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

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

- Inserted new section, “Addressing Complex Issues in Home Care,” in the Introduction (INTRO) chapter to help organizations address complex care issues
- Added new Medication Compounding (MC) chapter and applicable definitions added to the Glossary (GL), which will apply to all compounding pharmacies and meet the need for a more focused and specialized evaluation of pharmacy compounding practices
- Completed Phase 4 of the Standards Review Project, resulting in the consolidation and movement of standards within the “Human Resources” (HR), “Infection Prevention and Control” (IC), and “Rights and Responsibilities of the Individual” (RI) standards
- Additional revisions made to the “Environment of Care” (EC) and “Life Safety” (LS) chapters as part of the alignment with the US Centers for Medicare & Medicaid and the 2012 Life Safety Code®
- Revised Medication Management (MM) standards to assure that they continue to reflect evidence-based practices and quality and safety issues that have emerged from the field in recent years, which also affects EC and Record of Care, Treatment, and Services (RC) standards
- Reformatted the applicability grids in each standards chapter to provide applicability for each EP in the entire chapter, at a glance
- Made changes for home health agencies that elect to use The Joint Commission deemed status to align with revised US Centers for Medicare & Medicaid Services requirements

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

Effective January 1, 2018

- About the Comprehensive Accreditation Manual for Home Care Organizations:
  - 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
- Inserted new section, “Addressing Complex Issues in Home Care,” to help organizations address challenging patient quality and safety issues, including new Table 1. Standards That Address Complex Issues in Home Care Settings
- Table 1. Acronyms Used in This Manual: Renumbered to Table 2 and updated acronyms
- Accreditation Requirements: Added description for new “Medication Compounding” (MC) chapter
- Accreditation Process Information: Clarified that the “Patient Safety Systems” (PS) chapter does not contain new standards or requirements
- Identifying Applicable Standards:
  - Added reference for the new MC chapter
  - Renamed Figure 2 and updated to reflect changes to the standards applicability grid
  - Renumbered Table 2. Abbreviations Used for Applicability Grids in Standards Chapters to Table 3
  - Removed reference to the Standards for Office-Based Surgery Practices, which is no longer printed (content is available via E-dition only)
- Use the Standards to Improve Care, Treatment, or Services: Removed and replaced section with new “Addressing Complex Issues in Home Care” section
- Assess Compliance with the Standards: Added references for more information on the Survey Analysis for Evaluating Risk™ (SAFER™) matrix
- Stimulate Improvement:
  - Updated guidance on standards compliance frequently asked questions
Updated Joint Commission Connect resources and tools listing specific to home care

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

**Accreditation Requirements**

**Accreditation Participation Requirements (APR)**

*Effective January 1, 2018*

- Standards applicability grid: Consolidated grid at the beginning of the chapter
- Minor editorial revisions

*Effective January 13, 2018*

- Unless noted otherwise, the following changes are effective for home health agencies that elect to use The Joint Commission deemed status
- Standards applicability grid: Updated service categories to reflect standards changes
- APR.01.03.01, EP 1: Clarified that organizations that manage home health agencies must disclose their contact information to CMS
- Standard APR.04.01.01 and EP 27: Updated applicability to include home health agencies
Environment of Care (EC)

Effective January 1, 2018

- Standards applicability grid: Consolidated grid at the beginning of the chapter and updated to reflect standards changes
- EC.02.01.03, new EP 4: Added EP requiring organizations to keep smoking materials and sources of ignition away from patients requiring respiratory therapy and areas where oxygen delivery equipment is administered
- EC.02.03.01, EP 9: Revised requirement that a plan be available to instruct and inform staff and licensed independent practitioners of their duties
- EC.02.03.01, new EP 13: Added EP requiring organizations to meet all other Health Care Facilities Code fire protection requirements, as related to NFPA 99-2012: Chapter 15
- EC.02.03.03, EP 1: Deleted cross-reference to LS.02.01.70, EP 6
- EC.02.03.03, EP 3: Revised requirement to hold fire drills at unannounced times and under varying conditions; added new Note 1 that specifies audible fire alarms may be replaced with alternative staff notification between 9:00 p.m. and 6:00 a.m.; added new Note 2 with NFPA references.
- EC.02.03.05, EPs 1, 7, 14, and 17: Revised the NFPA references
- EC.02.03.05, EP 20: Revised to include testing of sliding and rolling fire doors and revised Note to direct user to full text of listed NFPA references
- EC.02.03.05, new EP 27: Added requirement for organizations to document monthly testing of elevators with fire fighter’s emergency operations, along with icon
- EC.02.03.05, new EP 28: Added new requirement listing the documentation requirements of maintenance, testing, and inspection activities for EC.02.03.05, EPs 1–20 and 25, along with icon
- EC.02.05.01, new EP 2: Added new requirement that building systems are designed to meet the National Fire Protection Association’s Categories 1–4 requirements
- EC.02.05.01, EPs 3: Renumbered as EPs 4, 5, and 28–30, respectively
- EC.02.05.01, EP 19: Revised ??
- EC.02.05.01, new EP 24: Added new requirement that organizations cannot substitute extension cord for fixed wiring in a building
- EC.02.05.03, EPs 1–3: Revised the NFPA references
EC.02.05.03, EP 4: Renumbered as EP 5 and revised the NFPA references
EC.02.05.03, EP 10: Renumbered as EP 11
EC.02.05.03, new EP 12: Added EP regarding equipment designated to be powered by emergency power supply
EC.02.05.03, new EP 14: Added EP and Note requiring organizations to implement a policy to provide emergency backup for essential medication dispensing equipment, along with icon
EC.02.05.03, new EP 15: Added EP requiring organizations to implement a policy to provide emergency backup for essential refrigeration for medications, along with icon
EC.02.05.05, EP 7: Renumbered as EP 8
EC.02.05.07, EP 1: Clarified that organizations will perform a functional test monthly of emergency lighting systems and exit signs, as well as a visual inspection of other exit signs, and revised Note to direct user to full text of listed references and added NFPA reference
EC.02.05.07, EP 2: Revised to require organizations to perform a functional test of battery-powered lights and exit signs and added a cross-reference to LS.02.01.20, EP 39, and NFPA references
EC.02.05.07, EPs 4–6: Revised to direct user to full text of listed NFPA references
EC.02.05.07, EP 7: Clarified that organizations will test all automatic and manual switches on the inventory and revised to direct user to full text of listed NFPA reference
EC.02.05.07, EP 9: Deleted cross-reference to EC.02.05.03, EPs 5 and 6
EC.02.05.07, EP 10: Added new Note 2 with NFPA reference
EC.02.05.09, new EP 1: Added EP regarding classification of systems into three categories according to the severity of possible injury or death to patients
EC.02.05.09, EP 1: Renumbered as EP 7 and clarified that components of medical gas and vacuum systems will be inspected, tested, maintained, and results documented; specified that individuals maintaining the systems are qualified and certified according to requirements of the American Society of Sanitary Engineers; included NFPA reference
EC.02.05.09, new EP 2: Added EP specifying that alarm systems for medical gas and vacuum systems comply with the category warning system
EC.02.05.09, new EP 3: Added EP requiring that containers, cylinders, and tanks are designed, fabricated, tested, and marked according to 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 requiring organizations to label doors for locations with oxygen or medical air and other gases

EC.02.05.09, EP 5: Renumbered as EP 11 and revised to require hospices to clearly label and identify piping and shutoff valves and to direct user to full text of listed NFPA references

EC.02.05.09, new EP 5: Added EP requiring organizations to post precautionary signs on each door or gate of a cylinder storage room which are readable from five feet away

EC.02.05.09, new EP 6: Added EP concerning secure storage locations for cylinders with integral pressure gauges

EC.02.05.09, EP 6: Renumbered as EP 12 and revised to require hospices to implement a policy to label, handle, and transport cylinders according to added NFPA references; added Note to direct user to full text of listed NFPA references

EC.02.05.09, EP 7: Renumbered as EP 14

EC.02.05.09, new EP 13: Added EP regarding the transfilling of gas cylinders

EC.02.06.01, EP 1: Added cross-reference to Standard MC.05.02.01, EP 1

Written Documentation Checklist: Updated EPs and applicable services categories

Minor editorial revisions

Emergency Management (EM)

Effective November 12, 2017

Chapter Outline: Revised to align with standards changes

Added the following Emergency Management (EM) requirements for home health agencies and hospices that use accreditation for deemed status purposes to align with revised requirements from the US Centers for Medicare & Medicaid Services (CMS):

- EM.01.01.01, EP 9
- EM.02.01.01, EPs 10–12
- EM.02.02.01, EPs 18–22
- EM.02.02.07, EPs 7, 12, 13
- EM.03.01.03, EPs 10, 20
New EM.04.01.01, Introduction, and EPs 1–3

- Added the following Emergency Management (EM) requirements for inpatient hospices that use accreditation for deemed status purposes to align with revised requirements from the US Centers for Medicare & Medicaid Services (CMS):
  - EM.02.01.01, EPs 7, 14, 17
  - EM.02.02.01, EP 24
  - EM.02.02.03, EP 9
  - Standard EM.02.02.05 and EP 4
  - EM.02.02.07, EP 11
  - EM.02.02.09, EPs 2–4, 7
  - EM.02.02.11, EPs 5, 12, 13

- EM.02.02.09, EP 7: Added Note regarding essential utility systems and maintaining temperatures protecting patient health and safety and safe and sanitary storage of provisions.

- EM.02.02.11, EP 1: Added documentation icon and cross reference to PC.01.03.01, new EP 55

- EM.02.02.11, EP 3: Added documentation icon and cross reference to EM.02.02.03, new EP 9

**Effective January 1, 2018**

- Standards applicability grid: Consolidated grid at the beginning of the chapter and updated to reflect standards changes

- Added the following Emergency Management (EM) requirements for inpatient hospices that use accreditation for deemed status purposes to align with revised requirements from the US Centers for Medicare & Medicaid Services (CMS):
  - EM.02.01.01, EP 15

- EM.02.02.01, EP 21: Added Note 2 regarding privacy and disclosure requirements specified under 45 CFR 164.510(b)(1)(ii) and 45 CFR 164.510(b)(4)

- EM.02.02.03, EP 3: Clarified that nonmedical supplies replenished in an emergency include food, bedding, and other provisions for sheltering on site

- For home health agencies and hospices that elect to use The Joint Commission deemed status option:
  - EM.03.01.03, EP 21
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- EM.04.01.01, EP 1: Clarified that the community-based risk assessment be developed by the system’s integrated all-hazards emergency management program
- Written Documentation Checklist: Updated EPs and applicable service categories
- Minor editorial revisions

Equipment Management (EQ)

Effective January 1, 2018
- Standards applicability grid: Consolidated grid at the beginning of the chapter and updated service categories to reflect standards changes
- EQ.01.03.01, EP 9: Renumbered as EP 10
- EQ.01.03.01, new EP 9: Added new requirement that organizations clearly and permanently label all equipment listed for use in oxygen-enriched atmospheres
- Added cross-references to new Medication Compounding standards throughout the chapter
- Written Documentation Checklist: Updated EPs and applicable service categories

Human Resources (HR)

Effective January 1, 2018
- Chapter Outline: Revised to align with standards changes
- Standards applicability grid: Consolidated grid at the beginning of the chapter and updated HR.01.01.01, EP 2, to include all service categories
- Standard HR.01.01.01: Added new Rationale and clarified the standard to require organizations to define and verify staff qualifications
- HR.01.01.01, EP 8: Renumbered as HR.01.02.05, EP 8, and revised to require organizations to provide skilled nursing services under the supervision of a registered nurse
- HR.01.01.01, EPs 9 and 18–20: Renumbered as HR.01.02.05, EPs 9 and 18–20, respectively
- Standard HR.01.02.01: Deleted standard and moved EPs under HR.01.01.01
- HR.01.02.01, EPs 1–5, 8, 9, 11, 14, 20–29: Renumbered HR.01.01.01, EPs 1, 8, 11–16, and 19–29
- Standard HR.01.02.05: Simplified to require organizations to verify staff qualifications
- HR.01.02.05, EPs 1, 2 and 8: Combined and numbered as HR.01.01.01, EP 2
HR.01.02.05, EPs 3–5 and 9: Renumbered as HR.01.01.01, EPs 3–5 and 9
HR.01.02.07, EP 2: Deleted cross-reference to HR.01.02.05, EPs 1 and 2
HR.01.03.01, EP 2: Deleted EP
HR.01.04.01, EPs 1 and 2: Combined and numbered as EP 1, related to orienting staff to key safety content before providing care, treatment, and services (including icon)
HR.01.04.01, EPs 3 and 4: Combined and numbered as EP 3, related to orienting staff to policies and procedures and job duties relative to infection prevention and pain management
HR.01.05.03, EPs 1 and 4: Combined and numbered as EP 1, related to staff participation in ongoing education and training
HR.01.06.01, EP 16: Deleted EP
Added cross-references to new Medication Compounding standards throughout the chapter
Written Documentation Checklist: Updated EPs and applicable service categories
Minor editorial revisions

Effective January 13, 2018
Unless noted otherwise, the following changes are effective for home health agencies that elect to use The Joint Commission deemed status
Standards applicability grid: Updated service categories to reflect standards changes
HR.01.01.01: Made the following changes:
- EP 11: Defined personnel qualifications according to updated federal regulations and added terms to the Glossary
- EP 12: Updated applicability to deemed-status hospices only
- EP 13: Deleted requirement
- EP 21: Updated applicability to include home health agencies, clarified that supervisors must meet federal qualifications and practice according to organizations’ policies and procedures, added Note 1 to specify the regulations, and renumbered former Note to Note 2
- New EP 34: Added new requirement regarding training and competency evaluation programs for qualified home health aides
New EP 35: Added new requirement regarding additional training for home health or nurse aides who haven’t provided patient care for compensation for 24 months after initial training

HR.01.02.05: Made the following changes:
- EP 8: Clarified educational and licensing requirements for registered nurses providing skilled nursing services and supervision
- EP 18: Specified oversight responsibilities for qualified clinical managers
- New EP 29: Added new requirement regarding availability of administrators or designated individuals during operating hours

HR.01.02.07: Made the following changes:
- EP 3: Identified the responsibilities of home health aides
- EP 4: Updated applicability to deemed-status hospices only
- New EP 13: Added new requirement identifying the responsibilities of skilled professionals
- New EP 14: Added new requirement regarding the assigning of patients to home health aides

HR.01.03.01: Made the following changes:
- EP 10: Deleted requirement
- EP 13: Deleted requirement and removed documentation icon
- EP 14: Updated applicability to deemed-status hospices only
- EP 15: Identified home health aide services requiring an on-site visit to the patient’s location by a registered nurse
- EP 18: Deleted requirement
- EP 19: Clarified supervision of rehabilitative therapy services by occupational or physical therapists and added Note regarding related terms in the Glossary
- EP 20: Deleted requirement
- EP 21: Clarified that social workers supervise medical social services and added new Note regarding related terms in the Glossary
- EP 23: Updated applicability to include home health agencies and clarified that aides may be observed and assessed regarding concerns in their services
- New EP 27: Added new requirement regarding visits by registered nurses or skilled professionals to the patient’s home no less than every 14 days to maintain home health aide services, a plan of care, and written instructions
New EP 28: Added new requirement regarding supervision of home health aide responsibilities
New EP 29: Added new requirement regarding an annual on-site observation and assessment of aides at the location where they care for patients
New EP 30: Added new requirement regarding competency evaluations of aides if service deficiencies are verified during an on-site visit by a registered nurse or other skilled professional

HR.01.05.01: Made the following changes:
EP 1: Renumbered “Note” as “Note 1” and revised as applicable to deemed-status hospices and added new Note 2 applicable to home health agencies regarding the supervision of practical training while trainees provide services to a patient
EP 2: Updated federal regulations references, added conditions under which training or competency evaluations would not be offered to home health agencies or hospices, and made editorial revisions
EP 4: Clarified specific skills and responsibilities addressed in training programs and revised Note for home health agencies regarding patient skin conditions

HR.01.05.03: Made the following changes:
EP 10: Deleted requirement
EP 11: Updated applicability to include home health agencies and added Note regarding in-service training

HR.01.06.01: Made the following changes:
EP 4: Specified the competency evaluation process of home health aides by registered nurses
EP 8: Specified skills included on competency evaluations of home health aides
EP 9: Specified that evaluators of aides for home health agencies must be registered nurses
EP 10: Clarified communication skills required for aides in home health agencies
EP 11: Made minor editorial revision
EP 12: Clarified that aides may not perform tasks until undergoing additional training following unsatisfactory competency evaluations
EP 13: Specified that home health aides may only perform personal care attendant services if qualified by state qualification standards
HR.01.07.01, EP 3: Deleted requirement
Worksheets: Updated to reflect standards changes

Infection Prevention and Control (IC)

Effective January 1, 2018
- Standards applicability grid: Consolidated grid at the beginning of the chapter and updated to reflect standards changes
- IC.01.01.01, EP 3: Changed cross-reference from HR.01.02.01, EP 1 to HR.01.01.01, EP 1
- IC.01.03.01, EPs 1–3: Combined and numbered as EP 1, related to identifying infection risks IC.01.03.01, EP 5: Renumbered as EP 3
- IC.01.03.01, EP 5: Renumbered as EP 3
- IC.01.05.01, EP 6: Deleted cross-reference to HR.01.04.01, EPs 2 and 4
- IC.02.01.01, EP 7: Deleted cross-reference to HR.01.04.01, EP 4
- IC.02.03.01, EPs 2 and 3: Combined and numbered as EP 2, related to support for licensed independent practitioners exposed to 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
- Written Documentation Checklist: Updated EPs and applicable service categories
- Minor editorial revisions

Effective January 13, 2018
- Unless noted otherwise, the following changes are effective for home health agencies that elect to use The Joint Commission deemed status
- Standards applicability grid: Updated service categories to reflect standards changes
- IC.01.05.01: Made the following changes:
  - EP 9: Updated applicability to include home health agencies and emphasized the importance of the infectious and communicable disease program to the quality assessment and performance improvement (QAPI) program
  - EP 10: Deleted requirement
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Information Management (IM)

Effective November 12, 2017
- IM.01.01.03, new EP 5: Added requirement for home health agencies and hospices that use accreditation for deemed status purposes to align with revised requirements from the US Centers for Medicare & Medicaid Services (CMS)

Effective January 1, 2018
- Standards applicability grid: Consolidated grid at the beginning of the chapter and updated to reflect standards changes
- Written Documentation Checklist: Added IM.01.01.03, EP 5 and applicable service category

Effective January 13, 2018
- Unless noted otherwise, the following changes are effective for home health agencies that elect to use The Joint Commission deemed status
- Standards applicability grid: Updated service categories to reflect standards changes
- IM.02.01.01: Made the following changes:
  - EP 6: Added Note regarding clinical records
  - EP 9: Deleted requirement and removed Documentation icon
- IM.02.01.03, EP 6: Revised requirement for home health agencies regarding compliance with rules concerning protected health information
- IM.02.02.01, EP 4: Deleted requirement and removed Documentation icon
- IM.02.02.03: Made the following changes:
  - EP 5: Revised requirement regarding compliance with the Federal Information Processing Standard
  - EP 9: Clarified that the Outcome and Assessment Information Set (OASIS) assessment would include information required for Medicare beneficiaries
  - EP 10: Revised requirement regarding home health agencies’ transmission of data to either the Quality Improvement and Evaluation System (QIES) or to the OASIS contractor
  - EP 11: Deleted requirement and removed Documentation icon

Leadership (LD)

Effective January 1, 2018
- Standards applicability grid: Consolidated grid at the beginning of the chapter
LD.01.03.01, EP 3: Deleted cross-reference to PC.01.01.01, EP 7
LD.01.03.01, EP 6: Added cross-reference to LD.01.03.01, EP 17
Added cross-references to new Medication Compounding standards throughout the chapter
Minor editorial revisions

Effective January 13, 2018

Unless noted otherwise, the following changes are effective for home health agencies that elect to use The Joint Commission deemed status
Standards applicability grid: Updated service categories to reflect standards changes
LD.01.01.01, EP 4: Made editorial revisions
LD.01.03.01: Made the following changes:
  - EP 12: Clarified the responsibilities included in the overall operation of the organization
  - EPs 13–18: Deleted requirements and removed Documentation icons at EPs 15, 16, and 18
LD.01.04.01: Made the following changes:
  - EP 4: Clarified the appointment and responsibilities of an administrator reporting to the governing body and added a Note concerning the role of a clinical manager
  - EP 10: Updated applicability to deemed-status hospices only
  - EP 11: Added a Note qualifying a predesignated individual to serve in the role of chief executive for an absent administrator of the organization and added Documentation icon
LD.04.01.01: Made the following changes:
  - EP 1: Clarified that the licensure of home health agencies and hospices be subject to state or local law
  - EP 2: Updated federal regulations references for home health agencies furnishing outpatient physical therapy or speech-language pathology services
LD.04.01.03, EP 13: Added requirement for home health agencies regarding achieving goals and outcomes in a patient’s plan of care
LD.04.01.07, EP 3: Deleted requirement and removed Documentation icon
LD.04.02.03, EP 9: Clarified that charges for services not covered by Medicare, Medicaid, or other federally funded programs are communicated verbally and in writing to patients

LD.04.03.03, new EP 35: Added new requirement for home health agencies regarding arrangements for patient care in all services

LD.04.03.09: Made the following changes:
- EP 11: Revised to clarify responsibilities of home health parent agencies regarding control of their branch locations
- EP 12: Added a new Note regarding meeting specific requirements of the Social Security Act
- EP 13: Deleted requirement
- EP 14: Added Note regarding the definition of home health aide services provided under arrangement according to the Social Security Act
- New EP 25: Added new requirement regarding exceptions made to an agency’s status and ability to provide contractual services

LD.04.04.01: Made the following changes:
- EP 1: Updated applicability to include home health agencies
- EP 8: Updated applicability to include home health agencies and clarified that deemed-status hospices be evaluated annually
- EP 9: Updated applicability to include home health agencies and specified criteria for meeting QAPI
- EP 10: Updated applicability to include home health agencies
- New EP 32: Added new requirement to use quality indicator data, including data from OASIS and QAPI programs
- New EP 33: Added new requirement regarding immediate correction of problems that threaten patients’ health and safety
- New EP 34: Added new requirement regarding the QAPI program and improvements for the health, safety, and care of patients

LD.04.04.05: Made the following changes:
- EP 1: Renumbered Note as Note 1 and added new Note 2 regarding responsibilities for patient safety and new Note 3 to clarify that deemed-status hospices are evaluated annually
- EP 15: Updated applicability to include home health agencies
- Worksheets: Updated to reflect standards changes
Life Safety (LS)

Effective January 1, 2018

- Standards applicability grid: Consolidated grid to the beginning of the chapter and updated to reflect standards changes
- LS.01.01.01, EP 6: Revised to direct user to full text of NFPA reference
- LS.02.01.10, EPs 1 and 2: Revised NFPA reference
- LS.02.01.10, EP 3: Renumbered as EP 6
- LS.02.01.10, new EP 3: Added EP regarding changes in building use or occupancy classification
- LS.02.01.10, EP 4: Renumbered as EP 7 and revised requirement regarding fire-rating times between buildings
- LS.02.01.10, new EP 4: Added EP requiring organizations to comply with NFPA requirements when making building additions
- LS.02.01.10, EP 5: Renumbered as EP 9
- LS.02.01.10, new EP 5: Added EP related to buildings without automatic sprinkler systems and requirements during major rehabilitation
- LS.02.01.10, EP 6: Renumbered as EP 10 and clarified NFPA fire-rating requirements for low-rise buildings
- LS.02.01.10, EP 7: Renumbered as EP 11 and clarified NFPA fire-rating requirements for doors
- LS.02.01.10, EPs 8–11: Renumbered as EPs 12–15, respectively
- LS.02.01.10, new EP 8: Added EP that organizations with multiple occupancies comply with the most stringent NFPA requirements
- LS.02.01.20, EP 1: Clarified that locked doors are allowed if compliant with NFPA requirements
- LS.02.01.20, EP 2: Clarified that patient sleeping rooms are only locked if patients require specialized security or pose a security threat and staff can unlock doors at all times
- LS.02.01.20, EPs 3–6: Renumbered as EPs 5–8, respectively
- LS.02.01.20, EP 7: Renumbered as EP 9 and clarified that means of egress and areas of refuge must comply with NFPA requirements
- LS.02.01.20, EP 8: Renumbered as EP 10 and specified requirements for signs identifying floor landings in stairwells and giving floor-level information
- LS.02.01.20, EP 9: Renumbered as EP 12 and revised regarding NFPA exit passageways requirements
- LS.02.01.20, EPs 10–12: Renumbered as EPs 13–15, respectively
- LS.02.01.20, new EP 11: Added EP regarding the capacity of the means of egress
- LS.02.01.20, EP 13: Renumbered as EP 16 and clarified exits and egress paths related to smoke compartments
- LS.02.01.20, EPs 14–18: Renumbered as EPs 18, 19, and 22–24, respectively
- LS.02.01.20, new EP 17: Added EP regarding corridor access to at least two approved exits
- LS.02.01.20, EP 19: Renumbered as EP 25 and specified the allowed length for dead-end corridors and the common path of travel
- LS.02.01.20, EP 20: Renumbered as EP 26 and clarified safe distance between patient sleeping rooms and an exit access corridor
- LS.02.01.20, new EP 20: Added EP regarding appropriate 32-inch clearance for existing access and exit doors in compliance with NFPA requirements
- LS.02.01.20, EP 21: Renumbered as EP 27
- LS.02.01.20, new EP 21: Added EP regarding appropriate 41.5-inch clearance for new access and exit doors and requirements for a pair of doors in compliance with NFPA requirements
- LS.02.01.20, EP 22: Renumbered as EP 2
- LS.02.01.20, EPs 23–32: Renumbered as EPs 28–36 and 38, respectively
- LS.02.01.20, EP 33: Renumbered as EP 39 and specified requirements for emergency lighting in means of egress
- LS.02.01.20, EP 34: Renumbered as EP 40 and clarified when exit and directional signs be served by emergency lighting
- LS.02.01.20, EPs 35 and 36: Renumbered as EPs 41 and 42, respectively
- LS.02.01.20, new EP 37: Added EP regarding travel distances to exits
- LS.02.01.30, EPs 2 and 3: Added Note for hospices electing The Joint Commission deemed status option to have positive latching hardware on doors containing flammable or combustible materials
- LS.02.01.30, EP 4: Renumbered as EP 5
- LS.02.01.30, EP 5: Renumbered as EP 6 and revised requirements for the storage and handling of alcohol-based rubs to comply with NFPA requirements
- LS.02.01.30, EPs 6–10: Renumbered as EPs 7–11, respectively
• LS.02.01.30, EP 11: Renumbered as EP 12 and clarified requirements for corridor doors and positive latching hardware related to the passage of smoke
• LS.02.01.30, EP 12: Renumbered as EP 13 and revised to include positive latching hardware
• LS.02.01.30, EPs 13–18: Renumbered as EPs 14–19, respectively
• LS.02.01.30, EP 19: Renumbered as EP 20 and revised to include requirement that doors in a means of egress meet NFPA requirements
• LS.02.01.30, EPs 20–22: Renumbered as EPs 21–23, respectively
• LS.02.01.30, EP 23: Renumbered as EP 24 and deleted NFPA reference
• LS.02.01.30, EP 24: Renumbered as EP 25 and clarified that requirement pertains to buildings constructed after July 5, 2016, and deleted NFPA reference
• LS.02.01.30, EP 25: Renumbered as EP 26
• LS.02.01.34, EP 1: Renumbered as EP 7
• LS.02.01.34, new EP 1: Added EP requiring the installation of fire alarm systems and components to provide effective warning
• LS.02.01.34, EP 2: Added language related to some detectors in areas not continuously occupied and protected and in newly designated occupancies, as well as the monitoring of system integrity
• LS.02.01.34, EPs 3 and 4: Renumbered as EPs 9 and 10, respectively
• LS.02.01.34, new EP 3: Added EP regarding the initiation of fire alarm systems and location of manual alarm boxes
• LS.02.01.34, new EP 4: Added EP regarding occupant notification by fire alarms and zoning requirements in new buildings, including annunciation zoning
• LS.02.01.34, new EP 5: Added EP regarding occupant notification by fire alarms and zoning requirements in existing buildings
• LS.02.01.34, new EP 6: Added EP regarding automatic activation of fire alarms and alternative power supplies
• LS.02.01.34, new EP 8: Added EP requiring smoke detection systems in spaces open to corridors in accordance with NFPA requirements
• LS.02.01.35, EPs 9 and 11: Revised NFPA references
• LS.02.01.50, EP 1: Renumbered as EP 5 and clarified that fireplaces are direct-vent
• LS.02.01.50, new EP 1: Added EP requiring equipment using gas or gas piping and electrical wiring and equipment to comply with NFPA standards (existing installations may remain if there are no hazards)
Comprehensive Accreditation Manual for Home Care

- LS.02.01.50, new EP 2: Added EP specifying heating, ventilation, and air conditioning must comply with NFPA requirements and be installed according to manufacturers’ specifications
- LS.02.01.50, EPs 2–7: Renumbered as EPs 7 and 9–13, respectively
- LS.02.01.50, new EP 3: Added EP and Note related to the design and installation of heating devices with regard to combustible materials and ignition failures
- LS.02.01.50, new EP 4: Added EP related to suspended unit heater locations and safety features
- LS.02.01.50, new EP 6: Added EP regarding allowable solid fuel-burning fireplaces in areas other than patient sleeping rooms in accordance with NFPA requirements
- LS.02.01.50, EP 8: Renumbered as EP 14 and updated NFPA reference
- LS.02.01.50, new EP 8: Added EP requiring escalators, dumbwaiters, and moving walks to comply with NFPA and ASME/ANSI requirements
- LS.02.01.70, EP 3: Renumbered as EP 5
- LS.02.01.70, new EP 3: Added EP and Note requiring organizations to comply with NFPA requirements related to draperies and other loosely hanging fabrics
- LS.02.01.70, EP 4: Renumbered as EP 6 and updated NFPA references
- LS.02.01.70, new EP 4: Added EP related to upholstered furniture and mattresses purchased on or after July 5, 2016, in buildings without sprinkler protection
- LS.02.01.70, EP 5: Renumbered as EP 8
- LS.02.01.70, EP 6: Renumbered as EP 9 and deleted NFPA reference
- LS.02.01.70, new EP 7: Added EP requiring testing of new and existing engineered smoke control systems
- Minor editorial revisions

Effective January 13, 2018
- Worksheets: Updated to reflect standards changes mentioned previously

Medication Compounding (MC)

Effective January 1, 2018
- Added entire chapter

Effective January 13, 2018
- MC.01.01.01, EP 5: Updated USP reference
- MC.01.01.03, EP 1: Updated USP reference
Medication Management (MM)

Effective January 1, 2018

- Standards applicability grid: Consolidated grid to the beginning of the chapter and updated to reflect standards changes
- Standard MM.01.01.03, Rationale: Revised information defining and identifying high-alert medications
- MM.01.01.03, EP 1: Updated links
- MM.04.01.01, EP 1: Added additional types of medication orders
- MM.05.01.07, EPs 1 and 4: Deleted EPs
- MM.08.01.01, new EP 16: Added EP requiring a policy that describes the review of medication overrides related to automatic dispensing cabinets, along with icon
- Added cross-references to new Medication Compounding standards throughout the chapter
- Written Documentation Checklist: Updated EPs and applicable service categories
- Minor editorial revisions

Effective January 13, 2018

- Worksheets: Updated to reflect standards changes mentioned previously

National Patient Safety Goals (NPSG)

Effective January 1, 2018

- Standards applicability grid: Consolidated grid to the beginning of the chapter and updated to reflect standards changes

Provision of Care, Treatment, and Services (PC)

Effective November 12, 2017

- PC.01.03.01, new EP 55: Added requirement for home health agencies that use accreditation for deemed status purposes to align with revised requirements from the US Centers for Medicare & Medicaid Services (CMS)
- PC.02.03.01, EP 10: Added documentation icon and cross reference to PC.01.03.01, new EP 55

**Effective January 1, 2018**
- Standards applicability grid: Consolidated grid to the beginning of the chapter and updated to reflect standards changes
- PC.01.01.01, EP 7: Deleted cross-reference to LD.01.03.01, EP 3
- Written Documentation Checklist: Added PC.01.03.01, EP 55

**Effective January 13, 2018**
- Unless noted otherwise, the following changes are effective for home health agencies that elect to use The Joint Commission deemed status
- Standards applicability grid: Updated service categories to reflect standards changes
- PC.01.01.01, EP 13: Revised to include rehabilitative needs as part of services home health agencies can provide in patient residences
- PC.01.02.01: Made the following changes:
  - EP 10: Deleted requirement
  - EP 11: Updated applicability to deemed-status hospices only
  - EP 12: Clarified OASIS items be included in a comprehensive assessment
  - EP 24: Deleted requirement
  - EP 25: Specified patient information to be included in a comprehensive assessment and added Documentation icon
- PC.01.02.03: Made the following changes:
  - EP 11: Clarified that home health agencies must provide comprehensive assessments and verify patient eligibility
  - EP 13: Clarified conditions under which home health agencies must update and revise comprehensive assessments
- PC.01.02.05: Made the following changes:
  - EP 2: Clarified that registered nurses may determine care and support for patients and eligibility for the Medicare home health benefit (including homebound status) during an initial assessment visit and added cross-reference
  - EP 3: Specified that an occupational therapist may make an initial assessment visit if it is the only service ordered by a physician and deleted Note
  - EP 5: Added criteria under which an occupational therapist may complete the comprehensive assessment
EP 6: Deleted requirement
EP 9: Deleted requirement

PC.01.02.09, EP 6: Added requirement that home health agencies must report findings of abuse, neglect, and exploitation to the organization

PC.01.03.01: Made the following changes:
EP 9: Deleted requirement
EP 10: Specified numerous areas of patient care to be identified in a comprehensive assessment and added Documentation icon
EP 12: Clarified when home health agencies might modify a patient’s plan of care prior to a physician’s evaluation visit
EP 21: Deleted requirement
EP 23: Revised for home health agencies information to be included in a revised patient plan of care and added Documentation icon
EP 30: Revised Note by deleting a description of duties home health aides should not exceed under state law
New EP 56: Added new requirement regarding any revisions related to plans for patient discharge and added a cross-reference

PC.02.01.01: Made the following changes:
EP 2: Clarified that home health agencies must provide services compliant with current clinical practice guidelines
EPs 7–10: Deleted requirements

PC.02.01.03: Made the following changes:
EP 2: Deleted requirement
EP 8: Clarified that home health agencies follow physician orders when providing care, treatment, or services
New EP 21: Added new requirement that home health aides may administer medications to patients that are also self-administered unless prohibited by policy or law

PC.02.01.05: Made the following changes:
EP 10: Clarified for home health agencies how often a patient’s individualized plan of care must be reviewed and revised
EP 11: Revised a physician’s responsibility to a patient’s plan of care per his or her licensing, certification, or registration and added Documentation icon
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- EP 12: Clarified that home health agencies must alert physicians in instances requiring an alteration for improved outcomes in a patient’s plan of care
- EPs 15, 18, and 23: Deleted requirements

- PC.02.02.01: Made the following changes:
  - EP 5 and 6: Deleted requirements
  - EP 10: Clarified resources and coordination required by all disciplines in providing patient care
  - New EP 28: Added new requirement for the coordination of patient care services

- PC.02.03.01: Made the following changes:
  - EP 4: Revised requirement for ongoing education and training for both patients and caregivers
  - EPs 6–9: Deleted requirements
  - New EP 33: Added new requirement regarding information included in written instructions for patients and caregivers and added Documentation icon

- PC.04.01.01: Made the following changes:
  - New EP 29: Added new requirement clarifying the conditions under which an agency may transfer or discharge a patient and added Documentation icon
  - New EP 30: Added new requirement clarifying responsibilities prior to discharging a patient and added Documentation icon

- PC.04.01.03, EP 7: Deleted requirement

- PC.04.02.01: Made the following changes:
  - EP 2: Added Note regarding the deadline for transfer summaries in the event of unplanned transfers
  - EP 3: Revised requirement regarding the completion of discharge summaries

- Worksheets: Updated to reflect standards changes

Performance Improvement (PI)

Effective January 1, 2018

- Standards applicability grid: Consolidated grid to the beginning of the chapter and updated to reflect standards changes
- PI.03.01.01, EP 2: Added cross-reference to MM.08.01.01, EP 6
- Added cross-references to new Medication Compounding standards throughout the chapter

CAMHC, January 2018
Effective January 13, 2018
- Unless noted otherwise, the following changes are effective for home health agencies that elect to use The Joint Commission deemed status
- Standards applicability grid: Updated service categories to reflect standards changes
- PI.01.01.01, EP 33: Updated applicability to include home health agencies
- PI.02.01.01, EP 10: Updated applicability to include home health agencies
- PI.03.01.01, EPs 8 and 9: Updated applicability to include home health agencies
- Worksheets: Updated to reflect standards changes

Record of Care, Treatment, and Services (RC)

Effective January 1, 2018
- Standards applicability grid: Consolidated grid to the beginning of the chapter and updated to reflect standards changes
- RC.02.01.01, EP 2: Added Note 3 regarding the applicability of this EP and a ◊ icon
- Written Documentation Checklist: Updated RC.02.01.01, EP 2

Effective January 13, 2018
- Unless noted otherwise, the following changes are effective for home health agencies that elect to use The Joint Commission deemed status
- Standards applicability grid: Updated service categories to reflect standards changes
- RC.01.01.01: Made the following changes:
  - EP 3: Revised requirement for maintaining and documenting accurate patient records and added Documentation icon
  - EP 8: Added Note that patients’ records be available to physicians as needed
  - New EP 17: Added new requirement regarding the availability of patient records
- RC.01.02.01, EP 9: Updated applicability to include home health agencies regarding maintaining patient records and added Documentation icon
- RC.01.04.01, EPs 2 and 5: Deleted requirements
- RC.01.05.01: Made the following changes:
  - EP 3: Clarified how long to retain patient records per state laws
  - EP 7: Specified that when home health agencies discontinue operations they inform state agencies regarding patient (clinical) records’ maintenance
RC.02.01.01: Made the following changes:
- EP 2: Made minor editorial change
- EP 3: Clarified types of information to be included in patient records, added cross-references, and added Documentation icon
- EPs 11–16 and 20: Deleted requirements

RC.02.03.07: Made the following changes:
- EP 2: Added Note regarding when staff may receive and record verbal orders as per law, regulation, and policies and added Documentation icon
- EP 3: Clarified that verbal orders are documented, signed, and dated by a registered nurse or qualified practitioner and added Documentation icon

Worksheets: Updated to reflect standards changes

Rights and Responsibilities of the Individual (RI)

Effective January 1, 2018

Chapter Outline: Revised to align with standards changes

Standards applicability grid: Consolidated grid to the beginning of the chapter and updated to reflect standards changes

RI.01.02.01, EPs 3 and 7: Combined and numbered as EP 4, related to a patient’s surrogate decision-maker’s right to make decisions on a patient’s behalf

RI.01.02.01, EP 6: Renumbered as EP 2 and revised cross-reference

RI.01.02.01, EPs 20 and 21: Combined and numbered as EP 20, related to a patient’s surrogate decision-maker’s right to information related to outcomes of the patient’s care, treatment, and services, including sentinel events

RI.01.03.01, EPs 1–3, 5, 6, and 13: Combined and numbered as RI.01.03.01, EP 1, related to written policies on informed consent (including a icon)

RI.01.03.01, EPs 7, 9, and 11: Combined and numbered as EP 2, related to the informed consent process

RI.01.03.01, EPs 8 and 10: Renumbered as EPs 5 and 4, respectively

Standard RI.01.03.03: Deleted standard

RI.01.03.03, EP 1: Renumbered as RI.01.03.01, EP 3, and revised informed consent document requirements in advance of recordings, films, and other images of patients; revised Note 1 to include digital media as an example; added Note 2 regarding applicability to security cameras
RI.01.03.05, EPs 4–7: Combined and numbered as EP 4, related to informing patients about research consent forms

RI.01.05.01, EPs 1, 2, and 5: Combined and numbered as EP 1, related to written policies on advance directives (including a © icon)

RI.01.07.01, EPs 1 and 2: Combined and numbered EP 1, regarding the complaint resolution process

Written Documentation Checklist: Updated EPs and applicable service categories

Minor editorial revisions

Effective January 13, 2018

Unless noted otherwise, the following changes are effective for home health agencies that elect to use The Joint Commission deemed status

Standards applicability grid: Updated service categories to reflect standards changes

RI.01.01.01: Made the following changes:

- EP 2: Clarified process for written notification of patients’ rights and responsibilities and the organization’s transfer and discharge policies within a specified time frame
- EP 11: Revised requirement for obtaining a patient’s or patient representative’s signature confirming receipt of a patient’s rights and responsibilities notice
- New EP 35: Added new requirement for information to be provided to patients and/or their representatives prior to an initial evaluation visit and added Documentation icon
- New EP 36: Added new requirement regarding a patient’s right to receive services in the plan of care

RI.01.01.03: Made the following changes:

- EP 1: Added Note regarding use of appropriate language and manner to assure understanding of patient’s rights and added a cross-reference
- EP 3: Revised for home health agencies their responsibility to communicate in a way that aligns with the needs of disabled persons
- New EP 8: Added new requirement that home health agencies provide interpreter services, free of charge, when needed

RI.01.02.01: Made the following changes:

- EP 15: Clarified the right of patients to be informed about and consent or refuse care in advance of and during treatment (when possible)
EP 16: Specified that patient representatives, caregivers, and physicians be informed if plan of care is revised due to a change in patient health status

EP 23: Updated applicability to deemed-status hospices only

EPs 24 and 25: Deleted requirements

EP 26: Clarified that patients be informed of any changes in charges and payment information in advance of the next home health visit and added Note requiring compliance with federal regulations

RI.01.04.01, EP 3: Deleted requirement

RI.01.05.01: Made the following changes:

- EP 7: Deleted requirement and removed Documentation icon
- EP 18: Updated applicability to deemed-status hospices

RI.01.07.01: Made the following changes:

- EP 4: Added Note that agencies document complaints from patients and their families and added Documentation icon
- EP 11: Made editorial revision
- EP 12: Deleted requirement
- EP 13: Specified that home health agencies provide patients with contact information (including home health hotline), explain the hotline’s purpose and hours of operation and added Documentation icon
- New EP 33: Added new requirement that the organization provides patients with specified federally- and state-funded entities serving the patient’s area of residence

**Waived Testing (WT)**

*Effective January 1, 2018*

- Standards applicability grid: Consolidated grid to the beginning of the chapter and updated to reflect standards changes

*Effective January 13, 2018*

- Unless noted otherwise, the following changes are effective for home health agencies that elect to use The Joint Commission deemed status
- WT.01.01.01, EP 9: Specified that home health agencies may not substitute their equipment for a patient’s equipment during self-administered tests
- Worksheets: Updated to reflect standards changes
Accreditation Process Information

The Accreditation Process (ACC)

Currently effective

- Eligibility for Home Care Accreditation: Made the following changes:
  - Home Medical Equipment: Removed criterion that limited services to those provided to patients in their residence from Clinical Respiratory Services Eligibility
  - Pharmacy Services: Added applicability of new Medication Compounding requirements to Pharmacy Dispensing Services, Long-Term Care Pharmacy Services, and Freestanding Ambulatory Infusion Services
  - Pharmacy Services: Clarified that Clinical/Monitoring Pharmacist Services are provided in conjunction with the other dispensing pharmacy services

- 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

- 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 footnotes addressing initial payment and circumstances in which accredited organizations are not charged a deposit

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

- Survey Agenda: Made the following changes:
  - Added language to reflect that surveyors will discuss the Survey Analysis for Evaluating Risk™ (SAFER™) reporting process during the opening and exit conferences as well as during daily briefings
- Changed “planning” category to “preparedness” phase in Environment of Care and Emergency Management (EM) session to align with introduction to EM chapter
- 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 6. SAFER Matrix placement and required follow-up activities: Revised language to align with updated Evidence of Standards Compliance (ESC) format
- Corrective ESC: Updated to include the components of leadership involvement and preventive analysis
- Additional Surveys: Included adding an optional certification as a reason for conducting an extension survey
- Made minor editorial revisions

Effective January 1, 2018
- Decision Rules for Organizations Seeking Initial Accreditation: Made the following changes:
  - Added introductory text regarding the approval of decision rules by executive leadership (language applies to organizations seeking reaccreditation as well)
  - In Denial of Accreditation (DA) decision rule DA07, replaced the bulleted list of how an organization provides information to The Joint Commission with the words “in any way”
  - Added new rule DA10 regarding 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 organizations that implement sufficient corrective action as demonstrated in an on-site validation survey (related to Preliminary Denial of Accreditation [PDA] rule PDA02)

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

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

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

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

Sentinel Events (SE)

Effective January 1, 2018

- Definition of Sentinel Event: Updated link in “severe, temporary harm” footnote
- Responding to Sentinel Standards: Deleted paragraph referencing Standard RI.01.02.01 and EP 21
- Appendix: Deleted Standard RI.01.02.01 and EP 21
- Editorial revisions
The Joint Commission Quality Report (QR)

Effective January 1, 2018
- What Is the Joint Commission Quality Report?: Clarified the type of information available on the Quality Report website
- What Will My Quality Report Contain?: Removed reference to Quality Indicators that compare organizations on a state and national level
- How Does My Hospital Submit a Commentary?: Clarified the approval process necessary for submitting a commentary to accompany your Quality Report
- Updated or added web addresses throughout the chapter
- Minor editorial revisions

Required Written Documentation (RWD)

Effective November 12, 2017
- Added documentation requirements to the following EPs as applicable to the appropriate home care services:
  - EM.01.01.01, EP 9
  - EM.02.01.01, EPs 7, 10–12, 14, 15
  - EM.02.02.01, EPs 18–22, 24
  - EM.02.02.03, EP 9
  - EM.02.02.05, EP 4
  - EM.02.02.07, EPs 7, 11–13
  - EM.02.02.09, EPs 2–4, 7
  - EM.02.02.11, EPs 1, 3, 5, 12, 13
  - EM.03.01.03, EPs 20, 21
  - EM.04.01.01, EPs 1–3
  - IM.01.01.03, EP 5
  - PC.01.03.01, EP 55
  - PC.02.03.01, EP 10

Effective January 1, 2018
- Revised documentation requirements throughout the chapter as appropriate to reflect consolidated and renumbered standards
- Added a documentation requirement for the following existing EPs to the applicable services:
Added a documentation requirement for the following new EPs to the applicable services:

- EC.02.03.05, EPs 27, 28
- EC.02.05.03, EP 14, 15
- EM.02.01.01, EPs 17, 18, 24
- MC.01.02.01, EP 2
- MC.02.01.03, EP 5
- MC.02.01.05, EP 3
- MC.02.01.07, EP 4
- MC.02.01.09, EP 8
- MC.02.01.11, EPs 1, 6
- MC.02.01.13, EP 1
- MC.03.05.01, EP 1
- MC.03.05.03, EPs 9, 14
- MC.03.05.03, EPs 15, 18
- MC.03.06.01, EP 1
- MC.03.06.05, EP 11
- MC.03.06.11, EP 2
- MC.03.07.01, EPs 7, 8
- MC.03.08.09, EPs 1, 2
- MC.03.08.11, EP 8
- MC.04.01.01, EP 6
- MC.04.02.03, EP 8
- MC.05.01.01, EPs 4, 9
- MC.05.01.03, EPs 3, 13, 15
- MC.05.02.03, EPs 3, 6–8, 10, 14
- MC.05.05.01, EP 2–7
- MC.05.06.01, EP 2
- MM.08.01.01, EP 16

Effective January 13, 2018
Updated to align with changes made to the standards chapters, as identified previously

**Early Survey Policy (ESP)**

*Effective November 12, 2017*

- Added the following new EPs applicable to a first survey under the Survey Policy Option:
  - EM.01.01.01, EP 9
  - EM.02.01.01, EPs 7, 10–12, 14, 15
  - EM.02.02.01, EPs 18–22, 24
  - EM.02.02.03, EPs 1, 9
  - EM.02.02.05, EP 4
  - EM.02.02.07, EPs 7, 9, 11, 12
  - EM.02.02.09, EPs 2–4, 7
  - EM.02.02.11, EPs 5, 12, 13
  - EM.04.01.01, EPs 1, 3
  - PC.01.03.01, EP 55

*Effective January 1, 2018*

- Added the following EPs applicable to a first survey under the Survey Policy Option:
  - EC.02.01.03, EP 4
  - EC.02.03.01, EP 13
  - EC.02.03.05, EPs 27, 28
  - EC.02.05.01, EPs 2, 5, 24
  - EC.02.05.03, EPs 5, 11, 12, 14, 15
  - EC.02.05.05, EP 8
  - EC.02.05.09, EPs 2, 3, 10–14
  - EM.01.01.01, EP 9
  - EM.02.01.01, EPs 7, 10–12, 14, 15
  - EM.02.02.01, EPs 18–22, 24
  - EM.02.02.03, EPs 1, 9
  - EM.02.02.05, EP 4
  - EM.02.02.07, EPs 7, 11, 12
■ EM.02.02.09, EPs 2–4, 7
■ EM.02.02.11, EPs 5, 12, 13
■ EM.04.01.01, EPs 1, 3
■ EQ.01.03.01, EP 10
■ HR.01.01.01, EP 8
■ IC.01.03.01, EP 3
■ LS.02.01.10, EPs 12–15
■ LS.02.01.20, EPs 37–42
■ LS.02.01.30, EP 26
■ LS.02.01.34, EPs 5–10
■ LS.02.01.50, EPs 9–14
■ LS.02.01.70, EPs 7–9
■ MC new EPs, as appropriate
■ MM.08.01.01, EP 16
■ PC.01.03.01, EP 55
■ RI.01.03.05, EP 4

■ Deleted the following EPs:
■ EC.02.05.01, EP 3
■ EC.02.05.03, EPs 4, 10
■ EC.02.05.05, EP 7
■ IC.01.03.01, EP 5
■ HR.01.02.01, EP 2
■ LS.02.01.30, EP 4
■ RI.01.03.01, EPs 2, 3, 5–7
■ RI.01.05.01, EP 2

Effective January 13, 2018
■ Added the following EPs applicable to a first survey under the Survey Policy Option:
■ HR.01.01.01, EP 34
■ HR.01.02.05, EP 29
■ HR.01.02.07, EPs 13 and 14
■ HR.01.03.01, EPs 27, 28, and 30
■ LD.04.03.03, EP 35
Community-Based Palliative Care Certification (CBPC)

Effective January 1, 2018

- Standard APR.01.02.01 and EP 1: Added standard and EP clarifying that an organization must provide accurate information throughout the accreditation process
- Standard APR.01.03.01 and EP 1: Added standard and EP regarding an organization’s requirement to disclose changes in ownership, control, location, capacity, or services offered to The Joint Commission within 30 days of any change and the Centers for Medicare & Medicaid Services when applicable
- Standard APR.06.01.01 and EP 1: Added standard and EP clarifying that applicants and accredited organizations not use Joint Commission employees to provide accreditation-related consulting services
- Standard HR.01.02.01: Renumbered as HR.01.01.01 and clarified that staff qualifications must be verified

Appendix A: Medicare Requirements for Hospice (AXA)

- No changes

Glossary

Effective January 1, 2018

- Added several terms to support the new Medication Compounding (MC) chapter
- Deleted the term *environmental tours*
Effective January 13, 2018

- Added the following terms:
  - clinical manager
  - licensed practical (vocational) nurse
  - licensed practical nurse
  - qualified home health aide
  - skilled professional services
  - verbal order

- Deleted the following terms:
  - bylaws (or equivalent)
  - nonprofit agency
  - progress note
  - subdivision
  - subunit
  - supervision

- Revised the following terms:
  - administrator, home health agency
  - branch office
  - clinical note (home health)
  - compounding supervisor
  - engineering control
  - parent home health agency
  - physician
  - primary home health agency
  - representative
  - social work assistant
  - social worker (home health)
  - specification

Index (IX)

Effective January 1, 2018

- Updated Index
Updated Index
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 Home Care (CAMHC) 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 and the Home Care Accreditation Program and its certification options.
2. Part II explains the organization and content of the CAMHC.
3. Part III explains how you can use the CAMHC 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 Home Care Accreditation Program and the structure and content of the CAMHC. After you have a better understanding of the value of accreditation in improving and maintaining the quality of care, treatment, or 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
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 home care organization is committed to providing the highest quality services. It also sets you apart from other home care organizations offering the same types of care, treatment, or services.

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

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

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

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

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

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

Figure 1. The Joint Commission’s Home Care Accreditation Program is designed to help home care organizations 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 Home Care Accreditation Program

The Joint Commission’s Home Care Accreditation Program uses a patient-centered quality framework and collaborative approach to help organizations proactively identify and address vulnerabilities to safeguard patients.

Addressing Complex Issues in Home Care

There are many factors that affect outcomes for patients in the home setting, such as an appropriate complement of services to provide interdisciplinary care planning, compliance with medical and medication regimen, and access to advanced care therapies (including wound and infusion therapy). Likewise, having sufficient numbers of competent and properly trained staff positively impacts the delivery of safe, high quality care to patients.

Some of the most challenging areas for home care are complex patient issues involving abuse and neglect, financial exploitation, infection prevention, promotion of patient-centered care, lack of community resources, and noncompliance with treatment plans. Staff and leadership strive to deliver professional health care services in accordance with law and agency policy within diverse settings such as the patient’s home, assisted living, skilled nursing facilities, and inpatient settings.

The Home Care Accreditation Program helps providers achieve, maintain, and demonstrate consistent excellence in the services they provide. The standards specifically listed in Table 1 can help home care organizations begin to develop strategies to address some of the most challenging and complex patient issues.

Note: Table 1 does not address all of the issues facing leaders in home care.
Introduction: How The Joint Commission Can Help You Move Toward High Reliability

Table 1. Standards That Address Complex Issues in Home Care Settings

<table>
<thead>
<tr>
<th>Abuse/Neglect Prevention</th>
<th>Infection Prevention</th>
<th>Safety Culture</th>
</tr>
</thead>
<tbody>
<tr>
<td>LD.03.06.01</td>
<td>HR.01.04.01</td>
<td>APR.09.02.01</td>
</tr>
<tr>
<td>PC.01.02.09</td>
<td>IC.01.01.01</td>
<td>HR.01.04.01</td>
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<td>LD.03.01.01</td>
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<td>Medication Compounding</td>
<td>Staff Training/Competence</td>
</tr>
<tr>
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<td>MC.01.01.01</td>
<td>HR.01.02.05</td>
</tr>
<tr>
<td>PC.02.02.01</td>
<td>MC.03.01.01</td>
<td>HR.01.04.01</td>
</tr>
<tr>
<td>PC.04.02.01</td>
<td>MC.03.03.01</td>
<td>HR.01.05.03</td>
</tr>
<tr>
<td></td>
<td>MC.03.04.01</td>
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<td>MC.02.01.01</td>
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<td>MC.04.01.01</td>
<td>MC.02.01.05</td>
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<td>MC.04.02.01</td>
<td>MC.02.01.07</td>
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<td>MC.05.01.01</td>
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<td>Medication Management</td>
<td>Treatment &amp; Care Plans</td>
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<td>MM.01.01.03</td>
<td>PC.01.03.01</td>
</tr>
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<td>PC.02.01.03</td>
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<td>MM.03.01.01</td>
<td>RC.02.01.01</td>
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<td></td>
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<td>MM.05.01.09</td>
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<td></td>
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<td>Promoting Patient-Centered Care</td>
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<tr>
<td>PC.01.03.01</td>
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</tbody>
</table>

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

The CAMHC (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, or services a home care organization provides (see the “Identifying Applicable Standards” section in this chapter). The CAMHC includes all the information a home care organization needs to achieve and maintain continuous compliance with the Joint Commission’s accreditation and optional specialty certification standards. The manual also will help home care organizations 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 home care organization receives complimentary access to E-dition (which contains accreditation standards) and access to the Joint Commission Connect extranet (which contains various accreditation tools and resources). This secure extranet site also serves as the primary avenue for communication between an organization and The Joint Commission.

The Joint Commission may revise accreditation or certification standards periodically throughout the year and publish those changes online, in the accreditation manual, or in *Joint Commission Perspectives*. This official Joint Commission newsletter publishes revised or updated standards, EPs, scoring, standards clarifications and interpretations, and other useful information as the year progresses. **Your organization is responsible for meeting all applicable standards published in Perspectives**, and staff need access to aid in your compliance efforts (see “Keep Current With Standards Changes via Perspectives” section). *Perspectives* is available on your Joint Commission Connect extranet site, under the “Resources” tab or is available for purchase at www.jcinc.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 CAMHC manual is published once a year in the fall and a print update service is available to keep your manual current through the year. The print manual or updates are only available for purchase at http://www.jcrinc.com/store/publications/manuals/. The “What’s New” table, provided with each print manual and accessible from the blue navigation bar across the top of the E-dition, offers a summary of the changes made since the CAMHC was last published or posted.

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

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

Following is more detail about each section. See Table 2 for a list of acronyms used in this manual.
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Meaning</th>
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<tbody>
<tr>
<td>ACC</td>
<td>“The Accreditation Process” chapter</td>
</tr>
<tr>
<td>AFS</td>
<td>Accreditation with Follow-up Survey</td>
</tr>
<tr>
<td>APR</td>
<td>“Accreditation Participation Requirements” chapter</td>
</tr>
<tr>
<td>CAMHC</td>
<td>Comprehensive Accreditation Manual for Home Care</td>
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<tr>
<td>CBPC</td>
<td>Community-Based Palliative Care Certification</td>
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<tr>
<td>CMS</td>
<td>US Centers for Medicare &amp; Medicaid Services</td>
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<tr>
<td>CoP</td>
<td>Conditions of Participation (for CMS)</td>
</tr>
<tr>
<td>DA</td>
<td>Denial of Accreditation</td>
</tr>
<tr>
<td>DMEPOS</td>
<td>Durable medical equipment, prosthetics, orthotics, and supplies</td>
</tr>
<tr>
<td>E-App</td>
<td>electronic application for accreditation</td>
</tr>
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<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>HAI</td>
<td>health care–associated infection</td>
</tr>
<tr>
<td>HHA</td>
<td>home health agency</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>
</tr>
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</table>

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
<table>
<thead>
<tr>
<th>INTRO</th>
<th>“Introduction: How The Joint Commission Can Help You Move Toward High Reliability” chapter</th>
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</thead>
<tbody>
<tr>
<td>LD</td>
<td>“Leadership” chapter</td>
</tr>
<tr>
<td>LS</td>
<td>“Life Safety” chapter</td>
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<td>LSC</td>
<td>Life Safety Code®</td>
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<tr>
<td>LTA</td>
<td>Limited, Temporary Accreditation</td>
</tr>
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<td>MC</td>
<td>“Medication Compounding” chapter</td>
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<tr>
<td>MM</td>
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</tr>
<tr>
<td>NPSG</td>
<td>National Patient Safety Goal (also a chapter in this manual)</td>
</tr>
<tr>
<td>OQPS</td>
<td>Office of Quality and Patient Safety</td>
</tr>
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<td>OSHA</td>
<td>Occupational Safety and Health Administration</td>
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<tr>
<td>PC</td>
<td>“Provision of Care, Treatment, and Services” chapter</td>
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<tr>
<td>PDA</td>
<td>Preliminary Denial of Accreditation</td>
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<td>PFI</td>
<td>Plan for Improvement</td>
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<tr>
<td>PI</td>
<td>“Performance Improvement” chapter</td>
</tr>
<tr>
<td>POA</td>
<td>Plan of Action</td>
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<tr>
<td>PS</td>
<td>“Patient Safety Systems” chapter</td>
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<tr>
<td>QR</td>
<td>“The Joint Commission Quality Report” chapter</td>
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<tr>
<td>RC</td>
<td>“Record of Care, Treatment, and Services” chapter</td>
</tr>
<tr>
<td>RCA</td>
<td>root cause analysis</td>
</tr>
<tr>
<td>RFI</td>
<td>Requirement for Improvement</td>
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<tr>
<td>RI</td>
<td>“Rights and Responsibilities of the Individual” chapter</td>
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<tr>
<td>RWD</td>
<td>“Required Written Documentation” chapter</td>
</tr>
<tr>
<td>SAFER™</td>
<td>Survey Analysis for Evaluating Risk™</td>
</tr>
<tr>
<td>SAP</td>
<td>“Standards Applicability Process” chapter</td>
</tr>
</tbody>
</table>

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

This manual contains the following standards chapters:

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

“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.

“Equipment Management” (EQ): Outlines processes for managing and maintaining equipment.

“Human Resources” (HR): Outlines processes for staff management, including visiting physicians and nurse practitioners in the home.

“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 home care organizations.

“Medication Compounding” (MC): Addresses the evaluation of sterile and nonsterile medication compounding, including hazardous medications, radiopharmaceuticals, and allergens (as applicable to the organization) in pharmacy organizations where compounding is performed.

“Medication Management” (MM): Addresses the stages of medication use, including selection, storage, and safe management of medications, ordering, preparing and dispensing, administration, monitoring of effect, and evaluation of the processes.

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

“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.

“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, “Community-Based Palliative Care Certification Option” (CBPC), 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.

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

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

**“Required Written Documentation” (RWD):** Lists the standards that require written documentation beyond that required in the 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 home care organization has chosen the Early Survey Policy option. This chapter can be referenced as you prepare for first-time accreditation under the ESP. See “The Accreditation Process” (ACC) chapter for details on the ESP.

“Community-Based Palliative Care” (CBPC): Contains the Joint Commission’s Community-Based Palliative Care Certification standards and EPs necessary to achieve or maintain the optional CBPC Certification for Home Care organizations (Home Health and/or Hospice).

“Appendix A: Medical Requirements for Hospice” (AXA): Contains the US Centers for Medicare & Medicare Services (CMS) Conditions of Participation (CoP) for Hospices. Hospice organizations that are seeking deemed status must comply with these conditions.

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

For example, standards and EPs that apply only to organizations pursuing certification for community-based palliative care are preceded by the following boldface lead-in phrase: For organizations that elect the Community-Based Palliative Care Certification (CBPC) option. Another example are the standards and EPs in the “Medication Compounding” (MC) chapter. These are only applicable to home care pharmacy organizations that compound medications.
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 home care organization and the specific services you provide. This selection, in turn, drives the standards applied to your organization by surveyors during the on-site survey process. To view your organization’s services in E-dition, click “Service Profile” on the top navigation bar. Check with your Joint Commission account executive if you have questions or to help ensure your E-App is complete and accurate.

Each standards chapter in the print manual now features a comprehensive applicability grid that identifies the service categories within the Home Care Accreditation Program to each standard and EP in that chapter. An example of an applicability grid appears as Figure 2. The column on the far left of the grid lists the related EPs vertically by number. Service categories (defined in Table 3) are listed horizontally along the top of the grid. Applicability is indicated with an “X” in a service category column. The applicability grid follows the chapter outline that begins each standards chapter.

Figure 2. Sample Standards Applicability Grid

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<th>Standard/Requirement Number</th>
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<td>X</td>
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</tr>
</tbody>
</table>

Table 3. Abbreviations Used for Applicability Grids in Standards Chapters

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>HH</td>
<td>Home Health</td>
</tr>
<tr>
<td>HH</td>
<td>Home Health</td>
</tr>
<tr>
<td>PCS</td>
<td>Personal Care and Support Services</td>
</tr>
<tr>
<td>HOS</td>
<td>Hospice</td>
</tr>
</tbody>
</table>

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
Some organizations provide care, treatment, or services that are covered under more than one accreditation program and manual (for example, a home care agency that provides personal care services may also be providing community-based supportive living services for individuals with disabilities, so they will need to maintain compliance with certain standards in the behavioral health care accreditation manual as well as the

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Category</th>
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<tbody>
<tr>
<td>H</td>
<td>Patient Residence</td>
</tr>
<tr>
<td>F</td>
<td>Facility Based</td>
</tr>
<tr>
<td>DME</td>
<td>Durable Medical Equipment</td>
</tr>
<tr>
<td>H</td>
<td>Patient Residence</td>
</tr>
<tr>
<td>F</td>
<td>Facility Based</td>
</tr>
<tr>
<td>M</td>
<td>Mail Order</td>
</tr>
<tr>
<td>RESP</td>
<td>Respiratory Equipment</td>
</tr>
<tr>
<td>SUPP</td>
<td>Supplies</td>
</tr>
<tr>
<td>H</td>
<td>Patient Residence</td>
</tr>
<tr>
<td>M</td>
<td>Mail Order</td>
</tr>
<tr>
<td>OP</td>
<td>Orthotics and Prosthetics</td>
</tr>
<tr>
<td>H</td>
<td>Patient Residence</td>
</tr>
<tr>
<td>F</td>
<td>Facility Based</td>
</tr>
<tr>
<td>CRS</td>
<td>Clinical Respiratory Services</td>
</tr>
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<td>RT</td>
<td>Rehabilitation Technology</td>
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<td>Patient Residence</td>
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<td>Facility Based</td>
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<tr>
<td>PH</td>
<td>Pharmacy</td>
</tr>
<tr>
<td>DISP</td>
<td>Pharmacy Dispensing</td>
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<tr>
<td>CCP</td>
<td>Clinical/Monitoring Pharmacist</td>
</tr>
<tr>
<td>FAI</td>
<td>Freestanding Ambulatory Infusion</td>
</tr>
<tr>
<td>LTP</td>
<td>Long Term Care Pharmacy</td>
</tr>
</tbody>
</table>

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
CAMHC). The Joint Commission will work with your home care 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: A surgeon-owned or -operated organization (for example, a professional services corporation, private physician office, or small group practice) that provides invasive procedures and administers local anesthesia, minimal sedation, conscious sedation, or general anesthesia that renders three or fewer patients incapable of self-preservation at any time, and is classified as a business occupancy.

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

**Understanding the Organization of the Standards Chapters**

Each standards chapter in the “Accreditation Requirements” section is organized as follows (see Figure 3):

- **Overview:** The overview is located at the beginning of each chapter. The overview explains the chapter’s purpose and the principles on which the standards were built.
- **Chapter outline:** This part shows how the chapter is laid out and provides a frame of reference for the numbering of standards.
- **Introduction:** Some standards (or cluster of standards) have an introduction at the beginning, which provides information about the standard’s origin and any issues that surround it.
- **Standards:** Standards (also known as requirements) are statements that define the performance expectations and/or structures or processes that must be in place for organizations to provide safe, high-quality care, treatment, and services.
- **Rationale:** A rationale explains the purpose of a standard by providing additional background, justification, or other information, but it is not scored. In many cases, the rationale for a standard is self-evident; therefore, not every standard has a written rationale.
References: This part of a chapter is placed in parentheses following a standard to help identify related standards, whether they are located in the same chapter or a different chapter. These references should help the user to quickly find related standards concerning a particular topic.

Elements of performance (EPs): EPs are statements that detail the specific performance expectations and/or structures or processes that must be in place for an organization to provide high-quality care, treatment, or 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 home care organizations and are omitted from this accreditation manual. Consequently, gaps may exist in the sequence. For example, if a standard lists EP 1, EP 2, and EP 5, this indicates that EP 3 and EP 4 do not apply to the Home Care Accreditation Program and, therefore, your organization does not have to comply with them.

Notes: Notes are used to provide organizations and surveyors with additional or clarifying information about a specific EP.

Worksheets: The following worksheets are accessible on the chapter navigation bar in the E-dition and included at the end of each standards chapter in the print manual:

- Prompts to Assess Your Compliance: These worksheets contain questions to prompt discussion in your organization about compliance with the standards in a particular chapter. In some instances, there are tips with helpful standards compliance strategies.
- Written Documentation Checklist: These checklists contain the EPs that require written documentation (shown with a icon in the chapter) that a surveyor may ask to see during a survey to assess compliance.
- Action Planning Tool: These forms can be used to track EPs that are out of compliance and to document the steps your organization will take to bring them into compliance.
- Chapter Notes: These blank sheets in your print manual can be used to record notes and information, such as the location of documents or medical record numbers used to assess compliance, so you have them at the ready for reference.
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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:

![Standard](image)

A statement that, when achieved, facilitates safe, quality care, treatment, or services

![Rationale](image)

Additional text that describes the purpose of the requirement/standard

![Element of Performance](image)

Identifies performance expectations—only the elements of performance are scored

![Documentation Icon](image)

Identifies performance expectations—only the elements of performance are scored

![Risk Icon](image)

Indicates an identified risk for the purposes of the Focused Standards Assessment

Figure 3. Components of a standards chapter in the print manual. The components are further described in the “Understanding the Icons Used in the Manual” section.
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 Written Documentation Checklist at the end of each standards chapter in this manual.

The risk icon (▲) identifies specific risks by accreditation program (not program segment). Risk is assessed by a system’s proximity to the 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.

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 CAMHC 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 CAMHC or Home Care 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.

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: What is the time frame for admission? Is the admission completed within the defined period and with all components completed? What process do we use to supervise staff? What do the supervisors do if they find unsatisfactory performance?
- Monitor closely the general Joint Commission website for free tools and resources provided.
- Use the worksheets at the end of each standards chapter to track compliance with the standards in the chapter and to trace progress for coming into compliance.
- 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 4). Contact your account executive for support.
- Compile information on your performance improvement activity for discussion during your on-site survey.
- Form a team to develop creative ways to assess, achieve, and maintain standards compliance, such as the following:
  - Question of the week or month
  - Standards-related posters
  - Column in a weekly all-staff newsletter or electronic bulletin board
- Speak to other accredited program coordinators. To find other accredited programs, go to http://www.qualitycheck.org and search by organization, service/setting, state, city, or zip code.
- Conduct a gap analysis for the activities required by the standards and evaluate your organization against each standard. Identify whether the standard is being (or has been) met or not met.
KEY MILESTONES IN THE ACCREDITATION PROCESS

Joint Commission Activities

- **Full on-site survey is conducted using tracer methodology**
- **Summary of findings left for organization**
- **Accreditation decision rendered**
- **Quality Report™ posted on Quality Check®**
- **SIG conducts TouchPoint conference call with organization**
- **SIG conducts TouchPoint conference call with organization**
- **SIG conducts TouchPoint conference call with organization**
- **On-site resurvey is scheduled**
- **Full survey is conducted between months 18 and 36**

Accredited Organization Activities

- **Application**
  - Organization completes and submits E-App and deposit
  - E-dition and ICM FSA tool made available
- **Year One**
  - Organization updates and submits E-App for resurvey
- **Year Two**
  - Organization submits ICM profile (including selected FSA option), develops POA for standards identified as noncompliant, and identifies their date of compliance
- **Year Three**
  - Organization updates and submits E-App

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

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

After a standards assessment has been completed, there likely will be follow-up action needed to bring your organization into compliance. Following are tips to make sure your organization complies with Joint Commission standards and meets the needs of 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 to achieve compliance. You can use the Action Planning Worksheets at the back of each standards chapter to track your progress (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 home care organizations 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:
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, home oxygen safety).

Targeted Solutions Tool®: An online application that guides health care organizations through a step-by-step process to accurately measure their organization’s actual performance, identify their barriers to excellent performance, and direct them to proven solutions that are customized to address their particular barriers.

Standards Interpretation: A landing page that allows organizations to submit questions and view FAQs related to the interpretation of standards.

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

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

IV. Get Extra Help
All home care organizations—regardless of size and scope of services—are entitled to contact The Joint Commission and access 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 630-792-5235 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

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- 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 CAMHC 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 home care organization leaders. This chapter exemplifies that commitment.

The intent of this “Patient Safety Systems” (PS) chapter is to provide home 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 home care organizations to improve home care systems to protect patients. The first obligation of health and home 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 home 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 and home care is the degree to which its processes and results meet or exceed the needs and desires of the people it serves.1,2 Those needs and desires include safety.

The components of a quality management system should include the following:

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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 home 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 system 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. Home care organizations 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.

Unlike hospitals, the home care environment is not under the control of the home care organization. Nonetheless, home care organizations are complex environments that require strong leadership to support a safe, patient-integrated 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 in an effort to effectively coordinate and deliver home care products and services.
What Does This Chapter Contain?
The “Patient Safety Systems” (PS) chapter is intended to help inform and educate home care organizations 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 home 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 home care organizations can develop into learning organizations
- Explains how home care organizations can continually evaluate the status and progress of their patient safety systems
- Describes how home care organizations can work to prevent or respond to patient/client safety events (Sidebar 1, below, defines key terminology)
- Serves as a framework to guide home care organization leaders as they work to improve patient safety in their organizations
- Contains a list of standards and requirements related to patient/client 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.

continued on next page
Sidebar 1. (continued)

- **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

- **Close call** or “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.

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**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 home care organization must have a fair and just safety culture, a strong reporting system, and a commitment to put that

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1 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.
data to work by driving improvement. Each of these require the support and active
gengagement of home care organization leadership to support and nurture the just and
safe culture.

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 home care organization can define the problem, identify solutions,
achieve sustainable results, and disseminate the changes or lessons learned to the rest of
the home care organization. In a learning organization, the home care organization
provides staff with information regarding improvements based on reported concerns.
This helps foster trust that encourages further reporting.

The Role of Home Care Organization Leaders in Patient Safety

Leaders provide the foundation for an effective patient safety system by doing the
following:

- Promoting learning
- Motivating staff to uphold a fair and just safety culture
- Providing a transparent environment in which quality measures and patient harms
  are freely shared with staff
- Modeling professional behavior
- Removing intimidating behavior that might prevent safe behaviors, while creating
  and maintaining a culture of safety and quality throughout the organization
- Providing the resources and training necessary to take on improvement initiatives

For these reasons, many of the standards that are focused on the home care
organization’s patient safety system appear in the Joint Commission’s Leadership (LD)
standards, including Standard LD.04.04.05 (which focuses on creating and maintaining
a culture of safety and quality throughout the organization).

Without the support of home care organization leaders, sustainable organizationwide
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. Thus, leadership should take on a long-term commitment to transform the
home care organization.
Safety Culture

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

The safety culture of a home care organization 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. Home care organizations that have a robust safety culture are characterized by communications founded on mutual trust, by shared perceptions of the importance of safety, and by confidence in the efficacy of preventive measures. 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.
- Safety as everyone’s first priority.
- 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.
- 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. 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.
- 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. 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.
- By reporting and learning from patient safety events, staff create a learning organization.
A safety culture operates effectively when the home care organization fosters a cycle of trust, reporting, and improvement.\textsuperscript{10,15} In home care organizations 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 home care organizations can use these reports to inform their improvement efforts. In the trust-report-improve cycle, leaders foster trust, which enables staff to report, which enables the home care organization 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.)

![Figure 1. The Trust-Report-Improve Cycle with Robust Process Improvement™ (RPI)](image)

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 home care organization are addressed, so as not to inhibit others from reporting safety concerns.\textsuperscript{16} 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 \textbf{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 home care organizations 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% reported that they had encountered impatience with questions or had been hung up on during a phone conversation.

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, home care organizations 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 LD.04.04.05, EP 6, which requires leaders to provide and encourage the use of systems for blame-free reporting of a system or process failure or the results of proactive risk assessments. Reporting enables both proactive and reactive risk reduction. Proactive risk reduction solves problems before patients/clients 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. Refer to Standard LD.04.01.05, EP 4, which requires that staff are held accountable for their responsibilities.

It is important to note that for some actions for which 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.

Sidebar 2. Assessing Staff Accountability
The aim of a safety culture is not a "blame-free" culture but one that balances learning with accountability. To achieve this, it is essential that leaders assess errors and patterns of behavior in a manner that is applied consistently, with the goal of eliminating behaviors that undermine a culture of safety. There has to exist within the continued on next page
Sidebar 2. (continued)

home care organization a clear, equitable, and transparent process for recognizing and separating the blameless errors that fallible humans make daily from the unsafe or reckless acts that are blameworthy.\textsuperscript{1–10}

There are a number of sources for information (some of which are listed immediately following) 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}

References


\textit{continued on next page}
Sidebar 2. (continued)

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Data Use and Reporting Systems

An effective culture of safety is evidenced by a robust reporting system and use of measurement to improve. When home care organizations adopt a transparent, nonpunitive approach to reports of patient safety events or other concerns, the organization 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. Home care organizations should note that this is but one type of data among many that should be collected and used to drive improvement.

When there is continuous reporting for adverse events, close calls, and hazardous conditions, the home care organization 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 PI.01.01.01, which requires home care organizations to collect data to monitor their performance, and Standard LD.03.02.01, which requires organizations to use data and information to guide decisions and to understand variation in the performance of processes supporting safety and quality.

Home care organizations can engage frontline staff in internal reporting in a number of ways, including the following:
- Create a nonpunitive approach to patient safety event reporting
- 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 home care organizations 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.\(^{25}\) The effective use of data enables home care organizations to identify problems, prioritize issues, develop solutions, and track to determine success.\(^{9}\) Objective data can be used to support decisions, influence people to change their behaviors, and to comply with evidence-based care guidelines.\(^{9,26}\)
The Joint Commission and the Centers for Medicare & Medicaid Services (CMS) both require home care organizations to collect and use data related to adverse patient events, incidents, or outcomes and patient harms. Some key Joint Commission standards related to data collection and use require home care organizations to do the following:

- Identify risks for acquiring and transmitting infection (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 inpatient hospices) 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 home care organization 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 home care organization to monitor the performance of a system, detect variation, and identify opportunities to improve. This can help the home care organization not only understand the current performance of organizational systems but also can help it predict its performance going forward.23

Analyzing data with tools such as run charts, statistical process control (SPC) charts, and capability charts helps a home care organization determine what has occurred in a system and provides clues as to why the system responded as it did.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 Chart¹</td>
<td>- When the home care organization needs to identify variation within a system</td>
<td><img src="image1" alt="Run Chart Example" /></td>
</tr>
<tr>
<td></td>
<td>- When the home care organization needs a simple and straightforward analysis of a system</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- As a precursor to an SPC chart</td>
<td></td>
</tr>
<tr>
<td>Statistical Process Control Chart</td>
<td>- When the home care organization needs to identify variation within a system and find indicators of why the variation occurred</td>
<td><img src="image2" alt="Statistical Process Control Chart Example" /></td>
</tr>
<tr>
<td></td>
<td>- When the home care organization needs a more detailed and in-depth analysis of a system</td>
<td></td>
</tr>
<tr>
<td>Capability Chart²</td>
<td>- When the home care organization needs to determine whether a process will function as expected, according to requirements or specifications</td>
<td><img src="image3" alt="Capability Chart Example" /></td>
</tr>
</tbody>
</table>

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

After data has been turned into information, leadership should ensure the following (per the requirements shown):  

- 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

Sidebar 3. Strategies for an Effective Risk Assessment

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

- Describe the chosen process (for example, through the use of a flowchart).
- Identify ways in which the process could break down or fail to perform its desired function, which are often referred to as “failure modes.”
- Identify the possible effects that a breakdown or failure of the process could have on 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.
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 admissions. 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 home care organizations assess and enhance patient activation. Achieving this requires leadership engagement in the effort to establish patient-centered care as a top priority throughout the home care organization. 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 home care organization 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.

Home care organizations 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 home care organizations seeking to improve patient activation. These standards require that organizations 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 home care organizations 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 home care organizations guidance and support when they experience a sentinel event. Organizations can call the Sentinel Event Hotline (630-792-3700) to clarify whether a 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 home care organization’s comprehensive systematic analysis as well as the action plan to help the home care organization prevent the hazardous or unsafe conditions from occurring again.

- **Joint Commission Center for Transforming Healthcare**: A Joint Commission not-for-profit affiliate that offers highly effective, durable solutions to health care’s most critical safety and quality problems to help hospitals and home care organizations transform into high reliability organizations. For specific quality and patient problems, the Center’s Targeted Solutions Tool™ (TST) guides home 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, handoff 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

- **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

- **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 waived testing, restraint and seclusion, management of hazardous waste, environment of care (including Standards EC.04.01.01 and EC.04.01.03), and sample collection. And one that is particularly useful for home care is the BoosterPak on oxygen safety.
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 home care organizations and reviewed by Joint Commission standards experts.

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

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

References

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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 organization notifies the public it serves about how to contact its organization 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 organization’s website.

**Elements of Performance for APR.09.01.01**

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

2. The organization 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, or services can report concerns about safety or the quality of care to The Joint Commission without retaliatory action from the organization.

**Elements of Performance for APR.09.02.01**

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

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

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

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

Elements of Performance for EC.04.01.01

1. The organization establishes and implements a process(es) for internally reporting, investigating, and documenting the following:
   - Injuries to patients, staff, or others within the organization’s facilities
   - Security incidents involving patients, staff (including staff in the field), or others
   - Hazardous materials and waste spills and exposures
   - Fire safety management problems, deficiencies, and failures

   **Note 1:** This bullet on fire safety management is applicable only for inpatient hospice, ambulatory infusion, and facility-based rehabilitation technology.
   - Equipment management problems, failures, and use errors.
   - Utility systems management problems, failures, or use errors.

   **Note 2:** This bullet on utility systems management is applicable only for inpatient hospice, ambulatory infusion, and facility-based rehabilitation technology.

17. The organization identifies, reports within the organization, and investigates equipment management problems, failures, and use errors for equipment provided to the patient.

18. The organization investigates any incident or injury in which equipment or supplies may have contributed to the incident or injury.

   **Note:** The investigation includes all necessary information, pertinent conclusions about what happened, and whether changes in systems or processes are needed. The organization considers possible links between the items and services furnished and the adverse event.

19. **For DMPOPOS suppliers serving Medicare beneficiaries:** When the supplier becomes aware of an incident or injury resulting in a Medicare beneficiary’s hospitalization or death, it initiates an investigation within 24 hours.

