might include continuing to provide care, treatment, and services to those affected, containing the risk to others, and preserving factual information for subsequent analysis.
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.03.04.01, EP 5; LD.04.04.03, EP 3; PI.01.01.01, EP 8)

**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 a serious adverse outcome or result in an adverse event, often referred to as a close call or near miss.

8. The hospital 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 individuals.

10. At least every 18 months, the hospital selects one high-risk process and conducts a proactive risk assessment. (*See also* LD.04.04.03, EP 3)

**Note:** For suggested components, refer to the “Proactive Risk Assessment” section at the beginning of this chapter.

11. To improve safety and to reduce the risk of medical errors, the hospital analyzes and uses information about system or process failures and 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 patients and the families were informed of the event
   - All actions taken to improve safety, both proactively and in response to actual occurrences
   - **For hospitals that use Joint Commission accreditation for deemed status purposes**: The determined number of distinct improvement projects to be conducted annually
   - All results of the analyses related to the adequacy of staffing (See also PI.02.01.01, EP 14)

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.

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**Medical Staff (MS)**

**Standard MS.05.01.01**

The organized medical staff has a leadership role in organization performance improvement activities to improve quality of care, treatment, and services and patient safety.

**Elements of Performance for MS.05.01.01**

Information used as part of the performance improvement mechanisms, measurement, or assessment includes the following:

10. Sentinel event data. (See also PI.03.01.01, EPs 2 and 4)
11. Patient safety data. (See also PI.03.01.01, EPs 2 and 4)
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 hospital’s performance on National Patient Safety Goals, National Quality Improvement Goals for those hospitals reporting ORYX® chart-abstracted performance measure data through a vendor, as well as certain 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 hospital, as well as comparative information gathered from other accredited hospitals. The Joint Commission provides Quality Reports to surveyed hospitals 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:
- **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 are measures that compare hospitals accredited by The Joint Commission. The comparison occurs on both a state and a national level (depending on the Quality Indicator). Quality Indicators include the following:

National Patient Safety Goals: 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.

National Quality Improvement Goals: Key treatments that affect tens of thousands of patients every year. The report tracks hospital performance on ORYX chart-abstracted performance measures, such as influenza immunization, perinatal care, emergency department, venous thromboembolism, tobacco use screening, substance use, and hospital-based inpatient psychiatric services. Detailed information on measure reporting requirements by hospital type can be found on The Joint Commission’s website at: https://www.jointcommission.org/performance_measurement.aspx. Detailed information on each National Quality Improvement Goal and the symbols used to report results are available online at Quality Check (http://www.qualitycheck.org).
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
  - 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 Hospital?
Yes. The amount of information available on the report depends on the type of hospital 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 Hospital Comment on Its Quality Report?
Yes. The Joint Commission offers each organization the opportunity to provide its perspective on its Quality Report commentary. Your hospital has the option of submitting a commentary of up to two pages. Submission of the commentary is voluntary.

How Does My Hospital Submit a Commentary?
If your hospital 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 hospital, regardless of the number of the hospital’s accredited services that were evaluated in a survey.
- The commentary is limited to a maximum of two pages.
What Are the Marketing and Communication Guidelines for Using Quality Reports?
The Joint Commission recognizes your hospital’s right to communicate your accreditation decision. Indeed, many hospitals across the country point with pride to Joint Commission accreditation as a “seal of approval” of their efforts to provide high-quality care, treatment, and 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/goldseal_downloads.aspx).

However, your hospital 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. A hospital 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 an accredited organization accurately describe to the public the nature and meaning of its accreditation and its decision award. Any accredited hospital 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:
- If your hospital has sites or offers services that are not accredited, any reference to accreditation must clearly specify which sites/services are accredited. For example, if you are a hospital with multiple service components, such as a hospital with a long
term care component, and The Joint Commission did NOT review your long term care component, you must insert the following language into your materials: “This award excludes skilled nursing and nursing home services.”

- Accreditation does not “endorse” or “guarantee” a hospital’s quality or safety of care, nor does it “prove,” “assure,” or “testify” that a hospital provides high quality, safe care. Such language should not be used in your materials.
- Correctly state the hospital’s accreditation accomplishment. To say that your hospital is the “first” or the “only” hospital 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, hospitals 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 medical errors from occurring, such as patient misidentification and medication errors. All Joint Commission–accredited health care organizations are surveyed for compliance with the requirements of the goals—or acceptable alternatives—as appropriate to the services the organization provides. The Joint Commission develops program-specific goals for each of its accreditation and certification programs.

Guidelines for publicizing your hospital’s compliance with the National Patient Safety Goals include the following:

- You may state that your hospital 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 hospital 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 patients to “look for the check mark” when evaluating health care providers.
If your hospital 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.

Information Released by The Joint Commission
The display of hospital performance on the National Quality Improvement Goal individual measures is updated quarterly, using the most recent rolling four quarters (12 months) of chart-abstracted data.

Hospital performance at the individual measure level is displayed. The display includes that hospital’s observed rate of performance on each reported chart-abstracted measure through the use of various comparative symbols (plus ☑️, minus ☐️, check ☑️, or star ☀️), a display of the hospital’s performance against a target range of performance established using data received from all hospitals reporting on each measure, and a comparison of the hospital’s performance on each measure on both a nationwide and statewide level.

Aggregate National Quality Improvement Goal data for the most recent four calendar quarters are available for download at both the quarterly and yearly level, and at the individual hospital reporting level at http://www.healthcarequalitydata.org.

Guidelines for Publication
Your hospital can publicize its performance on the measures, including how it performed compared to other accredited hospitals nationwide and statewide, in the following manner:

- State the date—State the date ranges of the results. For example, “National Quality Improvement Goal results for 2017” or “for January 2017 to December 2017.”
- State the site—State that the latest data are available on Quality Check at http://www.qualitycheck.org.
State the measure level performance—Indicate your performance on the individual chart-abstracted measure when publicizing measure level performance. For example, if you publicize that your hospital completed tobacco use screening 99% of the time, you must also state, as applicable based on the assigned comparative symbol, that your hospital does the following:

- **Star**: Achieves the best possible results for tobacco use screening
- **Check**: Performs above the target range/value on tobacco use screening
- **Plus**: Performs similarly to the target range/value on tobacco use screening
- **Minus**: Performs below the target range/value on tobacco use screening

Compare performance—State your performance relative to nationwide or statewide performance, e.g., “tobacco use screening above 90% but was below most other organizations.” Some measures, such as tobacco use screening, have very high compliance rates. Therefore, it is possible to get a minus with a score of 92%. The Quality Report will state that such a hospital “scored above 90% but was below most other organizations.”

For more information, please visit our website at https://www.jointcommission.org/accreditation/guidelines_for_publicizing_nqigs.aspx.
Performance Measurement and the ORYX Initiative (PM)

Overview
The use of performance measures and performance measure data are essential to the credibility of any modern evaluation activity. The Joint Commission’s ORYX® initiative integrates the use of performance measurement data into the standards-based survey process. The use of ORYX performance measure data in the survey process supplements and helps guide that process by providing a more targeted basis for the regular accreditation survey. The Joint Commission’s ORYX performance measurement requirements also are intended to support Joint Commission–accredited hospitals in their quality improvement efforts through the continuous monitoring of actual performance, and by helping guide and stimulate continuous improvement.

The Continued Role of ORYX
Hospitals and The Joint Commission use ORYX data to continuously assess key performance areas. In addition, the hospital’s use of ORYX data is assessed in the survey process (see “Use of Performance Measure Data” section).

ORYX performance measure data reported by hospitals provide surveyors with specific information about a hospital’s performance in important care, treatment, and services areas and the hospital’s ability to effect change in clinical processes. ORYX chart-abstracted performance measure data also are among the key data elements included in a hospital’s Quality Report (see “The Joint Commission Quality Report” [QR] chapter).

The inclusion of ORYX chart-abstracted measure information on The Joint Commission’s Quality Check® website provides a wide array of audiences with valuable information on hospital performance on the measures while providing Joint Commission–accredited hospitals with the opportunity to distinguish themselves among other hospitals based upon their performance on the chart-abstracted measures.

A hospital can also use ORYX data in intracycle, continuous performance improvement activities to proactively identify potential opportunities for improvement.
Current Requirements for Hospitals:
The most current and detailed information on ORYX performance measurement requirements  can be found on The Joint Commission’s Performance Measurement webpage, https://www.jointcommission.org/performance_measurement.aspx. For questions on current ORYX requirements, contact the ORYX Help Line at 630-792-5085 or e-mail HCOORYX@jointcommission.org.

ORYX Performance Measure Report
ORYX Performance Measure Reports are available to each accredited hospital and critical access hospital. Updated ORYX Performance Measure Reports are available through each hospital’s secure Joint Commission Connect extranet site approximately four weeks after each submission of quarterly chart-abstracted measure data to The Joint Commission. Currently data are due at The Joint Commission January 31, April 30, July 31, and October 31 of each year.

The reports are designed to better support and help guide accredited hospitals in their performance assessment and improvement activities. In addition, the reports help surveyors better assess the hospital’s use of performance measure data in performance improvement activities.

The ORYX Performance Measure Report provides a user-friendly format with summary dashboards, comprehensive measure details, automated links to specific sections, and selective printing capabilities.

The ORYX Performance Measure Report highlights desirable and undesirable data trends. Key features include the following:

- A dashboard of color-coded symbols at both the measure topic area level and individual measure level provides a quick and easy graphical summary of a hospital’s performance on its measures. Each topic area and individual measure on the dashboard provides a hyperlink that the user can click on to access more detailed information.

- At the topic area level, the dashboard displays the total number of measures within the topic area and highlights the topic area(s) where there may be desirable or undesirable data trends, and/or statistical process control issues.

*For current ORYX requirements for critical access hospitals, please refer to the “Performance Measurement and the ORYX Initiative” (PM) chapter in the Comprehensive Accreditation Manual for Critical Access Hospitals.*

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
An easy-to-use legend that defines each of the color-coded symbols
- At the individual measure level, the dashboard identifies desirable and undesirable data trends, and/or statistical process control issues
- Control charts and target charts
- Individual measures that require a hospital’s attention are highlighted when statistically undesirable trends are identified

**Analyzing ORYX Data**
The Joint Commission uses a combination of control charts and target charts to evaluate ORYX data. Control chart analysis is based on a hospital’s own historical (longitudinal) data and is used to assess internal process stability. Target chart analysis is used to evaluate a hospital’s relative performance level. The use of target chart analysis in addition to control chart analysis is a key feature of the Joint Commission’s analytic methods in the ORYX initiative. These types of analyses evaluate hospital performance from two distinct perspectives and thus can provide a more comprehensive framework to assess the hospital’s overall performance level.

Because of their different foci, the control and target chart analyses may portray different interpretations of performance. For example, a control chart may show a desirable pattern (one that is statistically in control), but the target chart may illustrate undesirable outliers (for example, a high rate of infections relative to the target range). Perhaps the hospital’s performance has been consistently poorer than that of other hospitals using the same measure or below the target range. In such a case, the hospital needs to think about changing its process for the measure concerned in order to improve its performance. On the other hand, a hospital without outliers in the target chart analysis may have special cause variation (that is, a statistically out-of-control pattern) detected in the control chart. In such a case, the hospital needs to investigate the special cause variation in its process before making any conclusions about performance level. In general, a hospital should do control chart analysis before target chart analysis to ensure that a given process is stable before it tries to evaluate relative performance level.

**Use of Performance Measure Data**
As part of the Joint Commission’s accreditation process, during the on-site survey, Joint Commission surveyors assess the following:
- The hospital’s integration and use of ORYX chart-abstracted data into internal performance improvement activities
Comprehensive Accreditation Manual for Hospitals

- The hospital’s data collection processes (such as data accuracy, reliability, and security)
- The hospital’s data analysis methodologies and related training
- The dissemination of findings

For general information on ORYX requirements, contact the ORYX Help Line at 630-792-5085 or e-mail HCOORYX@jointcommission.org.
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 medical 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 medical record. Other examples in which the documentation icon is applied are EPs that require a policy, a written plan, bylaws, 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 hospital carries out the functions described in the Comprehensive Accreditation Manual for Hospitals (CAMH). The surveyors may use a combination of data sources, including interviews with leaders of the hospital, staff, patients, and patients’ family members; visits to patient care settings; and review of documentation to arrive at an assessment of your hospital’s compliance with a standard.

Note: This list is meant to be a guide. The names and format of specific documents may vary from organization to organization.
List of EPs Requiring Written Documentation for Hospitals

### Accreditation Participation Requirements (APR)

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<thead>
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Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
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| NPSG.03.06.01, EPs 1, 4 |
| NPSG.06.01.01, EP 3 |
| NPSG.07.04.01, EPs 6, 12 |
| NPSG.15.01.01, EP 1 |
| UP.01.01.01, EP 2 |
| UP.01.02.01, EP 5 |
| UP.01.03.01, EP 5 |

#### Nursing (NR)

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

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Early Survey Policy (ESP)

A hospital seeking accreditation 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 hospital must undergo two surveys. The first survey, which is announced, would cover a limited selection of standards. The second survey, which is unannounced, would be a full survey. For a detailed explanation of the Early Survey Policy, please see “The Accreditation Process” (ACC) chapter in this manual.

The following tables list the selected elements of performance (EPs) and requirements that are applicable to a first survey when a hospital has chosen the Early Survey Policy option.

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# Early Survey Policy

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Primary Care Medical Home Certification Option (PCMH)

Overview
This chapter describes the Primary Care Medical Home Model and the operational characteristics that serve as the foundation for the certification requirements. It also includes the standards and elements of performance (EPs) that relate directly to the Primary Care Medical Home Model. Hospitals interested in this optional certification need to comply with all applicable Hospital Accreditation Program requirements in addition to the standards and EPs listed in this chapter. See the “Standards Applicability Grid” (SAG) chapter for a detailed guide to identifying all requirements applicable to your organization.

Primary Care Medical Home Model
The Joint Commission’s Primary Care Medical Home Model is based on the Agency for Healthcare Research and Quality’s (AHRQ) definition of a medical home. This definition describes a medical home as a model of primary health care that has the following core functions and attributes:
- Patient-centered care
- Comprehensive care
- Coordinated care
- Superb access to care
- Systems-based approach to quality and safety

These five operational characteristics, outlined on the following pages, also describe the components of The Joint Commission’s Primary Care Medical Home Model. They address the roles and functions of the patient, organization, primary care clinician, and interdisciplinary team. These individuals and entities are interdependent and, therefore, key to the provision of patient-centered, comprehensive, coordinated, accessible, and collaborative primary care services.
These operational characteristics serve as the basis for The Joint Commission’s primary care medical home requirements. Since this option is applicable only to accredited hospitals, the characteristics outlined below were based on the AHRQ definition and are addressed through the applicability of both existing requirements and newly developed hospital requirements for The Joint Commission’s Primary Care Medical Home optional certification.

I. Patient-Centered Care
The primary care medical home provides primary health care that is relationship-based with an orientation toward the whole person. Partnering with patients and their families requires understanding and respecting each patient’s unique needs, culture, values, and preferences. The primary care medical home practice actively supports patients in learning to manage and organize their own care at the level the patient chooses. Recognizing that patients and families are core members of the care team, primary care medical home practices ensure that patients are fully informed partners in establishing care plans.