20. **For DMPOPOS suppliers serving Medicare beneficiaries:** When the supplier becomes aware of an incident or injury that does not result in a Medicare beneficiary’s hospitalization or death, it initiates an investigation within 72 hours.
21. The organization reports incidents in which a medical device is connected to the death, serious injury, or serious illness of any individual, as required by the Safe Medical Devices Act of 1990.

Infection Prevention and Control (IC)

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

Elements of Performance for IC.01.03.01
1. The organization identifies infection risks based on the following:
   - Its geographic location, community, and population served
   - The care, treatment, or services it provides
   - The analysis of its surveillance activities and other infection control data

   **Note 1:** Surveillance activities may address processes and/or outcomes.

   **Note 2:** For organizations that provide personal care and support services:
   Surveillance activities may include verification of infection control education for all employees and supervisor observations of employees' hand-washing techniques.

3. The organization prioritizes the identified risks for acquiring and spreading infections. These prioritized risks are documented.

Leadership (LD)

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

Elements of Performance for LD.02.01.01
1. Leaders work together to create the organization’s mission, vision, and goals.
2. The organization’s mission, vision, and goals guide the actions of leaders.
3. Leaders communicate the mission, vision, and goals to staff and the population(s) the organization serves.
Standard LD.03.01.01
Leaders create and maintain a culture of safety and quality throughout the organization.

Elements of Performance for LD.03.01.01
1. Leaders regularly evaluate the culture of safety and quality.
2. Leaders prioritize and implement changes identified by the evaluation.
4. Leaders develop a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety.
5. Leaders create and implement a process for managing behaviors that undermine a culture of safety.

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

Elements of Performance for LD.03.02.01
1. Leaders set expectations for using data and information to improve the safety and quality of care, treatment, or services.
3. The organization uses processes to support systematic data and information use.
4. Leaders provide the resources needed for data and information use, including staff, equipment, and information systems.
5. The organization uses data and information in decision making that supports the safety and quality of care, treatment, or services. *(See also PI.02.01.01, EP 8)*
6. The organization uses data and information to identify and respond to internal and external changes in the environment.
7. Leaders evaluate how effectively data and information are used throughout the organization.
8. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program uses patient satisfaction data that are specific to the care, treatment, and services it provides in order to improve care of patients and families.

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
Standard LD.03.03.01

Leaders use organizationwide 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. Leaders can describe how planning supports a culture of safety and 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, or services.
5. Safety and quality planning is organizationwide.
6. Planning activities adapt to changes in the environment.
7. Leaders evaluate the effectiveness of planning activities.
8. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The program leaders communicate with and educate the organization in order to gain recognition of and support for the program.
9. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The program leaders secure the resources it requires from the organization in order to meet the scope of care, treatment, and services it provides.
10. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: Organization and program leaders support participation in continuing education by providing or facilitating access to ongoing continuing education in palliative care for the interdisciplinary team members and program staff.

Standard LD.03.04.01

The organization communicates information related to safety and quality to those who need it, including staff, 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. Leaders are able to describe how communication supports a culture of safety and quality.

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

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

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

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

7. Leaders evaluate the effectiveness of communication methods.

8. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** Upon request, the program provides the public with information about its performance improvement activities.

   **Note:** This information can be general in nature and consist of patient satisfaction data or general information about how the program improves its performance.

**Standard LD.03.05.01**

Leaders implement changes in existing processes to improve the performance of the organization.

**Elements of Performance for LD.03.05.01**

1. Structures for managing change and performance improvements exist that foster the safety of the patient and the quality of care, treatment, or services.

2. Leaders are able to describe how the organization’s approach to performance improvement and its capacity for change support a culture of safety and quality.

3. The organization has a systematic approach to change and performance improvement.

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

5. Leaders maintain quality and safety while major changes and improvements are being carried out.

6. The organization’s internal structures can adapt to changes in the environment.
7. Leaders evaluate the effectiveness of processes for the management of change and performance improvement.

**Standard LD.03.06.01**

Those who work in the organization are focused on improving safety and quality.

**Elements of Performance for LD.03.06.01**

1. Leaders design work processes to focus individuals on safety and quality issues.

2. Leaders are able to describe how those who work in the organization support a culture of safety and quality.

3. Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, or services. *(See also IC.01.01.01, EP 3)*  
   **Note:** For hospices providing inpatient care in their own facilities: Staffing for all services should reflect the volume of patients, patient acuity, and the intensity of services needed to achieve the outcomes described in patients’ plans of care and to avoid negative outcomes.

4. Those who work in the organization are competent to complete their assigned responsibilities.

6. Leaders evaluate the effectiveness of those who work in the organization to promote safety and quality.

10. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program has dedicated leadership and staff necessary to meet the scope of care, treatment, and services it provides.

11. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program leaders coach and mentor staff in order to improve their ability to provide care, treatment, and services in a manner that builds mutual trust with the patient and family.

12. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** Program leaders provide clinical support and guidance to promote staff’s confidence in their ability to provide palliative care for patients.

13. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program provides for emotional support for leaders, members of the interdisciplinary team, staff, and volunteers.
Note: Emotional support is especially important in helping manage the stress of caring for seriously ill palliative care patients and their families.

Standard LD.04.01.01
The organization complies with law and regulation.

Elements of Performance for LD.04.01.01

1. ☑️ The organization is licensed, is certified, or has a permit, in accordance with law and regulation, to provide the care, treatment, or services for which the organization is seeking accreditation from The Joint Commission.† (See also MC.03.06.01, EP 1)

Note 1: For home health agencies and hospices that elect to use The Joint Commission deemed status option: If state or local law requires licensure of home health agencies or hospices, then the home health agency or hospice must be licensed.

Note 2: Applicable law and regulation include, but are not limited to, individual and facility licensure, certification, US Food and Drug Administration regulations, Drug Enforcement Agency regulations, Centers for Medicare & Medicaid Services regulations, Occupational Safety and Health Administration regulations, Department of Transportation regulations, Health Insurance Portability and Accountability Act, and other local, state, and federal laws and regulations.

Note 3: Each service location that performs laboratory testing (waived or nonwaived) must have a Clinical Laboratory Improvement Amendments of 1988 (CLIA ‘88) certificate as specified by the federal CLIA regulations (42 CFR 493.55 and 493.3) and applicable state laws. (See also WT.01.01.01, EP 1; WT.04.01.01, EP 1)

2. The organization provides care, treatment, or services in accordance with licensure requirements, laws, and rules and regulations. (See also MC.03.06.01, EP 1; MC.04.02.01, EP 1)

Note: For home health agencies that elect to use The Joint Commission deemed status option: Organizations that furnish outpatient physical therapy or speech-language pathology services must meet federal requirements at §42 CFR 484.38 in

† For more information on how to obtain a CLIA certificate, see http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/How_to_Apply_for_a_CLIA_Certificate_International_Laboratories.html.

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
addition to health and safety requirements at §42 CFR 485.711, 485.713, 485.715, 485.719, 485.723, and 485.727. For the federal definition of outpatient physical therapy services, see 1861(p) of the Social Security Act.

3. Leaders act on or comply with reports or recommendations from external authorized agencies, such as accreditation, certification, or regulatory bodies. (See also MC.03.06.01, EP 1)

10. The organization displays all licenses, certificates, and permits to operate in an area accessible to customers and patients.

13. For DMEPOS suppliers serving Medicare beneficiaries: The supplier complies with Medicare statutes, regulations, manuals, program instructions, and contractor policies and articles.

**Standard LD.04.01.05**

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

**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.

3. The organization defines, in writing, the responsibility of those with administrative and clinical direction of its programs, services, sites, or departments.

4. Staff are held accountable for their responsibilities.

5. Leaders provide for the coordination of care, treatment, or services among the organization’s different programs, services, sites, or departments.

14. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The program makes staff throughout the organization aware of the program’s objectives and the process for referring patients to the program.

15. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: Program leaders integrate the care, treatment, and services provided by the program with those of the organization.
Standard LD.04.04.01
Leaders establish priorities for performance improvement. (Refer to the “Performance Improvement” [PI] chapter.)

Elements of Performance for LD.04.04.01

1. Leaders set priorities for performance improvement activities and patient health outcomes. *(See also PI.01.01.01, EPs 1 and 3)*
   
   **For home health agencies and hospices that elect to use The Joint Commission deemed status option:** The organization’s governing body is ultimately accountable for making sure that the priorities that are selected address improvements to the safety and quality of patient care.

2. Leaders give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities. *(See also PI.01.01.01, EPs 14 and 15)*

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

4. Performance improvement occurs organizationwide.

8. **For home health agencies and hospices that elect to use The Joint Commission deemed status option:** The organization has an ongoing, organization-wide, data-driven quality assessment and performance improvement program.
   
   **For hospices that elect to use The Joint Commission deemed status option:** This program is evaluated annually.
   
   **Note:** The organization’s governing body is ultimately accountable for the development, implementation, maintenance, and evaluation of the quality assessment and improvement program.

9. **For home health agencies and hospices that elect to use The Joint Commission deemed status option:** The organization’s governing body is responsible for making sure the quality assessment and performance improvement program (QAPI) meets the following criteria:
   
   - Reflects the complexity of the organization and its services
   - Involves all services provided by the organization, including those provided under contract or arrangement
   - Takes actions to demonstrate improvement in the organization’s performance...
For home health agencies that elect to use The Joint Commission deemed status option: The QAPI program focuses on indicators related to improved outcomes, including hospital admissions, hospital readmissions, and the use of emergent care services.

For hospices that elect to use The Joint Commission deemed status option: The QAPI program focuses on indicators that are related to improved palliative outcomes.

10. ⬤ For home health agencies and hospices that elect to use The Joint Commission deemed status option: The organization maintains documentation of the quality assessment and performance improvement program and is able to demonstrate its operation.

11. For hospices that elect to use The Joint Commission deemed status option: The quality assessment and performance improvement program demonstrates improvement in the indicators related to improved palliative outcomes and hospice services.

12. For hospices that elect to use The Joint Commission deemed status option: The hospice uses quality indicator data, including patient care and other relevant data, in the design of its quality assessment and improvement program.

13. For hospices that elect to use The Joint Commission deemed status option: The hospice selects performance improvement activities that affect palliative outcomes, patient safety, and the quality of care and that are based on the prevalence and severity of problems in its high-volume, high-risk, and problem-prone areas.

14. For hospices that elect to use The Joint Commission deemed status option: The governing body designates one or more individuals to be responsible for operating the quality assessment and performance improvement program.

15. For hospices that elect to use The Joint Commission deemed status option: Licensed professionals participate in the hospice’s quality assessment and performance improvement program.

27. ⬤ For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The program has a written performance improvement plan.
28. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program sets performance improvement priorities and describes how the priorities are adjusted in response to unusual or urgent events.

29. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program plans process and performance improvement activities to encompass multiple disciplines and/or settings.

30. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program implements its performance improvement plan.

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**Standard LD.04.04.05**

The organization has an organizationwide, integrated patient safety program.

**Elements of Performance for LD.04.04.05**

1. The leaders implement an organizationwide patient safety program.

   **Note 1:** *For home health agencies and hospices that elect to use The Joint Commission deemed status option:* The governing body is ultimately accountable for the development, implementation, maintenance, and evaluation of the patient safety program.

   **Note 2:** *For home health agencies that elect to use The Joint Commission deemed status option:* The patient safety program establishes, implements, and maintains clear expectations for patient safety.

   **Note 3:** *For hospices that elect to use The Joint Commission deemed status option:* This program is evaluated annually.

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

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

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

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

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)

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

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

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

11. To improve safety, the organization analyzes and uses information about system or process failures and, when conducted, the results of proactive risk assessments. (See also LD.04.04.03, EP 3)
12. The leaders disseminate lessons learned from comprehensive systematic analyses (for example, root cause analyses), system or process failures, and the results of proactive risk assessments to all staff who provide services for the specific situation. (See also LD.03.04.01, EP 5)

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

14. Leaders facilitate mandatory reporting of significant adverse events, and voluntary reporting of such events to programs in which the organization participates.

   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.

15. For home health agencies and hospices that elect to use The Joint Commission deemed status option: The organization tracks adverse patient events, analyzes their causes, and implements preventive actions and mechanisms that include feedback and learning throughout the organization.

Medication Management (MM)

Standard MM.07.01.03
The organization responds to actual or potential adverse drug events, significant adverse drug reactions, and medication errors.

Elements of Performance for MM.07.01.03
1. The organization has a written process to respond to actual or potential adverse drug events, significant adverse drug reactions, and medication errors.
   (See also MC.02.01.13, EP 2)

   Note: This element of performance is also applicable to sample medications.
2. The organization 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 organization 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 organization implements its process for responding to adverse drug events, significant adverse drug reactions, and medication errors. *(See also MC.02.01.13, EP 2)*

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

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**Standard MM.08.01.01**

The organization evaluates the effectiveness of its medication management processes.

**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 organization collects data on the performance of its medication management processes. *(See also PI.01.01.01, EPs 14 and 15)*

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

2. The organization analyzes data on its medication management processes.

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

3. The organization compares data over time to identify risk points, levels of performance, patterns, trends, and variations of its medication management processes.

   **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 organization identifies opportunities for improvement in its medication management processes.
6. The organization takes action on improvement opportunities identified as priorities for its medication management processes. *(See also PI.03.01.01, EP 2)*

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

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

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

9. The primary pharmacy includes input from the long term care facility when evaluating its medication management system.

10. The long term care pharmacy or consultant pharmacist provides education to the long term care facility regarding the processes to reduce medication errors.

11. The long term care pharmacy or consultant pharmacist provides education to the long term care facility regarding the collection and use of medication management performance measures.

12. The long term care pharmacy or consultant pharmacist provides education to the long term care facility regarding processes to minimize medication waste.

13. The clinical or consultant pharmacist provides a written report regarding identified medication management problems to the long term care clinical and administrative leaders, and to other health professionals responsible for dispensing medications.

14. The clinical or consultant pharmacist helps to prioritize and develop an action plan to resolve problems associated with medication management.

15. In collaboration with the long term care facility, the primary pharmacy implements improvements to its medication management processes based on its evaluation.

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**Provision of Care, Treatment, and Services (PC)**

**Standard PC.03.05.19**

The organization reports deaths associated with the use of restraint and seclusion.
Elements of Performance for PC.03.05.19

1. For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option: The organization reports the following information to the Centers for Medicare & Medicaid Services (CMS):
   - Each unexpected death that occurs while a patient is in restraint or seclusion
   - Each unexpected death that occurs within 24 hours after the patient has been removed from restraint or seclusion
   - Each death known to the organization 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

   **Note:** This element of performance 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.
Accreditation Participation Requirements (APR)

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

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

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

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

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

IV. Performance Measurement
   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)

X. Federal Requirements—Not applicable to home care

XI. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option
   A. Representation of Certification (APR.11.01.01)
   B. Type of Measures and Data Collection (APR.11.02.01)
   C. Sharing of Performance Measure Data (APR.11.03.01)
**Applicability for Accreditation Participation Requirements**

This grid is meant to be a resource to determine which standards and elements of performance (EPs) apply to the service categories within the Home Care Accreditation Program. The column on the far left of the grid lists the related EPs vertically by number. Service categories (defined in Table 3 of the Introduction) are listed horizontally along the top of the grid. Applicability is indicated with an “X” in a service category column.

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Requirements, Rationales, and Elements of Performance

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

Element of Performance for APR.01.01.01

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

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

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

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

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

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

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

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

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

   **Note 3:** For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: This standard also applies to the organization throughout the certification process.

**APR.01.03.01**

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

Element of Performance for APR.01.03.01

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

   **Note 1:** When the organization changes ownership, control, location, capacity, or services offered, it may be necessary for The Joint Commission to survey the organization again. If the organization does not provide written notification to The Joint Commission within 30 days of these changes, the organization could lose its accreditation.
**Note 2:** The hospice, home health agency, or DMEPOS supplier is also required to disclose to the Centers for Medicare & Medicaid Services or the Medicare administrative contractor or fiscal intermediary, the names and addresses of its owners, those with a controlling interest in the organization, or any subcontractor in which the organization directly or indirectly has a 5% or more ownership interest. The home health agency must also disclose the name and business address of the corporation, association, or other company that is responsible for the management of the home health agency, and the names and addresses of the chief executive officer and the chairperson of the board of directors of that corporation, association, or other company responsible for the management of the home health agency.

**Note 3:** For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The organization reports any changes in the information provided in the application for certification and any changes made between surveys.

**APR.02.01.01**

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

**Element of Performance for APR.02.01.01**

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

**APR.03.01.01**

The organization fulfills requirements for Focused Standards Assessment.

**Rationale for APR.03.01.01**

The Focused Standards Assessment (FSA) helps organizations incorporate The Joint Commission standards into routine daily operations. When organizations use the FSA tool to self-assess, monitor, and improve services, 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 organization, at 12 and 24 months after its full triennial survey, updates and submits to The Joint Commission the full Focused Standards Assessment (FSA) and its Plan of Action on any recommendations cited. (Refer also to the “Focused Standards Assessment [FSA]” section in “The Accreditation Process” [ACC] chapter.)
Note 1: For organizations that select Options 1, 2, or 3, the requirement to transmit the FSA and its Plan of Action to The Joint Commission may not apply in part or in whole.

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

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

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

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

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

6. ☐ The organization exercising Option 2 for the Focused Standards Assessment agrees to undergo a limited survey and then submit a Plan of Action for recommendations cited as a result of the survey.

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

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

APR.04.01.01

For home health agencies and hospices that elect to use The Joint Commission deemed status option: The organization uses performance measures relevant to the services it provides and the population(s) it serves.

Element of Performance for APR.04.01.01

27. For home health agencies and hospices that elect to use The Joint Commission deemed status option: The organization measures, analyzes, and tracks quality indicators that include adverse patient events and other aspects of performance that enable the organization to assess its processes of care, services, and operations. (Refer to PI.01.01.01.)
APR.05.01.01
The organization allows The Joint Commission to review the results of external evaluations from publicly recognized bodies.

Rationale for APR.05.01.01
In order to conduct a meaningful accreditation survey, The Joint Commission collects information on many aspects of the organization’s performance. External bodies other than The Joint Commission evaluate areas related to safety and quality. These evaluations complement accreditation reviews but may have a different focus or emphasis. These evaluations may contain information The Joint Commission needs to make accreditation decisions.

Elements of Performance for APR.05.01.01
1.  If When requested, the organization provides The Joint Commission with all official records and reports of licensing, examining, reviewing, or planning bodies.
2.  If When requested, the supplier of medical equipment provides government officials or their authorized agents with copies of reports from licensing, examining, reviewing, or planning bodies.

APR.06.01.01
Applicants and accredited organizations do not use Joint Commission employees to provide accreditation-related consulting services.

Element of Performance for APR.06.01.01
1. The organization does not use Joint Commission employees to provide any accreditation-related or certification-related consulting services.

Note: Consulting services include, but are not limited to, the following:
- Helping the organization to meet Joint Commission standards
- Helping the organization to meet Joint Commission Community-Based Palliative Care certification standards
- Helping the organization to complete its Focused Standards Assessment (FSA)
- Assisting the organization in remedying areas identified in its FSA as needing improvement
- Conducting mock surveys
**APR.07.01.01**
The organization accepts the presence of Joint Commission surveyor management staff or a Board of Commissioners member in the role of observer of an on-site survey.

**Element of Performance for APR.07.01.01**

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

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

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

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

**Elements of Performance for APR.08.01.01**

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

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

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

**Elements of Performance for APR.09.01.01**

1. The organization informs the public it serves about how to contact its management to report concerns about patient safety and quality of care.
2. The organization 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, or services can report concerns about safety or the quality of care to The Joint Commission without retaliatory action from the organization.

**Rationale for APR.09.02.01**

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

**Elements of Performance for APR.09.02.01**

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

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

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

**APR.09.03.01**

The organization is truthful and accurate when describing information in its Quality Report to the public.

**Element of Performance for APR.09.03.01**

1. The organization adheres to The Joint Commission’s published guidelines for how it describes information in its Quality Report.
APR.09.04.01
The organization provides care, treatment, services, and an environment that pose no risk of an “Immediate Threat to Health or Safety,” also known as “Immediate Threat to Life” or ITL situation.

Element of Performance for APR.09.04.01
1. The organization provides care, treatment, services, and an environment that pose no risk of an “Immediate Threat to Health or Safety,” also known as “Immediate Threat to Life” or ITL situation.

APR.11.01.01
For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The organization accurately represents its certification status and the facilities and services to which Joint Commission certification applies.

Elements of Performance for APR.11.01.01
1. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The organization’s advertising accurately reflects the scope of facilities and services that are certified by The Joint Commission.
2. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The organization does not engage in any false or misleading advertising about its certification award.

APR.11.02.01
For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The organization uses performance measures relevant to the services provided and populations served.

Elements of Performance for APR.11.02.01
1. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: A minimum of 4 performance measures must be identified by the program.
2. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: A minimum of 2 of the 4 identified performance measures must be clinical in nature.
3. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** Organizations seeking this certification are required to have collected performance measure data for a minimum of 4 months prior to the initial on-site certification survey.

4. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The organization collects performance measure data; analyzes the data internally; and generates run charts, control charts, or other appropriate applicable performance improvement tools, showing monthly data points, for use in performance improvement activities.

**APR.11.03.01**

For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The organization submits performance measurement data to The Joint Commission on a routine basis.

**Elements of Performance for APR.11.03.01**

1. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The organization continues to use a measure if data suggests an unstable pattern of performance or identifies an opportunity for improvement.

2. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The organization changes to a new measure if data reflects continuing stable and satisfactory performance.

3. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The organization makes its performance measure data available during on-site certification reviews.

4. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The organization submits data on performance measures to The Joint Commission upon request at the time of the intracycle and recertification reviews.
Prompts to Assess Your Compliance

Please note: Tips do not represent new accreditation requirements. They are intended to provide helpful strategies for standards compliance.

When is the Intracycle Monitoring process due? Will you complete a full Focused Standards Assessment (FSA) or one of the three options?

TIP: Start the annual evaluation early, so the report is thorough and thoughtful.

Who is responsible for updating and maintaining the electronic application (E-App) for survey? When was the E-App last updated? When was the last time you updated your organization’s average daily census in the E-App?

How were staff and the public informed about reporting concerns to The Joint Commission?
Written Documentation Checklist
This worksheet lists elements of performance (EPs) that require written documentation that a surveyor could ask to see during a survey to show compliance with a standard. (Note: Documentation can be on paper or in an electronic format.)

Accreditation Participation Requirements (APR)

<table>
<thead>
<tr>
<th>√</th>
<th>Standard</th>
<th>EP</th>
<th>Accreditation Participation Requirement Standards</th>
<th>Home Care Service</th>
<th>Date last verified</th>
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<tr>
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<td>APR.01.03.01</td>
<td>1</td>
<td>The organization notifies The Joint Commission in writing within 30 days of a change in ownership, control, location, capacity, or services offered.</td>
<td>All services and CBPC Certification</td>
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|   | APR.03.01.01 | 1, 3, 4, 6 | EP 1—The organization, at 12 and 24 months after its full triennial survey, updates and submits to The Joint Commission the full Focused Standards Assessment (FSA) and its Plan of Action on any recommendations cited.  
EP 3—The organization exercising Option 1, 2, or 3 for the Focused Standards Assessment (FSA) attests at 12 and 24 months after its full triennial survey that the organization has decided not to participate in the submission of the full FSA.  
EP 4—The organization exercising Option 1 for the Focused Standards Assessment (FSA) completes an FSA and Plan of Action.  
EP 6—The organization exercising Option 2 for the Focused Standards Assessment agrees to undergo a limited survey and then submit a Plan of Action for recommendations cited as a result of the survey. | All services |                    |
|   | APR.05.01.01 | 1, 2 | EP 1—When requested, the organization provides The Joint Commission with all official records and reports of licensing, examining, reviewing, or planning bodies. | EP 1—All services |                    |
| APR.11.02.01 4 | EP 2—When requested, the supplier of medical equipment provides government officials or their authorized agents with copies of reports from licensing, examining, reviewing, or planning bodies. | EP 2—CRS, RESP, OP, SUPP, RT, DME |
| APR.11.03.01 3 | EP 3—For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The organization makes its performance measure data available during on-site certification reviews. | CBPC Certification, HH (HH), HOS |
| APR.11.02.01 4 | EP 4—For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The organization collects performance measure data; analyzes the data internally; and generates run charts, control charts, or other appropriate applicable performance improvement tools, showing monthly data points, for use in performance improvement activities. | CBPC Certification, HH (HH), HOS |
# Action Planning Tool

Use this form to track noncompliant elements of performance (EPs) and your action steps for bringing them into compliance.

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<th>Standard and EP</th>
<th>Observation/Issue</th>
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Chapter Notes

Use this page to take notes about ideas for meeting the standards in this chapter, your organization’s policies and procedures that address requirements in this chapter, or the data or patient record numbers used to determine compliance or noncompliance for EPs. If a standard is found not compliant, it can be helpful to know which data were used so they can be easily accessed when developing action plans for compliance.
Environment of Care (EC)

Overview
The goal of this chapter is to promote a safe, functional, and supportive environment within the organization so that quality and safety are preserved. The environment of care is made up of three basic elements:

- The building or space, including how it is arranged and special features that protect 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 organization, 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, or services. Any organization, regardless of its size or location, faces risks in the environment, including those associated with safety and security, fire, hazardous materials and waste, 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 of results. The chapter calls for written plans for managing risks in each of these areas. Organizations may choose to address all required components of the environment in a single management plan or in several different plans. If an organization has multiple sites, it may have separate management plans for each of its locations, or it may choose to have one comprehensive set of plans. In any case, the organization must address specific risks and the unique conditions at each of its sites.

The standards address the need to identify someone to manage environmental risks as well as to intervene when situations threaten people or property; both responsibilities may be assigned to one person. It is important to remember that the standards in this chapter do not prescribe a particular structure (such as a safety committee) or individual (such as one employee hired to be a safety officer) for managing the environment, nor do they prescribe how required planning activities are conducted.
Important aspects of the environment addressed in the standards include the following:

- Safety and security. This section addresses risks in the physical environment, access to security-sensitive areas, product recalls, and smoking.
- Hazardous materials 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, 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 organization that provides care, treatment, or services in space it does not own (for example, in leased or complimentary space) may need to communicate with the property owner about maintenance expectations for building equipment and features not under its control. For example, an organization such as this needs access to the maintenance documents. This organization and the property owner may want to discuss any building or equipment problems that could adversely affect the safety or health of patients, staff, and other people coming to the organization, as well as the property owner’s plan to resolve such issues.

2. A number of elements of performance describe time frames for completing certain tasks or functions. The Joint Commission recognizes that it will not always be possible to meet the exact time frames cited in the requirements. For evaluation purposes, therefore, the following intervals are acceptable:
   - Every 36 months/every 3 years = 36 months from the last event, plus or minus 45 days
   - Annually/every 12 months/once a year/every year = 1 year from the last event, plus or minus 30 days

\[ \text{Life Safety Code}^* \] is a registered trademark of the National Fire Protection Association, Quincy, MA.
- Every 6 months = 6 months from the last event, plus or minus 20 days
- Quarterly/every quarter = every three months, plus or minus 10 days
- Monthly/30-day intervals/every month = 12 times a year, once per calendar month
- Every week = once per calendar week
Chapter Outline

I. Plan—Not applicable to home care

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. Utilities (EC.02.05.01, EC.02.05.03, EC.02.05.05, EC.02.05.07, EC.02.05.09)
   E. Other Physical Environment Requirements (EC.02.06.01)

III. Staff Demonstrate Competence—Not applicable to home care

IV. Monitor and Improve (EC.04.01.01, EC.04.01.03)
Applicability for Environment of Care

This grid is meant to be a resource to determine which standards and elements of performance (EPs) apply to the service categories within the Home Care Accreditation Program. The column on the far left of the grid lists the related EPs vertically by number. Service categories (defined in Table 3 of the Introduction) are listed horizontally along the top of the grid. Applicability is indicated with an “X” in a service category column.

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

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Standards, Rationales, and Elements of Performance

Standard EC.02.01.01

The organization manages safety and security risks.

Note 1: For hospices that elect to use The Joint Commission deemed status option: The organization complies with the 2012 edition of NFPA 99: Health Care Facilities Code. Chapters 7, 8, 12, and 13 of the Health Care Facilities Code do not apply.

Note 2: 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.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 organization. It is important to identify these risks in advance so that the organization can prevent or effectively respond to incidents. In some organizations, safety and security are treated as a single function, although in others they are treated as separate functions.

Safety risks may arise from the structure of the physical environment, from the performance of everyday tasks, or from situations beyond the organization’s control, such as the weather. Other examples of environmental risks include the physical location of equipment and supplies, architectural barriers, infestations, mobility risks such as scatter rugs, stairs, staff safety in traveling to patient homes, and location of oxygen cylinders within the patient’s home and at the organization’s site. 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 the potential for violence to patients, violence to staff in the workplace and in the community, theft, and unrestricted access to medications. Security incidents are caused by individuals from either outside or inside the organization.

Elements of Performance for EC.02.01.01

1. The organization implements its process to identify safety and security risks associated with the environment of care that could affect all patients, all staff, and people coming to the organization’s facilities.
2. The organization identifies potential safety and security risks in the patient’s home.

3. The organization takes action to minimize identified safety and security risks.  

   **Note:** In the patient’s home, actions may be limited to education.

4. The organization safely stores and handles medical gases.  

   **Note:** Safe handling and storage of medical gases should be done in a manner consistent with the Food and Drug Administration, the Department of Transportation, and the Occupational Safety and Health Administration laws and regulations.

7. The organization identifies individuals entering the organization’s buildings.

   **Note:** Determination of those individuals requiring identification and the method for doing so is at the organization’s discretion.

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

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**Standard EC.02.01.03**

The organization prohibits smoking except in specific circumstances.

**Elements of Performance for EC.02.01.03**

1. Smoking is not permitted in the organization’s buildings except for hospice patients in inpatient settings.

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

3. The organization develops criteria identifying the circumstances under which a patient may smoke.

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.

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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)

**Standard EC.02.02.01**
The organization manages risks related to hazardous materials and waste.

**Rationale for EC.02.02.01**
Hazardous materials and waste cause harm if they are not managed properly. Examples of such materials include chemicals (cleaning products, solvents, pesticides, et cetera) and hazardous energy sources. Federal, state, or local regulations often guide the handling, use, and storage of hazardous materials and waste. The organization identifies materials it uses that need special handling to minimize the risks of unsafe use and improper disposal.

**Note:** *This standard does not address oxygen because it is not a “hazardous material.” Oxygen is addressed under the safety standard (see EC.02.01.01).*

**Elements of Performance for EC.02.02.01**

1. ⚫ The organization 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 organization manages hazardous materials and waste from receipt or generation through final use or disposal.

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

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

11. ⚫ For managing hazardous materials and waste, the organization has the permits, licenses, manifests, and safety data sheets required by law and regulation.
12. The organization labels hazardous materials and waste.\(^\dagger\) Labels identify the contents and hazard warnings. \textit{(See also IC.02.01.01, EP 6)}

16. \textbf{For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:} The hospice has procedures for the routine storage and prompt disposal of trash and medical waste.

\textbf{Standard EC.02.03.01} \\
The organization manages fire risks.

\textbf{Elements of Performance for EC.02.03.01} \\
1. The organization minimizes the potential for harm from fire, smoke, and other products of combustion.

4. The organization maintains free and unobstructed access to all exits.

\textbf{Note:} This requirement applies to all buildings classified as business occupancy. The “Life Safety” (LS) chapter addresses the requirements for all other occupancy types.

9. Fire response planning identifies the specific roles of those who work within the organization at and away from a fire’s point of origin, including when and how to sound fire alarms, how to contain smoke and fire, how to use a fire extinguisher, 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.

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

\textbf{Standard EC.02.03.03} \\
The organization conducts fire drills.

\(^\dagger\) 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.
Rationale for EC.02.03.03
The organization’s plan for fire response is an important part of achieving a fire-safe environment. It is important that this response be evaluated in drill scenarios or actual fire situations in order to assess performance of staff and fire safety equipment. Testing the fire response plan should involve realistic situations, although actual evacuation of patients during the drills is not required.

Elements of Performance for EC.02.03.03

1. ☐ The organization conducts quarterly fire drills. *(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 organization may use alternative methods to notify staff instead of activating audible alarms.
   
   **Note 3:** In leased or rented facilities, drills need be conducted only in areas of the building that the organization occupies.

2. ☐ In areas where patients are housed or treated, the organization conducts one fire drill every 12 months from the date of the last drill.
   
   **Note:** In leased or rented facilities, drills need be conducted only in areas of the building that the organization occupies.

3. When quarterly fire drills are required, they are unannounced and held at unexpected times and under varying conditions. Fire drills include transmission of fire alarm signal and simulation of emergency fire conditions.
   
   **Note 1:** When drills are conducted between 9:00 P.M. and 6:00 A.M., the organization may use alternative methods to notify staff instead of activating audible alarms.
   
   **Note 2:** For full text, refer to NFPA 101-2012: 18/19: 7.1.7; 7.1; 7.2; 7.3.

4. Staff who work in buildings where patients are housed or treated participate in drills according to the organization’s fire response plan.

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

Standard EC.02.03.05
The organization maintains fire safety equipment and fire safety building features.
**Note 1:** This standard does not require organizations 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.

**Note 2:** The references to the National Fire Protection Association (NFPA) guidelines noted at the elements of performance are for information only.

**Elements of Performance for EC.02.03.05**

1. ☑ At least quarterly, the organization tests supervisory signal devices on the inventory (except valve tamper switches). The results and completion dates are documented.

   **Note 1:** For additional information on performing tests, see NFPA 72-2010: Table 14.4.5.

   **Note 2:** Supervisory signals include the following: control valves; pressure supervisory; pressure tank, pressure supervisory for a dry pipe (both high and low conditions), steam pressure; water level supervisory signal initiating device; water temperature supervisory; and room temperature supervisory.

2. ☑ Every 6 months, the organization tests vane-type and pressure-type water flow devices and valve tamper switches on the inventory. The results and completion dates are documented.

   **Note 1:** For additional information 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. ☑ Every 12 months, the organization tests duct detectors, heat detectors, manual fire alarm boxes, and smoke detectors on the inventory. The results and completion dates are documented.

   **Note:** For additional information on performing tests, see NFPA 72-2010: Table 14.4.5; 17.14.

4. ☑ Every 12 months, the organization tests visual and audible fire alarms, including speakers and door-releasing devices on the inventory. The results and completion dates are documented.
Note: For additional information on performing tests, see NFPA 72-2010: Table 14.4.5.

5. ⑥ Every 12 months, the organization tests fire alarm equipment on the inventory for notifying off-site fire responders. The results and completion dates are documented.

Note: For additional information on performing tests, see NFPA 72-2010: Table 14.4.5.

6. ⑥ For automatic sprinkler systems: The organization tests electric motor–driven fire pumps monthly and diesel engine–driven fire pumps weekly under no-flow conditions. The results and completion dates are documented.

Note: For additional guidance on performing tests, see NFPA 25-2011: 8.3.1; 8.3.2.

7. ⑥ For automatic sprinkler systems: Every six months, the organization tests water-storage tank high- and low-water level alarms. The results and completion dates are documented.

Note: For additional information on performing tests, see NFPA 25-2011: 9.3; Table 9.1.1.2.

8. ⑥ For automatic sprinkler systems: Every month during cold weather, the organization tests water-storage tank temperature alarms. The results and completion dates are documented.

Note: For additional information on performing tests, see NFPA 25-2011: 9.2.4; Table 9.1.1.2.

9. ⑥ For automatic sprinkler systems: Every 12 months, the organization tests main drains at system low point or at all system risers. The results and completion dates are documented.

Note: For additional information on performing tests, see NFPA 25-2011: 13.2.5; 13.3.3.4; Table 13.1.1.2; Table 13.8.1.

10. ⑥ For automatic sprinkler systems: Every quarter, the organization inspects all fire department water supply connections. The results and completion dates are documented.

Note: For additional information on performing tests, see NFPA 25-2011: 13.7; Table 13.1.1.2.
11. **For automatic sprinkler systems:** Every 12 months, the organization tests fire pumps under flow. The results and completion dates are documented.

   **Note:** For additional information on performing tests, see NFPA 25-2011: 8.3.3.

12. Every 5 years, the organization conducts hydrostatic and water-flow tests for standpipe systems. The results and completion dates are documented.

   **Note:** For additional guidance on performing tests, see NFPA 25-2011: 6.3.1; 6.3.2; Table 6.1.1.2.

13. Every 6 months, the organization inspects any automatic fire-extinguishing system in a kitchen. The results and completion dates are documented.

   **Note 1:** Discharge of the fire-extinguishing systems is not required.

   **Note 2:** For additional information on performing inspections, see NFPA 96-2011: 11.2.

14. Every 12 months, the organization tests carbon dioxide and other gaseous automatic fire-extinguishing systems. The results and completion dates are documented.

   **Note 1:** Discharge of the fire-extinguishing systems is not required.


15. At least monthly, the organization inspects portable fire extinguishers. The results and completion dates are documented.

   **Note 1:** There are many ways to document the inspections, such as using bar-coding equipment, using check marks on a tag, or using an inventory.

   **Note 2:** Inspections involve a visual check for the correct type of and clear and unobstructed access to fire extinguisher, in addition to a check for broken parts and full charge.

   **Note 3:** For additional information on inspection of fire extinguishers, see NFPA 10-2010: 7.2.2; 7.2.4.

16. Every 12 months, the organization performs maintenance on portable fire extinguishers, including recharging. Individuals performing annual maintenance on extinguishers are certified. The results and completion dates are documented.
**Note 1:** There are many ways to document the maintenance, such as using bar-coding equipment, using check marks on a tag, or using an inventory.

**Note 2:** For additional guidance on maintaining fire extinguishers, see NFPA 10-2010: 7.1.2; 7.2.2; 7.2.4; 7.3.1.

17. ☑ The organization conducts hydrostatic tests on standpipe occupant hoses 5 years after installation and every 3 years thereafter. The results and completion dates are documented.

**Note:** For additional guidance on hydrostatic testing, see NFPA 1962-2008: Chapter 7 and NFPA 25-2011: Chapter 6.

18. ☑ The organization operates fire and smoke dampers one year after installation and then at least every four years to verify that they fully close. The results and completion dates are documented.

**Note:** For additional guidance on performing tests, see NFPA 90A-2012: 5.4.8; NFPA 80-2010: 19.4; NFPA 105-2010: 6.5.

19. ☑ Every 12 months, the organization tests automatic smoke-detection shutdown devices for air-handling equipment. The results and completion dates are documented.

**Note:** For additional information on performing tests, see NFPA 90A-2012: 6.4.1.

20. ☑ Every 12 months, the organization tests sliding and rolling fire doors, smoke barrier sliding or rolling doors, and sliding and rolling fire doors in corridor walls and partitions for proper operation and full closure. The results and completion dates are documented.

**Note:** For full text, refer to NFPA 80-2010: 5.2.14.3; NFPA 105-2010: 5.2.1; 5.2.2.

25. ☑ The organization has 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.
26. ☐ Every 12 months, the organization tests the following:
   - Manual pull stations
   - Smoke detectors
   - Visual and audible fire alarms

   The results and completion dates are documented.

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

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 EC.02.03.05, EPs 1–20, 25 (including fire alarm and fire protection features) includes the following:
   - Name of the activity
   - Date of the activity
   - Inventory of devices, equipment, or other items
   - Required frequency of the activity
   - Name and contact information, including affiliation, of the person who performed the activity
   - NFPA standard(s) referenced for the activity
   - Results of the activity

   **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; NFPA 101-2012: 18/19, 7.2.1.5.10.1; 7.2.1.5.11.

**Standard EC.02.05.01**

The organization manages risks associated with its utility systems.

**Elements of Performance for EC.02.05.01**

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.)

4. ☐ The organization identifies, in writing, inspection and maintenance activities for all operating components of utility systems.
Note: Organizations may use different approaches to maintenance. For example, activities such as predictive maintenance, reliability-centered maintenance, interval-based maintenance, corrective maintenance, or metered maintenance may be selected to ensure dependable performance.

5. The organization identifies, in writing, the intervals for inspecting, testing, and maintaining all components of the utility systems, based on criteria such as manufacturers’ recommendations, risk levels, or organization experience.

16. In non–critical care areas, the ventilation system provides required pressure relationships, temperature, and humidity.

Note: Examples of non–critical care areas are general care nursing units; clean and soiled utility rooms in acute care areas; laboratories, pharmacies, diagnostic and treatment areas, food preparation areas, and other support departments.

18. Medical gas storage rooms and transfer and manifold rooms comply with NFPA 99-2012: 9.3.7.

19. The emergency power supply system’s equipment and environment are maintained per manufacturers’ recommendations, including ambient temperature not less than 40°F; ventilation supply and exhaust; and water jacket temperature (when required). (For full text, refer to NFPA 99-2012: 9.3.10)

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)

28. For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option: The hospice has procedures for controlling the reliability and quality of light, temperature, and ventilation/air exchanges throughout the building.

29. For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option: The hospice has procedures for controlling the reliability and quality of emergency gas and water supplies.

30. For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option: The hospice has procedures for the scheduled and emergency maintenance and repair of all equipment.
Standard EC.02.05.03
The organization has a reliable emergency electrical power source.

Rationale for EC.02.05.03
Emergency power sources are critical for operating essential equipment, utilities, and other building features during power failures. Emergency power sources must also support fire safety equipment. The source must be adequately designed and fueled so that the equipment functions properly.

Elements of Performance for EC.02.05.03
1. For facilities that were constructed, or had a change in occupancy type, or have undergone an electrical system upgrade since 1983, the organization has a Type 1 or Type 3 essential electrical system in accordance with NFPA 99, 2012 edition. This essential electrical system must be divided into three branches, including the life safety branch, critical branch, and equipment branch. Both the life safety branch and the critical branch are kept independent of all other wiring and equipment, and they transfer within 10 seconds of electrical interruption. Each branch has at least one automatic transfer switch. For additional guidance, see NFPA 99-2012: 6.4.2.2.

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

2. Alarm systems.

   **Note:** For information on 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.

   **Note:** For guidance in establishing a reliable emergency power system (that is, an essential electrical distribution system), see NFPA 99-2012: 6.4.1.1; 6.4.2.2; NFPA 110-2010: 4.1; Table 4.1(b).

5. Emergency communication systems, as required by the *Life Safety Code*.

   **Note:** For guidance in establishing a reliable emergency power system (that is, an essential electrical distribution system), see NFPA 99-2012: 6.4.2.2; NFPA 110-2010: 4.1; Table 4.1(b).
11. Emergency lighting at emergency generator locations. The organization’s emergency power system (EPS) has a remote manual stop station (with identifying label) to prevent inadvertent or unintentional operation. A remote annunciator (powered by storage battery) is located outside the EPS location.

**Note:** For guidance in establishing a reliable emergency power system (that is, an essential electrical distribution system), refer to NFPA 99-2012: 6.4.1.1.6; 6.4.1.1.17; 6.4.2.2; NFPA 110-2010: 5.6.5.6; 7.3.1.

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

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

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

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

**Standard EC.02.05.05**

The organization inspects, tests, and maintains utility systems.

**Note:** At times, maintenance is performed by an external service. In these cases, organizations are not required to possess maintenance documentation but 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 organization has a process to manage risks associated with air-quality requirements; infection control; utility requirements; noise, odor, dust, vibration; and other hazards that affect care, treatment, or services for patients, staff, and visitors.

2. The organization tests utility system components before initial use. The completion dates and test results are documented.

The organization inspects, tests, and maintains the following:

3. Utility systems. The completion dates and test results are documented.

8. The organization meets NFPA 99-2012: Health Care Facilities Code requirements related to electrical systems and heating, ventilation, and air conditioning (HVAC). (For full text, refer to NFPA 99-2012: Chapters 6 and 9)

   **Note:** For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option: The organization 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 organization inspects, tests, and maintains emergency power systems.

**Note:** This standard does not require organizations 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 organization unable to deliver safe care, treatment, or 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 organization performs a functional test of emergency lighting systems and exit signs required for egress and task lighting for a minimum duration of 30 seconds, along with a visual inspection of other exit signs. The test results and completion dates are documented. (For full text, refer to NFPA 101-2012: 7.9.3; 7.10.9; NFPA 99-2012: 6.3.2.2.11.5)

2. Every 12 months, the organization either performs a functional test of battery-powered lights on the inventory required for egress and exit signs for a duration of 1½ hours. The test results and completion dates are documented. (See also LS.02.01.20, EP 39) (For full text, refer to NFPA 101-2012: 7.9.3; 7.10.9; NFPA 99-2012: 6.3.2.2.11.5)

3. The organization performs a functional test of Level 1 stored emergency power supply systems (SEPSS) on a monthly basis and performs a test of Level 2 SEPSS on a quarterly basis. Test duration is for five minutes or as specified for its class (whichever is less). The organization performs an annual test at full load for 60% of the full duration of its class. The test results and completion dates are documented.

Note 1: Non–SEPSS battery backup emergency power systems that the organization has determined to be critical for operations during a power failure (for example, laboratory equipment or electronic 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 information, see NFPA 111-2010: 8.4

4. At least weekly, the organization inspects the emergency power supply system (EPSS), including all associated components and batteries. The results and completion dates of weekly inspections are documented. (For full text, refer to NFPA 110-2010: 8.3.1; 8.3.3; 8.3.4; 8.4.1)
5. At least monthly, the organization tests each emergency generator under load for at least 30 continuous minutes. The cooldown period is not part of the 30 continuous minutes. The test results and completion dates are documented. (For full text, refer to NFPA 99-2012: 6.4.4.1)

6. The monthly tests for diesel-powered emergency generators are conducted with a dynamic load that is at least 30% of the nameplate rating of the generator or meets the manufacturer’s recommended prime movers’ exhaust gas temperature. If the organization does not meet either the 30% of nameplate rating or the recommended exhaust gas temperature during any test in EC.02.05.07, EP 5, then it must test the emergency generator once every 12 months using supplemental (dynamic or static) loads of 50% of nameplate rating for 30 minutes, followed by 75% of nameplate rating for 60 minutes, for a total of 1½ continuous hours. (For full text, refer to NFPA 99-2012: 6.4.4.1)

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

7. At least monthly, the organization tests all automatic and manual transfer switches on the inventory. The test results and completion dates are documented. (For full text, refer to NFPA 99-2012: 6.4.4.1)

9. At least once every 36 months, organizations 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.

Standard EC.02.05.09
The hospice inspects, tests, and maintains medical gas and vacuum systems.
Note: This standard does not require hospices to have the medical gas and vacuum systems discussed below. However, if a hospice 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 organization 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 hospice, the hospice 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).

10. The hospice 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 hospice 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 hospice implements a policy on all cylinders within the hospice 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
- 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 organization 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 hospice 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 hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option: The organization 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 organization’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 organization establishes and maintains a safe, functional environment.

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, or services provided. *(See also* MC.05.02.01, EP 1)*

2. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** The hospice designs and equips patient rooms for nursing care and for the comfort and privacy of patients.

3. **For complex rehabilitation and assistive technology services:** When patients are evaluated in the organization’s facility, the organization provides private, clean, and safe rooms for fittings and evaluations.

14. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** The hospice supplies an adequate amount of hot water at all times for patient use and has plumbing fixtures with control valves that automatically regulate the temperature of the hot water.
15. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** Each patient’s room has the following characteristics:

- Is at or above grade level
- Has a suitable bed and other furniture for each patient
- Has closet space that provides security and privacy for clothing and personal belongings
- Accommodates no more than two patients and their family members
- Measures at least 100 square feet for a single-patient room, or 80 square feet for each patient in a double room
- Is equipped with an easily activated, functioning, accessible device for calling the staff member on duty

**Note:** The Centers for Medicare & Medicaid Services (CMS) may waive the space and occupancy requirements if they would cause unreasonable hardship on the hospice if strictly enforced or jeopardize the hospice’s ability to continue to participate in the Medicare program, and if CMS determines that waiving the requirements meets patients’ needs and does not adversely affect their health and safety.

16. When patients are evaluated in the organization’s facility, the organization has a repair shop, located either in the facility or in close proximity, for repair, assembly, or modification of products.

17. The organization’s buildings are accessible to physically and visually impaired individuals.

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

32. The organization provides space for staff to perform their required work safely and accurately.

35. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** Each patient room is equipped with, or conveniently located near, toilet and bathing facilities.

**Standard EC.04.01.01**

The organization collects information to monitor conditions in the environment.

**Elements of Performance for EC.04.01.01**

1. The organization establishes and implements a process(es) for internally reporting, investigating, and documenting the following:
Injuries to patients, staff, or others within the organization’s facilities
- Security incidents involving patients, staff (including staff in the field), or others
- Hazardous materials and waste spills and exposures
- Fire safety management problems, deficiencies, and failures

**Note 1:** *This bullet on fire safety management is applicable only for inpatient hospice, ambulatory infusion, and facility-based rehabilitation technology.*
- Equipment management problems, failures, and use errors.
- Utility systems management problems, failures, or use errors.

**Note 2:** *This bullet on utility systems management is applicable only for inpatient hospice, ambulatory infusion, and facility-based rehabilitation technology.*

17. The organization identifies, reports within the organization, and investigates equipment management problems, failures, and use errors for equipment provided to the patient.

18. The organization investigates any incident or injury in which equipment or supplies may have contributed to the incident or injury.

**Note:** *The investigation includes all necessary information, pertinent conclusions about what happened, and whether changes in systems or processes are needed. The organization considers possible links between the items and services furnished and the adverse event.*

19. **For DMEOPOS suppliers serving Medicare beneficiaries:** When the supplier becomes aware of an incident or injury resulting in a Medicare beneficiary’s hospitalization or death, it initiates an investigation within 24 hours.

20. **For DMEOPOS suppliers serving Medicare beneficiaries:** When the supplier becomes aware of an incident or injury that does not result in a Medicare beneficiary’s hospitalization or death, it initiates an investigation within 72 hours.

21. The organization reports incidents in which a medical device is connected to the death, serious injury, or serious illness of any individual, as required by the Safe Medical Devices Act of 1990.

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

2. The organization uses the results of data analysis to identify opportunities to resolve environmental safety issues.
Prompts to Assess Your Compliance

Please note: Tips do not represent new accreditation requirements. They are intended to provide helpful strategies for standards compliance.

Do you have a process that includes routine building and environmental inspections to identify safety and security risks? (EC.02.01.01)

Are no-smoking signs posted in areas where smoking is prohibited? (EC.02.01.03)

Have all hazardous materials and waste been identified? (EC.02.02.01)

**TIP:** Evaluate your organization and staff to determine compliance with managing such materials.

Have you reviewed the types of environmental data being collected? (EC.04.01.01)

**TIP:** In reviewing this data collection, confirm that the organization is capturing all relevant information related to the following:
- Internal reporting of injuries to patients, staff, and others
- Security incidents
- Hazardous materials and waste spills and exposures
- Fire safety, when applicable
- Equipment management problems, failures, and errors
- Utility systems, when applicable

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
**Written Documentation Checklist**

This worksheet lists elements of performance (EPs) that require written documentation that a surveyor could ask to see during a survey to show compliance with a standard. *(Note: Documentation can be on paper or in an electronic format.)*

<table>
<thead>
<tr>
<th>√</th>
<th>Standard</th>
<th>EP</th>
<th>Environment of Care Standards</th>
<th>Home Care Service</th>
<th>Date last verified</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EC.02.01.01</td>
<td>1</td>
<td>EP 1—The organization implements its process to identify safety and security risks associated with the environment of care that could affect all patients, all staff, and people coming to the organization’s facilities.</td>
<td>EP 1—HOS (F), DME, FAI, OP, RT</td>
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<td>EC.02.01.03</td>
<td>3</td>
<td>EP 3—The organization develops criteria identifying the circumstances under which a patient may smoke.</td>
<td>HOS (F)</td>
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<td>EC.02.02.01</td>
<td>1, 3, 11</td>
<td>EP 1—The organization 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. EP 3—The organization has written procedures, including the use of precautions and personal protective equipment, to follow in response to hazardous material and waste spills or exposures. EP 11—For managing hazardous materials and waste, the organization has the permits, licenses, manifests, and safety data sheets required by law and regulation.</td>
<td>EP 1—All services except CCP</td>
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Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
| EC.02.03.01 | EP 9 | Fire response planning identifies the specific roles of those who work within the organization at and away from a fire's point of origin, including when and how to sound fire alarms, how to contain smoke and fire, how to use a fire extinguisher, 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. |
| EC.02.03.03 | 1, 2, 5 | EP 1—The organization conducts quarterly fire drills. EP 2—In areas where patients are housed or treated, the organization conducts one fire drill every 12 months from the date of the last drill. EP 5—The organization critiques fire drills to evaluate fire safety equipment, fire safety building features, and staff response to fire. The evaluation is documented. |
| EC.02.03.05 | 1–20, 25–28 | EP 1—At least quarterly, the organization tests supervisory signal devices on the inventory (except valve tamper switches). The results and completion dates are documented. EP 2—Every 6 months, the organization tests vane-type and pressure-type water flow devices and valve tamper switches and water-flow devices on the inventory. The results and completion dates are documented. EP 3—Every 12 months, the organization tests duct detectors, heat detectors, manual fire alarm boxes, and smoke detectors on the inventory. The results and completion dates are documented. EP 4—Every 12 months, the organization tests visual and audible fire alarms, including speakers and door-releasing devices on the inventory. The results and completion dates are documented. |

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<table>
<thead>
<tr>
<th>EP 5—Every 12 months, the organization tests fire alarm equipment on the inventory for notifying off-site fire responders. The results and completion dates of the tests are documented.</th>
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<tr>
<td>EP 6—For automatic sprinkler systems: The organization tests electric motor-driven fire pumps monthly and diesel-engine-driven fire pumps weekly under no-flow conditions. The results and completion dates of the tests are documented.</td>
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<td>EP 7—For automatic sprinkler systems: Every six months, the organization tests water-storage tank high- and low-water level alarms. The results and completion dates of the tests are documented.</td>
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<td>EP 8—For automatic sprinkler systems: Every month during cold weather, the organization tests water-storage tank temperature alarms. The results and completion dates of the tests are documented.</td>
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<tr>
<td>EP 9—For automatic sprinkler systems: Every 12 months, the organization tests main drains at system low point or at all system risers. The results and completion dates of the tests are documented.</td>
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<td>EP 10—For automatic sprinkler systems: Every quarter, the organization inspects all fire department water supply connections. The results and completion dates are documented.</td>
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<td>EP 11—For automatic sprinkler systems: Every 12 months, the organization tests fire pumps under flow. The results and completion dates are documented.</td>
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<td>EP 12—Every 5 years, the organization conducts hydrostatic and water-flow tests for standpipe systems. The results and completion dates are documented.</td>
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<tr>
<td>EP 13—Every 6 months, the organization inspects any automatic fire-extinguishing system in a kitchen. The results and completion dates are documented.</td>
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<tr>
<td>EP 14—Every 12 months, the organization tests carbon dioxide and other gaseous automatic fire-extinguishing systems. The results and completion dates are documented.</td>
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</table>
EP 15—At least monthly, the organization inspects portable fire extinguishers. The results and completion dates of the inspections are documented.

EP 16—Every 12 months, the organization performs maintenance on portable fire extinguishers, including recharging. Individuals performing annual maintenance on extinguishers are certified. The results and completion dates are documented.

EP 17—The organization conducts hydrostatic tests on standpipe occupant hoses five years after installation and every 3 years thereafter. The results and completion dates are documented.

EP 18—The organization operates fire and smoke dampers one year after installation and then at least every four years to verify that they fully close. The results and completion dates are documented.

EP 19—Every 12 months, the organization tests automatic smoke-detection shutdown devices for air-handling equipment. The results and completion dates of the tests are documented.

EP 20—Every 12 months, the organization tests sliding and rolling fire doors, smoke barrier sliding or rolling doors, and sliding and rolling fire doors in corridor walls and partitions for proper operation and full closure. The results and completion dates are documented.

EP 25—The organization 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.

EP 26—Every 12 months, the organization tests the following:

- Manual pull stations
- Smoke detectors
- Visual and audible fire alarms

The results and completion dates are documented.
| EC.02.05.01 | 4, 5 | EP 4—The organization identifies, in writing, inspection and maintenance activities for all operating components of utility systems. | EPs 4, 5—HOS (F) DISP, FAI, LTP |
| EC.02.05.03 | 14, 15 | EP 14—The organization implements a policy to provide emergency backup for essential medication dispensing equipment identified by the organization, such as automatic dispensing cabinets, medication carousels, and central medication robots. | EPs 14, 15—DISP, FAI, LTP, HOS (F) |
| EC.02.05.05 | 2, 3 | EP 2—The organization tests utility system components before initial use. The completion date and the results of the tests are documented. | EP 2—HOS (F) |

**Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.**
<table>
<thead>
<tr>
<th>EP 3— The organization inspects, tests, and maintains Utility systems. The completion date and the results of the activities are documented.</th>
<th>EP 3—HOS (F), RT, FAI</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EC.02.05.07</strong> 1–7, 9, 10</td>
<td>EP 1— At least monthly, the organization performs a functional test of emergency lighting systems and exit signs required for egress and task lighting for a minimum duration of 30 seconds, along with a visual inspection of other exit signs. The test results and completion dates are documented.</td>
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<tr>
<td>EP 2— Every 12 months, the organization either performs a functional test of battery-powered lights on the inventory required for egress and exit signs for a duration of 1 1/2 hours. The test results and completion dates are documented.</td>
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<tr>
<td>EP 3— The organization performs a functional test of Level 1 stored emergency power supply systems (SEPSS) on a monthly basis and performs a test of Level 2 SEPSS on a quarterly basis. Test duration is for five minutes or as specified for its class (whichever is less). The organization performs an annual test at full load for 60% of the full duration of its class. The test results and completion dates are documented.</td>
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<td>EP 4— At least weekly, the organization inspects the emergency power supply system (EPSS), including all associated components and batteries. The results and completion dates of weekly inspections are documented.</td>
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<td>EP 5— At least monthly, the organization tests each emergency generator 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.</td>
<td>EPs 3–7, 9, 10—HOS (F)</td>
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<td>EP 6—</td>
<td>The monthly tests for diesel-powered emergency generators are conducted with a dynamic load that is at least 30% of the nameplate rating of the generator or meets the manufacturer’s recommended prime movers’ exhaust gas temperature. If the organization does not meet either the 30% of nameplate rating or the recommended exhaust gas temperature during any test in EC.02.05.07, EP 5, then it must test the emergency generator once every 12 months using supplemental (dynamic or static) loads of 50% of nameplate rating for 30 minutes, followed by 75% of nameplate rating for 60 minutes, for a total of 1 ½ continuous hours.</td>
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<td>EP 7—</td>
<td>At least monthly, the organization tests all automatic and manual transfer switches on the inventory. The test results and completion dates are documented.</td>
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<td>EP 9—</td>
<td>At least once every 36 months, organizations 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.</td>
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<tr>
<td>EP 10—</td>
<td>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.</td>
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| EC.02.05.09 | EP 7—In time frames defined by the hospice, the hospice 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. |

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| EC.04.01.01 | 1 | The organization establishes and implements a process(es) for internally reporting, investigating, and documenting the following:
- Injuries to patients, staff, or others within the organization’s facilities
- Security incidents involving patients, staff (including staff in the field), or others
- Hazardous materials and waste spills and exposures
- Fire safety management problems, deficiencies, and failures | EP 1—All services except CCP |
## Action Planning Tool

Use this form to track noncompliant elements of performance (EPs) and your action steps for bringing them into compliance.

<table>
<thead>
<tr>
<th>Standard and EP</th>
<th>Observation/Issue</th>
<th>Action Step</th>
<th>Individual Responsible</th>
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**EC – 40**

CAMHC, January 2018
Chapter Notes

Use this page to take notes about ideas for meeting the standards in this chapter, your organization’s policies and procedures that address requirements in this chapter, or the data or patient record numbers used to determine compliance or noncompliance for EPs. If a standard is found not compliant, it can be helpful to know which data were used so they can be easily accessed when developing action plans for compliance.
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 organization’s ability to provide care, treatment, or services for an extended length of time. This is particularly true in situations where the community cannot adequately support the organization. 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 organization.

About This Chapter
The “Emergency Management” (EM) chapter is organized to allow organizations 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 Plan 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.

Organizations should identify the types of emergencies that could impact the organization’s capacity to provide care, treatment, or services for its patients. This assessment is designed to assist organizations in gaining a realistic understanding of their vulnerabilities in order to help them mitigate and prepare to respond to emergencies and their impact. No organization can predict the nature of a future emergency, nor can it
predict the date of its arrival. However, organizations can plan for managing the following critical areas of their organizations so that they can respond effectively regardless of the cause(s) of an emergency:

- Communications
- Resources and assets
- Staff responsibilities
- Utilities (for inpatient hospice only)
- Patient activities

When organizations consider their capabilities in these areas, they are taking an approach to emergency management that supports a level of preparedness sufficient to address a range of emergencies. This approach lays the foundation for developing an Emergency Operations Plan that is scalable to emergencies that may escalate in complexity, scope, or duration. Organizations should 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 organizationwide 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)
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)

III. Evaluation (EM.03.01.03)

IV. Integrated Emergency Management Program (EM.04.01.01)
**Comprehensive Accreditation Manual for Home Care**

**Applicability for Emergency Management**

This grid is meant to be a resource to determine which standards and elements of performance (EPs) apply to the service categories within the Home Care Accreditation Program. The column on the far left of the grid lists the related EPs vertically by number. Service categories (defined in Table 3 of the Introduction) are listed horizontally along the top of the grid. Applicability is indicated with an “X” in a service category column.

<table>
<thead>
<tr>
<th>Standard/Requirement Number</th>
<th>EP Number</th>
<th>HH</th>
<th>HOS</th>
<th>DME</th>
<th>RESP</th>
<th>SUPP</th>
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Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
| Standard/Requirement Number | EP Number | HH | HOS | DME | RESP | SUPP | OP | CRS | RT | PH | HH | PCS | H | F | M | H | M | F | M |
|-----------------------------|-----------|----|-----|-----|------|------|----|-----|----|----|----|-----|---|---|---|---|---|---|---|---|---|
|                             |           | 7  | X   | X   | X    | X    | X  | X   | X  | X  | X   | X    | X |   |   | X |   | X | X  | X  | X  | X  |
|                             |           | 9  | X   | X   | X   | X    | X  | X   | X  | X  | X   | X    | X |   |   | X |   | X | X  | X  | X  | X  |
|                             |           | 10 | X   | X   | X   | X    | X  | X   | X  | X  | X   | X    | X |   |   | X |   | X | X  | X  | X  | X  |
|                             |           | 11 | X   |     |     |      | X  |     |    |    |     |      |   |   |   |   |   |   |   |   |   |   |
|                             |           | 12 | X   | X   |     |      | X  |     |    |    |     |      |   |   |   |   |   |   |   |   |   |   |
|                             |           | 13 | X   | X   |     |      | X  |     |    |    |     |      |   |   |   |   |   |   |   |   |   |   |
| EM.02.02.09                 |           | 1  | X   |     |     |      | X  |     |    |    |     |      |   |   |   |   |   |   |   |   |   |   |
|                             |           | 2  | X   |     |     |      | X  |     |    |    |     |      |   |   |   |   |   |   |   |   |   |   |
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|                             |           | 7  | X   |     |     |      | X  |     |    |    |     |      |   |   |   |   |   |   |   |   |   |   |
|                             |           | 8  | X   | X   |     |      | X  |     |    |    |     |      |   |   |   |   |   |   |   |   |   |   |
| EM.02.02.11                 |           | 1  | X   | X   | X   | X    | X  | X   | X  | X  | X   | X    | X |   |   | X |   | X | X  | X  | X  | X  |
|                             |           | 3  | X   |     |     |      | X  |     |    |    |     |      |   |   |   |   |   |   |   |   |   |   |
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|                             |           | 13 | X   |     |     |      | X  |     |    |    |     |      |   |   |   |   |   |   |   |   |   |   |
| EM.03.01.03                 |           | 1  | X   | X   | X   | X    | X  | X   | X  | X  | X   | X    | X |   |   | X |   | X | X  | X  | X  | X  |
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|                             |           | 16 | X   | X   | X   | X    | X  | X   | X  | X  | X   | X    | X |   |   | X |   | X | X  | X  | X  | X  |
|                             |           | 17 | X   | X   | X   | X    | X  | X   | X  | X  | X   | X    | X |   |   | X |   | X | X  | X  | X  | X  |
|                             |           | 18 | X   | X   | X   | X    | X  | X   | X  | X  | X   | X    | X |   |   | X |   | X | X  | X  | X  | X  |
|                             |           | 19 | X   | X   | X   | X    | X  | X   | X  | X  | X   | X    | X |   |   | X |   | X | X  | X  | X  | X  |
|                             |           | 20 | X   |     |     |      | X  |     |    |    |     |      |   |   |   |   |   |   |   |   |   |   |
|                             |           | 21 | X   |     |     |      | X  |     |    |    |     |      |   |   |   |   |   |   |   |   |   |   |
| EM.04.01.01                 |           | 1  | X   |     |     |      | X  |     |    |    |     |      |   |   |   |   |   |   |   |   |   |   |
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Standards, Rationales, and Elements of Performance

Standard EM.01.01.01

The organization 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 those services. Therefore, it is important that organizations consider the effects of emergencies on their ability to care for their patients. Because some emergencies that affect an organization originate in the community, organizations need to take advantage of opportunities where possible to collaborate with relevant parties in their communities in their planning efforts.

Elements of Performance for EM.01.01.01

1. The organization’s leaders participate in planning activities prior to developing an Emergency Operations Plan.

2. The organization identifies in writing the potential emergencies that could affect its ability to provide services and the likely consequences of those emergencies. (See also IC.01.06.01, EP 4)

   Note 1: Some organizations refer to this process as a hazard vulnerability analysis.

   Note 2: If the organization identifies a surge in infectious patients as a potential emergency, this issue is addressed in the “Infection Prevention and Control” (IC) chapter.

3. The organization prioritizes the potential emergencies it has identified.
4. The organization determines what its role will be, if any, in the community response plan.

**Note:** A community response plan is the response plan of the organization’s city, county, region, or state, whichever plan is activated by community leadership.

5. The organization uses its prioritized emergencies as a basis for defining mitigation activities (that is, activities designed to reduce the risk of and potential damage from an emergency).

**Note 1:** 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.

**Note 2:** Home care organizations may mitigate emergencies by identifying patients who are vulnerable to particular conditions and taking proactive measures within their control to reduce risk. For example, in areas prone to heat wave or persistent drought, home care organizations may identify potentially vulnerable patients to a) increase monitoring of the patient and his or her home environment during scheduled visits; b) facilitate adjustments in medication, diet, or personal care regimen; c) enhance education to family or care-givers on measures for keeping cool; or d) provide the utility company with a listing of potentially vulnerable patients in the event of a power failure.

6. The organization uses its prioritized emergencies as a basis for defining the preparedness activities that will organize and mobilize essential resources. (See also IM.01.01.03, EPs 1–4)

9. For home health agencies and hospices that elect to use The Joint Commission deemed status option: The Emergency Operations Plan includes documentation of potential risks in the community that could impact the organization’s ability to provide care for its patients.

**Standard EM.02.01.01**

The organization has an Emergency Operations Plan.

**Note:** The organization’s Emergency Operations Plan (EOP) is designed to coordinate its communications, resources and assets, staff responsibilities, utilities, and patient clinical and support activities during an emergency (refer to Standards EM.02.02.01, EM.02.02.03, EM.02.02.07, 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 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 organization’s leaders participate in the development of the Emergency Operations Plan.

2. The organization has a written Emergency Operations Plan that describes the response procedures to follow when emergencies occur. *(See also EM.03.01.03, EP 5 and EP 19)*

   **Note 1:** The response procedures address the prioritized emergencies but can also be adapted to other emergencies that the organization may experience. Response procedures could include the following:
   - Maintaining or expanding services
   - Conserving resources
   - Curtailing services
   - Helping patients and families develop a home emergency plan
   - Educating them about self-care and sources of alternative care in the community
   - Coordinating home visits from another agency office or alternative care site in the community
   - Supplementing resources from outside the local community
   - Curtailing admissions of new patients
Note 2: These expectations do not require the organization to expand services to new patients or evacuate patients from their homes. Organizations that do not provide 24-hour care may plan to close in response to an emergency; their activities may be focused on notification and communication to patients and their families, and strategies for resuming service following an emergency.

4. The organization has a written Emergency Operations Plan that describes the recovery strategies, actions, and individual responsibilities necessary to restore the organization’s care, treatment, or services after an emergency.

5. The Emergency Operations Plan describes the processes for initiating and terminating the organization’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) responsible for activating the response and recovery phases of the emergency response.

7. For inpatient hospices that elect to use The Joint Commission deemed status option: The Emergency Operations Plan identifies alternative sites for care, treatment, and services that meet the needs of the organization’s patients during emergencies.

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

10. For home health agencies and hospices that elect to use The Joint Commission deemed status option: The Emergency Operations Plan, including the communication plan, must be reviewed and updated at least annually.

11. For home health agencies and hospices that elect to use The Joint Commission deemed status option: The Emergency Operations Plan describes the patient population served by the organization and the extent to which additional populations may be cared for during an emergency based on the organization’s capabilities (staff, space, supplies, equipment).
12.  For home health agencies and hospices that elect to use The Joint Commission deemed status option: The Emergency Operations Plan includes a continuity of operations strategy that covers the following:

- Continuity of facilities and communications to support organizational functions at the original site or alternate site(s), in case the original site is incapacitated
- A succession plan that lists who replaces the key leader(s) during an emergency if the 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.

14.  For inpatient hospices that elect to use The Joint Commission deemed status option: The inpatient hospice 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.  For inpatient hospices that elect to use The Joint Commission deemed status option: The Emergency Management Plan addresses a means to shelter inpatient hospice staff on site who remain in the organization during an emergency, including essential space, utilities, and supplies.
17. **For inpatient hospices that elect to use The Joint Commission deemed status option:** The inpatient hospice provides staff and volunteers access to the emergency preparedness plan to review procedures that are necessary to protect patients and others. This review is performed at least annually.

**Standard EM.02.02.01**

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

**Rationale for EM.02.02.01**

The organization maintains reliable communications capabilities for the purpose of communicating response efforts to staff, patients, and external organizations. The organization 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**

1. The Emergency Operations Plan describes how staff will be notified that emergency response procedures have been initiated.

5. The Emergency Operations Plan describes how the organization will communicate with patients during an emergency.

14. The organization establishes backup procedures in the event that communications fail during an emergency.

17. The organization implements the components of its Emergency Operations Plan that require advance preparation to support communications during an emergency.

18. **For home health agencies and hospices that elect to use The Joint Commission deemed status option:** The Emergency Operations Plan describes how the organization will inform state and local emergency preparedness officials before, during, and after emergencies on the following:

- Patients the organization is unable to contact (to determine service needs)
- Patients in need of evacuation due to their medical or behavioral health condition or home environment
Note: Depending upon location and type of emergency, the relevant officials will be from a city, county, or state health department; local incident command or emergency operations center; fire department; or local health care coalition. Some health care organizations will have direct contact with these officials, and some will work through their systems or parent organizations to make such contacts.

19. ⬜ For home health agencies and hospices that elect to use The Joint Commission deemed status option: The Emergency Operations Plan describes how the organization informs state and local officials of any on-duty staff they are unable to contact.

20. ⬜ For home health agencies and hospices that elect to use The Joint Commission deemed status option: As part of its communication plan, the organization maintains the names and contact information of the following:
   - Staff
   - Physicians
   - Other potential response partners (depending upon services provided, these may be home health agencies, hospices, or other sources of collaboration or assistance)
   - Volunteers
   - Entities providing services under arrangement
   - Relevant federal, state, tribal, regional, and local emergency preparedness staff

21. ⬜ For home health agencies and hospices that elect to use The Joint Commission deemed status option: The Emergency Operations Plan describes the following:
   - The organization’s primary and alternate means of communicating with staff and federal, state, tribal, and local emergency management agencies
   - The organization’s arrangements for communicating information and medical documentation on patients under the organization’s care, as necessary, with other health care providers in order to maintain continuity of care
   - 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
   - How the organization will communicate information about its needs (including for inpatient hospices, its inpatient hospice occupancy needs) and ability to provide assistance to the authority having jurisdiction, the incident command center, or designee
Note 1: Depending upon the type of emergency, the authority having jurisdiction might be the municipal, county, or state health department, or another governmental entity.

Note 2: 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 home health agencies and hospices that elect to use The Joint Commission deemed status option: 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).

24. For inpatient hospices that elect to use The Joint Commission deemed status option: The Emergency Operations Plan addresses alternate sources of energy to maintain fire detection, extinguishing, and alarm systems.

Standard EM.02.02.03
As part of its Emergency Operations Plan, the organization prepares for how it will manage resources and assets during emergencies.

Rationale for EM.02.02.03
The organization that continues to provide care, treatment, or 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. The organization should also recognize the risk that some resources may not be available from planned sources, particularly in emergencies of long duration or broad geographic scope, and that contingency plans will be necessary for critical supplies. This situation may occur when multiple organizations are vying for a limited supply from the same vendor.
Elements of Performance for EM.02.02.03

1. The Emergency Operations Plan describes how the organization will obtain and replenish medications and related supplies that will be required in response to an emergency.

2. The Emergency Operations Plan describes how the organization will obtain and replenish medical supplies that will be required in response to an emergency.

The Emergency Operations Plan describes the following:

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

8. The organization’s arrangements with other organizations in the event that it cannot serve its own customers as the result of an emergency.

**For inpatient hospices that elect to use The Joint Commission deemed status option:**

The Emergency Operations Plan describes the following:

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

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

**Standard EM.02.02.05**

As part of its Emergency Operations Plan, the organization prepares for how it will manage security and safety during an emergency.

Elements of Performance for EM.02.02.05

**For inpatient hospices that elect to use The Joint Commission deemed status option:**

The Emergency Operations Plan describes the following:

4. How the inpatient hospice will manage hazardous materials and waste.
Standard EM.02.02.07
As part of its Emergency Operations Plan, the organization 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).

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

1. How the organization will manage staff during emergencies.
2. The roles and responsibilities of leaders and staff 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 emergencies.
5. The Emergency Operations Plan describes how the organization will manage staff support needs (for example, providing staff with information on developing their family’s emergency response plan before an emergency or helping staff with housing, transportation, and incident stress debriefing when the organization remains open to its patients during an emergency).
6. For home health agencies and hospices that elect to use The Joint Commission deemed status option: The organization trains staff for their assigned emergency response roles.
7. The Emergency Operations Plan describes how the organization will identify staff and authorized volunteers during emergencies.

Note: This identification could include identification cards, wristbands, vests, hats, or badges.
8. The organization implements the components of its Emergency Operations Plan that require advance preparation to manage staff during an emergency.
11. ⑤ For inpatient hospices that elect to use The Joint Commission deemed status option: The inpatient hospice has a system to track the location of on-duty staff during an emergency.

12. ⑤ For home health agencies and hospices that elect to use The Joint Commission deemed status option: The Emergency Operations Plan describes how state and federally designated health care professionals will be incorporated into the staffing strategy for addressing a surge in needs during an emergency. This coordination will vary depending on the type of emergency, whether the organization chooses to use volunteers, and the organization’s role, if any, in community response plans.

13. ⑤ For home health agencies and hospices that elect to use The Joint Commission deemed status option: Initial and ongoing training relevant to their emergency response roles is provided to staff, volunteers, and individuals providing on-site services under contracts and other arrangements. This training is documented and then reviewed and updated annually and when these roles change.

Standard EM.02.02.09
As part of its Emergency Operations Plan, the organization 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 organization; negotiated relationships with the primary suppliers; provision through a parent entity; Memoranda of Understanding (MOU) with other organizations in the community). Organizations should determine how long they expect to remain open to care for patients and plan for their utilities accordingly.

Elements of Performance for EM.02.02.09
1. The Emergency Operations Plan describes how the organization will provide for alternative means of meeting essential building utility needs when the organization needs to provide continuous service during an emergency.
For inpatient hospices that elect to use The Joint Commission deemed status option: As part of its Emergency Operations Plan, the inpatient hospice identifies alternative means of providing the following:

2. ⤵️ Electricity.

   **Note:** Requirements addressing reliable power sources for equipment essential for patient care and safety are addressed in the “Environment of Care” (EC) chapter.

3. ⤵️ Water needed for consumption and essential care activities.

4. ⤵️ Water needed for equipment and sanitary purposes.

7. ⤵️ Utility systems that the organization defines as essential (for example, vertical and horizontal transport, heating and cooling systems).

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

**Standard EM.02.02.11**

As part of its Emergency Operations Plan, the organization 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, or 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.

**Elements of Performance for EM.02.02.11**

1. ⤵️ The Emergency Operations Plan describes how the organization will manage activities related to care, treatment, or services during an emergency. *(See also PC.01.03.01, EP 55)*
3. The Emergency Operations Plan describes how the organization will evacuate (from one section or floor to another within the building, or, completely outside the building) when the building cannot support care, treatment, or services. (See also EM.02.02.03, EP 9)

**Note:** Evacuation response strategies apply only to inpatient hospice settings.

**For inpatient hospices that elect to use The Joint Commission deemed status option:**
The Emergency Operations Plan describes the following:

5. How the inpatient hospice will manage the personal hygiene and sanitation needs of its patients, residents, and staff.

11. The organization implements the components of its Emergency Operations Plan that require advance preparation to manage patients during an emergency.

12. **For inpatient hospices that elect to use The Joint Commission deemed status option:** The inpatient hospice 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 operations plan, formal transfer agreements, or other accessible documents.

13. **For inpatient hospices that elect to use The Joint Commission deemed status option:** Procedures for evacuating patients from the inpatient hospice during an emergency address, at a minimum, the following:

- Care and treatment needs of patients when deciding where they will be evacuated (for example, transfer to a higher level of care, transport to an alternative site in the community, discharge to home)
- Primary and alternate means of communication with external sources of assistance regarding patient care
- Transportation for the evacuated patient to an alternative site
Introduction to Standard EM.03.01.03

Standard EM.03.01.03 requires accredited home care organizations to activate and test their Emergency Operations Plans (EOPs) once each year, either in response to an actual event or through the use of a planned exercise.

Exercise Scope

The scope of the exercise reflects the response requirements defined in the EOP, focusing on capabilities that support patient care, treatment, or service. As such, organizations that plan to serve patients during an emergency may have complex plans that require multiple capabilities to be tested; organizations that intend to close and reopen patient services after the emergency may have simpler plans that focus on a more limited range of activities. For example:

- A home care organization may conduct a flood exercise at the home care office that affects operations for six hours. The areas that might be most affected would be staff responsibilities, patient care, and resources and assets, and they should be tested to the point of stress. Stressing the organization involves pushing the exercise far enough to identify weaknesses in the plan that could potentially jeopardize patient care or service during an emergency. Communication might be minimally affected, and would be included in monitoring and evaluation, but not exercised to the point of stress.

- A transit strike exercise could test the organization’s plan for utilizing shuttle buses, rail service, or taxis for nurses and aides to get to their patients. Patient care staff responsibilities, communications, deployment of resources and assets (including petty cash disbursements to aides) would all be tested; utilities would not be affected, and would not be monitored unless the organization offered inpatient services.

- Prior to hurricane season, the organization enacts its EOP to test patient communications regarding closing and alternate care arrangements. The organization reviews, confirms, and updates patient and employee disaster response and evacuation instructions. The organization also confirms the location of special needs patients and registers any new patients who may need shelter with the County Emergency Shelter system. Primary and alternate modes of communication with patients and staff are tested, and decision criteria and protocols for reopening service post-disaster are reviewed and updated as needed.
Exercise Types

When organizations use planned exercises, they have some flexibility with regard to the type of exercises they can carry out. An organization using a planned exercise to comply with EM.03.01.03 can use the type of exercise it chooses—a tabletop exercise, a functional exercise, or some hybrid of the two. They are defined as follows:

- **Tabletop**: A tabletop exercise 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.

- **Functional**: A functional exercise 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.

**Standard EM.03.01.03**
The organization 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 (EOP’s) appropriateness and adequacy, and the effectiveness of logistics, human resources, training, policies, procedures, and protocols. Exercises (whether tabletop, functional, or a hybrid of the two) 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 emergencies and test the organization’s ability to respond to their effects on the organization. Those effects may be related to communications, resources and assets, staff responsibilities, utilities (for inpatient hospice only), and patient care activities.

**Exercise Design**
The exercise should be demanding enough to surface weaknesses, gaps, or opportunities for improvement in the organization’s response efforts. Well-designed exercises typically have the following components:

- EOP
- Exercise scenario
- Goals of the exercise (specific to organization capabilities to be tested)
- Implementation steps (activities to carry out the exercise)
- Assigned roles for management, office, and field staff
- Evaluation tool
- Evaluation debriefing
- Update of the EOP and response capabilities

In most emergencies, the organization will have to operate (for however long it decides to stay open) under deficits of time, information, personnel, space, supplies, equipment or other resources, and/or an increase in patient demand. A well-designed exercise can escalate these deficits using new pieces of information provided to simulate the unpredictable nature of emergencies (a snowstorm becomes a snowstorm plus 20% staff attrition plus a gas leak). These variables prevent exercises of familiar scenarios from becoming rote and unproductive, prompting new lines of problem solving, decision making, and opportunities for improvement.

**Patient Care and Continuity of Operations**  A number of home care segments serve vulnerable patients who, in an emergency, would potentially rely on the organization for life-dependent needs:

- Hospice—inpatient
- Hospice—patient residence
- Home health
- Personal care and support
- DME—patient residence
- Supplies—patient residence
- Respiratory equipment
- Clinical respiratory services
- Pharmacy—freestanding ambulatory infusion
- Pharmacy—dispensing services

To test any care, treatment, or service response procedures defined in their EOPs, these segments are required to actively test the following:

- Components of their plans related to identifying and locating high-risk individuals
- Planned response activities, for example, management of medication, medical equipment and supplies, instructions for self-evaluation, medical record documentation, coordination of information with alternative care site

By working through issues and problems encountered, staff will be better prepared to respond in a proactive and flexible manner during an actual emergency, especially when responding with colleagues or external parties who also have assigned roles in response that may differ from their daily responsibilities. This action-based approach is especially important when assessing preparedness in organizations that provide direct clinical services to vulnerable populations.
The other home care segments typically provide products, supplies, and in some cases personnel which, though important, are not life-sustaining or essential for the care of vulnerable individuals during an emergency:

- DME facility
- DME mail order
- Supplies mail order
- Orthotics & prosthetics (patient residence)
- Orthotics & prosthetics (facility based)
- Rehabilitation technology (patient residence)
- Rehabilitation technology (facility based)
- Pharmacy (dispensing mail order pharmacy only)
- Pharmacy (clinical consultant)
- Pharmacy (long term care dispensing)

Continuity of operations is an issue that is often effectively explored using more discussion-based exercises (such as table tops); participants and tasks can be incorporated via telephone or web access, and event variables can be scripted in to sufficiently stress the plan and identify weaknesses and opportunities for improvement.

**Elements of Performance for EM.03.01.03**

1. The organization activates its Emergency Operations Plan once a year at each site included in the plan, either in response to an actual emergency or as a planned exercise.

   **Note:** Planned exercises should focus on the organization’s response to an emergency that is likely to affect continuation of care, treatment, or services. Exercises do not need to be conducted in each community served by the organization but should be based on a regional or county response strategy where applicable. Exercises that involve substitutes for patients (such as pillows, bundles, mannequins, or live volunteers) are acceptable.

5. Emergency response exercises incorporate likely disaster scenarios that allow the organization to evaluate its handling of communications, resources and assets, staff, utilities (for facility-based care only), and patients. (See also EM.02.01.01, EP 2)

**For home health agencies and hospices that elect to use The Joint Commission deemed status option:** During emergency response exercises, the organization monitors its management of the following:
10. **Staff roles and responsibilities.**

13. Management and staff evaluate all emergency response exercises and all responses to actual emergencies.

14. The evaluation of all emergency response exercises and all responses to actual emergencies includes the identification of deficiencies and opportunities for improvement. This evaluation is documented.


   **Note:** Organizations are required to implement modifications; however, 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.

18. The scope of the exercise reflects the response procedures described in the organization’s Emergency Operations Plan; at a minimum the exercise does the following:
   - Reviews and confirms staff communication procedures and content as well as assigned roles related to essential response functions
   - Reviews and confirms how the organization will communicate with patients during an emergency
   - Reviews and confirms communications with any response partners as described in the Emergency Operations Plan (for example, vendors, contracted providers, drug suppliers, parent home care agency, local hospital, county emergency operations center)
   - Reviews and confirms business continuity and recovery strategies for restoring the organization’s capabilities to provide care, treatment, or services after an emergency

19. The organization’s exercise sufficiently stresses its Emergency Operations Plan to identify weaknesses in key areas of safety; this exercise does the following:
   - Activates and tests patient acuity assignment and tracking procedures to validate the organization’s ability to identify and locate high risk patients
Activates and tests key care, treatment, or service processes consistent with planned response activities (for example, management of medication, medical equipment and supplies, instructions for self-evacuation, medical record documentation, coordination of information with alternative care site).

(See also EM.02.01.01, EP 2)

**Note:** The home care segments to which this element of performance applies typically serve vulnerable patients or clients who, in an emergency, would potentially rely on the organization for life-dependent needs.

20. ☐ For home health agencies and hospices that elect to use The Joint Commission deemed status option: The organization conducts an additional exercise each year as follows:
   - One of the two annual exercises must be an operations-based exercise that is conducted either as part of a full-scale community exercise, or if a community exercise is not available, is conducted as an exercise within the organization. (Refer to EM.03.01.03, EP 1)
   - The other of the two annual exercises may be a tabletop exercise.

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

21. ☐ For home health agencies and hospices that elect to use The Joint Commission deemed status option: If the organization conducts a tabletop exercise to fulfill this requirement, the tabletop exercise includes a group discussion led by a facilitator using a narrated, clinically relevant emergency scenario and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency 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. Health care organizations 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 organization to serve its patients, protect its facilities, mobilize its staff, and aid its system and/or community by serving more patients.

Depending on the organization’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 organization 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 organization’s plan, the organization’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 organization must be able to readily access and use its individual plan for its preparedness, response, and recovery efforts. The organization 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 home health agencies and hospices that elect to use The Joint Commission deemed status option: If the organization 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 organization participates in planning, preparedness, and response activities with the system.

Elements of Performance for EM.04.01.01

1. For home health agencies and hospices that elect to use The Joint Commission deemed status option: The organization 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 organization has reviewed the community-based risk assessment developed by the system’s integrated all-hazards emergency management program
   - Documentation that the organization’s individual risk assessment is incorporated into the system’s integrated program

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
Comprehensive Accreditation Manual for Home Care

- Documentation that the organization’s patient population, services offered, and any unique circumstances of the organization 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 organization participates in the annual review of the system’s integrated program

2. ① For home health agencies and hospices that elect to use The Joint Commission deemed status option: The organization has implemented communication procedures for emergency planning and response activities in coordination with the system’s integrated emergency preparedness program.

3. ② For home health agencies and hospices that elect to use The Joint Commission deemed status option: The organization’s integrated emergency management policies, procedures, or plans address the following:
   - Identification of the organization’s emergency preparedness, response, and recovery activities that are 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 organization’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
Prompts to Assess Your Compliance

**Please note:** Tips do not represent new accreditation requirements. They are intended to provide helpful strategies for standards compliance.

Can each staff person who has a role in mitigation, preparedness, response, or recovery activities describe his or her assigned responsibilities? (EM.01.01.01)

What is the chain of command? How should communication occur in the event of an emergency? (EM.02.01.01)

How have you prepared to communicate with staff during an emergency? (EM.02.01.01)

What processes do you have in place to communicate with vendors, contracted providers, your parent company, and external authorities as needed when an emergency occurs? (EM.02.02.03)

**TIP:** Review with your staff your current Emergency Operations Plan, descriptions of your planned exercises, and evaluations of your exercises and responses to emergencies.
How do you communicate with patients about emergency management when they come on service and when an emergency actually occurs? (EM.02.02.01, EM.02.02.11)

What provisions have you made for patient tracking, service prioritization and, if necessary, coordination with alternative care sites? (EM.02.02.11)

How have you prepared to manage medications, medical supplies, equipment, and non-medical supplies for your patients during an emergency? (EM.02.02.03, EM.02.02.11)

**TIP:** Health departments and statewide home health associations provide tips and resources to help agencies work with their patients to prepare home disaster preparedness kits; “To Go” evacuation kits; and contact information for Red Cross and other response agencies in their communities.

How do you provide for your organization’s utility system needs (for example, electricity, water) during an emergency? (EM.02.02.09)
**TIP:** Think beyond direct patient services to continuity of operations. Some emergencies or disasters may not impact your care staff or patients in the community, but may have a direct impact on your home or satellite offices, warehouses, transportation routes, or infrastructure supporting functions such as communications or payroll. These risks should be considered in your emergency planning, training, and drills.

Who participates in emergency management exercises? Who doesn’t participate in emergency management exercises, and why are they not included? (EM.03.01.03)

What changes have you made in your Emergency Operations Plan and in your preparedness based on the evaluations of your exercises and responses? (EM.03.01.03)

How have your EM exercises prepared you to address your areas of greatest risk? (EM.03.01.03)

**TIP:** It’s not enough to say that “everything went well”; any weaknesses or gaps should be identified, improvements prioritized, and action plans put into place. Involve clinical, clerical, and administrative staff in planning exercises and evaluation to help get different perspectives and solutions others might not have considered.
Written Documentation Checklist

This worksheet lists elements of performance (EPs) that require written documentation that a surveyor could ask to see during a survey to show compliance with a standard. *(Note: Documentation can be on paper or in an electronic format.)*

### Emergency Management (EM)

<table>
<thead>
<tr>
<th>Standard</th>
<th>EP</th>
<th>Emergency Management Standards</th>
<th>Home Care Service</th>
<th>Date last verified</th>
</tr>
</thead>
<tbody>
<tr>
<td>EM.01.01.01 9</td>
<td>For home health agencies and hospices that elect to use The Joint Commission deemed status option: The Emergency Operations Plan includes documentation of potential risks in the community that could impact the organization’s ability to provide care for its patients.</td>
<td>Deemed HH, Deemed HOS</td>
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<tr>
<td>EM.02.01.01 2, 4, 7, 10–12, 14, 15, 17</td>
<td>EP 2—The organization has a written Emergency Operations Plan that describes the response procedures to follow when emergencies occur. EP 4—The organization has a written Emergency Operations Plan that describes the recovery strategies, actions, and individual responsibilities necessary to restore the organization’s care, treatment, or services after an emergency.</td>
<td>EPs 2, 4—All services</td>
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<td>EP 7—For inpatient hospices that elect to use The Joint Commission deemed status option: The Emergency Operations Plan identifies alternative sites for care, treatment, and services that meet the needs of the organization’s patients during emergencies.</td>
<td>Deemed HH, Deemed HOS (F) EPs 14, 15, 17—Deemed HOS (F)</td>
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<td>EP 10—For home health agencies and hospices that elect to use The Joint Commission deemed status option: The Emergency Operations Plan, including the communication plan, must be reviewed and updated at least annually.</td>
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Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
EP 11—For home health agencies and hospices that elect to use The Joint Commission deemed status option:
The Emergency Operations Plan describes the patient population served by the organization and the extent to which additional populations may be cared for during an emergency based on the organization’s capabilities (staff, space, supplies, equipment).

EP 12—For home health agencies and hospices that elect to use The Joint Commission deemed status option:
The Emergency Operations Plan includes a continuity of operations strategy that covers the following:

- Continuity of facilities and communications to support organizational functions at the original site or alternate site(s), in case the original site is incapacitated
- A succession plan that lists who replaces the key leader(s) during an emergency if the 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
EP 14—**For inpatient hospices that elect to use The Joint Commission deemed status option:** The inpatient hospice 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.

EP 15—**For inpatient hospices that elect to use The Joint Commission deemed status option:** The Emergency Management Plan addresses a means to shelter inpatient hospice staff on site who remain in the organization during an emergency, including essential space, utilities, and supplies.

EP 17—**For inpatient hospices that elect to use The Joint Commission deemed status option:** The inpatient hospice provides staff and volunteers access to the emergency preparedness plan to review procedures that are necessary to protect patients and others. This review is performed at least annually.

EP 18—**For home health agencies and hospices that elect to use The Joint Commission deemed status option:** The Emergency Operations Plan describes how the organization will inform state and local emergency preparedness officials before, during, and after emergencies on the following:

- Patients for whom the organization is unable to contact to determine service needs
- Patients in need of evacuation due to their medical or behavioral health condition or home environment

EPs 18–22—Deemed HH, HOS
EP 24—Deemed HOS (F)
EP 19—For home health agencies and hospices that elect to use The Joint Commission deemed status option: The Emergency Operations Plan describes how the organization informs state and local officials of any on-duty staff they are unable to contact.

EP 20—For home health agencies and hospices that elect to use The Joint Commission deemed status option: As part of its communication plan, the organization maintains the names and contact information of the following:

- Staff
- Physicians
- Other potential response partners (depending upon services provided, these may be home health agencies, hospices, or other sources of collaboration or assistance).
- Volunteers
- Entities providing services under arrangement
- Relevant federal, state, tribal, regional, and local emergency preparedness staff
EP 21—For home health agencies and hospices that elect to use The Joint Commission deemed status option:
The Emergency Operations Plan describes the following:

- The organization’s primary and alternate means of communicating with staff and federal, state, tribal, and local emergency management agencies.
- The organization’s arrangements for communicating information and medical documentation on patients under the organization’s care, as necessary, with other health care providers in order to maintain continuity of care.
- 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.
- How the organization will communicate information about its needs (including for inpatient hospices, its inpatient hospice occupancy needs) and ability to provide assistance to the authority having jurisdiction, the incident command center, or designee.

EP 22—For home health agencies and hospices that elect to use The Joint Commission deemed status option:
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.

EP 24—For inpatient hospices that elect to use The Joint Commission deemed status option: The Emergency Operations Plan addresses alternate sources of energy to maintain fire detection, extinguishing, and alarm systems.
<p>| EM.02.02.03 | 9 | <strong>EP 9</strong>—For inpatient hospices that elect to use The Joint Commission deemed status option: The Emergency Operations Plan describes the following: The inpatient hospice's arrangements for transporting some or all patients and residents, their requisite medications, supplies, and equipment, and staff to an alternative care site(s) when the organization's environment cannot support care, treatment, and services. |
| EM.02.02.05 | 4 | <strong>EP 4</strong>—For inpatient hospices that elect to use The Joint Commission deemed status option: The Emergency Operations Plan describes the following: How the inpatient hospice will manage hazardous materials and waste. |
| EM.02.02.07 | 7, 11–13 | <strong>EP 7</strong>—For home health agencies and hospices that elect to use The Joint Commission deemed status option: The organization trains staff for their assigned emergency response roles. <strong>EPs 7, 12, 13—Deemed HH, HOS</strong> <strong>EP 11—Deemed HOS (F)</strong> |
| | | <strong>EP 11</strong>—For inpatient hospices that elect to use The Joint Commission deemed status option: The inpatient hospice has a system to track the location of on-duty staff during an emergency. |
| | | <strong>EP 12</strong>—For home health agencies and hospices that elect to use The Joint Commission deemed status option: The Emergency Operations Plan describes how state and federally designated health care professionals will be incorporated into the staffing strategy for addressing a surge in needs during an emergency. This coordination will vary depending on the type of emergency, whether the organization chooses to use volunteers, and the organization’s role, if any, in community response plans. |
| | | <strong>EP 13</strong>—For home health agencies and hospices that elect to use The Joint Commission deemed status option: Initial and ongoing training relevant to their emergency response roles is provided to staff, volunteers, and individuals providing on-site services under contracts and other arrangements. This training is documented and then reviewed and updated annually and when these roles change. |</p>
<table>
<thead>
<tr>
<th>EM.02.02.09 2–4, 7</th>
<th>EP 2—For inpatient hospices that elect to use The Joint Commission deemed status option: As part of its Emergency Operations Plan, the inpatient hospice identifies alternative means of providing electricity.</th>
<th>EPs 2–4, 7—Deemed HOS (F)</th>
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<tr>
<td>EP 3—For inpatient hospices that elect to use The Joint Commission deemed status option: As part of its Emergency Operations Plan, the inpatient hospice identifies alternative means of providing water needed for consumption and essential care activities.</td>
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<td>EP 7—For inpatient hospices that elect to use The Joint Commission deemed status option: As part of its Emergency Operations Plan, the inpatient hospice identifies alternative means of providing utility systems that the organization defines as essential (for example, vertical and horizontal transport, heating and cooling systems).</td>
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<tr>
<td>EM.02.02.11 1, 3, 5, 12, 13</td>
<td>EP 1—The Emergency Operations Plan describes how the organization will manage activities related to care, treatment, or services during an emergency.</td>
<td>EPs 1, 3—HOS (F)</td>
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<td>EP 3—The Emergency Operations Plan describes how the organization will evacuate (from one section or floor to another within the building, or, completely outside the building) when the building cannot support care, treatment, or services.</td>
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<td>EP 5—For inpatient hospices that elect to use The Joint Commission deemed status option: The Emergency Operations Plan describes how the inpatient hospice will manage the personal hygiene and sanitation needs of its patients, residents, and staff.</td>
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<td>Primary and alternate means of communication with external sources of assistance regarding patient care</td>
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<td>Transportation for the evacuated patient to an alternative site</td>
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<td>EM.03.01.03 14, 20, 21</td>
<td>EP 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.</td>
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<td>EP 20—For home health agencies and hospices that elect to use The Joint Commission deemed status option:</td>
<td>The organization conducts an additional exercise each year as follows:</td>
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<td>One of the two annual exercises must be an operations-based exercise that is conducted either as part of a full-scale community exercise, or if a community exercise is not available, is conducted as an exercise within the organization.</td>
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<td>The other of the two annual exercises may be a tabletop exercise.</td>
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<td>EP 21—For home health agencies and hospices that elect to use The Joint Commission deemed status option: If the organization conducts a tabletop exercise to fulfill this requirement, the tabletop exercise includes a group discussion led by a facilitator using a narrated, clinically relevant emergency scenario and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.</td>
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| EM.04.01.01 | 1–3 | EP 1—For home health agencies and hospices that elect to use The Joint Commission deemed status option: The organization 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 organization has reviewed the community-based risk assessment developed by the system’s integrated all-hazards emergency management program
- Documentation that the organization’s individual risk assessment is incorporated into the system’s integrated program
- Documentation that the organization’s patient population, services offered, and any unique circumstances of the organization 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 organization participates in the annual review of the system’s integrated program |

| | | EPs 1–3—Deemed HH, HOS |

EP 2—For home health agencies and hospices that elect to use The Joint Commission deemed status option: The organization has implemented communication procedures for emergency planning and response activities in coordination with the system’s integrated emergency preparedness program.
EP 3—For home health agencies and hospices that elect to use The Joint Commission deemed status option:
The organization’s integrated emergency management policies, procedures, or plans address the following:
- Identification of the organization’s emergency preparedness, response, and recovery activities that are 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 organization’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
Action Planning Tool

Use this form to track noncompliant elements of performance (EPs) and your action steps for bringing them into compliance.

<table>
<thead>
<tr>
<th>Standard and EP</th>
<th>Observation/Issue</th>
<th>Action Step</th>
<th>Individual Responsible</th>
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Chapter Notes

Use this page to take notes about ideas for meeting the standards in this chapter, your organization’s policies and procedures that address requirements in this chapter, or the data or patient record numbers used to determine compliance or noncompliance for EPs. If a standard is found not compliant, it can be helpful to know which data were used so they can be easily accessed when developing action plans for compliance.
Equipment Management (EQ)

Overview
Medical equipment and supplies are used in a variety of settings to assist patients in achieving therapeutic benefits and to enhance the activities of daily living. The “Equipment Management” (EQ) chapter makes available in one place all the standards that address the provision of medical equipment and supplies.

The goal of these standards is to promote the safe and effective use of medical equipment and supplies. Significant variables exist pertaining to the provision of medical equipment and supplies that must be addressed by accredited organizations, such as alternative sites of care, advances in manufacturing and technology, availability of equipment (both over-the-counter and by prescription), and patient compliance with the intended use of the equipment and supplies. It is important for organizations to comply with these standards in order to improve the safety and quality of the provision of medical equipment and supplies under these circumstances.

About This Chapter
The standards in this chapter cover the following processes important to the management of equipment and supplies:
- Selection and delivery
- Setup
- Maintenance
- Back up and emergency maintenance
- Storage

Applicability
In most cases, the standards are applicable both for equipment that the patient rents and for equipment the patient purchases. However, the standards for equipment maintenance, backup, and on-call availability do not apply to equipment that the patient purchases, unless the organization chooses to retain responsibility for these activities.

The first five standards are applicable to organizations that provide medical equipment and supplies directly to patients.
The last standard addresses equipment that is not provided to patients, but rather is used by the organization’s staff and, therefore, is applicable to all services.
Chapter Outline

I. Management of Equipment Provided to Patients
   A. Selection and Delivery (EQ.01.01.01)
   B. Setup (EQ.01.02.01)
   C. Maintaining, Testing, and Inspecting (EQ.01.03.01)
   D. Emergency Maintenance and Backup Equipment (EQ.01.04.01)
   E. Storage (EQ.01.05.01)

II. Management of Equipment Used by Staff in the Provision of Care
   A. Maintaining, Testing, and Inspecting (EQ.02.01.01)
## Applicability for Equipment Management
This grid is meant to be a resource to determine which standards and elements of performance (EPs) apply to the service categories within the Home Care Accreditation Program. The column on the far left of the grid lists the related EPs vertically by number. Service categories (defined in Table 3 of the Introduction) are listed horizontally along the top of the grid. Applicability is indicated with an “X” in a service category column.

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Standards, Rationales, and Elements of Performance

Standard EQ.01.01.01

The organization selects and delivers equipment and supplies.

Elements of Performance for EQ.01.01.01

1. The organization has a process for selecting and acquiring the medical equipment and supplies it provides to patients. *(See also MC.01.01.01, EP 4)*

2. The organization provides only durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) and other items that meet applicable Food and Drug Administration regulations and medical device effectiveness and safety standards.

3. **For custom orthotics and prosthetics services:** The organization assesses custom orthotics and prosthetics for structural safety and follows the manufacturer’s guidelines prior to face-to-face fitting or delivery of the product.

   **Note:** Considerations might include weight limits, functioning closures, and absence of defects.

4. **For custom orthotics and prosthetics services:** The organization has access, either directly or through another provider, to the equipment needed to modify or adjust custom orthotics and prosthetics.

5. **For DMEPOS suppliers serving Medicare beneficiaries:** The supplier provides the beneficiary with equipment for trial and simulation, as needed.

6. The organization informs the patient of the expected time frames for delivery of medical equipment and supplies.

7. The organization secures medical equipment and supplies during transport and delivery to prevent damage and to avoid staff injury.

8. The organization delivers medical equipment and supplies in a time frame that meets the patient’s needs, as agreed upon by the patient or caregiver, organization, and prescribing physician.

9. The organization delivers medical equipment and supplies that are sanitary, clean, and undamaged. *(See also IC.02.02.01, EP 4)*
10. The organization selects and delivers medical equipment and supplies to the patient that are consistent with the patient’s known and identified needs, risks, and limitations.

11. **For DMEPOS suppliers serving Medicare beneficiaries:** When delivering respiratory equipment, supplies, and services to Medicare beneficiaries, the supplier complies with all of the following current American Association for Respiratory Care Practice Guidelines:
   - Oxygen Therapy in the Home or Extended Care Facility
   - Long Term Invasive Mechanical Ventilation in the Home
   - Intermittent Positive Pressure Breathing
   
   *(See also PC.02.03.01, EP 16)*

12. ◥ The organization verifies that the patient received the medical equipment and supplies. Verification of delivery is documented.

   **Note:** Some examples of methods for verifying delivery include, but are not limited to the following: Contacting the patient to confirm that delivery occurred, providing the patient with a return receipt to complete upon delivery, and retaining a copy of the delivery service’s tracking slip as well as the supplier’s own invoice. Proof of delivery can also be demonstrated by verifying a sample of deliveries and using the data collected for a performance improvement indicator.

13. ◥ For DMEPOS suppliers serving Medicare beneficiaries: Prior to delivery of equipment or supplies, the organization verifies or authenticates that the equipment and supplies meet the following:
   - Are not adulterated, counterfeit, or suspected of being counterfeit
   - Have not been obtained by fraud or deceit
   - Are branded correctly and labeled for their intended distribution channels

   The verification or authentication of the equipment and supplies is documented.

---

**Standard EQ.01.02.01**

The organization safely sets up medical equipment in the patient’s home.

**Elements of Performance for EQ.01.02.01**

1. **For DMEPOS suppliers serving Medicare beneficiaries:** The supplier sets up all medical equipment in the time frame agreed to by the beneficiary or caregiver, the organization, and the prescribing physician.
2. **For DMEPOS suppliers serving Medicare beneficiaries:** When the supplier coordinates setup of medical equipment with another organization, all equipment is set up in the time frame agreed to by the beneficiary or caregiver, the organization, and the prescribing physician.

When setting up medical equipment in the home, the organization does the following:

3. Provides all supplies that are necessary to operate the equipment.

When setting up medical equipment in the patient’s home, the organization does the following:

4. Determines whether equipment can be used safely within the patient’s home. The determination includes, as appropriate to the equipment, an evaluation of all of the following:
   - The condition of electrical outlets and extension cords, grounding, and the possibility of circuit overload
   - The possibility of exposure to heat sources or open flames
   - The possibility of exposure to liquids
   - The availability of an emergency power source, such as a generator or a charged backup battery
   - Whether the home can accommodate the specific electrical and environmental requirements of the equipment

   **Note:** The determination considers the electrical and environmental requirements of the equipment that need to be met and is intended to bring to light any concerns about the equipment’s safe use in the patient’s home.

When setting up medical equipment in the home, the organization does the following:

5. Unpacks and assembles the equipment and performs safety and operational checks.

6. Adapts, fits, or adjusts the medical equipment to meet the patient’s needs.

7. Correctly stores the medical equipment and associated supplies.

8. **For DMEPOS suppliers serving Medicare beneficiaries:** When setting up respiratory equipment and supplies for Medicare beneficiaries, the supplier complies with all of the following current American Association for Respiratory Care Practice Guidelines:
   - Oxygen Therapy in the Home or Extended Care Facility
   - Long Term Invasive Mechanical Ventilation in the Home

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
Intermittent Positive Pressure Breathing

*(See also PC.02.03.01, EP 16)*

**Standard** EQ.01.03.01

The organization maintains, tests, and inspects the medical equipment it provides to patients.

**Elements of Performance for EQ.01.03.01**

1. The organization obtains from the manufacturer copies of features, warranties, and instructions for each type of non-custom-fabricated item it supplies to patients.

2. The organization performs routine and preventive maintenance on its medical equipment at defined intervals and according to manufacturers’ guidelines. The organization documents the performance of this maintenance.  

   **Note:** If the manufacturer does not have guidelines for routine and/or preventive maintenance, the organization establishes such guidelines. For example, the organization may choose to have discussions with the manufacturer, observe its own failure rates for the equipment, examine maintenance schedules of like products, or use any other method that is effective.

3. The organization performs basic safety, operation, and function checks and repairs on medical equipment according to the organization’s policy and manufacturers’ guidelines. The organization documents the performance of these checks and repairs.

4. Basic safety and operational checks of infusion pumps include a volumetric test of the accuracy of each pump’s infusion rate between use by different patients (when used in the home) or at intervals defined by the organization (when used in a freestanding ambulatory infusion center).

5. The organization inspects medical equipment between use by different patients. The organization documents the performance of these inspections.

6. **For DMEPOS suppliers serving Medicare beneficiaries:** The supplier provides or arranges for loaner equipment equivalent to the original equipment during any repair of beneficiary-owned equipment.

   **Note:** Loan equipment may be provided free of charge or for a fee.
7. The organization documents identification information for medical equipment and supplies in order to respond to recalls.

**Note:** Such information may include the name of the manufacturer, model number, serial number, lot number, or internal tracking systems.

8. The organization acts on recalls and equipment hazard notices, including notifying patients, staff, and prescribing physicians, when necessary.

9. Equipment listed for use in oxygen-enriched atmospheres are 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. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** The organization meets all other Health Care Facilities Code requirements for electrical equipment in the patient care vicinity as related to NFPA 99-2012: Chapter 10.

   **Note:** The hospice meets the applicable provisions of the Health Care Facilities Code Tentative Interim Amendments (TIA) 12-5.

**Standard EQ.01.04.01**

The organization provides patients with emergency maintenance, replacement, or backup of medical equipment, when needed.

**Elements of Performance for EQ.01.04.01**

1. The organization identifies the medical equipment it provides that would threaten a patient’s life or health if it were to fail or malfunction.
2. For any equipment that would threaten a patient’s life if it were to fail or malfunction, the organization provides patients with access to services 24 hours a day, 7 days a week.

3. For any equipment that would threaten a patient’s life if it were to fail or malfunction, the organization provides a backup system that duplicates the function of the equipment to be replaced.

4. For all patients who are ventilator dependent, the organization provides a backup system, a self-inflating resuscitation bag, and a spare breathing circuit. The backup system must duplicate the function of the ventilator for a minimum of three times the organization’s maximum response time.

5. For patients receiving life-sustaining infusions, the organization provides infusion control devices with an alternative power source designed to provide service for a minimum of three times the organization’s maximum response time.

6. For any equipment that would threaten a patient’s health if it were to fail or malfunction, the organization provides or arranges for either backup equipment, equipment repair, or equipment replacement.

7. When an equipment failure or malfunction could threaten a patient’s health and no backup equipment is in the home, the organization repairs or replaces the equipment, or arranges for repair or replacement if the patient’s home is too far from the organization (for example, with an affiliated partner or contractor closer to the patient’s residence).

8. For all patients receiving oxygen therapy where equipment malfunction would threaten the patient’s life, the organization provides a backup oxygen supply that will last a minimum of three times the organization’s maximum response time and function at the prescribed flow rate, frequency, and duration.

9. For patients with an oxygen concentrator, the organization determines the amount of backup oxygen required by considering its maximum response time and providing a backup supply of oxygen sufficient to ensure no interruption in the prescribed oxygen use.

10. For patients with an oxygen concentrator, when a patient refuses a backup supply of oxygen, the organization educates the patient about what to do in the event that the oxygen concentrator fails.
Standard  **EQ.01.05.01**
The organization receives and stores medical equipment and supplies at its site(s).

**Elements of Performance for EQ.01.05.01**

1. The organization designates clearly identified, separate areas for storing each of the following types of equipment:
   - Obsolete equipment
   - Equipment requiring maintenance or repair
   - Dirty equipment
   - Clean equipment
   - Patient-ready equipment

   *(See also IC.02.02.01, EP 4)*

2. The organization stores equipment and supplies in the appropriately designated areas, addressing storage considerations such as expiration dates, temperature requirements, and battery charge requirements. *(See also IC.02.02.01, EP 4)*

3. The organization processes equipment that requires cleaning and disinfecting in a separate area designated for this use. *(See also IC.02.02.01, EPs 1 and 4)*

4. The organization maintains the cleanliness of patient-ready medical equipment. *(See also IC.02.02.01, EPs 1 and 4)*

5. The organization maintains the cleanliness of all storage areas. *(See also IC.02.02.01, EP 4)*

*Standard EQ.02.01.01*
The organization maintains, tests, and inspects medical equipment used by staff in the provision of care, treatment, or services.

**Elements of Performance for EQ.02.01.01**

1. The organization performs routine and preventive maintenance on medical equipment used by staff in the provision of care, treatment, or services at defined intervals and according to the manufacturers’ guidelines. The organization documents the performance of these checks. *(See also MC.03.06.05, EP 10; MC.03.07.01, EP 5; MC.05.06.01, EP 6)*

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
Note: If the manufacturer does not have guidelines for routine and/or preventive maintenance, the organization establishes such guidelines. For example, the organization may choose to have discussions with the manufacturer, observe its own failure rates for the equipment, examine maintenance schedules of like products, or use any other method that is effective.

2. ☐ The organization performs basic safety and operational checks on medical equipment used by staff in the provision of care, treatment, or services, according to organization policy and the manufacturers’ guidelines. The organization documents the performance of these checks. [See also MC.03.06.05, EP 10; MC.03.07.01, EP 5; MC.05.06.01, EP 6]

3. ☐ The organization evaluates the performance of devices used for analyzing, measuring, and testing medical equipment, according to the manufacturers’ guidelines. The organization documents the performance of these checks. [See also MC.03.06.05, EP 10; MC.03.07.01, EP 5; MC.05.06.01, EP 6]

4. ☐ The organization periodically inspects equipment used in compounding or preparing drugs for operational effectiveness and accuracy. The organization documents the performance of these checks.

5. ☐ The organization certifies laminar flow hoods and clean rooms every 12 months. The organization documents the performance of these checks.

Note: There are many ways to document the certification, such as using bar coding equipment, check marks on a tag, or an inventory.
Prompts to Assess Your Compliance

Please note: *Tips do not represent new accreditation requirements. They are intended to provide helpful strategies for standards compliance.*

Is there a clear process for inspecting delivery vehicles prior to equipment delivery that includes: (EQ.01.01.01)

- Securing equipment and supplies for transport?
- Separating clean equipment and supplies from dirty equipment?
- Checking that all components and supplies needed for equipment operation are included for delivery?

**TIP 1:** Equipment should be secured to the walls or floor of larger delivery vehicles with straps or cords that will not stretch and are of sufficient strength to not break.

**TIP 2:** The organization can determine its own process for separating clean and dirty equipment/supplies in the delivery vehicle. Examples include but are not limited to segregating specific areas within the vehicle to be clean and dirty or utilizing a bagging process to differentiate clean equipment from dirty.

Is there a systematic process for maintaining, inspecting, and testing medical equipment? (EQ.01.03.01)
TIP: Develop a systematic tracking process to ensure that staff know when equipment maintenance is required prior to the due date. This will allow for adequate time to address the need before the due date occurs.

Does the durable medical equipment organization have a process to determine whether or not an equipment malfunction or failure would threaten a patient’s health or life? (EQ.01.04.01)

TIP: To assist with this process, develop a patient risk analysis process that considers the following:
- The patient’s medical condition
- The patient’s and/or caregiver’s ability to respond to malfunctioning equipment
- The type of equipment the patient is using
- The frequency or duration of use
- The organization’s response time to get to the patient

For more information, use this link to access the American Association for Respiratory Care (AARC) Clinical Practice Guidelines: http://www.rcjournal.com/cpgs
Written Documentation Checklist
This worksheet lists elements of performance (EPs) that require written documentation that a surveyor could ask to see during a survey to show compliance with a standard. *(Note: Documentation can be on paper or in an electronic format.)*

<table>
<thead>
<tr>
<th>Standard</th>
<th>EP</th>
<th>Equipment Management Standards</th>
<th>Home Care Service</th>
<th>Date last verified</th>
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<tbody>
<tr>
<td>EQ.01.01.01</td>
<td>12, 13</td>
<td>EP 12—The organization verifies that the patient received the medical equipment and supplies. Verification of delivery is documented.</td>
<td>EP 12—DME (H, M), RESP, SUPP, OP (home), RT (H), DISP</td>
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<td><strong>EP 13—For DMEPOS suppliers serving Medicare beneficiaries:</strong> Prior to delivery of equipment or supplies, the organization verifies or authenticates that the equipment and supplies meet the following:</td>
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<td>- Are not adulterated, counterfeit, or suspected of being counterfeit</td>
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<td>- Have not been obtained by fraud or deceit</td>
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<td>- Are branded correctly and labeled for their intended distribution channels</td>
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<td>The verification or authentication of the equipment and supplies is documented.</td>
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<td><strong>EP 1—The organization obtains from the manufacturer copies of features, warranties, and instructions for each type of non-custom-fabricated item it supplies to patients.</strong></td>
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<td><strong>EP 2—The organization performs routine and preventive maintenance on its medical equipment at defined intervals and according to manufacturers’ guidelines. The organization documents the performance of this maintenance.</strong></td>
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<td><strong>EP 1—DME, RESP, SUPP, OP, RT, DISP, FAI, LTP</strong></td>
<td><strong>EPs 2 &amp; 3—HOS, DME, RESP, OP, RT, DISP, FAI, LTP</strong></td>
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<td>EQ.01.03.01</td>
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<td>EQ.02.01.01</td>
<td><strong>1–5</strong></td>
<td><strong>EP 1</strong>—The organization performs routine and preventive maintenance on medical equipment used by staff in the provision of care, treatment, or services at defined intervals and according to the manufacturers’ guidelines. The organization documents the performance of these checks.</td>
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<td>EP 1—<strong>HH, HOS, DME (H, F), RESP, OP, RT (H), PH</strong></td>
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<td>EP 4—The organization periodically inspects equipment used in compounding or preparing drugs for operational effectiveness and accuracy. The organization documents the performance of these checks.</td>
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<td>EPs 4, 5—<strong>DISP, FAI, LTP</strong></td>
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<td>EP 5—The organization certifies laminar flow hoods and clean rooms every 12 months. The organization documents the performance of these checks.</td>
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Action Planning Tool

Use this form to track noncompliant elements of performance (EPs) and your action steps for bringing them into compliance.

<table>
<thead>
<tr>
<th>Standard and EP</th>
<th>Observation/Issue</th>
<th>Action Step</th>
<th>Individual Responsible</th>
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Chapter Notes

Use this page to take notes about ideas for meeting the standards in this chapter, your organization’s policies and procedures that address requirements in this chapter, or the data or patient record numbers used to determine compliance or noncompliance for EPs. If a standard is found not compliant, it can be helpful to know which data were used so they can be easily accessed when developing action plans for compliance.
Human Resources (HR)

Overview
The contribution that human resources management makes to an organization’s ability to provide safe, quality care cannot be overestimated. The quality of the organization’s staff will, in large part, determine the quality of the care, treatment, or 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 organization 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 organization’s responsibility to establish and verify staff qualifications, orient staff, and provide staff with the training they need to support the care, treatment, or services the organization provides. After staff are on the job, human resources must provide for the assessment of staff competence and performance.

Chapter Outline

I. Staff
   A. Qualifications (HR.01.01.01, HR.01.02.07)
   B. Staffing (HR.01.02.05)
   C. Supervision (HR.01.03.01)
   D. Orientation (HR.01.04.01)
   E. Training and Education (HR.01.05.01, HR.01.05.03)
   F. Competence (HR.01.06.01)
   G. Evaluation of Performance (HR.01.07.01)
### Applicability for Human Resources
This grid is meant to be a resource to determine which standards and elements of performance (EPs) apply to the service categories within the Home Care Accreditation Program. The column on the far left of the grid lists the related EPs vertically by number. Service categories (defined in Table 3 of the Introduction) are listed horizontally along the top of the grid. Applicability is indicated with an “X” in a service category column.

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Standards, Rationales, and Elements of Performance

Standard HR.01.01.01
The organization defines and verifies staff qualifications.

Rationale for HR.01.01.01
The home care organization needs to establish requirements for verifying the qualifications of staff, including contract staff who provide services to the home care organization’s patients. To support safe, quality care, contract staff need to be managed in the same manner as employees. Consistent with Standards LD.03.06.01 and LD.04.03.09, the home care organization defines essential requirements, such as the provision of only qualified staff, and clarification of the responsibility (the home care organizations or the contractors) for verifying qualifications of contract staff. The home care organization needs to have verification of the information required in this standard, whether the home care organization or the contract firm verifies the information. This evidence may include information such as copies of documents obtained from the contract firm, an audit performed by the contract firm of its staff files, or an audit performed by the home care organization.

Elements of Performance for HR.01.01.01

1. The organization defines staff qualifications specific to their job responsibilities. *(See also IC.01.01.01, EP 3; MC.03.01.01, EP 6)*
   
   **Note:** 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).

2. ⑥ The organization 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.
For home health agencies that elect to use The Joint Commission deemed status option: The organization maintains current licensure and qualifications in personnel records.

**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 organization verifies and documents that the applicant has the education and experience required by the job responsibilities.

4. The organization obtains a criminal background check on the applicant as required by law and regulation or organization policy. Criminal background checks are documented. **For hospices that elect to use The Joint Commission deemed status option:** In the absence of state requirements, criminal background checks are obtained within three months of the date of employment for the states that the individual has lived in or worked in during the past three years.

5. Staff comply with applicable health screening as required by law and regulation or organization policy. Health screening compliance is documented.

8. The organization has written policies and job descriptions that specify the following staff requirements specific to the specialized equipment, supplies, and services it provides to patients:
   - Qualifications
   - Experience
   - Applicable certification, registration, or licensure
   - Training requirements
   - Continuing education requirements

9. The organization maintains copies or other verification of licenses, registrations, and certifications for personnel who provide patient care, treatment, or services.
11. **For home health agencies and hospices that elect to use The Joint Commission deemed status option:** The organization defines personnel qualifications as required by Centers for Medicare & Medicaid Services’ regulations (at 42 CFR 484.115(f) and (h) for home health agencies and at 42 CFR 418.114 and 42 CFR 418.76(a) for hospices).

**Note:** The following terms are defined in the Glossary: administrator, audiologist, clinical manager, qualified home health aide, qualified hospice aide, occupational therapist, occupational therapy assistant, physical therapist, physical therapist assistant, physician, practical (vocational) nurse, public health nurse, registered nurse, skilled professional services, social worker, social work assistant, speech-language pathologist.

12. **For hospices that elect to use The Joint Commission deemed status option:** The organization uses qualified hospice aides who have been trained and who have passed a competency evaluation.

**Note:** If a hospice aide has not provided services for compensation for a consecutive 24-month period, the individual is considered to not have completed a training or competence program and must complete a program before providing services.

**For DMEPOS suppliers serving Medicare beneficiaries:** The organization employs a qualified rehabilitation technology supplier (RTS) that possesses one of the following credentials:

14. Certified Rehabilitative Technology Supplier (CRTS) or Assistive Technology Professional (ATP). (*See also* HR.01.02.05, EP 19)

15. **For organizations that provide complex rehabilitative wheelchairs and assistive technology:** The trained technicians have all of the following:

- Factory training from manufacturers of the products the organization supplies
- Experience in the field of rehabilitation technology

**Note:** Experience includes, but is not limited to, on-the-job training or familiarity with rehabilitation patients, products, and services.

- **For DMEPOS suppliers serving Medicare beneficiaries:** Completed at least 10 hours annually of continuing education specific to rehabilitation technology
- Ability to program and repair sophisticated electronics associated with power wheelchairs, alternative drive controls, and power seating systems (*See also* HR.01.02.05, EP 20)
16. **For hospices that elect to use The Joint Commission deemed status option:** Hospice volunteers have defined administrative or direct patient care roles.

19. ⑤ Upon request, the organization provides copies of policies, job descriptions, certifications, registrations, and licensures to its accreditation organization and government officials or their authorized agents.

20. ⑥ **For DMEPOS suppliers serving Medicare beneficiaries:** Staff who provide patient care, treatment, or services have the qualifications required by the organization’s job descriptions and policies.

21. **For home health agencies and hospices that elect to use The Joint Commission deemed status option:** Licensed skilled professional services that are provided directly or under arrangement are authorized, delivered, and supervised only by health care professionals who meet federal qualifications and who practice according to the organization’s policies and procedures.

   **Note 1:** The qualifications are specified for home health under 42 CFR 484.115 and for hospice under 42 CFR 418.114.

   **Note 2:** The following terms are defined in the Glossary:

   - physician, social worker, speech-language pathologist, occupational therapist, occupational therapy assistant, physical therapist, physical therapist assistant, registered nurse, licensed practical nurse

22. **For hospices that elect to use The Joint Commission deemed status option:** When dietary counseling is identified in the plan of care, it is provided by a qualified individual; this includes dietitians and other individuals who are able to address the patient’s dietary needs.

23. **For hospices that elect to use The Joint Commission deemed status option:** If the state regulates personal care aides, the hospice provides personal aide services using only those individuals who have met the competencies required by the state’s regulations.

   **Note:** The individual needs to demonstrate competence only in the services that the individual will be required to provide.

24. **For hospices that elect to use The Joint Commission deemed status option:** Homemaker services are provided by a qualified hospice aide or by a qualified homemaker.
Note: A qualified homemaker is an individual who can provide assistance in maintaining a safe and healthy environment as well as services that enable the patient to carry out the treatment plan. For more information on coverage requirements for homemaker services, see 42 CFR 418.202(g) in the Appendix.

25. For hospices that elect to use The Joint Commission deemed status option: The individual(s) supervising the provision of bereavement services is a qualified professional with experience or education in grief or loss counseling.

26. For hospices that elect to use The Joint Commission deemed status option: The interdisciplinary group confers with an individual with education and training in medication management as defined in hospice policies and procedures and state law to ensure that drugs and biologicals meet each patient’s needs.

Note: This individual may be an employee or may be under contract.

27. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: Program staff have palliative care education, experience, training, and/or certification consistent with the program’s policies and its philosophy and scope of care, treatment, and services. (For more information, refer to HR.01.02.01, EPs 1 and 3)

28. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: For programs that provide care for pediatric patients: Members of the interdisciplinary team have expertise in providing care for children.

29. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: For programs that provide care for pediatric patients: Health care professionals with experience in the developmental stages and needs of infants, children, and adolescents perform and document the psychosocial and developmental assessment.

34. For home health agencies that elect to use The Joint Commission deemed status option: A qualified home health aide is a person who has successfully completed one of the following programs:

- A training and competency evaluation program as specified in 42 CFR 484.80 (b) and (c); or
- A competency evaluation program that meets the requirements of 42 CFR 484.80 (c); or
- A nurse aide training and competency evaluation program approved by the state and is currently listed in good standing on the state nurse aide registry; or
- The requirements of a state licensure program that meets the provisions of paragraphs 42 CFR 484.80 (b) and (c)

35. **For home health agencies that elect to use The Joint Commission deemed status option:** If a home health aide or nurse aide has not provided any patient services for compensation during a continuous period of 24 consecutive months after completing his or her initial training program, the individual must complete another program before providing services.

**Standard HR.01.02.05**
The organization has the necessary staff to support the care, treatment, or services it provides.

**Elements of Performance for HR.01.02.05**

8. **For home health agencies that elect to use The Joint Commission deemed status option:** The organization provides skilled nursing services by or under the supervision of a registered nurse that has graduated from an approved school of nursing and is licensed in the state where practicing.

9. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** A registered nurse provides direct patient care, treatment, or services on each shift.

18. **For home health agencies that elect to use The Joint Commission deemed status option:** One or more qualified clinical manager(s) must provide oversight of all patient care services and staff. Oversight includes the following:
   - Making patient and staff assignments
   - Coordinating patient care
   - Coordinating referrals
   - Assuring that patient needs are continually assessed
   - Assuring the development, implementation, and updates of the individualized plan of care

19. **For DMEPOS suppliers serving Medicare beneficiaries:** The organization employs (as a W-2 employee) at least one qualified individual per location as a rehabilitation technology supplier (RTS). *(See also HR.01.01.01, EP 14)*
20. **For DMEPOS suppliers serving Medicare beneficiaries:** The organization determines the number of trained technicians available to serve each location, based on the size and scope of the location’s business. *(See also HR.01.01.01, EP 15)*

29. **For home health agencies that elect to use The Joint Commission deemed status option:** The administrator or a designated individual is available during all operating hours. *(See also LD.01.04.01, EP 11)*

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**Standard HR.01.02.07**

The organization determines how staff function within the organization.

**Elements of Performance for HR.01.02.07**

1. All staff who provide patient care, treatment, or services possess a current license, certification, or registration, in accordance with law and regulation.

2. Staff who provide patient care, treatment, or services practice within the scope of their license, certification, or registration and as required by law and regulation.

3. **For home health agencies and hospices that elect to use The Joint Commission deemed status option:** The role of a home health aide or hospice aide includes all of the following functions:
   - Provision of hands-on personal care
   - Performance of simple procedures as an extension of therapy or nursing services
   - Assistance in ambulation or exercises
   - Assistance in administering medications that are ordinarily self-administered

   **For home health agencies that elect to use The Joint Commission deemed status option:** Home health aides also do the following:
   - Hold membership on the interdisciplinary team
   - Report changes in the patient’s condition to a registered nurse or other appropriate skilled professional
   - Complete pertinent records in compliance with the organization’s policies and procedures

4. **For hospices that elect to use The Joint Commission deemed status option:** A registered nurse assigns patients to a hospice aide.

5. When students provide care, treatment, or services, they are supervised by staff.
6. **For hospices that elect to use The Joint Commission deemed status option:**
   Registered nurses see, treat, and write orders for patients only if permitted to do so by state law.

7. **For hospices that elect to use The Joint Commission deemed status option:**
   Licensed professionals do the following:
   - Participate in the coordination of the patient’s hospice care in accordance with professional standards of practice
   - Participate in ongoing interdisciplinary comprehensive assessments
   - Participate in the development and evaluation of the plan of care
   - Contribute to patient and family counseling and education

8. **For hospices that elect to use The Joint Commission deemed status option:**
   Homemaker services are coordinated and supervised by a member of the interdisciplinary group.

9. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:**
   Program staff are knowledgeable about their roles and responsibilities relative to patient safety in the home.

10. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:**
    The program’s core interdisciplinary team is comprised of the following:
    - Physician(s) (doctor of medicine or osteopathy) who has specialized training in palliative care and/or hospice care; clinical experience in palliative medicine and/or hospice care; or is board-certified or board-eligible for certification in Hospice and Palliative Medicine
    - Registered nurse(s) or advanced practice nurse(s) who has training in palliative care and/or hospice care; clinical experience in hospice or palliative care; or one who has, or is eligible for, palliative care certification
    - Chaplain(s) who has training in palliative care and/or hospice care; experience in hospice or palliative care; or one who has or is eligible for board certification; or, a spiritual care professional(s)† who has training in palliative care and/or hospice care or experience in hospice or palliative care

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Note: The program may choose to have a full- or part-time chaplain or spiritual care provider on staff, utilize a chaplain or spiritual care provider from another program within the organization (such as the hospital or hospice), or utilize chaplains and/or spiritual care providers in the local community (including parish nurses). The patient also has the right to involve his or her personal spiritual care provider (such as a pastor, priest, rabbi, or religious leader) rather than the program’s chaplain.

- Social worker(s) who has training in palliative care and/or hospice care; experience in hospice or palliative care; or one who has, or is eligible for, palliative care certification

Note: The program may choose to have a full- or part-time social worker on staff, utilize a social worker from another program within the organization (such as the hospital or hospice), or utilize social workers from other organizations in the community if they are available.

11. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: Based on the care, treatment, and services provided, the population served, and the patient’s and family’s needs, the palliative care program’s interdisciplinary team may utilize additional individuals from other health care disciplines.

12. (©) For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The program defines in writing the interdisciplinary team members’ responsibilities.

13. For home health agencies that elect to use The Joint Commission deemed status option: Skilled professionals have responsibility for, but are not limited to, the following:

- Participation in the patient’s coordination of care
- Ongoing interdisciplinary assessment of the patient
- Development and evaluation of the plan of care in partnership with the patient, representative (if any), and caregiver(s)
- Providing services that are ordered by the physician as indicated in the plan of care
- Patient, caregiver, and family counseling
- Patient and caregiver education
- Preparing clinical notes
- Communication with all physicians involved in the plan of care and other health care practitioners (as appropriate) related to the current plan of care

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
- Participation in the organization’s quality assessment and performance improvement (QAPI) program
- Participation in organization-sponsored in-service training

**Note:** See glossary for the definition of skilled professional services.

14. **For home health agencies that elect to use The Joint Commission deemed status option:** A registered nurse or other appropriate skilled professional assigns patients to a home health aide.

**Standard HR.01.03.01**

*Staff are supervised effectively.*

**Elements of Performance for HR.01.03.01**

1. Supervisors understand the care, treatment, or services provided by staff under their supervision.

3. Supervisors have clinical and supervisory experience pertinent to the level of care and service provided and in accordance with law and regulation and organization policy.

14. **For hospices that elect to use The Joint Commission deemed status option:** In order to assess the quality of care and services provided by the hospice aide and to ensure that services ordered meet the patient’s needs, the registered nurse supervises the hospice aide during an on-site visit to the patient’s home no less frequently than every 14 days. If nursing services are not provided, a physical or occupational therapist or speech-language pathologist can supervise the hospice aide.

**Note:** The aide does not need to be present during the supervisor’s visit.

15. **For home health agencies that elect to use The Joint Commission deemed status option:** When home health aide services are provided to a patient who is not receiving skilled nursing care, physical or occupational therapy, or speech-language pathology services, the registered nurse makes an on-site visit to the location where the patient is receiving care. This visit occurs no less frequently than every 60 days in order to observe and assess each aide while he or she is performing care.
19. **For home health agencies that elect to use The Joint Commission deemed status option:** Rehabilitative therapy services are provided under the supervision of an occupational therapist or physical therapist.

*Note: The following terms are defined in the Glossary: administrator, audiologist, clinical manager, qualified home health aide, qualified hospice aide, occupational therapist, occupational therapy assistant, physical therapist, physical therapist assistant, physician, practical (vocational) nurse, public health nurse, skilled professional services, registered nurse, social worker, social work assistant, speech-language pathologist.*

21. **For home health agencies that elect to use The Joint Commission deemed status option:** Medical social services are provided under the supervision of a social worker.

*Note: The following terms are defined in the Glossary: administrator, audiologist, clinical manager, qualified home health aide, qualified hospice aide, occupational therapist, occupational therapy assistant, physical therapist, physical therapist assistant, physician, practical (vocational) nurse, public health nurse, registered nurse, social worker, social work assistant, speech-language pathologist.*

22. **For hospices that elect to use The Joint Commission deemed status option:** A designated hospice employee supervises volunteers.

23. **For home health agencies and hospices that elect to use The Joint Commission deemed status option:** If an area of concern in aide services is noted by the supervising registered nurse, then the supervising individual must make an on-site visit to the location where the patient is receiving care in order to observe and assess the aide while he or she is providing care.

*For home health agencies that elect to use The Joint Commission deemed status option:* An area of concern may be identified and the visit to the patient to observe and assess the aide may be made by a registered nurse or any skilled professional.

24. **For hospices that elect to use The Joint Commission deemed status option:** If an area of concern is verified by the hospice during the on-site visit with the hospice aide, the hospice conducts a competency evaluation of the hospice aide.
25. **For hospices that elect to use The Joint Commission deemed status option:** A registered nurse makes an annual on-site visit to the location where the patient is receiving care in order to observe and assess each aide while he or she is providing care.

26. **For hospices that elect to use The Joint Commission deemed status option:** The supervising nurse assesses the aide’s ability to demonstrate initial and continued satisfactory performance in the following:
   - Completing the tasks in the plan of care assigned to the hospice aide by the registered nurse
   - Creating successful interpersonal relationships with the patient and family
   - Demonstrating competence with assigned tasks
   - Complying with infection control policies and procedures
   - Reporting changes in the patient’s condition

27. **For home health agencies that elect to use The Joint Commission deemed status option:** When home health aide services are provided to a patient who is receiving skilled nursing, physical or occupational therapy, or speech-language pathology services, a registered nurse or other appropriate skilled professional who is familiar with the patient, the patient’s plan of care, and the patient care instructions written by a registered nurse or appropriate skilled professional, must make an on-site visit to the patient’s home no less frequently than every 14 days. The home health aide does not have to be present during this visit.

28. **For home health agencies that elect to use The Joint Commission deemed status option:** Home health aide supervision confirms that home health aides furnish care in a safe and effective manner, including, but not limited to, the following aide responsibilities:
   - Following the patient’s plan of care for completion of tasks
   - Maintaining an open communication process with the patient, representative (if any), caregivers, and family
   - Demonstrating competency with assigned tasks
   - Complying with infection control policies and procedures
   - Reporting changes in the patient’s condition
   - Honoring patient rights
29. **For home health agencies that elect to use The Joint Commission deemed status option:** A registered nurse or other appropriate skilled professional must make an annual on-site visit to the location where the patient is receiving care in order to observe and assess each aide while he or she is performing care.

30. **For home health agencies that elect to use The Joint Commission deemed status option:** If a deficiency in aide services is verified by the registered nurse or other appropriate skilled professional during an on-site visit, then the agency must conduct, and the home health aide must complete, a competency evaluation in accordance with 42 CFR 484.80(c). *(See HR.01.06.01, EP 8)*

**Standard HR.01.04.01**

The organization provides orientation to staff.

**Rationale for HR.01.04.01**

Members of the organization’s community-based palliative care interdisciplinary team need to be educated on the basic concepts of palliative care during orientation and on an ongoing basis as needed. The organization decides how this education is provided; for example, education can be taught by palliative care, home health, and hospice staff; or the organization may allow team members and staff to obtain this education via online training courses or at local or national seminars. The organization’s leaders also decide which other staff members are required to attend education on these concepts.

**Elements of Performance for HR.01.04.01**

1. ⚫ The organization orients its staff to the key safety content it identifies before staff provides care, treatment, or services. Completion of this orientation is documented.

   **Note:** Key safety content may include specific processes and procedures related to the provision of care, treatment, and services; the environment of care; and infection control.

2. ⚫ The organization orients staff on the following:
   - Relevant policies and procedures
   - Their specific job duties, including those related to infection prevention and control and assessing and managing pain

   Completion of this orientation is documented. *(See also MC.04.02.03, EP 1)*
Note: For organizations that provide personal care and support services:
Orientation to assessing and managing pain is not required for personal care staff members.

21. For hospices that elect to use The Joint Commission deemed status option: The hospice provides orientation about the hospice philosophy to all employees and contracted staff who have patient and family contact. The hospice also provides, maintains, and documents volunteer orientation and training that are consistent with current standards of hospice practice.

22. For hospices that elect to use The Joint Commission deemed status option: For hospice care provided to a resident of a Skilled Nursing Facility (SNF), Nursing Facility (NF), or Intermediate Care Facility for the Mentally Retarded (ICF/MR), the hospice orientates and trains the SNF, NF, or ICF/MR staff providing care to hospice patients in the hospice philosophy, including hospice policies regarding methods of comfort, pain control, and symptom management; principles about death and dying; individual responses to death; patient rights; and appropriate forms and record-keeping requirements.

23. For hospices that elect to use The Joint Commission deemed status option: The homemaker has successfully completed a hospice orientation that addresses the needs and concerns of patients and families in coping with a terminal illness.

24. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The program provides or facilitates access to orientation for the interdisciplinary team members, program staff, and volunteers as needed to fulfill their responsibilities. The orientation plan and specific content are defined by the program leaders and include, but are not limited to, the following areas:
- The domains of palliative care

Note: The eight domains of palliative care are described in the Clinical Practice Guidelines for Quality Palliative Care by the National Consensus Project for Quality Palliative Care, 3rd ed. (2013).
- Assessment and management of pain and other physical symptoms
- Assessment and management of psychological symptoms and psychiatric diagnoses
- Communication skills
- Cross-cultural knowledge and skills
- Information on specific population(s) served

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
Grief and bereavement
Ethical principles that guide provision of palliative care
Community resources for patients and families
Hospice care

Note: Orientation may be provided over a period of time and in a variety of methods, including live and video presentations; electronic or written materials; clinical experience with a preceptor or mentor; or education at a seminar or other organization.

25. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: For programs that provide care for pediatric patients:
The program provides access to pediatric-specific orientation and ongoing education for the interdisciplinary team members, staff, and volunteers that provide care for pediatric patients.

Standard HR.01.05.01
Medicare-certified hospices and home health agencies provide initial training to home health and hospice aides.

Elements of Performance for HR.01.05.01

1. For home health agencies and hospices that elect to use The Joint Commission deemed status option: When a home health aide or hospice aide training program is offered, this training totals at least 75 hours, with at least 16 hours of classroom training and 16 hours of supervised practical training. The classroom training is conducted before the supervised practical training.

Note 1: For hospices that elect to use The Joint Commission deemed status option: Supervised practical training refers to training in a laboratory or setting in which, under the direct supervision of a registered nurse or licensed practical nurse, the trainee demonstrates knowledge while performing tasks on an individual.

Note 2: For home health agencies that elect to use The Joint Commission deemed status option: Supervised practical training is in a setting where the trainee demonstrates knowledge while providing services to a patient under the direct supervision of a registered nurse or a licensed practical nurse who is under the supervision of a registered nurse.
2. **For home health agencies and hospices that elect to use The Joint Commission deemed status option:** An organization cannot offer a home health aide training or competency evaluation program, or a hospice aide training program, if any of the following issues occurred within the previous two years:
   - Surveyed out of compliance with requirements of 42 CFR 484.80 (b), (c), (d), or (e) for home health aides, or 483.151 through 483.154 for hospice aides
   - Found to permit an individual who does not meet the definition of a "qualified home health aide" (see Glossary) to furnish home health aide services (with the exception of licensed health professionals and volunteers)
   - Had an extended or partially extended survey as a result of furnishing substandard care (or for other reasons at the discretion of CMS or the state)
   - Assessed a civil monetary penalty of $5,000 or more as an intermediate sanction
   - Compliance deficiencies that endanger the health and safety of the home health agency’s patients, and has had temporary management appointed to oversee the management of the home health agency
   - All or part of its Medicare payments suspended
   - Participation in the Medicare program terminated
   - Assessed a penalty of $5,000 or more for deficiencies in federal or state standards for home health agencies
   - Suspension of Medicare payments to which it otherwise would have been entitled
   - Operated under a temporary management that was appointed to oversee the operation of the home health agency and to ensure the health and safety of the home health agency’s patients
   - Been closed or had its patients transferred by the state
   - **For home health agencies that elect to use The Joint Commission deemed status option:** Excluded from participating in federal health care programs or debarred from participating in any government program

   **Note:** Organizations that have not had these issues may still provide aide in-service education.

3. **For hospices that elect to use The Joint Commission deemed status option:** The organization provides orientation and training that is consistent with acceptable standards of hospice practice. The orientation and training are documented.
4. **For home health agencies and hospices that elect to use The Joint Commission deemed status option:** The home health aide or hospice aide training program addresses all of the following:

- Communication skills, including the ability to read, write, and verbally report clinical information to patients, representatives, and caregivers, as well as to other staff.
- Observation, reporting, and documentation of patient status and the care, treatment, or service furnished.
- How to read and record temperature, pulse, and respiration.
- Basic infection control procedures.
- Basic elements of body functioning and changes in body function that must be reported to an aide’s supervisor.
- Maintenance of a clean, safe, and healthy environment.
- Recognizing emergencies and initiating necessary emergency procedures.
- The physical, emotional, and developmental needs of and ways to work with the populations served by the home health aide or hospice aide, including the need to respect the patient and his or her privacy and property.
- Appropriate and safe techniques in personal hygiene and grooming that include bed, sponge, tub, and shower bath; sink, tub, and bed shampoo; nail and skin care; oral hygiene; and toileting and elimination.
- Safe transfer techniques and ambulation.
- Normal range of motion and positioning.
- Adequate nutrition and fluid intake.
- Other tasks that the organization may choose to have the aide perform as permitted under state law.

**Note:** *For home health agencies that elect to use The Joint Commission deemed status option:* The home health aide training program includes the recognition and reporting of changes in skin condition.

5. **For home health agencies and hospices that elect to use The Joint Commission deemed status option:** The organization maintains documentation that demonstrates compliance with initial home health aide or hospice aide training requirements.
6. **For home health agencies and hospices that elect to use The Joint Commission deemed status option:** A registered nurse supervises the classroom and practical training portion of aide training; this registered nurse possesses a minimum of two years of nursing experience, at least one year of which must be in the provision of home health care.

   **Note:** Other individuals may provide classroom instruction under the supervision of a qualified registered nurse.

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**Standard HR.01.05.03**

Staff participate in ongoing education and training.

**Rationale for HR.01.05.03**

Ongoing education is critical to providing patients with clinically competent health care professionals. The home care organization is not required to provide continuing education units (CEUs) but should facilitate ongoing education and training by identifying the educational needs of its clinical staff. Ways in which this can be accomplished are by identifying risks in the environment and analyzing data gathered in competence assessment results, patient feedback, performance improvement activities, staff self-assessment, current practice guidelines changes, or legislative initiatives.

**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. *(See also MC.04.02.03, EP 1)*

2. The organization’s education and training comply with law and regulation.

5. ‡ Staff participate in education and training that is specific to the needs of the patient population served by the organization. Staff participation is documented. *(See also PC.01.02.09, EP 3)*

9. **For home health agencies and hospices that elect to use The Joint Commission deemed status option:** Each home health aide or hospice aide participates in at least 12 hours of in-service training during each 12-month period.

   **Note:** This in-service training may be furnished while the aide is providing care to a patient.
11. **For home health agencies and hospices that elect to use The Joint Commission deemed status option:** In-service training for home health and hospice aides is supervised by a registered nurse.

   **Note:** *In-service training may be offered by any organization.*

12. ⚫ **For hospices that elect to use The Joint Commission deemed status option:** The hospice has a written description of the in-service training provided in the previous 12 months.

27. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** Program leaders identify and respond to the specific learning needs of the interdisciplinary team and program staff. This includes determining education topics and number of hours of continuing education and providing or arranging for needed education. (For more information, refer to HR.01.05.03, EP 5)

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**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 organization know whether its staff have the ability to use specific skills and to employ the knowledge necessary to perform their jobs. Examples of competencies that might be assessed for home health or hospice services could be a staff member’s ability to insert an intravenous catheter; for home medical equipment services it could be a staff member’s ability to program a continuous positive airway pressure machine; for pharmacy services, a staff member’s ability to admix chemotherapy agents.

When the organization 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. An example of a specific competency that could be assessed for home health or hospice services could be a staff member’s ability to perform a sterile irrigation of a wound on a confused, elderly patient; for home medical equipment services the competency could be a staff member’s ability to program a ventilator for a patient on total assist; for pharmacy services, the competency could be a staff member’s ability to admix chemotherapy for geriatric patients.
Where competency assessment focuses on specific knowledge, skill, and ability, performance evaluations are broader in scope. Performance evaluations are not only focused on a staff member’s competence, they also include other expectations that have been established for each staff member. For example, a performance evaluation might include expectations relative to whether a staff member participates in education and training offered by the organization or how well he or she carries out job responsibilities and manages time.

What competency assessments and performance evaluations share is the requirement that they are performed at least once every three years. This does not mean, however, that they have to be performed together at the same time. Some organizations, often those that are smaller in size, may choose to combine competency assessments with performance evaluations. Others may choose to handle these activities separately. If an organization chooses to combine the activities, it needs to make sure that the performance evaluation contains specific competencies. However these two activities are conducted, feedback on performance is most useful to staff if it is given whenever an opportunity arises.

**Standard HR.01.06.01**
Staff are competent to perform their responsibilities.

**Elements of Performance for HR.01.06.01**

1. The organization defines the competencies it requires of its staff who provide patient care, treatment, or services. *(See also MC.02.01.11, EP 7; MC.04.02.03, EP 5; 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 organization can utilize an outside individual for this task. If a suitable individual inside or outside the organization cannot be found, the organization may consult the competency guidelines from an appropriate professional organization to make its assessment.

4. **For home health agencies and hospices that elect to use The Joint Commission deemed status option:** A registered nurse performs the competency evaluation of a home health aide or hospice aide.
For home health agencies that elect to use The Joint Commission deemed status: The registered nurse performs the competency evaluation of a home health aide in consultation with other skilled professionals as appropriate.

5. ☐ Staff competence is initially assessed and documented as part of orientation. (See also MC.02.01.11, EP 7) R

6. ☐ Staff competence is assessed and documented once every three years, or more frequently as required by organization policy or in accordance with law and regulation. (See also MC.02.01.11, EP 7) R

7. For home health agencies and hospices that elect to use The Joint Commission deemed status option: Home health aides and hospice aides successfully complete a competency evaluation before providing patient care.

8. For home health agencies and hospices that elect to use The Joint Commission deemed status option: The home health aide and hospice aide competency evaluation includes the following skills:

   - Communication skills
   - For home health agencies that elect to use The Joint Commission deemed status: This includes the ability to read, write, and verbally report clinical information to patients, representatives, and caregivers, as well as to other home health agency staff
   - Observation, reporting, and documentation of patient status and the care, treatment, and service furnished
   - How to read and record temperature, pulse, and respiration
   - Basic infection control procedures
   - Basic elements of body functioning and changes in body function that must be reported to an aide’s supervisor
   - Maintenance of a clean, safe, and healthy environment
   - Recognizing emergencies and knowing how to institute emergency procedures
   - The physical, emotional, and developmental needs of and ways to work with the populations served by the home health aide or hospice aide, including the need to respect the patient and his or her privacy and property
   - Appropriate and safe techniques in personal hygiene and grooming that include bed, sponge, tub, and shower bath; sink, tub, and bed shampoo; nail and skin care; oral hygiene; and toileting and elimination
   - Safe transfer techniques and ambulation
Normal range of motion and positioning
Adequate nutrition and fluid intake

**For home health organizations that elect to use The Joint Commission deemed status option:** Skills not covered in the basic checklist
Other tasks that the organization may choose to have the aide perform as permitted under state law

9. **For home health agencies and hospices that elect to use The Joint Commission deemed status option:** The supervisor evaluates the following areas by observing a home health or hospice aide’s performance of the tasks with a patient:
- Appropriate and safe techniques in personal hygiene and grooming that include bed, sponge, tub, or shower bath; sink, tub, or bed shampoo; nail and skin care; oral hygiene; toileting and elimination
- Safe transfer techniques and ambulation
- Normal range of motion and positioning

**For home health agencies that elect to use The Joint Commission deemed status:**
The supervisor evaluating the aide must be a registered nurse.

10. **For home health agencies and hospices that elect to use The Joint Commission deemed status option:** The organization evaluates the following subject areas through written examination, oral examination, or after observation of a home health aide or hospice aide with a patient:
- Communication skills
- **For home health agencies that elect to use The Joint Commission deemed status:** This includes the ability to read, write, and verbally report clinical information to patients, representatives, and caregivers, as well as to other staff
- Observation, reporting, and documentation of patient status and the care or service furnished
- Reading and recording temperature, pulse, and respirations
- Basic infection control procedures
- Basic elements of body functioning and changes in body function that must be reported to an aide’s supervisor
- Maintenance of a clean, safe, and healthy environment
- Recognizing emergencies and initiating necessary emergency procedures
- The physical, emotional, and developmental needs of and ways to work with the populations served by the home health aide or hospice aide, including the need to respect the patient and his or her privacy and property

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
Adequate nutrition and fluid intake

Any other task that the home health agency or hospice may choose to have the home health aide or hospice aide perform as permitted under state law.

11. **For home health agencies and hospices that elect to use The Joint Commission deemed status option:** The organization does not deem an aide competent when the aide rates an “unsatisfactory” in more than one of the required tasks.

   **Note:** The organization determines its rating scale for satisfactory competency.

12. **For home health agencies and hospices that elect to use The Joint Commission deemed status option:** The home health aide or hospice aide does not perform any task for which he or she tested as “unsatisfactory” without direct supervision by a registered nurse until the aide has additional training and passes a subsequent competency evaluation.

13. **For home health agencies that elect to use The Joint Commission deemed status option:** When home health aides provide personal care attendant services under the Medicaid personal care benefit, the aide provides personal care services only after he or she has met all qualification standards established by the state.

   **Note:** The aide does not have to be competent in services he or she does not provide.

14. Technical staff are competent to deliver and set up equipment, provide services, and train patients and caregivers.

17. **For hospices that elect to use The Joint Commission deemed status option:** The hospice has written policies and procedures that describe its method of assessment of competence.

26. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** Program leaders, or designees, determine and evaluate the qualifications, training, and experience of individuals who are considered for membership on the program interdisciplinary team and staff. (For more information, refer to HR.01.02.07, EP 10)

27. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** Program leaders assess each program staff member’s competence to perform job responsibilities through observation within program-defined time frames. This assessment is documented. (For more information, refer to HR.01.06.01, EP 1)
Standard HR.01.07.01

The organization evaluates staff performance.

Elements of Performance for HR.01.07.01

1. The organization evaluates staff based on performance expectations that reflect their job responsibilities. *(See also* MC.02.01.13, EP 1)*

2. ☰ The organization evaluates staff performance once every three years, or more frequently as required by organization policy or in accordance with law and regulation. This evaluation is documented. *(See also* MC.02.01.13, EP 1)*
Prompts to Assess Your Compliance

Please note: Tips do not represent new accreditation standards. They are intended to provide helpful strategies for standards compliance.

Does your organization have the appropriate licensed professional, qualified staff, and so forth, supporting the appropriate service lines in your business?  (HR.01.01.01)

Have all licenses and certification been checked with primary sources on hire and prior to expiration?  (HR.01.02.05)

Have all new hires completed orientation? Are initial and repeating competencies up to date and documented for all staff, per organization policy? Are all the identified competencies still relevant for our operations? Do we need to add or revise any of our competencies based on new equipment or practices?  (HR.01.04.01)

Are your staff members aware of their job responsibilities?  (HR.01.02.07, HR.01.06.01)

What is the process to maintain human resource records—for example, health screenings, competencies, performance evaluations?  (HR.01.04.01)
Are the appropriate staff members conducting competencies for the appropriate skill classifications? (HR.01.06.01)

Are your staff members aware of your organization’s policies and procedures? (HR.01.04.01)

Have performance evaluations been completed within the time frames defined by organization policy? (HR.01.07.01)

What is the process to maintain credentialing records for licensed independent practitioners? (HR.01.02.05)

**TIP:** Develop a systematic process for auditing the organization’s HR records. Include a method for “flagging” items that are missing or that must be addressed in the near future.
**Written Documentation Checklist**

This worksheet lists elements of performance (EPs) that require written documentation that a surveyor could ask to see during a survey to show compliance with a standard. *(Note: Documentation can be on paper or in an electronic format.)*

### Human Resources (HR)

<table>
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|   | HR.01.01.01 | 2–5, 8, 9, 19, 20 | EP 2—The organization 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.  

**For home health agencies that elect to use The Joint Commission deemed status option:** The organization maintains current licensure and qualifications in personnel records.  

EP 3—The organization verifies and documents that the applicant has the education and experience required by the job responsibilities. | EPs 2–5—All services  
EPs 8, 19, 20—DME, RESP, SUPP, OP, CRS, RT  
EP 9—HOS (F), DME, RESP, SUPP, OP, CRS, RT | |
EP 4—The organization obtains a criminal background check on the applicant as required by law and regulation or organization policy. Criminal background checks are documented. For hospices that elect to use The Joint Commission deemed status option: In the absence of state requirements, criminal background checks are obtained within three months of the date of employment for the states that the individual has lived in or worked in during the past three years.

EP 5—Staff comply with applicable health screening as required by law and regulation or organization policy. Health screening compliance is documented.

EP 8—The organization has written policies and job descriptions that specify the following staff requirements specific to the specialized equipment, supplies, and services it provides to patients:
- Qualifications
- Experience
- Applicable certification, registration, or licensure
- Training requirements
- Continuing education requirements

EP 9—The organization maintains copies or other verification of licenses, registrations, and certifications for personnel who provide patient care, treatment, or services.

EP 19—Upon request, the organization provides copies of policies, job descriptions, certifications, registrations, and licensures to its accreditation organization and government officials or their authorized agents.

EP 20—For DMEPOS suppliers serving Medicare beneficiaries: Staff who provide patient care, treatment, or services have the qualifications required by the organization's job descriptions and policies.

EP 12—For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The program defines in writing the interdisciplinary team members’ responsibilities.
| EP 1—The organization orients its staff to the key safety content it identifies before staff provides care, treatment, or services. Completion of this orientation is documented. EP 3—The organization orients staff on the following:  
- Relevant policies and procedures  
- Their specific job duties, including those related to infection prevention and control and assessing and managing pain. Completion of this orientation is documented. EP 21—For hospices that elect to use The Joint Commission deemed status option: The hospice provides orientation about the hospice philosophy to all employees and contracted staff who have patient and family contact. The hospice also provides, maintains, and documents volunteer orientation and training that are consistent with current standards of hospice practice. EP 24—For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The program provides or facilitates access to orientation for the interdisciplinary team members, program staff, and volunteers as needed to fulfill their responsibilities. The orientation plan and specific content are defined by the program leaders and include, but are not limited to, the following areas:  
- The domains of palliative care  
- Communication skills  
- Cross-cultural knowledge and skills  
- Information on specific population(s) served  
- Grief and bereavement  
- Ethical principles that guide provision of palliative care  
- Community resources for patients and families  
- Hospice care |
| HR.01.05.01 | 3, 5 | EP 3—For hospices that elect to use The Joint Commission deemed status option: The organization provides orientation and training that is consistent with acceptable standards of hospice practice. The orientation and training are documented. | EP 3—Deemed HOS |
| HR.01.05.03 | 1, 5, 12 | EP 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. | EPs 1, 5—All services EP 12—Deemed HOS |
| HR.01.06.01 | 5, 6, 17, 27 | EP 5—Staff competence is initially assessed and documented as part of orientation. EP 6—Staff competence is assessed and documented once every three years, or more frequently as required by organization policy or in accordance with law and regulation. EP 17—For hospices that elect to use The Joint Commission deemed status option: The hospice has written policies and procedures that describe its method of assessment of competence. | EPs 5–6—All services EP 17—Deemed HOS |
| | | EP 27—For hospices that elect to use The Joint Commission deemed status option: Program leaders assess each program staff member's competence to perform job responsibilities through observation within program-defined time frames. This assessment is documented. | EP 27—HH, Deemed HOS |
| HR.01.07.01 | 2 | EP 2—The organization evaluates staff performance once every three years, or more frequently as required by organization policy or in accordance with law and regulation. This evaluation is documented. | All services |
**Action Planning Tool**

Use this form to track noncompliant elements of performance (EPs) and your action steps for bringing them into compliance.

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<th>Standard and EP</th>
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Chapter Notes

Use this page to take notes about ideas for meeting the standards in this chapter, your organization’s policies and procedures that address requirements in this chapter, or the data or patient record numbers used to determine compliance or noncompliance for EPs. If a standard is found not compliant, it can be helpful to know which data were used so they can be easily accessed when developing action plans for compliance.
Infection Prevention and Control (IC)

Overview
When most people think of health care–associated infections (HAIs), they think of infections acquired in the hospital setting. However, recent publicity surrounding Methicillin-resistant Staphylococcus aureus (MRSA) and other antibiotic-resistant infections has raised concern that HAIs can be acquired in almost any setting, including home health agencies, hospices, and even pharmacies and home medical equipment providers. The contact home care staff have with patients and medical equipment and supplies makes infection prevention and control a matter of high concern. As home care staff know all too well, the patient’s home environment is often far from sterile, making the work of infection prevention and control all the more difficult, but still a priority. All home care staff should observe good hand hygiene. However, infection prevention and control measures should extend well beyond this practice. For example, home health and hospice staff need to be careful of infectious body fluids from wounds and the secretions from upper respiratory infections. They should always be mindful of decontamination processes, particularly of equipment used for evaluation. Home care pharmacies need to be on the alert for breaches in the sterile processes used for compounding drugs. And suppliers of home medical equipment need to watch for contamination, which may not always be visible, in water reservoirs from continuous positive airway pressure (C-PAP) machines. They should also be careful not to mishandle contaminated equipment. Clearly, all home care staff, regardless of position, need to observe proper infection prevention and control techniques at all times.

To help reduce the possibility of acquiring and spreading an infection, home care organizations 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 also need to be practical and reasonable to follow. No organization wants to jeopardize a patient’s health because its infection prevention and control activities are obsolete or too confusing to
practice daily. To create a successful program, leadership should have input and lend support. After an effective program is in place, the organization takes measures so that the program operates according to plan and is properly evaluated.

**About This Chapter**
The processes outlined in the “Infection Prevention and Control” (IC) chapter are applicable to all infections or potential sources of infection that occur in a home care setting, including a sudden increase in the number of potentially infectious patients. The standards are designed to assist home care organizations, both large and small, in developing and maintaining an effective program. However, the applicability of some elements of performance (EPs), particularly those related to infectious outbreaks, have been limited to certain home care settings and/or service providers because evidence suggests that these organizations are more likely than others to experience a need for infection prevention and control in these areas.

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 home care organization, 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 approach that consists of monitoring, 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 organization’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)
### Applicability for Infection Prevention and Control

This grid is meant to be a resource to determine which standards and elements of performance (EPs) apply to the service categories within the Home Care Accreditation Program. The column on the far left of the grid lists the related EPs vertically by number. Service categories (defined in Table 3 of the Introduction) are listed horizontally along the top of the grid. Applicability is indicated with an “X” in a service category column.

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CAMHC, January 2018
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 activities to be effective, they need to be well managed. Toward that end, the home care organization assigns one or more people to be responsible for the development of its infection prevention and control activities and their daily use. Large, complex home care organizations may want to hire a contractor or consultant. Smaller organizations may do well by simply designating a current employee. Each home care organization should assess its own needs in this regard. After this person is in place, the work of planning the infection prevention and control activities can begin by gathering staff with expertise in infection control and other key team members who can perform a risk assessment and then build activities based on their risks. The infection prevention and control team may want to consult with community leaders and outside infection control experts who can provide important information about their population and associated health risks.

The risks will be different for each organization. Certainly, a small hospice organization will have different risks from a large provider of home medical equipment. A medium-size provider of home health services in a rural area will have a different set of challenges still. Regardless of the size and type of home care organization, the results of its infection risk assessment should be organized according to level of importance, ideally in order of level of probability and potential for harm. The organization can then set goals for reducing the risks of the infections that pose the greatest threat to its patients. These goals should lead to focused activities, based on relevant professional guidelines and sound scientific practices.

**Standard IC.01.01.01**
The organization identifies the individual(s) responsible for infection prevention and control.

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
Element of Performance for IC.01.01.01

3. The organization assigns responsibility for the management of infection prevention and control activities to one or more individuals. (See also HR.01.01.01, EP 1; LD.03.06.01, EP 3)

Standard IC.01.02.01
Organization leaders allocate needed resources for infection prevention and control activities.

Elements of Performance for IC.01.02.01

1. The organization provides access to information needed to support infection prevention and control activities. (See also IM.02.02.03, EP 2)

3. The organization provides equipment and supplies to support infection prevention and control activities.

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

Elements of Performance for IC.01.03.01

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

Note 1: Surveillance activities may address processes and/or outcomes.

Note 2: For organizations that provide personal care and support services:
Surveillance activities may include verification of infection control education for all employees and supervisor observations of employees’ hand-washing techniques.

3. The organization prioritizes the identified risks for acquiring and spreading infections. These prioritized risks are documented.

Standard IC.01.04.01
Based on the identified risks, the organization sets goals to minimize the possibility of spreading infections.

Note: See NPSG.07.01.01 for hand hygiene guidelines.
Elements of Performance for IC.01.04.01

The organization’s written infection prevention and control goals include the following:

1. Addressing its prioritized risks.
2. Limiting unprotected exposure to pathogens.
3. Limiting the spread of infections associated with procedures.
4. Limiting the spread of infections associated with the use of medical equipment, devices, and supplies.
5. Improving compliance with hand hygiene guidelines. (See also NPSG.07.01.01, EP 1)

Standard IC.01.05.01

The organization plans for preventing and controlling infections.