Concepts addressed in Joint Commission primary care medical home EPs include the following:
1. Patient-selected primary care clinician
2. Primary care clinician and interdisciplinary team work in partnership with the patient
3. Consideration of the patient’s cultural, linguistic, language, and educational needs and preferences
4. Patient involvement in establishing the treatment plan
5. Support for patient self-management

II. Comprehensive Care
The primary care medical home is accountable for meeting the large majority of each patient’s physical and mental health care needs, including prevention and wellness, acute care, and chronic care. Providing comprehensive care requires a team of care providers. This team might include physicians, advanced practice nurses, physician assistants, nurses, pharmacists, nutritionists, mental health workers, social workers, educators, and care coordinators. Although some primary care medical home practices may bring...
together large and diverse teams of care providers to meet the needs of their patients, many others—including smaller practices—will build virtual teams linking themselves and their patients to providers and services in their communities.

Concepts addressed in Joint Commission primary care medical home EPs include the following:
1. The provision of acute, preventive, and chronic care
2. Provision of continuous and comprehensive care
3. Team-based approach and the use of a multidisciplinary team to provide care
4. Use of internal and external resources to meet patient needs
5. Primary care clinician with the educational background and broad-based knowledge and experience necessary to handle most medical needs of the patient and resolve conflicting recommendations for care
6. Primary care clinician who works collaboratively with an interdisciplinary team
7. Care that addresses various phases of a patient’s life span, including end-of-life care
8. Disease management

**III. Coordinated Care**
The primary care medical home coordinates care across all elements of the broader health care system, including specialty care, hospitals, home health care, and community services and support. Such coordination is particularly critical during transitions between sites of care, such as when patients are being discharged from the hospital. Primary care medical home practices also excel at building clear and open communication among patients and families, the medical home, and members of the broader care team.

Concepts addressed in Joint Commission primary care medical home EPs include the following:
1. Use of internal and external resources to meet patient needs
2. Responsibility for care coordination
3. Team-based approach
IV. Superb Access to Care

The primary care medical home delivers accessible services with shorter waiting times for urgent needs, enhanced in-person hours, around-the-clock telephone or electronic access to a member of the care team, and alternative methods of communication such as e-mail and telephone. The medical home practice is responsive to patients’ preferences regarding access.

Concepts addressed in Joint Commission primary care medical home EPs include the following:

1. Enhanced access, defined as responsiveness to patients’ preferences regarding access, including timely response to and shorter wait times for urgent needs, flexible appointment hours and days of service, telephonic or electronic access to a member of the care team, and alternative methods of communication such as e-mail
2. Availability 24 hours a day, 7 days a week
3. Access for non-visit related patient needs
4. Access for patients with special communication needs

V. Systems-Based Approach to Quality and Safety

The primary care medical home demonstrates a commitment to quality and quality improvement through ongoing engagement in activities such as using evidence-based medicine and clinical decision support tools to guide shared decision making with patients and families, engaging in performance measurement and improvement, measuring and responding to patient experiences and patient satisfaction, and practicing population health management. Sharing robust quality and safety data and improvement activities publicly is also an important marker of a system-level commitment to quality.

Concepts addressed in Joint Commission primary care medical home EPs include the following:

1. Population-based care
2. Use of health information technology, including electronic prescribing
3. Primary care clinician and team members who function within their scope of practice and in accordance with law and regulation and privileges granted
4. Use of evidence-based medicine and decision support tools
5. The provision of care to a panel of patients
6. Patient involvement in performance monitoring and improvement efforts
Standards, Rationales, Elements of Performance, and Scoring Specific to the Primary Care Medical Home Certification Option
The following standards and EPs directly relate to the operational characteristics of the Primary Care Medical Home Model.

I. Patient-Centered Care

Leadership (LD)

Standard LD.03.04.01
The hospital communicates information related to safety and quality to those who need it, including staff, licensed independent practitioners, patients, families, and external interested parties.

Elements of Performance for LD.03.04.01

1. Communication processes foster the safety of the patient and the quality of care.
2. Communication is designed to meet the needs of internal and external users.
3. Leaders provide the resources required for communication, based on the needs of patients, the community, physicians, staff, and management.
4. Communication supports safety and quality throughout the hospital. (See also LD.04.04.05, EPs 6 and 12)
5. When changes in the environment occur, the hospital communicates those changes effectively.
6. Leaders evaluate the effectiveness of communication methods.
Standard LD.04.04.01
Leaders establish priorities for performance improvement. (For more information, refer to the “Performance Improvement” [PI] chapter)

Elements of Performance for LD.04.04.01
24. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** Leaders involve patients in performance improvement activities.

   *Note:* Patient 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 hospital’s design of new or modified services or processes incorporates the needs of patients, staff, and others.

3. The hospital’s design of new or modified services or processes incorporates information about potential risks to patients. (*See also* LD.04.04.05, EPs 6, 10, and 11)

   *Note:* A proactive risk assessment is one of several ways to assess potential risks to patients. For suggested components, refer to the “Proactive Risk Assessment” section at the beginning of this chapter.

**Provision of Care, Treatment, and Services (PC)**

Standard PC.01.03.01
The hospital plans the patient’s care.

Elements of Performance for PC.01.03.01
1. The hospital plans the patient’s care, treatment, and services based on needs identified by the patient’s assessment, reassessment, and results of diagnostic testing. (*See also* PC.01.02.13, EP 2)

5. The written plan of care is based on the patient’s goals and the time frames, settings, and services required to meet those goals.
Note: For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: The patient’s goals include both short- and long-term goals.

22. Based on the goals established in the patient’s plan of care, staff evaluate the patient’s progress.

23. The hospital revises plans and goals for care, treatment, and services based on the patient’s needs. (See also RC.02.01.01, EP 2) R

Standard PC.02.01.01
The hospital provides care, treatment, and services for each patient.

Elements of Performance for PC.02.01.01
1. The hospital provides the patient with care, treatment, and services according to his or her individualized plan of care. R

16. For hospitals that elect The Joint Commission Primary Care Medical Home option: Each patient has a designated primary care clinician.

Standard PC.02.01.21
The hospital effectively communicates with patients when providing care, treatment, and services.

Elements of Performance for PC.02.01.21
1. The hospital identifies the patient’s oral and written communication needs, including the patient’s preferred language for discussing health care. (See also RC.02.01.01, EP 1) R

   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.

2. The hospital communicates with the patient during the provision of care, treatment, and services in a manner that meets the patient’s oral and written communication needs. (See also RI.01.01.03, EPs 1–3) R
Standard **PC.02.02.01**
The hospital coordinates the patient’s care, treatment, and services based on the patient’s needs.

**Elements of Performance for PC.02.02.01**

17. The hospital coordinates care, treatment, and services within a time frame that meets the patient’s needs.

Standard **PC.02.03.01**
The hospital provides patient education and training based on each patient’s needs and abilities.

**Elements of Performance for PC.02.03.01**

1. The hospital performs a learning needs assessment for each patient, which includes the patient’s cultural and religious beliefs, emotional barriers, desire and motivation to learn, physical or cognitive limitations, and barriers to communication.

10. Based on the patient’s condition and assessed needs, the education and training provided to the patient by the hospital include any of the following:
   - An explanation of the plan for care, treatment, and services
   - Basic health practices and safety
   - Information on the safe and effective use of medications (See also MM.06.01.01, EP 9; MM.06.01.03, EPs 3–6)
   - Nutrition interventions (for example, supplements) and modified diets
   - Discussion of pain, the risk for pain, the importance of effective pain management, the pain assessment process, and methods for pain management
   - Information on oral health
   - Information on the safe and effective use of medical equipment or supplies provided by the hospital
   - Habilitation or rehabilitation techniques to help the patient reach maximum independence
   - Fall reduction strategies

25. The hospital evaluates the patient’s understanding of the education and training it provided.
27. The hospital provides the patient education on how to communicate concerns about patient safety issues that occur before, during, and after care is received.

28. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The primary care clinician and the interdisciplinary team educate the patient on self-management tools and techniques based on the patient’s individual needs.

30. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The interdisciplinary team identifies the patient’s health literacy needs.

   **Note:** Typically this is an interactive process. For example, patients may be asked to demonstrate their understanding of information provided by explaining it in their own words.

31. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The primary care clinician and the interdisciplinary team incorporate the patient’s health literacy needs into the patient’s education.

**Standard PC.02.04.05**

**For hospitals that elect The Joint Commission Primary Care Medical Home option:** The primary care clinician and the interdisciplinary team work in partnership with the patient to support the continuity of care and the provision of comprehensive and coordinated care, treatment, or services.

**Elements of Performance for PC.02.04.05**

9. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The interdisciplinary team works in partnership with the patient to achieve planned outcomes.

11. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The interdisciplinary team involves the patient in the development of his or her treatment plan.

**Record of Care, Treatment, and Services (RC)**
Standard RC.02.01.01
The medical record contains information that reflects the patient’s care, treatment, and services.

Elements of Performance for RC.02.01.01
1. The medical record contains the following demographic information:
   - The patient’s name, address, and date of birth and the name of any legally authorized representative
   - The patient’s sex
   - The legal status of any patient receiving behavioral health care services
   - The patient’s communication needs, including preferred language for discussing health care (See also PC.02.01.21, EP 1; LD.04.05.17, EP 4)

   Note: If the patient is a minor, is incapacitated, or has a designated advocate, the communication needs of the parent or legal guardian, surrogate decision-maker, or legally authorized representative is documented in the medical record.

28. The medical record contains the patient’s race and ethnicity.

29. For hospitals that elect The Joint Commission Primary Care Medical Home option: The medical record includes the patient’s self-management goals and the patient’s progress toward achieving those goals.

Rights and Responsibilities of the Individual (RI)

Standard RI.01.01.01
The hospital respects, protects, and promotes patient rights.

Elements of Performance for RI.01.01.01
1. The hospital has written policies on patient rights.

   Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The hospital’s written policies address procedures regarding patient visitation rights, including any clinically necessary or reasonable restrictions or limitations.
2. The hospital informs the patient of his or her rights. (See also RI.01.01.03, EPs 1–3)

**Note 1:** *For hospitals that use Joint Commission accreditation for deemed status purposes:* The hospital informs the patient (or support person, where appropriate) of his or her visitation rights. Visitation rights include the right to receive the visitors designated by the patient, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend. Also included is the right to withdraw or deny such consent at any time.

**Note 2:** *For hospitals that use Joint Commission accreditation for deemed status purposes:* The hospital makes sure that each patient, or his or her family, is informed of the patient’s rights in advance of furnishing or discontinuing patient care whenever possible.

4. The hospital treats the patient in a dignified and respectful manner that supports his or her dignity.

5. The hospital respects the patient’s right to and need for effective communication. (See also RI.01.01.03, EPs 1–3)

6. The hospital respects the patient’s cultural and personal values, beliefs, and preferences.

7. The hospital respects the patient’s right to privacy. (See also IM.02.01.01, EPs 1–4)

**Note 1:** *This element of performance (EP) addresses a patient’s personal privacy.*

**Note 2:** *For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds:* The resident’s right to privacy includes privacy and confidentiality of his or her personal records and written communications, including the right to send and receive mail promptly.

8. The hospital respects the patient’s right to pain management. (See also LD.04.03.13, EP 3)

10. The hospital allows the patient to access, request amendment to, and obtain information on disclosures of his or her health information, in accordance with law and regulation.
29. The hospital prohibits discrimination based on age, race, ethnicity, religion, culture, language, physical or mental disability, socioeconomic status, sex, sexual orientation, and gender identity or expression.

**Standard RI.01.01.03**
The hospital respects the patient’s right to receive information in a manner he or she understands.

**Elements of Performance for RI.01.01.03**

1. The hospital provides information in a manner tailored to the patient’s age, language, and ability to understand. *(See also PC.02.01.21, EP 2; RI.01.01.01, EPs 2 and 5)*

2. The hospital provides language interpreting and translation services. *(See also HR.01.01.01, EP 1; PC.02.01.21, EP 2; RI.01.01.01, EPs 2 and 5)*

   **Note:** Language interpreting options may include hospital-employed language interpreters, contract interpreting services, or trained bilingual staff. These options may be provided in person or via telephone or video. The hospital determines which translated documents and languages are needed based on its patient population.

3. The hospital provides information to the patient who has vision, speech, hearing, or cognitive impairments in a manner that meets the patient’s needs. *(See also PC.02.01.21, EP 2; RI.01.01.01, EPs 2 and 5)*

**Standard RI.01.02.01**
The hospital respects the patient’s right to participate in decisions about his or her care, treatment, and services.

**Note:** For hospitals that use Joint Commission accreditation for deemed status purposes:
This right is not to be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.

**Elements of Performance for RI.01.02.01**

1. The hospital involves the patient in making decisions about his or her care, treatment, and services, including the right to have his or her family and physician promptly notified of his or her admission to the hospital.
2. When a patient is unable to make decisions about his or her care, treatment, and services, the hospital involves a surrogate decision maker in making these decisions. *(See also PC.01.02.07, EP 5; RI.01.03.01, EP 1)*

3. The hospital provides the patient or surrogate decision-maker with written information about the right to refuse care, treatment, and services. *(See also PC.01.02.07, EP 5)*

4. The hospital respects the patient’s or surrogate decision maker’s right to refuse care, treatment, and services, in accordance with law and regulation. *(See also PC.01.02.07, EP 5)*

8. The hospital involves the patient’s family in care, treatment, and services decisions to the extent permitted by the patient or surrogate decision-maker, in accordance with law and regulation. *(See also PC.01.02.07, EP 5)*

20. The hospital provides the patient or surrogate decision-maker with the information about the following:
   - Outcomes of care, treatment, and services that the patient needs in order to participate in current and future health care decisions.
   - Unanticipated outcomes of the patient’s care, treatment, and services that are sentinel events as defined by The Joint Commission. This information is provided by the licensed independent practitioner responsible for managing the patient’s care, treatment, and services, or his or her designee. (Refer to the Glossary for a definition of sentinel event.)

**Note:** In settings where there is no licensed independent practitioner, the staff member responsible for managing the care of the patient is responsible for sharing information about such outcomes.

31. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home respects the patient’s right to make decisions about the management of his or her care.

32. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home respects the patient’s right and provides the patient the opportunity to do the following:
   - Obtain care from other clinicians of the patient’s choosing within the primary care medical home
   - Seek a second opinion from a clinician of the patient’s choosing
   - Seek specialty care
Note: This element of performance does not imply financial responsibility for any activities associated with these rights.

**Standard RI.01.03.01**
The hospital honors the patient’s right to give or withhold informed consent.

**Elements of Performance for RI.01.03.01**

1. The hospital follows a written policy on informed consent that describes the following:
   - The specific care, treatment, and services that require informed consent
   - Circumstances that would allow for exceptions to obtaining informed consent
   - The process used to obtain informed consent
   - How informed consent is documented in the patient record

   Note: Documentation may be recorded in a form, in progress notes, or elsewhere in the record.

   - When a surrogate decision-maker may give informed consent (See also PC.01.02.07, EP 5; RI.01.02.01, EP 2)

2. The informed consent process includes a discussion about the following:
   - The patient’s proposed care, treatment, and services.
   - Potential benefits, risks, and side effects of the patient’s proposed care, treatment, and services; the likelihood of the patient achieving his or her goals; and any potential problems that might occur during recuperation.
   - Reasonable alternatives to the patient’s proposed care, treatment, and services. The discussion encompasses risks, benefits, and side effects related to the alternatives and the risks related to not receiving the proposed care, treatment, and services.

**Standard RI.01.04.01**
The hospital respects the patient’s right to receive information about the individual(s) responsible for, as well as those providing, his or her care, treatment, and services.

**Elements of Performance for RI.01.04.01**

1. The hospital informs the patient of the following:
   - The name of the physician, clinical psychologist, or other practitioner who has primary responsibility for his or her care, treatment, or services
- The name of the physician(s), clinical psychologist(s), or other practitioner(s) who will provide his or her care, treatment, and services

**Note:** The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

7. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home allows the patient to select his or her primary care clinician.

**Standard RI.01.04.03**

For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home provides patients with information about its functions and services.

**Elements of Performance for RI.01.04.03**

1. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home provides information to the patient about: Its mission, vision, and goals. (Refer to LD.02.01.01, EP 3)

**Note:** This may include how it provides for patient-centered and team-based comprehensive care, a systems-based approach to quality and safety, and enhanced patient access.

2. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home provides information to the patient about: The scope of care and types of services it provides. (Refer to PC.01.01.01, EP 7; LD.01.03.01, EP 3)

3. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home provides information to the patient about: How it functions, including the following:
   - Processes supporting patient selection of a primary care clinician
   - Involving the patient in his or her treatment plan
   - Obtaining and tracking referrals
   - Coordinating care
   - Collaborating with patient-selected clinicians who provide specialty care or second opinions
Note: Supporting patients in selecting a primary care clinician may include providing patients with information regarding the clinician’s credentials, area(s) of specialty, interests, languages spoken, and gender.

4. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home provides information to the patient about: How to access the organization for care or information.

5. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home provides information to the patient about: Patient responsibilities, including providing health history and current medications, and participating in self-management activities. (Refer to RI.02.01.01, EP 2)

6. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home provides information to the patient about: The patient’s right to obtain care from other clinicians within the primary care medical home, to seek a second opinion, and to seek specialty care. (Refer to PC.02.03.01, EP 4; RI.01.01.03, EPs 1 and 3)

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**Standard RI.01.05.01**

The hospital addresses patient decisions about care, treatment, and services received at the end of life.

**Elements of Performance for RI.01.05.01**

1. ☐️ The hospital follows written policies on advance directives, forgoing or withdrawing life-sustaining treatment, and withholding resuscitative services that address the following:
   - Providing patients with written information about advance directives, forgoing or withdrawing life-sustaining treatment, and withholding resuscitative services.
   - Providing the patient upon admission with information on the extent to which the hospital is able, unable, or unwilling to honor advance directives.
   - **For outpatient hospital settings:** Communicating its policy on advance directives upon request or when warranted by the care, treatment, and services provided.
   - Whether the hospital will honor advance directives in its outpatient settings.
- That the hospital will honor the patient’s right to formulate or review and revise his or her advance directives.
- Informing staff and licensed independent practitioners who are involved in the patient’s care, treatment, and services whether or not the patient has an advance directive.

10. Upon request, the hospital refers the patient to resources for assistance in formulating advance directives.

**Standard RI.01.07.01**
The patient and his or her family have the right to have complaints reviewed by the hospital.

**Elements of Performance for RI.01.07.01**

1. The hospital establishes a complaint resolution process and informs the patient and his or her family about it. *(See also LD.04.01.07, EP 1; MS.09.01.01, EP 1)*

   **Note:** The governing body is responsible for the effective operation of the complaint resolution process unless it delegates this responsibility in writing to a complaint resolution committee.

4. The hospital reviews and, when possible, resolves complaints from the patient and his or her family. *(See also MS.09.01.01, EP 1)*

**II. Comprehensive Care**

**Leadership (LD)**

**Standard LD.04.01.06**

For hospitals that elect The Joint Commission Primary Care Medical Home option:
Qualified individuals serve in the role of primary care clinician.

**Element of Performance for LD.04.01.06**

1. For hospitals that elect The Joint Commission Primary Care Medical Home option: Primary care clinicians have the educational background and broad-based knowledge and experience necessary to handle most medical and other health care needs of the patients who selected them. This includes resolving conflicting
recommendations for care. (See also MS.03.01.01, EP 18 and refer to MS.03.01.01, EP 2; MS.06.01.03, EP 2; MS.06.01.03, EP 6; MS.06.01.05, EP 2; MS.06.01.07, EP 2)

Medical Staff (MS)

Standard MS.03.01.01
The organized medical staff oversees the quality of patient care, treatment, and services provided by practitioners privileged through the medical staff process.

Elements of Performance for MS.03.01.01

18. For hospitals that elect The Joint Commission Primary Care Medical Home option: Through the privileging process, the organized medical staff determines which practitioners are qualified to serve in the role of primary care clinician. (See also LD.04.01.06, EP 1)

Provision of Care, Treatment, and Services (PC)

Standard PC.02.01.05
The hospital provides interdisciplinary, collaborative care, treatment, and services.

Element of Performance for PC.02.01.05

1. Care, treatment, and services are provided to the patient in an interdisciplinary, collaborative manner.

Standard PC.02.04.03
For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home is accountable for providing patient care. (Refer to Standard PC.02.04.05)

Elements of Performance for PC.02.04.03

1. For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home manages transitions in care and provides or facilitates patient access to care, treatment, or services including the following:
Primary Care Medical Home Certification Option

- Acute care
- Management of chronic care
- Preventive services that are age- and gender-specific
- Behavioral health needs
- Oral health care
- Urgent and emergent care
- Substance abuse treatment

Note: Some of these services may be obtained through the use of community resources as available, or in collaboration with other organizations.

2. For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home provides care that addresses various phases of a patient’s lifespan, including end-of-life care.

3. For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home provides disease and chronic care management services to its patients.

Standard PC.02.04.05

For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care clinician and the interdisciplinary team work in partnership with the patient to support the continuity of care and the provision of comprehensive and coordinated care, treatment, or services.

Elements of Performance for PC.02.04.05

1. For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home identifies the composition of the interdisciplinary team, based on individual patient needs.

2. For hospitals that elect The Joint Commission Primary Care Medical Home option: The members of the interdisciplinary team provide comprehensive and coordinated care, treatment, or services and maintain the continuity of care.

Note: The provision of care may include making internal and external referrals.

5. For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care clinician is responsible for making certain that the interdisciplinary team provides comprehensive and coordinated care, treatment, or services and maintains the continuity of care as described in EPs 6–12.
Note: Coordination of care may include making internal and external referrals, developing and evaluating treatment plans, and resolving conflicts in the provision of care.

8. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The interdisciplinary team participates in the development of the patient’s treatment plan.

12. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The interdisciplinary team assesses patients for health risk behaviors.

### III. Coordinated Care

#### Human Resources (HR)

**Standard HR.01.02.07**

The hospital determines how staff function within the organization.

**Elements of Performance for HR.01.02.07**

2. Staff who provide patient care, treatment, and services practice within the scope of their license, certification, or registration and as required by law and regulation. *(See also HR.01.01.01, EP 32)*

#### Medical Staff (MS)

**Standard MS.03.01.01**

The organized medical staff oversees the quality of patient care, treatment, and services provided by practitioners privileged through the medical staff process.

**Elements of Performance for MS.03.01.01**

2. Practitioners practice only within the scope of their privileges as determined through mechanisms defined by the organized medical staff.
Provision of Care, Treatment, and Services (PC)

Standard PC.01.03.01
The hospital plans the patient’s care.

Elements of Performance for PC.01.03.01

44. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** Patient self-management goals are identified, agreed upon with the patient, and incorporated into the patient’s treatment plan. (Refer to RI.01.02.01, EP 1)

Standard PC.02.02.01
The hospital coordinates the patient’s care, treatment, and services based on the patient’s needs.

Elements of Performance for PC.02.02.01

1. The hospital has a process to receive or share patient information when the patient is referred to other internal or external providers of care, treatment, and services. *(See also PC.04.02.01, EP 1)*

2. The hospital’s process for hand-off communication provides for the opportunity for discussion between the giver and receiver of patient information. *(See also PC.04.02.01, EP 1)*
   
   **Note:** Such information may include the patient’s condition, care, treatment, medications, services, and any recent or anticipated changes to any of these.

3. The hospital coordinates the patient’s care, treatment, and services. *(See also PC.04.02.01, EP 1)*
   
   **Note:** Coordination involves resolving scheduling conflicts and duplication of care, treatment, and services.

10. When the hospital uses external resources to meet the patient’s needs, it coordinates the patient’s care, treatment, and services.

17. The hospital coordinates care, treatment, and services within a time frame that meets the patient’s needs.
Standard PC.02.04.03

For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home is accountable for providing patient care. (Refer to Standard PC.02.04.05)

Elements of Performance for PC.02.04.03

4. For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home provides population-based care.

5. For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home uses health information technology to do the following:
   - Support the continuity of care, and the provision of comprehensive and coordinated care, treatment, or services
   - Document and track care, treatment, or services
   - Support disease management, including providing patient education
   - Support preventive care, treatment, or services
   - Create reports for internal use and external reporting
   - Facilitate electronic exchange of information among providers
   - Support performance improvement

Standard PC.02.04.05

For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care clinician and the interdisciplinary team work in partnership with the patient to support the continuity of care and the provision of comprehensive and coordinated care, treatment, or services.

Elements of Performance for PC.02.04.05

4. For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care clinician and the interdisciplinary team provide care for a designated group of patients.

6. For hospitals that elect The Joint Commission Primary Care Medical Home option: When a patient is referred internally or externally, the interdisciplinary team reviews and tracks the care provided to the patient.
7. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The interdisciplinary team acts on recommendations from internal and external referrals for additional care, treatment, or services.

10. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The interdisciplinary team monitors the patient’s progress toward achieving treatment goals.

**Standard PC.04.01.01**

The hospital has a process that addresses the patient’s need for continuing care, treatment, and services after discharge or transfer.

**Elements of Performance for PC.04.01.01**

1. The hospital describes the reason(s) for and conditions under which the patient is discharged or transferred.

2. The hospital describes the method for shifting responsibility for a patient’s care from one clinician, hospital, program, or service to another.

**Standard PC.04.01.03**

The hospital discharges or transfers the patient based on his or her assessed needs and the organization’s ability to meet those needs.

**Elements of Performance for PC.04.01.03**

2. The hospital identifies any needs the patient may have for psychosocial or physical care, treatment, and services after discharge or transfer.

3. The patient, the patient’s family, licensed independent practitioners, physicians, clinical psychologists, and staff involved in the patient’s care, treatment, and services participate in planning the patient’s discharge or transfer.

**Note 1:** The definition of “physician” is the same as that used by the Centers for Medicare & Medicaid Services (CMS) (refer to the Glossary).

**Note 2:** For psychiatric hospitals that use Joint Commission accreditation for deemed status purposes: Social service staff responsibilities include, but are not limited to, participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of information with sources outside the hospital.
Note 3: For hospitals that use Joint Commission accreditation for deemed status purposes and have swing beds: The hospital notifies the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and reasons for the move in writing. The hospital also provides sufficient preparation and orientation to residents to make sure that transfer or discharge from the hospital is safe and orderly.

4. Prior to discharge, the hospital arranges or assists in arranging the services required by the patient after discharge in order to meet his or her ongoing needs for care and services.

Standard PC.04.01.05
Before the hospital discharges or transfers a patient, it informs and educates the patient about his or her follow-up care, treatment, and services.

Elements of Performance for PC.04.01.05
1. When the hospital determines the patient’s discharge or transfer needs, it promptly shares this information with the patient, and also with the patient’s family when it is involved in decision making or ongoing care.

7. The hospital educates the patient, and also the patient’s family when it is involved in decision making or ongoing care, about how to obtain any continuing care, treatment, and services that the patient will need.

Standard PC.04.02.01
When a patient is discharged or transferred, the hospital gives information about the care, treatment, and services provided to the patient to other service providers who will provide the patient with care, treatment, or services.

Element of Performance for PC.04.02.01
1. At the time of the patient’s discharge or transfer, the hospital informs other service providers who will provide care, treatment, or services to the patient about the following:
   - The reason for the patient’s discharge or transfer
   - The patient’s physical and psychosocial status
   - A summary of care, treatment, and services it provided to the patient
   - The patient’s progress toward goals
   - A list of community resources or referrals made or provided to the patient

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
Record of Care, Treatment, and Services (RC)

Standard RC.01.01.01
The hospital maintains complete and accurate medical records for each individual patient.

Elements of Performance for RC.01.01.01

5. The medical record contains the information needed to support the patient’s diagnosis and condition.

7. The medical record contains information that documents the course and result of the patient’s care, treatment, and services. *(See also PC.01.02.07, EP 7)*

8. The medical record contains information about the patient’s care, treatment, or services that promotes continuity of care among providers.

   **Note:** For hospitals that elect The Joint Commission Primary Care Medical Home option: This requirement refers to care provided by both internal and external providers.

11. All entries in the medical record are dated.

IV. Superb Access to Care

Provision of Care, Treatment, and Services (PC)

Standard PC.02.04.01
For hospitals that elect The Joint Commission Primary Care Medical Home option: The patient has access to the primary care medical home 24 hours a day, 7 days a week.

**Note:** Access may be provided through a number of methods, including telephone, e-mail, websites, portals, and flexible hours.
Elements of Performance for PC.02.04.01

1. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home provides patients with access to the following 24 hours a day, 7 days a week:
   - Appointment availability/scheduling
   - Requests for prescription renewal
   - Test results
   - Clinical advice for urgent health needs

2. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home offers flexible scheduling to accommodate patient care needs.

   **Note:** This may include open scheduling, same-day appointments, group visits, expanded hours, and arrangements with other organizations.

3. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home has a process to address patient urgent care needs 24 hours a day, 7 days a week.

**V. Systems-Based Approach to Quality and Safety**

**Leadership (LD)**

**Standard LD.01.03.01**
The governing body is ultimately accountable for the safety and quality of care, treatment, and services.

Elements of Performance for LD.01.03.01

20. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home evaluates the effectiveness of how the primary care clinician and the interdisciplinary team partner with the patient to support continuity of care and comprehensive, coordinated care.
Standard LD.03.04.01

The hospital communicates information related to safety and quality to those who need it, including staff, licensed independent practitioners, patients, families, and external interested parties.

Elements of Performance for LD.03.04.01

1. Communication processes foster the safety of the patient and the quality of care.
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 patients, the community, physicians, staff, and management.
5. Communication supports safety and quality throughout the hospital. (See also LD.04.04.05, EPs 6 and 12)
6. When changes in the environment occur, the hospital communicates those changes effectively.
7. Leaders evaluate the effectiveness of communication methods.

Standard LD.04.04.01

Leaders establish priorities for performance improvement. (For more information, refer to the “Performance Improvement” [PI] chapter)

Elements of Performance for LD.04.04.01

1. Leaders set priorities for performance improvement activities and patient 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 4, 6–8, 11, 14, and 15)
3. Leaders reprioritize performance improvement activities in response to changes in the internal or external environment.
5. For hospitals that elect The Joint Commission Primary Care Medical Home option: Ongoing performance improvement occurs hospitalwide for the purpose of demonstrably improving the quality and safety of care, treatment, or services.
6. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The interdisciplinary team actively participates in performance improvement activities.