Elements of Performance for IC.01.05.01

1. When developing infection prevention and control activities, the organization uses evidence-based national guidelines or, in the absence of such guidelines, expert consensus, or, in the absence of both, a review and evaluation of the health care literature.

2. The organization plans infection prevention and control activities, including surveillance, to minimize, reduce, or eliminate the risk of infection. These activities are documented.

5. The organization describes, in writing, the process for investigating outbreaks of infectious disease. (See also IC.02.01.01, EP 5)

6. Everyone who works in the organization has responsibilities for preventing and controlling infection.

9. For home health agencies and hospices that elect to use The Joint Commission deemed status option: The organization maintains an infection control program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases. The infectious and communicable disease program is described in writing. (See also LD.04.04.01, EP 8)
For home health agencies that elect to use The Joint Commission deemed status option: The organization’s coordinated, agency-wide infectious and communicable disease program is an integral part of its quality assessment and performance improvement (QAPI) program.

**Standard IC.01.06.01**
The organization prepares to respond to an increased number of potentially infectious patients.

**Elements of Performance for IC.01.06.01**

2. The organization obtains information from its resources regarding new infections that could cause an increased number of infectious patients.

3. The organization has a method for communicating critical information to licensed independent practitioners and staff about emerging infections that could cause an increased number of potentially infectious patients.

4. The organization describes, in writing, how it will respond to an increased number of potentially infectious patients. *(See also EM.01.01.01, EP 2)*

   **Note:** One acceptable response is to continue to provide care, treatment, or services to current patients, but not accept new 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 staff. Everyone who works for the home care organization should have a role. Important infection prevention and control information should be available to staff, patients and their families. Precautions need to be used, and any infection that spreads within the organization should be investigated.

**Standard IC.02.01.01**
The organization implements the infection prevention and control activities it has planned.
Elements of Performance for IC.02.01.01

1. The organization implements its infection prevention and control activities, including surveillance, to minimize, reduce, or eliminate the risk of infection.

   **Note:** Surveillance activities address processes and/or outcomes.

2. The organization 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. In addition to standard precautions, the organization takes precautions in response to the way suspected or identified infections are spread within the organization’s service setting and community.

5. The organization investigates outbreaks of infectious disease within its staff and patient populations. *(See also IC.01.05.01, EP 5)*

6. The organization minimizes the risk of infection when storing and disposing of infectious waste. *(See also EC.02.02.01, EPs 1 and 12)*

   **Note:** Potentially infectious waste may include emesis, urine, and stool.

7. The organization 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 organization reports infection surveillance, prevention, and control information to the appropriate staff within the organization.

9. The organization reports infections 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 precautions for the way certain infections are spread (such as contact, droplet, or airborne), 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. The organization informs the receiving organization when it becomes aware that it transferred a patient who has an infection requiring monitoring, treatment, and/or additional precautions in response to the way the infection spreads.

11. The organization informs the referring organization (for example, an infection control department at a hospital) when it becomes aware that it received a patient from that organization who has an infection requiring action, and the information was not communicated by the referring organization.

Note: Infections requiring action include the following: infections that require additional precautions to prevent transmission throughout the organization, infections with public reporting requirements, and infections that prompt the referring organization’s surveillance activities. Surveillance activities address processes and/or outcomes.

Standard IC.02.02.01
The organization reduces the risk of infections associated with medical equipment, devices, and supplies.

Rationale for IC.02.02.01
People are at risk of developing an infection from contact with medical equipment, devices, or supplies while seeking health services. Failure to properly clean or disinfect, 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 spread of infections.

There are numerous steps involved in the cleaning and disinfecting 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
- Reinforcing the process (for example, the use of placards which list the steps to be followed, according to manufacturer’s guidelines)
- Ongoing quality monitoring
Elements of Performance for IC.02.02.01

The organization implements infection prevention and control activities when doing the following:

1. Cleaning and performing disinfection of medical supplies and devices.‡ *(See also EQ.01.05.01, EPs 3 and 4)*

   **Note:** 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.

3. Disposing of medical equipment, devices, and supplies in accordance with law and regulation.

4. Storing medical equipment, devices, and supplies. *(See also EQ.01.01.01, EP 9; EQ.01.05.01, EPs 1–5)*

6. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** The hospice has available at all times the quantity of linen required for the proper care and comfort of patients.

7. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** Linens are handled, stored, processed, and transported in a manner that prevents the spread of infection.

Standard IC.02.03.01

The organization works to prevent the spread of infectious disease among patients and staff.

Elements of Performance for IC.02.03.01

1. The organization arranges for screening of staff for exposure and/or immunity to infectious disease when workplace contact is possible, and as required by law and regulation or organization policy.

‡ For further information regarding cleaning and performing 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.
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 organization 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 organization 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](http://www.hhs.gov/ash/initiatives/hai/hcpflu.html)).

The Joint Commission’s Standard IC.02.04.01 reflects current science and the national focus on influenza vaccination. It requires that each organization has an influenza vaccination program and that the influenza vaccination is offered to staff 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 organization offers vaccination against influenza to licensed independent practitioners and staff.

Note: This standard is not applicable to staff and licensed independent practitioners that provide care, treatment, or services through telemedicine or telephone consultation.

Elements of Performance for IC.02.04.01

1. The organization establishes an annual influenza vaccination program that is offered to licensed independent practitioners and staff.

2. The organization 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 organization provides the influenza vaccination at sites accessible to licensed independent practitioners and staff.

4. The organization includes in its infection control plan the goal of improving influenza vaccination rates. (For more information, refer to Standard IC.01.04.01.)

5. The organization sets incremental influenza vaccination goals, consistent with achieving the 90% rate established in the national influenza initiatives for 2020.


6. The organization has a written description of the methodology used to determine influenza vaccination rates.

Note: The National Quality Forum (NQF) Measure Submission and Evaluation Worksheet 5.0 provides recommendations for the numerator and denominator for NQF performance measure #0431 Influenza Vaccination Coverage Among Healthcare Personnel (see http://www.qualityforum.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=68275). While The Joint Commission recommends that organizations use the Centers for Disease Control and Prevention (CDC) and the NQF proposed performance measure to calculate influenza vaccination rates for staff and licensed independent practitioners, it does not include all contracted staff. Therefore, The Joint Commission recommends...
Commission additionally recommends that organizations also track influenza vaccination rates for all individuals providing care, treatment, and services through a contract, since contracted individuals also transmit influenza.

7. The organization evaluates the reasons given by staff and licensed independent practitioners for declining the influenza vaccination. This evaluation occurs at least annually.

8. The organization improves its vaccination rates according to its established goals at least annually. (For more information, refer to Standards PI.02.01.01 and PI.03.01.01.)

Note: Organizations with a small number of staff and licensed independent practitioners (10 or less) providing care, treatment, or services may present the data in a manner other than a percentage (for example, raw numbers).

9. The organization provides influenza vaccination rate data to key stakeholders which may include leaders, licensed independent practitioners, nursing staff, and other staff at least annually.

**Introduction to Standard IC.03.01.01—Evaluation and Improvement**

The importance of evaluation and improvement of the infection prevention and control activities cannot be stressed enough, particularly if the initiative has not had continuous, visible support from leadership. Infection prevention and control practices need to become a routine part of the care, treatment, or services the home care organization provides to patients. They expect and deserve hygienic and safe care, even if their home reflects neither of these qualities. Continuous review of the goals, activities, and outcomes of the organization’s initiative are therefore followed by improvement activities that are realistic in expectation and, above all, effective.

**Standard IC.03.01.01**

The organization evaluates the effectiveness of its infection prevention and control activities.
Elements of Performance for IC.03.01.01

1. The organization evaluates the effectiveness of its planned infection prevention and control activities annually and whenever risks change.

The evaluation includes a review of the following:

2. The infection prevention and control prioritized risks.

3. The infection prevention and control goals. (*See also* NPSG.07.01.01, EP 2)

4. Implementation of the infection prevention and control 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 organization uses the findings of its evaluation to revise its planned approach for preventing and controlling infections.
Prompts to Assess Your Compliance

**Please note:** Tips do not represent new accreditation requirements. They are intended to provide helpful strategies for standards compliance.

Did the infection control (IC) risk analysis address the following: (IC.01.03.01)
- Geographic location, community, and population served?
- The care, treatment, and services provided?
- Analysis of surveillance activities and other IC data?

**TIP:** Review the Department of Health and Human Services or Centers for Disease Control and Prevention website, or contact your local Department of Health. These sources can help you identify the risks in the organization’s geographic location and community. It may also prove helpful to work with your local hospital’s infection preventionist to identify health care–associated infectious agents important in your population, and risks associated with certain devices or procedures.

Based on the risk analysis, have IC priorities been established and measurable goals for those priorities? (IC.01.04.01)
**TIP:** Establish goals that you can influence. For example, your organization may have limited control over the number of health care–associated infections that are present in the home care population. Your organization does have the ability to identify current compliance with the use of personal protective equipment (PPE) and set measurable goals for improvement in this area. Hence, an appropriate measurable goal would be one that establishes a baseline percentage of compliance for the use of personal protective equipment consistent with policy.

How are responsibilities about preventing and controlling infection communicated to staff, patients, and families, especially related to respiratory etiquette and hand hygiene practices? (IC.01.05.01)

**TIP:** Incorporate this information into the education that is already provided in the patient admission packet; for staff, include this information in their orientation materials.

What is your organization’s policy on bag technique in the patient’s home? (Each organization needs to establish their policy; The Joint Commission does not establish bag technique criteria. Bag technique is observed during patient tracers and will be compared to the organization’s policy.) (IC.02.01.01)
Does the organization have a clear process for the cleaning and disinfecting of reusable medical equipment (for example, stethoscopes, sphygmomanometers, scales)? How do you know if staff are following this process? (IC.02.02.01; see also EQ.01.05.01 in the "Equipment Management" [EQ] chapter)

**TIP:** Be sure that staff members caring for patients are not using a single lancet device on more than one patient. Lancet devices (such as an Ultralet) are to be patient specific, per CDC regulations: [https://www.cdc.gov/injectionsafety/blood-glucose-monitoring.html](https://www.cdc.gov/injectionsafety/blood-glucose-monitoring.html).

**TIP:** Proper cleaning of medical equipment is an excellent measurable goal for addressing IC.01.04.01, EP 5.

Does the organization’s influenza vaccination program include the following: (IC.02.04.01)
- Measurable goals?
- Opportunities for patients and staff to receive vaccinations?
- A process to identify the reasons why staff have declined the vaccination?
  - Addressing these reasons in the plan for the next season?

**TIP:** Accredited organizations are encouraged to directly provide such vaccinations but are not required to do so. Simply providing a list of locations is not enough to assure influenza vaccination uptake. Take ownership of the process and engage in active interventions that will encourage staff participation.
Has the organization’s IC program evaluation been completed annually and whenever risks significantly change? (IC.03.01.01)
### Written Documentation Checklist

This worksheet lists elements of performance (EPs) that require written documentation that a surveyor could ask to see during a survey to show compliance with a standard. 

*(Note: Documentation can be on paper or in an electronic format.)*

<table>
<thead>
<tr>
<th>Standard</th>
<th>EP</th>
<th>Infection Control Standards</th>
<th>Home Care Service</th>
<th>Date last verified</th>
</tr>
</thead>
<tbody>
<tr>
<td>IC.01.03.01</td>
<td>3</td>
<td>EP 3—The organization prioritizes the identified risks for acquiring and spreading infections. These prioritized risks are documented.</td>
<td>All services except DME (M)</td>
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<tr>
<td>IC.01.04.01</td>
<td>1–5</td>
<td>EP 1—The organization’s written infection prevention and control goals include the following: Addressing its prioritized risks. EP 2—The organization’s written infection prevention and control goals include the following: Limiting unprotected exposure to pathogens. EP 3—The organization’s written infection prevention and control goals include the following: Limiting the spread of infections associated with procedures.</td>
<td>EP 1—All services except DME (M) EP 2—All services except DME (M), SUPP (M), and CCP EP 3—HH, HOS, DME (H), RESP, SUPP (H), O&amp;P, CRS, RT, DISP, FAI, LTP</td>
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<tr>
<td>IC.01.05.01</td>
<td>2, 5, 9</td>
<td>EP 2—The organization plans infection prevention and control activities, including surveillance, to minimize, reduce, or eliminate the risk of infection. These activities are documented.</td>
<td>EP 2—All services EPs 5—HH, HOS, CRS, FAI EP 9—Deemed HOS</td>
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<td>IC.01.06.01</td>
<td>4</td>
<td>EP 4—The organization describes, in writing, how it will respond to an increased number of potentially infectious patients.</td>
<td>EP 4—HH, HOS, CRS</td>
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<tr>
<td>IC.02.04.01</td>
<td>4–6, 8</td>
<td>EP 4—The organization includes in its infection control plan the goal of improving influenza vaccination rates. EP 5—The organization sets incremental influenza vaccination goals, consistent with achieving the 90% rate established in the national influenza initiatives for 2020. EP 6—The organization has a written description of the methodology used to determine influenza vaccination rates. EP 8—The organization improves its vaccination rates according to its established goals at least annually.</td>
<td>EPs 4, 5, 6, 8—All services</td>
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</table>
# Action Planning Tool

Use this form to track noncompliant elements of performance (EPs) and your action steps for bringing them into compliance.

<table>
<thead>
<tr>
<th>Standard and EP</th>
<th>Observation/Issue</th>
<th>Action Step</th>
<th>Individual Responsible</th>
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</table>
Chapter Notes

Use this page to take notes about ideas for meeting the standards in this chapter, your organization’s policies and procedures that address requirements in this chapter, or the data or patient record numbers used to determine compliance or noncompliance for EPs. If a standard is found not compliant, it can be helpful to know which data were used so they can be easily accessed when developing action plans for compliance.
Information Management (IM)

Overview
Every episode of care generates health information that must be managed systematically by the organization. All data and information used by the organization are categorized, filed, and maintained. The system should accurately capture health information generated by the delivery of care, treatment, or services. Health information should be accessed by authorized users who will use health information to provide safe, quality care. Unauthorized access can be limited by the adoption of policies that address the privacy, security, and integrity of health information.

Depending on the type of organization, the system used for information management may be basic or sophisticated. As technology develops, many organizations find their information management systems in a state of transition from paper to fully electronic or a combination of the two. Regardless of the type of system used, these standards are designed to be equally compatible with noncomputerized systems and evolving technologies.

About This Chapter
As with other chapters, planning is the initial focus of “Information Management” (IM). A well planned system meets the internal and external information needs of the organization with efficiency and accuracy. Planning also provides for continuity in the event that the organization’s operations are disrupted or fail. The organization also plans to protect the privacy, security, and integrity of the data and information it collects, which results in preserving confidentiality. The chapter concludes with a standard on maintaining accurate health information.

Requirements in this chapter apply to all types of information managed by the organization, unless the requirement specifically limits the type of information to health information. 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)

IV. Monitoring Data and Health Information Management Processes (IM.04.01.01)
## Applicability for Information Management

This grid is meant to be a resource to determine which standards and elements of performance (EPs) apply to the service categories within the Home Care Accreditation Program. The column on the far left of the grid lists the related EPs vertically by number. Service categories (defined in Table 3 of the Introduction) are listed horizontally along the top of the grid. Applicability is indicated with an “X” in a service category column.

<table>
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<tr>
<th>Standard/Requirement Number</th>
<th>EP Number</th>
<th>HH</th>
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Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
Introduction to Standard IM.01.01.01
Planning is the most critical part of the organization’s information management process and requires the collaborative involvement of all levels and areas of the organization. The organization’s plan for information management considers the full spectrum of data generated and used by the organization; financial data, human resources data, supply inventories, and health information are examples of the different types of data that are considered in the information management planning process. Planning for the management of information does not necessarily result in a single, comprehensive written information management plan; however, planning does establish clear relationships between the organization’s needs and its goals. In addition to the organization’s goals, the organization’s mission, services, staff, patient safety practices, modes of service delivery, resources, and technology are considered during the information management planning process.

Information management planning supports effective information sharing among staff, administration, and patients; patients can help the organization identify barriers to effective communication among caregivers. Planning takes into account and supports key relationships with outside services and contractors; licensing, accrediting, and regulatory bodies; as well as purchasers, payers, and employers. By identifying internal and external information needs, organizations can make information available when and where it is needed. Understanding the flow of information results in efficient data collection and distribution and the effective security of health information.

Standard IM.01.01.01
The organization plans for managing information.

Element of Performance for IM.01.01.01
2. The organization 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 organization to normal operations as soon as possible with minimal downtime and no data loss. The organization needs to be prepared for events that could impact the availability of data and information regardless of whether interruptions are scheduled or unscheduled (due to a local or regional disaster or an emergency). Interruptions to an organization’s information system can potentially have a devastating impact on its ability to deliver quality care and continue its business operations. Planning for emergency situations helps the organization mitigate the impact that interruptions, emergencies, and disasters have on its ability to manage information. The organization plans for interruptions by training staff on alternative procedures, testing the organization’s Emergency 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. Organizations 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 organization plans for continuity of its information management processes.

Elements of Performance for IM.01.01.03
1. The organization has a written plan for managing interruptions to its information processes (paper-based, electronic, or a mix of paper-based and electronic). (See also EM.01.01.01, EP 6)

   The organization’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)
For home health agencies and hospices that elect to use The Joint Commission deemed status option: The organization implements a system of medical documentation that preserves patient information during an emergency.

Introduction to Standard IM.02.01.01
The privacy of health information is a critical information management concern. Privacy of health information applies to electronic, paper, and verbal communications. Protecting the privacy of health information is the responsibility of the entire organization. Organizations protect privacy by limiting the use of information to only what is needed to provide care, treatment, or services.

Privacy, along with security, results in the confidentiality of health information. Health information is kept confidential when the information is secure (kept from intentional harm) and its use is limited (privacy). The end result of protecting the security and privacy of the information system is the preservation of confidentiality. To illustrate this relationship, confidentiality is violated in situations when a patient’s health information is used or accessed by an individual who does not have permission to access the information or uses it for purposes outside of delivering care, treatment, or services. A confidentiality violation occurs when an individual is able to bypass security measures and systems to gain access to health information.

Standard IM.02.01.01
The organization protects the privacy of health information.

Elements of Performance for IM.02.01.01

1. The organization has a written policy addressing the privacy of health information. (See also RI.01.01.01, EP 7)

2. The organization implements its policy on the privacy of health information. (See also RI.01.01.01, EP 7) R

* For additional guidance about limiting the use of information, refer to 45 CFR 164.502(b) and 164.514(d) under “Minimum Necessary” within the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
3. The organization uses health information only for purposes permitted by law and regulation or as further limited by its policy on privacy. (*See also* MM.01.01.01, EP 1; RI.01.01.01, EP 7)

4. The organization discloses health information only as authorized by the patient or as otherwise consistent with law and regulation. (*See also* RI.01.01.01, EP 7)

6. The organization maintains confidential patient records in accordance with privacy and security standards of the Health Insurance Portability and Accountability Act (HIPAA) and other applicable state laws. (*See also* RI.01.01.01, EP 7)

**Note:** Patient records include clinical records.

7. **For home health agencies that elect to use The Joint Commission deemed status option:** The home health agency and any agent acting on behalf of the home health agency in accordance with a written contract ensures the confidentiality of all patient-identifiable information, including OASIS data, in the record. (*See also* RI.01.01.01, EP 7)

8. **[6]** **For home health agencies that elect to use The Joint Commission deemed status option:** The home health agency and any agent acting on behalf of the home health agency in accordance with a written contract may not release patient-identifiable OASIS information to the public. (*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 organization. As a result, breaches in security can lead to the unauthorized disclosure or alteration of health information. When this occurs, the integrity of the data and information is compromised. Even simple mistakes, such as writing the incorrect date of service or diagnosis, can undermine data integrity just as easily as intentional breaches. For these reasons, an examination of the use of paper and electronic information systems is considered in the organization’s approach to maintaining the security and integrity of health information. Regardless of the type of system, security measures should address the use of security levels, passwords, and other forms of controlled access. Because information technology and its associated security measures are continuously changing, the organization should do its best to stay informed about technological developments and best practices that can help it improve information security and therefore protect data integrity.

Monitoring access to health information can help organizations be vigilant about protecting health information security. Regular security audits can identify system vulnerabilities in addition to security policy violations. For example, as part of the process, the organization could identify system users who have altered, edited, or deleted information. The results from this audit process can be used to validate that user permissions are appropriately set. Conducting security audits can be particularly effective in identifying when employee turnover causes vulnerabilities in security because user access and permissions were not removed or updated.

Standard IM.02.01.03
The organization maintains the security and integrity of health information.

Elements of Performance for IM.02.01.03

1. The organization has a written policy that addresses the security of health information, including access, use, and disclosure.

2. The organization has a written policy addressing the integrity of health information against loss, damage, unauthorized alteration, unintentional change, and accidental destruction.

3. The organization has a written policy addressing the intentional destruction of health information.
4. ☐ The organization has a written policy that defines when and by whom the removal of health information is permitted.

**Note:** *Removal refers to those actions that place health information outside the organization’s control.*

5. The organization protects against unauthorized access, use, and disclosure of health information.

6. The organization protects health information against loss, damage, unauthorized alteration, unintentional change, and accidental destruction.

   **For home health agencies that elect to use The Joint Commission deemed status option:** The HHA must be in compliance with the rules regarding protected health information set out at 45 CFR parts 160 and 164.

7. The organization controls the intentional destruction of health information.

9. The organization maintains secure patient records in accordance with privacy and security standards of the Health Insurance Portability and Accountability Act (HIPAA) and other applicable state laws. ☐

10. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program informs staff and patients about its policy on privacy and security of health information.

**Standard IM.02.02.01**
The organization effectively manages the collection of health information.

**Rationale for IM.02.02.01**
Within the organization, health information can come from multiple sources. The use of standardized language can help clarify information that is used by different individuals for various purposes. Capturing data in standardized language can lead to greater data integrity and reliability, as well as an increased potential for ease of use by internal and external systems and users. The more consistent the organization’s efforts are to capture accurate data in standardized language, the more likely the organization will be to rely on that data for patient-related purposes, including reimbursement, risk management, performance improvement, and infection surveillance.

**Elements of Performance for IM.02.02.01**

2. ☐ The organization uses standardized terminology, definitions, abbreviations, acronyms, symbols, and dose designations.
3. The organization follows its list of prohibited abbreviations, acronyms, symbols, and dose designations, which includes the following:

- U, u
- IU
- Q.D., QD, q.d., qd
- Q.O.D., QOD, q.o.d, qod
- Trailing zero (X.0 mg)
- Lack of leading zero (.X mg)
- MS
- MSO₄
- MgSO₄

**Note 1:** A trailing zero may be used only when required to demonstrate the level of precision of the value being reported, such as for laboratory results, imaging studies that report the size of lesions, or catheter/tube sizes. It may not be used in medication orders or other medication-related documentation.

**Note 2:** The prohibited list applies to all orders, preprinted forms, and medication-related documentation. Medication-related documentation can be either handwritten or electronic.

5. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program assists the patient in collecting, organizing, and communicating important health information that is needed by staff to provide safe, quality care.

**Introduction to Standard IM.02.02.03**
Standardizing the collection of data, a concept that is supported by the requirements of Standard IM.02.02.03, helps with the effective dissemination of data and information. Consistency in data collection systems (paper-based, electronic, or a combination) creates the foundation for retrieving and disseminating data and information in the most useful format. For information about data collection and dissemination, visit the websites of the Office of the National Coordinator for Health Information Technology (ONC) (http://www.healthit.gov/) and the Certification Commission for Healthcare Information Technology (CCHIT) (http://www.cchit.org).
Standard IM.02.02.03
The organization retrieves, disseminates, and transmits health information in useful formats.

Rationale for IM.02.02.03
The ease of use of health information between systems and users contributes to its potential usefulness within the organization and for external reporting purposes. Data stored in different formats cannot easily be converted to a new format or transferred to other organizations or providers. For example, immediate access to infection control data can impact patient safety within the organization and outside of the organization. As more organizations automate various processes and activities, these systems need to allow for transmitting and receiving critical data while maintaining data integrity.

Elements of Performance for IM.02.02.03
2. The organization’s storage and retrieval systems make health information accessible when needed for patient care, treatment, or services. (See also IC.01.02.01, EP 1)

3. The organization disseminates data and information in useful formats within time frames that are defined by the organization and consistent with law and regulation.

4. For home health agencies that elect to use The Joint Commission deemed status option: The home health agency reports all OASIS data electronically.

5. For home health agencies that elect to use The Joint Commission deemed status option: The home health agency transmits data using electronic communications software that complies with the Federal Information Processing Standard (FIPS 140-2, issued May 25, 2001) from the home health agency or its contractor to the Centers for Medicare & Medicaid Services (CMS) collection site.

6. For home health agencies that elect to use The Joint Commission deemed status option: The home health agency transmits data that include the Centers for Medicare & Medicaid Services (CMS)-assigned branch identification number.

7. For home health agencies that elect to use The Joint Commission deemed status option: The home health agency encodes and transmits data using the software available from the Centers for Medicare & Medicaid Services (CMS) or software that includes the required OASIS data set which conforms to CMS standard electronic record layout, edit specifications, and data dictionary.
8. **For home health agencies that elect to use The Joint Commission deemed status option:** For all completed OASIS assessments, the organization transmits OASIS data in the format required by 42 CFR 484.20(d).

9. **For home health agencies that elect to use The Joint Commission deemed status option:** The home health agency encodes and electronically transmits each completed Outcome and Assessment Information Set (OASIS) assessment with the information required for each Medicare beneficiary to the Centers for Medicare & Medicaid Services’ (CMS) system within 30 days of completing the patient assessment.

10. **For home health agencies that elect to use The Joint Commission deemed status option:** The home health agency transmits test data to either the Quality Improvement and Evaluation System (QIES)—Assessment Submission and Processing (ASAP) System or Centers for Medicare & Medicaid Services’ Outcome and Assessment Information Set (OASIS) contractor.

**Standard IM.03.01.01**

Knowledge-based information resources are available, current, and authoritative.

**Elements of Performance for IM.03.01.01**

1. The organization provides access to knowledge-based information resources during hours of operation. *(See also IM.01.01.03, EP 2)*

7. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program assists staff in obtaining palliative care references that are necessary for the patient’s care and self-management and information on community resources that are available to the patient and family.

**Standard IM.04.01.01**

The organization maintains accurate health information.

**Rationale for IM.04.01.01**

The integrity and quality of health information influences the usefulness and effectiveness of all internal and downstream systems, as well as external reporting. When the integrity of the data has been compromised, additional resources will be needed to scan the data and correct errors. Inaccurate data can lead to poor decision making.
Element of Performance for IM.04.01.01

2. **For home health agencies that elect to use The Joint Commission deemed status option:** Encoded OASIS data accurately reflect the patient’s status at the time of assessment.
Prompts to Assess Your Compliance

**Please note:** Tips do not represent new accreditation requirements. They are intended to provide helpful strategies for standards compliance.

For organizations that have electronic information systems: When was the plan for managing interruptions to electronic information systems last tested? (IM.01.01.03)

**TIP:** For efficiency, consider testing the plan for managing interruptions to electronic information systems when testing the Emergency Operations Plan.

Do chart audits evaluate inappropriate editing, prohibited abbreviation use, or accuracy? (IM.02.02.01)

Does the information management process provide staff members with the specific information they need at the time they need it? (IM.03.01.01)

**TIP:** Engage staff in assessing the information management process. Ask what is working and what is not.
Has the security of protected information been maintained? (IM.02.01.03)

**TIP:** Think about different scenarios when staff are utilizing protected information. Can others access any information that they should not have access to?
**Written Documentation Checklist**

This worksheet lists elements of performance (EPs) that require written documentation that a surveyor could ask to see during a survey to show compliance with a standard. 

*(Note: Documentation can be on paper or in an electronic format.)*

<table>
<thead>
<tr>
<th>Standard</th>
<th>EP</th>
<th>Information Management Standards</th>
<th>Home Care Service</th>
<th>Date last verified</th>
</tr>
</thead>
<tbody>
<tr>
<td>IM.01.01.03</td>
<td>1, 5</td>
<td>EP 1—The organization has a written plan for managing interruptions to its information processes (paper-based, electronic, or a mix of paper-based and electronic).</td>
<td>EP 1—All services</td>
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<td><strong>EP 5—For home health agencies and hospices that elect to use The Joint Commission deemed status option:</strong> The organization implements a system of medical documentation that preserves patient information during an emergency.</td>
<td>EP 5—Deemed HH, HOS</td>
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<tr>
<td>IM.02.01.01</td>
<td>1, 8</td>
<td>EP 1—The organization has a written policy addressing the privacy of health information. EP 8—<strong>For home health agencies that elect to use The Joint Commission deemed status option:</strong> The home health agency and any agent acting on behalf of the home health agency in accordance with a written contract may not release patient-identifiable OASIS information to the public.</td>
<td>EP 1—All services</td>
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<td><strong>EPs 8—Deemed HH</strong></td>
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<td>IM.02.01.03</td>
<td>1–4</td>
<td>EP 1—The organization has a written policy that addresses the security of health information, including access, use, and disclosure. EP 2—The organization has a written policy addressing the integrity of health information against loss, damage, unauthorized alteration, unintentional change, and accidental destruction. EP 3—The organization has a written policy addressing the intentional destruction of health information.</td>
<td>All services</td>
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Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
| IM.02.02.01  | 2 | EP 2—The organization uses standardized terminology, definitions, abbreviations, acronyms, symbols, and dose designations. | EP 2—All but PCS |

EP 4—The organization has a written policy that defines when and by whom the removal of health information is permitted.
## Action Planning Tool

Use this form to track noncompliant elements of performance (EPs) and your action steps for bringing them into compliance.

<table>
<thead>
<tr>
<th>Standard and EP</th>
<th>Observation/Issue</th>
<th>Action Step</th>
<th>Individual Responsible</th>
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Chapter Notes

Use this page to take notes about ideas for meeting the standards in this chapter, your organization’s policies and procedures that address requirements in this chapter, or the data or patient record numbers used to determine compliance or noncompliance for EPs. If a standard is found not compliant, it can be helpful to know which data were used so they can be easily accessed when developing action plans for compliance.
Leadership (LD)

Overview
The safety and quality of care, treatment, or services depend on many factors, including the following:

- A culture that fosters safety as a priority for everyone who works in the organization
- The planning and provision of services that meet the needs of patients
- The availability of resources—human, financial, and physical—for providing care, treatment, or services
- The existence of competent staff and other care providers
- Ongoing evaluation of and improvement in performance

Management of these important functions is the direct responsibility of leaders; they are, in effect, responsible for the care, treatment, or services that the organization provides to its patients. In organizations with a governing body, governance has ultimate responsibility for this oversight. In larger organizations, 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 organization performance. In smaller organizations, these responsibilities may be handled by just one or two individuals. This chapter addresses the role of leaders in managing their diverse and, at times, complex responsibilities.

Leaders shape the organization’s culture, and the culture, in turn, affects how the organization accomplishes its work. A healthy, thriving culture is built around the organization’s mission and vision, which reflect the core values and principles that the organization finds important. Leaders must ask some basic questions in order to provide this focus: How does the organization plan to meet the needs of its population(s)? By what ethical standards will the organization operate? What does the organization want to accomplish through its work? Once leaders answer these questions, the culture of the organization will begin to take shape. Leaders also have an obligation to set an example of how to work together to fulfill the organization’s mission.

On a more practical level, leaders oversee operations and guide the organization on a day-to-day basis. They keep operations running smoothly so that the important work of the organization—serving its patients—can continue.
To meet their obligations effectively, leaders must collaborate, which means working together in a spirit of collegiality to achieve a common end. In smaller organizations, this may mean that a single leader or small group of leaders works closely with staff in order to meet the organization’s managerial needs. In this case, key staff members share governance and decision making with senior leadership in order to direct the day-to-day operations, assess needs, secure resources, and plan for the future. Senior managers direct the day-to-day operations of the organization; governance determines what resources the organization needs and then secures those resources.

**Proactive Risk Assessment**

By undertaking a proactive risk assessment, an organization can correct process problems and reduce the likelihood of experiencing adverse events. An organization can use a proactive risk assessment to evaluate a process to see how it could fail, to understand the consequences of such a failure, and to identify parts of the process that need improvement. The term “process” applies broadly to processes that are integral to patient care, such as medication administration and wound care.

Proactive risk assessments are useful for analyzing new processes before they are implemented. Processes need to be designed with a focus on quality and reliability to achieve desired outcomes and protect patients. Proactive risk assessments are also used to evaluate existing processes that have the greatest potential for affecting patient safety. An organization’s choice of which process it will assess may be based in part on information published periodically by The Joint Commission about frequently occurring sentinel events and processes that pose high risk 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 it.

Although there are several methods that could be used to conduct a proactive risk assessment, the following steps make up one approach:

1. Describe the chosen process (for example, through the use of a flowchart).
2. Identify ways in which the process could break down or fail to perform its desired functions, which is often referred to as failure mode.
3. Identify the possible effects that a breakdown or failure of the process could have on 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,” “Organization Culture and System Performance Expectations,” and “Operations.” The organization’s culture, systems, and leadership structure and relationships all come together to shape and drive its operations.

The standards in the “Leadership Structure” section identify and define the various leadership groups and their responsibilities. The standards in “Leadership Relationships” address the development of the organization’s mission, vision, and goals as well as communication among leaders. The standards in the “Organization Culture and System Performance Expectations” section focus on the framework for the organization’s culture and systems. These standards also demonstrate how leaders help shape the culture of an organization and how culture, in turn, affects important systems within the organization (for example, data use, planning, communication, changing performance, staffing). The standards in the “Operations” section address the functions that are important to patient safety and high-quality care, treatment, or services. Some leaders may not be directly involved in the day-to-day operations of the organization, but the decisions they make and the initiatives they implement do affect operations.
Chapter Outline

I. Leadership Structure
   A. Leadership Structure (LD.01.01.01)
   B. Governance Accountabilities (LD.01.03.01)
   C. The Chief Executive Responsibilities (LD.01.04.01)

II. Leadership Relationships
   A. Mission, Vision, and Goals (LD.02.01.01)

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.04.01.07, 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.04.03.03, LD.04.03.07, LD.04.03.09)
   D. Managing Safety and Quality (LD.04.04.01, LD.04.04.03, LD.04.04.05, LD.04.04.09)
## Applicability for Leadership

This grid is meant to be a resource to determine which standards and elements of performance (EPs) apply to the service categories within the Home Care Accreditation Program. The column on the far left of the grid lists the related EPs vertically by number. Service categories (defined in Table 3 of the Introduction) are listed horizontally along the top of the grid. Applicability is indicated with an “X” in a service category column.

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<thead>
<tr>
<th>Standard/Requirement Number</th>
<th>EP Number</th>
<th>HH</th>
<th>HOS</th>
<th>DME</th>
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Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
CAMHC, January 2018
LD – 7
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Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
Standards, Rationales, and Elements of Performance

Introduction to Leadership Structure, Standards LD.01.01.01 Through LD.01.04.01
Each organization, regardless of its complexity, has a structured leadership. Many leadership responsibilities directly affect the provision of care, treatment, or services, as well as the day-to-day operations of the organization. In some cases, these responsibilities will be shared among leaders, and in other cases, a particular leader has primary responsibility. Individual leaders may have several different roles. Regardless of the organization’s structure, it is important that leaders carry out all their responsibilities.

A variety of individuals may work in the organization, including licensed independent practitioners, staff, volunteers, students, and independent contractors. These standards describe the overall responsibility of governance for the safety and quality of care, treatment, or services provided by all of these individuals.

How well leaders work together is key to effective organization performance, and the standards emphasize this. Leaders with different responsibilities—governance, management, and the clinical staff—bring different skills, experiences, and perspectives to the organization. Working together means that leaders have the opportunity to participate in discussions and have their opinions heard. Depending on the topic and the organization, individuals may participate in decision making, and the governing body may delegate decision making to certain leaders. Final decisions, however, are always the ultimate responsibility of governance; this key principle is assumed in any standard that describes how leaders work together.

Standard LD.01.01.01
The organization has a leadership structure.

Rationale for LD.01.01.01
Every organization has a leadership structure to support operations. Many functions need to be carried out, including governance, administration, and oversight of care, treatment, or services. In some organizations leaders have distinct roles in carrying out these functions; in others a single individual may perform all leadership functions.
Elements of Performance for LD.01.01.01

1. The organization identifies those responsible for governance.
2. Governance identifies those responsible for planning, management, and operational activities.
3. Governance identifies those responsible for the provision of care, treatment, or services.
4. For home health agencies that elect to use The Joint Commission deemed status option: The home health agency identifies and documents its organizational structure, the services it furnishes, and the structure of its administrative control, including lines of authority.
5. For home health agencies that elect to use The Joint Commission deemed status option: The home health agency retains its administrative and supervisory functions and does not delegate them to another agency or organization.

Standard LD.01.03.01
Governance is ultimately accountable for the safety and quality of care, treatment, or services.

Rationale for LD.01.03.01
Governance’s ultimate responsibility for safety and quality derives from its legal responsibility and operational authority for organization performance. In this context, governance provides for internal structures and resources, including staff, that support safety and quality.

Elements of Performance for LD.01.03.01

1. Governance defines in writing its responsibilities.
2. Governance provides for organization management and planning.
3. Governance approves the organization’s written scope of services.
4. Governance selects the chief executive.
5. Governance provides for the resources needed to maintain safe, quality care, treatment, or services.
6. Governance works with other leaders to annually evaluate the organization’s performance in relation to its mission, vision, and goals. (See also LD.01.03.01, EP 17)
12. **For home health agencies and hospices that elect to use The Joint Commission deemed status option:** The organization has a governing body that assumes full legal authority and responsibility for the overall operation of the organization.

For home health agencies that elect to use The Joint Commission deemed status option: Overall operation of the organization includes provision of services, fiscal operations, review of the agency’s budget and operational plans, and its quality assessment and performance improvement (QAPI) program.

19. The organization has one or more individuals who perform leadership functions, with the authority, responsibility, and accountability to direct the organization and its key activities and operations.

23. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program defines its leaders’ accountabilities. (For more information, refer to LD.04.01.05, EP 3)

24. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program defines its scope of care, treatment, and services.

25. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The organization provides program leaders with opportunities for sharing best practices with leaders of other palliative care programs.

26. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program evaluates whether its activities for identifying and minimizing risks to patients meets its objectives.

**Standard LD.01.04.01**

A chief executive manages the organization.

**Elements of Performance for LD.01.04.01**

The chief executive provides for the following:

1. Information and support systems.
2. Physical and financial assets.
3. **For home health agencies that elect to use The Joint Commission deemed status option:** The administrator is appointed by and reports to the governing body and is responsible for the following:
Leadership

- All day-to-day operations of the organization
- Availability of a clinical manager during all operating hours
- Maintaining an ongoing link among the governing body, group of professional personnel, and staff
- Development of staff qualifications and policies
- Ensuring that staff employed by the organization are qualified

**Note:** The role of the clinical manager is described in 484.105(c).

10. **For hospices that elect to use The Joint Commission deemed status option:** The governing body appoints a qualified administrator.

11. ⚫ When the chief executive or administrator is absent from the organization, a qualified individual is designated to perform the duties of this position.

**Note:** For home health agencies that elect to use The Joint Commission deemed status option: When the administrator is not available, a qualified pre-designated individual is authorized in writing by the chief executive or administrator and the governing body. The pre-designated person may be the clinical manager. (See also HR.01.02.05, EP 29)

17. **For hospices that elect to use The Joint Commission deemed status option:** The administrator is a hospice employee and has the education and experience required by the hospice’s governing body.

18. **For hospices that elect to use The Joint Commission deemed status option:** The hospice designates a physician to serve as medical director. The medical director is a doctor of medicine or osteopathy who is an employee or is under contract with the hospice.

**Note:** The hospice may contract with a self-employed physician or with a physician employed by a physician’s group.

19. ⚫ **For hospices that elect to use The Joint Commission deemed status option:** When the hospice contracts for medical director services, the contract specifies the name of the physician who assumes the medical director responsibilities.

20. **For hospices that elect to use The Joint Commission deemed status option:** When the medical director is not available, a physician designated by the hospice assumes the same responsibilities as the medical director.
21. **For hospices that elect to use The Joint Commission deemed status option:** The medical director or physician designee is responsible for the medical component of the hospice’s patient care program.

### Introduction to Leadership Relationships, Standard LD.02.01.01

How well leaders work together and manage conflict affects an organization’s performance. In fulfilling its role, the governance involves senior managers and leaders of the clinical staff in governance and management functions.

Good relationships thrive when leaders work together to develop the mission, vision, and goals of the organization; encourage honest and open communication; and address conflicts of interest.

#### Standard LD.02.01.01

The mission, vision, and goals of the organization support the safety and quality of care, treatment, or services.

#### Rationale for LD.02.01.01

The primary responsibility of leaders is to provide for the safety and quality of care, treatment, or services. The purpose of the organization’s mission, vision, and goals is to define how the organization will achieve safety and quality. The leaders are more likely to be aligned with the mission, vision, and goals when they create them together. The common purpose of the organization is most likely achieved when it is understood by all who work in or are served by the organization.

#### Elements of Performance for LD.02.01.01

1. Leaders work together to create the organization’s mission, vision, and goals.
2. The organization’s mission, vision, and goals guide the actions of leaders.
3. Leaders communicate the mission, vision, and goals to staff and the population(s) the organization serves.
6. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program leaders describe the philosophy that guides its provision of care, treatment, and services. The program’s philosophy is aligned with the organization’s mission.

7. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** Program leaders and organization leaders work together to formulate the program’s goals for providing care, treatment, and services to patients.

8. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program’s leaders are empowered by the organization’s leaders to provide care, treatment, and services.

**Introduction to Organization Culture and System Performance Expectations, Standards LD.03.01.01 Through LD.03.06.01**

An organization’s culture reflects the beliefs, attitudes, and priorities of its members, and it influences the effectiveness of performance. Although there may be a dominant culture, in many larger organizations diverse cultures exist that may or may not share the same values. In fact, diverse cultures can exist even in smaller organizations. Organization performance can be effective in either case. Successful organizations will work to develop a culture of safety and quality.

In a culture of safety and quality, all individuals are focused on maintaining excellence in performance. They accept the safety and quality of patient care, treatment, or services as personal responsibilities and work together to minimize any harm that might result from unsafe or poor quality of care, treatment, or services. Leaders create this culture by demonstrating their commitment to safety and quality and by taking actions to achieve the desired state. In a culture of this kind, one finds teamwork, open discussions of concerns about safety and quality, and the encouragement of and reward for internal and external reporting of safety and quality issues. The focus of attention is on the performance of systems and processes instead of the individual, although reckless behavior and a blatant disregard for safety are not tolerated. Organizations are committed to ongoing learning and have the flexibility to accommodate changes in technology, science, and the environment.
The leaders provide for the effective functioning of the organization with a focus on safety and quality. Leaders plan, support, and implement key systems critical to this effort. The Joint Commission has identified five key systems that influence the effective performance of an organization:

1. Using data
2. Planning
3. Communicating
4. Changing performance
5. Staffing

The following diagram illustrates the role of leadership in the performance of these systems.

Leadership provides the foundation for effective performance. The five key systems serve as pillars that are based on the foundation set by leadership and, in turn, support the many organizationwide processes (such as medication management) that are important to individual care, treatment, or services. Culture permeates the entire structure.
The five key systems are interrelated and need to function well together. The integration of these systems throughout the organization will facilitate the effective performance of the organization as a whole. Leaders develop a vision and goals for the performance of these systems and evaluate their performance. Leaders use results to develop strategies for future improvements.

Performance of many aspects of these systems may be directly observable. But in many cases organizations demonstrate compliance through performance in standards located in other sections of this manual. These leadership standards are cited when patterns of performance suggest organizationwide issues.

The effective performance of these systems results in a culture in which safety and quality are priorities. The organization demonstrates this through a proactive, nonpunitive culture that is monitored and sustained by related reporting systems and improvement initiatives.

Many of the concepts in the following section have long existed in the standards.

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

**Rationale for LD.03.01.01**
Safety and quality thrive in an environment that supports teamwork and respect for other people, regardless of their position in the organization. Leaders demonstrate their commitment to quality and set expectations for those who work in the organization. Leaders evaluate the culture on a regular basis using a variety of methods, such as formal surveys, focus groups, staff interviews, and data analysis.

Leaders encourage teamwork and create structures, processes, and programs that allow this positive culture to flourish, motivating staff to provide input that advances safe, quality care. For example, do organizational structures support staff, whether office-based, facility-based, or in the field, in giving feedback? Are staff across the organization (support staff as well as clinicians) given the same access to communicate concerns to leadership?

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 organization, including management, clinical and administrative staff, licensed independent practitioners, and governing body members.
Elements of Performance for LD.03.01.01

1. Leaders regularly evaluate the culture of safety and quality.
2. Leaders prioritize and implement changes identified by the evaluation.
3. Leaders develop a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety.
4. Leaders create and implement a process for managing behaviors that undermine a culture of safety.

Standard LD.03.02.01

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

Rationale for LD.03.02.01

Data help organizations make the right decisions. When decisions are supported by data, organizations are more likely to move in directions that help them achieve their goals. Successful organizations measure and analyze their performance. When data are analyzed and turned into information, this process helps organizations see patterns and trends and understand the reasons for their performance. Many types of data are used to evaluate performance, including data on outcomes of care, performance on safety and quality initiatives, 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, or services.
2. Leaders are able to describe how data and information are used to create a culture of safety and quality.
3. The organization uses processes to support systematic data and information use.
4. Leaders provide the resources needed for data and information use, including staff, equipment, and information systems.
5. The organization uses data and information in decision making that supports the safety and quality of care, treatment, or services. (See also PI.02.01.01, EP 8)
6. The organization uses data and information to identify and respond to internal and external changes in the environment.
7. Leaders evaluate how effectively data and information are used throughout the organization. R

8. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program uses patient satisfaction data that are specific to the care, treatment, and services it provides in order to improve care of patients and families.

**Standard LD.03.03.01**
Leaders use organizationwide planning to establish structures and processes that focus on safety and quality.

**Rationale for LD.03.03.01**
Planning is essential to the following:
- The achievement of short- and long-term goals
- Meeting the challenge of external changes
- The design of services and work processes
- The creation of communication channels
- The improvement of performance
- The introduction of innovation

Planning includes contributions from the populations served, from those who work for the organization, and from other interested groups or individuals.

**Elements of Performance for LD.03.03.01**
1. Planning activities focus on improving patient safety and health care quality.
2. Leaders can describe how planning supports a culture of safety and 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, or services.
5. Safety and quality planning is organizationwide.
6. Planning activities adapt to changes in the environment.
7. Leaders evaluate the effectiveness of planning activities.
8. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The program leaders communicate with and educate the organization in order to gain recognition of and support for the program.

9. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The program leaders secure the resources it requires from the organization in order to meet the scope of care, treatment, and services it provides.

10. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: Organization and program leaders support participation in continuing education by providing or facilitating access to ongoing continuing education in palliative care for the interdisciplinary team members and program staff.

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

Rationale for LD.03.04.01
Effective communication is essential among individuals and groups within the organization, and between the organization and external parties. Poor communication often contributes to adverse events and can compromise safety and quality of care, treatment, or services. Effective communication is timely, accurate, and usable by the audience.

Elements of Performance for LD.03.04.01
1. Communication processes foster the safety of the patient and the quality of care.
2. Leaders are able to describe how communication supports a culture of safety and quality.
3. Communication is designed to meet the needs of internal and external users.
4. Leaders provide the resources required for communication, based on the needs of patients, staff, and administration.
5. Communication supports safety and quality throughout the organization. (See also LD.04.04.05, EPs 6 and 12)
6. When changes in the environment occur, the organization communicates those changes effectively.
7. Leaders evaluate the effectiveness of communication methods.

8. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** Upon request, the program provides the public with information about its performance improvement activities.

   **Note:** This information can be general in nature and consist of patient satisfaction data or general information about how the program improves its performance.

**Standard LD.03.05.01**
Leaders implement changes in existing processes to improve the performance of the organization.

**Rationale for LD.03.05.01**
Change is inevitable, and agile organizations are able to manage change and rapidly execute new plans. The ability of leaders to manage change is necessary for performance improvement, for successful innovation, and to meet environmental challenges. The organization integrates change into all relevant processes so that its effectiveness can be sustained, assessed, and measured.

**Elements of Performance for LD.03.05.01**
1. Structures for managing change and performance improvements exist that foster the safety of the patient and the quality of care, treatment, or services.
2. Leaders are able to describe how the organization’s approach to performance improvement and its capacity for change support a culture of safety and quality.
3. The organization has a systematic approach to change and performance improvement.
4. Leaders provide the resources required for performance improvement and change management, including sufficient staff, access to information, and training.
5. Leaders maintain quality and safety while major changes and improvements are being carried out.
6. The organization’s internal structures can adapt to changes in the environment.
7. Leaders evaluate the effectiveness of processes for the management of change and performance improvement.

**Standard LD.03.06.01**
Those who work in the organization are focused on improving safety and quality.
Rationale for LD.03.06.01
The safety and quality of care, treatment, or services are highly dependent on the people who work in the organization. The mission, scope, and complexity of services define the design of work processes and the skills and number of individuals needed. In a successful organization, work processes and the environment make safety and quality paramount. This standard, therefore, applies to all those who work in or for the organization, including staff and licensed independent practitioners.

Elements of Performance for LD.03.06.01
1. Leaders design work processes to focus individuals on safety and quality issues.
2. Leaders are able to describe how those who work in the organization support a culture of safety and quality.
3. Leaders provide for a sufficient number and mix of individuals to support safe, quality care, treatment, or services. (See also IC.01.01.01, EP 3)  
   
   Note: For hospices providing inpatient care in their own facilities: Staffing for all services should reflect the volume of patients, patient acuity, and the intensity of services needed to achieve the outcomes described in patients’ plans of care and to avoid negative outcomes.
4. Those who work in the organization are competent to complete their assigned responsibilities.
6. Leaders evaluate the effectiveness of those who work in the organization to promote safety and quality.
10. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The program has dedicated leadership and staff necessary to meet the scope of care, treatment, and services it provides.
11. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The program leaders coach and mentor staff in order to improve their ability to provide care, treatment, and services in a manner that builds mutual trust with the patient and family.
12. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: Program leaders provide clinical support and guidance to promote staff’s confidence in their ability to provide palliative care for patients.
Introduction to Operations, Standards LD.04.01.01 Through LD.04.03.07

Although some leaders may not be involved in the day-to-day, hands-on operations of the organization, their decisions and work affect, either directly or indirectly, every aspect of operations. They are the driving force behind the culture of the organization. Leaders establish the ethical framework in which the organization operates, create policies and procedures, and secure resources and services that support patient safety and quality care, treatment, or services. Policies, procedures, resources, and services are all influenced by the culture of the organization, and, in turn, influence the culture.

Standard LD.04.01.01

The organization complies with law and regulation.

Elements of Performance for LD.04.01.01

1.  ☐ The organization is licensed, is certified, or has a permit, in accordance with law and regulation, to provide the care, treatment, or services for which the organization is seeking accreditation from The Joint Commission. *(See also MC.03.06.01, EP 1)*

   Note 1: For home health agencies and hospices that elect to use The Joint Commission deemed status option: If state or local law requires licensure of home health agencies or hospices, then the home health agency or hospice must be licensed.

   Note 2: Applicable law and regulation include, but are not limited to, individual and facility licensure, certification, US Food and Drug Administration regulations, Drug Enforcement Agency regulations, Centers for Medicare & Medicaid Services

* For more information on how to obtain a CLIA certificate, see http://www.cms.gov/Regulations-and-Guidance/Legislation/CLIA/ How_to_Apply_for_a_CLIA_Certificate_International_Laboratories.html.

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
regulations, Occupational Safety and Health Administration regulations, Department of Transportation regulations, Health Insurance Portability and Accountability Act, and other local, state, and federal laws and regulations.

**Note 3:** Each service location that performs laboratory testing (waived or nonwaived) must have a Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88) certificate as specified by the federal CLIA regulations (42 CFR 493.55 and 493.3) and applicable state laws. (See also WT.01.01.01, EP 1; WT.04.01.01, EP 1)

2. The organization provides care, treatment, or services in accordance with licensure requirements, laws, and rules and regulations. (See also MC.03.06.01, EP 1; MC.04.02.01, EP 1)

**Note:** For home health agencies that elect to use The Joint Commission deemed status option: Organizations that furnish outpatient physical therapy or speech-language pathology services must meet federal requirements at §42 CFR 484.38 in addition to health and safety requirements at §42 CFR 485.711, 485.713, 485.715, 485.719, 485.723, and 485.727. For the federal definition of outpatient physical therapy services, see 1861(p) of the Social Security Act.

3. Leaders act on or comply with reports or recommendations from external authorized agencies, such as accreditation, certification, or regulatory bodies. (See also MC.03.06.01, EP 1)

10. The organization displays all licenses, certificates, and permits to operate in an area accessible to customers and patients.

13. For DMEPOS suppliers serving Medicare beneficiaries: The supplier complies with Medicare statutes, regulations, manuals, program instructions, and contractor policies and articles.

**Standard LD.04.01.03**

The organization develops an annual operating budget and, when needed, a long-term capital expenditure plan.

**Elements of Performance for LD.04.01.03**

1. Leaders solicit comments from those who work in the organization when developing the operational and capital budgets.
2. **For home health agencies that elect to use The Joint Commission deemed status option:** The home health agency prepares an overall plan and budget that includes an annual operating budget and a capital expenditure plan. The overall plan and budget is prepared under the direction of the governing body by a committee consisting of representatives of the governing body, the administrative staff, and the medical staff (if any) of the home health agency. The governing body has the responsibility to adopt and periodically review written bylaws and oversee fiscal affairs.

3. The operating budget reflects the organization’s goals and objectives.

4. **Governance approves an annual operating budget and, when needed, a long-term capital expenditure plan.**

8. **For home health agencies that elect to use The Joint Commission deemed status option:** The annual operating budget includes all anticipated income and expenses.

   **Note:** *The home health agency does not need to prepare an item-by-item identification of the components of each type of anticipated income or expense.*

9. **For home health agencies that elect to use The Joint Commission deemed status option:** The capital expenditure plan covers at least a three year period, including the operating budget year.

10. **For home health agencies that elect to use The Joint Commission deemed status option:** The capital expenditure plan identifies reasons for and the anticipated sources of financing for each anticipated expenditure of more than $600,000.

   **Note:** *In determining if a single capital expenditure exceeds $600,000, the following costs are included: the cost of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, modernization, expansion, or replacement of land, plant building, and equipment. Also included are expenditures such as grading, paving, broker commissions, taxes, and costs involved in demolishing or razing structures. Other included costs are title fees, permit and license fees, broker commissions, architect, legal, accounting, and appraisal fees, interest, finance, or carrying charges on bonds, notes, and other costs incurred for borrowing funds.*
11. **For home health agencies that elect to use The Joint Commission deemed status option:** If the anticipated source of financing is in any part payment from Medicare, Medicaid, or Maternal and Child Health and Crippled Children’s Services, the capital expenditure plan specifies the following qualifications:

- Whether the proposed expenditure is likely to be required to be in accordance with the Public Health Service Act or the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963
- Whether a capital expenditure proposal has been submitted to the designated planning agency for approval
- Whether the designated planning agency has approved or disapproved the proposed expenditure

12. **For home health agencies that elect to use The Joint Commission deemed status option:** The committee that prepared the overall plan and budget reviews and updates it annually.

13. The organization manages revenues and expenses on an ongoing basis as they relate to patient services, including planning to meet the needs of patients and maintain business operations by having an operating budget, as appropriate to the business’ size and scope of services.

**For home health agencies that elect to use The Joint Commission deemed status option:** The organization manages its resources in order to achieve the goals and outcomes identified in the patient’s plan of care, for each patient’s medical, nursing, and rehabilitative needs.

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**Standard LD.04.01.05**
The organization 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 organization to fulfill its mission and meet its goals. They support staff and instill in them a sense of ownership of their work processes. Leaders may delegate work to qualified staff, but the leaders are responsible for the care, treatment, or services provided in their areas.

**Elements of Performance for LD.04.01.05**

2. Programs, services, sites, or departments providing patient care are directed by one or more qualified professionals.
3. The organization defines, in writing, the responsibility of those with administrative and clinical direction of its programs, services, sites, or departments.

4. Staff are held accountable for their responsibilities.

5. Leaders provide for the coordination of care, treatment, or services among the organization’s different programs, services, sites, or departments.

14. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The program makes staff throughout the organization aware of the program’s objectives and the process for referring patients to the program.

15. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: Program leaders integrate the care, treatment, and services provided by the program with those of the organization.

**Standard LD.04.01.07**
The organization has policies and procedures that guide and support patient care, treatment, or services.

**Elements of Performance for LD.04.01.07**

1. Leaders review and approve policies and procedures that guide and support patient care, treatment, or services.

   **Note: For hospices that elect to use The Joint Commission deemed status option:** Establishment of policies governing the provision of hospice care is the responsibility of the hospice’s interdisciplinary group.

2. The organization manages the implementation of policies and procedures.

11. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The program has policies and procedures that support its clinical practices.

**Standard LD.04.01.11**
The organization makes space and equipment available as needed for the provision of care, treatment, or services.
Rationale for LD.04.01.11
The resources allocated to services provided by the organization 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 organization.

Elements of Performance for LD.04.01.11
3. The interior and exterior space provided for care, treatment, or services meets the needs of patients.
4. The grounds, equipment, and special activity areas are safe, maintained, and supervised.
5. The leaders provide for equipment, supplies, and other resources. *(See also MC.01.01.01, EP 4; MC.03.01.01, EP 5)*
6. The organization governs its business so that it obtains and provides appropriate quality equipment, items, and services to patients.
7. The organization has a physical location.

Standard LD.04.02.01
The leaders address any conflict of interest involving staff that affects or has the potential to affect the safety or quality of care, treatment, or services.

Elements of Performance for LD.04.02.01
1. ☐ The leaders define conflict of interest involving staff. This definition is in writing.
2. ☐ The leaders develop a written policy that defines how the organization will address conflicts of interest involving staff.
3. Existing or potential conflicts of interest involving staff, as defined by the organization, are disclosed.
4. The organization reviews its relationships with other care providers, educational institutions, manufacturers, and payers to determine whether conflicts of interest exist and whether they are within law and regulation.
5. Information about the relationship between care, treatment, or services and financial incentives is available upon request to all patients and those individuals who work in the organization.
Standard LD.04.02.03
Ethical principles guide the organization’s business practices.

Elements of Performance for LD.04.02.03

1. The organization has a process that allows staff, patients, and families to address ethical issues or issues prone to conflict.

2. The organization uses its process to address ethical issues or issues prone to conflict.

3. The organization has a process that allows staff, patients, and families to address ethical issues or issues prone to conflict.

4. Marketing materials accurately represent the organization and address the care, treatment, or services that the organization provides either directly or by contractual arrangement.

5. Care, treatment, or services are provided based on patient needs, regardless of compensation or financial risk-sharing with those who work in the organization, including staff and licensed independent practitioners.

6. Patients receive information about charges for which they will be responsible.

9. For home health agencies that elect to use The Joint Commission deemed status option: Before care is initiated, the home health agency informs the patient verbally and in writing of the following:
   - The extent to which payment for services may be expected from Medicare, Medicaid, or any other federally funded program known to the home health agency
   - The charges for services that may not be covered by Medicare, Medicaid, or any other federally funded program known to the home health agency, prior to the service(s) being provided
   - The charges the individual may have to pay before care is initiated
   - The need to reduce or terminate on-going care, in advance of any change to reduce or terminate care

17. The organization implements business practices to prevent and control fraud, waste, and abuse by using procedures that articulate standards of conduct so that the organization complies with applicable law and regulation.

18. The organization implements business practices to prevent and control fraud, waste, and abuse by designating one or more individuals in leadership positions to address compliance issues.
19. **For DMEPOS suppliers serving Medicare beneficiaries:** The supplier implements financial management practices for accurate accounting and billing to beneficiaries and the Medicare program.

20. ☐ The organization’s financial records are accurate, complete, current, and reflect cash- or accrual-based accounting practices.

21. ☐ The organization maintains accounts that link equipment and items to the patient.

22. ☐ The organization manages revenues and expenses on an ongoing basis, as they relate to patient services, including reconciliation of charges to patients for equipment, supplies, and services, with invoices, receipts, and deposits, and by tracking actual revenues and expenses.

**Standard LD.04.02.05**

When internal or external review results in the denial of care, treatment, or services, or payment, the organization makes decisions regarding the ongoing provision of care, treatment, or services, and discharge or transfer, based on the assessed needs of the patient.

**Rationale for LD.04.02.05**

The organization is professionally and ethically responsible for providing care, treatment, or services within its capability and law and regulation. At times, such care, treatment, or services are denied because of payment limitations. In these situations, the decision to continue providing care, treatment, or services or to discharge the patient is based solely on the patient’s identified needs.

**Elements of Performance for LD.04.02.05**

1. Decisions regarding the provision of ongoing care, treatment, or services or discharge are based on the assessed needs of the patient and ordered by the licensed independent practitioner when such order is required, regardless of the recommendations of any internal or external review.

2. The safety and quality of care, treatment, or services do not depend on the patient’s ability to pay.

**Standard LD.04.03.01**

The organization 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.

13. For organizations providing a hospice program, planning addresses the following:
   - The philosophy of hospice care
   - Care for the patients’ and families’ physical, psychological, spiritual, and social needs
   - Bereavement services for the survivors

16. For hospices that elect to use The Joint Commission deemed status option:
The hospice documents its efforts to recruit and retain volunteers.

17. For hospices that elect to use The Joint Commission deemed status option:
The hospice documents the cost savings achieved through the use of volunteers. The documentation includes the following:
   - The positions occupied by volunteers
   - The work time spent by volunteers occupying those positions
   - Estimated dollar costs that the hospice would have incurred if paid employees occupied those positions for the same amount of time that volunteers spent working in those positions

18. For hospices that elect to use The Joint Commission deemed status option:
Volunteer staff provide administrative or direct patient care in an amount that equals 5% of the total patient care hours of all paid hospice employees and contract staff. The hospice documents the level of volunteer activity and also records any increased care and services achieved through the use of volunteers. Documentation includes the type of volunteer services and time worked.

Standard LD.04.03.03
The organization provides for its planned scope and level of care, treatment, or services.

Elements of Performance for LD.04.03.03

1. For home health agencies that elect to use The Joint Commission deemed status option: The home health agency provides the following services on a visiting basis in the patient’s place of residence:
   - Skilled nursing services
1. At least one of the following services: physical therapy, speech-language pathology, occupational therapy, medical social services, home health aide services

2. **For home health agencies that elect to use The Joint Commission deemed status option:** At least one of the organization’s services is provided directly through home health agency employees.

   **Note:** Any additional services may be provided under contractual arrangement with another agency or organization.

3. **For hospices that elect to use The Joint Commission deemed status option:** The hospice is primarily engaged in providing the hospice services covered by Medicare as well as bereavement counseling.

4. **For hospices that elect to use The Joint Commission deemed status option:** The hospice provides nursing care by, or under the supervision of, a registered nurse.

   **Note:** During a period when the patient requires continuous care to achieve palliation or management of acute medical symptoms, nursing care may be provided on a continuous basis, 24 hours a day. For more information on special coverage requirements, see 418.204(a) in the Appendix.

5. **For hospices that elect to use The Joint Commission deemed status option:** Nursing services are directed and staffed to assure that the nursing needs of the hospice’s patients are met.

6. **For hospices that elect to use The Joint Commission deemed status option:** The hospice provides medical social services by a social worker under the direction of a physician. (Refer to HR.01.02.01 for staff qualifications.)

7. **For hospices that elect to use The Joint Commission deemed status option:** The hospice provides physician services.

   **Note:** The hospice may contract for physician services.

8. **For hospices that elect to use The Joint Commission deemed status option:** The hospice medical director, physician employees of the hospice, and physicians contracted by the hospice, in conjunction with the patient’s attending physician, are responsible for meeting the patient’s needs for palliation and management of the terminal illness and related conditions.
9. **For hospices that elect to use The Joint Commission deemed status option:** The hospice makes counseling services available to the patient and family or other persons caring for the patient at home. *(See also RI.01.01.01, EP 20)*

   **Note:** Counseling includes bereavement counseling provided after the patient’s death, dietary counseling, spiritual counseling, and any other counseling services provided while the patient is enrolled in the hospice. Counseling may be offered to train the patient’s family or other caregivers to provide care as well as to help the patient and those caring for him or her to adjust to the patient’s approaching death. Counseling may be offered to assist the patient and family in managing the stress and other problems that arise from the terminal illness, related conditions, and the dying process.

10. **For hospices that elect to use The Joint Commission deemed status option:** The hospice provides an organized program for the provision of bereavement services.

11. **For hospices that elect to use The Joint Commission deemed status option:** The hospice provides short-term inpatient care for pain control, symptom management, and respite. Short-term inpatient care is provided in a participating Medicare or Medicaid facility.

   **Note:** Inpatient care may be required for procedures necessary for pain control or management of acute or chronic symptoms. Inpatient care may also be provided as a means of providing respite for the patient’s family or other persons caring for the patient at home. Respite care is short-term inpatient care provided when necessary to relieve the family members or other persons caring for the patient.

12. **For hospices that elect to use The Joint Commission deemed status option:** Inpatient care for pain control and symptom management is provided in one of the following:

   - A Medicare-certified hospice that meets the conditions of participation for providing inpatient care directly
   - A Medicare-certified hospital or skilled nursing facility that provides all of the following:
     - 24-hour nursing services
     - A registered nurse who provides direct patient care on each shift
     - Patient areas designed and equipped for patient comfort and privacy
     - Physical space for patient and family visiting
     - Accommodations for family members to remain with the patient throughout the night
     - Accommodations for family privacy after a patient’s death
13. **For hospices that elect to use The Joint Commission deemed status option:**
Inpatient care for respite purposes is provided in one of the following types of facilities:
- A Medicare-certified hospice that meets the conditions of participation for providing inpatient care directly *(See 42 CFR 418.110)*
- A Medicare-certified hospital that meets 24-hour nursing care requirements for patient areas *(See 42 CFR 418.110(b) and (e))*
- A Medicare-certified skilled nursing facility that meets 24-hour nursing care requirements and requirements for patient areas *(See 42 CFR 418.110(b) and (e))*
- A Medicare- or Medicaid-certified nursing facility that meets the requirements for patient rooms *(See 42 CFR 418.110(f))*

**Note:** The requirements for providing inpatient care directly are found at 42 CFR 418.110. The requirements for 24-hour nursing care are found at CFR 418.110(b). The requirements for patient areas are located at CFR 418.110(e). The requirements for patient rooms are located at CFR 418.110(f). The full text of these requirements is located in the “Medicare Requirements for Hospice” appendix.

14. **For hospices that elect to use The Joint Commission deemed status option:**
The total number of inpatient days used by the hospice’s Medicare beneficiaries does not exceed 20 percent of the total number of hospice days for these beneficiaries.

**Note:** Any hospice that began operations before January 1, 1975 is not subject to this limitation.

**For hospices that elect to use The Joint Commission deemed status option:**
The hospice makes the following items available:

15. Medical supplies and appliances, durable medical equipment, medications, and biologicals.

**Note 1:** The hospice provides these items as they relate to the palliation and management of the terminal illness and related conditions and in accordance with each patient’s hospice plan of care.
Note 2: Further information describing medical supplies and appliances is available at 42 CFR 410.36, and further information describing durable medical equipment is available at 42 CFR 410.38.

16. For hospices that elect to use The Joint Commission deemed status option: The hospice provides hospice aide, volunteer, and homemaker services.

17. For hospices that elect to use The Joint Commission deemed status option: The hospice provides physical therapy, occupational therapy, and speech-language pathology services for the purposes of symptom management or to enable the patient to maintain activities of daily living and basic functional skills.

20. For hospices that elect to use The Joint Commission deemed status option: The hospice’s core services (nursing services, medical social services, and counseling services) are routinely provided directly by hospice employees. The hospice’s noncore services are provided either directly by hospice employees or under contractual arrangement.

Note 1: The hospice may use contracted staff or enter into a written agreement with another Medicare-certified hospice program for the provision of core services to meet patient needs under extraordinary circumstances or other nonroutine circumstances. Such circumstances include unanticipated periods of high patient loads, staffing shortages due to illness, temporary travel of a patient outside the hospice’s service area or other short-term situations that interrupt patient care.

Note 2: Highly specialized nursing services may be provided under contract if they are provided so infrequently that the provision of such services by hospice employees would be impractical and prohibitively expensive.

21. For hospices that elect to use The Joint Commission deemed status option: When the hospice contracts for nursing staff, it obtains from the Centers for Medicare & Medicaid Services (CMS) a waiver of the requirement stating that a substantial portion of all nursing services are routinely provided directly by the hospice.

Note: Hospices that wish to request a waiver should contact the CMS Regional Office. Further information about the process of requesting a waiver and the criteria that CMS uses to grant a waiver can be found at 42 CFR 418.66(a) through (d).
22. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** The hospice either employs a licensed pharmacist or has a written agreement with a licensed pharmacist.

   **Note:** The pharmacist’s role is to evaluate the patient’s response to medication therapy, identify potential adverse drug reactions, and recommend appropriate corrective action.

24. **For hospices that elect to use The Joint Commission deemed status option:** The medical director supervises all physician employees and physicians under contract.

   **Note:** The medical director may also serve as the physician member of the interdisciplinary group.

25. **For hospices that elect to use The Joint Commission deemed status option:** All physician employees and physicians under contract either provide services directly or coordinate patient care with the attending physician.

26. **For hospices that elect to use The Joint Commission deemed status option:** If the attending physician is unavailable, the medical director, contracted physician, or hospice physician employee is responsible for the medical needs of the patients.

27. **For hospices that elect to use The Joint Commission deemed status option:** When the hospice is located in a nonurban area and does not make physical therapy, occupational therapy, speech-language pathology, or dietary counseling services available on a 24-hour basis, the hospice obtains a written waiver from the Centers for Medicare & Medicaid Services (CMS) of the requirement to provide these services on a 24-hour basis.

   **Note:** Hospices that wish to request a waiver should contact the CMS Regional Office. Further information about the process of requesting a waiver and the criteria that CMS uses to grant a waiver can be found at 42 CFR 418.74(a) through (d).

28. **For hospices that elect to use The Joint Commission deemed status option:** The hospice organizes, manages, and administers its resources to provide the hospice care and services needed by patients, caregivers, and families for palliation and the management of terminal illness and related conditions.

29. **For hospices that elect to use The Joint Commission deemed status option:** If a hospice operates in multiple locations, it meets the following requirements:
The hospice has Medicare approval to operate each of its locations before hospice care is provided to Medicare patients.

Each location shares administration, supervision, and services with the hospice issued the Medicare certification number.

The lines of authority and professional and administrative control are clearly delineated in the hospice’s organizational structure and in practice, and are under the authority of the location that was issued the certification number.

**Note:** The determination that a location does or does not meet these criteria is made by the Centers for Medicare & Medicaid Services (CMS) and is an initial determination. Refer to 42 CFR 498.3 for further information about determinations that affect participation in the Medicare program.

30. **For hospices that elect to use The Joint Commission deemed status option:** The hospice monitors and manages all services provided at all of its locations so that they are delivered safely and effectively and each patient and family receives the care and services outlined in the plan of care.

31. **For hospices that elect to use The Joint Commission deemed status option:** The hospice assumes responsibility for the professional management of hospice services provided to the resident of a Skilled Nursing Facility, Nursing Facility, or an Intermediate Care Facility for the Mentally Retarded in accordance with the hospice plan of care and makes any arrangements necessary for hospice-related inpatient care in a participating Medicare/Medicaid facility.

32. **For hospices that elect to use The Joint Commission deemed status option:** The hospice provides personal care services under the Medicaid personal care benefit only to the extent that the hospice would routinely use the services of a hospice patient’s family in implementing the plan of care.

33. **For hospices that elect to use The Joint Commission deemed status option:** A facility providing respite care makes 24-hour nursing services available to meet the patient’s nursing needs as described in the plan of care.

34. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** Programs have a process for making referrals to one or more hospices that will accept palliative care patient referrals.

35. **For home health agencies that elect to use The Joint Commission deemed status option:** The primary home health agency is responsible for patient care and must provide, either directly or under arrangement, all services rendered to patients.
Standard LD.04.03.07
Patients with comparable needs receive the same standard of care, treatment, or services throughout the organization.

Rationale for LD.04.03.07
Comparable standards of care mean that the organization can provide the services that patients need within established time frames and that those providing care, treatment, or services have the required competence. Organizations 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. Also, organizations may choose to have branch offices that offer different services from one another. 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, or services in a negative way.

Introduction to Oversight of Care, Treatment, or Services Provided Through Contractual Agreement, Standard LD.04.03.09
The same level of care should be delivered to patients regardless of whether services are provided directly by the organization or through contractual agreement. Leaders provide oversight to make sure that care, treatment, or services provided directly are safe and effective. Likewise, leaders must also oversee contracted services to make sure that they are provided safely and effectively. Standard LD.04.03.09 outlines the requirements for leadership oversight of care, treatment, or services provided through contractual agreement.

The only contractual agreements subject to the requirements in Standard LD.04.03.09 are those for the provision of care, treatment, or services provided to the organization’s patients. Such services include any licensed professional service, personal care or support, pharmacy dispensing, clinical/consultant pharmacist, long term care pharmacy, ambulatory infusion, home medical equipment, clinical respiratory, rehabilitation technology, and hospice services. 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 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 organization’s expertise as they do for contracted services within the organization’s expertise, it is more difficult to determine how to monitor such services. In these cases, information from relevant professional organizations can provide guidance for setting expectations.

The EPs do not prescribe the methods for evaluating contracted services; leaders are expected to select the best methods for their organization to oversee the quality and safety of services provided through contractual agreement. Examples of sources of information that may be used for evaluating contracted services include the following:

- Review of information about the contractor’s Joint Commission accreditation or certification status
- Direct observation of the provision of care
- Audit of documentation, including patient records
- Review of incident reports
- Review of periodic reports submitted by the individual or organization providing services under contractual agreement
- Collection of data that address the efficacy of the contracted service
- Review of performance reports based on indicators required in the contractual agreement
- Input from staff and 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, or services. In some cases, it may be best to work with the contractor to make improvements, whereas in other cases it may be best to renegotiate or terminate the contractual relationship. When the leaders anticipate the renegotiation or termination of a contractual agreement, planning needs to occur so that the continuity of care, treatment, or services is not disrupted.

**Standard LD.04.03.09**

Care, treatment, or services provided through contractual agreement are provided safely and effectively.

**Elements of Performance for LD.04.03.09**

2. (D) The organization describes, in writing, the nature and scope of services provided through contractual agreements.

3. (D) Designated leaders approve contractual agreements. [R]

4. Leaders monitor contracted services by establishing expectations for the performance of the contracted services.

5. (D) Leaders monitor contracted services by communicating the expectations in writing to the provider of the contracted services.

   **Note:** *A written description of the expectations can be provided either as part of the written agreement or in addition to it.*

6. Leaders monitor contracted services by evaluating these services in relation to the organization’s expectations. [R]

7. Leaders take steps to improve contracted services that do not meet expectations.

   **Note:** *Examples of improvement efforts to consider include the following:*
   - Increase monitoring of the contracted services.
   - Provide consultation or training to the contractor.
   - Renegotiate the contract terms.
   - Apply defined penalties.
   - Terminate the contract.

8. When contractual agreements are renegotiated or terminated, the organization maintains the continuity of patient care.
10. Reference and contract laboratory services meet the federal regulations for clinical laboratories and maintain evidence of the same.†

11. **For home health agencies that elect to use The Joint Commission deemed status option:** The parent home health agency is responsible for:
   - Reporting all branch locations of the organization to the state survey agency at the time of the request for initial certification; at each survey; and at the time the parent proposed to add or delete a branch.
   - Providing direct support and administrative control of its branches.

12. **For home health agencies that elect to use The Joint Commission deemed status option:** If personnel under hourly or per visit contracts are used, the home health agency has a written agreement with the other organization or individual concerning services under arrangement to the home health agency’s patients.

   **Note:** The home health agency ensures that all services furnished under arrangement provided by other entities or individuals meet the requirements of section 1861(w) of the Social Security Act (42 U.S.C. 1395x (w)).

14. **For home health agencies that elect to use The Joint Commission deemed status option:** When the home health agency provides home health aide services under contractual arrangement, the home health agency’s responsibilities include, but are not limited to, the following:
   - Providing for the overall quality of the care provided by the home health aide
   - Supervising the aide’s services as described in HR.01.03.01, EPs 15 and 27
   - Verifying that the home health aide has met the training or competency requirements (or both) outlined in HR.01.05.01, EP 4

   **Note:** Provision of home health aide services under arrangement is defined in section 1861(w)(1) of the Social Security Act.

15. **For hospices that elect to use The Joint Commission deemed status option:**
   The written agreement with an outside agency providing contracted services for the hospice includes the following:
   - Identification of the services to be provided
   - A stipulation that services may be provided only with the authorization of the hospice

† For law and regulation guidance on the Clinical Laboratory Improvement Amendments of 1988, see 42 CFR 493.
A stipulation that services will be delivered in accordance with the patient’s plan of care
- The manner in which contracted services will be coordinated, supervised, and evaluated by the hospice
- The delineation of the role of the hospice and contractor in the admission process, patient/family assessment, and the interdisciplinary group conferences
- Requirements for documenting that services are furnished in accordance with the agreement
- The qualifications of the individuals providing the services
- A stipulation that the outside agency will complete criminal background checks on contracted employees who provide direct patient care or have access to patient records

16. **For hospices that elect to use The Joint Commission deemed status option:** The hospice retains management responsibility for the contracted services and verifies that they are furnished in a safe and effective manner.

17. **For hospices that elect to use The Joint Commission deemed status option:** The written agreement for inpatient care includes the following:
- That the hospice furnishes the inpatient provider with a copy of the patient’s plan of care and will specify the inpatient services to be provided
- That the inpatient provider has policies that are consistent with those of the hospice and that it agrees to abide by the patient care protocols established by the hospice for its patients
- That the record will include documentation of all inpatient services and events and that a copy of the discharge summary and, if requested, a copy of the record will be provided to the hospice
- The party responsible for the implementation of the provisions of the agreement
- That the hospice retains responsibility for appropriate training of the personnel who provide hospice care under the agreement
- That the hospice documents a description of the training provided along with the names of those providing the training

21. **For hospices that elect to use The Joint Commission deemed status option:** For hospice care provided to residents of a Skilled Nursing Facility (SNF), Nursing Facility (NF), or Intermediate Care Facility for the Mentally Retarded (ICF/MR), the written agreement includes the following:

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
The manner in which the SNF, NF, or ICF/MR and the hospice will communicate with each other and will document the communications to make sure the needs of the patients are met 24 hours a day

A provision that the SNF, NF, or ICF/MR notifies the hospice immediately when there is a significant change in the patient’s physical, mental, social, or emotional status; when clinical complications appear that suggest a need to alter the plan of care; when there is a need to transfer the patient (in this case the hospice makes arrangements for and remains responsible for any necessary care); or when the patient dies

A provision stating the hospice assumes responsibility for determining the appropriate course of hospice care, including the decision to change the level of services provided

An agreement that it is the responsibility of the SNF, NF, or ICF/MR to furnish 24-hour room and board and meet the personal care and nursing needs that would have been provided by the primary caregiver at home. The level of care is the same as that provided before the patient elected hospice care.

An agreement that it is the hospice’s responsibility to provide services at the same level as those services that would be provided if the SNF, NF, or ICF/MR resident were in his or her own home

A delineation of the hospice’s responsibilities, which include, but are not limited to, providing medical direction and management of the patient; nursing; counseling; social work; medical supplies; durable medical equipment; medications necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident’s terminal illness and related conditions

A provision that the hospice may use the SNF, NF, or ICF/MR nursing staff when permitted by state law and only to the extent that the hospice would routinely use the services of a hospice patient’s family in implementing the plan of care

A provision stating that the hospice will report all mistreatment, neglect, or verbal, mental, sexual, and physical abuse to the SNF, NF, or ICF/MR administrator within 24 hours of the hospice becoming aware of the alleged violation, including injuries of unknown source, and misappropriation of patient property by anyone unrelated to the hospice
A delineation of the responsibilities of the hospice and the SNF, NF, or ICF/MR to provide bereavement services to SNF, NF, or ICF/MR staff

22. **For hospices that elect to use The Joint Commission deemed status option:** The hospice contracts for durable medical equipment services only with suppliers that meet Medicare’s Quality Standards for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies.

24. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** Program leaders evaluate care, treatment, and services provided through contractual arrangement to ascertain whether the scope and level of care, treatment, and services are consistently provided. (For more information, refer to LD.04.03.09, EP 4)

25. **For home health agencies that elect to use The Joint Commission deemed status option:** None of the following can be applicable for an organization or individual providing services under contractual arrangement:
   - Denied Medicare or Medicaid enrollment
   - Revoked Medicare or Medicaid billing privileges
   - Excluded or terminated from any federal health care program
   - Debarred from participating in any government program

**Standard LD.04.04.01**

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

**Elements of Performance for LD.04.04.01**

1. Leaders set priorities for performance improvement activities and patient health outcomes. *(See also PI.01.01.01, EPs 1 and 3)*

   **For home health agencies and hospices that elect to use The Joint Commission deemed status option:** The organization’s governing body is ultimately accountable for making sure that the priorities that are selected address improvements to the safety and quality of patient care.

2. Leaders give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities. *(See also PI.01.01.01, EPs 14 and 15)*

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

4. Performance improvement occurs organizationwide.
8. For **home health agencies and hospices that elect to use The Joint Commission deemed status option:** The organization has an ongoing, organization-wide, data-driven quality assessment and performance improvement program.