### Standard LD.04.04.03

New or modified services or processes are well designed.

#### Elements of Performance for LD.04.04.03

2. The hospital’s design of new or modified services or processes incorporates the results of performance improvement activities.

4. The hospital’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 hospital’s design of new or modified services or processes incorporates information about sentinel events.

### Standard LD.04.04.05

The hospital has an organizationwide, integrated patient safety program within its performance improvement activities.

#### Elements of Performance for LD.04.04.05

1. The leaders implement a hospitalwide patient safety program.

2. One or more qualified individuals or an interdisciplinary group manages 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 departments, programs, and services within the hospital participate in the safety program.

5. As part of the safety program, the leaders create procedures for responding to system or process failures.
Note: Responses might include continuing to provide care, treatment, and services to those affected, containing the risk to others, and preserving factual information for subsequent analysis.

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.03.04.01, EP 5; LD.04.04.03, EP 3; PI.01.01.01, EP 8)

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 a serious adverse outcome or result in an adverse event, often referred to as a close call or near miss.

8. The hospital 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 individuals.

11. To improve safety and to reduce the risk of medical errors, the hospital analyzes and uses information about system or process failures and 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 patients and the families were informed of the event
   - All actions taken to improve safety, both proactively and in response to actual occurrences
   - **For hospitals that use Joint Commission accreditation for deemed status purposes:** The determined number of distinct improvement projects to be conducted annually
   - All results of the analyses related to the adequacy of staffing *(See also PI.02.01.01, EP 14)*

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.

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**Standard LD.04.04.07**
The hospital considers clinical practice guidelines when designing or improving processes.

**Elements of Performance for LD.04.04.07**

2. When clinical practice guidelines will be used in the design or modification of processes, the hospital identifies criteria to guide their selection and implementation.

3. The hospital manages and evaluates the implementation of the guidelines used in the design or modification of processes.

4. The leaders of the hospital review and approve the clinical practice guidelines.
5. The organized medical staff reviews the clinical practice guidelines and modifies them as needed.

Medication Management (MM)

Standard MM.04.01.01
Medication orders are clear and accurate.

Elements of Performance for MM.04.01.01

21. For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home uses an electronic prescribing process.

Provision of Care, Treatment, and Services (PC)

Standard PC.01.03.01
The hospital plans the patient’s care.

Elements of Performance for PC.01.03.01

45. For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home uses clinical decision support tools to guide decision making. (Refer to LD.04.04.07, EPs 2–5)

Performance Improvement (PI)

Standard PI.01.01.01
The hospital 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 leaders identify the frequency for data collection.
Note: For hospitals that use Joint Commission accreditation for deemed status purposes: The leaders that specify the frequency and detail of data collection is the governing body.

The hospital collects data on the following:

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

4. Operative or other procedures that place patients at risk of disability or death. (See also LD.04.04.01, EP 2; MS.05.01.01, EP 6)

5. All significant discrepancies between preoperative and postoperative diagnoses, including pathologic diagnoses.

16. Patient perception of the safety and quality of care, treatment, or services.

For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home collects data on the following:

40. Disease management outcomes.

41. Patient access to care within time frames established by the hospital.

42. For hospitals that elect The Joint Commission Primary Care Medical Home option: The primary care medical home collects data on the following:

- Patient experience and satisfaction related to access to care, treatment, or services, and communication
- Patient perception of the comprehensiveness of care, treatment, or services
- Patient perception of the coordination of care, treatment, or services
- Patient perception of the continuity of care, treatment, or services

(Refer to PI.01.01.01, EP 16)

Standard PI.02.01.01

The hospital compiles and analyzes data.

Elements of Performance for PI.02.01.01

4. The hospital analyzes and compares internal data over time to identify levels of performance, patterns, trends, and variations.

8. The hospital uses the results of data analysis to identify improvement opportunities. (See also LD.03.02.01, EP 5)
Standard PI.03.01.01

The hospital improves performance on an ongoing basis.

**Elements of Performance for PI.03.01.01**

2. The hospital takes action on improvement priorities. (*See also* MM.08.01.01, EP 6; MS.05.01.01, EPs 1–11)

4. The hospital takes action when it does not achieve or sustain planned improvements. (*See also* MS.05.01.01, EPs 1–11)

11. **For hospitals that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home uses the data it collects on the patient’s perception of the safety and quality of care, treatment, or services to improve its performance. This data includes the following:
   - Patient experience and satisfaction related to access to care, treatment, or services and communication
   - Patient perception of the comprehensiveness of care, treatment, or services
   - Patient perception of the coordination of care, treatment, or services
   - Patient perception of the continuity of care, treatment, or services
Appendix A: Medicare Requirements for Hospitals (AXA)

Hospitals seeking to obtain or maintain Medicare certification must meet all requirements for participation in the Medicare program. The standards and elements of performance (EPs) in this manual meet or exceed the Conditions of Participation for hospitals. For a complete list of all regulations that may apply, see Code of Federal Regulations, Title 42—Public Health at http://www.ecfr.gov.

The following subset of Conditions of Participation is highlighted in this Appendix because of the specificity of the requirements. Your hospital should be familiar with specific Medicare language in order to make certain that compliance with the entire Medicare requirement can be demonstrated.

Part 409 Subpart B—Inpatient Hospital Services and Inpatient Critical Access Hospital Services
409.17: Physical Therapy, Occupational Therapy, and Speech-Language Pathology Services
409.17(a) General rules.

409.17(a)(1) Except as specified in this section, physical therapy, occupational therapy, or speech-language pathology services must be furnished by qualified physical therapists, physical therapist assistants, occupational therapists, occupational therapy assistants, or speech-language pathologists who meet the requirements specified in part 484 of this chapter.

409.17(a)(2) Physical therapy, occupational therapy or speech-language pathology services must be furnished under a plan that meets the requirements of paragraphs (b) through (d) of this section, or plan requirements specific to the payment policy under which the services are rendered, if applicable.
409.17(b) **Establishment of the plan.** The plan must be established before treatment begins by one of the following:

- **409.17(b)(1)** A physician.
- **409.17(b)(2)** A nurse practitioner, a clinical nurse specialist or a physician assistant.
- **409.17(b)(3)** The physical therapist furnishing the physical therapy services.
- **409.17(b)(4)** A speech-language pathologist furnishing the speech-language pathology services.
- **409.17(b)(5)** An occupational therapist furnishing the occupational therapy services.

409.17(c) **Content of the plan.** The plan:

- **409.17(c)(1)** Prescribes the type, amount, frequency, and duration of the physical therapy, occupational therapy, or speech-language pathology services to be furnished to the individual; and
- **409.17(c)(2)** Indicates the diagnosis and anticipated goals.

409.17(d) **Changes in the plan.** Any changes in the plan are implemented in accordance with the provider’s policies and procedures.

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**482.12 Condition of Participation: Governing Body**

482.12(a) **Standard: Medical Staff.** The governing body must:

- **482.12(a)(8)** Ensure that, when telemedicine services are furnished to the hospital’s patients through an agreement with a distant-site hospital, the agreement is written and that it specifies that it is the responsibility of the governing body of the distant-site hospital to meet the requirements in paragraphs (a)(1) through (a)(7) of this section with regard to the distant site hospital’s physicians and practitioners providing telemedicine services. The governing body of the hospital whose patients are receiving the telemedicine services may, in accordance with §482.22(a)(3) of this part, grant privileges based on its medical staff recommendations that rely on information provided by the distant-site hospital.

- **482.12(a)(9)** Ensure that when telemedicine services are furnished to the hospital’s patients through an agreement with a distant-site telemedicine entity, the written agreement specifies that the distant-site telemedicine entity is a contractor of
services to the hospital and as such, in accordance with §482.12(e), furnishes the contracted services in a manner that permits the hospital to comply with all applicable conditions of participation for the contracted services, including, but not limited to, the requirements in paragraphs (a)(1) through (a)(7) of this section with regard to the distant-site telemedicine entity’s physicians and practitioners providing telemedicine services. The governing body of the hospital whose patients are receiving the telemedicine services may, in accordance with §482.22(a)(4) of this part, grant privileges to physicians and practitioners employed by the distant-site telemedicine entity based on such hospital’s medical staff recommendations; such staff recommendations may rely on information provided by the distant-site telemedicine entity.

**482.12(d) Standard: Institutional Plan and Budget.** The institution must have an overall institutional plan that meets the following conditions:

**482.12(d)(1)** The plan must include an annual operating budget that is prepared according to generally accepted accounting principles.

**482.12(d)(2)** The budget must include all anticipated income and expenses. This provision does not require that the budget identify item by item the components of each anticipated income or expense.

**482.12(d)(3)** The plan must provide for capital expenditures for at least a 3-year period, including the year in which the operating budget specified in paragraph (d)(2) of this section is applicable.

**482.12(d)(4)** The plan must include and identify in detail the objective of, and the anticipated sources of financing for, each anticipated capital expenditure in excess of $600,000 (or a lesser amount that is established, in accordance with section 1122(g)(1) of the Act, by the State in which the hospital is located) that relates to any of the following:

**482.12(d)(4)(i)** Acquisition of land;

**482.12(d)(4)(ii)** Improvement of land, buildings, and equipment; or

**482.12(d)(4)(iii)** The replacement, modernization, and expansion of buildings and equipment.

**482.12(d)(5)** The plan must be submitted for review to the planning agency designated in accordance with section 1122(b) of the Act, or if an agency is not designated, to the appropriate health planning agency in the State. (See part 100 of
A capital expenditure is not subject to section 1122 review if 75 percent of the health care facility’s patients who are expected to use the service for which the capital expenditure is made are individuals enrolled in a health maintenance organization (HMO) or competitive medical plan (CMP) that meets the requirements of section 1876(b) of the Act, and if the department determines that the capital expenditure is for services and facilities that are needed by the HMO or CMP in order to operate efficiently and economically and that are not otherwise readily accessible to the HMO or CMP because—

482.12(d)(5)(i) The facilities do not provide common services at the same site;
482.12(d)(5)(ii) The facilities are not available under a contract of reasonable duration;
482.12(d)(5)(iii) Full and equal medical staff privileges in the facilities are not available;
482.12(d)(5)(iv) Arrangements with these facilities are not administratively feasible; or
482.12(d)(5)(v) The purchase of these services is more costly than if the HMO or CMP provided the services directly.

482.22 Condition of Participation: Medical staff

482.22 Condition of Participation: Medical staff. The hospital must have an organized medical staff that operates under bylaws approved by the governing body and is responsible for the quality of medical care provided to patients by the hospital.

482.22(a) Standard: Eligibility and process for appointment to medical staff. The medical staff must be composed of doctors of medicine or osteopathy. In accordance with State law, including scope-of-practice laws, the medical staff may also include other categories of physicians (as listed at 482.12(c)(1)) and nonphysician practitioners who are determined to be eligible for appointment by the governing body.

482.22(a)(3) When telemedicine services are furnished to the hospital’s patients through an agreement with a distant-site hospital, the governing body of the hospital whose patients are receiving the telemedicine services may choose, in lieu of the requirements in paragraphs (a)(1) and (a)(2) of this section, to have its medical staff rely upon the credentialing and privileging decisions made by the distant-site hospital when making recommendations on privileges for the individual distant-site
Appendix A: Medicare Requirements for Hospitals

physicians and practitioners providing such services, if the hospital’s governing body ensures, through its written agreement with the distant-site hospital, that all of the following provisions are met:

482.22(a)(3)(i) The distant-site hospital providing the telemedicine services is a Medicare-participating hospital.

482.22(a)(3)(ii) The individual distant-site physician or practitioner is privileged at the distant-site hospital providing the telemedicine services, which provides a current list of the distant-site physician’s or practitioner’s privileges at the distant-site hospital.

482.22(a)(3)(iii) The individual distant-site physician or practitioner holds a license issued or recognized by the State in which the hospital whose patients are receiving the telemedicine services is located.

482.22(a)(3)(iv) With respect to a distant-site physician or practitioner, who holds current privileges at the hospital whose patients are receiving the telemedicine services, the hospital has evidence of an internal review of the distant-site physician’s or practitioner’s performance of these privileges and sends the distant-site hospital such performance information for use in the periodic appraisal of the distant-site physician or practitioner. At a minimum, this information must include all adverse events that result from the telemedicine services provided by the distant-site physician or practitioner to the hospital’s patients and all complaints the hospital has received about the distant-site physician or practitioner.

482.22(a)(4) When telemedicine services are furnished to the hospital’s patients through an agreement with a distant-site telemedicine entity, the governing body of the hospital whose patients are receiving the telemedicine services may choose, in lieu of the requirements in paragraphs (a)(1) and (a)(2) of this section, to have its medical staff rely upon the credentialing and privileging decisions made by the distant-site telemedicine entity when making recommendations on privileges for the individual distant-site physicians and practitioners providing such services, if the hospital’s governing body ensures, through its written agreement with the distant-site telemedicine entity, that the distant-site telemedicine entity furnishes services that, in accordance with §482.12(e), permit the hospital to comply with all applicable conditions of participation for the contracted services. The hospital’s governing body must also ensure, through its written agreement with the distant-site telemedicine entity, that all of the following provisions are met:
\textbf{482.22(a)(4)(i)} The distant-site telemedicine entity’s medical staff credentialing and privileging process and standards at least meet the standards at §482.12(a)(1) through (a)(7) and §482.22(a)(1) through (a)(2).

\textbf{482.22(a)(4)(ii)} The individual distant-site physician or practitioner is privileged at the distant-site telemedicine entity providing the telemedicine services, which provides the hospital with a current list of the distant-site physician’s or practitioner’s privileges at the distant-site telemedicine entity.

\textbf{482.22(a)(4)(iii)} The individual distant-site physician or practitioner holds a license issued or recognized by the State in which the hospital whose patients are receiving such telemedicine services is located.

\textbf{482.22(a)(4)(iv)} With respect to a distant-site physician or practitioner, who holds current privileges at the hospital whose patients are receiving the telemedicine services, the hospital has evidence of an internal review of the distant-site physician’s or practitioner’s performance of these privileges and sends the distant-site telemedicine entity such performance information for use in the periodic appraisal of the distant-site physician or practitioner. At a minimum, this information must include all adverse events that result from the telemedicine services provided by the distant-site physician or practitioner to the hospital’s patients, and all complaints the hospital has received about the distant-site physician or practitioner.

\textbf{482.22(c) Standard: Medical Staff Bylaws.} The medical staff must adopt and enforce bylaws to carry out its responsibilities. The bylaws must:

\textbf{482.22(c)(6)} [The bylaws must:] Include criteria for determining the privileges to be granted to individual practitioners and a procedure for applying the criteria to individuals requesting privileges. For distant-site physicians and practitioners requesting privileges to furnish telemedicine services under an agreement with the hospital, the criteria for determining privileges and the procedure for applying the criteria are also subject to the requirements in §482.12(a)(8) and (a)(9), and 482.22(a)(3) and (a)(4).
482.27 Condition of Participation: Laboratory Services

482.27(b) Standard: Potentially Infectious Blood and Blood Components.

482.27(b)(1) Potentially human immunodeficiency virus (HIV) infectious blood and blood components. Potentially HIV infectious blood and blood components are prior collections from a donor—

482.27(b)(1)(i) Who tested negative at the time of donation but tests reactive for evidence of HIV infection on a later donation;

482.27(b)(1)(ii) Who tests positive on the supplemental (additional, more specific) test or other follow-up testing required by FDA; and

482.27(b)(1)(iii) For whom the timing of seroconversion cannot be precisely estimated.

482.27(b)(2) Potentially hepatitis C virus (HCV) infectious blood and blood components. Potentially HCV infectious blood and blood components are the blood and blood components identified in 21 CFR 610.47.

482.27(b)(3) Services furnished by an outside blood collecting establishment. If a hospital regularly uses the services of an outside blood collecting establishment, it must have an agreement with the blood collecting establishment that governs the procurement, transfer, and availability of blood and blood components. The agreement must require that the blood collecting establishment notify the hospital

482.27(b)(3)(i) Within 3 calendar days if the blood collecting establishment supplied blood and blood components collected from a donor who tested negative at the time of donation but tests reactive for evidence of HIV or HCV infection on a later donation or who is determined to be at increased risk for transmitting HIV or HCV infection;

482.27(b)(3)(ii) Within 45 days of the test, of the results of the supplemental (additional, more specific) test for HIV or HCV, as relevant, or other follow-up testing required by FDA;

482.27(b)(3)(iii) Within 3 calendar days after the blood collecting establishment supplied blood and blood components collected from an infectious donor, whenever records are available, as set forth at 21 CFR 610.48(b)(3).
482.27(b)(4) Quarantine of blood and blood components pending completion of testing. If the blood collecting establishment (either internal or under an agreement) notifies the hospital of the reactive HIV or HCV screening test results, the hospital must determine the disposition of the blood or blood component and quarantine all blood and blood components from previous donations in inventory.

482.27(b)(4)(i) If the blood collecting establishment notifies the hospital that the result of the supplemental (additional, more specific) test or other follow-up testing required by FDA is negative, absent other informative test results, the hospital may release the blood and blood components from quarantine.

482.27(b)(4)(ii) If the blood collecting establishment notifies the hospital that the result of the supplemental (additional, more specific) test or other follow-up testing required by FDA is positive, the hospital must—

482.27(b)(4)(ii)(A) Dispose of the blood and blood components; and

482.27(b)(4)(ii)(B) Notify the transfusion recipients as set forth in paragraph (b)(6) of this section.

482.27(b)(4)(iii) If the blood collecting establishment notifies the hospital that the result of the supplemental (additional, more specific) test or other follow-up testing required by FDA is indeterminate, the hospital must destroy or label prior collections of blood or blood components held in quarantine as set forth at 21 CFR 610.46(b)(2), 610.47(b)(2), and 610.48(c)(2).

482.27(b)(5) Recordkeeping by the hospital. The hospital must maintain—

482.27(b)(5)(i) Records of the source and disposition of all units of blood and blood components for at least 10 years from the date of disposition in a manner that permits prompt retrieval; and

482.27(b)(5)(ii) A fully funded plan to transfer these records to another hospital or other entity if such hospital ceases operation for any reason.

482.27(b)(6) Patient notification. If the hospital has administered potentially HIV or HCV infectious blood or blood components (either directly through its own blood collecting establishment or under an agreement) or released such blood or blood components to another entity or appropriate individual, the hospital must take the following actions:
Appendix A: Medicare Requirements for Hospitals

482.27(b)(6)(i) Make reasonable attempts to notify the patient, or to notify the attending physician who ordered the blood or blood component and ask the physician to notify the patient, or other individual as permitted under paragraph (b)(10) of this section, that potentially HIV or HCV infectious blood or blood components were transfused to the patient and that there may be a need for HIV or HCV testing and counseling.

482.27(b)(6)(ii) If the physician is unavailable or declines to make the notification, make reasonable attempts to give this notification to the patient, legal guardian or relative.

482.27(b)(6)(iii) Document in the patient’s medical record the notification or attempts to give the required notification.

482.27(b)(7) Timeframe for notification.

482.27(b)(7)(i) For donors tested on or after February 20, 2008. For notifications resulting from donors tested on or after February 20, 2008, as set forth at 21 CFR 610.46 and 21 CFR 610.47 the notification effort begins when the blood collecting establishment notifies the hospital that it received potentially HIV or HCV infectious blood and blood components. The hospital must make reasonable attempts to give notification over a period of 12 weeks unless—

482.27(b)(7)(i)(A) The patient is located and notified; or

482.27(b)(7)(i)(B) The hospital is unable to locate the patient and documents in the patient’s medical record the extenuating circumstances beyond the hospital’s control that caused the notification timeframe to exceed 12 weeks.

482.27(b)(7)(ii) For donors tested before February 20, 2008. For notifications from donors tested before February 20, 2008, as set forth at 21 CFR 610.48(b) and (c), the notification effort begins when the blood collecting establishment notifies the hospital that it received potentially HCV infectious blood and blood components. The hospital must make reasonable attempts to give notification and must complete the actions within 1 year of the date on which the hospital received notification from the outside blood collecting establishment.
482.27(b)(8) Content of notification. The notification must include the following information:

482.27(b)(8)(i) A basic explanation of the need for HIV or HCV testing and counseling.

482.27(b)(8)(ii) Enough oral or written information so that an informed decision can be made about whether to obtain HIV or HCV testing and counseling.

482.27(b)(8)(iii) A list of programs or places where the person can obtain HIV or HCV testing and counseling, including any requirements or restrictions the program may impose.

482.27(b)(9) Policies and procedures. The hospital must establish policies and procedures for notification and documentation that conform to Federal, State, and local laws, including requirements for the confidentiality of medical records and other patient information.

482.27(b)(10) Notification to legal representative or relative. If the patient has been adjudged incompetent by a State court, the physician or hospital must notify a legal representative designated in accordance with State law. If the patient is competent, but State law permits a legal representative or relative to receive the information on the patient’s behalf, the physician or hospital must notify the patient or his or her legal representative or relative. For possible HIV infectious transfusion recipients that are deceased, the physician or hospital must inform the deceased patient’s legal representative or relative. If the patient is a minor, the parents or legal guardian must be notified.

482.27(b)(11) Applicability. HCV notification requirements resulting from donors tested before February 20, 2008, as set forth at 21 CFR 610.48 will expire on August 24, 2015.

482.27(c) Standard: General blood safety issues. For lookback activities only related to new blood safety issues that are identified after August 24, 2007, hospitals must comply with FDA regulations as they pertain to blood safety issues in the following areas:

482.27(c)(1) Appropriate testing and quarantining of infectious blood and blood components.

482.27(c)(2) Notification and counseling of recipients that may have received infectious blood and blood components.
482.30 Condition of Participation: Utilization Review

482.30 Condition of Participation: Utilization Review. The hospital must have in effect a utilization review (UR) plan that provides for review of services furnished by the institution and by members of the medical staff to patients entitled to benefits under the Medicare and Medicaid programs.

482.30(a) Standard: Applicability. The provisions of this section apply except in either of the following circumstances:

482.30(a)(1) A Utilization and Quality Control Quality Improvement Organization (QIO) has assumed binding review for the hospital.

482.30(a)(2) CMS has determined that the UR procedures established by the State under title XIX of the Act are superior to the procedures required in this section, and has required hospitals in that State to meet the UR plan requirements under §§456.50 through 456.245 of this chapter.

482.30(b) Standard: Composition of Utilization Review Committee. A UR committee consisting of two or more practitioners must carry out the UR function. At least two of the members of the committee must be doctors of medicine or osteopathy. The other members may be any of the other types of practitioners specified in §482.12(c)(1).

482.30(b)(1) Except as specified in paragraphs (b)(2) and (3) of this section, the UR committee must be one of the following:

482.30(b)(1)(i) A staff committee of the institution;

482.30(b)(1)(ii) A group outside the institution—

482.30(b)(1)(ii)(A) Established by the local medical society and some or all of the hospitals in the locality; or

482.30(b)(1)(ii)(B) Established in a manner approved by CMS.

482.30(b)(2) If, because of the small size of the institution, it is impracticable to have a properly functioning staff committee, the UR committee must be established as specified in paragraph (b)(1)(ii) of this section

482.30(b)(3) The committee or group’s reviews may not be conducted by any individual who—
482.30(b)(3)(i) Has a direct financial interest (for example, an ownership interest) in that hospital; or

482.30(b)(3)(ii) Was professionally involved in the care of the patient whose case is being reviewed.

482.30(c) Standard: Scope and Frequency of Review.

482.30(c)(1) The UR plan must provide for review for Medicare and Medicaid patients with respect to the medical necessity of—

482.30(c)(1)(i) Admissions to the institution;

482.30(c)(1)(ii) The duration of stays; and

482.30(c)(1)(iii) Professional services furnished including drugs and biologicals.

482.30(c)(2) Review of admissions may be performed before, at, or after hospital admission.

482.30(c)(3) Except as specified in paragraph (c) of this section, reviews may be conducted on a sample basis.

482.30(c)(4) Hospitals that are paid for inpatient hospital services under the prospective payment system set forth in Part 412 of this chapter must conduct review of duration of stays and review of professional services as follows:

482.30(c)(4)(i) For duration of stays, these hospitals need review only cases that they reasonably assume to be outlier cases based on extended length of stay, as described in §412.80(a)(1)(i) of this chapter; and

482.30(c)(4)(ii) For professional services, these hospitals need review only cases that they reasonably assume to be outlier cases based on extraordinarily high costs, as described in §412.80(a)(1)(ii) of this chapter.

482.30(d) Standard: Determination Regarding Admissions or Continued Stays.

482.30(d)(1) The determination that an admission or continued stay is not medically necessary—

482.30(d)(1)(i) May be made by one member of the UR committee if the practitioner or practitioners responsible for the care of the patient, as specified of §482.12(c), concur with the determination or fail to present their views when afforded the opportunity; and
482.30(d)(1)(ii) Must be made by at least two members of the UR committee in all other cases.

482.30(d)(2) Before making a determination that an admission or continued stay is not medically necessary, the UR committee must consult the practitioner or practitioners responsible for the care of the patient, as specified in §482.12(c), and afford the practitioner or practitioners the opportunity to present their views.

482.30(d)(3) If the committee decides that admission to or continued stay in the hospital is not medically necessary, written notification must be given, no later than 2 days after the determination, to the hospital, the patient, and the practitioner or practitioners responsible for the care of the patient, as specified in §482.12(c);

482.30(e) Standard: Extended Stay Review.

482.30(e)(1) In hospitals that are not paid under the prospective payment system, the UR committee must make a periodic review, as specified in the UR plan, or each current inpatient receiving hospital services during a continuous period of extended duration. The scheduling of the periodic reviews may—

482.30(e)(1)(i) Be the same for all cases; or

482.30(e)(1)(ii) Differ for different classes of cases.

482.30(e)(2) In hospitals paid under the prospective payment system, the UR committee must review all cases reasonably assumed by the hospital to be outlier cases because the extended length of stay exceeds the threshold criteria for the diagnosis, as described in §412.80(a)(1)(i). The hospital is not required to review an extended stay that does not exceed the outlier threshold for the diagnosis.

482.30(e)(3) The UR committee must make the periodic review no later than 7 days after the day required in the UR plan.

482.30(f) Standard: Review of Professional Services. The committee must review professional services provided, to determine medical necessity and to promote the most efficient use of available health facilities and services.
Comprehensive Accreditation Manual for Hospitals

CoP Requirements Assessed by CMS or the Fiscal Intermediary

Code of Federal Regulations Title 42 includes additional requirements that may be applicable. Compliance with these additional regulations may be assessed by the Centers for Medicare & Medicaid Services (CMS) or the Fiscal Intermediary. Hospitals should be aware of the following additional regulations that require compliance.

482.11(b) The hospital must be—

(1) Licensed; or

(2) Approved as meeting standards for licensing established by the agency of the State or locality responsible for licensing hospitals.

Interpretive Guidelines §482.11(b)

Hospitals applying for initial Medicare certification as a hospital or hospitals currently participating in Medicare must, among other things, meet the statutory definition of a hospital under section 1861(e) of the Act. Section 1861(e)(7) of the Act further requires that a hospital located in a state which provides for the licensing of hospitals, the hospital must be licensed in accordance with state law or approved as meeting standards for licensing as established by the agency of the State or locality responsible for the licensing of hospitals.

While a facility may have a license from a state to operate as a hospital or may have been approved by a state as a hospital under state or local standards and authorities, that facility may still not meet the Medicare definition of a hospital as per the Act. The criteria used by a state to determine that a hospital meets the requirements for state licensure as a hospital is not the same criteria used to define a hospital for the purpose of participation in Medicare, and each state has its own criteria and standards for licensure.

The definition of a hospital and the issue of whether the facility is Primarily Engaged are issues not applicable to a Critical Access Hospital (CAH).

482.1 Basis and scope.

(a) Statutory basis. (1) Section 1861(e) of the [Social Security] Act provides that—

(i) Hospitals participating in Medicare must meet certain specified requirements; and
(ii) The Secretary may impose additional requirements if they are found necessary in the interest of the health and safety of the individuals who are furnished services in hospitals.

...  

(b) Scope. Except as provided in subpart A of part 488 of this chapter, the provisions of this part serve as the basis of survey activities for the purpose of determining whether a hospital qualifies for a provider agreement under Medicare and Medicaid.

Interpretive Guidelines §482.1(a)(1)

Hospital Definition and Regulatory Enforcement Authorities

In order to qualify for a provider agreement as a hospital (other than a psychiatric hospital as defined at section 1861(f) of the Act) under Medicare and Medicaid, an entity must meet and continue to meet all of the statutory provisions of §1861(e) of the Act, including the Condition of Participation requirements. See also 42 CFR 488.3(a)(1) and 42 CFR 489.12. This means the entity must:

- Be primarily engaged in providing, by or under the supervision of physicians, to inpatients (A) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (B) rehabilitation services for the rehabilitation of injured, disabled, or sick persons;
- Maintain clinical records on all patients [addressed in 42 CFR 482.24, Medical Records];
- Have medical staff bylaws [42 CFR 482.12, Governing Body, and 42 CFR 482.22, Medical Staff];
- Have a requirement that every patient with respect to whom payment may be made under Title XVIII must be under the care of a physician except that a patient receiving qualified psychologist services (as defined in section 1861(ii) of the Act) may be under the care of a clinical psychologist with respect to such services to the extent permitted under State law [42 CFR 482.12, Governing Body];
- Provide 24-hour nursing service rendered or supervised by a registered professional nurse, and has a licensed practical nurse or registered professional nurse on duty at all times . . . [42 CFR 482.23, Nursing Services];
- Have in effect a hospital utilization review plan which meets the requirements of section 1861(k) of the Act [42 CFR 482.30, Utilization Review];
- Have in place a discharge planning process that meets the requirements of section 1861(ee) of the Act [42 CFR 482.43, Discharge Planning];
If located in a state in which state or applicable local law provides for the licensing of hospitals, be licensed under such law or be approved by the agency of the State or locality responsible for licensing hospitals as meeting the standards established for such licensing [42 CFR 482.11, Compliance with Federal, State, and Local Laws];

Have in effect an overall plan and budget that meets the requirements of section 1861(z) of the Act [42 CFR 482.12, Governing Body]; and

Meet any other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the institution [42 CFR Parts 482 and 489, among others].