**For hospices that elect to use The Joint Commission deemed status option:** This program is evaluated annually.

**Note:** The organization’s governing body is ultimately accountable for the development, implementation, maintenance, and evaluation of the quality assessment and improvement program.

9. For **home health agencies and hospices that elect to use The Joint Commission deemed status option:** The organization’s governing body is responsible for making sure the quality assessment and performance improvement program (QAPI) meets the following criteria:

- Reflects the complexity of the organization and its services
- Involves all services provided by the organization, including those provided under contract or arrangement
- Takes actions to demonstrate improvement in the organization’s performance

**For home health agencies that elect to use The Joint Commission deemed status option:** The QAPI program focuses on indicators related to improved outcomes, including hospital admissions, hospital readmissions, and the use of emergent care services.

**For hospices that elect to use The Joint Commission deemed status option:** The QAPI program focuses on indicators that are related to improved palliative outcomes.

10. For **home health agencies and hospices that elect to use The Joint Commission deemed status option:** The organization maintains documentation of the quality assessment and performance improvement program and is able to demonstrate its operation.

11. **For hospices that elect to use The Joint Commission deemed status option:** The quality assessment and performance improvement program demonstrates improvement in the indicators related to improved palliative outcomes and hospice services.

12. **For hospices that elect to use The Joint Commission deemed status option:** The hospice uses quality indicator data, including patient care and other relevant data, in the design of its quality assessment and improvement program.
13. **For hospices that elect to use The Joint Commission deemed status option:** The hospice selects performance improvement activities that affect palliative outcomes, patient safety, and the quality of care and that are based on the prevalence and severity of problems in its high-volume, high-risk, and problem-prone areas.

14. **For hospices that elect to use The Joint Commission deemed status option:** The governing body designates one or more individuals to be responsible for operating the quality assessment and performance improvement program.

15. **For hospices that elect to use The Joint Commission deemed status option:** Licensed professionals participate in the hospice’s quality assessment and performance improvement program.

27. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program has a written performance improvement plan.

28. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program sets performance improvement priorities and describes how the priorities are adjusted in response to unusual or urgent events.

29. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program plans process and performance improvement activities to encompass multiple disciplines and/or settings.

30. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program implements its performance improvement plan.

31. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program’s performance improvement plan, including its data analysis, is communicated at least annually to the organization’s leaders.

32. **For home health agencies that elect to use The Joint Commission deemed status option:** The home health agency uses quality indicator data, including measures derived from OASIS, when applicable, along with other relevant data in the design of its quality assessment and improvement program.
33. For home health agencies that elect to use The Joint Commission deemed status option: The home health agency considers incidence, prevalence, and severity of problems in its high-risk, high-volume, problem-prone areas when selecting performance improvement activities that will lead to an immediate correction of any identified problem that directly or potentially threaten the health and safety of patients.

34. For home health agencies that elect to use The Joint Commission deemed status option: The quality assessment and performance improvement program demonstrates improvement in the indicators that will improve health outcomes, patient safety, and quality of care.

**Standard LD.04.04.03**

New or modified services or processes are well designed.

**Elements of Performance for LD.04.04.03**

1. The organization’s design of new or modified services or processes incorporates the needs of patients, staff, and others.

2. The organization’s design of new or modified services or processes incorporates the results of performance improvement activities.

3. The organization’s design of new or modified services or processes incorporates information about potential risks to patients, sentinel events experienced by the organization, and general information about sentinel events relevant to the organization. (See also LD.04.04.05, EPs 6 and 11)

   **Note:** A proactive risk assessment is one of several ways to assess potential risks to patients. For suggested components, refer to the “Proactive Risk Assessment” section at the beginning of this chapter.

4. The organization’s design of new or modified services or processes incorporates evidence-based information in the decision-making process.

   **Note:** For example, evidence-based information could include practice guidelines, successful practices, information from current literature, and clinical standards.

8. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: Program leaders create opportunities for staff to participate in the design of the care, treatment, and services provided.
Introduction to Standard LD.04.04.05

This standard describes a safety program that integrates safety priorities into all processes, functions, and services within the organization, including patient care, support, and contract services. It addresses the responsibility of leaders to an organizationwide safety program; to proactively explore potential system failures; to analyze and take action on problems that have occurred; and to encourage the reporting of adverse events and close calls (“near misses”), both internally and externally. The organization’s culture of safety and quality supports the safety program (refer to Standard LD.03.01.01).

This standard does not require the creation of a new structure or office in the organization. It only emphasizes the need to integrate patient safety activities, both existing and newly created, with the organization’s leadership, which is ultimately responsible for this integration.

It is also critical that the organization, when establishing a patient safety program, integrate the roles and responsibilities of the patient and his or her family with reducing unanticipated adverse events or adverse outcomes by providing sufficient information about the risks related to the care or services provided, instructions on minimizing those risks, and the consequences of not following such instructions aimed at reducing risk.

Standard LD.04.04.05

The organization has an organizationwide, integrated patient safety program.

Elements of Performance for LD.04.04.05

1. The leaders implement an organizationwide patient safety program.

   **Note 1:** For home health agencies and hospices that elect to use The Joint Commission deemed status option: The governing body is ultimately accountable for the development, implementation, maintenance, and evaluation of the patient safety program.

   **Note 2:** For home health agencies that elect to use The Joint Commission deemed status option: The patient safety program establishes, implements, and maintains clear expectations for patient safety.

   **Note 3:** For hospices that elect to use The Joint Commission deemed status option: This program is evaluated annually.

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

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

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

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

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)*

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

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

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

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

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

14. Leaders facilitate mandatory reporting of significant adverse events, and voluntary reporting of such events to programs in which the organization participates.

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.

15. For home health agencies and hospices that elect to use The Joint Commission deemed status option: The organization tracks adverse patient events, analyzes their causes, and implements preventive actions and mechanisms that include feedback and learning throughout the organization.

Standard LD.04.04.09

For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The program uses current clinical practice guidelines and evidence-based practices to guide the provision of palliative care services.
Note: Clinical practice guidelines and evidence-based practices include both nationally recognized guidelines and practices, as well as guidelines and practices developed by individual organizations to address their particular circumstances.

Element of Performance for LD.04.04.09

7. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The program reviews and revises its clinical practices in response to changes in evidence-based national guidelines or expert consensus, or results of its performance improvement activities.
Prompts to Assess Your Compliance

**Please note:** Tips do not represent new accreditation requirements. They are intended to provide helpful strategies for standards compliance.

What is included on your organization chart, and where is it located? (LD.01.01.01)

**TIP:** Review the organization chart twice a year. Verify that names and titles are accurate and that the chart correctly identifies reporting lines and responsibilities. Be sure that staff know where the organization chart is located and can refer to it.

**TIP:** When applicable, set the clocks ahead in the spring and fall back in autumn as a quick reminder.

What types of resources (for example, books, articles, videos) does your organization provide for use by the staff? (LD.03.03.01)
**TIP:** Health care resources that are five or more years old are typically considered out of date and should be replaced. Look at government websites such as the Centers for Disease Control and Prevention, Occupational Safety and Health Administration, Food and Drug Administration, Centers for Medicare & Medicaid (CMS), and the National Fire Protection Association for current and educational resources you can download and use in your organization.

**TIP:** To achieve consistency when orienting various leaders, create an electronic folder of PDF copies of the policies and documents that the leaders must review and learn. Include a signature-capable PDF verification document for each individual to electronically sign to confirm that he or she has read the material. After this document is signed, keep it and other documents in an electronic folder in your computer. These steps can also be completed by creating a hard-copy binder and including a paper document for each individual to sign. When members miss a meeting, be sure to send them the information and get signed verification that they have reviewed the material so that they are up to date.
**TIP:** Leaders should become thoroughly familiar with the concept and implications of “corporate culture” especially as it relates to safety and quality. Organizations should have a way to evaluate their corporate culture—a method that can be used to prioritize changes when needed. Take advantage of free resources and links available on The Joint Commission website to find out more about just and safe cultures.

How will organization leaders communicate among themselves when high-risk, unplanned events occur? [LD.03.04.01]

What expectations have been set by leadership for using data collected from patients and clients to improve safety and quality of care? What safeguards have been put in place to ensure that the data is secure and unadulterated? [LD.03.02.01]

If the organization uses contract staff, how does leadership assure that the work processes used by contract staff to promote safe quality care are consistent with those used by direct employees? [LD.04.03.09]

In ordering equipment and supplies for the organization, do leaders order the items needed (such as pediatric blood pressure cuffs for pediatric patients) by the populations served by the agency? [LD.04.01.11]
Deemed hospices: CMS requires that deemed hospices have a formalized program of bereavement with options for survivors who are experiencing complicated grief. Consider how your formalized bereavement program supports survivors through the different phases of grieving. Is the same support process useful in all the phases of the grieving process? How do the support processes change to meet the needs of survivors through their periods of grief? (LD.04.03.03)

**TIP:** The organization is required to have a process to reliably evaluate the hospice bereavement program. This includes looking at the outcomes that are measured and determining how they can be used to improve the program.

Deemed hospices: CMS requires that deemed hospices must be able to readily and adequately staff patients with needs for continuous care services. What is the leaders’ plan to provide this staff when needed? (LD.04.03.03)
**Written Documentation Checklist**

This worksheet lists elements of performance (EPs) that require written documentation that a surveyor could ask to see during a survey to show compliance with a standard. *(Note: Documentation can be on paper or in an electronic format.)*

### Leadership (LD)

<table>
<thead>
<tr>
<th>Standard</th>
<th>EP</th>
<th>Leadership Standards</th>
<th>Home Care Service</th>
<th>Date last verified</th>
</tr>
</thead>
<tbody>
<tr>
<td>LD.01.01.01</td>
<td>4</td>
<td>EP 4—For home health agencies that elect to use The Joint Commission deemed status option: The home health agency identifies and documents its organizational structure, the services it furnishes, and the structure of its administrative control, including lines of authority.</td>
<td>Deemed HH</td>
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<tr>
<td>LD.01.03.01</td>
<td>1, 3</td>
<td>EP 1—Governance defines in writing its responsibilities.</td>
<td>EPs 1, 3—All services</td>
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<td>EP 3—Governance approves the organization’s written scope of services.</td>
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<td>LD.01.04.01</td>
<td>11,</td>
<td>EP 11—When the chief executive or administrator is absent from the organization, a qualified individual is designated to perform the duties of this position. EP 19—For hospices that elect to use The Joint Commission deemed status option: When the hospice contracts for medical director services, the contract specifies the name of the physician who assumes the medical director responsibilities.</td>
<td>EP 11—All services</td>
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<td></td>
<td>19</td>
<td></td>
<td>EP 19—Deemed HOS</td>
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<tr>
<td>LD.03.01.01</td>
<td>4</td>
<td>EP 4—Leaders develop a code of conduct that defines acceptable behavior and behaviors that undermine a culture of safety.</td>
<td>All services</td>
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<tr>
<td>LD.04.01.01</td>
<td>1</td>
<td>EP 1—The organization is licensed, is certified, or has a permit, in accordance with law and regulation, to provide the care, treatment, or services for which the organization is seeking accreditation from The Joint Commission.</td>
<td>All services</td>
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</tbody>
</table>

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
| LD.04.01.03 | 2, 4 | EP 2—**For home health agencies that elect to use The Joint Commission deemed status option:** The home health agency prepares an overall plan and budget that includes an annual operating budget and a capital expenditure plan. The overall plan and budget is prepared under the direction of the governing body by a committee consisting of representatives of the governing body, the administrative staff, and the medical staff (if any) of the home health agency. The governing body has the responsibility to adopt and periodically review written bylaws and oversee fiscal affairs. |
| EP 2—Deemed HH |
| EP 4—Governance approves an annual operating budget and, when needed, a long-term capital expenditure plan. |
| LD.04.01.05 | 3 | EP 3—The organization defines, in writing, the responsibility of those with administrative and clinical direction of its programs, services, sites, or departments. |
| All services |
| LD.04.02.01 | 1, 2 | EP 1—The leaders define conflict of interest involving staff. This definition is in writing. EP 2—The leaders develop a written policy that defines how the organization will address conflicts of interest involving staff. |
| All services |
| LD.04.02.03 | 4, 9, 20–22 | EP 4—Marketing materials accurately represent the organization and address the care, treatment, or services that the organization provides either directly or by contractual arrangement. |
| EP 4—All services |
| LD.04.03.01 | 16–18 | EP 15—For home health agencies that elect to use The Joint Commission deemed status option: Before care is initiated, the home health agency informs the patient verbally and in writing of the following:
- The extent to which payment for services may be expected from Medicare, Medicaid, or any other federally funded program known to the home health agency
- The charges for services that may not be covered by Medicare, Medicaid, or any other federally funded program known to the home health agency, prior to the service(s) being provided
- The charges the individual may have to pay before care is initiated
- The need to reduce or terminate ongoing care, in advance of any change to reduce or terminate care

EP 20—The organization’s financial records are accurate, complete, current, and reflect cash- or accrual-based accounting practices.

EP 21—The organization maintains accounts that link equipment and items to the patient.

EP 22—The organization manages revenues and expenses on an ongoing basis, as they relate to patient services, including reconciliation of charges to patients for equipment, supplies, and services, with invoices, receipts, and deposits, and by tracking actual revenues and expenses.
| EP 17—For hospices that elect to use The Joint Commission deemed status option: The hospice documents the cost savings achieved through the use of volunteers. The documentation includes the following:  
| The positions occupied by volunteers  
| The work time spent by volunteers occupying those positions  
| Estimated dollar costs that the hospice would have incurred if paid employees occupied those positions for the same amount of time that volunteers spent working in those positions  
| EP 18—For hospices that elect to use The Joint Commission deemed status option: Volunteer staff provide administrative or direct patient care in an amount that equals 5% of the total patient care hours of all paid hospice employees and contract staff. The hospice documents the level of volunteer activity and also records any increased care and services achieved through the use of volunteers. Documentation includes the type of volunteer services and time worked.  
| LD.04.03.03 21, 22, 27  
| EP 21—For hospices that elect to use The Joint Commission deemed status option: When the hospice contracts for nursing staff, it obtains from the Centers for Medicare & Medicaid Services (CMS) a waiver of the requirement stating that a substantial portion of all nursing services are routinely provided directly by the hospice.  
| EP 22—For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option: The hospice either employs a licensed pharmacist or has a written agreement with a licensed pharmacist.  
| EP 21—Deemed HOS  
| EP 22—Deemed HOS (F)  

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
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<tr>
<td>EP 27—For hospices that elect to use The Joint Commission deemed status option: When the hospice is located in a nonurban area and does not make physical therapy, occupational therapy, speech-language pathology, or dietary counseling services available on a 24-hour basis, the hospice obtains a written waiver from the Centers for Medicare &amp; Medicaid Services (CMS) of the requirement to provide these services on a 24-hour basis.</td>
<td>EP 27—Deemed HOS</td>
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<tr>
<td>EP 2—The organization describes, in writing, the nature and scope of services provided through contractual agreements.</td>
<td>EPs 2, 3, 5—All services</td>
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<td>EP 3—Designated leaders approve contractual agreements.</td>
<td>EP 10—HH, HOS</td>
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<tr>
<td>EP 5—Leaders monitor contracted services by communicating the expectations in writing to the provider of the contracted services.</td>
<td>EP 12—Deemed HH</td>
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<td>EP 10—Reference and contract laboratory services meet the federal regulations for clinical laboratories and maintain evidence of the same.</td>
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<td>EP 12—For home health agencies that elect to use The Joint Commission deemed status option: If personnel under hourly or per visit contracts are used, the home health agency has a written agreement with the other organization or individual concerning services under arrangement to the home health agency’s patients.</td>
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</table>
EP 15—For hospices that elect to use The Joint Commission deemed status option: The written agreement with an outside agency providing contracted services for the hospice includes the following:

- Identification of the services to be provided
- A stipulation that services may be provided only with the authorization of the hospice
- A stipulation that services will be delivered in accordance with the patient’s plan of care
- The manner in which contracted services will be coordinated, supervised, and evaluated by the hospice
- The delineation of the role of the hospice and contractor in the admission process, patient/family assessment, and the interdisciplinary group conferences
- Requirements for documenting that services are furnished in accordance with the agreement
- The qualifications of the individuals providing the services
- A stipulation that the outside agency will complete criminal background checks on contracted employees who provide direct patient care or have access to patient records

EPs 15, 17—Deemed HOS
### EP 17—For hospices that elect to use The Joint Commission deemed status option

The written agreement for inpatient care includes the following:

- That the hospice furnishes the inpatient provider with a copy of the patient’s plan of care and will specify the inpatient services to be provided.
- That the inpatient provider has policies that are consistent with those of the hospice and that it agrees to abide by the patient care protocols established by the hospice for its patients.
- That the record will include documentation of all inpatient services and events and that a copy of the discharge summary and, if requested, a copy of the record will be provided to the hospice.
- The party responsible for the implementation of the provisions of the agreement.
- That the hospice retains responsibility for appropriate training of the personnel who provide hospice care under the agreement.
- That the hospice documents a description of the training provided along with the names of those providing the training.

### EP 10—For home health agencies and hospices that elect to use The Joint Commission deemed status option

The organization maintains documentation of the quality assessment and performance improvement program and is able to demonstrate its operation.

### EP 27—For organizations that elect The Joint Commission Community-Based Palliative Care Certification option

The program has a written performance improvement plan.
| LD.04.04.05 | 13 | EP 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 | EP 13—All services |
Action Planning Tool

Use this form to track noncompliant elements of performance (EPs) and your action steps for bringing them into compliance.

<table>
<thead>
<tr>
<th>Standard and EP</th>
<th>Observation/Issue</th>
<th>Action Step</th>
<th>Individual Responsible</th>
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Chapter Notes

Use this page to take notes about ideas for meeting the standards in this chapter, your organization’s policies and procedures that address requirements in this chapter, or the data or patient record numbers used to determine compliance or noncompliance for EPs. If a standard is found not compliant, it can be helpful to know which data were used so they can be easily accessed when developing action plans for compliance.
Life Safety (LS)

Overview

Applicability of the Standards
These standards apply to the following hospice settings:

- Freestanding, inpatient hospice facilities
- A segregated hospice unit in a hospital or nursing home that is not accredited by The Joint Commission. In these organizations, the following areas will be assessed:
- The space in which the hospice unit is located
- All exits from the unit to the outside at grade level
- Any Life Safety Code® building systems supporting the unit. Examples of such systems include fire alarms and automatic sprinklers

The first two standards, LS.01.01.01 and LS.01.02.01, apply to both inpatient hospice settings. Hospices are considered health care occupancies, and those standards begin with LS.02.01.10.

Note: While a segregated hospice unit in an accredited hospital or nursing home is expected to meet the Life Safety Code requirements, compliance will be reviewed as part of the host organization’s survey and Focused Standards Assessment.

These standards are not applicable to leased beds that are dispersed throughout the facility (that is, the beds are not considered a segregated unit) in a hospital or nursing home, regardless of whether the host organization is accredited.

About This Chapter
Fire is a concern for everyone, but it is a special concern in organizations 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 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 organizations must take to protect occupants from the dangers of fire constitute the

*Life Safety Code® is a registered trademark of the National Fire Protection Association, Quincy, MA.
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 organization are addressed in the “Environment of Care” (EC) chapter.

From time to time, building codes are updated to incorporate new technology that often cannot be introduced easily into older buildings. These settings tend to rely more on passive systems (such as doors and walls) for fire protection. In new buildings, fire protection is more often provided by active systems, such as fire alarms and automatic sprinkler systems. This chapter addresses both existing and new 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 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*. Requirements for Rooming and Lodging occupancies are found in Chapter 26.

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
- Protection provided by door features, fire windows, stairs, and other vertical openings; corridors; smoke barriers; and interior finishes
- Fire alarm notification, including audible and coded alarms
- Suppression of fires, including sprinkler systems
- Building services, including elevators and chutes
- Decorations, furnishings, and portable heaters
Chapter Outline

I. Administrative Activities
   A. Statement of Conditions (LS.01.01.01)
   B. Interim Life Safety Measures (LS.01.02.01)

II. Health Care Occupancy
   A. All Health Care Occupancy Buildings
      1. General Building Requirements (LS.02.01.10)
      2. Means of Egress Requirements (LS.02.01.20)
      3. Protection (LS.02.01.30)
         a. Fire Alarm (LS.02.01.34)
         b. Extinguishment (LS.02.01.35)
      4. Special Provisions (LS.02.01.40)
      5. Building Services (LS.02.01.50)
      6. Operating Features (LS.02.01.70)
Applicability for Life Safety

This grid is meant to be a resource to determine which standards and elements of performance (EPs) apply to the service categories within the Home Care Accreditation Program. The column on the far left of the grid lists the related EPs vertically by number. Service categories (defined in Table 3 of the Introduction) are listed horizontally along the top of the grid. Applicability is indicated with an “X” in a service category column.

<table>
<thead>
<tr>
<th>Standard/Requirement Number</th>
<th>EP Number</th>
<th>HH</th>
<th>HOS</th>
<th>DME</th>
<th>RESP</th>
<th>SUPP</th>
<th>OP</th>
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Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
### Comprehensive Accreditation Manual for Home Care

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Standards, Rationales, and Elements of Performance

Introduction to Standard LS.01.01.01
Organizations must be vigilant about fire safety. An ongoing assessment of compliance with the Life Safety Code is an effective way to identify and minimize risks. The electronic Statement of Conditions™ (SOC) is used in a management process that continually identifies, assesses, and resolves Life Safety Code deficiencies. The SOC includes two main sections: Basic Building Information (BBI) and a Plan for Improvement (PFI). The organization uses the BBI to identify the life safety features of its building(s). When an organization has multiple sites, one BBI form is prepared for each site; however, a single BBI form may cover multiple buildings at that site if they are physically connected. Alternatively, the organization may prepare a separate BBI form for each building. In either case, the organization must address specific risks and the unique conditions at each of its sites and buildings.

The organization should establish the qualifications of the individuals(s) it selects to assess compliance with the Life Safety Code. These individuals are not required to have any specific education or experience, although knowledge of the Life Safety Code and its application in unique occupancies is important. Qualifications should be based on the scope of the Life Safety Code assessment activities and the complexity of the building and occupancy being assessed.

Standard LS.01.01.01
The organization designs and manages the physical environment to comply with the Life Safety Code.

Note: This standard applies only to facilities with hospice beds that are either in a freestanding, inpatient hospice facility or in a segregated hospice unit in a hospital or nursing home that is not accredited by The Joint Commission.

Elements of Performance for LS.01.01.01

2. In time frames defined by the organization, the organization performs a building assessment to determine compliance with the “Life Safety” (LS) chapter.
**Note:** For hospices that elect to use The Joint Commission deemed status option: The organization complies with the 2012 Life Safety Code.

4. When the organization plans to resolve a deficiency through a Survey-Related Plan for Improvement (SPFI), the organization meets the 60-day time frame.

**Note 1:** If the corrective action will exceed the 60-day time frame, the organization must request a time-limited waiver within 30 days from the end of survey.

**Note 2:** If there are alternative systems, methods, or devices considered equivalent, the organization may submit an equivalency request using its Statement of Conditions (SOC).

**Note 3:** For further information on waiver and equivalency requests, see [https://www.jointcommission.org/life_safety_code_information_resources/](https://www.jointcommission.org/life_safety_code_information_resources/ and NFPA 101-2012: 1.4).

6. The organization does not remove or minimize an existing life safety feature when such feature is a requirement for new construction. Existing life safety features, if not required by the Life Safety Code, can be either maintained or removed. (For full text, refer to NFPA 101-2012: 4.6.12.2; 4.6.12.3; 18/19.7.9)

**Standard LS.01.02.01**

The organization protects occupants during periods when the Life Safety Code is not met or during periods of construction.

**Note:** This standard applies only to facilities with hospice beds that are either in a freestanding, inpatient hospice facility or in a segregated hospice unit in a hospital or nursing home that is not accredited by The Joint Commission.

**Elements of Performance for LS.01.02.01**

1. The organization 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 organization 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.
2. When the organization identifies *Life Safety Code* deficiencies that cannot be immediately corrected or during periods of construction, the organization evacuates the building or notifies the fire department (or other emergency response group) and initiates a fire watch when a fire alarm system is out of service more than 4 out of 24 hours or a sprinkler system is out of service more than 10 hours in a 24-hour period in an occupied building. Notification and fire watch times are documented. (For full text, refer to NFPA 101-2012: 9.6.1.6; 9.7.6; NFPA 25-2011: 15.5.2)

When the organization identifies *Life Safety Code* deficiencies that cannot be immediately corrected or during periods of construction, the organization does the following:

3. Posts signage identifying the location of alternative exits to everyone affected.

4. Inspects exits in affected areas on a daily basis. The need for these inspections is based on criteria in the organization’s interim life safety measure (ILSM) policy.

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 organization’s interim life safety measure (ILSM) policy.

6. Provides additional firefighting equipment. The need for this equipment is based on criteria in the organization’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 organization’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 organization’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 organization’s interim life safety measure (ILSM) policy.

10. Provides additional training to those who work in the organization on the use of firefighting equipment. The need for additional training is based on criteria in the organization’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 organization’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 organization’s interim life safety measure (ILSM) policy.

13. The organization 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 organization’s interim life safety measure (ILSM) policy.

14. The organization trains those who work in the organization to compensate for impaired structural or compartmental fire safety features. The need for training is based on criteria in the organization’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 organization’s policy allows the use of other ILSMs not addressed in EPs 2–14.

**Note 1:** The organization’s ILSM policy addresses Life Safety Code Requirements for Improvement (RFI) that are not immediately corrected during survey.

**Note 2:** The “other” ILSMs used are documented by selecting “other” and annotating the associated text box in the organization’s Survey-Related Plan for Improvement (SPFI) within the Statement of Conditions™ (SOC).
Standard **LS.02.01.10**

Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.

**Note:** The elements of performance of this standard apply only to the space in which the hospice unit is located, all exits from the unit to the outside at grade level, and any Life Safety Code building systems that support the unit (for example, fire alarm system, automatic sprinkler system).

**Rationale for LS.02.01.10**

A building should be designed, constructed, and maintained in order to minimize danger from the effects of fire, including smoke, heat, and toxic gases. The structural characteristics of the building, as well as its age, determine the types of fire protection features that are needed. The features covered in this standard include the structure, automatic sprinkler systems, building separations, and doors.

**Note:** When remodeling or designing a new building, the organization should also satisfy any requirements of other codes and standards (local, state, or federal) that may be more stringent than the Life Safety Code. Also, the Life Safety Code contains special considerations for minor and major renovation.

**Elements of Performance for LS.02.01.10**


2. When building rehabilitation occurs, the organization incorporates NFPA 101-2012: Chapters 18, 19, and 43. (For full text, refer to NFPA 101-2012: Chapter 43; 18/19.1.1.4.3; 18.4.3.1–18.4.3.5; 19.4.3)

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.

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.
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
Note 1: Labels on fire door assemblies must be maintained in legible condition.

Note 2: For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option: The organization 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 1/8 of an inch wide, and undercuts are no larger than 3/4 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 organization maintains the integrity of the means of egress.

Note: *The elements of performance of this standard apply only to the space in which the hospice unit is located; all exits from the unit to the outside at grade level; and any Life Safety Code building systems that support the unit (for example, fire alarm system, automatic sprinkler system).*

**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 hospice 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). Organizations should make sure that a sufficient number of exits exist and that they are configured to provide protection from fire. Egress doors should not be locked in a way that restricts passage to safety. Means of egress include corridors, stairways, and doors that allow individuals to leave a building or to move between specific spaces in a building. They allow individuals to escape from fire and smoke and, therefore, are an integral part of a fire protection strategy.

Note: *The Life Safety Code does permit select doors to be locked when there are clinical reasons to restrict the movement of the 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 hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option: The organization 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)

5. Walls containing horizontal exits are fire rated for two or more hours, extend from the lowest floor slab to the floor or roof slab above, and extend continuously from exterior wall to exterior wall. (For full text, refer to NFPA 101-2012: 7.2.4.3.1; 18/19.2.2.5)

6. Doors in new buildings that are a part of horizontal exits have approved vision panels, are installed without a center mullion, and swing in the opposite direction of one another. Doors in existing construction are not required to swing with egress travel. (For full text, refer to NFPA 101-2012: 18.2.2.5.6; 18.2.2.5.4; 19.2.2.5.3)

7. When horizontal exit walls in new buildings terminate at outside walls at an angle of less than 180 degrees, the outside walls are fire rated for 1 hour for a distance of 10 or more feet. Openings in the walls in the 10-foot span are fire rated for ¾ of an hour. (For full text, refer to NFPA 101-2012: 7.2.4.3.4)

8. Outside exit stairs are separated from the interior of the building by walls with the same fire rating required for enclosed stairs. The wall extends vertically from the ground to a point 10 feet or more above the top landing of the stairs or roofline (whichever is lower) and extends 10 feet or more horizontally. (For full text, refer to NFPA 101-2012: 18/19.2.2.3; 7.2.2.6.3)

9. Stairs and ramps serving as a required means of egress have handrails and guards on both sides in new buildings and on at least one side in existing buildings. Ramps, exit passageways, fire and slide escapes, alternating tread devices, and areas of refuge are in accordance with NFPA 101-2012: 7.2.5–7.5.12. (For full text, refer to NFPA 101-2012: 18/19.2.2.3; 18/19.2.2.6–18/19.2.2.10; 7.2.2.4; 7.2.5–7.2.12)

10. New stairs serving three or more stories and existing stairs serving five or more stories have signs on each floor landing in the stairwell that identify the story, the stairwell, the top and bottom, and the direction to and story of exit discharge.
Floor level information is also presented in tactile lettering. The signs are placed five feet above the floor landing in a position that is easily visible when the door is open or closed. (For full text, refer to NFPA 101-2012: 18/19.2.2.3; 7.2.2.5.4)

11. The capacity of the means of egress is in accordance with NFPA 101-2012: 7.3. (For full text, refer to NFPA 101-2012: 18/19.2.3.1)

12. Exits discharge to the outside at grade level or through an approved exit passageway that is continuous and provides a level walking surface. The exit discharge is a hard-packed, all-weather travel surface that is free from obstructions and terminates at a public way or at an exterior exit discharge. (For full text, refer to NFPA 101-2012: 18/19.2.7; 7.1.7; 7.1.10.1; 7.2.6; 7.7.2)

13. An exit enclosure is not used for any purpose that has the potential to interfere with its use as an exit and, if so designated, as an area of refuge. Open space within the exit enclosure is not used for any purpose that has the potential to interfere with egress. (For full text, refer to NFPA 101-2012: 18/19.2.2.3; 7.1.3.2.3; 7.2.2.5.3.1)

14. Exits, exit accesses, and exit discharges (means of egress) are clear of obstructions or impediments to the public way, such as clutter (for example, equipment, carts, furniture), construction material, and snow and ice. (For full text, refer to NFPA 101-2012: 18/19.2.5.1; 7.1.10.1; 7.5.1.1)

**Note 1:** Wheeled equipment (such as equipment and carts currently in use, equipment used for 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. (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 41½ inches in clear width. Doors not subject to patient use or in exit stairway enclosures 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; 19.3.4; 19.3.5.7; 19.3.5.8.) If the suite is provided with direct visual supervision, an approved electrically supervised sprinkler system, and a total coverage (complete) smoke detection system, the suite is permitted to be increased to 10,000 square feet. (For full text, refer to NFPA 101-2012: 9.6.2.9; 19.2.5.7.2.1(D)(1)(a); 19.2.5.7.2.3; 19.3.4; 19.3.5.8)

33. For new buildings, 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 organization provides and maintains building features to protect individuals from the hazards of fire and smoke.

**Note:** The elements of performance of this standard apply only to the space in which the hospice unit is located; all exits from the unit to the outside at grade level; and any Life Safety Code building systems that support the unit (for example, fire alarm system, automatic sprinkler system).

**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. Organizations should design and maintain these openings to contain fire to a compartment or floor.

**Elements of Performance for LS.02.01.30**

1. In new construction, vertical openings, including exit stairs, are enclosed by one-hour fire-rated walls when connecting three or fewer floors and two-hour fire-rated walls when connecting four or more floors. Existing vertical openings, including exit stairs, are enclosed with a minimum of one-hour fire-rated construction.

**Note:** These vertical openings include, but are not limited to, shafts (including elevator, light and ventilation), communicating stairs, ramps, trash chutes, linen chutes, and utility chases. (For full text, refer to NFPA 101-2012: 8.6; 18/19.3.1; 7.1.3.2.1)
2. All new hazardous areas have doors that are self-closing or automatic-closing, except for laboratories using flammable or combustible materials deemed less than a severe hazard and storage rooms greater than 50 square feet, but less than 100 square feet that are used for storage of combustible material. Hazardous areas have a fire barrier with a one-hour fire-resistive rating. These areas include, but are not limited to, boiler and fuel-fired heater rooms, central/bulk laundries larger than 100 square feet, paint shops, repair shops, soiled linen rooms, trash collection rooms with containers exceeding 64 gallons, laboratories considered a severe hazard, and storage rooms larger than 100 square feet that contain combustible material. (For full text, refer to NFPA 101-2012: 18.3.2.1; 18.3.2.2; 18.3.2.3; 18.3.2.4; Table 18.3.2.1)

**Note:** For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option: 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 hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option: Doors to rooms containing flammable or combustible materials are provided with positive latching hardware. Roller latches are prohibited on such doors.

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 hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option: The organization 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 ½ hour, continuous from the floor slab to the floor or roof slab above, extended through any concealed spaces (such as those above suspended ceilings and interstitial spaces), properly sealed, and constructed to limit the transfer of smoke. (For full text, refer to NFPA 101-2012: 19.3.6.2)
11. Within corridors in smoke compartments that are protected throughout with an approved supervised sprinkler system, partitions are allowed to terminate at the ceiling if the ceiling is constructed to limit the passage of smoke. The passage of smoke can be limited by an exposed, suspended-grid acoustical tile ceiling with penetrating items such as sprinkler piping and sprinklers that penetrate the ceiling, ducted heating, ventilating, and air-conditioning (HVAC) supply and return-air diffusers, speakers, and recessed lighting fixtures. (For full text, refer to NFPA 101-2012: 18/19.3.6.2)

12. In new buildings, all corridor doors are constructed to resist the passage of smoke, hinged so that they swing, and 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 1¾-inch or thicker solid bonded wood core or constructed to resist fire for not less than 20 minutes, and the doors do not have ventilating louvers or transfer grills (with the exception of bathrooms, toilets, and sink closets that do not contain flammable or combustible materials). 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.
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 ⅛ of an inch. In new buildings, undercuts are no larger than ¾ of an inch, and doors in a means of egress swing in the opposite direction. (For full text, refer to NFPA 101-2012: 18.3.7.6; 18/19.3.7.8; 8.5.4.1; NFPA 80-2010: 4.8.4.1; 6.3.1.7.1)

21. In smoke compartments without sprinkler systems, fixed fire windows in 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 organization provides and maintains fire alarm systems.

**Note 1:** This standard applies only to facilities with 12 or more hospice beds that are either in a freestanding, inpatient hospice facility or in a segregated hospice unit in a hospital or nursing home that is not accredited by The Joint Commission.

**Note 2:** The elements of performance of this standard apply only to the space in which the hospice unit is located; all exits from the unit to the outside at grade level; and any Life Safety Code building systems that support the unit (for example, fire alarm system, automatic sprinkler system).

**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)

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 organization provides and maintains systems for extinguishing fires.

**Note:** The elements of performance of this standard apply only to the space in which the hospice unit is located; all exits from the unit to the outside at grade level; and any Life Safety Code building systems that support the unit (for example, fire alarm system, automatic sprinkler system).

**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)

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 organization provides and maintains special features to protect individuals from the hazards of fire and smoke.

**Note:** The elements of performance of this standard apply only to the space in which the hospice unit is located; all exits from the unit to the outside at grade level; and any Life Safety Code building systems that support the unit (for example, fire alarm system, automatic sprinkler system).
Elements of Performance for LS.02.01.40

1. High-rise buildings have an approved automatic sprinkler system that meets the requirements of NFPA 101-2012: 18/19.4.2. (For full text, refer to NFPA 101-2012: 11.8)

   **Note:** Organizations that do not have approved automatic sprinkler systems in high-rise buildings (over 75 feet tall) as of July 5, 2016, have 12 years to install them.


Standard LS.02.01.50

The organization provides and maintains building services to protect individuals from the hazards of fire and smoke.

**Note:** The elements of performance of this standard apply only to the space in which the hospice unit is located; all exits from the unit to the outside at grade level; and any *Life Safety Code* building systems that support the unit (for example, fire alarm system, automatic sprinkler system).

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

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
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: 18/19.5.2.3)

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 organization provides and maintains operating features that conform to fire and smoke prevention requirements.

**Note:** The elements of performance of this standard apply only to the space in which the hospice unit is located; all exits from the unit to the outside at grade level; and any Life Safety Code building systems that support the unit (for example, fire alarm system, automatic sprinkler system).
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.

Prompts to Assess Your Compliance

Please note: Tips do not represent new accreditation requirements. They are intended to provide helpful strategies for standards compliance.

Who is assigned to oversee the building assessment, managing the repair of deficiencies, and managing the Statement of Conditions (SOC)?

TIP: One or more persons can be identified in the role. Job descriptions can be used.

Does all door hardware operate as designated including exit doors, hazardous waste doors, stair doors, any doors off corridors, smoke barrier doors, and fire barrier doors? (LS.02.01.10, LS.02.01.20, LS.02.01.30, LS.02.01.50, LS.02.01.70)

TIP: Placing doors on a maintenance schedule will assist in identifying problems. Ranking of doors based on low or high use may be of value in establishing inspection frequency.
Are all corridors and stairwells clear of obstructions? (LS.02.01.20, LS.02.01.30, LS.02.01.34)

**TIP:** Monitor corridors and stairwells for staff storing items. Storage is defined as items not in use for greater than 30 minutes.

Do all exits and intersections in the egress path have adequate lighting? (LS.02.01.20)

**TIP:** Place exits on the fire drill inspection form to evaluate whether the lighting is operational and ensures illumination. At no time may the exit light be a single bulb (two or more bulbs should provide backup lighting).

**TIP:** Sprinkler coverage may be considered a plane of protection at 18 inches below the sprinkler head diffuser. Use regular inspections to confirm that nothing interferes with this plane of protection.
**Written Documentation Checklist**

This worksheet lists elements of performance (EPs) that require written documentation that a surveyor could ask to see during a survey to show compliance with a standard. *Note: Documentation can be on paper or in an electronic format.***

<table>
<thead>
<tr>
<th>✓</th>
<th>Standard</th>
<th>EP</th>
<th>Life Safety Standards</th>
<th>Home Care Service</th>
<th>Date last verified</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>LS.01.01.01</td>
<td>2</td>
<td>EP 2—In time frames defined by the organization, the organization performs a building assessment to determine compliance with the “Life Safety” (LS) chapter.</td>
<td>EP 2—HOS (F)</td>
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<tr>
<td></td>
<td>LS.01.02.01</td>
<td>1, 2, 12</td>
<td>EP 1—The organization has a written interim life safety measure (ILSM) policy that covers situations when <em>Life Safety Code</em> deficiencies cannot be immediately corrected or during periods of construction. The policy includes criteria for evaluating when and to what extent the organization implements LS.01.02.01, EPs 2–14 to compensate for increased life safety risk. The criteria include the assessment process to determine when interim life safety measures are implemented. EP 2—When the organization identifies <em>Life Safety Code</em> deficiencies that cannot be immediately corrected or during periods of construction, the organization evacuates the building or notifies the fire department (or other emergency response group) and initiates a fire watch when a fire alarm system is out of service more than 4 out of 24 hours or a sprinkler system is out of service more than 10 hours in a 24-hour period in an occupied building. Notification and fire watch times are documented. (For full text, refer to NFPA 101-2012: 9.6.1.6 and 9.7.6.1 and NFPA 25-2011:15.5.2)</td>
<td>HOS (F)</td>
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<tr>
<td>EP 12—When the organization identifies <em>Life Safety Code</em> deficiencies that cannot be immediately corrected or during periods of construction, the organization does the following: 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 organization's interim life safety measure (ILSM) policy.</td>
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# Action Planning Tool

Use this form to track noncompliant elements of performance (EPs) and your action steps for bringing them into compliance.

<table>
<thead>
<tr>
<th>Standard and EP</th>
<th>Observation/Issue</th>
<th>Action Step</th>
<th>Individual Responsible</th>
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Chapter Notes

Use this page to take notes about ideas for meeting the standards in this chapter, your organization’s policies and procedures that address requirements in this chapter, or the data or patient record numbers used to determine compliance or noncompliance for EPs. If a standard is found not compliant, it can be helpful to know which data were used so they can be easily accessed when developing action plans for compliance.
Medication Compounding (MC)

Overview
In recent years, multistate outbreaks of fungal meningitis and other infections among patients who received contaminated compounded medications raised the importance of updated national compounding standards.† Microbial contamination of compounded sterile preparations occurs through direct contact or exposure to moisture or particles in the air generated by personnel, objects, or other mechanisms. A major concern is preventing contamination of critical sites including fluid pathway surfaces (for example, vial septa, injection ports, beakers) or openings (for example, opened ampules, needle hubs). When accepted standards for safe compounding are not met, compounded medications may be chemically or microbiologically contaminated or contain less or more than the intended dose, resulting in potentially serious adverse consequences for patients.

Since 2012, The Joint Commission has conducted extensive research, literature reviews, and stakeholder engagement related to medication compounding, including Technical Advisory Panels, in-depth environmental assessments, and strategic leadership meetings with internal and external stakeholders. Extensive collaboration with the US Pharmacopeial Convention (USP) has resulted in the Joint Commission’s development of the Medication Compounding standards for organizations that are accredited through the Home Care pharmacy program. These standards were adapted from USP requirements to support field compliance with USP chapter <795> Pharmaceutical Compounding—Nonsterile Preparations, USP chapter <797> Pharmaceutical Compounding—Sterile Preparations, and in the future USP chapter <800> Hazardous Drugs—Handling in Healthcare Settings (effective July 1, 2018).

What Is Compounding?

The USP defines compounding* as the preparation, mixing, assembling, altering, packaging, and labeling of a drug, drug-delivery device, or device in accordance with a licensed practitioner’s prescription, medication order, or initiative based on the practitioner/patient/pharmacist/compounder relationship in the course of professional practice. Compounding includes the following:

- Preparation of drug dosage forms for human patients
- Preparation of drugs or devices in anticipation of prescription drug orders based on routine, regularly observed prescribing patterns
- Reconstitution or manipulation of commercial products that may require the addition of one or more ingredients
- Preparation of drugs or devices for the purposes of, or as an incident to, research (clinical or academic), teaching, or chemical analysis
- Preparation of drugs and devices for prescriber’s office use where permitted by federal and state law.

**About This Chapter**

The MC standards are designed to define and encourage technical and clinical excellence, safety, quality, and accountability in the environments where compounding is performed. These standards are organized into the following five sections:

I. General Responsibilities

II. Education, Training, and Evaluation

III. Compounding Sterile Preparations

IV. Compounding Sterile and Nonsterile Preparations

V. Compounding Nonsterile Preparations

The MC chapter applies to all Home Care pharmacy organizations that compound medications. The standards that address specific types of compounding not performed in the organization do not apply and will not be assessed for compliance during the on-site survey.
Chapter Outline

I. General Responsibilities
   A. Responsibility of Leadership and Compounding Staff (MC.01.01.01, MC.01.01.03)
   B. Patient Education (MC.01.02.01)

II. Education, Training, and Evaluation
   A. Education, Training, and Evaluation of Staff for Sterile and Nonsterile Compounding (MC.02.01.01, MC.02.01.03, MC.02.01.05, MC.02.01.07, MC.02.01.09, MC.02.01.11, MC.02.01.13)

III. Compounding Sterile Preparations
   A. Compounded Sterile Preparations - Microbial Contamination Risk Levels (MC.03.01.01)
   B. Immediate Use Compounded Sterile Preparations (MC.03.02.01)
   C. Single-Dose and Multiple Dose Containers (MC.03.03.01)
   D. Radiopharmaceuticals as Compounded Sterile Preparations (MC.03.04.01)
   E. Verification of Compounding Accuracy and Sterility (MC.03.05.01, MC.03.05.03)
   F. Environmental Quality and Control for Sterile Compounding (MC.03.06.01, MC.03.06.03, MC.03.06.05, MC.03.06.07, MC.03.06.09, MC.03.06.11)
   G. Verification of Automated Compounding Devices (ACD) (MC.03.07.01)
   H. Maintaining Sterility, Purity, and Stability of Dispensed and Distributed Compounded Sterile Preparations (CSPs) (MC.03.08.01, MC.03.08.03, MC.03.08.05, MC.03.08.07, MC.03.08.09, MC.03.08.11)

IV. Compounding Sterile and Nonsterile Preparations
   A. Storage and Beyond Use Dating (MC.04.01.01, MC.04.01.03)
   B. Hazardous Medications (MC.04.02.01, MC.04.02.03)

V. Compounding Nonsterile Preparations
   A. General Categories and Principles of Nonsterile Compounding (MC.05.01.01, MC.05.01.03)
   B. Facilities for Nonsterile Compounding (MC.05.02.01, MC.05.02.03)
   C. Equipment for Nonsterile Compounding (MC.05.03.01)
   D. Packaging and Medication Preparation Containers for Nonsterile Compounding (MC.05.04.01)
   E. Documentation for Nonsterile Compounding (MC.05.05.01)
   F. Quality Control for Nonsterile Compounding (MC.05.06.01)
## Applicability for Medication Compounding

This grid is meant to be a resource to determine which standards and elements of performance (EPs) apply to the service categories within the Home Care Accreditation Program. The column on the far left of the grid lists the related EPs vertically by number. Service categories (defined in Table 3 of the Introduction) are listed horizontally along the top of the grid. Applicability is indicated with an “X” in a service category column.

<table>
<thead>
<tr>
<th>Standard/Requirement Number</th>
<th>EP Number</th>
<th>HH</th>
<th>HOS</th>
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Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.

MC – 6

CAMHC, January 2018
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Standards, Rationales, and Elements of Performance

Standard MC.01.01.01
The organization’s leaders are responsible for the safety and quality of care provided through its medication compounding services. (For more information, refer to Standards LD.01.03.01, LD.04.01.05, and LD.04.04.01)

Elements of Performance for MC.01.01.01

1. Leaders develop medication compounding policies in collaboration with the compounding supervisor.
2. Leaders approve medication compounding policies and procedures.
3. Leaders provide for a sufficient number and mix of individuals to support the safety and quality of medication compounding.
4. Leaders provide for the space, equipment, and utility systems to support the scope of medication compounding performed in the organization. (See also EQ.01.01.01, EP 1 and LD.04.01.11, EP 5)
5. Leaders are responsible for assuring that quality standards on medication compounding, such as USP chapters <795> and <797> for nonsterile, sterile, and hazardous preparations, are effectively implemented in the organization.
6. The organization implements and maintains quality assurance procedures for in-process inspections, consistent with USP and state board of pharmacy requirements. These inspections include, but are not limited to, the following:
   - Identity
   - Sterility
   - Accuracy
   - Precision
   - Particulate matter
   - Safe limits and ranges for strength of preparation
   - Beyond-use dating
   - Packaging and storage
   - Antimicrobial effectiveness testing for compounded multiple-dose containers
7. The organization collects and analyzes data on medication compounding. (See also PI.02.01.01, EP 4)
8. The organization takes action on improvement opportunities identified for medication compounding. (*See also* PI.03.01.01, EPs 1–3)

**Standard MC.01.01.03**

The organization defines the responsibilities of staff who compound and dispense sterile and nonsterile medication preparations. (For more information, refer to Standards HR.01.02.01 and HR.01.02.05)

**Note:** Refer to USP chapter <71> for testing requirements on extending beyond-use dates (*BUDs*).

**Elements of Performance for MC.01.01.03**

1. The compounding supervisor(s) is responsible for safe preparation, accurate strength, precise labeling, integrity, and sterility of all compounded preparations in accordance with current requirements in USP chapters <795> and <797> for nonsterile, sterile, and hazardous preparations.

2. The compounding supervisor(s) is responsible for implementing quality assurance procedures that focus on the following:
   - Aseptic techniques
   - Beyond-use dating
   - Facility requirements
   - Environmental monitoring requirements
   - Ingredients’ identity, quality, and purity
   - Labeling
   - Packaging
   - Sterility and sterilization methods
   - Training and competency assessment of staff
   - All other requirements as detailed in the current USP compounding chapters for sterile, nonsterile, and hazardous compounding

3. The compounding staff have defined responsibilities related to the following:
   - Adherence to the prescription or medication order
   - The strength, quality, and purity of compounded preparations
   - Packaging, labeling, and dispensing consistent with applicable state agencies, boards of pharmacy, laws and regulations

(*See also* Standards MM.04.01.01, MM.05.01.07, MM.05.01.09, and MM.05.01.11, EPs 1–4)
Standard **MC.01.02.01**

When dispensing a compounded preparation, the organization provides education to the patient or the patient’s caregiver on the safe storage, handling, and administration of dispensed compounded medications.

**Elements of Performance for MC.01.02.01**

1. Education of the patient or caregiver includes, but is not limited to, the following:
   - How to inspect, store, and handle the preparation and related supplies and equipment to support effective and safe use
   - Signs of therapeutic complications or infection
   - When to contact the organization, the patient’s physician, or emergency services
   - When and how to report to the compounder any adverse events or changes in the characteristics of the compounded preparation
   - Safe disposal and cleaning practices

   (For more information, refer to Standard MM.06.01.03)

2. The compounder reviews, documents, and resolves all reported problems with a compounded preparation reported by the patient or caregiver.

Standard **MC.02.01.01**

The organization has policies and procedures that facilitate the knowledge, skill, and effective performance of all compounding staff. (For more information, refer to Standards HR.01.03.01, HR.01.04.01, HR.01.05.03, and HR.01.06.01)

**Elements of Performance for MC.02.01.01**

1. The organization has written policies and procedures requiring training and competency assessment for all compounding staff consistent with USP chapters <795>, <797>, laws and regulations, and state board of pharmacy requirements.

2. Compounding staff have been oriented to and have ongoing access to the following information and resources, consistent with their job descriptions:

   - USP General Notices
     - USP chapter <795> Pharmaceutical Compounding – Nonsterile Preparations
     - USP chapter <797> Pharmaceutical Compounding – Sterile Preparations
     - USP chapter <1151> Pharmaceutical Dosage Forms
- USP chapter <1160> Pharmaceutical Calculations in Pharmacy Compounding
- USP chapter <1163> Quality Assurance in Pharmaceutical Compounding
- USP chapter <1176> Prescription Balances and Volumetric Apparatus Used in Compounding
- USP chapter <1191> Stability Considerations in Dispensing Practice
- USP chapter <1265> Written Prescription Drug Information – Guidelines
- USP chapter <51> Antimicrobial Effectiveness Testing
- USP chapter <71> Sterility Tests
- USP chapter <17> Prescription Container Labeling
- USP chapter <1225> Validation of Compendial Methods
- USP chapter <659> Packaging and Storage Requirements
- USP chapter <1066> Physical Environments that Promote Safe Medication Use
- USP chapter <7> Labeling – All applicable compounding laws and regulations

3. Compounding staff are oriented on how to access, retrieve, and interpret information from the safety data sheets (SDSs).

4. Compounding staff are provided education, training, and supervision consistent with their job descriptions. Sterile compounding education and training includes, but is not limited to, mastering aseptic techniques, safe labeling, storage, and dispensing.

5. The organization provides education, training, and supervision to compounding staff who do not regularly work in the clean room but get assigned compounding tasks in specific or exceptional situations (for example, compounding staff absences).

6. The organization either provides or provides for ongoing education to compounding staff consistent with their assigned job functions.

**Standard MC.02.01.03**

The compounding supervisor(s) implements a program for initial and ongoing education and training of all staff involved in the compounding, evaluating, packaging, and/or dispensing of sterile and nonsterile compounded preparations. (For more information, refer to Standard HR.01.05.03)
Elements of Performance for MC.02.01.03

1. Compounding staff are trained in procedures, relevant to their job functions, related to facilities, equipment, compounding, evaluation, packaging, storage, and dispensing.

2. Before participating in the storage, handling, or disposal of hazardous medications, any staff performing such functions are trained in the safe and effective practices specific to hazardous medications.

3. Staff who prepare, store, or handle hazardous medications are trained in safe practices that minimize the risk of exposure to themselves and the environment.

4. Staff assigned to clean and remove waste from hazardous medication storage and preparation areas are trained in safe practices that protect themselves and others and prevent contamination. Disposal of all hazardous medication wastes complies with all applicable federal and state regulations.

**Note:** The following are references for the safe handling of antineoplastic and hazardous medications in health care settings: OSHA Technical Manual—Section VI: Chapter 2, Controlling Occupational Exposure to Hazardous Drugs and NIOSH Alert: Preventing Occupational Exposure to Antineoplastic and Other Hazardous Drugs in Health Care Settings [DHHS (NIOSH) Publication No. 2004-165].

5. Education and training activities of all staff involved in compounding are documented.

**Standard MC.02.01.05**

Education and training in nonsterile compounding procedures includes observation and demonstration of competency.

Elements of Performance for MC.02.01.05

1. The compounding supervisor(s) demonstrates compounding procedures and then observes and guides the staff member in carrying out the procedures.

2. In order for a staff member to demonstrate the required knowledge to perform compounding procedures accurately without supervision, a compounding supervisor is present to approve all ingredients, observe technique, and inspect the final preparations.
3. When the staff member achieves the required knowledge and competency, a compounding supervisor signs documentation confirming the completion of training.

**Standard MC.02.01.07**

Education and training in sterile compounding procedures includes knowledge and competency concerning designated compounding equipment and spaces. (For more information, refer to Standards HR.01.05.03 and HR.01.07.01)

**Elements of Performance for MC.02.01.07**

1. The training program for staff conducting sterile compounding includes:
   - Training on the use of all equipment, apparatuses, and devices staff members are required to operate or manipulate when preparing compounded sterile preparations (CSPs)
   - Development of the ability to identify malfunctioning equipment, apparatuses, and devices

2. Compounding staff are trained and have competency assessed on the avoidance of touching critical sites as described in USP chapter <797>.

3. Sampling of compounding staff glove fingertips is done for all CSP risk levels using sterile contact agar plates after staff garbing and after completing the media-fill preparation without applying sterile 70% isopropyl alcohol (IPA), as described in USP chapter <797>.

4. The visual observation of compounding staff garbing and gloving to assess competency is documented using a standardized form.

   **Note:** One example of a standardized form is the Sample Form for Assessing Hand Hygiene and Garbing Related Practices of Compounding Staff, described in the Appendix section of USP chapter <797>.

5. Ancillary supportive services staff performing cleaning and disinfecting in the clean room (such as cleaning staff or services) are trained in proper hand hygiene, garbing, cleaning, and disinfecting procedures as described in USP chapter <797>. This training is conducted by the compounding supervisor, other qualified compounding staff, or, if the organization chooses, a qualified compounding consultant.
6. Use and storage procedures for CSPs in the patient care setting include, but are not limited to, the training of patient care–setting staff on delivering the CSP to the designated storage location.

**Standard MC.02.01.09**

Education and training in aseptic manipulation skills for sterile compounding includes testing of technique and demonstration of competency. (For more information, refer to Standards HR.01.05.03 and HR.01.07.01)

**Elements of Performance for MC.02.01.09**

1. Staff compounding sterile preparations are trained in aseptic manipulation skills consistent with USP requirements, current literature, and evidence-based didactic sources.

2. Compounding staff are assessed for the competency of their aseptic technique through written, media-fill, and fingertip sample testing based on the risk level of the preparations, as described in USP chapter <797>.

3. Media-fill and glove fingertip testing of aseptic technique of compounding staff is performed as described in USP chapter <797>, including the following:
   - Before beginning to prepare compounded sterile preparations (CSPs)
   - At least every six months thereafter for high risk–level compounding
   - At least every 12 months thereafter for low and medium risk–level compounding

4. Compounding staff successfully pass an initial competency evaluation and gloved fingertip sampling procedure no less than three times before initially compounding CSPs for human use; success is defined by zero colony-forming unit (CFU) findings. For details regarding fingertip sampling procedure and incubation period, refer to USP chapter <797>.

5. Compounding staff who fail assessment of their aseptic technique are retrained and reevaluated by expert compounding staff to address all aseptic technique deficiencies as described in USP chapter <797>.

6. Compounding staff must pass all aseptic technique evaluations as described in USP chapter <797> (such as didactic testing, gloved fingertip sampling, and media-fill testing) before they can compound.
7. Compounding staff demonstrate competence in proper hand hygiene, garbing, and consistent cleaning procedures in the compounding area as described in USP chapter <797>.

8. \(\textcircled{5}\) Staff training and competency assessments are conducted and documented consistent with USP chapter <797> and are readily available for review.

**Standard MC.02.01.11**

The organization evaluates compounding staff performance.

### Elements of Performance for MC.02.01.11

1. \(\textcircled{5}\) The organization maintains a list of all staff who compound medication.

2. Staff who compound nonsterile preparations are evaluated at least every 12 months.

3. Staff who perform high-risk sterile compounding are evaluated at least every 6 months.

4. Staff who perform low- and medium-risk sterile compounding are evaluated at least every 12 months.

5. Compounding staff are evaluated in accordance with USP requirements, current literature, evidence-based didactic sources, and, for staff conducting sterile compounding preparations, practical skills of aseptic manipulation.

6. \(\textcircled{5}\) All evaluations of staff involved in compounding sterile preparations are documented in a standardized format (paper or electronic).

**Note:** The organization can develop or adopt a standardized evaluation form. Examples of standardized forms are the Sample Form for Assessing Hand Hygiene and Garbing Related Practices of Compounding Staff and Sample Form for Assessing Cleaning and Disinfection Procedures, described in the Appendix section of USP chapter <797>.

7. Ancillary supportive services staff performing cleaning and disinfecting in the clean room, buffer area, and anteroom (such as cleaning staff or services) have a competency assessment for proper hand hygiene, garbing, cleaning, and disinfecting procedures as described in USP chapter <797>. These assessments are conducted, at a minimum, when newly assigned and when procedures change. (See also HR.01.06.01, EPs 1, 5, 6)
Standard MC.02.01.13
The organization evaluates staff competency as it relates to quality improvement processes.

Elements of Performance for MC.02.01.13
1. Competency assessment of compounding staff includes the assessment and documentation of the following:
   - Procedural breaches
   - Administrative errors
   - Complications associated with medication dosage or administration

   (See also HR.01.07.01, EPs 1 and 2)

2. Adverse events that are identified through competence assessments are reviewed using the organization’s adverse event reporting system or quality improvement process. (See also MM.07.01.03, EPs 1 and 5)

Standard MC.03.01.01
The organization maintains work practices and an environment that is consistent with the low-, medium-, and high-risk levels of sterile compounding described in USP chapter <797>.

Elements of Performance for MC.03.01.01
1. The compounding supervisor(s) is responsible for implementing the following as defined in USP chapter <797>:
   - Aseptic processing
   - Cleaning and disinfecting procedures
   - Environmental sampling
   - Staff training and competency evaluation of garbing, gloving, and use of protective equipment

   (For more information, refer to Standard HR.01.06.01)

2. The compounding supervisor(s) is responsible for implementing quality assurance work practices per compounded sterile preparation (CSP) risk levels and as described in USP chapter <797>. These practices include, but are not limited to, the following:
   - Environmental monitoring (for example, surface sampling and viable and nonviable air sampling)
   - Routine disinfection

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
- Maintaining International Organization of Standardization (ISO) 5 air quality in the compounding area
- Visual inspection of particulate matter in CSPs
- Visual inspection for discoloration or other loss of integrity in CSPs
- Visual inspection for the absence of leakage from vials and bags
- Review of medication orders
- Review of ingredient packages
- Review for accuracy and thoroughness of labeling

*(See also MM.05.01.07, EP 3)*

3. The compounding supervisor(s) is responsible for performing a media-fill test procedure that represents the most challenging or stressful conditions actually encountered by the compounding staff being evaluated per the CSP’s risk level, initially before beginning to prepare CSPs, at least every 12 months for low- and medium-risk levels, and every six months for high-risk levels, as described in USP chapter <797>.

4. The compounding supervisor(s) is responsible for implementing a compounding environment (that is, compounding aseptic isolators [CAI], compounding aseptic containment isolators [CACI], laminar airflow workbench [LAFW], ante-area, buffer areas, walls, floors, ceilings, fixtures, furniture, equipment, environmental temperature, room pressure, and so forth) that is consistent with the risk levels of CSPs and meets USP chapter <797>, applicable state board of pharmacy compounding requirements, and all applicable laws and regulations.

5. Leaders provide for a compounding environment consistent with the risk level of CSPs that meets USP chapter <797>, applicable board of pharmacy compounding requirements, and all applicable laws and regulations. This environment includes, but is not limited to, CAI, CACI, LAFW, ante-area, buffer areas, walls, floors, ceilings, fixtures, furniture, equipment, environmental temperature, and room pressure. *(See also LD.04.01.11, EP 5)*

6. The compounding supervisor(s) meets all other responsibilities of his or her role as defined in the current USP chapter <797> and in evidence-based practices. *(See also HR.01.01.01, EP 1)*

**Standard MC.03.02.01**

Compounded sterile preparations (CSPs) for immediate use are not to be batch-compounded or stored in anticipation of future needs.
Elements of Performance for MC.03.02.01

1. Only low risk–level CSPs can be prepared as immediate-use CSPs.

   **Note:** Immediate-use situations are limited to emergency or immediate patient administration.

2. Immediate-use CSPs meet specific criteria to be exempt from low risk–level CSP requirements as described in USP chapter <797>. These criteria relate to limiting the number of transfers of product from packages, vials, or bags to containers and devices; limiting the duration of the compounding procedure; the timing of administration; and the supervision, labeling, and disposal of product. (For more information, refer to Standard MM.05.01.09 regarding labeling of medications)

3. Hazardous medications such as antineoplastics are not to be prepared as immediate-use CSPs.

Standard MC.03.03.01
The manipulation, workflow, and storage of single-dose and multiple-dose containers follow safe practices as defined in USP chapter <797>. (For more information, refer to Standard MM.03.01.01)

Elements of Performance for MC.03.03.01

1. Single-dose containers opened in less than an International Organization of Standardization (ISO) Class 5 environment must be used within one hour; any remaining product must be disposed.

2. Single-dose containers opened in an ISO Class 5 environment or better can be stored and must be used within a six-hour period (or sooner if required by the manufacturer) from initial puncture.

3. Single-dose ampules are not stored for any time period once opened.

4. Opened multiple-dose containers are stored in an environment that protects their integrity and must be used within 28 days unless otherwise specified by the manufacturer.

Standard MC.03.04.01
The organization has written policies and procedures on compounding, handling, storing, dispensing, transporting, and administering radiopharmaceuticals.
Note: This standard and elements of performance are only applicable to pharmacy organizations that compound, handle, store, dispense, transport or administer radiopharmaceuticals.

Elements of Performance for MC.03.04.01

1. Written policies and procedures include environmental requirements as described in USP chapters <797> and <823>, state board of pharmacy requirements, and laws and regulations.

2. All reasonable methods limiting staff exposure to radiopharmaceuticals should be followed based on the “as low as reasonably achievable” (ALARA) concept and all applicable laws and regulations.

3. Radiopharmaceuticals prepared as low risk–level compounded sterile preparations with 12-hour-or-less beyond-use dates are prepared in a segregated compounding area as specified in USP chapter <797>.

4. The radiopharmaceutical policies and procedures meet all other related requirements in USP chapters <797> and <823>, board of pharmacy requirements, and applicable laws and regulations.

Standard MC.03.05.01

The accuracy and sterility of compounded sterile preparations (CSPs) is verified per USP chapter <797> requirements, state board of pharmacy, laws and regulations.

Elements of Performance for MC.03.05.01

1. Verification of the CSPs accuracy, purity, and sterility includes planned testing, monitoring, practices, documentation, environmental quality requirements, loss-on-drying test, pharmaceutical calculations in prescription compounding in adherence with USP chapters <731>, <797>, <1160>, <1211>, and <1229.5>; state board of pharmacy requirements; and laws and regulations.

Note: Loss-on-drying is a test to determine the moisture content of a sample.

2. The compounding supervisor(s) is responsible for selecting the sterilization method for sterility assurance based on USP chapters <797> and <1211>, state board of pharmacy requirements, and laws and regulations.

Standard MC.03.05.03

High risk–level compounded sterile preparations (CSPs) are sterilized by filtration, steam, or dry heat or other USP-allowed methods as described in USP chapter <1211>.

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

CAMHC, January 2018
Elements of Performance for MC.03.05.03

1. **For sterilization by filtration:** Filters used to sterilize CSPs by filtration meet the following minimal requirements and tests:
   - The filters must be sterile, pyrogen-free, and approved for human use
   - The filters must be chemically and physically stable at the pressure and temperature conditions to be used
   - The filters must have a nominal pore size of 0.2 or 0.22 micron
   - The filters must retain $10^7$ microorganisms of a strain of pseudomonas diminuta on each square centimeter of upstream filter surface area

2. **For sterilization by filtration:** The filter’s capacity allows for rapid filtration of the required volume without requiring replacement.

3. **For sterilization by filtration:** Manufacturer-recommended integrity testing (for example, bubble-point testing) is performed on filters used to sterilize CSPs.

4. **For sterilization by steam:** Autoclaving is performed as described under sterilization and sterility assurance in USP chapter <1211>.

5. **For sterilization by steam:** Specifications for the containers require that stoppered and crimped empty containers have a small amount of moisture so they can generate steam internally once sealed.

6. **For sterilization by steam:** Solutions used to fill containers that are to be sterilized by steam are passed through a filter with a pore not larger than 1.2 microns.

7. **For sterilization by steam:** All material to be sterilized by steam is tightly wrapped in low-particle shedding fabric or paper or sealed in envelopes that prevent post-sterilization microbial penetration as described in USP chapter <797>.

8. **For sterilization by steam:** All wrapped material to be sterilized by steam is exposed to steam 121 degrees Celsius under a pressure of about 1 atmosphere or 15 psi for the duration required to achieve sterility as described in USP chapter <797>.

9. **For sterilization by steam:** The description of steam sterilization conditions and duration for specific CSPs must be included in written documentation in the compounding facility.

10. The effectiveness of steam sterilization is verified using appropriate biological indicators of Bacillus stearothermophilus (described in USP chapter <1229.5>) and other confirmation methods for sterilization such as temperature-sensing devices (described in USP chapters <1211> and <71>).
11. **For sterilization by dry heat:** Sterilization by dry heat is used only for materials that cannot be sterilized by steam.

   **Note:** Examples of such materials are zinc peroxide, polypropylene copolymer, and electronics.

12. **For sterilization by dry heat:** Sterilization by dry heat is conducted using an oven designed for sterilization and a blower device that evenly distributes heated filtered air.

13. **For sterilization by dry heat:** Space is left between materials to be sterilized by dry heat to allow good circulation of hot air.

14. **For sterilization by dry heat:** Sterility of CSPs are to be verified and documented based on the following:
   - Sterilization and sterility assurance as described in USP chapter <1211>
   - Using biological indicators (BIs) of Bacillus stearothermophilus as applicable for the method of sterilization used (described in USP chapter <1229.5>)
   - Other confirmation methods for sterility tests as described in USP chapter <71>

15. **For depyrogenation by dry heat:** Compounding supervisors are responsible for utilizing, verifying, and documenting depyrogenation by dry heat or other applicable methods of depyrogenation as described in USP chapters <797>, <1211>, and <85>.

16. **For depyrogenation by dry heat:** The compounding supervisor(s) is responsible for verifying effectiveness of depyrogenation by dry heat or other methods of depyrogenation using endotoxin challenge vials. The dry heat cycle should achieve at least a 3-log reduction in endotoxins as described in USP chapters <85>, <797>, and <1211>.

17. **For endotoxin testing:** Endotoxin testing is required for all high risk–level CSPs that meet one of the following:
   - Prepared in groups of more than 25 identical individual single-dose packages, or
   - Prepared in multiple-dose vials for administration to multiple patients, or
   - Exposed longer than 12 hours at 2 to 8 degrees Celsius and no longer than 6 hours at warmer than 8 degrees Celsius before they are sterilized.
18. **For endotoxin testing:** Compounding supervisors are responsible for documenting all results from endotoxin testing.

19. **For endotoxin testing:** The sterilization of high-risk CSPs meets all other related USP chapter <797> requirements, state board of pharmacy requirements, and laws and regulations.

**Standard MC.03.06.01**

The organization has written policies and procedures for environmental quality control for compounded sterile preparations (CSPs) encompassing each risk level per USP chapter <797>, state board of pharmacy requirements, and laws and regulations. (For more information, refer to Standard EQ.02.01.01)

**Elements of Performance for MC.03.06.01**

1. **Written policies and procedures (as described in USP chapters <797> and <1116>) include, but are not limited to, the following:**
   - Maintaining the sterility and cleanliness of critical sites.
   - Maintaining certification of primary engineering control (PEC) and secondary engineering control (SEC) at a minimum of every 6 months and when modified, including documentation of the results and measures taken.
   - Continuously monitoring pressure differentials between the ante-area and buffer area and between the ante-area and the general surrounding area. Results are documented.
   - Monitoring air quality via viable air sampling and nonviable air sampling as described in USP chapter <797> at a minimum of every 6 months and when modified.
   - Monitoring surface requirements via surface sampling as described in USP chapter <797> including, but not limited to, sampling locations, methods of collections, sampling frequency, time of day as related to compounding activities, and action levels.
   - Measures to be taken when action levels based on colony-forming unit (CFU) counts for microbial contamination are exceeded.
   - Measures to be taken when pathogenic organisms are identified during airborne particle and surface sampling.

*(See also LD.04.01.01, EPs 1–3)*

**Note:** USP chapter <1116> addresses microbiological control and monitoring of aseptic processes and environments.
2. Sampling locations include locations within each International Organization for Standardization (ISO) Class 5, Class 7, Class 8 areas, and in segregated compounding areas at greater risk of contamination (for example, work areas near ISO Class 5 environment, counters near doors, pass-through boxes).

3. Primary engineering controls (PECs) are required to be certified every 6 months as described in USP chapter <797>.

   **Note:** Primary Engineering Controls (PECs) include biological safety cabinets (BSCs), unidirectional airflow isolators (i.e. CAI and CACI), and laminar air flow workbenches (LAFW).

4. All primary engineering controls (PECs) are tested for total particle counts (ISO Class 5 certification) and have air/surface microbial sampling.

5. Secondary engineering control (SEC) certification includes the following:
   - Total particle counts (ISO Class 7 or Class 8)
   - Supply HEPA filter airflow
   - HEPA filter leak tests
   - Room air changes
   - Room pressurization
   - Surface microbial sampling
   - Air microbial sampling

6. Compounding staff protect critical sites by preventing physical contact and airborne contamination.

   **Note:** Critical sites are equipment and locations that include any component or fluid pathway surfaces (for example, injection ports, beakers) or openings (for example, opened ampoules) that are exposed and at risk of direct contact with air (ambient room), moisture (for example, oral secretions), or touch contamination. See Glossary for detailed definition of critical sites.

7. The compounding supervisor(s) reviews the report from the certification company and forwards the report to leadership with recommendations for improvement on any deficiencies noted.

**Standard MC.03.06.03**
The compounding area has International Organization for Standardization (ISO) Class 5 (or better conditions) provided by primary engineering control (PEC) (that is, compounding aseptic isolators [CAI], compounding aseptic containment isolators...
[CACI], laminar airflow workbenches [LAFW], biological safety cabinets [BSCs]), and secondary engineering control (SEC) provided by buffer areas, ante-areas, and segregated compounding areas.

**Elements of Performance for MC.03.06.03**

1. PECs (LAFWs, BSCs, CAIs, and CACIs) are located within a restricted-access ISO Class 7 buffer area or segregated compounding area as described in USP chapter <797>.

2. The compounding supervisor(s) is responsible for implementing a comprehensive quality management program that includes environmental sampling.

3. Environmental sampling is conducted prior to the first use, during initial certification, during recertification, and after servicing facilities and equipment.

4. Environmental sampling is conducted when any of the following situations occurs as described in USP chapter <797>:
   - Issues related to staff technique or work practices
   - Concerns about CSPs or other end products
   - In response to patient-related infections potentially related to CSPs

**Standard MC.03.06.05**

The compounding supervisor(s) implements policies and procedures that address the integrity of the compounding area, the handling of compounded sterile preparations (CSPs), and staff use of protective equipment and practices.

**Elements of Performance for MC.03.06.05**

1. The compounding supervisor(s) implements policies and procedures that prohibit food, drinks, and materials exposed in patient care areas from entering ante-areas, buffer areas, and segregated compounding areas where components of CSPs are located.

2. The compounding supervisor(s) implements policies and procedures that mitigate cross-contamination when manipulating patient blood–derived material or other biological material, per USP chapter <797>.

3. The compounding supervisor(s) implements policies and procedures regarding handling packaged compounding supplies and components (needles, syringes, tubing sets) per USP chapter <797>.
4. The compounding supervisor(s) implements policies and procedures for cart workflows across demarcation lines consistent with USP chapter <797> as follows:
   - Movement of supply carts between the storeroom and ante-room
   - Cleaning and disinfecting carts used in the buffer area

5. The compounding supervisor(s) implements policies and procedures addressing supplies that are frequently required in the compounding area including the following:
   - Supplies that must be readily available are decontaminated and stored in the ante-area.
   - Paper-related items (for example, paper syringe overwraps, work records contained in a protective sleeve) are not brought into the buffer area until they are wiped with an appropriate disinfecting agent as described in USP chapter <797>.

6. The compounding supervisor(s) implements policies and procedures addressing the presence, use, and prohibition of nonessential supplies in the compounding area, as described in USP chapter <797>.

7. Nonessential objects that shed particles (for example, pencils, cardboard cartons, paper towels, cotton items, gauze pads) are not permitted in the buffer area.

8. The compounding supervisor(s) implements policies and procedures regarding movement within and through the compounding area as follows:
   - All supply items are arranged to provide maximum workflow efficiency and reduce clutter.
   - Traffic in the compounding area is minimized and controlled.

9. For compounding pharmacies performing high risk–level compounding using nonsterile ingredients and devices, compounding supervisors implement policies and procedures addressing compounding using nonsterile components and devices in accordance with USP chapter <797>, state board of pharmacy requirements, and laws and regulations.

10. Compounding supervisors implement the following procedures with defined time frames as described in USP chapter <797>:
    - Required equipment calibration
    - Routine and annual maintenance of the equipment
    - Monitoring proper function of the equipment
Controlled procedures for use of the equipment

(See also EQ.02.01.01, EPs 1–3)

11. Results from equipment calibration, routine maintenance, and annual maintenance reports are documented and kept on file either as a hardcopy or electronically for the lifetime of the equipment as described in USP chapter <797>.

12. Packages are removed from their cartons and wiped down with a disinfectant that does not leave a residue in an ante-area prior to supplies going to the buffer areas, per USP chapter <797>.

13. Unit-dose swabs are used to disinfect the sterile entry point of containers and devices, per USP chapter <797>.

Note: Particle-generating material (such as gauze) should not be used in lieu of unit dose swabs.

14. The compounding supervisor(s) implements policies and procedures addressing hand hygiene and garbing performed in the ante-area, per USP chapter <797>.

15. The compounding supervisor(s) enforces clean-room policies and procedures regarding the prohibition of specific staff activities as described in USP chapter <797>; these include, but are not limited to, the following:

- Wearing or removing outerwear (such as hats and sweaters) in restricted areas
- Wearing makeup and nail polish
- Wearing jewelry that can interfere with the effectiveness of personal protective equipment (PPE)
- Chewing gum
- Coming to work with infectious conditions (such as conjunctivitis, upper respiratory infection, rashes)

**Standard MC.03.06.07**
The compounding supervisor(s) implements policies and procedures for the use of personal protective equipment in sterile compounding.

**Elements of Performance for MC.03.06.07**

1. The workflow for garbing activities proceeds from the dirtiest activities to the cleanest.
Note: Garbing activities considered the dirtiest include putting on dedicated shoes, shoe covers, head and facial covers (for example, beard covers in addition to face masks), and face masks.

2. Eye shields are required when working with irritants or when preparing hazardous medications.

Standard MC.03.06.09
The compounding supervisor(s) implements policies and procedures for hand and forearm cleansing prior to sterile compounding.

Elements of Performance for MC.03.06.09

1. Compounding staff start cleansing procedures by removing debris from underneath fingernails using a nail cleaner under warm running water followed by rigorous hand washing as described in USP chapter <797>.

2. Compounding staff wash hands and forearms to the elbows for at least 30 seconds with soap and water in the ante-area, as described in USP chapter <797>.

3. Compounding staff use lint-free disposable towels or hand dryers to dry hands and forearms, as described in USP chapter <797>.

4. Compounding staff are required to wear a nonshedding gown with sleeves with a snug fit around the wrist and neck that is disposable or laundered, as described in USP chapter <797>.

5. Compounding staff in the buffer area or segregated compounding area use antiseptic hand cleansing with a waterless, alcohol-based surgical hand rub, following hand-hygiene guidelines defined by the Centers for Disease Control and Prevention (CDC) and in USP chapter <797>.

6. Compounding staff allow hands to dry thoroughly before putting on sterile gloves.

Note: Putting sterile gloves on should be the last step in the sterile compounding garbing process in the clean area as described in USP chapter <797>.

7. Contaminated gloves are disinfected by rubbing sterile 70% isopropyl alcohol (IPA) to all contact surface areas of the gloves and letting the gloves dry thoroughly. Routine disinfection of the gloves occurs throughout the compounding procedure and whenever nonsterile surfaces are touched, as described in USP chapter <797>.
8. Compounding staff routinely inspect their donned gloves for holes, punctures, tears and then replace them immediately if such are discovered, as described in USP chapter <797>.

9. If the exterior gown is not visibly soiled, compounding staff may remove it and leave it in the compounding area to be redonned when exiting the compounding space. Exterior gowns must be discarded at the end of the compounding staff’s work day.

10. When reentering the compounding area, proper hand hygiene is conducted and new shoe covers, hair and facial hair covers, face masks, eye shields, and gloves are used, as described in USP chapter <797>.

11. When performing high-risk compounding activities that precede terminal sterilization, including weighing and mixing nonsterile ingredients, compounding staff are garbed and gloved the same as when performing compounding in an International Organization for Standardization (ISO) Class 5 environment, as described in USP chapter <797>.

12. Whenever properly garbed compounding staff are exposed or suspected of exposure to a less than ISO Class 7 environment, they put on new personal protective equipment, wash and perform hand cleansing with a waterless alcohol-based surgical hand rub, and put on sterile gloves upon reentering the ISO Class 7 buffer area, as described in USP chapter <797>.

13. Compounding staff are required to follow either the garbing and cleansing requirements described in USP chapter <797> when compounding in ISO Class 5 environments created by compounding aseptic isolators (CAIs) or compounding aseptic containment isolators (CACIs), or the garbing and cleansing requirements provided in writing by the manufacturer and validated through recognized environmental testing.

Standard MC.03.06.11
Compounding staff follow evidence-based cleaning and disinfecting practices in the sterile compounding areas.

Elements of Performance for MC.03.06.11

1. For International Organization for Standardization (ISO) Class 5 primary engineering controls (PECs), cleaning and disinfecting activities occur in the following time frames consistent with USP chapter <797>: 

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
- At the beginning of every shift
- Before each batch
- Not longer than 30 minutes following the previous surface disinfection when ongoing compounding activities are occurring
- After spills
- When surface contamination is known or suspected

2. Staff clean and disinfect each month in the ISO Class 7 buffer areas and ISO Class 8 ante-areas as described in USP chapter <797> for counters, floors, work surfaces, walls, ceilings, and storage shelving. This cleaning and disinfecting are documented.

3. Cleaning and disinfecting agents used together do not produce toxic residues and are not otherwise incompatible in terms of safety or effectiveness.

4. Sponges, mops, and other cleaning materials are nonshedding, made of microfiber, and are otherwise consistent with composition requirements defined in USP chapter <797>.

5. Sponges, mops, and other cleaning materials are used exclusively in the buffer areas, clean areas, ante-areas and segregated compounding areas, and are removed only for disposal.

6. Supplies and equipment removed from shipping cartons are wiped with an appropriate disinfecting agent (that is, sterile 70% isopropyl alcohol [IPA]) per USP chapter <797>. The disinfectant is allowed to dry completely before items are used for compounding purposes.

7. Disinfecting entry points on bags and vials is done using sterile 70% isopropyl alcohol (IPA) unit dose swabs; entry points are vigorously swabbed and disinfecting agents are allowed to dry before piercing stoppers with sterile needles and opening ampules, per USP chapter <797>.

8. The unit dose swabs used to disinfect entry points of sterile containers do not contact any other object before contacting the surface of the entry point, per USP chapter <797>.

9. Sealed pouches containing sterile supplies may be opened as they enter the ISO Class 5 primary engineering control (PEC) without disinfecting the sterile entry point of packages and devices, per USP chapter <797>. 
10. Shipment boxes and external cartons are not taken into the buffer area or segregated compounding area, per USP chapter <797>.

11. The organization meets all other USP chapter <797> requirements related to cleaning and disinfecting the compounding area.

**Standard MC.03.07.01**

Automated compounding devices (ACDs), including those for parenteral nutrition compounding, IV robotics, IV room workflow systems, and repeater pumps, undergo comprehensive technological, clinical, and architectural assessments. (For more information, refer to Standard EQ.02.01.01)

**Elements of Performance for MC.03.07.01**

1. The organization develops and implements standard operating procedures (SOPs) addressing the accuracy assessments required for all ingredients in the final compounded sterile products.