Primarily Engaged. Generally, a hospital is primarily engaged in providing inpatient services under section 1861(e)(1) of the Act when it is directly providing such services to inpatients. Having the capacity or potential capacity to provide inpatient care is not the equivalent of actually providing such care. Inpatient hospital services are defined under section 1861(b) of the Act and in the regulations at 42 CFR Part 409, Subpart B. CMS guidance describes an inpatient as “a person who has been admitted to a hospital for bed occupancy for purposes of receiving inpatient hospital services . . . Generally, a patient is considered an inpatient if formally admitted as an inpatient with the expectation that he or she will require hospital care that is expected to span at least two midnights and occupy a bed even though it later develops that the patient can be discharged or transferred to another hospital and not actually use a hospital bed overnight.” (Medicare Benefit Policy Manual, Chapter 1, §10, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf)

The “expectation of a two midnight stay” for an inpatient is that the intent of the physician was that the patient be admitted to the hospital for an inpatient stay as opposed to that of observation status which is an outpatient service. Therefore, an average length of stay (ALOS) of two midnights would be one of the benchmarks considered for certification as a hospital.
Appendix B: Special Conditions of Participation for Psychiatric Hospitals (AXB)

Psychiatric hospitals that use accreditation for deemed status purposes must meet all requirements for participation in the Medicare program, including the hospital Conditions of Participation and the special Conditions of Participation for psychiatric hospitals. The standards and elements of performance (EPs) in this manual have been determined by the Centers for Medicare & Medicaid Services (CMS) to meet or exceed these Conditions of Participation. For a complete list of all regulations that may apply, see Code of Federal Regulations, Title 42—Public Health at http://www.ecfr.gov.

The following special Conditions of Participation for psychiatric hospitals are covered in Joint Commission standards and EPs. These conditions are included in this appendix to help your psychiatric hospital ascertain whether it complies with the specific details of these special Conditions of Participation.

Subpart E—Requirements for Specialty Hospitals

482.60 Special Provisions Applying to Psychiatric Hospitals

482.60 Special Provisions Applying to Psychiatric Hospitals. Psychiatric hospital must—

482.60(a) Be primarily engaged in providing, by or under the supervision of a doctor of medicine or osteopathy, psychiatric services for the diagnosis and treatment of mentally ill persons;

482.60(b) Meet the conditions of participation specified in §§482.1 through 482.23 and §§482.25 through 482.57;
482.60(c) Maintain clinical records on all patients, including records sufficient to permit CMS to determine the degree and intensity of treatment furnished to Medicare beneficiaries, as specified in §482.61; and

482.60(d) Meet the staffing requirements specified in §482.62.

482.61 Condition of Participation: Special Medical Record Requirements for Psychiatric Hospitals

482.61 Condition of Participation: Special Medical Record Requirements for Psychiatric Hospitals. The medical records maintained by a psychiatric hospital must permit determination of the degree and intensity of the treatment provided to individuals who are furnished services in the institution.

482.61(a) Standard: Development of Assessment/Diagnostic Data. Medical records must stress the psychiatric components of the record, including history of findings and treatment provided for the psychiatric condition for which the patient is hospitalized.

482.61(a)(1) The identification data must include the patient’s legal status.

482.61(a)(2) A provisional or admitting diagnosis must be made on every patient at the time of admission, and must include the diagnoses of intercurrent diseases as well as the psychiatric diagnoses.

482.61(a)(3) The reasons for admission must be clearly documented as stated by the patient and/or others significantly involved.

482.61(a)(4) The social service records, including reports of interviews with patients, family members, and others, must provide an assessment of home plans and family attitudes, and community resource contacts as well as a social history.

482.61(a)(5) When indicated, a complete neurological examination must be recorded at the time of the admission physical examination.

482.61(b) Standard: Psychiatric Evaluation. Each patient must receive a psychiatric evaluation that must—

482.61(b)(1) Be completed within 60 hours of admission;

482.61(b)(2) Include a medical history;

482.61(b)(3) Contain a record of mental status;
Appendix B: Special Conditions of Participation for Psychiatric Hospitals

482.61(b)(4) Note the onset of illness and the circumstances leading to admission;

482.61(b)(5) Describe attitudes and behavior;

482.61(b)(6) Estimate intellectual functioning, memory functioning, and orientation; and

482.61(b)(7) Include an inventory of the patient’s assets in descriptive, not interpretative, fashion.

482.61(c) Standard: Treatment Plan.

482.61(c)(1) Each patient must have an individual comprehensive treatment plan that must be based on an inventory of the patient’s strengths and disabilities. The written plan must include—

482.61(c)(1)(i) A substantiated diagnosis;

482.61(c)(1)(ii) Short-term and long-range goals;

482.61(c)(1)(iii) The specific treatment modalities utilized;

482.61(c)(1)(iv) The responsibilities of each member of the treatment team; and

482.61(c)(1)(v) Adequate documentation to justify the diagnosis and the treatment and rehabilitation activities carried out.

482.61(c)(2) The treatment received by the patient must be documented in such a way to assure that all active therapeutic efforts are included.

482.61(d) Standard: Recording Progress. Progress notes must be recorded by the doctor of medicine or osteopathy responsible for the care of the patient as specified in §482.12(c), nurse, social worker and, when appropriate, others significantly involved in active treatment modalities. The frequency of progress notes is determined by the condition of the patient but must be recorded at least weekly for the first 2 months and at least once a month thereafter and must contain recommendations for revisions in the treatment plan as indicated as well as precise assessment of the patient’s progress in accordance with the original or revised treatment plan.
482.61(e) **Standard: Discharge Planning and Discharge Summary.** The record of each patient who has been discharged must have a discharge summary that includes a recapitulation of the patient’s hospitalization and recommendations from appropriate services concerning follow-up or aftercare as well as a brief summary of the patient’s condition on discharge.

482.62 **Condition of Participation: Special Staff Requirements for Psychiatric Hospitals**

482.62 **Condition of Participation: Special Staff Requirements for Psychiatric Hospitals.** The hospital must have adequate numbers of qualified professional and supportive staff to evaluate patients, formulate written, individualized comprehensive treatment plans, provide active treatment measures, and engage in discharge planning.

482.62(a) **Standard: Personnel.** The hospital must employ or undertake to provide adequate numbers of qualified professional, technical, and consultative personnel to:

- 482.62(a)(1) Evaluate patients;
- 482.62(a)(2) Formulate written individualized, comprehensive treatment plans;
- 482.62(a)(3) Provide active treatment measures; and
- 482.62(a)(4) Engage in discharge planning.

482.62(b) **Standard: Director of Inpatient Psychiatric Services; Medical Staff.** Inpatient psychiatric services must be under the supervision of a clinical director, service chief, or equivalent who is qualified to provide the leadership required for an intensive treatment program. The number and qualifications of doctors of medicine and osteopathy must be adequate to provide essential psychiatric services.

- 482.62(b)(1) The clinical director, service chief, or equivalent must meet the training and experience requirements for examination by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.
- 482.62(b)(2) The director must monitor and evaluate the quality and appropriateness of services and treatment provided by the medical staff.

482.62(c) **Standard: Availability of Medical Personnel.** Doctors of medicine or osteopathy and other appropriate professional personnel must be available to provide necessary medical and surgical diagnostic and treatment services. If medical and surgical
Appendix B: Special Conditions of Participation for Psychiatric Hospitals

diagnostic and treatment services are not available within the institution, the institution must have an agreement with an outside source of these services to ensure that they are immediately available or a satisfactory agreement must be established for transferring patients to a general hospital that participates in the Medicare program.

482.62(d) Standard: Nursing Services. The hospital must have a qualified director of psychiatric nursing services. In addition to the director of nursing, there must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide nursing care necessary under each patient’s active treatment program and to maintain progress notes on each patient.

482.62(d)(1) The director of psychiatric nursing services must be a registered nurse who has a master’s degree in psychiatric or mental health nursing, or its equivalent from a school of nursing accredited by the National League for Nursing, or be qualified by education and experience in the care of the mentally ill. The director must demonstrate competence to participate in interdisciplinary formulation of individual treatment plans; to give skilled nursing care and therapy; and to direct, monitor, and evaluate the nursing care furnished.

482.62(d)(2) The staffing pattern must insure the availability of a registered professional nurse 24 hours each day. There must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide the nursing care necessary under each patient’s active treatment program.

482.62(e) Standard: Psychological Services. The hospital must provide or have available psychological services to meet the needs of the patients.

482.62(f) Standard: Social Services. There must be a director of social services who monitors and evaluates the quality and appropriateness of social services furnished. The services must be furnished in accordance with accepted standards of practice and established policies and procedures.

482.62(f)(1) The director of the social work department or service must have a master’s degree from an accredited school of social work or must be qualified by education and experience in the social services needs of the mentally ill. If the director does not hold a master’s degree in social work, at least one staff member must have this qualification.
482.62(f)(2) Social service staff responsibilities must include, but are not limited to, participating in discharge planning, arranging for follow-up care, and developing mechanisms for exchange of appropriate information with sources outside the hospital.

482.62(g) **Standard: Therapeutic Activities.** The hospital must provide a therapeutic activities program.

482.62(g)(1) The program must be appropriate to the needs and interests of patients and be directed toward restoring and maintaining optimal levels of physical and psychosocial functioning.

482.62(g)(2) The number of qualified therapists, support personnel, and consultants must be adequate to provide comprehensive therapeutic activities consistent with each patient’s active treatment program.
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 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
- Significant noncompliance with Joint Commission standards, and/or
- Patients 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 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.

**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.

**advanced practice registered nurse**  A registered nurse who has gained additional knowledge and skills through successful completion of an organized program of nursing education that prepares nurses for advanced practice roles, and who has been certified by the board of nursing to engage in the practice of advanced practice nursing.

**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 a patient.

**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.

**ALARA** An acronym for “as low as reasonably achievable,” which means making every reasonable effort to maintain exposures to ionizing radiation as far below NRC dose limits as practical.

**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.

**anesthesia and sedation** The administration to an individual, in any setting, for any purpose, by any route, of medication to induce a partial or total loss of sensation for the purpose of conducting an operative or other procedure. Definitions of four levels of sedation and anesthesia include the following:

1. Minimal sedation (anxiolysis): A drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.

2. Moderate sedation/analgesia (“conscious sedation”): A drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. Reflex withdrawal from a painful stimulus is not considered a purposeful response. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

3. Deep sedation/analgesia: A drug-induced depression of consciousness during which patients cannot be easily aroused, but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

4. Anesthesia: Consists of general anesthesia and spinal or major regional anesthesia. It does not include local anesthesia. General anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory
function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

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.

assessment An objective evaluation or appraisal of an individual’s health status, including acute and chronic conditions. The assessment gathers information through collection of data, observation, and physical examination.

autologous tissue Tissue intended for transplantation into the individual from whom the tissue was recovered. The recipient and donor are the same individual.
average daily census (ADC) for hospital  The hospital’s ADC is composed of the average number of inpatients (excluding newborns) receiving care each day in a health care organization during a reporting period.

aversive procedures  Procedures in which the patient or individual served is exposed to an unpleasant or noxious stimulus (the aversion) while engaging in the target behavior; the goal is to create an association of the aversion to the target behavior. Positive punishment is considered to be a type of aversive procedure. Positive punishment is a procedure in which target behavior is followed by the presentation of an unpleasant or noxious stimulus to decrease probability that the behavior will occur again (for example, spraying water mist in the face of the individual served. Negative punishment is not an aversive procedure). 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 (for example, turning off the television).

behavioral health advance directive  A document prepared by a consumer while competent that expresses the consumer’s wishes regarding care, treatment, or services in the event that he or she loses the capacity to make informed decisions about behavioral health care. There are two types of behavioral advance directives: (1) instructive directives, which provide specific instructions regarding care, treatment, or services (for example, type of medication, consumer’s wishes regarding special procedures) by the person who drafted the behavioral health advance directive, and (2) proxy directives, which give a specified person the power to make decisions regarding care, treatment, or services on behalf of the consumer.

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 management  The use of basic behavioral or learning-based programs designed to help the patient or resident develop socially appropriate and safe replacement behavior. Characteristics of a behavior management program are that all the direct care staff are trained in the application of the program; it is a written, planned program; it is applied at all times the patient or resident is under the supervision of direct care staff; and it is distinct from other therapeutic interactions with the patient or resident.

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.

**best practices** Clinical, scientific, or professional practices that are recognized by a majority of professionals in a particular field as being exemplary. These practices are typically evidence based and consensus driven.

**biologicals** Medicines made from living organisms and their products, including serums, vaccines, antigens, and antitoxins.

**blind specimen** A sample with known value tested by personnel who do not know the expected result.

**blood component** A fraction of separated whole blood (for example, red blood cells, plasma, platelets, granulocytes).

**boarded patients** Patients being held in the emergency department or another temporary location after the decision to admit or transfer has been made.

**bylaws** A governance framework that establishes the roles and responsibilities of a body and its members.

**caregiver** A family member, a significant other, a friend, a volunteer, or an individual employed by the patient or resident to provide services in the home.

**care plan (also plan of care)** A written plan based on data gathered during assessment that identifies care needs and treatment goals, describes the strategy for meeting those needs and goals, outlines the criteria for terminating any interventions, and documents progress toward meeting the plan’s objectives. The plan may include care, treatment, and services; habilitation; and rehabilitation.

**certification** For purposes of Joint Commission certification, determination by The Joint Commission that an eligible program or service complies with applicable Joint Commission certification requirements.

**child** A person between 0 and 12 years of age, or as determined by applicable law and regulation.

**chronic care** The provision of care to individuals with long-standing, persistent diseases or conditions. It includes oversight and education activities specific to a disease or condition, and measures to encourage patient self-care, promote health, and prevent loss of function.

**clinical alarm** A component of some medical devices that is designed to notify caregivers of an important change in a patient’s physiologic status. A clinical alarm typically provides audible and/or visible notification of the changed patient status.

**clinical decision support** Software designed to assist in clinical decision making. A clinical decision support system matches two or more characteristics of an individual patient to a computerized clinical knowledge base and provides patient-specific assessments or recommendations to the clinician. The clinician makes decisions based on clinical expertise, knowledge of the patient, and the information provided
through the clinical decision support system. A clinical decision support system can be used at different points in the care process such as diagnosis, treatment, and posttreatment care, including the prediction of future events.

**clinical laboratory**  See laboratory.

**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**  An individual with essential clinical knowledge who sets expectations, develops plans, and implements procedures to assess and improve the quality of the organization's clinical and support functions and processes.

**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 mother and/or newborn, patient, resident, 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 privileges**  Authorization granted by the appropriate authority (for example, the governing body) to a practitioner to provide specific care, treatment, or services in the organization within well-defined limits, based on the following factors: 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, residents, or individuals served. See also staff.

**close call**  A patient safety event that did not reach the patient; also called near miss or good catch.

**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.
computed tomography dose index (CTDI or CTDIvol) A measure of the radiation output of a computed tomography (CT) scanner. It represents CT radiation exposure to a test object and therefore does not represent the patient radiation dose.

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.

consultation report 1. A written opinion by a consultant that reflects, when appropriate, an examination of the individual and the individual’s medical record(s). 2. Information given verbally by a consulting practitioner to a care provider that reflects, when appropriate, an examination of the individual. The individual’s care provider usually documents those opinions in the medical record.

continuing care Care provided over time in various settings, programs, or services and spanning the illness-to-wellness continuum.

continuity The degree to which the care of individuals is coordinated among healthcare 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.

contracted 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.