2. The organization uses the assessment methods defined in its SOP (for example, spectroscopy, refractometry, specific gravity) to determine the quantitative accuracy of all ingredients in the final compounded sterile product.

3. The organization develops and implements standard operating procedures (SOPs) addressing precision assessments of all automatic compounding devices (ACDs).

4. The organization uses the assessment methods defined in its SOP to determine variations and deviations in the performance of ACDs to prevent errors.

5. The compounding supervisor(s) implements policies and procedures related to ACDs detailing the following:
   - Workflows
   - Cleansing
   - Maintenance (including changing the tubing on automated dispensing devices [ADCs] per manufacturers’ recommendations)
   - Competency
   - Routine checks of precision and accuracy of ACDs
   - Physical inspection and accuracy of compounded sterile products

*(See also EQ.02.01.01, EPs 1–3)*
6. The compounding supervisor(s) implements policies and procedures related to finished preparation release checks and tests in accordance with USP chapter <797>, state board of pharmacy requirements, and laws and regulations. These include, but are not limited to, physical inspection, double-checking accuracy of CSPs, and accuracy of labeling.

7. Compounding staff maintain a daily record of variations in accuracy and precision.

8. Trends in variations related to accuracy or precision are assessed and documented at least on a weekly basis as described in USP chapter <797>, and necessary actions are taken to correct these identified trends.

9. Compounded sterile products using ACDs meet sterility and stability requirements per each risk-level preparation as described in USP chapter <797>, state board of pharmacy requirements, and laws and regulations.

**Standard MC.03.08.01**

The organization develops and implements policies and procedures for maintaining the sterility, purity, and stability of compounded sterile preparations (CSPs) prepared by or dispensed by the organization. (For more information, refer to Standards MM.03.01.01 and MM.05.01.11)

**Elements of Performance for MC.03.08.01**

1. The organization has written policies that define how the organization will address the sterility, purity, stability, storage, and security of the CSPs that the organization dispenses and prepares.

2. CSPs are properly stored and secured by staff until their beyond-use date, unless they are dispensed to patients.

3. The organization implements procedures for proper packaging, handling, transport, and storage when preparing or dispensing CSPs.

4. The compounding supervisor(s) develops procedures to be used by compounding staff who do not regularly work in the clean room but are assigned compounding tasks in specific or exceptional situations (for example, compounding staff absences).
**Standard MC.03.08.03**

Organizational policies and procedures define the circumstances and methods for packaging, handling, and transporting compounded sterile preparations (CSPs).

**Elements of Performance for MC.03.08.03**

1. Procedures for packaging, handling, and transporting CSPs are developed by compounding staff in collaboration with other departments’ staff involved in CSP-related functions.

2. The organization monitors non-compounding staff on an ongoing basis to manage consistent implementation of procedures.

3. The organization evaluates the effectiveness and reliability of the packaging, handling, and transport procedures.

**Standard MC.03.08.05**

The organization protects the quality of compounded sterile preparations (CSPs) until they are administered.

**Note:** Refer to USP chapter <71> for testing requirements on extending beyond-use dates (BUDs).

**Elements of Performance for MC.03.08.05**

1. The organization implements procedures for use and storage of CSPs within the patient care setting that includes immediate labeling of the CSP container with the beyond-use date. (*See also* MM.03.01.01, EPs 1 and 2; MM.05.01.09, EPs 1 and 2)

2. Organizations that accept returned (expired or unused) CSPs in the compounding facility have defined procedures for handling their receipt and disposition.

   **Note:** *This element of performance does not apply to home care organizations.*

3. The organization implements procedures to maintain quality and sterility of CSPs for subsequent administration that are consistent with the type of CSP and devices or techniques in use. At a minimum, the procedures include the following:
   - Hand hygiene
   - Aseptic technique
   - Critical site of CSPs
Change of administration sets

**Note:** *This element of performance does not apply to home care organizations.*

**Standard MC.03.08.07**

The quality and safety of compounded sterile preparations (CSPs) is maintained when they are packed and transported for use outside the location where they were compounded.

**Elements of Performance for MC.03.08.07**

1. The organization uses packing procedures and materials that protect the integrity, sterility, and stability of the CSPs.

2. Packing procedures and materials protect staff from exposure when transporting CSPs.

3. Compounding staff obtain confirmation from the transporter that the temperature ranges required by the CSPs are maintained by the transporter for the duration of transit.

   **Note:** *Disposable thermometers can be used to validate that appropriate temperatures are maintained.*

4. Compounding staff communicate handling and exposure instructions to each transporter and attach the instructions to the exterior of packages containing CSPs.

5. The organization assesses that the mode of transportation protects the integrity, sterility, and stability of the CSPs.

**Standard MC.03.08.09**

The organization communicates refrigeration and storage requirements to patients and other recipients receiving shipments of compounded sterile preparations (CSPs).

**Note:** *Refer to USP chapter <71> for testing requirements on extending beyond-use dates (BUDs).*

**Elements of Performance for MC.03.08.09**

1. Before shipping CSPs to patients or other recipients outside its own premises, the organization informs the patient or recipient of the need for a properly functioning refrigerator or freezer as required for CSP storage. The organization
documents the patient’s or recipient’s confirmation that proper refrigerator or freezer capacity is available. (For more information, refer to Standard MM.06.01.03)

2. Before shipping CSPs to patients or other recipients outside their own premises, the organization labels the CSPs with beyond-use dates, storage instructions, and disposal instructions for out-of-date preparations.

**Standard MC.03.08.11**
The organization develops and implements an education and training program for patients and caregivers to facilitate safe storage, handling, and administration of compounded sterile preparations (CSPs) in the home. (For more information, refer to Standard MM.06.01.03)

**Elements of Performance for MC.03.08.11**

1. The scope of the formal education and training program includes the CSP storage, handling, and administration responsibilities that the patient and caregiver will need to carry out in the home.

2. The organization defines in writing the specific skills and competencies the patient or caregiver will need to develop before self-administering CSP(s) without the supervision of health care staff.

3. Education of the patient and caregiver includes, but is not limited to, the following:
   - The diagnosis and goals of therapy
   - The CSP(s) and its side effects
   - How to inspect, store, and handle the CSP and related supplies and equipment to support effective and safe use
   - Signs of therapeutic complications or infection
   - When to contact the organization, the patient’s physician, or emergency services
   - Safe disposal and cleaning practices

4. Education and training of the patient and caregiver includes the following:
   - A hands-on demonstration and return demonstration with items the patient or caregiver will use, including CSP containers, devices, and equipment
   - Patient or caregiver return demonstration of aseptic and injection technique under the direct observation of competent staff (for example, visiting nurses)
5. Following education and training, the patient or caregiver is assessed for understanding, competence, ability, and willingness to comply with the CSP procedures in the home.

6. The organization provides CSPs for home use only when competencies are met.

   **Note:** The organization provides additional training, information, or support, or consults with the patient's licensed independent practitioner for alternatives when competencies are not met.

7. The organization periodically reassesses the patient’s and caregiver’s competencies for using CSPs in the home in a time frame consistent with the patient’s assessed needs.

8. The education on and validation of required patient and caregiver competencies are documented in the patient record.

**Standard MC.04.01.01**
Compounding supervisors implement policies and procedures pertaining to storage of compounded sterile preparations (CSPs) and assigning beyond-use dates (BUDs) to maintain the sterility, strength, quality, and purity of the CSPs.

**Note:** Refer to USP chapter <71> for testing requirements on extending beyond-use dates (BUDs).

**Elements of Performance for MC.04.01.01**

1. Compounding staff assign beyond-use dates for sterile preparations using one of the following approaches:
   - Manufacturer’s recommendation for the specific product, based on chemical and physical stability parameters as described in USP chapter <797>
   - In the absence of manufacturer’s recommendations on a BUD, USP chapter <797> requirements based on risk level of a specific CSP

2. If sterility testing is lacking, low-risk CSPs are stored for a maximum of 48 hours at a controlled room temperature between 20 and 25 degrees Celsius, 14 days at a cold temperature between 2 and 8 degrees Celsius, and for a maximum of 45 days at a freezing temperature between -10 and -25 degrees Celsius.
3. If sterility testing is lacking, medium-risk CSPs are stored for a maximum of 30 hours at a controlled room temperature between 20 and 25 degrees Celsius, 9 days at a cold temperature between 2 and 8 degrees Celsius, and for a maximum of 45 days at a freezing temperature between -10 and -25 degrees Celsius.

4. If sterility testing is lacking, high-risk CSPs are stored for a maximum of 24 hours at a controlled room temperature between 20 and 25 degrees Celsius, 3 days at a cold temperature between 2 and 8 degrees Celsius, and for a maximum of 45 days at a freezing temperature between -10 and -25 degrees Celsius.

5. Whenever compounding staff assign BUDs exceeding USP chapter <797> requirements, they base the rationale for extended BUDs on one or more of the following references:
   - USP monographs
   - National Formulary (NF) monographs
   - Manufacturer recommendations
   - Evidence-based literature
   - Stability and sterility information through adequate testing
   - Storage environment
   - Peer-reviewed published studies

6. The BUDs and the rationale for assigning extended BUDs are documented in a master formula record (MFR).

   Note: A master formula record (MFR) is only required for nonsterile compounded preparations; it is not required for CSPs unless required by policy or state law.

7. BUDs for proprietary bag and vials systems are assigned based on manufacturers’ recommendations.

   Note: Examples of proprietary bag and vial systems are ADD-Vantage and Mini Bag Plus.

8. The storage and BUD policies and procedures meet all other related expectations in USP chapter <797>, evidence-based literature, state board of pharmacy requirements, and laws and regulations.

**Standard MC.04.01.03**
The organization implements policies and procedures addressing stability criteria and beyond-use dates (BUDs) for nonsterile preparations.
Elements of Performance for MC.04.01.03

1. Compounders base BUDs on evidence-based and best-practice literature on general stability and, where available, on the specific medication being compounded.

2. Compounders base beyond-use dates on the following, consistent with USP chapter <795>:
   - The nature of the drug and its degradation mechanism
   - The dosage form and its components
   - The potential for microbial proliferation in the preparation
   - The container in which it is packaged
   - The expected storage conditions
   - The intended duration of therapy

3. When evidence-based or best-practice literature is not available regarding stability for a specific medication and preparation, beyond-use dating follows the packaging, storage condition, and duration specified in the “BUD by Type of Formulation” requirements in USP chapter <795>.

Standard MC.04.02.01

The compounding supervisor(s) implements policies and procedures addressing hazardous sterile and nonsterile compounding operations based on the risk level for sterile compounding and the category of complexity for nonsterile compounding, consistent with USP chapters <795>, <797>, and <800> (effective July 1, 2018); state board of pharmacy requirements; and all applicable laws and regulations. (For more information, refer to Standard LD.04.01.01)

Note: Refer to the most up-to-date NIOSH list of hazardous medications and safety data sheets (SDSs).

Elements of Performance for MC.04.02.01

1. Leaders support and maintain a compounding environment that meets, at a minimum, the environmental requirements of USP chapter <797>; state board of pharmacy requirements; and all applicable laws and regulations while compounding sterile and nonsterile preparations. (See also LD.04.01.01, EP 2)

Note: Refer to the most up-to-date NIOSH list of hazardous medications and safety data sheets (SDSs).
2. The compounding supervisor(s) implements, audits, and performs quality control checks for compounded hazardous sterile and nonsterile preparations.

**Note:** Refer to the most up-to-date NIOSH list of hazardous medications and safety data sheets (SDSs).

3. The compounding supervisor(s) implements policies and procedures addressing garbing and personal protective equipment (PPE) such as eye protection, face masks, hair covers, gowns, double gloving with sterile chemotherapy-type gloves when compounding hazardous preparations.

**Note:** Refer to the most up-to-date NIOSH list of hazardous medications and safety data sheets (SDSs).

4. Hazardous medications and ingredients are stored separately from the rest of the medication inventory to prevent contamination and staff exposure while compounding sterile and nonsterile preparations.

**Note:** Refer to the most up-to-date NIOSH list of hazardous medications and safety data sheets (SDSs).

5. Compounding staff follow USP chapter <797> for double gloving using chemotherapy gloves when receiving, distributing, stocking, inventorying, preparing, dispensing, and disposing of hazardous medications.

**Note:** Refer to the most up-to-date NIOSH list of hazardous medications and safety data sheets (SDSs).

6. Sterile hazardous medications are prepared in an International Organization of Standardization (ISO) Class 5 environment with containment primary engineering controls (C-PECs) and aseptic technique per the risk level and complexity as defined in USP chapters <797> and <795>.

**Note:** Refer to the most up-to-date NIOSH list of hazardous medications and safety data sheets (SDSs).

7. Access to the hazardous compounding area is controlled by and restricted to the staff involved in compounding preparations.

**Note:** Refer to the most up-to-date NIOSH list of hazardous medications and safety data sheets (SDSs).

8. Tasks conducted prior to the sterile steps are, at a minimum, performed on a Class I biological safety cabinet (BSC).
9. Sterile hazardous medications are prepared in a Class II or III BSC or a compounding aseptic containment isolator (CACI) that meets or exceeds the standards for CACI as defined in USP chapter <797>.

**Note:** Refer to the most up-to-date NIOSH list of hazardous medications and safety data sheets (SDSs).

10. The ISO Class 5 BSC or CACI used to prepare sterile hazardous medications are placed in an ISO Class 7 area, as defined in USP chapter <797>. The ISO Class 7 area has the following characteristics:
   - The Class 7 area is physically separated from the other medication preparation areas.
   - The Class 7 area has not less than 0.01-inch water column negative pressure to adjacent positive pressure.
   - A pressure indicator is installed to monitor the hazardous sterile compounding area.

   Note 1: See USP Compounding Compendium, June 2015, Physical Tests; USP chapter <797>, Pharmaceutical Compounding – Sterile

   **Note 2:** Refer to the most up-to-date NIOSH list of hazardous medications and safety data sheets (SDSs).

11. The BSC and CACI used for sterile hazardous compounding are 100% vented to the outside air through HEPA filtration as described in USP chapter <797>.

   **Note:** Refer to the most up-to-date NIOSH list of hazardous medications and safety data sheets (SDSs).

12. If a CACI meeting USP chapter <797> requirements is used outside of a buffer area when compounding drugs, the compounding area maintains a minimum negative pressure of 0.01-inch water column and has a minimum of 12 ACPHs as described in USP chapter <797>.

   **Note:** Refer to the most up-to-date NIOSH list of hazardous medications and safety data sheets (SDSs).

13. Closed-system vial transfer devices (CSTD) are used within the ISO Class 5 environment of a BSC or CACI as described in USP chapter <797>.
14. Facilities preparing a low volume of hazardous medications may use a two-tier containment such as a CSTD within a BSC or CACI that is located in a non-negative pressure room as described in USP Chapter <797>.

Note: Refer to the most up-to-date NIOSH list of hazardous medications and safety data sheets (SDSs).

15. Personal protective equipment such as gowns, face masks, eye protection, hair covers, shoe covers or dedicated shoes, and double gloving with sterile chemotherapy-type gloves are used when compounding in a BSC or CACI and when using CSTDs based on USP chapter <797> requirements and manufacturers’ recommendations.

Note: Refer to the most up-to-date NIOSH list of hazardous medications and safety data sheets (SDSs).

16. If the organization prepares hazardous medications, it also performs environmental surface sampling to detect uncontained hazardous drugs.

Note: Refer to the most up-to-date NIOSH list of hazardous medications and safety data sheets (SDSs).

17. Environmental sampling occurs initially as a benchmark, and at least every 6 months as described in USP chapter <797>.

Note: Refer to the most up-to-date NIOSH list of hazardous medications and safety data sheets (SDSs).

18. Compounding staff dispose of all hazardous medication wastes in compliance with applicable laws and regulations and state board of pharmacy requirements.

Note: Refer to the most up-to-date NIOSH list of hazardous medications and safety data sheets (SDSs).

Standard MC.04.02.03

The compounding supervisor(s) implements policies and procedures that address hazardous sterile and nonsterile compounding training and competency assessments, per the risk level for sterile compounding, the category of complexity for nonsterile compounding, state board of pharmacy requirements, and all applicable laws and regulations.
Elements of Performance for MC.04.02.03

1. Before preparing or handling any hazardous preparations, staff who compound hazardous medications are provided education and training in the storage, handling, preparing, dispensing, and disposing of these medications. *(See also HR.01.04.01, EP 3; HR.01.05.03, EP 1)*

2. Education and training include a didactic overview of hazardous medications including mutagenic, teratogenic, and carcinogenic properties.

3. Education and training are provided for each new hazardous medication entering the market that is handled by the organization.

4. Training for compounding staff on hazardous compounded sterile preparations includes the following items, consistent with USP chapter <797>, state board of pharmacy requirements, and all applicable laws and regulations:
   - Safe aseptic technique
   - Negative pressure technique when utilizing a biological safety cabinet (BSC) or compounding aseptic containment isolators (CACI)
   - Correct use of closed-system vial transfer devices (CSTDs)
   - Containment, clean-up, and disposal procedures for breakages and spills
   - Treatment of staff contact and inhalation exposure

5. The compounding supervisor(s) verifies competency of compounding staff by testing specific hazardous medication preparation techniques. *(See also HR.01.06.01, EP 1)*

6. The organization advises all compounding staff of the risks to their reproductive systems when handling hazardous medications and confirms in writing that staff understand these risks.

7. Compounding staff who will dispose of hazardous medication waste receive initial education and training in procedures to protect themselves and prevent contamination.

8. The compounding supervisor(s) assesses competency at least every 12 months. The competency assessment is documented.

Standard MC.05.01.01

The compounding supervisor(s) implements policies and procedures addressing nonsterile compounding principles as described in USP chapter <795>, state board of pharmacy requirements, and laws and regulations.
Elements of Performance for MC.05.01.01

1. The compounding supervisor(s) defines the procedures required for the three specific categories of nonsterile compounding (simple, moderate, and complex) as described in USP chapter <795>.

2. The compounding supervisor(s) defines the staff training, competencies, assessment, and documentation required for the categories of simple, moderate, and complex nonsterile compounding.

3. Compounding staff follow a prescription or medication order for accurate and precise preparations. (See also MM.05.01.01, EP 1)

4. Compounding staff dispense nonsterile compounded preparations with appropriate packaging and labeling in accordance with the USP chapter <795>, state board of pharmacy requirements, and laws and regulations. (See also MM.05.01.09, EPs 1 and 2; MM.05.01.11, EP 2)

5. Nonsterile compounding ingredients are stored according to manufacturers’ recommendations and/or USP-NF monograph requirements.

6. Bulk component containers have appropriate labeling per OSHA (Occupational Safety and Health Administration) hazard communication labels, state board of pharmacy requirements, and laws and regulations. (See also MM.05.01.09, EPs 1 and 2; MM.05.01.11, EP 2)

7. Safety data sheets are readily available to compounding staff for all ingredients, bulk chemicals, and medications used for nonsterile compounding.

8. The organization implements procedures to prevent cross-contamination, especially when compounding medications requiring special precautions such as hazardous and known allergen medications like penicillin.

9. All procedural steps taken in the compounding process are documented; this documentation is readily accessible.

Standard MC.05.01.03
Compounding of nonsterile preparations is performed following defined procedures.

Elements of Performance for MC.05.01.03

1. All nonsterile compounding is made in accordance with USP chapter <795>, evidence-based practices, state board of pharmacy requirements, and all applicable laws and regulations.
2. The dose, safety, and intended use of the preparation or device has been evaluated for therapeutic appropriateness, correct dosage form, legal limitation, and the physical and chemical properties of the components.

3. Compounding staff initiate and complete a master formulation and compounding records as follows:
   - A master formulation record is created before proceeding with any nonsterile compounding preparation.
   - The master formulation record is followed every time that specific preparation is made.
   - A compounding record is completed each time a preparation is compounded.

4. Ingredients to be used for nonsterile compounding are purchased or acquired from a source that validates the identity, quality, strength, and purity of the ingredients consistent with laws and regulations.

5. Ingredients used in the nonsterile compounded preparations have their identity, quality, and purity checked per Food and Drug Administration (FDA) requirements such as Good Manufacturing Practice (GMP).

6. Nonsterile compounding is done in a clean and sanitized area dedicated to this activity.

7. Only authorized staff are allowed in the immediate environment of the medication compounding operations.

8. Only one nonsterile preparation is compounded at one time in a specific workspace.

9. Compounding equipment is selected and inspected for cleanliness, correct functioning, maintenance, and calibration and is then properly used.

10. The beyond-use date (BUD) is assigned consistent with the accepted potency, purity, quality, and characteristics that the nonsterile preparation must maintain.

11. Compounding staff members use good hand hygiene and wear clean clothing consistent with the type of compounding done (for example, wearing hair bonnets, coats, gowns, gloves, facemasks, shoes, aprons) as needed for protecting staff and preventing medication contamination.

12. Critical process steps such as weighing, measuring, and mixing are verified by the compounding staff for consistency in results and quality of preparation.
13. Final nonsterile compounding preparations are assessed through factors including weight, adequacy of mixing, clarity, odor, color, consistency, pH, and analytical testing. This assessment is documented in the compounding record consistent with USP chapter <1163>.

14. Nonsterile compounded preparations are packaged per the Packaging and Drug Preparation Containers section of USP chapter <795>.

15. Nonsterile compounded preparation containers are labeled consistent with board of pharmacy requirements and all applicable laws and regulations.
   - The label of the nonsterile compounded preparation includes the BUD, storage, and handling information.
   - The label states clearly that the contents are a compounded preparation.
   - The compounding record and the master formulation record are checked by the compounding staff to confirm an error-free compounding process.

   (For more information, refer to Standard MM.05.01.09)

16. Nonsterile compounded preparations are dispensed to patients or caregivers with registered pharmacist consultation.

17. Quality control procedures for the reproducibility of the intended and specified process are implemented.

18. Procedures designed to prevent errors are implemented.

19. Errors and failures that occur in compounding are investigated and audited, and then corrected in accordance with organization policies and procedures.

**Standard MC.05.02.01**

Compounding is conducted in a space that is dedicated and equipped specifically for compounding prescriptions.

**Note:** Refer to the most up-to-date NIOSH list of hazardous medications and safety data sheets (SDSs).

**Elements of Performance for MC.05.02.01**

1. The organization provides compounding space as follows:
   - Accommodates the required equipment
   - Supports a workflow that mitigates the risk of cross-contamination or a mix-up of supplies, materials, or preparations
   - Separates areas for sterile preparation from nonsterile preparation
2. The organization uses purified water for the following:
   - Compounding nonsterile medication preparations when specified in formulations
   - Rinsing equipment and utensils

   **Note:** Purified water is water that has been mechanically filtered or processed to remove impurities, and is used in the preparation of nonparenteral preparations and the cleaning of certain equipment (see USP <1231>).

3. Potable water is used for washing hands and equipment consistent with Environmental Protection Agency regulation 40 CFR Part 141.

   **Note:** Rinsing equipment and utensils with purified water shall be performed after washing equipment and utensils with potable water unless purified water is used to wash equipment and utensils.

4. The organization supports clean, sanitary, and safe practices by providing the following:
   - Staff access to hot and cold water, soap or detergent, and an air drier or single-use towels
   - Compounding area that is well lit and maintained in orderly condition, according to USP chapter <795>
   - Prompt repair of equipment and other furniture or furnishings used by staff in compounding
   - A safe, functioning plumbing system
   - Storing all components, equipment, and containers off the floor to prevent soiling and for ease of inspection and cleaning
   - Prompt and sanitary disposal of waste, consistent with laws and regulations

5. Heating, ventilation, and air conditioning systems for the compounding space are as follows:
   - Maintained to mitigate contamination and degradation of compounding materials and chemicals
   - Monitored to sustain appropriate temperature and humidity conditions for certain components and compounded dosages

**Standard MC.05.02.03**
Compounding supervisors implement policies and procedures addressing selection, handling, and storage of all components used to compound nonsterile preparations.
Elements of Performance for MC.05.02.03

1. Selection, handling, and storage policies and procedures for components used to compound nonsterile preparations reflect USP chapter <795>, state board of pharmacy requirements, and all applicable laws and regulations. A USP, National Formulary (NF), or Food Chemicals Codex (FCC) substance is the recommended source of ingredient for compounding.

2. Compounding staff use components manufactured in a facility registered by the Food and Drug Administration (FDA). If components cannot be obtained from an FDA-registered facility, then the following occurs:
   - Compounding staff use professional judgment in selecting an acceptable and reliable source
   - Purity and safety of the components are checked via methods such as certificate of analysis, manufacturer reputation, and reliability of source

3. Ingredients meeting requirements of the USP or NF compendial monographs are used to compound nonsterile compounded preparations; nonsterile compounded preparations are labeled with USP or NF accordingly.

4. If compendial quality components cannot be obtained, the compounding supervisor follows defined procedures, criteria, and authorizations to use alternative high-quality components such as those that are chemically pure, analytical reagent grade, or American Chemical Society certified.

5. If a container is opened, the following three conditions must be met for its original components to be used safely up to the manufacturer’s original expiration date:
   - The component is stored in its original container under conditions to avoid decomposition of the chemicals per USP chapters <1191> and <659>, unless other conditions are noted on the label.
   - There is minimal exposure of the remaining material when material is taken from the original container.
   - All withdrawals from the original container are done by compounding staff trained in the proper handling of the material.

6. For components transferred from their original container to a different container, the new container is as follows:
- Labeled with the component name, original manufacturer or supplier, lot or control number, transfer date, and expiration date
- Provides environmental integrity that is equivalent to or greater than the original container

7. ◆ For components that do not have expiration dates assigned by the manufacturer or supplier, the compounding staff label the container with the date of receipt and assigns a conservative expiration date not to exceed three years after receipt of the component.

8. ◆ If the source of active ingredients is a manufactured medication product, the compounding supervisor(s) verifies the following:
- The medication product is manufactured in an FDA-registered facility
- The manufacturer’s product container is labeled with a batch control number and expiration date

9. Nonsterile compounded preparations that are intended for use as dietary or nutritional supplements are prepared in accordance with USP chapter <795>, state board of pharmacy requirements, and all applicable laws and regulations.

10. ◆ Compounding supervisors obtain documented assurance from manufacturers and suppliers for all components derived from ruminant animals (for example, bovine, caprine, ovine) stating that components are in compliance with all applicable federal laws governing processing, use, and importation requirements for these components. The documented assurance is kept on file.

11. Compounding staff monitor the list of components that have been withdrawn or removed from the market for safety or efficacy reasons by the FDA.

12. All components for nonsterile compounded preparations are stored as directed in terms of clean area, controlled temperature, humidity conditions, and so forth. Components are consistent with manufacturers’ guidelines or USP, NF, or FCC monograph requirements.

13. All components for nonsterile compounded preparations are stored off the floor, handled and stored to prevent contamination, and rotated so the oldest stock is used first.

14. ◆ All containers for nonsterile compounded preparations are labeled appropriately per USP chapter <795>, state board of pharmacy requirements, and all applicable laws and regulations.
Standard **MC.05.03.01**
Compounding is conducted using the correct type and size of equipment to produce drug preparations with safety, accuracy, and integrity. (For more information, refer to Standards EQ.02.01.01 and IC.02.02.01)

**Elements of Performance for MC.05.03.01**

1. The equipment and supplies used for compounding medications are designed with the capacity for the quantities and dosage forms to be compounded, consistent with USP chapter <1176> and manufacturers’ instructions.

2. Equipment surfaces do not have reactive, additive, or sorptive properties and do not otherwise affect or alter the purity of the compounded preparations.

3. Equipment used in compounding or testing compounded preparations are inspected and calibrated based on time frames and criteria specified by the organization.

4. Compounding equipment is checked by the compounder immediately before operation for usage suitability and proper performance.

5. Equipment is located and stored in a manner that protects it from contamination and facilitates ease of its use, maintenance, and cleaning.

6. All equipment used in nonsterile compounding is clean and properly maintained, including thoroughly cleaned after use per organization protocol and manufacturers’ instruction.

   **Note:** If possible, disposable or dedicated equipment can be used to mitigate the risk of bio-burden and cross-contamination.

7. The organization implements additional cleaning protocols when the same equipment is being used for all medication products, as described in USP chapter <795>.

8. The organization implements additional cleaning protocols for equipment that is used in compounding preparations that require special precautions (for example, antibiotics, cytotoxic, other hazardous materials), as described in USP chapter <795>.

Standard **MC.05.04.01**
Containers and closures protect the integrity of compounded preparations. (For more information, refer to Standard MM.03.01.01)
Elements of Performance for MC.05.04.01

1. Compounding supervisors verify with container suppliers that containers and closures are performance tested in accordance with USP requirements and any applicable compounding monographs; documentation of this verification is maintained.

   **Note:** For more information, see USP chapters <795>; <659> (Packaging and Storage requirements); <660> (Containers—Glass); <661> (Plastic Packaging Systems and their Materials of Construction); <671> (Containers—Performance Testing); <1136> (Packaging and Repackaging—Single-Unit Containers).

2. Containers and closures for compounded products are compatible with the physical and chemical properties of the compounded preparation and meet the following requirements:
   - They are made of suitable clean material in order not to alter the quality, strength, or purity of the compounded medication preparation.
   - They do not have sorptive or leaching properties and do not adversely interact with the compounded preparations.

3. Containers and closures for compounded preparations are stored in a manner that assures the safety and quality of the preparations. The manner of storage is as follows:
   - Containers and closures are elevated from the floor and protected from contamination
   - Inspection and cleaning of the storage area is permitted
   - Staff rotate containers and closures so that the oldest stock is used first

4. Containers and closures intended for the compounding of nonsterile preparations are handled as described in USP chapter <795>.

**Standard MC.05.05.01**

Compounding supervisors implement policies and procedures addressing nonsterile compounding documentation. (For more information, refer to Standard MM.05.01.09)

Elements of Performance for MC.05.05.01

1. Policies and procedures addressing nonsterile compounding documentation are based on USP <795> standards, state board of pharmacy requirements, and all applicable laws and regulations.
2. ◼ Nonsterile compounding documentation is maintained throughout the compounding process so that staff can trace, evaluate, and replicate steps taken to compound each preparation.

3. ◼ Compounding staff follow manufacturer’s preparation and labeling instructions; any compounding staff not following manufacturer’s preparation and labeling instructions are required to follow further documentation instructions as described in USP chapter <795>.

4. ◼ Documentation records are retained for the time period required for any prescription under state law:
   - The record may be a copy of the prescription in written or machine-readable form
   - The record includes a master formulation record and a compounding record

5. ◼ The master formulation record (MFR), as described in USP chapter <795>, includes but is not limited to the following:
   - Official or assigned name, strength, and dosage form of the nonsterile compounded preparation
   - Calculations needed to determine and verify quantities of components and doses of active pharmaceutical ingredients
   - Description of all ingredients and their quantities
   - Compatibility and stability information, including references when available
   - Equipment used for the preparation, when appropriate
   - Mixing instructions including, but not limited to, order of mixing, temperature, duration of mixing, and related factors important to the replication of the compounded preparation
   - Dispensing container used for nonsterile compounded preparation
   - Packaging and storage requirements
   - Description of final preparation
   - Quality control procedures and expected results

For sample labeling, in addition to legally required information, the MFR should include generic name, quantity/concentration of each active ingredient, assigned beyond-use date (BUD), storage conditions, and prescription or control number.

6. ◼ The compounding record, as described in USP chapter <795>, includes but is not limited to the following:
   - Official or assigned name, strength, and dosage of the nonsterile compounded preparation
Medication Compounding

- Master formulation record reference for the nonsterile compounded preparation
- Names and quantities of all components
- Sources, lot numbers, and expiration dates of all components used in compounding nonsterile preparations
- Total quantity compounded
- Name of the staff who compounded the nonsterile preparation, name of the staff who performed the quality control procedures, and name of the staff who approved the preparation
- Date of preparation
- Assigned control or prescription number
- Assigned BUD
- Duplicate label as described in the master formulation record
- Description of final preparation
- Results of quality control procedures (for example, weight range of filled capsules, pH of aqueous liquids)
- Documentation of any quality control issues and any adverse reactions or preparation problems reported by the patient or caregiver

7. All significant operating procedures performed in the compounding area should be detailed and written as a standard operating procedure (SOP). SOPs are developed for at least the following:
   - The compounding facility
   - The equipment used for nonsterile compounding
   - Preparation of nonsterile compounded medications
   - Packaging of nonsterile compounded preparations
   - Storage of nonsterile compounded preparations
   - Accuracy of nonsterile compounded preparations
   - Quality of nonsterile compounded preparations
   - Safety of nonsterile compounded preparations
   - Uniformity in compounding nonsterile preparations

**Standard MC.05.06.01**
The organization implements quality control processes before compounded preparations are dispensed to patients.

**Elements of Performance for MC.05.06.01**

1. Compounding staff check each procedure at each stage of the process twice.
2. Compounding staff document all deviations from procedures as required in the master formulation record, the compounding record, and any associated written protocols.

3. The compounding supervisor observes the finished preparation for appearance, investigates any discrepancies, and takes appropriate corrective action before the prescription is dispensed to the patient.

4. The compounding supervisor reviews each procedure in the compounding process.

5. The compounding supervisor implements procedures for the tests of uniformity and integrity to be conducted on compounded preparations.

6. Compounding equipment is monitored for output and performance to mitigate variability in final compounded preparations. *(See also EQ.02.01.01, EPs 1–3)*

7. The organization meets all other responsibilities for quality control procedures as defined in USP chapter <1163>.
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, organizations 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 organization and those provided through contracted pharmacy services. However, the specifics of the medication management system used by the organization can vary depending on the care, treatment, or services it provides. Not all organizations will implement all of the medication processes. For example, home care settings implement the medication management process based on the care, treatment, or services they provide. For instance, inpatient hospice settings implement the majority of medication management processes, whereas home health settings implement select medication management processes based on the care, treatment, or services they provide.

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.
In addition, 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 organization
- Standardizing equipment and handling processes, including those for sample medications, across the organization to improve the medication management system
- Monitoring the medication management process for efficiency, quality, and safety

**About This Chapter**

The goal of the medication management standards is to provide a framework for an effective and safe medication management system. Effective and safe medication management is dependent on carefully implementing medication management processes based on the care, treatment, or services provided by the organization. Planning provides the groundwork for the following critical areas of performance outlined in this chapter:

- Managing high-alert and hazardous medications
- Selecting and procuring medications
- Storing medications
- Managing emergency medications
- Controlling medications brought into the organization by patients, their families, 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 organizations that permit their use. Medication Management EPs that do not include this note are not applicable to sample medications.
Chapter Outline

I. Planning
   A. Medication Planning (MM.01.01.01, MM.01.01.03)
   B. Look-alike/Sound-alike Medications (MM.01.02.01)

II. Selection and Procurement (MM.02.01.01)

III. Storage (MM.03.01.01, MM.03.01.03, MM.03.01.05)

IV. Ordering and Transcribing (MM.04.01.01)

V. Preparing and Dispensing (MM.05.01.01, MM.05.01.07, MM.05.01.09, MM.05.01.11, MM.05.01.13, MM.05.01.15, MM.05.01.17, MM.05.01.19)

VI. Administration (MM.06.01.01, MM.06.01.03, MM.06.01.05)

VII. Monitoring (MM.07.01.01, MM.07.01.03)

VIII. Evaluation (MM.08.01.01)
Applicability for Medication Management

This grid is meant to be a resource to determine which standards and elements of performance (EPs) apply to the service categories within the Home Care Accreditation Program. The column on the far left of the grid lists the related EPs vertically by number. Service categories (defined in Table 3 of the Introduction) are listed horizontally along the top of the grid. Applicability is indicated with an “X” in a service category column.

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Standards, Rationales, and Elements of Performance

Standard MM.01.01.01
The organization 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 organization plans each part of the process with care so that safety and quality are maintained. This planning may involve the coordinated efforts of multiple 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 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 IM.02.01.01, EP 3; PC.01.02.01, EP 8)

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

2. The organization implements its policy to make information about the patient accessible to 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 organization 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 organization needs to develop its own lists of both high-alert medications and hazardous drugs. These should be based on the organization’s unique utilization patterns, its own internal data about medication errors and sentinel events, and known safety issues published in professional literature. It is up to the organization to determine whether medications that are new to the market are high alert or hazardous. In addition, the organization may separately choose to include other drugs that require special precautions such as investigational medications, controlled substances, and psychotherapeutic medications.

Elements of Performance for MM.01.01.03

1. The organization identifies, in writing, its high-alert and hazardous medications.†

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

2. The organization has a process for managing high-alert and hazardous medications. (See also MM.03.01.01, EP 9)
3. The organization implements its process for managing high-alert and hazardous medications. *(See also EC.02.02.01, EP 1)*

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

**Standard MM.01.02.01**

The organization addresses the safe use of look-alike/sound-alike medications.

**Elements of Performance for MM.01.02.01**

1. The organization develops a list of look-alike/sound-alike medications it stores, dispenses, or administers.

   *Note 1: One source of look-alike/sound-alike medications is The Institute for Safe Medication Practices (http://www.ismp.org/Tools/confuseddrugnames.pdf).*

   *Note 2: This element of performance is also applicable to sample medications.*

2. The organization takes action to prevent errors involving the interchange of the medications on its list of look-alike/sound-alike medications.

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

3. The organization annually reviews and, as necessary, revises its list of look-alike/sound-alike medications.

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

**Standard MM.02.01.01**

The organization selects and procures medications.

**Elements of Performance for MM.02.01.01**

2. The organization develops and approves criteria for selecting medications, which include the following:
   - Indications for use
   - Effectiveness
   - Drug interactions
   - Potential for errors and abuse
   - Adverse drug events
   - Sentinel event advisories
   - Other risks

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
Costs

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

4. The organization maintains a written list of medications, including strength and dosage, for dispensing and administering. *(See also MM.03.01.01, EP 1)*

**Note:** In some settings, the term “formulary” is used instead of “list of medications available for use.” The terms are synonymous.

5. The organization makes its written list of medications readily available.

6. The organization standardizes and limits the number of drug concentrations.

8. The organization implements a process to select and procure medications that are not on its medication list.

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

9. The list of medications is reviewed at least annually based on emerging safety and efficacy.

11. The organization implements a process to communicate medication shortages and outages to prescribers and staff who participate in medication management.

12. The organization develops and approves written medication substitution protocols to be used in the event of a medication shortage or outage.

13. The organization implements its approved medication substitution protocols.

15. The organization implements a process to educate prescribers and staff who participate in medication management about the medication substitution protocols for shortages or outages.

**Standard MM.03.01.01**

The organization 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 organization’s approach to medication storage.
Elements of Performance for MM.03.01.01

1. For organizations that store medications at their site(s): The organization stores only approved medications and medications selected by the organization. (See also MC.03.08.05, EP 1; MM.02.01.01, EP 4)

2. For organizations that store medications at their site(s): The organization stores medications according to the manufacturers’ recommendations or, in the absence of such recommendations, according to a pharmacist’s instructions. (See also MC.03.08.05, EP 1)

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

3. For organizations that store medications at their site(s): The organization stores controlled (scheduled) medications to prevent diversion, in accordance with law and regulation.

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

4. For organizations that store medications at their site(s): The organization has a written process addressing the control of the medication between receipt by the organization and delivery to or administration at the designated site.

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

5. For organizations that store medications at their site(s): The organization implements its process addressing the control of medications between receipt and delivery.

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

6. For organizations that store medications at their site(s): The organization 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. For organizations that store medications at their site(s): 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. All expired, damaged, and/or contaminated medications are removed from patient care areas and stored separately from medications available for administration.

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

9. The organization 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)*

11. The long term care pharmacy or consultant pharmacist guides the facility in the development of policies and procedures addressing safe medication storage.

12. The long term care pharmacy informs the facility about any special storage requirements when medications are delivered to the facility.

13. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** The hospice develops procedures for the control and accountability of all medications within the hospice facility.

14. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** The hospice implements its procedures for the control and accountability of all medications within the hospice facility.

15. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** The hospice maintains records of receipt and disposition of all controlled medications to enable accurate reconciliation.

16. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** A pharmacist audits the hospice’s controlled medication records for accuracy and reconciliation.

17. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** The hospice stores all medications in a locked compartment in accordance with state and federal laws. The only personnel who have access to the locked compartment are those who are authorized to administer controlled drugs. *(For further information on authorized personnel, see 42 CFR 418.106(d)(2).)*

18. **For organizations that store medications at their site(s):** The organization periodically inspects all medication storage areas.
Note: This element of performance is also applicable to sample medications.

21. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** Discrepancies that occur at any point in the process of procuring, storing, dispensing, administering, disposing of, or returning controlled medications are immediately investigated by the pharmacist and the hospice administrator.

22. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** Discrepancies that occur at any point in the process of procuring, storing, dispensing, administering, disposing of, or returning controlled medications are immediately reported to the appropriate state authority.

23. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** A written report of any discrepancies that occur at any point in the process of procuring, storing, dispensing, administering, disposing of, or returning controlled medications is provided to state and federal officials, when required by law or regulation.

**Standard MM.03.01.03**
The organization safely manages emergency medications.

**Rationale for MM.03.01.03**
Patient emergencies occur frequently in health care settings. The organization, 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 organization treats emergency medications with the same care for safety as it does medications in nonemergency settings.

**Elements of Performance for MM.03.01.03**
1. Organization leaders determine which emergency medications and their associated supplies will be accessible for patient use in inpatient facilities, ambulatory infusion suites, and patient homes, and which medications and their associated supplies will be available directly from clinical staff.

3. Whenever possible, emergency medications are accessible in the most ready-to-administer forms.

6. When emergency medications or supplies are used, the organization replaces them as soon as possible to maintain a full stock.
Standard **MM.03.01.05**
The organization safely controls medications brought into the organization 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 organization 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 organization needs to define its responsibilities for the safe use of these medications.

**Elements of Performance for MM.03.01.05**
1. The organization defines when medications brought into the organization 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 organization by a patient, his or her family, or a licensed independent practitioner, the organization identifies the medication and visually evaluates the medication’s integrity. *(See also MM.05.01.07, EP 3; MM.06.01.01, EP 4)*

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

**Introduction to Standard MM.04.01.01**
Medication errors may occur when staff are communicating or transcribing medication orders. Verbal and telephone orders are particularly susceptible to error. The organization is responsible for reducing the potential for medication errors and the misinterpretation of these medication orders. As part of this process, the organization determines the required elements of a medication order, the type of medication orders that are deemed acceptable for use, and the actions to take when medication orders are incomplete, illegible, or unclear. Clear understanding and communication between staff and licensed independent practitioners involved in the medication process are essential.

**Standard **MM.04.01.01**
Medication orders or prescriptions are clear and accurate.
Note: For more information on verbal and telephone orders, refer to Standards RC.02.03.07 and PC.02.01.03.

Elements of Performance for MM.04.01.01

1. ⚫ For organizations that prescribe or receive medication orders verbally or via telephone, fax, or electronic media: The organization has a written policy that identifies the specific types of medication orders or prescriptions 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 specified in the instructions
- 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

For organizations that prescribe or receive medication orders verbally or via telephone, fax, or electronic media: The organization has a written policy that defines the following:

2. ⚫ The required elements of a complete medication order.
4. The precautions for ordering medications with look-alike or sound-alike names.

5. For organizations that prescribe or receive medication orders verbally or via telephone, fax, or electronic media: The organization has a written process for staff to follow when medication orders or prescriptions are incomplete, illegible, or unclear.

7. For organizations that prescribe or receive medication orders verbally or via telephone, fax, or electronic media: If the organization uses preprinted medication order sheets or prescriptions, it reviews and updates them at time frames it identifies, or sooner if necessary, based on current evidence and practice.

8. For organizations that prescribe or receive medication orders verbally or via telephone, fax, or electronic media: The organization prohibits summary (blanket) orders to resume previous medications.

9. For organizations that prescribe or receive medication orders verbally or via telephone, fax, or electronic media: A diagnosis, condition, or indication for use exists for each medication ordered.

Note: This information can be anywhere in the patient record and need not be on the order itself. For example, it might be part of the medical history.

11. For hospices that elect to use The Joint Commission deemed status option: Physicians give verbal medication orders only to a licensed nurse, nurse practitioner, pharmacist, or another physician.

13. For organizations that prescribe or receive medication orders verbally or via telephone, fax, or electronic media: The organization implements its written processes for medication orders or prescriptions.

14. For organizations that prescribe or receive medication orders verbally or via telephone, fax, or electronic media: The organization requires a physician order or, as permitted by law and regulation, organization-specific protocol(s) developed in consultation with a physician to administer influenza and pneumococcal polysaccharide vaccines.

15. For hospices that elect to use The Joint Commission deemed status option: A physician or a nurse practitioner as allowed by state law, orders all medications in accordance with the plan of care.
Standard MM.05.01.01
A pharmacist reviews the appropriateness of all medication orders or prescriptions for medications to be dispensed in the organization.

Elements of Performance for MM.05.01.01

1. For organizations that provide pharmacy services, a pharmacist reviews all medication orders or prescriptions prior to dispensing, in accordance with law and regulation. (See also MC.05.01.01, EP 3)

All medication orders and prescriptions 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 or prescription has been reviewed, all concerns, issues, or questions are clarified with the individual prescriber before dispensing. (See also PC.02.01.03, EP 5)

12. For hospices that elect to use The Joint Commission deemed status option: The organization obtains medications from community pharmacists, institutional pharmacists, or self stock.

14. For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option: The hospice has a written policy on dispensing accuracy.

Standard MM.05.01.07
The organization safely prepares medications.
Elements of Performance for MM.05.01.07

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 MC.03.01.01, EP 2; MM.03.01.05, EP 2; MM.06.01.01, EP 4)*

**Standard MM.05.01.09**

Medications are labeled.

*Note:* This standard is applicable to all organizations that prepare and administer medications.

**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. *(See also MC.03.08.05, EP 1; MC.05.01.01, EPs 4 and 6; MM.06.01.01, EP 3)*

*Note 1:* This element of performance does not apply to segregated pill boxes that store medications by day and time of day.

*Note 2:* 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 3:* 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. *(See also MC.03.08.05, EP 1; MC.05.01.01, EPs 4 and 6)*

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

All medications prepared in the organization 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. 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.

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.

12. Directions for use and applicable accessory and cautionary instructions.

**Standard MM.05.01.11**

The organization safely dispenses medications.

**Elements of Performance for MM.05.01.11**

1. The organization dispenses quantities of medications that are consistent with patient needs. *(See also MC.01.01.03, EP 3)*

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

2. The organization dispenses medications and maintains records in accordance with law and regulation, licensure, and professional standards of practice. *(See also MC.01.01.03, EP 3; MC.05.01.01, EPs 4 and 6)*

   **Note 1:** Dispensing practices and recordkeeping include antidiversion strategies.

   **Note 2:** This element of performance is also applicable to sample medications.

3. The organization dispenses medications in a timely manner as defined by the organization to meet patient needs. *(See also MC.01.01.03, EP 3)*
4. The organization dispenses medications in a form that minimizes the need for additional mixture or preparation. *(See also MC.01.01.03, EP 3)*

6. The organization delivers medications to the correct patient or long term care facility.

**Standard MM.05.01.13**

The organization 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 organization 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 organization has a process for providing medications to meet patient needs when the pharmacy is closed.

7. The organization implements its process for providing medications to meet patient needs when the pharmacy is closed.

**Standard MM.05.01.15**

The organization safely obtains medications when it does not operate a pharmacy.

**Elements of Performance for MM.05.01.15**

1. If the organization does not operate a pharmacy, the organization has a process for obtaining medications from a pharmacy to meet patient needs.

2. If the organization does not operate a pharmacy, the organization has a process for obtaining medications 24 hours a day, 7 days a week.

3. The organization implements its process for obtaining medications from a pharmacy.

**Standard MM.05.01.17**

The organization follows a process to retrieve recalled or discontinued medications.
Elements of Performance for MM.05.01.17

1. The organization has a written policy describing how it will retrieve and handle medications within the organization that are recalled or discontinued for safety reasons by the manufacturer or the US Food and Drug Administration (FDA).

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

2. The organization implements its policy on retrieving and handling medications when they are recalled or discontinued for safety reasons.

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

3. For organizations that store or dispense medications: When a medication is recalled or discontinued for safety reasons by the manufacturer or the US Food and Drug Administration, the organization notifies the prescribers and those who dispense or administer the medication.

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

4. When required by law and regulation or organization policy, the organization informs patients that their medication has been recalled or discontinued for safety reasons by the manufacturer or the US Food and Drug Administration (FDA).

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

Standard MM.05.01.19

The organization safely manages returned medications.

Rationale for MM.05.01.19

Medications may be returned to the organization when allowed by law or regulation and organization policy. Previously dispensed but unused, expired, or returned medications in the organization 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 organization determines under what circumstances unused, expired, or returned medications will be managed by the pharmacy or the organization.

   Note: This element of performance is also applicable to sample medications.
2. When the organization accepts unused, expired, or returned medications, it has a process for returning medications to the pharmacy or organization that includes procedures for preventing diversion.

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

4. The organization implements its process for managing unused, expired, or returned medications.

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

5. **For hospices that elect to use The Joint Commission deemed status option:** The hospice has written policies and procedures for the management and disposal of controlled medications in the home that are no longer needed by the patient.

6. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** The hospice disposes of controlled medications in accordance with hospice policy and state and federal requirements.

8. **For hospices that elect to use The Joint Commission deemed status option:** The hospice keeps current and accurate records of the receipt and disposition of all controlled medications.

9. **For hospices that elect to use The Joint Commission deemed status option:** At the time when controlled medications are first ordered, the hospice provides a copy of its written policies and procedures on the management and disposal of controlled medications to the patient or the patient’s representative and family.

10. **For hospices that elect to use The Joint Commission deemed status option:** At the time when controlled medications are first ordered, the hospice educates the patient, or the patient’s representative, and the family on the hospice’s policies and procedures for managing the safe use and disposal of controlled medications.

11. **For hospices that elect to use The Joint Commission deemed status option:** At the time when controlled medications are first ordered, authorized staff document in the patient’s record that the written policies and procedures for managing controlled medications were provided and discussed.

**Standard MM.06.01.01**
The organization safely administers medications.
Elements of Performance for MM.06.01.01

1. The organization defines, in writing, 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)

   *Note:* For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option: Medications are administered only by the following: A licensed nurse; a licensed physician; a health care professional in accordance with his or her scope of practice and state law; an employee who has completed a state-approved training program in medication administration; or the patient, upon approval by the interdisciplinary group. These individuals and each medication they are authorized to administer are specified in the patient’s plan of care.

2. Only authorized 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. (See also MM.05.01.09, EP 1)

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 physician, prescriber, and/or staff involved with the patient’s care, treatment, or services.

9. Before administering a new medication, the patient or family is informed about any potential for 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)
10. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** Clinical staff administer all medications in accordance with accepted standards of practice.

**Standard MM.06.01.03**

Medications are safely and accurately administered by patients and families.

**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 by patients or families, 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 organization implements its written processes for medication self-administration or medication administration.

3. The organization 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 organization 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 organization 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 organization 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 organization supervises patients and families until they determine the patient and family can safely and competently administer medications.

8. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** The organization obtains the interdisciplinary group’s approval for the administration of medications by the patient.
Standard MM.06.01.05

The organization 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 organization 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 organization has a written process addressing the use of investigational medications that includes review, approval, supervision, and monitoring.

2. If the organization operates a pharmacy, the 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 organization, the organization evaluates the patient’s continued participation in the protocol.

4. The organization implements its processes for the use of investigational medications.

Standard MM.07.01.01

The organization monitors patients to determine the effects of their medication(s).

Elements of Performance for MM.07.01.01

1. The organization monitors the patient’s perception of side effects and the effectiveness of his or her medication(s).

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

2. The organization monitors the patient’s response to medication(s) by taking into account clinical information from the patient record, relevant lab values, clinical response, and medication profile.

   Note: This element of performance is also applicable to sample medications.
4. The clinical or consultant pharmacist reviews each patient’s medication regimen at least monthly.

5. The clinical or consultant pharmacist documents in the record the findings, conclusions, and recommendations from monitoring the medication regimen.

6. The clinical or consultant pharmacist communicates to the prescriber problematic findings and recommendations from the medication regimen review.

**Standard MM.07.01.03**
The organization 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, organizations 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 organization has a written process to respond to actual or potential adverse drug events, significant adverse drug reactions, and medication errors. *(See also MC.02.01.13, EP 2)*

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

2. The organization 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 organization 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.*

4. The organization implements its process for responding to adverse drug events, significant adverse drug reactions, and medication errors. *(See also MC.02.01.13, EP 2)*

   **Note:** *This element of performance is also applicable to sample medications.*
Standard MM.08.01.01

The organization evaluates the effectiveness of its medication management processes.

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 organization collects data on the performance of its medication management processes. (See also PI.01.01.01, EPs 14 and 15)
   
   Note: This element of performance is also applicable to sample medications.

2. The organization analyzes data on its medication management processes.
   
   Note: This element of performance is also applicable to sample medications.

3. The organization compares data over time to identify risk points, levels of performance, patterns, trends, and variations of its medication management processes.
   
   Note: This element of performance is also applicable to sample medications.

4. Based on analysis of its data, as well as review of the literature for new technologies and best practices, the organization identifies opportunities for improvement in its medication management processes.

5. The organization takes action on improvement opportunities identified as priorities for its medication management processes. (See also PI.03.01.01, EP 2)
   
   Note: This element of performance is also applicable to sample medications.

6. The organization evaluates its actions to confirm that they resulted in improvements for its medication management processes.

7. The organization takes action when planned improvements for its medication management processes are either not achieved or not sustained.

8. The primary pharmacy includes input from the long term care facility when evaluating its medication management system.

9. The long term care pharmacy or consultant pharmacist provides education to the long term care facility regarding the processes to reduce medication errors.
11. The long term care pharmacy or consultant pharmacist provides education to the long term care facility regarding the collection and use of medication management performance measures.

12. The long term care pharmacy or consultant pharmacist provides education to the long term care facility regarding processes to minimize medication waste.

13. The clinical or consultant pharmacist provides a written report regarding identified medication management problems to the long term care clinical and administrative leaders, and to other health professionals responsible for dispensing medications.

14. The clinical or consultant pharmacist helps to prioritize and develop an action plan to resolve problems associated with medication management.

15. In collaboration with the long term care facility, the primary pharmacy implements improvements to its medication management processes based on its evaluation.

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

**Please note:** Tips do not represent new accreditation requirements. They are intended to provide helpful strategies for standards compliance.

Are medication orders clear and complete, including patient name, date, medication name, dose, route of administration, and frequency of administration? If it is a PRN medication, does it specify when the medication should be used? Are the names spelled correctly? (MM.04.01.01)

**TIP:** The organization is required to have a written policy that addresses the required elements of a medication order (see MM.04.01.01). Check the organization’s policy to make sure it includes each of the elements, and then check a random sample of written orders to see if they meet the policy.

What is the organization’s policy regarding “PRN” medication orders? Does the organization’s policy meet current standards of practice when documenting PRN medication orders? Can staff explain how PRN orders must be documented in accordance with organization policy? (MM.04.01.01)

Which medications has the organization identified as high-alert or hazardous medications? (MM.01.01.03)
Can staff members find the organization’s medication policies, including the list of “look-alike/sound-alike” medications? (MM.01.02.01)

What is the organization’s process at the time of patient transfer or admission to home care? (MM.03.01.05; see also NPSG.03.06.01 in the “National Patient Safety Goals” [NPSG] chapter)

**TIP:** At the time of transfer, use a medication reconciliation tool and ensure that your process addresses the following:
1. New orders are required at any transfer (level of care, setting). Note that “continue all meds” is not an appropriate order.
2. The physician must indicate whether to continue, stop, or change for each medication.
3. A comprehensive list of all ordered medications should be reviewed and reconciled with any other previous list and with other medications in the home.

Who in the organization is authorized to administer medications? (MM.06.01.01, MM.06.01.03)

Does your patient education program regarding medications include the following:
- Assessment of patient’s financial resources for purchasing medications?
- Determination of patient/caregiver literacy (the ability to read, understand, and act on health information)?
Identification of any barrier(s) to learning, such as health literacy, depression, or other causes?
• Development of an effective education plan?

**Hospice/pharmacy organizations:** What does the organization teach patients and families to do with extra or expired medications (including narcotics) on the discharge or death of a patient? (MM.05.01.19)

**Pharmacy organizations:** When reviewing prescriptions and orders, what do the pharmacists look for in each prescription or medication order? (MM.04.01.01, MM.05.01.01)

**Pharmacy organizations:** When preparing medications, what information is required to be on each label? (MM.05.01.09)

**TIP for deemed-status hospice organizations:** There are a number of standards in the MM chapter that are specific to both inpatient and home hospice settings. These standards focus on, but are not limited to, the following areas:

• Storage of medications (MM.03.01.01)
• Medication orders (MM.04.01.01)
• Management of returned medications (MM.05.01.19)
**Written Documentation Checklist**

This worksheet lists elements of performance (EPs) that require written documentation that a surveyor could ask to see during a survey to show compliance with a standard.

*(Note: Documentation can be on paper or in an electronic format.)*

### Medication Management (MM)

<table>
<thead>
<tr>
<th>✓</th>
<th>Standard</th>
<th>EP</th>
<th>Medication Management Standards</th>
<th>Home Care Service</th>
<th>Date last verified</th>
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|   | MM.01.01.01 | 1  | EP 1—The organization has a written policy that describes that the following information about the patient is accessible to 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 | HH, HOS, CRS, PH |  |
|   | MM.01.01.03 | 1  | EP 1—The organization identifies, in writing, its high-alert and hazardous medications. | HH, HOS, CRS, PH |  |
|   | MM.01.02.01 | 1  | EP 1—The organization develops a list of look-alike/sound-alike medications it stores, dispenses, or administers. | HOS (F), PH |  |
|   | MM.02.01.01 | 4, 12 | EP 4—The organization maintains a written list of medications, including strength and dosage, for dispensing and administering.  
EP 12—The organization develops and approves written medication substitution protocols to be used in the event of a medication shortage or outage. | EPs 4, 12—HOS, PH (except CCP) |  |
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<th>Document Section</th>
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<tr>
<td>MM.03.01.01</td>
<td>4, 23</td>
<td>EP 4—For organizations that store medications at their site(s): The organization has a written process addressing the control of the medication between receipt by the organization and delivery to or administration at the designated site.</td>
<td>EP 4—HH, HOS, CRS, PH (except CCP)</td>
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<td>MM.04.01.01</td>
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<td>EP 1—For organizations that prescribe or receive medication orders verbally or via telephone, fax, or electronic media: The organization has a written policy that identifies the specific types of medication orders or prescriptions that it deems acceptable for use. EP 2—For organizations that prescribe or receive medication orders verbally or via telephone, fax, or electronic media: The organization has a written policy that defines the following: The required elements of a complete medication order. EP 4—For organizations that prescribe or receive medication orders verbally or via telephone, fax, or electronic media: The organization has a written policy that defines the following: The precautions for ordering medications with look-alike or sound-alike names. EP 5—For organizations that prescribe or receive medication orders verbally or via telephone, fax, or electronic media: The organization has a written process for staff to follow when medication orders or prescriptions are incomplete, illegible, or unclear.</td>
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<td>MM.05.01.01</td>
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<td>EP 14—For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option: The hospice has a written policy on dispensing accuracy.</td>
<td>Deemed HOS (F)</td>
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Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
| MM.05.01.17 | 1 | EP 1—The organization has a written policy describing how it will retrieve and handle medications within the organization that are recalled or discontinued for safety reasons by the manufacturer or the US Food and Drug Administration (FDA). | HOS, DISP, FAI, LTP |
| MM.05.01.19 | 5, 8 | EP 5—For hospices that elect to use The Joint Commission deemed status option: The hospice has written policies and procedures for the management and disposal of controlled medications in the home that are no longer needed by the patient. EP 8—For hospices that elect to use The Joint Commission deemed status option: The hospice keeps current and accurate records of the receipt and disposition of all controlled medications. | EP 5—Deemed HOS (F) EP 8—Deemed HOS |
| MM.06.01.01 | 1 | The organization defines, in writing, 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) Note: For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option: Medications are administered only by the following: A licensed nurse; a licensed physician; a health care professional in accordance with his or her scope of practice and state law; an employee who has completed a state-approved training program in medication administration; or the patient, upon approval by the interdisciplinary group. These individuals and each medication they are authorized to administer are specified in the patient’s plan of care. | HH, HOS, CRS, FAI (see Note for Deemed HOS [F]) |
| MM.06.01.03 | 1 | If self-administration of medications is allowed by patients or families, 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. | HOS |
| MM.06.01.05 | 1 | The organization has a written process addressing the use of investigational medications that includes review, approval, supervision, and monitoring. | HH, HOS, CRS, PH |
| MM.07.01.03  | 1, 2 | EP 1—The organization has a written process to respond to actual or potential adverse drug events, significant adverse drug reactions, and medication errors. EP 2—The organization has a written process addressing prescriber notification in the event of an adverse drug event, significant adverse drug reaction, or medication error. | EPs 1, 2—HH, HOS, CRS, PH |
| MM.08.01.01  | 13, 16 | EP 13—The clinical or consultant pharmacist provides a written report regarding identified medication management problems to the long term care clinical and administrative leaders, and to other health professionals responsible for dispensing medications. EP 16—When automatic dispensing cabinets (ADC) are used, the organization has a policy that describes the types of medication overrides that will be reviewed for appropriateness and the frequency of the reviews. A 100% review of overrides is not required. | EP 13—CCP | EP 16—HOS (F), DISP, FAI, LTP |
## Action Planning Tool

Use this form to track noncompliant elements of performance (EPs) and your action steps for bringing them into compliance.

<table>
<thead>
<tr>
<th>Standard and EP</th>
<th>Observation/Issue</th>
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Chapter Notes

Use this page to take notes about ideas for meeting the standards in this chapter, your organization’s policies and procedures that address requirements in this chapter, or the data or patient record numbers used to determine compliance or noncompliance for EPs. If a standard is found not compliant, it can be helpful to know which data were used so they can be easily accessed when developing action plans for compliance.
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)

II. Goal 3—Improve the safety of using medications.
    A. Reconciling Medication Information (NPSG.03.06.01)

III. Goal 7—Reduce the risk of health care–associated infections.
     A. Meeting Hand Hygiene Guidelines (NPSG.07.01.01)

IV. Goal 9—Reduce the risk of patient harm resulting from falls.
    A. Implementing a Fall Reduction Program (NPSG.09.02.01)

V. Goal 15—The organization identifies safety risks inherent in its patient population.
   A. Not applicable to home care (NPSG.15.01.01)
   B. Identifying Risks Associated with Home Oxygen (NPSG.15.02.01)
**Applicability for National Patient Safety Goals**

This grid is meant to be a resource to determine which standards and elements of performance (EPs) apply to the service categories within the Home Care Accreditation Program. The column on the far left of the grid lists the related EPs vertically by number. Service categories (defined in Table 3 of the Introduction) are listed horizontally along the top of the grid. Applicability is indicated with an “X” in a service category column.

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Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
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, or services.

Note: In the home care setting, patient identification is less prone to error than in other settings. At the first encounter, the requirement for two identifiers is appropriate; thereafter, and in any situation of continuing one-on-one care in which the clinician “knows” the patient, one of the identifiers can be facial recognition. In the home, the correct address is also confirmed. The patient’s confirmed address is an acceptable identifier when used in conjunction with another individual-specific identifier.

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. R

2. Label containers used for blood and other specimens in the presence of the patient. R
Goal 3
Improve the safety of using medications.

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, or 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. ① Obtain and/or update information on the medications the patient is currently taking. This information is documented in a list or other format that is useful to those who manage medications. ③

   **Note 1:** The organization obtains the patient’s medication information during the first contact. The information is updated when the patient’s medications change.

   **Note 2:** Current medications include those taken at scheduled times and those taken on an as-needed basis. See the Glossary for a definition of medications.

   **Note 3:** It is often difficult to obtain complete information on current medications from 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 (for example, name, dose, route, frequency, purpose) to be collected in different settings and patient circumstances. 

3. Compare the medication information the patient is currently taking with the medications ordered for the patient in order to identify and resolve discrepancies. 

   **Note:** Discrepancies include omissions, duplications, contraindications, unclear information, and changes. A qualified individual, identified by the organization, 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 leaves the organization’s care (for example, name, dose, route, frequency, purpose). 

   **Note:** When the only additional medications prescribed are for a short duration, the medication information the organization provides 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. 

   **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 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, or 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 5)

2. Set goals for improving compliance with hand hygiene guidelines. (See also IC.03.01.01, EP 3)

3. Improve compliance with hand hygiene guidelines based on established goals.

Goal 9

Reduce the risk of patient harm resulting from falls.

NPSG.09.02.01

Reduce the risk of falls.

Rationale for NPSG.09.02.01

Falls account for a significant portion of injuries in hospitalized patients, long term care residents, and home care recipients. In the context of the population it serves, the services it provides, and its environment of care, the organization should evaluate the patient’s risk for falls and take action to reduce the risk of falling as well as the risk of injury, should a fall occur. The evaluation could include a patient’s fall history; review of medications and alcohol consumption; gait and balance screening; assessment of walking aids, assistive technologies, and protective devices; and environmental assessments.
Elements of Performance for NPSG.09.02.01

1. Assess the patient’s risk for falls.  
2. Implement interventions to reduce falls based on the patient’s assessed risk.  
3. Educate staff on the fall reduction program in time frames determined by the organization.  
4. Educate the patient and, as needed, the family on any individualized fall reduction strategies.  
5. Evaluate the effectiveness of all fall reduction activities including assessment, interventions and education.  

**Note:** Examples of outcome indicators to use in the evaluation include decreased number of falls and decreased number and severity of fall-related injuries.

**Goal 15**
The organization identifies safety risks inherent in its patient population.

**NPSG.15.02.01**
Identify risks associated with home oxygen therapy such as home fires.

**Rationale for NPSG.15.02.01**
A critical aspect of safe patient care at home relates to the use of oxygen. Oxygen administration presents a high risk for fire due to the acceleration of flame that oxygen causes in the presence of flammable substances (such as upholstery and clothing) and open flames (such as candles, gas appliances, and smoking materials). Smoking is a major reason for burn incidents involving home medical oxygen therapy. Oxygen cylinders that are not safely stored create risks for fire and explosion; standards addressing storage of cylinders are included in the “Environment of Care” (EC) chapter.

The Joint Commission has reviewed more than 40 sentinel events for home health care patients who were either injured or killed as a result of a fire in the home. A Sentinel Event Alert (#17) was issued on March 1, 2001 that outlines risk factors, root causes, and risk-reduction strategies for this serious patient safety problem.
This NPSG addresses the importance of a home oxygen assessment that identifies potential safety risks in the environment. Patients and families need to understand and modify behaviors that could lead to a serious safety event. For that reason, home care agencies that interact with their patients have a responsibility to reduce risk by assessing the environment and educating the patient and family. Issues to consider in both the home risk assessment and in patient and family education include whether or not the patient lives alone, the patient’s cognitive ability, and whether individuals smoke in the home.

An oxygen safety risk assessment should be conducted before starting oxygen therapy in the home and when home care services are initiated. However, when more than one organization provides services in the home, it is the responsibility of each organization to assess potential fire risks when its staff enters the home.

**Elements of Performance for NPSG.15.02.01**

1. ◊ Conduct a home oxygen safety risk assessment before starting oxygen therapy in the home and when home care services are initiated that addresses at least the following: 
   - Whether there are smoking materials in the home
   - Whether or not the home has functioning smoke detectors

   **Note:** Home care staff may ask the patient and family whether smoke detectors are functioning or may test the smoke detectors if they are accessible. However, testing smoke detectors is not required.
   - Whether there are other fire safety risks in the home, such as the potential for open flames

   *Document the performance of the risk assessment. (For more information on coordination among different providers of care, refer to PC.02.02.01, EPs 1 and 10, and PC.02.03.01, EP 5.)*

2. ◊ Reevaluate potential fire risks at intervals established by the organization. Evidence of unsafe practices leading to potential risk is used to establish these intervals. Document the reevaluation of potential fire risks.

3. ◊ Inform and educate the patient, family, and/or caregiver about the following:
   - The findings of the safety risk assessment
   - The causes of fire
   - Fire risks for neighboring residences and buildings
- Precautions that can prevent fire-related injuries
- Recommendations to address the specific identified risk(s)

Document the provision of information and education. (For more information on coordination among different providers of care, refer to PC.02.02.01, EPs 1 and 10, and PC.02.03.01, EP 5.)

4. ⑤ Assess the patient’s, family’s, and/or caregiver’s level of comprehension of identified risks and compliance with suggested interventions during home visits. Document this assessment. R

5. ⑤ Implement strategies to improve patient and/or family compliance with oxygen safety precautions when unsafe practices are observed in the home. This includes notifying the licensed independent practitioner ordering the oxygen. Document the implementation of strategies to address compliance. R

Note: Other strategies to be considered include additional education, placing written reminders in specific locations, and exploring alternative living arrangements with the patient and family.
Prompts to Assess Your Compliance

Please note: Tips do not represent new accreditation requirements. They are intended to provide helpful strategies for standards compliance.

Have staff members been educated about the NPSG that are applicable to home care? Where can staff access information about the NPSG?

What is one example of when a staff member has to use at least two patient identifiers? (NPSG.01.01.01)

Which home care services does NPSG.03.06.01 apply to? What is your organization’s policy/process for medication reconciliation? Does it meet the requirements of the NPSG.03.06.01?

TIP: Review your organization’s policy/process, and then observe a clinician on a start-of-care visit and another clinician on a repeat visit. Are they performing medication reconciliations at appropriate times and including all necessary information? If the policy/process does not reflect the requirements or the work being done by the staff, make appropriate revisions and repeat the observations.
What set of hand hygiene guidelines has the organization implemented with its staff? (NPSG.07.01.01)
- What is the organization’s goal for improving hand hygiene compliance?
- How is hand hygiene being monitored?

**TIP:** Be prepared to discuss the organization’s hand-hygiene program, the goals set for improvement, and how hand hygiene is being monitored.

What type of fall-risk program has the organization developed and implemented? What type of education is provided to both staff and patients concerning fall risks? (NPSG.09.02.01)

**TIP:** Note that NPSG.09.02.01 applies to all home-based services in home care, with the exception of the pharmacy. This includes home health, personal care and support, hospice (inpatient and patient residence); durable medical equipment (home); respiratory, orthotics and prosthetics (home); clinical respiratory services, and rehabilitation technology (home). The fall-risk program has several requirements for each service line.

When a patient in your organization has an order for home oxygen, what is your policy/process for completing an initial home oxygen safety assessment? (NPSG.15.02.01)
- Consider this scenario: A home health organization contacts a durable medical equipment company to deliver oxygen for a patient. According to your organization’s policy/process, who is responsible for completing a home oxygen safety assessment?
- In this scenario, who does the ongoing assessments and education of the patient and family concerning oxygen safety?

TIP: If you partner with a durable medical equipment company to deliver oxygen and supplies for your patients, develop an agreement (or contract) with them concerning their role in addressing oxygen safety, including the initial and ongoing safety assessments, patient education, and methods of documentation and communication concerning the patient.
Written Documentation Checklist
This worksheet lists elements of performance (EPs) that require written documentation that a surveyor could ask to see during survey to show compliance with a standard.
(Note: Documentation can be on paper or in an electronic format.)

National Patient Safety Goals (NPSG)

<table>
<thead>
<tr>
<th>✓</th>
<th>Standard</th>
<th>EP</th>
<th>National Patient Safety Goals Standards</th>
<th>Home Care Service</th>
<th>Date last verified</th>
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<tr>
<td></td>
<td>NPSG.03.06.01</td>
<td>1, 4</td>
<td>EP 1—Obtain and/or update information on the medications the patient is currently taking. This information is documented in a list or other format that is useful to those who manage medications. EP 4—Provide the patient (or family as needed) with written information on the medications the patient should be taking when he or she leaves the organization’s care (for example, name, dose, route, frequency, purpose).</td>
<td>EPs 1, 4—HH, HOS, CCP, FAI</td>
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<td>NPSG.15.02.01</td>
<td>1–5</td>
<td>EP 1—Conduct a home oxygen safety risk assessment before starting oxygen therapy in the home and when home care services are initiated that addresses at least the following: ▪ Whether there are smoking materials in the home ▪ Whether or not the home has functioning smoke detectors ▪ Whether there are other fire safety risks in the home, such as the potential for open flames Document the performance of the risk assessment. EP 2—Reevaluate potential fire risks at intervals established by the organization. Evidence of unsafe practices leading to potential risk is used to establish these intervals. Document the reevaluation of potential fire risks.</td>
<td>EPs 1–5—HH, HOS (H), DME (H), RESP, CRS</td>
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EP 3—Inform and educate the patient, family, and/or caregiver about the following:
- The findings of the safety risk assessment
- The causes of fire
- Fire risks for neighboring residences and buildings
- Precautions that can prevent fire-related injuries
- Recommendations to address the specific identified risk(s)

Document the provision of information and education.

EP 4—Assess the patient’s, family’s, and/or caregiver’s level of comprehension of identified risks and compliance with suggested interventions during home visits. Document this assessment.

EP 5—Implement strategies to improve patient and/or family compliance with oxygen safety precautions when unsafe practices are observed in the home. This includes notifying the licensed independent practitioner ordering the oxygen. Document the implementation of strategies to address compliance.

EP 3—Also includes HOS (F)
**Action Planning Tool**

Use this form to track noncompliant elements of performance (EPs) and your action steps for bringing them into compliance.

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<th>Observation/Issue</th>
<th>Action Step</th>
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Chapter Notes

Use this page to take notes about ideas for meeting the standards in this chapter, your organization’s policies and procedures that address requirements in this chapter, or the data or patient record numbers used to determine compliance or noncompliance for EPs. If a standard is found not compliant, it can be helpful to know which data were used so they can be easily accessed when developing action plans for compliance.
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 organization’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, or 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, or services is composed of four core components of the care process:
- Assessing patient needs
- Planning care, treatment, or services
- Providing care, treatment, or services
- Coordinating care, treatment, or 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, or 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, or 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 organization care process to discharge or transfer.

This chapter addresses the following:

- Accepting the patient for care, treatment or services
- Assessing and reassessing the patient
- Planning the patient’s care
- Providing the patient with care, treatment, or services
- Coordinating the patient’s care, treatment, or services
- Providing the patient with education
- Meeting the patient’s need for continuing care, treatment, or 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.01.02.09)
   C. Planning Care (PC.01.03.01)

II. Implement
   A. Providing Care (PC.02.01.01, PC.02.01.03, PC.02.01.05, PC.02.01.07)
   B. Coordinating Care (PC.02.02.01, PC.02.02.03, PC.02.02.05, PC.02.02.13)
   C. Patient Education (PC.02.03.01)

III. Special Conditions
   A. Restraint and Seclusion for Deemed Status (PC.03.05.01, PC.03.05.03,
      PC.03.05.05, PC.03.05.07, 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)
Applicability for Provision of Care, Treatment, and Services

This grid is meant to be a resource to determine which standards and elements of performance (EPs) apply to the service categories within the Home Care Accreditation Program. The column on the far left of the grid lists the related EPs vertically by number. Service categories (defined in Table 3 of the Introduction) are listed horizontally along the top of the grid. Applicability is indicated with an “X” in a service category column.

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Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
### Comprehensive Accreditation Manual for Home Care

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**PC – 6**

CAMHC, January 2018
### Provision of Care, Treatment, and Services

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Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
Standards, Rationales, and Elements of Performance

Standard PC.01.01.01

The organization accepts the patient for care, treatment, or services based on its ability to meet the patient’s needs.

Elements of Performance for PC.01.01.01

1. The organization has a written process for accepting a patient that is based on its ability to provide the care, treatment, or services required by the patient.

The organization has a written process for accepting a patient that includes the following:

2. Criteria to determine the patient’s eligibility for care, treatment, or services.


7. The organization follows its written process for accepting a patient for care, treatment, or services.

9. The hospice verifies with the patient’s physician that the patient has a terminal illness with a limited prognosis.

10. The hospice verifies with the patient and family that they are choosing hospice services.

11. The hospice verifies with the patient and family that they are choosing palliative, rather than curative, care or treatment.

13. **For home health agencies that elect to use The Joint Commission deemed status option:** The organization accepts patients for care, treatment, and services on the reasonable expectation that the organization can meet the patient’s medical, nursing, rehabilitative, and social needs in his or her place of residence.

14. **For hospices that elect to use The Joint Commission deemed status option:** The hospice accepts a patient for care under Medicare only when the patient is entitled to Medicare Part A and a physician certifies that the patient is terminally ill.
16. The hospice establishes criteria describing its primary patient caregiver designation requirements.

17. To improve its community’s access to care, the hospice, at least annually, evaluates the patient population it serves and its process for accepting patients.

48. **For hospices that elect to use The Joint Commission deemed status option:** The medical director or physician designee reviews the clinical information for each hospice patient and provides written certification that the patient’s life expectancy is six months or less if the illness runs its normal course.

   **Note:** *The determination of the patient’s life expectancy considers the following factors:*
   - The primary terminal condition
   - Related diagnoses, if any
   - Current subjective and objective medical findings
   - Current medication and treatment orders
   - Information about the medical management of the patient’s conditions unrelated to the terminal condition

49. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program has a process to identify patients for whom community-based palliative care services are indicated and communicates this to appropriate staff and interdisciplinary team members.

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**Introduction to Standard PC.01.02.01**

The goal of assessment is to determine the care, treatment, or services that will meet the patient’s initial and continuing needs. Patient needs must be reassessed throughout the course of care, treatment, or services.

Identifying and delivering the right care, treatment, or 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, or services.
3. Making care, treatment, or 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, or services provided. Assessment activities may vary between settings, as defined by the organization’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, or services sought; the patient’s presenting condition(s); and whether the patient agrees to the recommended care, treatment, or services.

**Standard PC.01.02.01**

The organization assesses and reassesses its patients.

**Rationale for PC.01.02.01**

For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The members of the palliative care interdisciplinary team are responsible for conducting and documenting a timely initial patient assessment. The information gathered during this assessment forms the basis of the patient and family’s plan of care. The elements of performance (EPs) in PC.01.02.01 for Community-Based Palliative Care certification specify the types of assessments that are to be conducted by the interdisciplinary team members.

Palliative care is characterized by the provision and coordination of care by an interdisciplinary team. Although the program team members are required to perform a coordinated, comprehensive assessment for each patient, the scope of this assessment is defined by the organization and based on the needs of the individual patient and family. Each organization’s interdisciplinary team, along with its leaders, need to decide what type(s) of assessment(s) they will require, and which team members are to conduct and document these assessments.

Depending on the type of program and the services it provides, not every patient that is referred for palliative care services may be required to have an assessment by a representative of each discipline on the team. For example, the organization may decide that the clinician performing the initial assessment determines whether the patient needs an assessment by the chaplain on the team, as they may already be meeting with their own pastor or spiritual care provider; or, the patient may refuse other services and assessments provided by other members of the team. However, if the organization
decides that each palliative care patient is required to be assessed by each of the four disciplines required on the core team, then these assessments must be completed and documented in each patient’s medical record in order to be in compliance with their own process and the EPs found in PC.01.02.01.

**Elements of Performance for PC.01.02.01**

1. The organization defines, in writing, the scope and content of screening, assessment, and reassessment information it collects. Patient information is collected according to these requirements. *(See also RC.02.01.01, EP 2)*

   **Note:** 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.

2. The organization defines, in writing, criteria that identify when additional, specialized, or more in-depth assessments are performed. *(See also PC.01.02.07, EP 1)*

   **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.

5. Based on the patient’s condition and the care, treatment, or services it provides, the organization defines, in writing, which of the following information it collects in the patient’s assessment and reassessment:
   - Pertinent diagnoses
   - Pertinent physical findings
   - Pertinent medical history
   - Functional status
   - Psychosocial status
   - Cultural or religious practices that may affect care
   - Care the family or support system is capable of and willing to provide
   - Educational needs, including the abilities, motivation, and readiness to learn
   - Barriers and safety hazards in the home environment
   - Any other relevant information that may affect the patient’s goals

6. Based on the patient’s condition and the care, treatment, or services it provides, the organization defines, in writing, which of the following information it collects in the patient’s assessment and reassessment:
   - Pertinent prognosis
Laboratory values
Medication history, including drug allergies, drug sensitivities, medication compliance, and past adverse drug reactions
Current medication use, including prescribed and over-the-counter medications

For hospice organizations that elect to use The Joint Commission deemed status option: Current medication use also includes herbal remedies, other alternative treatments that could affect drug therapy, and drug therapy currently associated with laboratory monitoring.

Nutritional status
Diet, including the therapeutic regimen, if any, reason for the therapeutic regimen, and its route of administration
Medical equipment in the home

7. The hospice’s written definition of information the organization collects during assessment and reassessment includes the following:

- The severity of symptoms
- Factors that alleviate or exacerbate physical symptoms
- The comfort level of a patient who chooses not to take nutrition therapy
- Patient and family spiritual orientation, including their desire for the involvement of a religious group
- Spiritual concerns or needs identified by the patient or family, such as despair, suffering, guilt, and forgiveness
- Patient and family involvement in a support group, if any
- Additional information about the patient’s psychosocial status, such as family relationships, social history, the source and adequacy of environmental and other resources, coping mechanisms, and the patient’s and family’s reactions to illness
- The need for volunteer services to offer support or respite to the patient, family, or other caregivers
- The need for an alternative setting or level of care
- Anticipated discharge needs, including bereavement and funeral needs
- Survivor risk factors, such as the nature of the relationship with the patient, circumstances surrounding the death, behaviors before and after the death, availability of coping mechanisms, and potential for pathological grief reactions
- **For hospices that elect to use The Joint Commission deemed status option:**
  Cultural factors that may impact the patient’s and family’s ability to cope with the patient’s death

- **For hospices that elect to use The Joint Commission deemed status option:**
  The need for referral to and evaluation by other health professionals

8. ☐ Based on the care, treatment, or services it provides, the pharmacy’s written definition of data and information collected during assessment and reassessment includes the following:
   - Pertinent prognosis (not applicable for pharmacy dispensing services or for clinical/consultant pharmacist services)
   - Nutritional status
   - Any equipment required for administering medication
   - Dietary intake related to allergies or drug-food interactions
   - Information contained in Standard MM.01.01.01 (See also MM.01.01.01, EP 1)

9. ☐ The home medical equipment or rehabilitation technology service’s written definition of data and information collected during assessment and reassessment includes any medical equipment the patient uses.

11. **For hospices that elect to use The Joint Commission deemed status option:** The organization assesses potential medication-related problems, including adverse effects, drug reactions, significant side effects, and significant drug interactions, including ineffective drug therapy, duplicate drug therapy, and noncompliance with drug therapy.

12. ☐ **For home health agencies that elect to use The Joint Commission deemed status option:** The home health agency’s comprehensive assessment must include the current version of the Outcome and Assessment Information Set (OASIS) items as follows:
   - Patient (clinical) record items
   - Demographics and patient history
   - Living arrangements
   - Supportive assistance
   - Sensory status
   - Integumentary status
   - Respiratory status
   - Elimination status

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- Neuro/emotional/behavioral status
- Activities of daily living
- Medications
- Equipment management
- Emergent care
- Data items collected at inpatient facility admission or discharge

25. **For home health agencies that elect to use The Joint Commission deemed status option:** The comprehensive assessment must accurately reflect the patient’s status and include, at a minimum, the following patient information:

- Current health, psychosocial, functional, and cognitive status
- Strengths, goals, and care preferences, including information that may be used to demonstrate the patient’s progress toward achievement of his or her goals and the measurable outcomes identified by the organization
- Continuing need for home care
- Medical, nursing, rehabilitative, social, and discharge planning needs
- A review of all current medications in order to identify potential medication-related problems, including adverse effects, drug reactions, significant side effects, and significant drug interactions, including ineffective drug therapy, duplicate drug therapy, and noncompliance with drug therapy
- Primary caregiver(s), if any, and other available supports, including their willingness and ability to provide care, availability, and schedules
- Patient’s representative (if any)
- Incorporation of the current version of the Outcome and Assessment Information Set (OASIS) items

*(See also PC.01.02.01, EP 12)*

29. **For custom orthotics and prosthetics services:** The organization performs an in-person diagnosis-specific functional clinical examination for the use of custom orthotics and prosthetics.

**Note:** Such an exam could include sensory function, range of motion, joint stability, skin condition (integrity, color, temperature), presence of edema and wounds, vascularity, pain, manual muscle testing, compliance, cognitive ability, and medical history.

30. **For DMEPOS suppliers serving Medicare beneficiaries:** The organization evaluates seating, positioning, and specialty assistive technology to verify that they meet the beneficiary’s needs.
31. **For DMEPOS suppliers serving Medicare beneficiaries:** The organization assesses the beneficiary’s need for and use of custom orthotics or prosthetics, previous use of a custom orthotic or prosthetic, results of diagnostic evaluations, and beneficiary expectations.

32. **For DMEPOS suppliers serving Medicare beneficiaries:** The organization determines the appropriate custom orthotic or prosthetic and specifications. The determination is based on the therapeutic benefits the beneficiary hopes to achieve and on the strength, durability, and function needed by the beneficiary for the custom orthotic or prosthetic being considered.

33. **For hospices that elect to use The Joint Commission deemed status option:** The hospice’s written definition of data and information to be collected during the initial assessment includes the patient’s need for hospice care and services. This assessment includes all areas of hospice care related to the palliation and management of terminal illness and related conditions.

34. **For hospices that elect to use The Joint Commission deemed status option:** The hospice’s written definition of data and information to be collected during the comprehensive assessment includes the following:
   - The patient’s physical, psychosocial, emotional, and spiritual needs related to the terminal illness that must be addressed in order to promote the patient’s well-being, comfort, and dignity throughout the dying process
   - The nature of the condition causing the patient’s admission to the hospice program, including the presence or absence of objective data and subjective complaints
   - Complications and risk factors that affect care planning
   - Functional status, including the patient’s ability to understand and participate in his or her care
   - Imminence of death

35. **For hospices that elect to use The Joint Commission deemed status option:** The hospice’s written definition of data and information to be collected during the comprehensive assessment includes data elements that measure outcomes and that can be documented in the same way for all patients.

   **Note:** These data elements must take into consideration aspects of both hospice and palliative care.

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36. **For hospices that elect to use The Joint Commission deemed status option:** The hospice’s interdisciplinary group updates the comprehensive assessment in collaboration with the patient’s attending physician, if any, as frequently as the patient’s condition requires, but no less than every 15 days.

37. **For hospices that elect to use The Joint Commission deemed status option:** The update of the comprehensive assessment is based on changes that have taken place since the initial assessment and includes information about the patient’s progress toward desired outcomes and a reassessment of the patient’s response to care.

38. **For hospices that elect to use The Joint Commission deemed status option:** Before the recertification period for each patient, the medical director or physician designee reviews the patient’s clinical information.

44. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The patient’s preferences about how he or she wants to receive information is communicated to staff across the care continuum who are involved in the patient’s care.

45. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** Program staff evaluate and revise the plan of care to meet the patient’s and family’s ongoing needs and document the revisions in the patient’s medical record.

46. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** A member of the interdisciplinary team conducts and documents an initial patient assessment, including a clinical assessment that is defined by the program and based on the patient’s needs.

47. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** As part of the initial assessment, the interdisciplinary team assesses and documents the patient’s pain, dyspnea, constipation, and other symptoms; standardized scales should be used when they are available. The scope of this assessment is defined by the program and based on patient needs.

48. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** As part of the initial assessment, the interdisciplinary team assesses and documents the patient’s functional status. The scope of this assessment is defined by the program and based on patient needs.
49. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** As part of the initial assessment, the interdisciplinary team completes and documents a psychosocial assessment of the patient and family. The scope of this assessment is defined by the program and based on patient needs.

50. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** As part of the initial assessment, the interdisciplinary team identifies and documents the cultural, spiritual, and religious beliefs and practices important to the patient and family that influence care, treatment, and services. The scope of this assessment is defined by the program and based on patient needs.

51. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** As part of the initial assessment, the interdisciplinary team assesses and documents the patient’s anxiety, stress, grief, coping, and other psychological symptoms using standardized scales when they are available. The scope of this assessment is defined by the program and based on patient needs.

52. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** For programs that provide care for pediatric patients: Assessment of infants, children, and adolescents must consider both the age and cognitive development of the patient.

**Standard PC.01.02.03**
The organization 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 organization 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 organization 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, or services; response to previous care, treatment, or services; and/or his or her setting requirements.

10. **For home health agencies that elect to use The Joint Commission deemed status option:** The initial assessment visit must be held within 48 hours of referral, or within 48 hours of the patient’s return home, or on the physician-ordered start-of-care date.

11. **For home health agencies that elect to use The Joint Commission deemed status option:** At the time of the initial assessment visit and at the time of the comprehensive assessment, the organization provides a patient-specific, comprehensive assessment, and verifies each patient’s eligibility, including homebound status, for the Medicare home health benefit. *(See also PC.01.02.05, EPs 4 and 5)*

12. **For home health agencies that elect to use The Joint Commission deemed status option:** The organization completes the comprehensive assessment within time frames that meet the patient’s needs, but no later than five calendar days after the start of care.

13. **For home health agencies that elect to use The Joint Commission deemed status option:** The comprehensive assessment updated and revised (including administration of the Outcome and Assessment Information Set [OASIS]) as frequently as the patient’s condition warrants due to a major decline or improvement in the patient’s health status, but no less frequently than the following:
   - The last 5 days of every 60 days beginning with the start-of-care date, unless there is a patient-elected transfer
   - A significant change in condition, or a discharge and return to the same home health agency within the 60-day episode
   - Within 48 hours of the patient’s return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests or the patient has a physician-ordered resumption date
   - At discharge

25. **For hospices that elect to use The Joint Commission deemed status option:** The hospice registered nurse completes the initial assessment of the patient within 48 hours of the election of hospice care. The hospice complies with any request by the physician, patient, or representative to conduct the assessment in less than 48 hours.
26. **For hospices that elect to use The Joint Commission deemed status option:** The hospice’s interdisciplinary group, in consultation with the patient’s attending physician, if any, completes the comprehensive assessment no later than five calendar days after the election of hospice care.

27. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The interdisciplinary team completes the initial assessment within its defined time frame.

28. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The interdisciplinary team reassesses the patient on a regular basis, including whenever there is a change in the patient’s condition or goals, when there is a change in the patient’s or family’s preferences, and as defined by the program. The reassessment is documented in the patient’s medical record.

29. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The interdisciplinary team assesses and then refers patients with symptoms of psychiatric diagnoses such as depression, anxiety, and suicidal ideation.

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**Standard PC.01.02.05**

Qualified staff or licensed independent practitioners assess and reassess the patient.

**Elements of Performance for PC.01.02.05**

2. **For home health agencies that elect to use The Joint Commission deemed status option:** A registered nurse conducts an initial assessment visit to determine the immediate care and support needs of the patient and determine eligibility for the Medicare home health benefit, including homebound status. (If physical therapy, occupational therapy, or speech-language pathology are the only services ordered, see also PC.01.02.05, EP 3)

3. **For home health agencies that elect to use The Joint Commission deemed status option:** The initial assessment visit may be made by an appropriate skilled rehabilitation professional (physical therapist, occupational therapist, or speech language pathologist) when rehabilitation therapy service (physical therapy, occupational therapy, or speech therapy) is the only service ordered by the physician responsible for the home health plan of care, and the need for that service establishes program eligibility.
4. **For home health agencies that elect to use The Joint Commission deemed status option:** A registered nurse completes the comprehensive assessment and determines eligibility for the Medicare home health benefit, including home-bound status, unless physical therapy, occupational therapy, or speech-language pathology are the only services ordered. (*See also* PC.01.02.03, EP 11)

5. **For home health agencies that elect to use The Joint Commission deemed status option:** When physical therapy, speech-language pathology, or occupational therapy is the only service ordered by a physician, a physical therapist, speech-language pathologist or occupational therapist may complete the comprehensive assessment and determine eligibility for the Medicare home health benefit, including homebound status. The occupational therapist may complete the comprehensive assessment if the need for occupational therapy establishes program eligibility. (*See also* PC.01.02.03, EP 11)

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**Standard PC.01.02.07**

The organization assesses and manages the patient’s pain.

**Rationale for PC.01.02.07**

The identification and management of pain is an important component of patient-centered care. Patients can expect that their health care providers will involve them in their assessment and management of pain. Both pharmacologic and nonpharmacologic strategies have a role in the management of pain. The following examples are not exhaustive, but strategies may include the following:

- **Nonpharmacologic strategies:** physical modalities (for example, acupuncture therapy, chiropractic therapy, osteopathic manipulative treatment, massage therapy, and physical therapy), relaxation therapy, and cognitive behavioral therapy
- **Pharmacologic strategies:** nonopioid, opioid, and adjuvant analgesics

**Elements of Performance for PC.01.02.07**

1. The organization conducts a comprehensive pain assessment that is consistent with its scope of care, treatment, or services and the patient’s condition. (*See also* PC.01.02.01, EP 2; RI.01.01.01, EP 8)

2. The organization uses methods to assess pain that are consistent with the patient’s age, condition, and ability to understand.

3. The organization reassesses and responds to the patient’s pain, based on its reassessment criteria.
4. The organization either treats the patient’s pain or refers the patient for treatment.

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

**Standard PC.01.02.09**
The organization assesses the patient who may be a victim of possible abuse and neglect or exploitation.

**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, neglect or exploitation 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, neglect, or exploitation. By assessing patients who may be possible victims of abuse, neglect, or exploitation, health care organizations fulfill an important role in helping to protect patients.

**Elements of Performance for PC.01.02.09**

1. The organization 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, neglect, and exploitation. *(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, neglect, and exploitation, the organization maintains a list of private and public community agencies that can provide or arrange for assessment and care.

3. The organization educates staff about how to recognize signs of possible abuse, neglect, and exploitation and about their roles in follow-up. (See also HR.01.05.03, EP 5)

4. The organization uses its criteria to identify possible victims of abuse, neglect, and exploitation at the time of contact.

6. The organization internally reports cases of possible abuse, neglect, and exploitation. (See also RI.01.06.03, EP 3)

For hospice agencies that elect to use The Joint Commission deemed status option: These cases are reported immediately to the hospice administrator.

For home health agencies that elect to use The Joint Commission deemed status option: All home health staff must report findings of abuse, neglect, and exploitation to the organization.

7. The organization reports cases of possible abuse, neglect, and exploitation to external agencies, in accordance with law and regulation. (See also RI.01.06.03, EP 3)

Introduction to Standard PC.01.03.01
Planning for care, treatment, or services is individualized to meet the patient’s unique needs. The first step in the process includes creating an initial plan for care, treatment, or 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, or services; or the patient’s achievement of goals. The modification of the plan for care, treatment, or services may result in planning for the patient’s transfer to another setting or discharge.

Standard PC.01.03.01
The organization plans the patient’s care.
Elements of Performance for PC.01.03.01

1. The organization plans the patient’s care, treatment, or services based on needs identified by the patient’s assessment.

   **Note 1:** The patient’s strengths are considered along with his or her identified needs.

   **Note 2:** For organizations that provide personal care and support services: The plan of care may be a part of the service agreement or service contract, a list of duties to be carried out by the personal care or support service staff, or another separate document.

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.

10. **For home health agencies that elect to use The Joint Commission deemed status option:** The individualized plan of care specifies the care and services necessary to meet the needs identified in the comprehensive assessment and addresses the following:
   - All pertinent diagnoses
   - Mental, psychosocial, and cognitive status
   - Types of services, supplies, and equipment required
   - The frequency and duration of visits
   - The patient’s prognosis
   - The patient’s potential for rehabilitation
   - The patient’s functional limitations
   - The patient’s permitted activities
   - The patient’s nutritional requirements
   - All medications and treatments
   - Safety measures to protect against injury
   - A description of the patient’s risk for emergency department visits and hospital readmission
   - Patient-specific interventions and education
   - Patient and caregiver education and training to facilitate timely discharge
   - Goals and measurable outcomes that the organization anticipates will occur as a result of implementing and coordinating the plan of care
   - Information related to any advanced directives
   - Identification of the disciplines involved in providing care
   - Any other relevant items, including revisions and deletions

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11. **For custom orthotics and prosthetics services:** The organization establishes goals and expected outcomes for the patient.

   **Note:** Examples of goals or outcomes include reducing pain, increasing comfort, enhancing function and independence, providing joint stability, preventing deformity, increasing range of motion, addressing cosmetic issues, and promoting healing.

12. **For home health agencies that elect to use The Joint Commission deemed status option:** When a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the staff consults with the physician to approve additions or modifications to the original plan of care.

13. **For hospices that elect to use The Joint Commission deemed status option:** The interdisciplinary group, in consultation with the patient’s attending physician, if any, prepares a written plan of care. If the patient resides in a Skilled Nursing Facility (SNF), Nursing Facility (NF), or Intermediate Care Facility for the Mentally Retarded (ICF/MR), the interdisciplinary group consults with representatives of the SNF, NF, or ICF/MR when establishing the plan of care. (See also PC.02.01.05, EP 6)

15. **For hospices that elect to use The Joint Commission deemed status option:** The plan of care includes an assessment of the patient’s needs and an identification of the provided services, including the management of discomfort and symptom relief.

17. **For hospices that elect to use The Joint Commission deemed status option:** The hospice makes bereavement services available to the family and other individuals specified in the bereavement plan of care for up to one year following the death of the patient.

   **Note:** Bereavement counseling also extends to the residents of a Skilled Nursing Facility (SNF), Nursing Facility (NF), or Intermediate Care Facility for the Mentally Retarded (ICF/MR) when appropriate and identified in the bereavement plan of care.

18. **For hospices that elect to use The Joint Commission deemed status option:** The plan of care includes all services needed for the palliation and management of the terminal illness and related conditions, including the following:
   - Interventions to manage pain and symptoms
   - A statement of the scope and frequency of the services necessary to meet the patient’s and family’s needs
- Measurable outcomes anticipated from implementing and coordinating the plan of care
- Medications and treatment necessary to meet the patient’s needs
- Medical supplies and appliances necessary to meet the patient’s needs

19. All team members have access to the interdisciplinary plan of care. 

22. Based on the goals established in the patient’s plan of care, staff evaluate the patient’s progress.

23. The organization revises plans and goals for care, treatment, or services based on the patient’s needs. (See also RC.02.01.01, EP 2)

   **For home health agencies that elect to use The Joint Commission deemed status option:** The revised plan of care reflects current information from the patient’s updated comprehensive assessment and the patient’s progress toward goals and measurable outcomes.

24. **For hospices that elect to use The Joint Commission deemed status option:** The interdisciplinary group, in collaboration with the patient’s attending physician, if any, reviews and revises the plan of care as frequently as the patient’s condition requires, but no less frequently than every 15 calendar days. These reviews are documented.

29. **For DMEPOS suppliers serving Medicare beneficiaries:** The organization, in collaboration with the prescribing physician, reviews the patient’s record and incorporates information related to the patient’s condition(s) or to the actual equipment, supplies, or services provided.

30. **For home health agencies that elect to use The Joint Commission deemed status option:** The registered nurse, or other appropriate skilled professional who is responsible for supervision of the home health aide, prepares written patient care instructions that specify the duties of the home health aide.

   **Note:** The duties of the home health aide should not exceed those the aide is permitted to perform under state law.

31. **For hospices that elect to use The Joint Commission deemed status option:** The hospice makes reasonable efforts to arrange for visits of clergy and other members of religious organizations in the community to patients who request such visits.
32. **For hospices that elect to use The Joint Commission deemed status option:** The plan of care revisions are based on information from updates to the patient’s comprehensive assessment and address the patient’s progress toward goals and outcomes.

33. ⬤ **For hospices that elect to use The Joint Commission deemed status option:** A registered nurse who is a member of the interdisciplinary group and is responsible for hospice aide supervision prepares written patient care instructions for the hospice aide.

34. ⬤ **For hospices that elect to use The Joint Commission deemed status option:** A member of the interdisciplinary group prepares written instructions for the homemaker.

35. **For hospices that elect to use The Joint Commission deemed status option:** Medical social services are based on the patient’s psychosocial assessment, the patient’s and family’s needs, and their acceptance of these services.

36. **For hospices that elect to use The Joint Commission deemed status option:** Bereavement services reflect the needs of the bereaved.

37. **For hospices that elect to use The Joint Commission deemed status option:** The hospice develops a bereavement plan of care that specifies the type of bereavement services to be offered and the frequency of service delivery.

   **Note:** Bereavement counseling is a required hospice service but is not reimbursable.

38. **For hospices that elect to use The Joint Commission deemed status option:** The hospice provides spiritual counseling to meet the patient’s and family’s needs in a manner consistent with the patient’s and family’s beliefs and acceptance of this service.

39. **For hospices that elect to use The Joint Commission deemed status option:** The hospice care provided is consistent with the patient’s and family’s needs and goals, with the patient’s needs and goals taking priority.

40. **For hospices that elect to use The Joint Commission deemed status option:** For hospice care provided to a resident of a Skilled Nursing Facility (SNF), Nursing Facility (NF), or Intermediate Care Facility for the Mentally Retarded (ICF/MR), the hospice plan of care identifies the care and services that are needed and identifies which provider is responsible for performing the functions that have been agreed upon and included in the plan of care.
41. **For hospices that elect to use The Joint Commission deemed status option:** For hospice care provided to a resident of a Skilled Nursing Facility (SNF), Nursing Facility (NF), or Intermediate Care Facility for the Mentally Retarded (ICF/MR), the hospice plan of care reflects the participation of the hospice, the SNF, NF, or ICF/MR, and the patient and family to the extent possible.

42. **For hospices that elect to use The Joint Commission deemed status option:** For hospice care provided to a resident of a Skilled Nursing Facility (SNF), Nursing Facility (NF), or Intermediate Care Facility for the Mentally Retarded (ICF/MR), any changes in the hospice plan of care are discussed with the patient or patient’s representative and the SNF, NF, or ICF/MR representatives and are approved by the hospice before implementation.

49. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The documented plan of care is developed and updated by the interdisciplinary team in collaboration with the patient, his or her family, and other health care providers involved in the care of the patient.

50. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The plan of care is based on the patient’s assessed needs in conjunction with the patient’s strengths, limitations, values, and goals.

51. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program communicates the plan of care to staff involved in the patient’s care.

52. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program arranges spiritual care as needed by the patient and family through the program’s chaplain or spiritual care provider, through the patient’s own relationship(s) with clergy, or through community spiritual care resources.

53. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program has a process for providing or making referrals for bereavement services for the patient’s family prior to the patient’s death.

**Note:** The process includes attention to children and adolescents who are family members of the patient.
54. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program leaders and staff participate in the evaluation of the provision of care, treatment, and services.

55. ⬤ **For home health agencies that elect to use The Joint Commission deemed status option:** There is a plan for the patient that provides instructions if there is an emergency in the organization or the community that might disrupt the care, treatment, or service provided by the organization. This plan is based on the patient’s assessed needs, including clinical, functional, and communication needs; reliance upon equipment or assistive devices; and available caregiver support. (*See also* PC.02.03.01, EP 10; EM.02.02.11, EP 1)

56. **For home health agencies that elect to use The Joint Commission deemed status option:** Revisions related to plans for the patient’s discharge must be communicated to the patient, representative, caregiver, all physicians issuing orders for the organization’s plan of care, and the patient’s primary care practitioner or other health care professional who will be responsible for providing care and services (if any) to the patient after discharge from the organization. (*See also* PC.04.01.03, EP 3)

**Standard PC.02.01.01**

The organization provides care, treatment, or services for each patient.

**Elements of Performance for PC.02.01.01**

1. The organization provides the patient with care, treatment, or services according to his or her individualized plan of care.

2. Staff provide care, treatment, or services in accordance with professional standards of practice, law, and regulation.

   **For home health agencies that elect to use The Joint Commission deemed status option:** All home health services must also be provided in accordance with current clinical practice guidelines.

4. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** The organization provides 24-hour nursing services in accordance with each patient’s plan of care.

11. **For hospices that elect to use The Joint Commission deemed status option:** The organization protects the patient from accident, injury, and infection.
12. **For hospices that elect to use The Joint Commission deemed status option:** The organization keeps the patient comfortable, clean, and well groomed.

13. **For hospices that elect to use The Joint Commission deemed status option:** The hospice provides care and services that are based on all assessments of the patient’s and family’s needs.

14. **For hospices that elect to use The Joint Commission deemed status option:** The hospice provides effective control of symptoms other than pain for conditions related to the terminal illness.

20. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program delivers care, treatment, and services according to the patient’s individualized plan of care.

21. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program has a process to provide the patient with or refer the patient for emergency/urgent care.

22. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The interdisciplinary team provides compassionate care consistent with the patient’s quality of life needs, while preserving the patient’s comfort and dignity.

23. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The interdisciplinary team manages the patient’s physical symptoms according to the patient’s plan of care by utilizing pharmacological and/or nonpharmacological methods according to their effectiveness in minimizing pain and suffering. These symptoms include, but are not limited to, the following:
   - Anorexia
   - Confusion
   - Constipation
   - Dyspnea
   - Fatigue
   - Insomnia
   - Nausea
   - Pain
   - Restlessness
24. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The patient’s psychological symptoms, including anxiety, stress, delirium, behavioral changes, and anticipatory grief are managed according to the patient’s plan of care.

**Standard PC.02.01.03**
The organization provides care, treatment, or services in accordance with orders or prescriptions, as required by law and regulation.

**Elements of Performance for PC.02.01.03**

1. Prior to providing care, the organization obtains or renews orders (verbal or written) from a licensed independent practitioner in accordance with professional standards of practice and law and regulation. 

2. The organization consults with the prescribing physician as needed to confirm the physician’s order(s).

3. The organization reviews orders and prescriptions for appropriateness and accuracy before providing care, treatment, or services.

4. Prior to implementing an order or prescription, staff obtain answers to any questions that exist. (See also MM.05.01.01, EP 11)

5. **For DMEPOS suppliers serving Medicare beneficiaries:** The organization recommends any necessary changes, refinements, or additional evaluations to the prescribed equipment, supplies, and services.

6. The organization provides care, treatment, or services using the most recent patient order(s).

7. **For home health agencies that elect to use The Joint Commission deemed status option:** The organization follows physician orders when administering medications or providing care, treatment, or services.

8. **For home health agencies and hospices that elect to use The Joint Commission deemed status option:** The home health aide or hospice aide provides services that are ordered by the physician in the plan of care, consistent with the aide’s training, and that the aide is permitted to perform under state law.

9. **For DMEPOS suppliers serving Medicare beneficiaries:** The organization provides all medical equipment and supplies to serve a medical purpose covered under the Medicare program and may require the physician to collaborate and
coordinate clinical services with other health care professionals (for example, providers of orthotics and prosthetics; occupational, physical, and respiratory therapists; and pedorthists).

11. The organization confirms that the item delivered to the patient is consistent with the prescribing physician’s order.

12. **For custom orthotics and prosthetics services:** The organization confirms that the implementation plan is consistent with the prescribing physician’s dispensing order and/or the written plan of care and that it is in accordance with Medicare rules.

16. **For hospices that elect to use The Joint Commission deemed status option:** Hospice aides report changes in the patient’s medical, nursing, rehabilitative, and social needs to a registered nurse, as the changes relate to the plan of care and quality assessment and performance and improvement activities.

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.

21. **For home health agencies that elect to use The Joint Commission deemed status option:** The home health aide provides assistance to patients in administering medications that are ordinarily self-administered, unless prohibited by agency policy or state law.

**Standard PC.02.01.05**

The organization provides interdisciplinary, collaborative care, treatment, or services.

**Rationale for PC.02.01.05**

The focus of this standard is on disciplines internal to the home care organization, not those external to it. The home care organization may communicate with and take steps to collaborate with providers outside of the home health organization, understanding that for some of these providers the home care organization will have little control.

**Elements of Performance for PC.02.01.05**

1. All disciplines that provide care, treatment or services to the patient collaborate in the care of the patient and coordinate their efforts to support the goals outlined in the plan of care.
3. **For complex rehabilitation and assistive technology services:** The organization coordinates services with the prescribing physician to conduct face-to-face evaluations of the patient in a setting conducive to the patient’s condition.

4. **For hospices that elect to use The Joint Commission deemed status option:** The hospice designates an interdisciplinary group(s) composed of individuals who work together to meet the physical, medical, psychosocial, emotional, and spiritual needs of hospice patients and families facing terminal illness and bereavement.

5. The interdisciplinary care, treatment, or services team includes a licensed physician, a registered nurse, a social worker, and a pastoral or other counselor.

6. **For hospices that elect to use The Joint Commission deemed status option:** The hospice establishes an interdisciplinary group(s) that includes at least the following individuals:
   - A doctor of medicine or osteopathy who is an employee of or under contract with the hospice
   - A registered nurse
   - A social worker
   - A pastoral or other counselor

   *(See also PC.01.03.01, EP 13)*

7. The organization defines the time frames for providing information about the patient to the responsible physician.

8. The organization informs the physician when there is an unanticipated change in the patient’s condition or the patient is discharged or transferred.

9. The organization provides information about the patient to the responsible physician within its defined time frames.

10. **For home health agencies that elect to use The Joint Commission deemed status option:** The individualized plan of care must be reviewed and revised by the physician responsible for the home health plan of care and the home health agency as frequently as the patient’s condition or needs require, but no less frequently than once every 60 days, beginning with the start of care date.
11. **For home health agencies that elect to use The Joint Commission deemed status option:** The patient’s plan of care is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatric medicine acting within the scope of his or her state license, certification, or registration.

12. **For home health agencies that elect to use The Joint Commission deemed status option:** The home health agency promptly alerts the relevant physician(s) to any changes in the patient’s condition or needs that suggest that outcomes are not being achieved and/or there is a need to alter the plan of care.

16. **For hospices that elect to use The Joint Commission deemed status option:** The hospice designates a registered nurse to coordinate the assessment of each patient’s and family’s needs and implementation of the patient’s plan of care.

17. When the organization cannot provide equipment, items, or services that have been ordered for a patient, it notifies the prescribing practitioner within five calendar days.

**Note:** In rare instances, there may be customized items for which the organization was not notified by the vendor within the five day time frame that the item cannot be provided as specified. The organization is still responsible for notifying the prescribing practitioner, even if it is outside the five day time frame.

19. **For custom orthotics and prosthetics services:** The organization communicates to the prescribing physician the recommended treatment plan and any optional plans, including disclosure of potential risks or benefits involved.

21. **For complex rehabilitation and assistive technology services:** The organization includes information from other health care team members, such as physical therapists, occupational therapists, and the physician, in the delivery of its products.

22. The hospice interdisciplinary care coordination team is available to patients or their families. *(See also PC.02.02.01, EP 17)*

24. **For DMEPOS suppliers serving Medicare beneficiaries:** The organization solicits feedback from the physician, as necessary, to determine the effectiveness of the device, prosthetic, orthotic, or shoe provided to the patient.

25. **For hospices that elect to use The Joint Commission deemed status option:** The interdisciplinary group members provide the care and services offered by the hospice and, in its entirety, supervises the hospice’s care and services.
26. **For hospices that elect to use The Joint Commission deemed status option:** If the hospice has more than one interdisciplinary group, it designates one of the groups as responsible for establishing policies governing the day-to-day provision of hospice care and services.

33. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: For programs that provide care for pediatric patients:** The interdisciplinary team provides family-centered care for the child and family.

34. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program and the organization promote and support a collaborative and trusting environment.

35. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** Program leaders facilitate communication among the interdisciplinary team members and other organization staff who are involved in the patient’s care.

36. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program demonstrates teamwork among the interdisciplinary team members and other organization staff who are involved in the patient’s care.

37. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** Patients and staff mutually agree upon patient-centered goals of care.

38. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** Patients’ co-occurring conditions, if present, are managed.

**Note:** If the patient’s co-occurring conditions are managed by the patient’s primary care physician, or staff from a setting(s) outside the program, the information necessary for its management is communicated to program staff and settings across the continuum of care.

**Standard PC.02.01.07**

The organization safely administers blood and blood component(s).

**Note:** This standard only applies to organizations that administer blood and blood components (for example, red blood cells, plasma, platelets, granulocytes).
Elements of Performance for PC.02.01.07

1. ☐ The organization identifies in writing the source of the blood or blood component(s), the types of blood or blood component(s) that staff can administer, and the laboratory results that require review.

3. ☐ The organization has a process, defined in writing, to respond to adverse blood transfusion reactions that includes notifying the physician and others involved in the patients care.

4. The organization’s process for handling adverse blood transfusion reactions includes: Educating staff about the signs and symptoms of such reactions and the action(s) staff take in response.

5. The organization’s process for handling adverse blood transfusion reactions includes: Educating the patient about recognizing an adverse reaction and his or her role in follow-up action.

6. The organization’s process for handling adverse blood transfusion reactions includes: Having available the necessary medications, supplies, and equipment to treat the patient.

7. The blood or blood component(s) administered to a patient is not contraindicated for that patient.

8. The stability of blood or blood component(s) is verified through a visual check for particulate matter or discoloration.

9. Blood or blood component(s) is administered to the patient as ordered or prescribed.

10. Blood or blood component(s) is administered prior to its expiration date.

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, or 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 organization coordinates the patient’s care, treatment, or services based on the patient’s needs.

**Elements of Performance for PC.02.02.01**

1. The organization maintains continuity in the way it shares and receives patient information with other providers of care, treatment, or services. *(See also PC.04.02.01, EP 1)*

2. The organization’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 organization coordinates the patient’s care, treatment, or services.

   **Note:** Coordination involves resolving scheduling conflicts and duplication of care, treatment, or services.

7. **For hospices that elect to use The Joint Commission deemed status option:** When care, treatment, or services are provided by written agreement, the hospice program is responsible for the continuity of patient/family care, treatment, or services in the home, outpatient, and inpatient settings.

10. When the organization uses external resources to meet the patient’s needs, it coordinates the patient’s care, treatment, or services.

   **For home health agencies that elect to use The Joint Commission deemed status option:** The organization integrates the services provided by both internal and external resources in the provision and coordination of safe patient care provided by all disciplines.

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
13. **For custom orthotics and prosthetics services**: The organization refers the patient to the physician for treatments or interventions that are beyond the organization’s scope of practice.

16. The organization provides follow-up to the patient consistent with the services or equipment provided and recommendations from the physician or health care team.

17. The organization coordinates care, treatment, or services within a time frame that meets the patient’s needs. *(See also PC.02.01.05, EP 22)*

19. **For hospices that elect to use The Joint Commission deemed status option**: The hospice coordinates its hospice aide and homemaker services with the Medicaid personal care benefit so that the patient receives the hospice aide and homemaker services he or she needs.

20. **For hospices that elect to use The Joint Commission deemed status option**: The homemaker reports all concerns about the patient or family to the member of the interdisciplinary group who is coordinating the homemaker services.

21. **For hospices that elect to use The Joint Commission deemed status option**: For hospice care provided to a resident of a Skilled Nursing Facility (SNF), Nursing Facility (NF), or Intermediate Care Facility for the Mentally Retarded (ICF/MR), the hospice designates a member of the interdisciplinary group to be responsible for the patient, including the following:
   - Providing overall coordination of the patient’s hospice care with SNF, NF, or ICF/MR representatives
   - Communicating with SNF, NF, or ICF/MR representatives and any other health care providers participating in the provision of care

22. **For hospices that elect to use The Joint Commission deemed status option**: For hospice care provided to a resident of a Skilled Nursing Facility (SNF), Nursing Facility (NF), or Intermediate Care Facility for the Mentally Retarded (ICF/MR), the interdisciplinary group coordinates the patient’s hospice care with the medical director of the SNF, NF, or ICF/MR, the patient’s attending physician, and other physicians participating in the provision of care.
23. **For hospices that elect to use The Joint Commission deemed status option:** For hospice care provided to a resident of a Skilled Nursing Facility (SNF), Nursing Facility (NF), or Intermediate Care Facility for the Mentally Retarded (ICF/MR), the hospice provides the SNF, NF, or ICF/MR with the following information:
   - The patient's most recent hospice plan of care
   - The patient’s hospice election form and any advance directives
   - The physician certification and recertification of the patient’s terminal illness
   - The names and contact information of hospice staff involved in the care of the patient
   - Instructions on how to access the hospice’s 24-hour on-call system
   - Information on the hospice medications for the patient
   - Orders from the hospice physician and attending physician, if any, for the patient

24. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** Program staff assist patients and families with identifying and accessing community resources that are available to meet patients’ physical, psychosocial, and spiritual needs.

   **Note:** Examples of such resources may include, but are not limited to, community service providers, transportation companies, legal assistance, local school personnel, respite care providers, and spiritual care providers.

25. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** Staff have the patient’s health information available for use in clinical decision making to provide care, treatment, and services.

26. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** In order to coordinate care, the program facilitates the exchange of the patient’s health information among staff, both internal and external to the program, and with other health care providers and organizations involved in the patient’s care.

   **Note:** If the patient’s primary care physician is involved in the care of the patient, the program should communicate with the physician to plan and coordinate the patient’s care.
27. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The interdisciplinary team conducts regular patient care conferences with its members and other program staff members as needed to discuss patient-centered goals of care, disease prognosis, and advance care planning. The frequency of these patient care conferences is defined by the program and based on the needs of the patients.

**Note:** Patient care conferences include members of the interdisciplinary team and other program staff members as required to meet the needs of the program’s patients and families. These conferences may be done in a variety of formats, including face-to-face meetings, teleconference, or videoconference.

28. **For home health agencies that elect to use The Joint Commission deemed status option:** The home health agency coordinates the patient’s care in the following ways:

- Coordinates communication with all physicians involved in the plan of care
- Integrates orders from all physicians involved in the plan of care so all services and interventions provided are coordinated
- Involves the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities in order to meet patient needs

**Standard PC.02.02.03**

The organization makes food and nutrition products available to its patients.

**Elements of Performance for PC.02.02.03**

4. Menus are easy to read and posted in areas that patients can access.

6. The organization prepares food and nutrition products using proper sanitation, temperature, light, moisture, ventilation, and security.

9. The organization accommodates the patient’s cultural, religious, or ethnic food and nutrition preferences, unless contraindicated.

11. The organization stores food and nutrition products, including those brought in by patients or their families, using proper sanitation, temperature, light, moisture, ventilation, and security.

15. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** The hospice obtains, stores, prepares, distributes, and serves all food under sanitary conditions.
17. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** The hospice serves at least three meals or their equivalent each day at regular times, with not more than 14 hours between a substantial evening meal and breakfast.

18. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** If the hospice has patients who require medically prescribed special diets, the menus for those patients are planned by a qualified dietitian.

20. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** The meals provided are palatable, attractive, and served at the proper temperature.

**Standard PC.02.02.05**

The organization provides the patient with access to care, treatment, or services during nonbusiness hours.

**Elements of Performance for PC.02.02.05**

1. **For hospices that elect to use The Joint Commission deemed status option:** The hospice makes available nursing services, physician services, and medications 24 hours a day, and makes all other covered services available on a 24-hour basis when necessary to meet the needs of a patient and family.

2. **For providers of respiratory equipment, supplies, and services:** The organization provides respiratory equipment and services 24 hours a day, 7 days a week, as needed by the patient.

3. The organization provides the patient with information about whom to contact for assistance when the organization is closed.

4. The organization provides the patient with information about normal business hours and how to contact the organization for assistance.

5. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program informs patients and families of how to access care, treatment, and services during business hours.

6. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program informs patients and families of how to contact staff in the case of an emergent situation during or after business hours.
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 organization meets the patient’s and his or her family’s physical and psychosocial needs related to death and grief.
2. The organization provides staff with education about the unique needs of dying patients and their families.
3. Hospice staff are available to attend to the patient at death.
4. Hospice staff assist the family with after-death care, in accordance with the family’s request and law and regulation.

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 organization provides patient education and training based on each patient’s needs and abilities.

Elements of Performance for PC.02.03.01
1. The organization assesses the patient’s learning needs.
Note: This assessment could include the patient’s cultural and religious beliefs, emotional barriers, desire and motivation to learn, physical or cognitive limitations, and barriers to communication.

2. The organization tailors education and training materials and techniques to the needs of individual patients or caregivers. R

3. The organization tailors education and training materials and techniques to accommodate the patient’s or caregiver’s learning preferences and language. (See also RI.01.01.03, EP 1)

4. The organization provides education and training to the patient based on his or her assessed needs.

For hospices that elect to use The Joint Commission deemed status option: The hospice also provides education and training to the primary caregiver as appropriate to the responsibilities assigned to him or her in the plan of care.

For home health agencies that elect to use The Joint Commission deemed status option: Each patient, and his or her caregiver(s) where applicable, receive ongoing education and training regarding the care and services identified in the plan of care. The organization must provide training, as necessary, to ensure a timely discharge.

5. The organization coordinates the patient education and training provided by all disciplines involved in the patient’s care, treatment, or services.

10. Based on the patient’s condition and assessed needs, the education and training provided to the patient by the organization include the following:
   - An explanation of the plan for care, treatment, or services
   - Procedures to follow if care, treatment, or services are disrupted by a natural disaster or emergency
   - 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
   - Infection prevention and control
   - Discussion of pain, the risk for pain, the importance of effective pain management, the pain assessment process, and methods for pain management
   - Information on personal hygiene and grooming
   - Information on oral health
   - Basic physical and structural home safety
- Information on the safe and effective use of medical equipment or supplies provided by the organization
- Information on the storage, handling, and access to medical gases and supplies
- Information on the identification, handling, and safe disposal of hazardous medications and infectious wastes
- Habilitation or rehabilitation techniques to help the patient reach maximum independence
- Information on the use of restraint

*(See also* PC.01.03.01, EP 55)*

11. The organization provides written and verbal instructions to the patient and/or caregiver about the equipment, supplies, and services provided. The instructions cover the following topics, as appropriate to the equipment, supplies, or services:
- Use of the equipment or supplies
- Maintenance of the equipment
- Potential hazards and safety considerations related to the equipment, supplies, or services

**Note:** Written instructions may include pictures to illustrate the information being provided.

12. The organization provides or coordinates the provision of instructions related to setup, features, routine use, troubleshooting, cleaning, and maintenance of equipment or supplies it provides.

**Note:** Setup includes preparation of formulas.

13. The organization provides information and instructions about infection control issues related to the equipment and supplies it provides.

14. **For mail-order supplies or equipment:** The organization verifies that the patient has received training and written instructions with the initial delivery of the equipment or supplies.

15. The organization provides education and training that is tailored to the risks, complexity, and manufacturers’ instructions or specifications for the items being provided.
16. **For DMPOS suppliers serving Medicare beneficiaries:** The organization provides education and training about respiratory equipment, supplies, and services to patients or caregivers. This training and instruction is consistent with the following current American Association for Respiratory Care Practice Guidelines:

- Long Term Invasive Mechanical Ventilation in the Home
- Oxygen Therapy in the Home or Extended Care Facility
- Intermittent Positive Pressure Breathing
- Providing Patient and Caregiver Training
- Suctioning of the Patient in the Home

*(See also EQ.01.01.01, EP 11; EQ.01.02.01, EP 8)*

17. **For custom orthotics and prosthetics services:** The organization provides the following instructions to the patient or caregiver:

- Use, cleaning, and maintenance instructions
- The procedure for repairing, replacing, or adjusting the items, including any risks involved and the estimated time for the repair, replacement, or adjustment process
- How to don and doff the custom orthotic or prosthetic, including how to adjust closures for proper fit
- How to inspect the skin for pressure areas, redness, irritation, skin breakdown, pain, or edema
- How and when to use an interface, such as stockinettes, socks, gloves, or shoes, to accommodate the custom orthotic or prosthetic
- How to report any problems related to the custom orthotic or prosthetic to the supplier or prescribing physician

**Note:** *Such problems include changes in skin condition, increased pain, increased edema, wound concerns, changes in general health, height and/or weight, and intolerance to wearing the custom orthotic or prosthetic.*

- How to schedule follow-up appointments as necessary
- How to establish a wear schedule based on tolerance of the custom orthotic or prosthetic
18. **For custom orthotics and prosthetics services:** The organization provides instructions to the patient or caregiver about the necessary supplies (for example, adhesives, solvents, and lubricants) needed to attach, maintain, and clean the items. The organization also provides information about how to obtain more of the necessary supplies.

25. The organization evaluates the patient’s understanding of the education and training it provided.

27. The organization provides the patient education on how to communicate concerns about patient safety issues that occur before, during, and after care is received. R

32. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program provides education and support to the patient and family based on their needs and the plan of care.

33. **For home health agencies that elect to use The Joint Commission deemed status option:** The organization provides the patient and caregiver with a copy of written instructions outlining the following:
   - Visit schedule, including frequency of visits by home health staff
   - Patient medication schedule and instructions, including medication name, dosage, and frequency and which medications will be administered by home health staff
   - Any treatments to be administered by home health staff, including therapy services
   - Any other pertinent instruction related to the patient’s care, treatments, and services that the organization will provide
   - Name and contact information of the home health agency clinical manager

**Standard PC.03.05.01**

The organization uses restraint or seclusion only when it can be clinically justified or when warranted by behavior that threatens the physical safety of the patient, staff, or others.

**Elements of Performance for PC.03.05.01**

1. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** The organization uses restraint or seclusion only to protect the immediate physical safety of the patient, staff, or others.
2. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** The organization does not use restraint or seclusion as a means of coercion, discipline, convenience, or staff retaliation.

3. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** The organization uses restraint or seclusion only when less restrictive interventions are ineffective.

4. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** The organization uses the type of restraint or seclusion that is the least restrictive intervention to protect the immediate physical safety of the patient, staff, or others.

5. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** The organization discontinues restraint or seclusion at the earliest possible time.

**Standard PC.03.05.03**

The organization uses restraint or seclusion safely.

**Elements of Performance for PC.03.05.03**

1. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** The organization implements restraint or seclusion using safe techniques identified by the organization’s policies and procedures in accordance with state law.

2. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** When the hospice uses restraint or seclusion, the patient’s plan of care is modified.

**Standard PC.03.05.05**

The organization initiates restraint or seclusion in accordance with a physician’s order.

**Elements of Performance for PC.03.05.05**

1. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** A physician orders the use of restraint or seclusion in accordance with organization policy and state law.

2. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** The organization does not use standing orders or PRN (also known as “as needed”) orders for restraint or seclusion.
3. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** The attending physician is consulted as soon as possible, in accordance with organization policy, if he or she did not order the restraint or seclusion.

4. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** Unless state law is more restrictive, orders for the use of restraint or seclusion are renewed for a total of no more than 24 hours, in accordance with 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

5. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** Unless state law is more restrictive, after 24 hours and before writing a new order for the use of restraint or seclusion, a physician sees and assesses the patient in accordance with organization policy and state law.

6. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** Orders for restraint used to protect the physical safety of the nonviolent or non-self-destructive patient may be renewed as authorized by organization policy.

**Standard PC.03.05.07**
The organization monitors patients who are restrained or secluded.

**Element of Performance for PC.03.05.07**

1. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** A physician or other staff monitor the condition of the patient in restraint or seclusion, at intervals determined by organization policy. *(See also PC.03.05.17, EP 3)*

**Standard PC.03.05.11**
The organization evaluates and reevaluates the patient who is restrained or secluded.
Elements of Performance for PC.03.05.11

1. For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option: A physician or registered nurse who has been trained in the use of restraint and seclusion evaluates the patient face-to-face within one hour of the initiation of restraint or seclusion.

   Note: States may have statute or regulation requirements that are more restrictive than the requirements in this element of performance.

2. For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option: When the face-to-face evaluation is done by a registered nurse, he or she consults with the medical director or physician designee as soon as possible after the evaluation.

3. For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option: The face-to-face evaluation within one hour of the initiation of restraint or seclusion includes the following:
   - An evaluation of the patient’s immediate situation
   - An evaluation of the patient’s reaction to the use of restraint or seclusion
   - An evaluation of the patient’s medical and behavioral condition
   - An evaluation of the need to continue or discontinue the restraint or seclusion

Standard PC.03.05.13
The organization continually monitors patients who are simultaneously restrained and secluded.

Element of Performance for PC.03.05.13

1. For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option: The patient who is simultaneously restrained and secluded is continually monitored by assigned trained staff either face-to-face 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 organization documents the use of restraint or seclusion.
Element of Performance for PC.03.05.15

1. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** Documentation of restraint and seclusion in the medical record includes the following:
   - Any face-to-face medical and behavioral evaluation for restraint or seclusion
   - 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

Standard PC.03.05.17

The organization trains staff to safely implement the use of restraint or seclusion.

Elements of Performance for PC.03.05.17

1. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** The hospice trains all patient care staff working in the hospice inpatient facility to be competent in the application of restraints and the implementation of seclusion, as well as monitoring, assessing, and providing care for a patient in restraint or seclusion.

2. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** Staff are trained and able to demonstrate their competence before participating in the use of restraint or seclusion, as part of their orientation and on a periodic basis as defined in hospice policy.

3. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** The content of training on the use of restraint or seclusion includes the following:
   - Techniques 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 organization, 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 organization policy associated with the face-to-face 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. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** Individuals providing staff training in restraint or seclusion have education, training, and experience in the techniques used to address patient behaviors.

5. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** The organization documents in staff records that restraint and seclusion training and demonstration of competence were completed.

6. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** Hospice policy specifies the training requirements for physicians, including attending physicians.

7. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** Physicians and attending physicians authorized by hospice policy in accordance with state law to order restraint or seclusion have a working knowledge of the hospice’s policy for the use of restraint or seclusion.

**Standard PC.03.05.19**
The organization reports deaths associated with the use of restraint and seclusion.
Elements of Performance for PC.03.05.19

1. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option**: The organization reports the following information to the Centers for Medicare & Medicaid Services (CMS):
   - Each unexpected death that occurs while a patient is in restraint or seclusion
   - Each unexpected death that occurs within 24 hours after the patient has been removed from restraint or seclusion
   - Each death known to the organization 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

   **Note**: This element of performance 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 hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option**: The deaths addressed in PC.03.05.19, EP 1 are reported to the Centers for Medicare & Medicaid Services (CMS) by telephone no later than the close of the next business day following knowledge of the patient’s death.

3. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option**: Staff document in the patient’s medical record the date and time that the patient death was reported to the Centers for Medicare & Medicaid Services (CMS).

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**Standard PC.04.01.01**

The organization has a process that addresses the patient’s need for continuing care, treatment, or services after discharge or transfer.

**Elements of Performance for PC.04.01.01**

1. The organization describes the reason(s) for and conditions under which the patient is discharged or transferred.

2. The organization describes the method for shifting responsibility for a patient’s care from one clinician, organization, program, or service to another.
10. The organization’s staff has access to information about community resources that are relevant to the care, treatment, or services it provides. *(See also PC.04.01.05, EPs 2 and 7)*

15. The organization coordinates the patient’s discharge or transfer with the patient, the patient’s family, the licensed independent practitioner primarily responsible for the patient, and the organization’s staff.

28. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program has a process that addresses the patient’s need for continuing care, treatment, and services after discharge or transfer.

29. ⚥ **For home health agencies that elect to use The Joint Commission deemed status option:** The home health agency may only transfer or discharge a patient for the following reasons:

   - The organization and the physician responsible for the home health plan of care agree that the organization can no longer meet the patient’s needs based on the patient’s acuity.
   - The patient or payer will no longer pay for the services provided by the organization.
   - The organization and the physician responsible for the home health plan of care agree that the patient no longer needs the organization’s services because the measurable outcomes and goals set forth in the plan of care (in accordance with 42 CFR 484.60(a)(2)(xiv)) have been achieved *(See also PC.01.02.01, EP 25)*.
   - The patient refuses services or elects to be transferred or discharged.
   - The home health agency has a policy that addresses discharge or transfer for cause when the patient’s (or other persons in the patient’s home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the organization to operate effectively is seriously impaired *(See also PC.04.01.01, EP 30)*.
   - The patient dies.
   - The organization ceases to operate.

30. ⚥ **For home health agencies that elect to use The Joint Commission deemed status option:** The organization does the following before it discharges a patient for cause:
Advise the patient, representative (if any), the physician(s) issuing orders for the home health plan of care, and the licensed independent practitioner primarily responsible for the patient after discharge (if any) that a discharge for cause is being considered.

Make efforts to resolve the problem(s) presented by the patient’s behavior, the behavior of other persons in the patient’s home, or situation.

Provide the patient and representative (if any), with contact information for other agencies or providers who may be able to provide care.

Document the problem(s) and efforts made to resolve the problem(s), and then enter this documentation into the patient record.

(See also PC.04.01.01, EP 29)

**Standard PC.04.01.03**

The organization 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 organization begins planning for the patient’s discharge early in the patient’s care, treatment, or services.

2. The organization identifies any needs the patient may have for psychosocial or physical care, treatment, or services after discharge or transfer.

3. The patient, the patient’s family or caregivers, physicians, and staff involved in the patient’s care, treatment, or services participate in planning the patient’s discharge or transfer.

4. Prior to discharge, the organization 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 organization discharges or transfers a patient, it informs and educates the patient about his or her follow-up care, treatment, or services.

**Elements of Performance for PC.04.01.05**

1. When the organization determines the patient’s discharge or transfer needs, it promptly shares this information with the patient.
2. Before the patient is discharged, the organization informs the patient of the kinds of continuing care, treatment, or services he or she will need. *(See also PC.04.01.01, EP 10)*

7. The organization educates the patient about how to obtain any continuing care, treatment, or services that he or she will need. *(See also PC.04.01.01, EP 10)*

**Standard PC.04.02.01**

When a patient is discharged or transferred, the organization gives information about the care, treatment, or services provided to the patient to other service providers who will provide the patient with care, treatment, or services.

**Elements of Performance for PC.04.02.01**

1. At the time of the patient’s discharge or transfer, the organization 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
   - A summary of care, treatment, or 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)*

2. **For home health agencies that elect to use The Joint Commission deemed status option:** When a patient is transferred to another health facility, the organization provides a copy of the record or a summary of the record within two business days.

   **Note:** In the event of an unplanned transfer, a completed transfer summary is sent within two business days of the organization becoming aware (if the patient is still receiving care in that health care facility at the time when the home health agency becomes aware of the transfer).

3. The organization provides a written discharge summary to the patient’s physician in accordance with law and regulation.

   **For hospices that elect to use The Joint Commission deemed status option:** Law and regulation require that the hospice inform the attending physician of the availability of a discharge summary. The discharge summary is provided to the physician upon the physician’s request and includes the patient’s medical and health status at the time of discharge.
For home health agencies that elect to use The Joint Commission deemed status option: A completed discharge summary is sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient (if any) after discharge from the organization within five business days of the patient’s discharge.

4. For hospices that elect to use The Joint Commission deemed status option: If the care of the patient is transferred to another Medicare/Medicaid-certified facility, the hospice provides the receiving facility with a copy of the hospice discharge summary and, if requested, a copy of the patient’s clinical record.

5. For hospices that elect to use The Joint Commission deemed status option: If the patient revokes the election of hospice care or is discharged from hospice care, the hospice provides the patient’s attending physician with a copy of the hospice discharge summary and, if requested, a copy of the patient’s clinical record.

6. For hospices that elect to use The Joint Commission deemed status option: The hospice discharge summary includes the following:
   - A summary of the patient’s stay, including treatments, symptoms, and pain management
   - The patient’s current plan of care
   - The patient’s latest physician orders
   - Any other documentation that will assist in postdischarge continuity of care or that is requested by the attending physician or receiving physician

9. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: At the time a patient is transferred to a different care setting, information about the patient’s goals, preferences, advanced care plan, and the patient’s clinical condition are communicated to staff in the new setting.
Prompts to Assess Your Compliance

Please note: Tips do not represent new accreditation requirements. They are intended to provide helpful strategies for standards compliance.

Is patient care being provided according to physician orders and the plan of care? (PC.02.01.01)

**TIP:** The registered nurse (RN) assigned to the patient and the case manager in the office should be monitoring to ensure that the frequency of visits made matches the frequency of visits ordered for all disciplines.

When reviewing patient care plans, are all required items included? (PC.01.03.01)

Is the verbal order “read-back” process in use? (PC.02.01.03)

Does the RN write the instructions for home health aides? (PC.01.03.01)

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
**TIP:** Review each home health aide’s list of duties. Is each item specific? If there are several choices for the patient’s bath, only one should be checked.

**Inpatient hospices:** Has the restraint policy been consistently implemented? (PC.03.05.01, PC.03.05.03, PC.03.05.05)

**Inpatient hospices:** How is the use of restraints measured and assessed? (PC.03.05.07, PC.03.05.11)

**Home health–deemed organizations:** What does your discharge process state about providing a copy of the patient record to the next provider? Does it address the roles of the “sending” and “receiving” organizations? (PC.04.02.01)

When patient and family education is provided, does staff evaluate the patient’s and family’s understanding of the education provided? (PC.02.03.01)
**TIP:** Use chart audits to evaluate the following:
- Complete and timely initial assessments and reassessments
- Complete pain assessments and reassessments
- Timeliness of plan-of-care updates from the interdisciplinary care team
- Consistent implementation of the discharge planning process
- Compliance with the restraint policy (inpatient hospice)
- Items required by organizational policy to be documented
**Written Documentation Checklist**

This worksheet lists elements of performance (EPs) that require written documentation that a surveyor could ask to see during a survey to show compliance with a standard.  
*(Note: Documentation can be on paper or in an electronic format.)*

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**Provision of Care, Treatment, and Services (PC)**

<table>
<thead>
<tr>
<th>√</th>
<th>Standard</th>
<th>EP</th>
<th>Provision of Care, Treatment, and Services Standards</th>
<th>Home Care Service</th>
<th>Date last verified</th>
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<tbody>
<tr>
<td></td>
<td>PC.01.01.01</td>
<td>1–3</td>
<td>EP 1—The organization has a written process for accepting a patient that is based on its ability to provide the care, treatment, or services required by the patient.</td>
<td>All services</td>
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<td>EP 2—The organization has a written process for accepting a patient that includes the following: Criteria to determine the patient’s eligibility for care, treatment, or services.</td>
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<td>EP 3—The organization has a written process for accepting a patient that includes the following: Procedures for accepting referrals.</td>
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<td></td>
<td>PC.01.02.01</td>
<td>1, 2, 5–9, 12, 25, 33–35, 45–51</td>
<td>EP 1—The organization defines, in writing, the scope and content of screening, assessment, and reassessment information it collects.</td>
<td>All services</td>
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<td>EP 2—The organization defines, in writing, criteria that identify when additional, specialized, or more in-depth assessments are performed.</td>
<td>EP 2—HH, HOS, OP, CRS, RT</td>
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<tr>
<td>EP 5—Based on the patient’s condition and the care, treatment, or services it provides, the organization defines, in writing, which of the following information it collects in the patient’s assessment and reassessment:</td>
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<tr>
<td>- Pertinent diagnoses</td>
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<td>- Pertinent physical findings</td>
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<td>- Pertinent medical history</td>
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<td>- Functional status</td>
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<td>- Psychosocial status</td>
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<td>- Cultural or religious practices that may affect care</td>
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<td>- Care the family or support system is capable of and willing to provide</td>
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<td>- Educational needs, including the abilities, motivation, and readiness to learn</td>
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<td>- Barriers and safety hazards in the home environment</td>
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<td>- Any other relevant information that may affect the patient’s goals</td>
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<td>EP 5—All services</td>
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**Comprehensive Accreditation Manual for Home Care**

<table>
<thead>
<tr>
<th>EP 6—Based on the patient’s condition and the care, treatment, or services it provides, the organization defines, in writing, which of following information it collects in the patient’s assessment and reassessment:</th>
<th>EP 6—HH, HOS</th>
</tr>
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</table>
| - Pertinent prognosis  
- Laboratory values  
- Medication history, including drug allergies, drug sensitivities, medication compliance and past adverse drug reactions  
- Current medication use, including prescribed and over-the-counter medications  
**For hospice organizations that elect to use The Joint Commission deemed status option:** Current medication use also includes herbal remedies, other alternative treatments that could affect drug therapy, and drug therapy currently associated with laboratory monitoring.  
- Nutritional status  
- Diet, including the therapeutic regimen, if any, reason for the therapeutic regimen, and its route of administration  
- Medical equipment in the home |  |

**EP 7**—The hospice’s written definition of information the organization collects during assessment and reassessment includes the following:

- The severity of symptoms  
- Factors that alleviate or exacerbate physical symptoms  
- The comfort level of a patient who chooses not to take nutrition therapy  
- Patient and family spiritual orientation, including their desire for the involvement of a religious group |  
**EP 7—HOS; some bullets specifically for deemed status**
- Spiritual concerns or needs identified by the patient or family, such as despair, suffering, guilt, and forgiveness

- Patient and family involvement in a support group, if any

- Additional information about the patient's psychosocial status, such as family relationships, social history, the source and adequacy of environmental and other resources, coping mechanisms, and the patient's and family's reactions to illness

- The need for volunteer services to offer support or respite to the patient, family, or other caregivers

- The need for an alternative setting or level of care

- Anticipated discharge needs, including bereavement and funeral needs

- Survivor risk factors, such as the nature of the relationship with the patient, circumstances surrounding the death, behaviors before and after the death, availability of coping mechanisms, and potential for pathological grief reactions

For hospices that elect to use The Joint Commission deemed status option:

- Cultural factors that may impact the patient's and family's ability to cope with the patient's death

For hospices that elect to use The Joint Commission deemed status option:

- The need for referral to and evaluation by other health professionals

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
EP 8—Based on the care, treatment, or services it provides, the pharmacy’s written definition of data and information collected during assessment and reassessment includes the following:
- Pertinent prognosis (not applicable for pharmacy dispensing services or for clinical/consultant pharmacist services)
- Nutritional status
- Any equipment required for administering medication
- Dietary intake related to allergies or drug-food interactions
- Information contained in Standard MM.01.01.01

EP 9—The home medical equipment or rehabilitation technology service’s written definition of data and information collected during assessment and reassessment includes any medical equipment the patient uses.

EP 12—For home health agencies that elect to use The Joint Commission deemed status option: The home health agency’s comprehensive assessment must include the current version of the Outcome and Assessment Information Set (OASIS) items as follows:
- Patient (clinical) record items
- Demographics and patient history
- Living arrangements
- Supportive assistance
- Sensory status
- Integumentary status
- Respiratory status
- Elimination status
- Neuro/emotional/behavioral status
- Activities of daily living
- Medications
- Equipment management
- Emergent care
- Data items collected at inpatient facility admission or discharge
EP 25—For home health agencies that elect to use The Joint Commission deemed status option: The comprehensive assessment must accurately reflect the patient’s status and include, at a minimum, the following patient information:

- Current health, psychosocial, functional, and cognitive status
- Strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress toward achievement of his or her goals and the measurable outcomes identified by the organization
- Continuing need for home care
- Medical, nursing, rehabilitative, social, and discharge planning needs
- A review of all current medications in order to identify potential medication-related problems, including adverse effects, drug reactions, significant side effects, and significant drug interactions, including ineffective drug therapy, duplicate drug therapy, and noncompliance with drug therapy
- Primary caregiver(s), if any, and other available supports, including their willingness and ability to provide care, availability, and schedules
- Patient’s representative (if any)
- Incorporation of the current version of the Outcome and Assessment Information Set (OASIS) items (See also PC.01.02.01, EP 12)
| EP 33—For hospices that elect to use The Joint Commission deemed status option: The hospice's written definition of data and information to be collected during the initial assessment includes the patient's need for hospice care and services. This assessment includes all areas of hospice care related to the palliation and management of terminal illness and related conditions.

EP 34—For hospices that elect to use The Joint Commission deemed status option: The hospice's written definition of data and information to be collected during the comprehensive assessment includes the following:

- The patient's physical, psychosocial, emotional, and spiritual needs related to the terminal illness that must be addressed in order to promote the patient’s well-being, comfort, and dignity throughout the dying process
- The nature of the condition causing the patient's admission to the hospice program, including the presence or absence of objective data and subjective complaints
- Complications and risk factors that affect care planning
- Functional status, including the patient's ability to understand and participate in his or her care
- Imminence of death

EP 35—For hospices that elect to use The Joint Commission deemed status option: The hospice's written definition of data and information to be collected during the comprehensive assessment includes data elements that measure outcomes and that can be documented in the same way for all patients.

EP 45—For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: Program staff evaluate and revise the plan of care to meet the patient’s and family’s ongoing needs and document the revisions in the patient’s medical record.

EPs 33–35—Deemed HOS

EPs 45–51—HH, HOS
| EP 46 | For organizations that elect the Joint Commission Community-Based Palliative Care Certification option: A member of the interdisciplinary team conducts and documents an initial patient assessment, including a clinical assessment that is defined by the program and based on the patient’s needs. |
| EP 47 | For organizations that elect the Joint Commission Community-Based Palliative Care Certification option: As part of the initial assessment, the interdisciplinary team assesses and documents the patient’s pain, dyspnea, constipation, and other symptoms; standardized scales should be used when they are available. The scope of this assessment is defined by the program and based on patient needs. |
| EP 48 | For organizations that elect the Joint Commission Community-Based Palliative Care Certification option: As part of the initial assessment, the interdisciplinary team assesses and documents the patient’s functional status. The scope of this assessment is defined by the program and based on patient needs. |
| EP 49 | For organizations that elect the Joint Commission Community-Based Palliative Care Certification option: As part of the initial assessment, the interdisciplinary team completes and documents a psychosocial assessment of the patient and family. The scope of this assessment is defined by the program and based on patient needs. |
| EP 50 | For organizations that elect the Joint Commission Community-Based Palliative Care Certification option: As part of the initial assessment, the interdisciplinary team identifies and documents the cultural, spiritual, and religious beliefs and practices important to the patient and family that influence care, treatment, and services. The scope of this assessment is defined by the program and based on patient needs. |
**EP 51—**For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: As part of the initial assessment, the interdisciplinary team assesses and documents the patient’s anxiety, stress, grief, coping, and other psychological symptoms using standardized scales when they are available. The scope of this assessment is defined by the program and based on patient needs.

| PC.01.02.03 | 1 | All services |
| PC.01.02.09 | 1, 2 | All services |

**EP 1—**The organization defines, in writing, the time frame(s) within which it conducts the patient’s initial assessment, in accordance with law and regulation.

**EP 10—**For home health agencies that elect to use The Joint Commission deemed status option: The individualized plan of care specifies the care and services necessary to meet the needs identified in the comprehensive assessment and addresses the following:

- All pertinent diagnoses
- Mental, psychosocial, and cognitive status
- Types of services, supplies, and equipment required
- The frequency and duration of visits
- The patient’s prognosis
- The patient’s potential for rehabilitation
- The patient’s functional limitations

| PC.01.03.01 | 10, 23, 30, 33, 34, 55 | EP 10, 30—Deemed HH |

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
The patient’s permitted activities
The patient’s nutritional requirements
All medications and treatments
Safety measures to protect against injury
A description of the patient’s risk for emergency department visits and hospital readmission
Patient-specific interventions and education
Patient and caregiver education and training to facilitate timely discharge
Goals and measurable outcomes that the organization anticipates will occur as a result of implementing and coordinating the plan of care
Information related to any advanced directives
Identification of the disciplines involved in providing care
Any other relevant items, including revisions and deletions

EP 23—The organization revises plans and goals for care, treatment, or services based on the patient’s needs. (See also RC.02.01.01, EP 2)

For home health agencies that elect to use The Joint Commission deemed status option: The revised plan of care reflects current information from the patient’s updated comprehensive assessment and the patient’s progress toward goals and measurable outcomes.

EP 30—For home health agencies that elect to use The Joint Commission deemed status option: The registered nurse, or other appropriate skilled professional who is responsible for supervision of the home health aide, prepares written patient care instructions that specify the duties of the home health aide.
| EP 33—For hospices that elect to use The Joint Commission deemed status option: A registered nurse who is a member of the interdisciplinary group prepares written patient care instructions for the hospice aide. | EP 33–34—Deemed HOS |
| EP 34—For hospices that elect to use The Joint Commission deemed status option: A member of the interdisciplinary group prepares written instructions for the homemaker. |  |
| EP 55—For home health agencies that elect to use The Joint Commission deemed status option: There is a plan for the patient that provides instructions if there is an emergency in the organization or the community that might disrupt the care, treatment, or service provided by the organization. This plan is based on the patient’s assessed needs, including clinical, functional, and communication needs; reliance upon equipment or assistive devices; and available caregiver support. | Deemed HH |
| PC.02.01.05 EP 11 | EP 11—For home health agencies that elect to use The Joint Commission deemed status option: The patient’s plan of care is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatric medicine acting within the scope of his or her state license, certification, or registration. | Deemed HH |
| PC.02.01.07 EP 1, 3 | EP 1—The organization identifies in writing the source of the blood or blood component(s), the types of blood or blood component(s) that staff can administer, and the laboratory results that require review. EP 3—The organization has a process, defined in writing, to respond to adverse blood transfusion reactions that includes notifying the physician and others involved in the patients care. | HH, HOS, FAI |
EP 10—Based on the patient’s condition and assessed needs, the education and training provided to the patient by the organization include the following:

- An explanation of the plan for care, treatment, or services
- Procedures to follow if care, treatment, or services are disrupted by a natural disaster or emergency
- Basic health practices and safety
- Information on the safe and effective use of medications.
- Nutrition interventions (for example, supplements) and modified diets
- Infection prevention and control
- Discussion of pain, the risk for pain, the importance of effective pain management, the pain assessment process, and methods for pain management
- Information on personal hygiene and grooming
- Information on oral health
- Basic physical and structural home safety
- Information on the safe and effective use of medical equipment or supplies provided by the organization
- Information on the storage, handling, and access to medical gases and supplies
- Information on the identification, handling, and safe disposal of hazardous medications and infectious wastes
- Habilitation or rehabilitation techniques to help the patient reach maximum independence
- Information on the use of restraint

EP 10—All services (except PCS)
### Comprehensive Accreditation Manual for Home Care

**EP 11**—The organization provides written and verbal instructions to the patient and/or caregiver about the equipment, supplies, and services provided. The instructions cover the following topics, as appropriate to the equipment, supplies, or services:

- Use of the equipment or supplies
- Maintenance of the equipment
- Potential hazards and safety considerations related to the equipment, supplies, or services

**EP 33**—For home health agencies that elect to use The Joint Commission deemed status option: The organization provides the patient and caregiver with a copy of written instructions outlining the following:

- Visit schedule, including frequency of visits by home health staff
- Patient medication schedule and instructions, including medication name, dosage, and frequency and which medications will be administered by home health staff
- Any treatments to be administered by home health staff, including therapy services
- Any other pertinent instruction related to the patient’s care, treatments, and services that the organization will provide
- Name and contact information of the home health agency clinical manager

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**PC.03.05.17**

**EP 5, 6**

**EP 5**—For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option: The organization documents in staff records that restraint and seclusion training and demonstration of competence were completed.

**EP 6**—For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option: Hospice policy specifies the training requirements for physicians, including attending physicians.
<table>
<thead>
<tr>
<th>PC.04.01.01</th>
<th>EP 29, 30</th>
<th>Deemed HH</th>
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<tbody>
<tr>
<td>For home health agencies that elect to use The Joint Commission deemed status option: The home health agency may only transfer or discharge a patient for the following reasons:</td>
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<td>The organization and the physician responsible for the home health plan of care agree that the organization can no longer meet the patient's needs based on the patient's acuity</td>
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<td>The patient or payer will no longer pay for the services provided by the organization</td>
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<td>The organization and the physician responsible for the home health plan of care agree that the patient no longer needs the organization's services because the measurable outcomes and goals set forth in the plan of care (in accordance with 42 CFR 484.60(a)(2)(xiv)) have been achieved (See also PC.01.02.01, EP 25)</td>
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<td>The patient refuses services or elects to be transferred or discharged</td>
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<td>The home health agency has a policy that addresses discharge or transfer for cause when the patient's (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the organization to operate effectively is seriously impaired (See also PC.04.01.01, EP 30)</td>
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<td>The patient dies</td>
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<td>The organization ceases to operate</td>
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**For home health agencies that elect to use The Joint Commission deemed status option:** The organization does the following before it discharges a patient for cause:

- Advise the patient, representative (if any), the physician(s) issuing orders for the home health plan of care, and the licensed independent practitioner primarily responsible for the patient after discharge (if any) that a discharge for cause is being considered.
- Make efforts to resolve the problem(s) presented by the patient's behavior, the behavior of other persons in the patient's home, or situation.
- Provide the patient and representative (if any), with contact information for other agencies or providers who may be able to provide care.
- Document the problem(s) and efforts made to resolve the problem(s), and then enter this documentation into the patient record. *(See also PC.04.01.01, EP 29)*
# Action Planning Tool

Use this form to track noncompliant elements of performance (EPs) and your action steps for bringing them into compliance.

<table>
<thead>
<tr>
<th>Standard and EP</th>
<th>Observation/Issue</th>
<th>Action Step</th>
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Chapter Notes

Use this page to take notes about ideas for meeting the standards in this chapter, your organization’s policies and procedures that address requirements in this chapter, or the data or medical record numbers used to determine compliance or noncompliance for EPs. If a standard is found not compliant, it can be helpful to know which data were used so they can be easily accessed when developing action plans for compliance.
Performance Improvement (PI)

Overview
All organizations want better patient outcomes and, therefore, are concerned about improving the safety and quality of the care, treatment, or 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 organization 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 organization collects, data are not useful if it is not analyzed. Analysis identifies trends, patterns, and performance levels that suggest opportunities for improvement. The organization can then make improvements based on the analysis. Of course, there is always the chance that analysis may reveal that more opportunities for improvement exist than an organization can manage at one time. In this case, leaders need to set priorities for improvement.
After a change has been made, the organization monitors that change by collecting and analyzing data to make sure the desired improvement is achieved and sustained. Organizations should identify the results that will signify sustained improvement. If the improvement does not meet expectations, the organization makes additional changes, and the cycle starts again. These principles of performance improvement also apply whenever the organization wants to design new processes, such as a new 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)
**Applicability for Performance Improvement**

This grid is meant to be a resource to determine which standards and elements of performance (EPs) apply to the service categories within the Home Care Accreditation Program. The column on the far left of the grid lists the related EPs vertically by number. Service categories (defined in Table 3 of the Introduction) are listed horizontally along the top of the grid. Applicability is indicated with an “X” in a service category column.

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<th>Standard/Requirement Number</th>
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Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
Standards, Rationales, and Elements of Performance

Introduction to Standard PI.01.01.01
Data provide organizations with important information that can be used in a variety of ways. Collecting and analyzing data on performance, outcomes, and other activities can help an organization improve its ability to provide quality care, treatment, or services. The organization 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, and community. The Joint Commission has identified important areas that should be measured regularly. In addition, the organization should establish data priorities particular to its needs.

Organizations should proactively seek to identify and reduce risks to the safety of patients by examining high-risk or problem-prone processes related to care, treatment, or services. In most home care settings the patient is not continuously monitored by the organization; therefore, the patient and his or her family are important partners in improving patient safety. It is critical that the patient and his or her family are provided with sufficient and appropriate information about the risks related to the patient’s condition or the care or services provided, instructions on minimizing these risks, and the consequences of not following such risk-reduction instructions.

Note: The organization also collects data on evaluation and improvement of conditions in the environment, infection control, and the medication management system. Standards addressing this data collection are located in the “Environment of Care” (EC), “Infection Prevention and Control” (IC), and “Medication Management” (MM) chapters.

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

Elements of Performance for PI.01.01.01
1. The leaders or managers delegated by leaders set priorities for data collection, including data related to high-risk, problem-prone processes. (See also LD.04.04.01, EP 1)
Note: Examples of areas of risk include blood-borne infections, wound care, undetected urinary tract infections, oxygen-related fires, and patient hand-off to or from the home care organization.

2. The organization identifies the frequency for data collection.

The organization collects data on the following:

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

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

15. Significant adverse 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 delivered by the organization.

17. Patient satisfaction with and complaints about products and services.

18. The timeliness of response to patient questions, problems, and concerns.

19. The impact of the organization’s business practices on the adequacy of patient access to equipment, items, services, and information.

For DMEPOS suppliers serving Medicare beneficiaries: The organization collects data on the following:

20. The frequency of billing and coding errors.

21. The organization collects data on adverse events involving patients due to inadequate or malfunctioning equipment, supplies, or services (for example, injuries, accidents, signs and symptoms of infection, and hospitalizations).

33. For home health agencies and hospices that elect to use The Joint Commission deemed status option: The organization’s governing body approves the frequency and detail of the data collection.

34. For hospices that elect to use The Joint Commission deemed status option: The hospice collects data on adverse patient events.
35. **For DMEPOS suppliers serving Medicare beneficiaries:** The organization seeks input from employees, beneficiaries, and referral sources when assessing the quality of its operations and services.

49. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program collects the data it needs to improve processes and outcomes.

50. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program uses consistent data sets, definitions, codes, classifications, and terminology.

51. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** Data collection is timely, accurate, complete, and relevant to the program.

52. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program selects valid, reliable performance measures based on evidence-based national guidelines or, in the absence of such guidelines, expert consensus, and in the absence of both, a review of the health care literature.

53. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program collects data related to processes and outcomes at the level of the individual patient.

54. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program collects patient satisfaction data that is specific to the care, treatment, and services it provides. (For more information, refer to LD.03.02.01, EP 8)

   **Note:** A variety of methods may be used to collect this data, such as an organization-wide patient satisfaction survey, a program-specific satisfaction survey, or a telephone survey of patients in the program.

55. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program monitors the quality of data collected.
Introduction to Standard PI.02.01.01

When data are collected, they are analyzed using statistical tools and techniques. When the organization analyzes data over time, it transforms raw data into useful information. Analysis of data from internal sources allows the organization to identify patterns and trends and to monitor its performance. The organization may also have access to external databases that allow it to compare its performance with other organizations on a specific topic, such as a procedure or outcome.

Standard PI.02.01.01

The organization compiles and analyzes data.

Elements of Performance for PI.02.01.01

4. The organization analyzes and compares internal data over time to identify levels of performance, patterns, trends, and variations. (See also MC.01.01.01, EP 7)

8. The organization uses the results of data analysis to identify improvement opportunities. (See also LD.03.02.01, EP 5; PI.03.01.01, EP 1)

10. For home health agencies and hospices that elect to use The Joint Commission deemed status option: The organization uses the data collected to monitor the effectiveness and safety of services and the quality of care.

15. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: When useful, the program uses statistical tools and techniques to analyze data.

16. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The program identifies and evaluates variables that affect outcomes.

17. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The program uses its data analysis to improve and sustain its performance.

Standard PI.03.01.01

The organization improves performance.

Elements of Performance for PI.03.01.01

1. Leaders prioritize the identified improvement opportunities. (See also MC.01.01.01, EP 8; PI.02.01.01, EP 8)
2. The organization takes action on improvement priorities. *(See also* MC.01.01.01, EP 8; MM.08.01.01, EP 6)*

3. The organization evaluates actions to confirm that they resulted in improvements. *(See also* MC.01.01.01, EP 8)*

   **Note:** *For hospices that elect to use The Joint Commission deemed status option: The hospice’s governing body is ultimately accountable for making sure that improvement actions are evaluated for effectiveness.*

4. The organization takes action when it does not achieve or sustain planned improvements.

8. **For home health agencies and hospices that elect to use The Joint Commission deemed status option:** The number and scope of annual performance improvement projects is based on the patients’ needs and internal organization needs. The projects reflect the scope, complexity, and past performance of the organization’s services and operations.

9. **For home health agencies and hospices that elect to use The Joint Commission deemed status option:** The organization documents what performance improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on them.

13. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** Patients have a defined role in the evaluation of the provision of care, treatment, and services.
Prompts to Assess Your Compliance

Please note: Tips do not represent new accreditation requirements. They are intended to provide helpful strategies for standards compliance.

Is your organization reviewing what projects—such as compliance projects related to state and federal regulations (for example, Outcome and Assessment Information Set [OASIS] outcomes, Hospice Quality Assurance/Performance Improvement [QAPI], Hospice Quality Reporting Program/Hospice Item Set [HQRP/HIS] data set)—are in place prior to creating a new project? (PI.01.01.01)

Who evaluates current initiatives to identify projects that qualify as performance improvement? If a team is currently working to solve a problem, who is assigned to collect data on the issue and use the collected data to track improvement? (PI.01.01.01)

TIP: Review the defined requirements in PI.01.01.01, EPs 2–19 to ensure you are tracking the required elements (such as medication errors and patient satisfaction).

DMPOSO organizations: Also refer to PI 01.01.01, EPs 20–35.

Are you collecting patient satisfaction data and using the results to improve your performance? (PI.01.01.01, PI.03.01.01)
**TIP:** Consider the following suggestions for patient satisfaction data collection:
- Accommodate data collection via surveys (mailed or electronic), phone calls, patient interviews, or a combination of these options.
- Determine the time frame to evaluate—such as at the start of care, midway through care, or at discharge.
- Avoid evaluating only at discharge because doing so may cause you to miss an opportunity for early intervention on a problem and illicit a low overall response.

How often does your organization perform data analysis? (PI.02.01.01)

**TIP:** Determine the frequency at which to review data to ensure the following:
- Adequate data is available to assess for trends. (For some items, quarterly analysis may be sufficient.)
- Timely response occurs to address serious issues. (For other items, monthly analysis may be required.)

Are you responding to data with changes in process as needed? (PI.03.01.01)

Did you continue to track and monitor to see if an implemented change has improved the process? (PI.03.01.01)
If data consistently show a positive outcome for a specific indicator, determine the following (PI.03.01.01):

- Do you need to continue to monitor?
  - If yes, how often do you need to monitor? (Determine how often and whether the frequency can be decreased over time.)
  - If no, what other issues or processes do you need to address?

**TIP:** Do not continue to monitor the same things over and over again when they are working well; you may be ignoring other problems that should be monitored and improved on.
Home health organizations: Are you using your OASIS and other data to monitor and improve your performance? (PI.02.01.01)

Hospice organizations:
- Did you include more than nursing in your QAPI initiatives? (see LD.04.04.01)
- Are you collecting and submitting your required HQRP data at admission and discharge?

DMEPOS organizations: Did you include someone from your billing staff as part of your PI team so that they can collect data on CMS-required tracking of coding and billing errors? (PI.01.01.01)

Pharmacy organizations: Do you monitor utilization of medications and supplies, checking for both over- and under-dispensing? (PI.01.01.01, PI.02.01.01)

Personal care and support organizations:
- Do you monitor employee hand washing?
- Do you review the content of home health aide care plans? (PI.01.01.01; see also NPSG.07.01.01)

Deemed home health organizations:
- Does your organization’s QAPI plan meet the CMS criteria?
  - Reflects complexity of all services provided
  - Takes action to demonstrate improvement
  - Uses indicators related to improved outcomes (see LD.04.04.01)
Written Documentation Checklist

This worksheet lists elements of performance (EPs) that require written documentation that a surveyor could ask to see during a survey to show compliance with a standard.  
(Note: Documentation can be on paper or in an electronic format.)

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<th>✓</th>
<th>Standard</th>
<th>EP</th>
<th>Performance Improvement Standards</th>
<th>Home Care Service</th>
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<td>PI.03.01.01</td>
<td>9</td>
<td><strong>EP 9</strong>—For home health agencies and hospices that elect to use The Joint Commission deemed status option: The organization documents what performance improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on them.</td>
<td>Deemed HOS</td>
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## Action Planning Tool

Use this form to track noncompliant elements of performance (EPs) and your action steps for bringing them into compliance.