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.

Cooperative Accreditation Initiative An initiative under which The Joint Commission relies on the process, findings, and decisions of other oversight accrediting organizations in circumstances where The Joint Commission would otherwise conduct potentially duplicative surveys of organizations seeking accreditation. Cooperative agreements are comparable to those of The Joint Commission. Entities that focus more on technical or clinical aspects of
departments or services (for example, laboratory, rehabilitation units) are eligible for cooperative agreements because their accreditation requirements complement The Joint Commission's by covering additional or more detailed aspects of care delivery.

**coordination of care**  The process of coordinating care, treatment, or services provided by a health care organization, including referral to appropriate community resources and liaison with others (such as the individual's physician, other health care organizations, or community services involved in care or services) to meet the ongoing identified needs of individuals, to ensure implementation of the plan of care, and to avoid unnecessary duplication of services.

**credentialing**  The process of obtaining, verifying, and assessing the qualifications of a practitioner to provide care or services in or for a health care organization.

**credentials**  Documented evidence of licensure, education, training, experience, or other qualifications.

**credentials verification organization (CVO)**  Any organization 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 agency providing the information initially and then periodically as appropriate. The 10 principles that guide such an evaluation include the following:

1. The agency makes known to the user the data and information it can provide.
2. The agency 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 agency (such as practitioners not included in the database), the time frame for agency 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 agency 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.

critical result Test result that is abnormal to a degree that may indicate a life-threatening situation (also known as critical value).

critical test A test or examination that always requires rapid communication of results, whether those results are normal or abnormal.

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).

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; postdoctoral 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/)

dietary service The delivery of care pertaining to the provision of nutrition and food service to patients.

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 The point at which an individual’s active involvement with an organization or program ends, and the organization or program no longer maintains active responsibility for the care of the individual. In ambulatory or office-based settings where episodes of care occur even though the organization continues to maintain active responsibility for the care of the individual, discharge is the point at which any encounter or episode of care (that is, an office or clinic visit for the purpose of diagnostic evaluation or testing, procedures, treatment, therapy, or management) ends.

discharge planning A formalized process in a health care organization through which a program of continuing and follow-up care is planned and carried out for each patient.

dispensing See medication management.

disruptive and inappropriate behavior See behaviors that undermine a culture of safety.

distant site In telemedicine, the site at which the practitioner providing the professional service is located.

dose length product (DLP) A measure of the radiation output of a computed tomography (CT) scanner. It factors in the length of the CT scan as well as the computed tomography dose index (CTDI). It provides an estimate of the radiation dose to a volume of tissue for a given patient in a clinical setting.

drug See medication.

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. Organizations receiving Preliminary Accreditation under this policy are not recognized by the Centers for Medicare & Medicaid Services (CMS) to meet the requirements for Medicare certification. The second survey addresses all accreditation requirements, and successful completion results in full accreditation and recognition by CMS if requesting deemed status. The CMS Regional Office makes the final determination regarding an organization’s Medicare participation and the effective date of participation.

electroconvulsive therapy (ECT)  A form of therapy that uses electricity to evoke a convulsive response.

electronic prescribing  The use of an automated data entry system by an authorized prescriber to transmit a prescription directly to a participating pharmacy. It is also referred to as e-prescribing.

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 Operations Plan (EOP)  An 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, and services.

emotional or behavioral disorder  For purposes of the National Patient Safety Goals, the phrase “emotional or behavioral disorders” refers to any diagnosis or condition recognized in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), including those related to substance abuse.

entry  The process by which an individual comes into a setting, including screening and/or assessment by the organization or the practitioner to determine the capacity of the organization or practitioner to provide the care, treatment, or services required to meet the individual’s needs.

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.
**equipment management**  Activities selected and implemented by the organization to assess and control the clinical and physical risks of fixed and portable equipment used for diagnosis, treatment, monitoring, and care.

**every 36 months**  Three years from the date of the last event, plus or minus 3 months.

**every 6 months**  Six months from the date of the last event, plus or minus 20 days.

**evidence-based guidelines**  Guidelines that have been scientifically developed based on recent literature review and are consensus driven.

**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 requirement 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.

**exploitation**  Taking unjust advantage of another for one’s own advantage or benefit.

**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 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.

**fear-eliciting**  Intentionally causing undue fear, fright, panic, or terror in order to obtain compliance by the individual.

**ferromagnetic object**  An item that is highly attracted to magnets. Such items pose a significant risk if allowed to enter the magnetic resonance imaging (MRI) scanner room or the area immediately preceding it. Ferromagnetic objects can become projectiles when they are rapidly drawn with considerable force toward the MRI unit. Examples of ferromagnetic items are those containing iron and nickel.

**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 professional practice evaluation** The time-limited evaluation of practitioner competence in performing a specific privilege. This process is implemented for all initially requested privileges and whenever a question arises regarding a practitioner’s ability to provide safe, high-quality patient care.

**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 submitted 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.

formulary  A list of medications and associated information related to medication use.

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. Governance may be a separate entity or it may fall within the medical advisory or executive committee. Other names for this group include the board, board of trustees, board of governors, board of commissioners, and partnership.

 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 care–associated infection (HAI)  An infection acquired concomitantly by an individual who is receiving or who has received care, treatment, or services from a health care organization. The infection may or may not have resulted from the care, treatment, or 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.

health literacy The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

health risk behaviors Activities undertaken by an individual that have a negative impact on his or her health and increase the risk of disease or injury. Examples of health risk behaviors include substance abuse, tobacco use, inadequate exercise, poor dietary practices, and unsafe sexual activity.

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 behavioral 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.

home care The term that is generally used to refer to services provided in the home or in the community to recovering, disabled, or chronically ill persons and their families. These services may include some combination of professional health care services and personal care and supportive services. Professional health care services (also known as “skilled care”) may include physical and/or psychological assessment, nursing and medical care, medication teaching and administration, wound care, pain management, disease education and management, physical therapy, speech therapy, or occupational therapy. Home supportive care services (also known as
“non-skilled care”) may include such things as light housekeeping, meal preparation, medication reminders, dressing, laundry, shopping, transportation, and companionship. In addition, home care can provide palliative care, respite care, hospice care, and other related services to those in need, including provision of medical equipment, medications, and supplies.

**hospice** 1. Hospice is an organized program that consists of services provided and coordinated by an interdisciplinary team to meet the needs of patients who are diagnosed with a terminal illness and have a limited life span. This includes all services such as pharmacies, medical equipment, and personal care provided to hospice patients at all sites of care. For example, if the hospice provides pharmacy or home medical equipment services, these services are surveyed as part of the hospice and are not required to be accredited separately under the pharmacy or home medical equipment service eligibility and survey process. Hospice programs specialize in palliative management of pain and other physical symptoms, meeting the psychosocial and spiritual needs of the patient and the patient’s family or other primary caregiver through utilization of volunteers and provision of bereavement care to survivors. This includes, but is not limited to, all programs licensed as hospices and Medicare certified hospice programs. All services provided by the hospice (for example, pharmacy and home medical equipment services) and care provided in all settings (for example, inpatient, nursing care center, and so forth) are included. 2. For hospices that elect The Joint Commission deemed status option: A public agency or private organization or subdivision of either of these that is primarily engaged in providing hospice care.

**imaging protocol** The collection of settings and parameters used in the acquisition of medical images. Examples of settings and parameters include the clinical indication for the imaging exam, the use of contrast, patient positioning, and expected radiation dose ranges.

**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.

**Incident Command System (ICS)** The combination of personnel, procedures, communications, equipment, and facilities, operating within a common organizational structure, designed to aid in incident management activities. ICS is used for a broad spectrum of emergencies, from small to complex incidents, both natural and human-made, including acts of catastrophic terrorism.

**infection** The transmission of a pathogenic microorganism to a host, with subsequent invasion and multiplication, with or without resulting symptoms of disease.
informed consent  Agreement or permission accompanied by full notice about the care, treatment, or service that is the subject of the consent. A patient must be apprised of the nature, risks, and alternatives of a medical procedure or treatment before the physician or other health care professional begins any such course. After receiving this information, the patient then either consents to or refuses such a procedure or treatment.

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 that provides services to patients who require care that warrants 24-hour treatment or habilitation and who may be incapable of self-preservation in case of an emergency in the organization.

in-service  Organized educational activity designed to enhance the skills of clinical staff relevant to their disciplines and job responsibilities.

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.

integrity  The property that data or information have not been altered or destroyed in an unauthorized manner.

interdisciplinary  An approach to care that involves two or more disciplines or professions (for example, social services, specialist consultation, nursing, medicine, therapies, spiritual support) collaborating to plan, treat, or provide care or services to a mother and/or newborn, patient, resident, or 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.

**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 standards to identify and manage risk in the organization. See also Focused Standards Assessment (FSA).

**intravenous (IV) admixture** A pharmaceutical product whose preparation requires the measured addition of a medication to a 50 mL or greater bag or bottle of IV fluid. It does not include the drawing up of medications into a syringe, the addition of medication to a buretrol, or the assembly and activation of an IV system that does not involve the measurement of the additive.

**invasive procedure** The puncture or incision of the skin, insertion of an instrument, or insertion of foreign material into the body for diagnostic or treatment-related purposes. Examples of invasive procedures include central line and chest tube insertions, and cardiac catheterization. Venipuncture is not categorized as an invasive procedure.

**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. This includes medication-related information such as information regarding drug interactions, drug therapy, side effects, toxicology, dosage, indications for use, and routes of administration. 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** An individual who sets expectations, develops plans, and implements procedures to assess and improve the quality of the organization’s governance, management, and clinical and support functions and processes. At a minimum, leaders include members of the governing body and medical staff, the chief executive officer and other senior managers, the nurse executive, clinical leaders, and staff members in leadership positions within the organization.
**leadership group**  Individuals in senior positions with clearly defined, unique responsibilities. These might include governance, management, medical staff, and clinical staff. Not every organization will have all of these groups, and an individual may be a member of more than one group.

**licensed independent practitioner**  An individual permitted by law and by the organization to provide care, treatment, and services without direction or supervision. A licensed independent practitioner operates within the scope of his or her license, consistent with individually granted clinical privileges. When standards reference the term licensed independent practitioner, this language is not to be construed to limit the authority of a licensed independent practitioner to delegate tasks to other qualified health care personnel (for example, physician assistants and advanced practice registered nurses) to the extent authorized by state law or a state’s regulatory mechanism or federal guidelines and organizational policy.

**licensure**  A legal right that is granted by a government agency in compliance with a statute governing an occupation (such as medicine, nursing, psychiatry, 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 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 revised 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.

**life-support equipment**  Any device used for the purpose of sustaining life and whose failure to perform its primary function, when used according to the manufacturer’s instructions and clinical protocol, will lead to patient death in the absence of immediate intervention (for example, ventilators, anesthesia machines, heart-lung bypass machines, defibrillators).

**long term care**  See nursing care center.

**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.

**magnetic resonance (MR) conditional**  An item that has been demonstrated to pose no known hazards in a specific magnetic resonance (MR) environment under specific conditions of use. Conditions that define the MR environment include static magnetic field strength, radiofrequency fields, specific absorption rate, and other factors. The item label must include the results of testing that characterize the behavior of the item in the MR environment. Any parameter that affects the safety of the item should be listed, and any condition that is known to produce an unsafe condition must be described.
magnetic resonance (MR) safe An item that poses no known hazards in all magnetic resonance (MR) environments. MR safe items are nonconducting, nonmetallic, and nonmagnetic items, such as a plastic Petri dish.

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.
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 equipment  Fixed and portable equipment used for the diagnosis, treatment, monitoring, and direct care of individuals.

medical history  A component of the medical 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.

medical record  See record.

Medical Reserve Corps (MRC)  Units comprised of locally-based medical and public health volunteers who can assist their communities during emergencies, such as an influenza epidemic, a chemical spill, or an act of terrorism.

medical staff  The group of all licensed independent practitioners and other practitioners privileged through the organized medical staff process that is subject to the medical staff bylaws. This group may include others, such as retired practitioners who no longer practice in the organization but who wish to continue their membership in the group, courtesy staff, scientific staff, and so forth. See also medical staff, organized.

medical staff, organized  A self-governing entity accountable to the governing body that operates under a set of bylaws, rules and regulations, and policies developed and adopted by the voting members of the organized medical staff and approved by the governing body. The organized medical staff is comprised of doctors of medicine and osteopathy and, in accordance with the medical staff bylaws, may include other practitioners.

medical staff, voting members of the organized  Those practitioners within the organized medical staff who have the right to vote on adopting and amending medical staff bylaws, rules and regulations, and policies. See also medical staff, organized.

medical staff bylaws  A document or group of documents adopted by the voting members of the organized medical staff
and approved by the governing body that defines the rights, responsibilities, and accountabilities of the medical staff and various officers, persons, and groups within the structure of the organized medical staff; the self-governance functions of the organized medical staff; and the working relationship with and accountability to the governing body of the organized medical staff.

**medical staff executive committee** A group of individuals, the majority of whom are licensed physician members of the medical staff practicing in the organization, that is selected and/or elected and removed according to the process contained in the medical staff bylaws. This group is responsible for making specific recommendations directly to the organization’s governing body for approval, as well as receiving and acting on reports and recommendations from medical staff committees, clinical departments or services, and assigned activity groups. The medical staff executive committee also acts on the behalf of the medical staff between meetings of the organized medical staff, within the scope of its responsibilities as defined by the organized medical staff. The medical staff as a whole may serve as the executive committee.

**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 patient or resident harm while the medication is in the control of the health care professional, patient, resident, or consumer. 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.

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.

nurse executive  A registered professional nurse who is responsible for the full-time, direct supervision of nursing services and who is currently licensed by the state in which he or she practices. Attributes of this position may be further defined in regulatory statutes.

nursing  The health profession dealing with nursing care and services as (1) 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.

nursing care center  Individuals receiving care in this setting require rehabilitative, supportive, or palliative care. This care may include time-limited medically complex or rehabilitative care, dementia-specific memory care, long term nursing care, and other specialty care services. These services may be provided within a hospital, in an organization affiliated with a hospital, or in a freestanding organization. Synonyms used by the health care field for this setting include nursing home, long term care facility, and skilled nursing facility (SNF).

nursing services  One or more defined units, departments, programs, or services within the organization that is accountable for the delivery of nursing care to individuals, families, communities, and/or populations.

nursing staff  Personnel within an organization who are accountable for providing and assisting in the provision of nursing care. Such personnel must include registered nurses (RNs), and may include others such as advanced practice registered nurses (APRNs), licensed practical or vocational nurses (LPNs/LVNs), and nursing assistants or other designated unlicensed assistive personnel.
nutrition, parenteral  Nutrients (such as protein, sugar, fat, and added vitamins and minerals as needed) that are provided intravenously, bypassing the digestive tract. Related terms are total parenteral nutrition (TPN), partial parenteral nutrition (PPN), and hyperalimentation (HA).

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.

- ambulatory health care occupancy  An occupancy used to provide services or treatment to four or more patients (or one or more patients in an ambulatory surgical center that elects to use The Joint Commission deemed status option) at the same time that either (1) renders them incapable of providing their own means of self-preservation in an emergency or (2) provides outpatient surgical treatment requiring general anesthesia.

- 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). For ambulatory surgical centers that elect to use The Joint Commission deemed status option, treatment of one or more incapacitated patients renders the area an ambulatory health care occupancy.

- health care occupancy  An occupancy used for purposes such as medical or other treatment or care of persons suffering from physical or mental illness, disease, or infirmity; and for the care of infants, convalescents, or infirm aged persons. Health care occupancies provide sleeping facilities for four or more occupants and are occupied by persons who are mostly incapable of self-preservation because of age, physical or mental disability, or security measures not under the occupant’s control. Health care occupancies include hospitals, critical access hospitals, skilled nursing homes, and limited care facilities.

office-based surgery practice  A surgeon-owned or -operated organization (for example, a professional services corporation, private physician office, 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.

ongoing professional practice evaluation  A document summary of ongoing data collected for the purpose of assessing a practitioner’s clinical competence and professional behavior. The information gathered during this process is factored into decisions to maintain, revise, or revoke
existing privilege(s) prior to or at the end of the two-year license and privilege renewal cycle.

**operative or other high-risk procedures** Operative or other invasive or noninvasive procedures that place the patient at risk; these procedures are performed to remedy an injury, ailment, defect, or dysfunction. The focus is on procedures and is not meant to include medications that place the patient at risk.

**organ** A human kidney, liver, heart, lung, pancreas, or intestines (or multivisceral organs).

**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 eight criteria:

1. The applicant organization and the component use the same process for determining membership of licensed independent practitioners in practitioner panels or medical or professional staff and/or use the same process for credentialing and assigning of privileges or clinical responsibilities to licensed independent practitioners, and/or share a common organized medical or professional staff between the applicant organization and the component.
2. 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.
3. The applicant organization’s policies and procedures are applicable to the component with few or no exceptions.
4. 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).
5. The component’s clinical records are integrated into the applicant organization’s clinical 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 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, bro-
organ procurement conversion rate
The organ procurement conversion rate is calculated using the number of actual donors (numerator) over the number of eligible donors (denominator) as defined by the organ procurement organization (OPO), using the most current quarterly data. At this time, the conversion rate will only apply to solid organs, such as kidney, liver, heart, lung, pancreas, and small intestine. Tissue such as cornea/eye, skin, bone, tendons, heart valves and veins are excluded from the requirement unless it is part of the procured solid organ and required for reattachment.

outcome measure
A tool used to assess data which indicates the results of performance or nonperformance of a function or procedure.

ownership
The entity that has ultimate control of resources and operation of the organization applying for accreditation.

pathology and clinical laboratory services
The services that provide information on diagnosis, prevention, or treatment of disease or the assessment of health, through the examination of the structural and functional changes in tissues and organs of the body that cause or are caused by disease. It also includes the biological, microbiological, serological, chemical, immunohematological, hematological, or other examination of materials derived from the human body.

patient
An individual who receives care, treatment, or services. Synonyms used by various health care fields include resident, patient and family unit, individual served, consumer, health care consumer, customer, or beneficiary.

patient identifiers
Information directly associated with an individual that reliably identifies the individual as the person for whom the service or treatment is intended. Acceptable identifiers may be the individu-
ual’s name, an assigned identification number, telephone number, or other person-specific identifier.

**patient safety event** An event, incident, or condition that could have resulted or did result in harm to 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, 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.

**performance improvement** The systematic process of detecting and analyzing performance problems, designing and developing interventions to address the problems, implementing the interventions, evaluating the results, and sustaining improvement.

**performance measurement system** See ORYX® vendor.

**phantom** An object used in medical imaging that simulates features of the human body. It is scanned or imaged and used to evaluate and analyze imaging equipment performance.

**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.

**physician** As defined by the Centers for Medicare & Medicaid Services in Sec. 1861.[42 U.S.C.1395x] of the Social Security Act:
The term “physician,” when used in connection with the performance of any function or action, means

1. A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section 1101(a)(7)),

2. A doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he performs such function and who is acting within the scope of his license when he performs such functions,

3. A doctor of podiatric medicine for the purposes of subsections (k), (m), (p)(1), and (s) of this section and sections 1814(a), 1832(a)(2)(F)(ii), and 1835 but only with respect to functions
which he is legally authorized to perform as such by the State in which he performs them,

(4) A doctor of optometry, but only for purposes of subsection (p)(1) with respect to the provision of items or services described in subsection (s) which he is legally authorized to perform as a doctor of optometry by the State in which he performs them, or

(5) A chiropractor who is licensed as such by the State (or in a State which does not license chiropractors as such, is legally authorized to perform the services of a chiropractor in the jurisdiction in which he performs such services), and who meets uniform minimum standards promulgated by the Secretary, but only for the purpose of sections 1861(s)(1) and 1861(s)(2)(A) and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation) which he is legally authorized to perform by the State or jurisdiction in which such treatment is provided. For the purposes of section 1862(a)(4) and subject to the limitations and conditions provided in the previous sentence, such term includes a doctor of one of the arts, specified in such previous sentence, legally authorized to practice such art in the country in which the inpatient hospital services (referred to in such section 1862(a)(4)) are furnished.

physician assistant  An individual who practices medicine with supervision by licensed physicians, providing services ranging from primary medicine to specialized surgical care. The scope of practice is determined by state law, the supervising physician’s delegation of responsibilities, the individual’s education and experience, and the specialty and setting in which the individual works. When standards reference the term “licensed independent practitioner,” this language is not to be construed to limit the authority of a licensed independent practitioner to delegate tasks to other qualified health care personnel (for example, physician assistants and advanced practice registered nurses) to the extent authorized by state law or a state’s regulatory mechanism or federal guidelines and organizational policy.

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.

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.

**policy** A principle or method that is developed for the purpose of guiding decisions and activities related to governance, management, care, treatment, and services. A policy is developed by organization leadership, approved by the governing body of the organization, and maintained in writing.

**population-based care** The assessment, monitoring, and management of the health care needs and outcomes of identified groups of patients and communities, rather than individual patients. The goal of population-based care is to improve the health of the population, increase awareness of behavior-related health risks, promote healthy lifestyle activities and patient self-management, and decrease health care inequities.

**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.

**preparedness, emergency** Activities an organization undertakes to build capacity and identify resources that may be used if an emergency occurs. See also emergency.

**prescribing or ordering** See medication management.

**preventive care** The provision of health care that focuses on disease prevention and health maintenance. It includes early diagnosis of disease as well as discovery and identification of individuals at risk for the development of specific health problems or in need of counseling or other necessary interventions to avert a health problem. Screening tests, health education, and immunization programs are common examples of preventive care.

**primary care clinician** A clinician operating within the primary care medical home who works collaboratively with an interdisciplinary team and in partnership with the patient to address the patient’s primary health care needs. Primary care clinicians have the educational background, broad-based knowledge, and experience necessary to handle most medical and other health care needs of the patients who have selected them, including resolving conflict-
ing recommendations for care. The primary care clinician is selected by the patient and serves as the primary point of contact for the patient and family. A primary care clinician operating within the primary care medical home is a doctor of medicine or doctor of osteopathy, advanced practice nurse, or physician assistant.

**primary care medical home (PCMH)** A model of primary health care that is based on five operational characteristics: patient-centered care; comprehensive care; coordinated care; superb access to care; and a system-based approach to quality and safety. They address the roles and functions of the patient, organization, primary care clinician, and interdisciplinary team. PCMH Certification is an optional certification that requires compliance with accreditation requirements plus an additional set of PCMH-specific requirements.

**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.

**primary source verification** Verification of an individual practitioner’s reported qualifications by the original source or an approved agent of that source. Methods for conducting primary source verification of credentials include direct correspondence, documented telephone verification, secure electronic verification from the original qualification source, or reports from credentials verification organizations (CVOs) that meet Joint Commission requirements. See also credentials verification organization (CVO).

**privacy (of information)** The right of an individual to limit the disclosure of personal information.

**privileging** The process whereby the specific scope and content of patient care services (that is, clinical privileges) are authorized for a health care practitioner by a health care organization based on evaluation of the individual’s credentials and performance. See also licensed independent practitioner.

**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 socioeconomic, 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 indi-
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.

**psychiatrist** A physician who specializes in assessing and treating persons having psychiatric disorders; is certified by the American Board of Psychiatry and Neurology or has the documented equivalent in education, training, or experience; and is fully licensed to practice medicine in the state in which he or she practices.

**psychologist** An individual who specializes and is licensed in psychological research, testing, or therapy.

**psychosocial** Pertaining to the influence of social factors on an individual’s mind or behavior and to the interrelation of behavioral and social factors.

**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.

**qualified social worker** As defined by the Centers for Medicare & Medicaid Services in 42 CFR 483.15(g)(3) for swing beds, a qualified social worker is an individual who has a bachelor’s degree in social work or a bachelor’s degree in a human services field including but not limited to sociology, special education, rehabilitation counseling, or psychology and has one year of supervised social work experience in a health care setting working directly with individuals.

**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 or behavioral health outcomes. Considerations include the appropriateness, efficacy, efficiency, timeliness, accessibility, and continuity of care; the safety of the care 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 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.

**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.

**record**  1. An account compiled by physicians and other health care professionals of a variety of health information, such as assessment findings, treatment details, and progress notes. 2. Data obtained from the records or documentation maintained on a patient or resident in any health care setting (for example, hospital, home care, nursing care center, practitioner office). The record includes automated and paper medical record systems.

**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.

**registered nurse (RN)**  A person who is licensed to practice professional nursing.
reportable range  The range of test values over which the relationship between the instrument, kit, or system’s measurement response is shown to be valid.

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.

response, emergency  Actions taken and procedures implemented by the organization when an emergency occurs. See also emergency.

restraint  1. Any method (chemical or physical) 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.

2. For hospitals and rehabilitation and psychiatric distinct part units in critical access hospitals that elect The Joint Commission deemed status option: 42 CFR 482.13(e)(1)(i)(B) (A restraint is— ) A drug or medication when it is used as a restriction to manage the patient’s behavior or restrict the patient’s freedom of movement and is not a standard treatment or dosage for the patient’s condition.

42 CFR 482.13(e)(1)(i)(c) A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).

resuscitative services  Qualified staff and licensed independent practitioners, supplies, and processes used to revive an individual.

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.

**rules and regulations and policies of the medical staff**  As used in these standards, documents other than medical staff bylaws. When adopted by the organized medical staff and approved by the governing body, pursuant to the provisions of Standard MS.01.01.01, these documents have the force and effect of medical staff bylaws.

**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 patients, staff, and/or visitors, and (2) the scope at which the finding was observed.

**safety**  The degree to which the risk of an intervention (for example, use of a drug, or a procedure) and risk in the care environment are reduced for a patient and other persons, including health care practitioners. Safety risks 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 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 performed by governance, managerial, clinical, or support staff.

**seclusion**  1. 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 serious criminal charges or who is serving a criminal sentence. 2. For hospitals and rehabilitation and psychiatric distinct part units in critical access hospitals that elect The Joint Commission deemed status option: The involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may be used only for the management of violent or self-destructive behavior. (42 CFR 482.13(e)(1)(ii))

**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 medi-
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, resident, or individual served, including medications that may be held by the organization for independent use.

**self-management** Activities performed by patients with one or more chronic conditions that enable them to take an active role in the management of their 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 the patient’s illness or underlying condition) that reaches a patient 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 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.

**simulation** Computer hardware and software allowing realistic interactions and interventions to occur in programmed scenarios to evaluate clinical practitioner competence.

**size-specific dose estimate (SSDE)** A measure of the radiation output of a computed tomography scanner. Along with the computed tomography dose index (CTDI), it factors in the patient’s size to provide a better estimate of the radiation dose to a volume of tissue for a given patient in a clinical setting.

**staff** As appropriate to their roles and responsibilities, all people who provide care, treatment, or services in the organiza-
tion, including those receiving pay (for example, permanent, temporary, part-time personnel, as well as contract employees), volunteers and health profession students. The definition of staff does not include licensed independent practitioners who are not paid staff or who are not contract employees.

**standard** A principle of patient safety and quality of care 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.

**support services** Services provided in an individual’s place of residence on a per-visit or per-hour basis to meet the identified needs of an individual who requires assistance in the maintenance and management of household routines, such as cleaning or shopping. These services may include, but are not limited to, those provided by homemakers, chore service workers, or companions. These services may be provided directly or through contract with another organization or individual.

**surrogate decision-maker** Someone legally appointed to make decisions on behalf of another. This individual can be a family member or someone not related to the individual. A surrogate decision-maker makes decisions when the individual is without decision-making capacity or when the individual has given permission to the surrogate to make decisions. Such an individual is sometimes referred to as a legally responsible representative. See also family.
**surveillance**  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 that information to those who can improve outcomes. Examples of surveillance data can include ventilator associated pneumonia, antibiotic prophylaxis, hemodialysis catheter infections, implant infections, surgical site infections, hand hygiene, drug resistant organisms (MRSA, VRE), equipment sterile processing, vaccinations, urinary tract infections, and health care worker 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.

**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.

**suspension, automatic**  Suspensions that are automatically enacted whenever the defined indication occurs, and do not require discussion or investigation. Examples are loss of licensure or exceeding the allowed medical record delinquency rate. Privileges are automatically suspended until the license is renewed, or the records are completed, or the delinquency rate falls to an acceptable level.

**suspension, summary**  While enacted automatically whenever the defined indication occurs, summary suspensions also require a subsequent evaluation or investigation of the reason the indication occurred and a decision as to whether the suspension should be continued and for what length of time. Examples are the occurrence of a sentinel event that might be related to the licensed independent practitioner’s performance, or a significant complaint against the licensed independent practitioner such as misconduct or assault. The summary suspension is enacted while the incident is under investigation.

**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.
telehealth  The use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration.

telemedicine  The use of medical information exchanged from one site to another via electronic communication to improve patients’ health status. Telemedicine is a subcategory of telehealth.

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.

time-out  A procedure used to help a patient or individual served to regain emotional control that involves removing him or her from the immediate environment and restricting him or her to a quiet area or an unlocked quiet room.

time-out, invasive procedure  An immediate pause by the entire surgical team to confirm the correct patient, procedure, and site.

tissue  Any group of cells that perform specific functions.

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 by following an individual patient or resident through the organization’s care process in the sequence experienced by each individual. Depending on the setting, this process may require surveyors to visit multiple care programs and services within an organization or within a single program or service to “trace” the care rendered.

transfer and discharge  As defined by the Centers for Medicare & Medicaid Services in 42 CFR 483.12(a)(1), movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility.

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 patho-
gen is transmitted. Categories include contact, droplet, airborne, and a combination of these.

**unit dose**  Medication to be given to a particular patient at a specific time packaged in the exact dosage required for that time.

**urgent**  A degree of severity of illness or injury that is not immediately life-threatening, but requires care more quickly than elective care.

**urgent care**  The delivery of ambulatory medical care to patients who have an injury or illness that requires immediate care but is not serious enough to warrant a visit to an emergency room. Urgent care centers often have extended hours and typically see patients on a walk-in basis without a scheduled appointment. Care may include diagnostic and therapeutic services, on-site x-ray, laboratory testing, pharmacy, and laceration and fracture care.

**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.

**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.

**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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