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<tr>
<th>Standard and EP</th>
<th>Observation/Issue</th>
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<th>Individual Responsible</th>
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Chapter Notes

Use this page to take notes about ideas for meeting the standards in this chapter, your organization’s policies and procedures that address requirements in this chapter, or the data or patient record numbers used to determine compliance or noncompliance for EPs. If a standard is found not compliant, it can be helpful to know which data were used so they can be easily accessed when developing action plans for compliance.
Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
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 patient 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 begins receiving services 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 staff that can facilitate the continuity of care and aid in clinical decision making.

Whether the organization keeps paper records, electronic records, or both, the contents of the record remain the same. Special care should be taken, however, by organizations that are transitioning from paper to electronic systems, as the period of transition can present increased opportunity for errors in recordkeeping that can affect the delivery of safe quality care.

About This Chapter
Within this chapter, those responsible for compiling the patient record can find a comprehensive set of requirements for its contents. The separate components of a complete patient record are listed and arranged within common groups (demographic, clinical, and additional information). This chapter also contains documentation requirements for screenings, assessments, and reassessments; the care, treatment, or services provided; and discharge. The standards provide a structure that guides 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, or Services (RC.02.01.01)
   B. Certification Statements (RC.02.02.01)
   C. Verbal Orders (RC.02.03.07)
### Applicability for Record of Care, Treatment, and Services

This grid is meant to be a resource to determine which standards and elements of performance (EPs) apply to the service categories within the Home Care Accreditation Program. The column on the far left of the grid lists the related EPs vertically by number. Service categories (defined in Table 3 of the Introduction) are listed horizontally along the top of the grid. Applicability is indicated with an “X” in a service category column.

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Standards, Rationales, and Elements of Performance

Standard RC.01.01.01
The organization maintains complete and accurate patient records.

Elements of Performance for RC.01.01.01

1. The organization defines the components of a complete patient record.

2. **For hospices that elect to use The Joint Commission deemed status option:** The hospice establishes and maintains a patient record for every individual who receives care, treatment, or services, in accordance with accepted standards of practice.

3. **For home health agencies that elect to use The Joint Commission deemed status option:** For every patient receiving home health services, the home health agency maintains an accurate patient record that contains pertinent past and current patient findings, documented in accordance with accepted standards of practice.

5. The patient record contains the information needed to support the patient’s diagnosis and condition.

6. The patient record contains the information needed to justify the patient’s care, treatment, or services.

7. The patient record contains information that documents the course and result of the patient’s care, treatment, or services.

8. The patient record contains information about the patient’s care, treatment, or services that promotes continuity of care among providers.

**Note: For home health agencies that elect to use The Joint Commission deemed status option:** Each patient’s record is available to the physician(s) issuing orders for the home health plan of care and to staff as needed.

10. The organization documents in the patient record the patient’s response to the care, treatment, or services provided.

11. All entries in the patient record are dated.
15. The organization maintains accurate, pertinent, and accessible patient records, in accordance with law and regulation.

16. **For hospices that elect to use The Joint Commission deemed status option:** The patient record is complete, promptly and accurately documented, readily accessible, and systematically organized to facilitate retrieval.

17. **For home health agencies that elect to use The Joint Commission deemed status option:** The patient record (hard copy or electronic form) is available to a patient upon request and free of charge either at the next home visit or within four business days, whichever comes first.

**Standard RC.01.02.01**
Entries in the patient record are authenticated.

**Elements of Performance for RC.01.02.01**

1. Only authorized individuals make entries in the patient record.

2. The organization defines the types of entries in the patient record made by nonindependent practitioners that require countersigning, in accordance with law and regulation.

3. The author of each patient record entry is identified in the patient record.

4. Entries in the patient record are authenticated by the author. Information introduced into the patient record through transcription or dictation is authenticated by the author.

**Note 1:** Authentication can be verified through electronic signatures, written signatures or initials, rubber-stamp signatures, or computer key.

**Note 2:** For paper-based records, signatures entered for purposes of authentication after transcription or for verbal orders are dated when required by law or regulation or organization policy. For electronic records, electronic signatures will be date-stamped.

9. **For home health agencies and hospices that elect to use The Joint Commission deemed status option:** All entries in the patient record are legible, clear, complete, and appropriately authenticated and dated in accordance with the organization’s policy and currently accepted standards of practice.

**For home health agencies that elect to use The Joint Commission deemed status option:**

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Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.

All entries in the patient record must also be timed.
Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry.

**Standard RC.01.03.01**

Documentation in the patient record is entered in a timely manner.

**Elements of Performance for RC.01.03.01**

1. The organization defines in writing the time frames for documenting entries into the patient record. *(See also PC.01.02.03, EP 1)*
2. The organization defines the time frame for completion of the patient record.
3. The organization documents entries into the patient’s record within its defined time frames. *(See also PC.01.02.03, EP 2)*

**Standard RC.01.04.01**

The organization audits its patient records.

**Elements of Performance for RC.01.04.01**

1. According to a time frame it defines, the organization reviews its patient records to confirm that the required information is present, accurate, legible, authenticated, and completed on time.

**Standard RC.01.05.01**

The organization retains its patient records.

**Elements of Performance for RC.01.05.01**

1. The retention time of the patient record is determined by its use and organization policy, in accordance with law and regulation.
2. **For hospices that elect to use The Joint Commission deemed status option:** The patient record is retained for six years after the death or discharge of the patient, unless state law stipulates a longer period of time.
3. **For home health agencies that elect to use The Joint Commission deemed status option:** The organization retains a patient’s record for a minimum of five years after the discharge of the patient, unless state law stipulates a longer period of time.
7. For home health agencies that elect to use The Joint Commission deemed status option: The organization’s policies require patient record retention regardless of whether the home health agency ceases to operate. When a home health agency discontinues operation, it must inform the state agency where patient (clinical) records will be maintained.

9. For hospices that elect to use The Joint Commission deemed status option: Hospice policies provide for the retention and storage of patient records in the event the hospice discontinues operation.

   **Note:** If the hospice discontinues operation, it informs its state agency and its Centers for Medicare & Medicaid Services (CMS) regional office where such records will be stored and how they may be accessed.

**Standard RC.02.01.01**

The patient record contains information that reflects the patient’s care, treatment, or services.

**Elements of Performance for RC.02.01.01**

1. The patient record contains the following demographic information:
   - The patient’s name, address, phone number, and date of birth and the name and phone number of any legally authorized representative
   - The patient’s sex
   - The patient’s language and communication needs
   - The name and telephone number of the person to be contacted in the event of emergency or death

2. The patient record contains the following clinical information:
   - Any medications administered, including dose
   - Any activity restrictions
   - Any changes in the patient’s condition
   - Any summaries of the patient’s care, treatment, or services furnished to the patient’s physician or licensed independent practitioner(s)
   - The patient’s medical history
   - Any allergies to medications
   - Any adverse drug reactions
   - The patient’s functional status
   - Any diet information or any dietary restrictions
   - Diagnostic and therapeutic tests, procedures, and treatments, and their results
Any specific notes on care, treatment, or services
- The patient’s response to care, treatment, or services
- Any assessments relevant to care, treatment, or services
- Physician orders
- Any information required by organization policy, in accordance with law and regulation
- A list of medications, including dose, strength, frequency, route, date, and time of administration for prescription and nonprescription medications, herbal products, and home remedies that relate to the patient’s care, treatment, or services
- The plan(s) of care
- **For DMEPOS suppliers serving Medicare beneficiaries:** The DMEPOS prescription, any certificates of medical necessity (CMN), and pertinent documentation from the beneficiary’s prescribing physician. *(See also PC.01.02.01, EP 1; PC.01.03.01, EP 23)*

**Note 1:** *For organizations that provide personal care and support services:* The plan of care may be a part of the service agreement or service contract, a list of duties to be carried out by the personal care or support service staff, or another separate document.

**Note 2:** *For organizations that provide personal care and support services:* The patient record contains the documentation on the list noted above that applies to the care, treatment, or services provided by the personal care and support staff.

3. **For home health agencies that elect to use The Joint Commission deemed status option:** The patient record contains the following:
- Identifying information
- The name of the physician
- The patient’s current comprehensive assessment, and the assessments from the most recent home health admission
- Any medication, dietary, treatment, and activity orders
- All interventions, including medication administration, treatments, and services, and responses to those interventions
- Patient’s responses to all interventions, medications, treatments and services
- Goals in the patient’s plans of care and the patient’s progress toward achieving them
- Any signed and dated clinical and progress notes
Contact information for the patient, the patient’s representative (if any) and the patient’s primary caregiver

Contact information for the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the home health agency

Any copies of summary reports sent to the attending physician

A completed discharge summary

(See also PC.04.02.01, EP 3 and RC.02.01.01, EP 2)

4. When applicable to the patient’s care, treatment, or services, the organization documents the following additional information: R

- Informed consent, as required by organization policy

Note: For organizations that provide personal care and support services: An informed consent can be a separate document, or included as part of the service agreement or service contract.

- Any wishes the patient has regarding advance directives
- Any medical equipment either provided by the organization or used for the patient’s care, treatment, or services
- Any documents that record the suitability of the patient’s home for, or the adaptation of the patient’s home to, the care, treatment, or services ordered
- Any safety measures employed to protect the patient from harm
- Any education provided to the patient and his or her family
- Any communication with the patient’s physician or other licensed independent practitioner(s)
- Any names of individuals and organizations involved in the patient’s care, treatment, or services
- Any information received about the patient from transferring organizations
- Any information that is provided to a receiving organization when a patient is transferred
- Any patient referrals made to internal and external health care professionals, including community agencies
- Any communication with the patient

5. For hospices that elect to use The Joint Commission deemed status option: The hospice documents in the patient record the patient’s initial assessment, comprehensive assessment, and updated comprehensive assessments.
6. **For hospices that elect to use The Joint Commission deemed status option:** The patient record contains complete documentation of all services and events provided directly or by arrangement, including evaluations, treatments, and progress notes.

8. **For hospices that elect to use The Joint Commission deemed status option:** The hospice initiates and maintains documentation of each patient’s plan of care in the patient record.

9. **For hospices that elect to use The Joint Commission deemed status option:** The interdisciplinary group documents its review and revision of the patient’s plan of care.

17. The organization documents in the patient record that the patient received training and instructions on the use of items supplied by mail order at the time of their initial delivery.

18. **For suppliers of complex rehabilitation and assistive technology services:** The organization documents in the patient record all information obtained during the assessment.

19. **For DMEPOS suppliers serving Medicare beneficiaries:** The organization collects pre-treatment photographic documentation when needed for custom orthotics and prosthetics to be provided to the beneficiary.

23. **For DMEPOS suppliers serving Medicare beneficiaries:** The organization documents in the patient record the make and model or any other identifier of the noncustom equipment provided.

24. **For DMEPOS suppliers serving Medicare beneficiaries:** The organization documents in the patient record the evaluation of the seating, positioning, and specialty assistive technology to be provided to the beneficiary.

25. **For hospices that elect to use The Joint Commission deemed status option:** The interdisciplinary group documents in the patient record the level of the patient’s or representative’s understanding of, involvement with, and agreement with the plan of care.

26. **For hospices that elect to use The Joint Commission deemed status option:** The patient record contains documentation of outcome measure data elements.
31. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** If the patient has an advance directive, a copy is included in the patient’s medical record.

32. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** If the patient has expressed preferences for treatment as his or her disease progresses, the interdisciplinary team will document these preferences in the medical record.

**Standard RC.02.02.01**
The patient record contains certification statements.

**Element of Performance for RC.02.02.01**
7. **For hospices that elect to use The Joint Commission deemed status option:** The organization files written certification statements in the patient record.

**Standard RC.02.03.07**
Qualified staff receive and record verbal orders.

**Elements of Performance for RC.02.03.07**
2. ☐ Only authorized staff receive and record verbal orders.

   **Note:** **For home health agencies that elect to use The Joint Commission deemed status option:** Staff are authorized to receive and record verbal orders by law and regulation and by the organization’s internal policies.

3. ☐ **For home health agencies that elect to use The Joint Commission deemed status option:** Verbal orders are documented in the patient record and signed, dated, and timed by a registered nurse or qualified practitioner responsible for furnishing or supervising the ordered care, treatment, or services.

5. **For hospices that elect to use The Joint Commission deemed status option:** When a verbal or electronic order for medication is received, the individual who receives it records and signs it immediately and has the prescriber sign it in accordance with state and federal regulations.
Prompts to Assess Your Compliance

Please note: Tips do not represent new accreditation requirements. They are intended to provide helpful strategies for standards compliance.

What is the organization’s policy for conducting ongoing review of patient records? (RC.01.04.01)

Is the documentation process streamlined to support compliance and accuracy? (RC.01.01.01)

Is there unnecessary duplication of documentation?

TIP: Work with staff members on specific identified problem areas in their documentation.
What is the organization’s policy concerning retention of records? (RC.01.05.01)

What is the organization’s policy concerning receiving and recording verbal orders? (RC.02.03.07; see also MM.04.01.01 in the “Medication Management” [MM] chapter)

**Hospice deemed organizations:** Do the records of Medicare hospice patients include the required documentation of the patient’s initial assessment, comprehensive assessment, and updated comprehensive assessments? (RC.02.01.01)

**DMEPOS organizations:** Does each patient’s record include the DMEPOS prescription and certificates of medical necessity (CMN) as needed? (RC.02.01.01)
**Written Documentation Checklist**

This worksheet lists elements of performance (EPs) that require written documentation that a surveyor could ask to see during a survey to show compliance with a standard. *(Note: Documentation can be on paper or in an electronic format.)*

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

<table>
<thead>
<tr>
<th>✓</th>
<th>Standard</th>
<th>EP</th>
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<td></td>
<td>RC.01.01</td>
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<td>EP 3—For home health agencies that elect to use The Joint Commission deemed status option: For every patient receiving home health services, the home health agency maintains an accurate patient record that contains pertinent past and current patient findings, documented in accordance with accepted standards of practice.</td>
<td>Deemed HH</td>
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</table>
|    | RC.01.02 | 9  | EP 9—For home health agencies and hospices that elect to use The Joint Commission deemed status option: All entries in the patient record are legible, clear, complete, and appropriately authenticated and dated in accordance with the organization’s policy and currently accepted standards of practice. For home health agencies that elect to use The Joint Commission deemed status option:  
  - All entries in the patient record must also be timed.  
  - Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry. | Deemed HH, HOS |        |
|    | RC.01.03 | 1  | EP 1—The organization defines in writing the time frames for documenting entries into the patient record. | All services |        |
|    | RC.01.05 | 1, 7, 9 | EP 1—The retention time of the patient record is determined by its use and organization policy, in accordance with law and regulation. | EP 1—All services |        |

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
| RC.02.01.01 | 2,3 | EP 2—The patient record contains the following clinical information:
- Any medications administered, including dose
- Any activity restrictions
- Any changes in the patient's condition
- Any summaries of the patient's care, treatment, or services furnished to the patient's physician or licensed independent practitioner(s)
- The patient's medical history
- Any allergies to medications
- Any adverse drug reactions
- The patient's functional status
- Any diet information or any dietary restrictions
- Diagnostic and therapeutic tests, procedures, and treatments, and their results
- Any specific notes on care, treatment, or services
- The patient's response to care, treatment, or services
- Any assessments relevant to care, treatment, or services
- Physician orders
- Any information required by organization policy, in accordance with law and regulation | EP 2—All services |
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<td>A list of medications, including dose, strength, frequency, route, date and time of administration for prescription and nonprescription medications, herbal products, and home remedies that relate to the patient's care, treatment, or services.</td>
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<td>The plan(s) of care.</td>
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<td><strong>For DMEPOS suppliers serving Medicare beneficiaries:</strong> The DMEPOS prescription, any certificates of medical necessity (CMN), and pertinent documentation from the beneficiary's prescribing physician.</td>
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<td>EP3—For home health agencies that elect to use The Joint Commission deemed status option:</td>
<td>The patient record contains the following:</td>
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- Contact information for the patient, the patient’s representative (if any) and the patient’s primary caregiver
- Contact information for the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the home health agency
- Any copies of summary reports sent to the attending physician
- A completed discharge summary (See also PC.04.02.01, EP 3 and RC.02.01.01, EP 2)

<table>
<thead>
<tr>
<th>RC.02.03.07 2,3</th>
<th>EP 2—Only authorized staff receive and record verbal orders.</th>
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<td>EP 3—For home health agencies that elect to use The Joint Commission deemed status option: Verbal orders are documented in the patient record and signed, dated, and timed by a registered nurse or qualified practitioner responsible for furnishing or supervising the ordered care, treatment, or services.</td>
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# Action Planning Tool

Use this form to track noncompliant elements of performance (EPs) and your action steps for bringing them into compliance.

<table>
<thead>
<tr>
<th>Standard and EP</th>
<th>Observation/Issue</th>
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Chapter Notes

Use this page to take notes about ideas for meeting the standards in this chapter, your organization’s policies and procedures that address requirements in this chapter, or the data or patient record numbers used to determine compliance or noncompliance for EPs. If a standard is found not compliant, it can be helpful to know which data were used so they can be easily accessed when developing action plans for compliance.
Rights and Responsibilities of the Individual (RI)

Overview

When the organization 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 organization and those people directly involved in their care, treatment, or services.

Recognizing and respecting patient rights directly affects the provision of care. Care, treatment, or 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, or 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 organization 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 organization shows its support of patient rights through its interactions with patients and by involving them in decisions about their care, treatment, or 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, or services
About This Chapter
This chapter presents a series of requirements that help organizations 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, RI.01.02.03)
   C. Informed Consent (RI.01.03.01, RI.01.03.05)
   D. Right to Know (RI.01.04.01)
   E. End-of-Life Issues (RI.01.05.01)
   F. Personal Rights (RI.01.06.03, RI.01.06.05, RI.01.06.09)
   G. Services Provided by Organizations to Respect Patient Rights (RI.01.07.01, RI.01.07.05)

II. Patient Responsibilities (RI.02.01.01)
Applicability for Rights and Responsibilities of the Individual

This grid is meant to be a resource to determine which standards and elements of performance (EPs) apply to the service categories within the Home Care Accreditation Program. The column on the far left of the grid lists the related EPs vertically by number. Service categories (defined in Table 3 of the Introduction) are listed horizontally along the top of the grid. Applicability is indicated with an “X” in a service category column.

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Standards, Rationales, and Elements of Performance

Introduction to Standard RI.01.01.01
This standard focuses on how the organization respects the rights of the patient during his or her encounter with the organization. However, a mere list of rights cannot guarantee the patient’s rights. An organization puts its respect for the patient’s rights into action by showing its support of these rights through the way, that staff interact with the patient and involve him or her in care, treatment, or services.

Standard RI.01.01.01
The organization respects, protects, and promotes patients’ rights.

Elements of Performance for RI.01.01.01

1. The organization has written policies on patient rights.

2. The organization informs the patient of his or her rights prior to beginning care, treatment, or services or during the initial evaluation visit before beginning care, treatment, or services. (See also RI.01.01.03, EPs 1–3)

   For hospice organizations that elect to use The Joint Commission deemed status option: The organization informs the patient of his or her rights both orally and in writing.

   For home health organizations that elect to use The Joint Commission deemed status option: The home health agency provides written notice of the patient’s rights and responsibilities and the organization’s transfer and discharge policies to a patient-selected representative within four business days of the initial evaluation visit.

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

4. The organization respects the patient’s right to and need for effective communication. (See also RI.01.01.03, EP 1)

5. The organization respects the patient’s cultural and personal values, beliefs, and preferences.
7. The organization respects the patient’s right to privacy. *(See also IM.02.01.01, EPs 1–9)*

**Note:** This element of performance (EP) addresses a patient’s personal privacy. For EPs addressing the privacy of a patient’s health information, please refer to Standard IM.02.01.01.

8. The organization respects the patient’s right to pain management. *(See also HR.01.04.01, EP 4; PC.01.02.07, EP 1)*

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

10. The organization 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.

11. **For home health agencies that elect to use The Joint Commission deemed status option:** The home health agency obtains the patient’s or legal representative’s signature confirming that he or she has received a copy of the notice of rights and responsibilities.

20. **For hospices that elect to use The Joint Commission deemed status option:** The hospice obtains the signature of the patient or representative to confirm that he or she has received a copy of the notice of rights and responsibilities. *(See also LD.04.03.03, EP 9)*

21. **For hospices that elect to use The Joint Commission deemed status option:** The hospice advises each patient and his or her family on the availability of spiritual counseling services.

33. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program provides care, treatment, and services in a manner that meets the patient’s communication needs.

34. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** While providing care, treatment, and services, program staff accommodate the patient’s and family’s cultural preferences and practices unless they are contraindicated or the accommodations affect the care of others.
35. **For home health agencies that elect to use The Joint Commission deemed status option:** The organization must provide the patient and the patient’s legal representative (if any) the following information during the initial evaluation visit (in advance of providing care):

- Written notice of the patient’s rights and responsibilities and the organization’s transfer and discharge policies (See also RI.01.01.03, EP 1)
- Contact information for the home health administrator, including the administrator’s name, business address, and business phone number in order to receive complaints (See also RI.01.07.01, EP 2)
- An Outcome and Assessment Information Set (OASIS) privacy notice to all patients for whom the OASIS data is collected (See also IM.02.01.01, EP 8)

36. **For home health agencies that elect to use The Joint Commission deemed status option:** The patient has the right to receive all services outlined in the plan of care.

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**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, or 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 organizations 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 organization has many options available to assist in communication with these individuals, such as interpreters, translated written materials, pen and paper, communication boards, and speech therapy. It is up to the organization to 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. Organizations may wish to reference these sources for additional information on providing interpreting and translation services to their patients.

**Standard RI.01.01.03**

The organization 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 organization provides information in a manner tailored to the patient’s age, language, and ability to understand. *(See also RI.01.01.01, EPs 2 and 5; PC.02.03.01, EP 3; PC.04.01.05, EP 8)*  

   **Note:** For home health organizations that elect to use The Joint Commission deemed status option: The patient and representative (if any) have the right to be informed of the patient’s rights in a language and manner the individual understands.

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

3. The organization communicates with the patient who has vision, speech, hearing, or cognitive impairments in a manner that meets the patient’s needs. *(See also RI.01.01.01, EP 2)*

   **For home health agencies that elect to use The Joint Commission deemed status option:** The home health agency provides information to patients in a manner that is understandable, accessible, and timely as follows:

   - Persons with disabilities are provided accessible web sites and auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.
   - Persons with limited English proficiency are provided language services at no cost to the individual, including oral interpretation and written translations.
6. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** Program staff discuss with patients how they want to receive information, including the type of information, the method in which it is provided, which family members are to receive this information, and whether a surrogate decision-maker is involved in care, treatment, and services. (For more information on the role of surrogate decision-makers, see Standard RI.01.02.01.)

7. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program respects the patient’s right to be informed about his or her care by providing information in a manner tailored to the patient’s age, language, and ability to understand.

8. **For home health agencies that elect to use The Joint Commission deemed status option:** The home health agency provides interpreter services, if necessary, free of charge. These services are provided no later than the completion of the second visit from a skilled professional.

**Standard RI.01.02.01**
The organization respects the patient’s right to participate in decisions about his or her care, treatment, or services.

**Rationale for RI.01.02.01**
The organization that recognizes the patient’s right to participate in his or her care decisions and involves the patient in making those decisions validates patient rights as a key aspect of care. Involving patients in care decisions helps the patient develop a better understanding of his or her care, which can lead to safer care and better care outcomes. This involvement includes informing the patient of outcomes of care, treatment, or services, including those outcomes that may have been unanticipated.

**Elements of Performance for RI.01.02.01**
1. The organization involves the patient in making decisions about his or her care, treatment, or services.
2. When a patient is unable to make decisions about his or her care, treatment, or services, the organization involves a surrogate decision maker in making these decisions. (See also RI.01.03.01, EP 1)
3. The organization respects the patient’s or surrogate decision maker’s right to refuse care, treatment, or services, in accordance with law and regulation.
8. The organization involves the patient’s family in care, treatment, or services decisions to the extent permitted by the patient or surrogate decision-maker, in accordance with law and regulation.

15. **For home health agencies that elect to use The Joint Commission deemed status option:** The patient has the right to participate in, be informed about, and consent or refuse care in advance of and during treatment, when appropriate, with respect to the following:
   - The completion of all assessments
   - The care to be furnished, based on the comprehensive assessment
   - Establishing and revising the plan of care
   - The disciplines that will furnish the care
   - The frequency of visits
   - Expected outcomes of care, including patient-identified goals and anticipated risks and benefits
   - Any factors that could impact treatment effectiveness
   - Any changes in the care to be furnished

16. **For home health agencies that elect to use The Joint Commission deemed status option:** The home health agency advises the patient, representative (if any), caregiver, and all physicians issuing orders for the plan of care when there is any revision in the plan of care due to a change in patient health status before the change is made.

17. The organization provides its contact information when the patient receives rental equipment.

18. **For DMEPOS suppliers serving Medicare beneficiaries:** The organization provides the patient with options for renting or purchasing equipment and items.

19. **For custom orthotics and prosthetics services:** The organization asks the patient for comments to determine the effectiveness of the custom orthotics and prosthetics provided.

   **Note:** Based on the type of custom orthotic or prosthetic, the patient might be asked about his or her wear schedule or tolerance of the orthotic or prosthetic, comfort, perceived benefits, ability to don and doff, satisfaction with the usefulness and function of the orthotic or prosthetic.

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

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
Comprehensive Accreditation Manual for Home Care

- Outcomes of the patient’s care, treatment, or services that he or she needs in order to participate in current and future health care decisions
- A sentinel event (either an incident or an unanticipated outcome) of the patient’s care, treatment, or service (Refer to the Glossary for a definition of sentinel event.)

23. **For hospices that elect to use The Joint Commission deemed status option**: The patient’s family or guardian may exercise the patient’s rights when the patient has been judged incompetent.

26. **For home health agencies that elect to use The Joint Commission deemed status option**: The home health agency advises the patient and his or her representative (if any) verbally and in writing of any changes in the charges and payment information as soon as possible in advance of the next home health visit.

   **Note**: The home health agency must also comply with the patient notice requirements at 42 CFR 411.408(d)(2) and 42 CFR 411.408(f).

29. **For hospices that elect to use The Joint Commission deemed status option**: The hospice provides the patient with information about the scope of services the hospice will provide and any limitations on those services.

30. **For hospices that elect to use The Joint Commission deemed status option**: The hospice provides the patient with information about the services covered under the hospice benefit.

36. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option**: Program staff educate the patient and family on disease processes and prognosis so that they are able to make informed care decisions.

37. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option**: In instances in which the patient has a designated surrogate decision-maker, a member of the interdisciplinary team documents the surrogate decision-maker’s name and contact information in the medical record.

38. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option**: For programs that provide care for pediatric patients: When developmentally appropriate, the child’s opinions and preferences are considered when making decisions and providing care.
39. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: For programs that provide care for pediatric patients:**

   When developmentally appropriate and proper for the clinical circumstance, the program provides age-appropriate information about the child’s illness, as well as potential treatments and outcomes, to the child as decided by the child’s family.

**Standard RI.01.02.03**

**For Medicare-certified hospices:** The organization respects the patient’s right to elect his or her hospice care.

**Element of Performance for RI.01.02.03**

1. **For hospices that elect to use The Joint Commission deemed status option:** The organization respects the patient’s right to elect and revoke hospice care, in accordance with Medicare hospice regulations.

   **Note:** Further information about electing and revoking hospice care can be found in 42 CFR 418.20, 418.21, 418.24, 418.28, and 418.30.

**Standard RI.01.03.01**

The organization 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 organization about the care, treatment, or services that the patient will receive. Unlike the consent to receive care, which acknowledges the patient’s agreement to receive care from the organization, 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 organization follows a written policy on informed consent that describes the following:
   - The specific care, treatment, or services that require informed consent
   - Circumstances that would allow for exceptions to obtaining informed consent
   - How informed consent is documented in the patient record
Note 1: Documentation may be recorded in a form, in progress notes, or elsewhere in the record.

Note 2: For organizations that provide personal care and support services: An informed consent can be a separate document, or included as part of the service agreement or service contract.

- When a surrogate decision-maker may give informed consent (See also RI.01.02.01, EP 2)

2. The informed consent process includes a discussion about the following:
   - The patient’s proposed care, treatment, or services.
   - Potential benefits, risks, and side effects of the patient’s proposed care, treatment, or services, and the likelihood of the patient achieving his or her goals.
   - Reasonable alternatives to the patient’s proposed care, treatment, or services. The discussion encompasses risks, benefits, and side effects related to the alternatives and the risks related to not receiving the proposed care, treatment, or services.

3. The organization obtains and documents informed consent in advance 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.

4. For custom orthotics and prosthetics services: The organization informs the patient about the potential risks, benefits, and precautions of the recommended treatment plan and any optional plans.

5. For custom orthotics and prosthetics services: The organization informs the patient of the recommended treatment plan.

Standard RI.01.03.05
The organization 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 organization 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, or services available to the patient that might prove advantageous to the patient

3. The organization 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, or services unrelated to the research.

4. The organization 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, or 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 organization respects the patient’s right to receive information about the individual(s) providing his or her care, treatment, or services.

Elements of Performance for RI.01.04.01

2. The organization provides the patient with information about the identity and role of the staff member(s) who will provide care, treatment, or services.

Standard RI.01.05.01

The organization addresses patient decisions about care, treatment, or services received at the end of life.
Elements of Performance for RI.01.05.01

1. The organization follows written policies on advance directives, forgoing or withdrawing life-sustaining treatment, and withholding resuscitative services that address the following:
   - Which patients the organization will ask about advance directives.
   - Limitations the organization has in respecting the patient’s advance directives.
   - Staff knowledge of the patient’s advance directives and any updates made to the advance directives.
   - How the organization will honor the patient’s advance directives.

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

18. **For hospices that elect to use The Joint Commission deemed status option:** The organization complies with the Medicare requirements regarding advance directives, which are located in subpart I of part 489 of the Code of Federal Regulations.

22. **For hospices that elect to use The Joint Commission deemed status option:** The hospice informs the patient of and provides the patient with written information about its policies on advance directives, including a description of any state law concerning advance directives.

23. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** As defined by the program, staff provide information and education about advance care planning to the patient and family as appropriate to the patient’s clinical status, based on the patient’s expressed values, religious or spiritual beliefs, cultural practices, and preferences for care. This information is documented in the medical record and shared with the interdisciplinary team.

**Standard RI.01.06.03**
The patient has the right to be free from neglect; exploitation; and verbal, mental, physical, and sexual abuse.

**Rationale for RI.01.06.03**
All patients should be protected from neglect, exploitation, and abuse. Home care organizations need to proactively decide what they will do to make sure that patients are protected. This includes doing whatever the organization can to make sure that the patient is safe while under the care of the organization. This standard differs from...
Standard PC.01.02.09 in that it addresses what the organization does to make sure that neglect, exploitation, and abuse do not happen, while Standard PC.01.02.09 addresses what an organization does if it suspects that a patient may be a victim of neglect, exploitation, or abuse.

### Elements of Performance for RI.01.06.03

1. The organization determines how it will protect the patient from neglect, exploitation, and abuse that could occur while the patient is receiving care, treatment, or services from the organization. R

   **Note: For hospices that elect to use The Joint Commission deemed status option:**
   The hospice also determines how it will protect residents so they are free from corporal punishment.

2. The organization evaluates all allegations, observations, and suspected cases of neglect, exploitation, and abuse that occur during the time that the patient is receiving care, treatment, or services from the organization. (See also PC.01.02.09, EP 1) R

3. The organization reports allegations, observations, and suspected cases of neglect, exploitation, and abuse to appropriate authorities based on its evaluation of the suspected events. (See also PC.01.02.09, EPs 6 and 7)

   **Note: For hospices that elect to use The Joint Commission’s deemed status option:**
   Verified violations are reported to the state and local bodies having jurisdiction and the state survey and certification agency within five working days from the time the hospice administration becomes aware of the violation.

4. **For hospices that elect to use The Joint Commission deemed status option:** The hospice takes corrective action when a violation involving anyone furnishing services on behalf of the hospice is confirmed by hospice administration or an outside body such as a local law enforcement agency.

5. **For hospices that elect to use The Joint Commission deemed status option:** The hospice uses established procedures to investigate and document all alleged violations.

### 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. The organization allows the patient to keep and use personal clothing and possessions, unless this infringes on others’ rights or is medically contraindicated, based on the setting or service.

5. **For home health agencies and hospices that elect to use The Joint Commission deemed status option:** The patient has the right to have his or her property treated with respect.

7. The organization provides environmental adaptations to help patients with dementia, cognitive impairment, or temporary confusion.

10. The organization informs the patient in advance of room and roommate assignments and changes.

23. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** The hospice has accommodations for family privacy after a patient’s death.

31. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** The hospice accommodates requests for a single room whenever possible.

**Standard RI.01.06.09**

The patient has the right to choose his or her medical, dental, and other licensed independent practitioner care providers.

**Element of Performance for RI.01.06.09**

1. **For hospices that elect to use The Joint Commission deemed status option:** The hospice respects the patient’s right to choose his or her attending physician.

**Standard RI.01.07.01**

The patient and his or her family have the right to have complaints reviewed by the organization.

**Elements of Performance for RI.01.07.01**

1. The organization establishes a complaint resolution process and informs the patient and his or her family about it.

4. The organization reviews and, when possible, resolves complaints from the patient and his or her family.
6. When a patient submits a complaint that the organization recognizes as significant, the organization acknowledges receipt of the complaint and notifies the patient of follow-up to the complaint.

7. The organization provides the patient with the phone number and address needed to file a complaint with the relevant state authority.

10. The organization allows the patient to voice complaints and recommend changes freely without being subject to coercion, discrimination, reprisal, or unreasonable interruption of care.

11. **For home health agencies and hospices that elect to use The Joint Commission deemed status option:** The patient has the right to voice grievances regarding care, treatment, or services that are (or fail to be) provided, or lack of respect for property shown by anyone who is furnishing care, treatment, or services on behalf of the organization.

13.  

14. **For DMEPOS suppliers serving Medicare beneficiaries:** Within five calendar days of receiving a patient’s complaint, the organization notifies the patient by telephone, e-mail, fax, letter, or in person that it has received the complaint and that it is being investigated.

15. **For DMEPOS suppliers serving Medicare beneficiaries:** Within 14 calendar days of receiving a patient’s complaint, the organization provides written notification to the patient of the results of its investigation and its response to those results.

16. **For DMEPOS suppliers serving Medicare beneficiaries:** The organization maintains documentation of all complaints, copies of investigations, and responses to patients.

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Note: For home health agencies that elect to use The Joint Commission deemed status option: The organization documents both the existence and resolution of each complaint.
30. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program encourages patients to express any concerns or complaints about their care to staff.

31. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** Program staff are aware of how to handle patients’ or families’ concerns or complaints about the program or their care.

32. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program’s leaders inform staff, patients, and families about the organization’s process to address concerns and resolve ethical concerns that may occur in the provision of community-based palliative care. (For more information, refer to Standard RI.01.07.01 and LD.04.02.03, EP 1.)

   **Note:** Examples of ethical concerns that may occur include, but are not limited to, changing or withdrawing treatments, conflict with advance directives and advance care planning decisions, and use of sedation and pain medications.

33. **For home health agencies that elect to use The Joint Commission deemed status option:** The organization provides the patient with the names, addresses, and telephone numbers of the following federally-funded and state-funded entities that serve the area where the patient resides:

   - Agency on Aging
   - Center for Independent Living
   - Protection and Advocacy Agency
   - Aging and Disability Resource Center
   - Quality Improvement Organization (QIO)

**Standard RI.01.07.05**

The patient has the right to receive and restrict visitors.

**Elements of Performance for RI.01.07.05**

1. The organization allows the patient to receive visitors at any time.

2. The organization provides space for the patient to receive visitors in comfort and privacy.

3. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** The hospice has space for private patient/family visiting.
7. The organization respects the patient’s right to refuse to talk to persons not associated with the organization or not directly involved in the patient’s care; such persons include visitors, vendors, accreditation surveyors, and representatives of community organizations.

8. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** The hospice has accommodations for family members to remain with the patient throughout the night.

9. **For hospices providing inpatient care in their own facilities that elect to use The Joint Commission deemed status option:** The patient is permitted to receive visitors, including young children, at any hour.

**Introduction to Standard RI.02.01.01**

The safety of patients is enhanced when patients are partners in the health care process. In addition, organizations are entitled to reasonable and responsible behavior on the part of patients and their families. When organizations inform patients and their families about their responsibilities, some of the topics that are discussed could include the following:

- Providing information. Patients should provide, to the best of their knowledge, accurate information about present complaints, past illnesses, hospitalizations, medications, and other matters related to their health.
- Sharing expectations. Patients should provide the organization with information about their expectations of and satisfaction with the organization.
- Asking questions. Patients should ask questions when they do not understand their care, treatment, or services or what they are expected to do.
- Following instructions. Patients should follow instructions about their care, treatment, or services. They should also express any concerns about their ability to follow the instructions.
- Accepting consequences. Patients should accept their share of responsibility for the outcomes of care, treatment, or services if they do not follow the instructions about their care, treatment, or services.
- Following policies and procedures. Patients should follow the organization’s policies and procedures.
- Showing respect and consideration. Patients should be considerate of the organization’s staff and property, as well as other patients and their property.
Meeting financial commitments. Patients should meet any financial obligation agreed to with the organization.

**Standard RI.02.01.01**

The organization informs the patient about his or her responsibilities related to his or her care, treatment, or services.

**Elements of Performance for RI.02.01.01**

1. ☑️ The organization has a written policy that defines patient responsibilities.

2. The organization 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.

4. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** Program staff inform patients and families of their responsibility to provide information that is important to care, treatment, and services.
Prompts to Assess Your Compliance

Please note: Tips do not represent new accreditation requirements. They are intended to provide helpful strategies for standards compliance.

How do leaders build support with staff on an approach to care that is patient and family centered? Consider the following: (RI.01.01.01, RI.01.01.03, RI.01.02.01)

- How do staff know who can participate in caregiving and make decisions on behalf of the patient?
- What processes support patient education and communication when the patient has vision, speech, hearing, or cognitive impairments?
- How are patient education and communication conducted when the patient does not speak English?
- How are staff educated about cultural or religious preferences that may be expressed by your patient population?
- How are expectations concerning patient rights communicated to contractors providing services on behalf of the organization?

TIP: Use supervisory visits in accordance with your policy to observe staff interaction with patient and caregivers relative to patient rights and to query patients regarding education received.

Do patient records capture the correct and complete informed consent information and signatures? (RI.01.03.01)
How do you know that staff are complying with the informed consent process as it is designed? (RI.01.03.01)

How are patients and caregivers educated about advance directives and end-of-life decisions? Who is involved in these decisions and where is this involvement documented? (RI.01.05.01)

Do you have a procedure for when a patient refuses care, treatment, or services? If yes, what procedures are followed? (RI.01.02.01)

**TIP:** Review a sample of your patient records to evaluate documentation of informed consent and advance directives, as well as any patient refusals of care, treatment, or services.

How do you ensure that discharge instructions are clearly conveyed to patients and caregivers? What process do you use to ensure that the patient/caregiver understands the discharge instructions? (RI.01.01.03; PC.04.01.05)
**TIP:** Follow up with patients to see that discharge instructions were provided using a language, level, and method the patient and caregiver can read and understand.

How do you handle situations in which patients are noncompliant in their homes with safety guidance, such as safe oxygen use or fall prevention? (RI.02.01.01)

**TIP:** Use a variety of reminders, such as small posters in the home to prompt visitors, as well as caregivers, about safety steps; focus on a different type of tip (kitchen safety, rugs and stairways, storage of cylinders) on each visit; enlist the support of the patient’s physician to reinforce safety messages.

What processes are in place to address patient or caregiver complaints (for example, about treatment, respect for property when in the home)? (RI.01.07.01)

**TIP:** Document the receipt of all complaints, and the resolution of each complaint.
Written Documentation Checklist
This worksheet lists elements of performance (EPs) that require written documentation that a surveyor could ask to see during a survey to show compliance with a standard. (Note: Documentation can be on paper or in an electronic format.)

<table>
<thead>
<tr>
<th>Standard</th>
<th>Rights and Responsibilities of the Individual Standards</th>
<th>Home Care Service</th>
<th>Date last verified</th>
</tr>
</thead>
<tbody>
<tr>
<td>RI.01.01</td>
<td>EP 1—The organization has written policies on patient rights.</td>
<td>EP 1—All services</td>
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<td>EP 2—The organization informs the patient of his or her rights prior to beginning care, treatment, or services during the initial evaluation visit before beginning care, treatment, or services.</td>
<td>EP 2—All services except LTP; see last statement specific to Deemed HOS</td>
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<td>For hospice organizations that elect to use The Joint Commission deemed status option: The organization informs the patient of his or her rights both orally and in writing.</td>
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<td>For home health organizations that elect to use The Joint Commission deemed status option: The home health agency provides written notice of the patient's rights and responsibilities and the organization's transfer and discharge policies to a patient-selected representative within four business days of the initial evaluation visit.</td>
<td>EP 11—Deemed HH</td>
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<td>EP 11—For home health agencies that elect to use The Joint Commission deemed status option: The home health agency obtains the patient’s or legal representative’s signature confirming that he or she has received a copy of the notice of rights and responsibilities.</td>
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</table>
### Rights and Responsibilities of the Individual

**EP 20** — *For hospices that elect to use The Joint Commission deemed status option:* The hospice obtains the signature of the patient or representative to confirm that he or she has received a copy of the notice of rights and responsibilities.

**EP 35** — *For home health agencies that elect to use The Joint Commission deemed status option:* The organization must provide the patient and the patient’s legal representative (if any) the following information during the initial evaluation visit (in advance of providing care):

- Written notice of the patient’s rights and responsibilities and the organization’s transfer and discharge policies *(See also RI.01.01.03, EP 1)*
- Contact information for the home health administrator, including the administrator’s name, business address, and business phone number in order to receive complaints *(See also RI.01.07.01, EP 2)*
- An Outcome and Assessment Information Set (OASIS) privacy notice to all patients for whom the OASIS data is collected *(See also IM.02.01.01, EP 8)*

**RI.01.02.01 26**

**EP 26** — *For home health agencies that elect to use The Joint Commission deemed status option:* The home health agency advises the patient and his or her representative (if any) verbally and in writing of any changes in the charges and payment information as soon as possible in advance of the next home health visit. Note: The home health agency must also comply with the patient notice requirements at 42 CFR 411.408(d)(2) and 42 CFR 411.408(f).
<table>
<thead>
<tr>
<th>RI.01.03.01</th>
<th>1, 3</th>
<th>EP 1—The organization follows a written policy on informed consent.</th>
<th>EP 1—HH, HOS, OP, CRS, FAI EP 3—All services (except DME (M), SUPP (M), CCP)</th>
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</thead>
</table>
| RI.01.03.05 | 4 | EP 4—The organization 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, or services unrelated to the research.  
- The name of the person who provided the information and the date the form was signed.  
- The research consent form describes the patient’s right to privacy, confidentiality, and safety. | EP 4—All services |
| RI.01.05.01 | 1, 22 | EP 1—The organization follows written policies on advance directives, forgoing or withdrawing life-sustaining treatment, and withholding resuscitative services that address the following:  
- Which patients the organization will ask about advance directives.  
- Limitations the organization has in respecting the patient’s advance directives. | EP 1—HH, HOS, CRS, RT, FAI |

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
| RI.01.07.01 | 4, 13, 15, 16 | EP 4—The organization reviews and, when possible, resolves complaints from the patient and his or her family. |
| EP 13—For home health agencies that elect to use The Joint Commission deemed status option: The organization provides patients with the state toll-free home health hotline, its contact information, its hours of operation, and the understanding that the purpose of the hotline is to receive complaints or questions about local home health agencies. |
| EP 15—For DMEPOS suppliers serving Medicare beneficiaries: Within 14 calendar days of receiving a patient's complaint, the organization provides written notification to the patient of the results of its investigation and its response to those results. |
| EP 16—For DMEPOS suppliers serving Medicare beneficiaries: The organization maintains documentation of all complaints, copies of investigations, and responses to patients. |
| RI.02.01.01 | 1 | EP 1—The organization has a written policy that defines patient responsibilities. |

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
Action Planning Tool

Use this form to track noncompliant elements of performance (EPs) and your action steps for bringing them into compliance.

<table>
<thead>
<tr>
<th>Standard and EP</th>
<th>Observation/Issue</th>
<th>Action Step</th>
<th>Individual Responsible</th>
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Chapter Notes

Use this page to take notes about ideas for meeting the standards in this chapter, your organization’s policies and procedures that address requirements in this chapter, or the data or patient record numbers used to determine compliance or noncompliance for EPs. If a standard is found not compliant, it can be helpful to know which data were used so they can be easily accessed when developing action plans for compliance.
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 nonwaived 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 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.accessdata.fda.gov/scripts/cdrh/cfdocs/cfClia/testswaived.cfm
■ http://wwwn.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)
**Applicability for Waived Testing**

This grid is meant to be a resource to determine which standards and elements of performance (EPs) apply to the service categories within the Home Care Accreditation Program. The column on the far left of the grid lists the related EPs vertically by number. Service categories (defined in Table 3 of the Introduction) are listed horizontally along the top of the grid. Applicability is indicated with an “X” in a service category column.

<table>
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<th>Standard/Requirement Number</th>
<th>EP Number</th>
<th>HH HH</th>
<th>PCS H</th>
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Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
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 organization whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88) certificate, or a qualified designee, establishes written policies and procedures for waived testing that address the following:

- Clinical usage and limitations of the test methodology
- Need for confirmatory testing (for example, recommendations made by the manufacturer for rapid tests) and result follow-up recommendations (for example, a recommendation to repeat the test when results are higher or lower than the reportable range of the test)
- Specimen type, collection, and identification, and required labeling
- Specimen preservation, if applicable
- Instrument maintenance and function checks, such as calibration
- Storage conditions for test components
- Reagent use, including not using a reagent after its expiration date
- Quality control (including frequency and type) and corrective action when quality control is unacceptable
- Test performance
- Result reporting, including not reporting individual patient results unless quality control is acceptable
- Equipment performance evaluation

**Note 1:** Policies and procedures for waived testing are made available to testing personnel.
Note 2: The designee should be knowledgeable by virtue of training, experience, and competence about the waived testing performed.

3. If manufacturers’ manuals or package inserts are used as the policies or procedures for each waived test, they are enhanced to include specific operational policies (that is, detailed quality control protocols and any other institution-specific procedures regarding the test or instrument).

4. The person from the organization whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88) certificate, or a qualified designee, approves in writing policies and procedures for waived testing at the following times:
   - Before initial use of the test for patient testing
   - Periodically thereafter, as defined by the person whose name appears on the CLIA certificate but at least once every three years
   - When changes in procedures occur (for example, when manufacturers’ updates to package inserts include procedural changes or when a different manufacturer is used)

5. Current and complete policies and procedures are available for use during testing to the person performing the waived test.

6. Written policies, procedures, and manufacturers’ instructions for waived testing are followed. (See also WT.04.01.01, EPs 3–6)

   Note: Manufacturers’ recommendations and suggestions are surveyed as requirements.

9. For home health agencies and hospices that elect to use The Joint Commission deemed status option: If the organization engages in laboratory testing, it maintains compliance with the Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88).

For home health agencies that elect to use The Joint Commission deemed status option: The organization may not substitute its equipment for a patient’s equipment when assisting with self-administered tests.

   Note: The organization is exempt from CLIA ’88 requirements when it only assists an individual in self-administering a waived test using an appliance that has been cleared by the Food and Drug Administration (FDA) for waived testing.
Standard WT.02.01.01
The person from the organization whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88) certificate identifies the staff responsible for performing and supervising waived testing.

Note 1: Responsible staff may be employees of the organization, contracted staff, or employees of a contracted service.

Note 2: Responsible staff may be identified within job descriptions or by listing job titles or individual names.

Elements of Performance for WT.02.01.01
1. The person from the organization whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88) certificate, or a qualified designee, identifies, in writing, the staff responsible for performing waived testing.

2. The person from the organization whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88) certificate, or a qualified designee, identifies, in writing, the staff responsible for supervising waived testing.

Standard WT.03.01.01
Staff and licensed independent practitioners performing waived tests are competent.

Elements of Performance for WT.03.01.01
1. The person from the organization whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88) certificate, or a qualified designee, provides orientation and training to, and assesses the competency of, staff 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 organization’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 organization policy at defined intervals, but at least at the time of orientation and annually thereafter. This competency is documented.

   Note: Provider-performed microscopy (PPM) procedures are not waived tests.

**Standard WT.04.01.01**

The organization performs quality control checks for waived testing on each procedure.

**Note:** Internal quality controls may include electronic, liquid, or control zone. External quality controls may include electronic or liquid.

**Elements of Performance for WT.04.01.01**

1. The person from the organization whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88) certificate establishes a written quality control plan for waived testing that specifies the method(s) for controlling procedures for quality, establishes timetables, and explains the rationale for choice of procedures and timetables. *(See also LD.04.01.01, EP 1)*

2. The documented quality control rationale for waived testing is based on the following:
   - How the test is used
   - Reagent stability
   - Manufacturers’ recommendations
   - The organization’s experience with the test
   - Currently accepted guidelines
3. For non-instrument-based waived testing, quality control checks are performed at the frequency and number of levels recommended by the manufacturer and as defined by the organization’s policies. *(See also WT.01.01.01, EP 6)*

**Note:** *If these elements are not defined by the manufacturer, the organization defines the frequency and number of levels for quality control.*

4. For instrument-based waived testing performed by a staff member in inpatient hospice or free-standing ambulatory infusion, quality control checks are performed on each instrument used for patient testing per manufacturers’ instructions. *(See also WT.01.01.01, EP 6)*

5. For instrument-based waived testing performed by a staff member in inpatient hospice or freestanding ambulatory infusion, quality control checks require two levels of control, if commercially available. *(See also WT.01.01.01, EP 6)*

6. For instrument-based waived testing performed by a staff member in home health or residential hospice settings, quality control checks are performed per manufacturers’ instructions. *(See also WT.01.01.01, EP 6)*

**Note:** *Quality control checks are not required on an individual instrument on days when it is not used for patient testing.*

---

**Standard WT.05.01.01**

The organization maintains records for waived testing.

**Elements of Performance for WT.05.01.01**

1. ☐ Quality control results, including internal and external controls for waived testing, are documented.

**Note 1:** *Internal quality controls may include electronic, liquid, or control zone. External quality controls may include electronic or liquid.*

**Note 2:** *Quality control results may be located in the patient record.*

2. Test results for waived testing are documented in the patient’s record.

3. Quantitative test result reports in the patient 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 record. The result must have a notation directing the reader to the location of the reference intervals (normal values) in the patient 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.
Prompts to Assess Your Compliance

Please note: Tips do not represent new accreditation requirements. They are intended to provide helpful strategies for standards compliance.

Does your organization have a Clinical Laboratory Improvement Amendments (CLIA) certificate? If so, who has your organization named on the CLIA certificate as the person responsible for waived testing? (WT.01.01.01, WT.02.01.01)

TIP: Assign someone to be responsible for the CLIA certificate:
- The certificate should be posted in a secure location, where it can be seen by both staff and surveyors.
- Keep track of the expiration date, and apply for renewal in a timely manner.
- If the person named on the certificate leaves the organization, someone else must be appointed and his or her name must be added to the certificate.

Does your organization have waived testing (WT) equipment that is used by the staff? If so, what types of equipment does your organization have, and what testing is being done by staff? (WT.03.01.01)
**TIP:** Any waived testing that is done by staff—either with equipment from the organization, equipment the staff member owns, or equipment that belongs to the patient—is regulated by CLIA, and must meet the regulations for this equipment and the testing. If staff are using the patient’s equipment only to provide instruction, then the CLIA regulations do not apply.

**Note:** As of January 13, 2018, the new Code of Federal Regulations (CFR) 42 CFR §484.100(c) and Joint Commission Standard WT.01.01.01, EP 9, go into effect. A deemed-status home health agency may not substitute its equipment for a patient’s equipment when assisting with self-administered tests.

Who does the quality control checks on WT equipment, and how often are the checks done? Where are the quality control results/logs kept? (WT.04.01.01, WT.05.01.01)

How does the organization instruct staff on the use of WT equipment? How are staff members assessed to ensure that they are competent to do waived testing? (WT.03.01.01)

**TIP:** Maintain documentation of the orientation, training, and competency records for staff related to waived testing. (Records can be maintained in writing or electronically.) Refer to the WT standards, your organization’s policies, and manufacturers’ guidelines for guidance and directions on the specific pieces of equipment.
Where do staff document the WT results for each patient? (WT.05.01.01)
Written Documentation Checklist

This worksheet lists elements of performance (EPs) that require written documentation that a surveyor could ask to see during a survey to show compliance with a standard. (Note: Documentation can be on paper or in an electronic format.)

<table>
<thead>
<tr>
<th>√</th>
<th>Standard</th>
<th>EP</th>
<th>Waived Testing Standards</th>
<th>Home Care Service</th>
<th>Date last verified</th>
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</table>
|   | WT.01.01.01 | 2–4 | EP 2—The person from the organization whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88) certificate, or a qualified designee, establishes written policies and procedures for waived testing that address the following:  
  - Clinical usage and limitations of the test methodology  
  - Need for confirmatory testing (for example, recommendations made by the manufacturer for rapid tests) and result follow-up recommendations (for example, a recommendation to repeat the test when results are higher or lower than the reportable range of the test)  
  - Specimen type, collection, and identification, and required labeling  
  - Specimen preservation, if applicable  
  - Instrument maintenance and function checks, such as calibration  
  - Storage conditions for test components  
  - Reagent use, including not using a reagent after its expiration date  
  - Quality control (including frequency and type) and remedial action  
  - Test performance  
  - Result reporting, including not reporting individual patient results unless quality control is acceptable  
  - Equipment performance evaluation | EPs 2–4—HH, HOS, FAI |
EP 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).

EP 4—The person from the organization whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88) certificate, or a qualified designee, approves in writing policies and procedures for waived testing at the following times:
- Before initial use of the test for patient testing
- Periodically thereafter, as defined by the person whose name appears on the CLIA certificate but at least once every three years
- When changes in procedures occur (for example, when manufacturers’ updates to package inserts include procedural changes or when a different manufacturer is used)

| WT.02.01.01 | 1, 2 | EP 1—The person from the organization whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88) certificate, or a qualified designee, identifies, in writing, the staff responsible for performing waived testing.

EP 2—The person from the organization whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88) certificate, or a qualified designee, identifies, in writing, the staff responsible for supervising waived testing.

EP 3—Staff and licensed independent practitioners who perform waived testing have received orientation in accordance with the organization’s specific services. The orientation for waived testing is documented.

EP 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.

| WT.03.01.01 | 2–4, 6 | EP 2—Staff and licensed independent practitioners who perform waived testing have received orientation in accordance with the organization’s specific services. The orientation for waived testing is documented.

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| WT.05.01.01 1 | EP 1—Quality control results, including internal and external controls for waived testing, are documented. | HH, HOS, FAI |

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
# Action Planning Tool

Use this form to track noncompliant elements of performance (EPs) and your action steps for bringing them into compliance.

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<th>Action Step</th>
<th>Individual Responsible</th>
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Chapter Notes

Use this page to take notes about ideas for meeting the standards in this chapter, your organization’s policies and procedures that address requirements in this chapter, or the data or patient record numbers used to determine compliance or noncompliance for EPs. If a standard is found not compliant, it can be helpful to know which data were used so they can be easily accessed when developing action plans for compliance.
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 home health and hospice organizations that use Joint Commission accreditation for deeming purposes.

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ACC Chapter Contents....................................................................................... ACC–1
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   Eligibility for Home Care Accreditation.................................................... ACC–5
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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 home care organizations must follow the policies and procedures listed in this chapter to participate in the accreditation process. Failure to follow the policies and procedures described in this chapter can result in denial of accreditation. Because this information is reviewed and revised as necessary on a continuous basis, all accredited home care organizations are responsible for keeping track of changes to these policies and procedures.

Changes made to accreditation requirements between manual updates can be viewed at “The Joint Commission Requirements” page on The Joint Commission website at http://www.jointcommission.org/standards_information/tjc_requirements.aspx.

The “Accreditation Participation Requirements” (APR) chapter also includes specific requirements for accreditation participation. The APRs are existing policies and are currently effective for accreditation purposes. Cross-references to the APRs are noted in the applicable sections of this chapter.

General Eligibility Requirements
Any health care organization may apply for Joint Commission accreditation if all the following requirements are met:
The organization is in the United States or its territories or, if outside the United States, is owned or operated by the US government or under a charter of the US Congress.

If required by law, the organization has a license or registration to conduct its scope of services.

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.

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 patients served with 2 active at the time of survey.

For home health deemed status, the organization must have taken 10 unduplicated skilled care patients under service with 7 skilled cases active at the time of survey. The organization must also provide nursing services and at least one other therapeutic service. A home health agency must provide at least one of the qualifying services directly through agency employees but may provide the second qualifying service and additional services under arrangements with (an)other agency(ies) or organization(s).

For hospice deemed status, the organization must have served at least 5 unduplicated patients, with a minimum of 3 active patients on service at the time of survey. CMS does not recognize bereavement cases as active patients.

Medically underserved areas, as designated by CMS, have altered requirements. Contact your account executive to discuss whether your organization is designated as an agency in a medically underserved area.

*Organizations that are new to The Joint Commission include those that have never been surveyed by The Joint Commission or have not been accredited for at least four months.
With the exception of organizations that provide services that do not require an order from a licensed independent practitioner, such as certain Personal Care Services or Durable Medical Equipment (DME), the tests, treatments, or interventions provided at the organization are prescribed or ordered by a licensed independent practitioner in accordance with state and federal requirements.

For Community-Based Palliative Care (CBPC) Certification, the organization must have provided palliative care services to at least 5 patients in the prior 12 months, 3 of which are active at the time of the survey.

Eligibility for Home Care Accreditation

A. Home Health Services. Home Health Services involve the provision of any health care services by health care professionals to a patient in his or her place of residence. These services include, but are not limited to, patient assessments; provision of care, treatment, education, or counseling; and/or monitoring of the patient’s health status by nurses (both intermittent skilled and private duty), occupational therapists, physical therapists, speech-language pathologists, audiologists, social workers, dietitians, dentists, nurse practitioners, physicians, and other licensed health care professionals in the patient’s home. It also includes the extension or follow-up of health care services provided by hospital professional staff in the patient’s home.

Note: Eligibility for Joint Commission accreditation for organizations providing home health, personal care, and/or support services is not based on ownership or control of the patient’s plan of care. An organization providing home health or personal care and/or support services to patients of long-term home care programs, managed long-term care programs, or home-based Medicaid waiver programs are eligible for home care accreditation—regardless of whether it is the agency managing the patient’s case. For example, a home health agency providing hourly home health aide services to a Medicaid waiver client is eligible for accreditation even if the agency receives the referral for this care from a certified home health agency that is case managing the individual.

B. Personal Care and/or Support Services. Personal Care and/or Support Services (sometimes called “Nonmedical Services”) involve the provision of assistance because of a health-related condition with personal care, activities of daily living, or management of household routine by paraprofessional staff to an individual in his or her home. These services include the provision of services by home health aides, personal care aides, home attendants, nursing assistants, companions, and homemakers.
C. Hospice. Hospice is an organized program of care and services provided and coordinated by an interdisciplinary team to meet the needs of a patient who is diagnosed with a terminal illness and has a limited life span. The program specializes in palliative management of pain and other symptoms, meeting the physical, psychosocial, and spiritual needs of the patient and the patient’s family. Medicare-certified hospices must use volunteers as part of their program, and all hospices must provide a formalized program of bereavement care to survivors. Hospice 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, home medical equipment services) and care provided in all settings (for example, inpatient, nursing home) are included.

D. Home Medical Equipment.

1. **General Eligibility.** Organizations are eligible to be surveyed under the Joint Commission’s standards for HME (Durable Medical Equipment, Prosthetics, Orthotics, and Supplies [DMEPOS]) under the following conditions:
   a. When they provide any of the following products to patients in their place of residence or through the mail (including common carrier)†:
      i. Durable medical equipment
      ii. Prosthetics
      iii. Orthotics
      iv. Rehabilitation technology (custom mobility)
      v. Supplies

2. **Special HME Consideration.** When the requirements of the General Eligibility (above) are not met, The Joint Commission, upon request from the organization and subsequent review, may grant eligibility to an HME organization if each of the following occurs:
   a. 100% of the services described above are provided through written agreement on behalf of another organization
   b. The HME organization provides no other eligible HME (DMEPOS) services
   c. The HME organization would be excluded from otherwise doing business as an HME provider if accreditation was not awarded
   d. At any site where DMEPOS is provided and the organization bills or is applying to bill Medicare

**Note:** When providing infusion pumps to patients, a dispensing pharmacy, freestanding ambulatory infusion organization, and/or long-term care pharmacy organization will be

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†Refer to the Glossary for the Joint Commission–specific definitions of these terms.
surveyed under the Pharmaceutical Services standards if the organization does not provide any other eligible HME services to patients and the organization does not bill Medicare Part B DMEPOS for the pumps. If the organization bills Medicare Part B DMEPOS for the pumps or other HME items, the organization will be surveyed under both the appropriate Pharmaceutical Services standards and the HME standards.

3. **Clinical Respiratory Services (CRS) Eligibility.** Organizations are eligible to be surveyed under the Joint Commission’s standards for HME (DMEPOS) and CRS (Clinical Respiratory Services) if they comply with all the following conditions:
   a. The organization meets the HME eligibility criteria
   b. Services are provided by respiratory care practitioners or other licensed health care professionals
   c. Services are associated with the provision of HME services by the same organization and
   d. The organization provides CRS\(^\dagger\) to patients

4. **Rehabilitation Technology.** Rehabilitation technology is a component of HME services that enhances the lifestyle of physically challenged individuals through the sale and rental of custom medical equipment and ongoing evaluation by trained rehabilitation technologists. These services include, but are not limited to, those related to customized mobility systems, seating and positioning systems, and adaptive equipment (for example, aids to daily living; artificial speech, hearing, and visual devices). These services may be provided in the patient’s home, rehabilitation clinics, schools, or the home care organization’s facility.

**E. Pharmacy Services.** Pharmacy Services involve the provision of pharmaceutical products, care, and services involving the preparation and dispensing of medications, medication-related devices, and supplies by a licensed pharmacy, with or without the provision of clinical or monitoring pharmacist services. These services include, but are not limited to, pharmacy services provided to a patient in his or her place of residence, long-term care facilities, ambulatory infusion suites, mail order, and specialty pharmacies. It specifically excludes only retail pharmacy practices with a walk-in business. Please note that this does not exclude dispensing activities to other care settings such as clinics and physician’s offices.

\(^\dagger\) *Clinical respiratory services* may include the following: patient assessment, such as history and physical, pulmonary function testing and oximetry (when used by the respiratory care practitioner and/or other licensed health care professional for clinical monitoring of the patient); clinical patient education related to disease management; medication and treatment administration; and monitoring outcomes of care.
1. **Pharmacy Dispensing Services.** These services involve the dispensing of medications, medication-related supplies and equipment, and other related services by a licensed pharmacy. These services also include the provision of the professional services of a pharmacist as a component of the dispensing process to ensure appropriate and safe medication use (for example, prescription review, medication profile review, patient counseling) as mandated by law and regulations and by standards of practice. The standards and elements of performance (EPs) in the new “Medication Compounding” (MC) chapter are applicable to this service if the organization is performing medication compounding.

2. **Clinical/Monitoring Pharmacist Services.** These services involve the provision of professional care and services by a qualified pharmacist to optimize outcomes of medication therapies and minimize the adverse effects of medications. These services include, but are not limited to, assessment of the appropriateness of medication orders, the ongoing evaluation and review of the patient’s medication regimen and pharmacy care plan, the ongoing monitoring of medication effects in individual patients, the provision of drug information, oversight of the medication use process to improve patient safety, and other related cognitive medication-related services.

3. **Long-Term Care Pharmacy Services.** These services involve the provision of pharmacy dispensing services to patients residing in a nursing home or another long-term care facility where regular nursing care is provided. The standards and EPs in the new MC chapter are applicable to this service if the organization is performing medication compounding.

4. **Freestanding Ambulatory Infusion Services.** These services involve the dispensing and administration of drug therapy by infusion or inhalation, as well as related services, under the supervision of a licensed health care professional (for example, a nurse) to ambulatory patients in a room or an office at a home care organization site that is not an extension of a physician’s office or hospital organization or part of a larger ambulatory organization. The standards and EPs in the new MC chapter are applicable to this service if the organization is performing medication compounding.

5. **Specialty Pharmacies.** A specialty pharmacy is a state-licensed pharmacy that solely or largely provides only medications for people with serious health conditions such as cancer, hepatitis C, rheumatoid arthritis, HIV/AIDS, multiple sclerosis, organ transplantation, or bleeding disorders. Specialty pharmacies connect severely ill patients with the medications that are prescribed for their conditions, provide the special handling and patient care services that these medications require, and support patients who are facing reimbursement challenges for these often costly medications.
F. Active Service. An eligible home care service provided to 10 or more patients during the past 12 months is considered to be “active.” In addition, for a particular service to be eligible for any survey (with the exception of the Early Survey Policy Option), the home care organization must have two active patients on service at the time of survey. If a home care organization is scheduled for survey and does not have two active patients, that service will not be surveyed and accredited until another survey can be scheduled. **DME exception:** For organizations that provide durable medical equipment for sale only (no rentals), the organization must have at least one patient on service within 45 days of the survey date and must have provided service to 10 or more patients during the past 12 months.

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**Eligibility Requirements for Community-Based Palliative Care Certification**

Palliative care comprises specialized home care services for patients with serious illnesses. The goal of palliative care is to improve the patient’s quality of life by relieving the symptoms, pain, and stress of the illness. Palliative care is provided by an interdisciplinary team of doctors, nurses, and other specialists who work together, optimally coordinating the patient’s care, to ensure the patient remains safely and comfortably in his or her place of residence. Palliative care is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment. A Joint Commission–accredited home health or hospice agency qualifies for the Community-Based Palliative Care Certification program option under the following conditions:

- The organization meets all of the general eligibility requirements for an organization seeking Joint Commission accreditation (see the “General Eligibility Requirements” section)
- The organization is accredited by The Joint Commission for home care services including Home Health or Hospice. Deemed accreditation is not required.
- The organization is able to provide community-based palliative care services 24 hours a day, 7 days a week. After-hours services may be provided on an on-call basis, including having team members available to answer and make phone calls nights and weekends and to provide home visits to patients as needed.
- The organization has provided community-based palliative care to at least 5 home care patients in the prior 12 months, 3 of which are active at the time of survey.

**Note:** It is strongly recommended that the organization wait to apply until it has provided community-based palliative care services for at least 6–12 months prior to pursuing CBPC Certification.
Community-based palliative care services are primarily delivered in the patient’s place of residence. A patient’s residence may include an assisted living facility. If a patient is temporarily receiving care at a nursing care center or similar skilled nursing facility, he or she may receive community-based palliative care services from the home care organization. If the home care organization staffs and provides community-based palliative care in an outpatient clinic or office setting, this setting(s) may be included in the survey and certified as a component of the total home care services provided. (Note: If the outpatient clinic or office is not staffed by any home care organization personnel, it cannot be included in the certification.)

The organization must utilize palliative care clinical practice guidelines and/or evidence-based practice in the delivery of home care community-based palliative care services.

Examples of organizations eligible to apply for the Community-Based Palliative Care Certification program option include the following:

- A home health agency seeking initial Joint Commission accreditation that wishes to include Community-Based Palliative Care Certification in its initial survey.
- A deemed-status Joint Commission–accredited hospice agency that wishes to include Community-Based Palliative Care Certification in its triennial survey.
- A Joint Commission–accredited agency (home health or hospice) that wishes to undergo a Community-Based Palliative Care Certification extension survey to add Community-Based Palliative Care Certification before its next triennial survey is due.
- A Joint Commission–accredited home care corporate owner that wishes to achieve Community-Based Palliative Care Certification for one or more of the corporation’s palliative care services/programs.

An example of an organization that would not be eligible for Community-Based Palliative Care Certification would be a community-based palliative care services provider that is licensed as a skilled nursing facility or an assisted living facility. Another example would be a community-based palliative care clinic for which the clinic is the primary service location.

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 EPs.

In addition to using standards and EPs, The Joint Commission also surveys organizations by using APRs and the Joint Commission National Patient Safety Goals (see the APR and “National Patient Safety Goals” [NPSG] chapters, respectively). Used in conjunction with the standards, these requirements help assess an organization’s performance.

Accreditation Policies
This section provides information on the policies that govern the accreditation process for home care organizations and describes how The Joint Commission shares information about an individual organization.

Tailored Survey Policy
The public expects all of the programs or services delivered under the auspices of an accredited organization to have been evaluated. As such, The Joint Commission applies its Tailored Survey Policy to components (for which there are applicable Joint Commission standards) that are organizationally and functionally integrated with the health care organization applying for accreditation (see the “Organizational and Functional Integration” section).

The Joint Commission will include another service, program, or related entity (that is, component), whether providing programs or services directly or through a contractual arrangement, in the survey of the applicant organization under the following circumstances:
- There are Joint Commission accreditation/certification requirements applicable to the component.
- There is organizational and functional integration between the component and the applicant organization.

\(^5\) Contractual arrangements are evaluated for tailoring applicability on a case-by-case basis.
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.

**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.

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A complex organization refers to an organization that is surveyed under more than one accreditation manual.
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 patient records are integrated into the applicant organization’s patient 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.
## Checklist to Determine Organizational and Functional Integration

<table>
<thead>
<tr>
<th>Organizational Characteristic</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Budgetary decisions</strong> — Does the governing body of the applicant organization control budget and resource allocation for component?</td>
<td></td>
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<tr>
<td><strong>2. Shared governance</strong> — If separate corporate entities, do the applicant organization and the component share over 50% of governing body membership?</td>
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</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Functional Characteristic</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Common medical staff</strong> — Is there a unified process for credentialing staff and/or licensed independent practitioner membership?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2. Human resources</strong> — Does the applicant organization have hiring/firing/performance appraisal authority over the component’s staff?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>3. Policies and procedures</strong> — Are there common policies and procedures?</td>
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<tr>
<td><strong>4. Management</strong> — Does the applicant organization manage operations of the component?</td>
<td></td>
<td></td>
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<tr>
<td><strong>5. Patient records</strong> — Is there an integrated patient record system?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>6. Performance improvement</strong> — Is there an integrated performance improvement program? Does the applicant organization have authority to implement performance improvement actions at component?</td>
<td></td>
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<tr>
<td><strong>7. Billing</strong> — Are the component’s services billed by the applicant organization?</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>8. Public portrayal</strong> — Is there public portrayal of component as part of a parent organization through names, logos, or such?</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Note:** Applicant organization needs minimum of one “Yes” response for organizational integration and three “Yes” responses for functional integration to include components as “sites” on the electronic application for accreditation (E-App).

**Figure 1.** Checklist to determine organizational and functional integration.
System Accreditation Option
System accreditation involves awarding a single accreditation decision to a “system”—an organization that has a corporate office or a main site, with multiple sites under the auspices of the main site. The main site has oversight of the performance of the sites in the system. Under the system accreditation approach, the corporate office or main site is visited to assess systemwide policies and functions; then a sample of sites within the system undergo unannounced surveys to assess the execution of the policies and the delivery of care. The sites are selected based on the risk level of the services provided (see Table 1 for a list of high-risk and low-risk services) and the size of the system (see Table 2).

Table 1. Sampling for System Surveys by Risk

<table>
<thead>
<tr>
<th>High-Risk Services</th>
<th>Low-Risk Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apnea monitors</td>
<td>Clinical consulting pharmacy</td>
</tr>
<tr>
<td>Biomedical vents maintenance</td>
<td>Clinical respiratory</td>
</tr>
<tr>
<td>Compounding pharmacy</td>
<td>DMEPOS—in-home, facility-based, mail-order</td>
</tr>
<tr>
<td>Freestanding ambulatory infusion</td>
<td>HME</td>
</tr>
<tr>
<td></td>
<td>Home health/PCSS—skilled; PT, OT, ST, medical social, aides</td>
</tr>
<tr>
<td></td>
<td>Hospice—in-home, facility-based (freestanding and segregated units)</td>
</tr>
<tr>
<td></td>
<td>Long-term care pharmacy (SNF or VA setting)</td>
</tr>
<tr>
<td></td>
<td>Warehouse—storage only</td>
</tr>
<tr>
<td></td>
<td>Warehouse—clean/repair/test</td>
</tr>
</tbody>
</table>
Table 2. Sampling for System Surveys by Size

<table>
<thead>
<tr>
<th>High-Risk Sites</th>
<th>Low-Risk Sites</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of Sites in System</strong></td>
<td><strong>Survey Volume</strong></td>
</tr>
<tr>
<td>75 or fewer</td>
<td>All sites up to 19</td>
</tr>
<tr>
<td>76 or more</td>
<td>25% of sites up to a maximum of 30 sites</td>
</tr>
</tbody>
</table>

With system accreditation, the entire system undergoes the accreditation process during a concentrated period of time. In addition, the entire system will be assigned a single, dedicated account executive.

Eligibility requires a minimum of four sites/locations and a common governance structure with system management in the following areas:

- Overseeing quality of care
- Overseeing performance improvement
- Setting strategic goals and expectations
- Developing policies and monitoring execution
- Approving and monitoring site budgets
- Overseeing site managers’ performance
- Credentialing/privileging licensed independent practitioners

**Extension Surveys**

As systems expand their scope of services or add more sites, The Joint Commission needs to determine whether changes to the size and scope of the system warrant an additional survey. The Joint Commission will review the composition of systems providing high-risk services at two intervals—9 months and 18 months—in the system’s three-year accreditation cycle to determine whether an extension survey of the system is warranted. Systems providing low-risk services will be reviewed at the midpoint of their accreditation cycle to determine whether an extension is warranted.
For more information about system accreditation for home care organizations, please contact Margherita Labson, executive director, Home Care Accreditation Program, at 630-792-5284 or MLabson@jointcommission.org.

**Concurrent Survey Option**
The Joint Commission offers a concurrent survey option for an organization with more than one accredited entity under its corporate structure if the organizations maintain distinct Centers for Medicare & Medicaid (CMS) Certification Numbers (CCNs). This option has the following components:
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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 corporation. Each organization with a distinct CCN will receive a separate survey report and accreditation decision.

The concurrent survey process works best when conducted in organizations 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.

**Deemed Status Option**

A home health or hospice organization eligible to achieve or continue Medicare certification may choose to participate in a Joint Commission accreditation survey that can be used for both Medicare certification and accreditation. An organization that chooses to have its survey conducted by The Joint Commission will undergo an unannounced Joint Commission survey in place of a Medicare survey conducted by a state agency. The unannounced survey is required by CMS. Once an organization is accredited by The Joint Commission through this process, CMS will determine the home health or hospice organization to be in compliance with federal requirements specified in the Conditions of Participation. Please note that the CMS regional office makes the final determination regarding the Medicare participation and the effective date of participation in accordance with the regulations at 42 CFR 489.13. CMS retains the authority to conduct random validation surveys and complaint investigations for Medicare-certified organizations. In addition, home health agencies choosing the deemed status option may undergo an interim survey (between triennial surveys). Interim surveys are conducted by Joint Commission surveyors.

Joint Commission accreditation is voluntary, and seeking deemed status through Joint Commission accreditation is an option, not a requirement. Joint Commission accreditation and Medicare deemed status processes do not eliminate current state requirements.
for state licensure surveys, except in those states that have also recognized The Joint Commission survey process for licensure. A home health or hospice organization interested in seeking Medicare certification through Joint Commission accreditation must declare its intention to seek deemed status by indicating such on the E-App, as well as by notifying CMS and/or the state of its intentions.

**Initial Surveys**

An organization that is seeking Joint Commission accreditation for the first time or that has not been denied accreditation by The Joint Commission during the previous four months is eligible for an initial survey if it serves the required minimum number of 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 meets parameters for the minimum number of patients/volume of services required for organizations seeking Joint Commission accreditation for the first time, as defined in the “General Eligibility Requirements” section.**

- **For organizations electing the Community-Based Palliative Care certification option:** The organization meets parameters for the minimum number of patients/volume of services required for this certification (as defined in the “Eligibility Requirements for Community-Based Palliative Care Certification” section).

The accreditation effective date for an organization that undergoes an initial survey is the date on which an acceptable ESC was submitted, if the organization has a Requirement for Improvement (RFI). If there are no RFIs, the effective date is the day after the last day of the survey.
Survey Postponement Policy
In rare circumstances, it may be appropriate to request a survey postponement. An organization should direct a request for a postponement to its account executive. A request to postpone a survey may be granted if a major unforeseen event has occurred that has totally or substantially disrupted operations, such as the following:

- A natural disaster or major disruption of service due to a facility failure
- The organization’s involvement in an employment strike
- The organization’s cessation of admitting or treating 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
The Accreditation Process

- Allows the treatment or access to services of any individual or staff member to be adversely affected by his or her or a family member’s communication with The Joint Commission.

- Standards compliance. If an organization’s/program’s conduct reflects a lack of commitment to standards compliance, issues of good faith may be raised. For example, an intentional refusal to attempt to comply with a standard could suggest a cavalier view of the accreditation/certification process.

The good faith participation requirement applies continuously throughout the accreditation/certification process.

Public Information Policy

Introduction
The Joint Commission is committed to making relevant and accurate information about health care organizations available to interested parties. Information regarding a health care organization’s quality and safety can help organizations improve their services. This information may also help educate consumers and health care purchasers in making informed choices about health care. At the same time, it is important that confidentiality of certain information be maintained to encourage candor in the accreditation and certification processes. The Joint Commission’s primary vehicle for providing public information are Quality Check and Quality Reports.

Quality Check. Quality Check is The Joint Commission’s website for making available descriptive and performance information about accredited organizations and certified programs.

Quality Reports. The Quality Reports located on Quality Check are publicly available and include relevant and useful information about the quality and safety of care provided in individual Joint Commission–accredited organizations and –certified 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.

*This policy meets the requirements of the Health Insurance Portability and Accountability Act of 1996.*
Publicly Available Accreditation and Certification Information

Joint Commission Quality Reports for each accredited organization and/or certified program include the following information:

- The date of an organization’s/program’s most recent full on-site survey/review, and if the organization/program has had any subsequent surveys/reviews since its last full survey/review
- The accreditation/certification decision based on the most recent full on-site survey/review, as well as any subsequent updates to the decision
  - Organizations that are successful in obtaining accreditation following an initial survey will be posted on the Quality Check website.
  - Programs that achieve certification will be posted on the Quality Check website.
- For organizations in the accreditation renewal process, with an accreditation decision of Preliminary Denial of Accreditation or Denial of Accreditation, the standards with Requirements for Improvement leading to the decision
- Services included within the scope of the organization’s accreditation and/or certification decision
- A list of an organization’s previous accreditation and/or program’s certification decisions and the effective date of those decisions for the past seven (7) years
  - If the organization had a previous decision of Preliminary Denial of Accreditation, the standards with Requirements for Improvement
- The receipt of national quality recognition awards, as recognized by the Board of Commissioners
- Compliance with National Patient Safety Goal requirements

Each accredited organization/certified program is afforded the opportunity to prepare a commentary of up to two pages regarding its Quality Report. The commentary will accompany any organization/program Quality Reports distributed by The Joint Commission, whether via hard copy or The Joint Commission’s website.

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.

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.

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CAMHC Update 2, January 2018
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

††The term complaint refers to an alleged adverse event, unsafe condition, or concern.
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.
- 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.

‡‡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.
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.

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:

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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. 

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
• 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
  - 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 required to do so usually 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.

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**Sidebar 1. Early Survey Policy**

**First Survey**
- Conducted up to two months before opening or operating
- Licensed (according to law and regulation) or in licensing process
- Building identified, constructed, and equipped
- CEO or administrator, 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
- Announced (except for deemed status purposes)
- Full initial survey
- Outcome: Change in Limited, Temporary Accreditation decision to Accredited or Denial of Accreditation. The effective date of the accreditation decision is the day after the second survey if the organization does not receive any Requirements for Improvement (RFIs). If the organization receives at least one RFI and therefore must submit an ESC that resolves all RFIs, the effective date of the accreditation decision is the day after the second survey.

*continued on next page*
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.

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 to meet 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 conducted under the Early Survey Policy (see the “Early Survey Policy Option” [ESP] chapter for a list of these requirements). Since a Limited, Temporary Accreditation decision does not reflect an organization’s compliance with the full set of Joint...
Commission standards, the organization cannot use the Joint Commission’s Gold Seal of Approval®. An organization that is not in satisfactory compliance must reapply and begin the accreditation process again.

The Limited, Temporary Accreditation decision includes assignment of an additional announced survey against the full set of applicable standards within six months of the first survey. (Note: The second survey will be unannounced for organizations seeking to meet CMS deemed status requirements.) 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 (again, this full survey will be unannounced if the organization is using Joint Commission accreditation for deemed status purposes) 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 announced (or unannounced, for organizations seeking to meet CMS deemed status requirements), 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 Accreditation Survey Findings Report and its ESC report are posted on the organization’s secure site. *(See the “Stimulate Improvement” section in the INTRO chapter for more details about what is available on Joint Commission Connect.)*
While full access to *Joint Commission Connect* can only be granted via an organization’s password, employees with an e-mail address from their Joint Commission–accredited health care organization can register themselves for guest access. Guest access enables viewers to see the Leading Practice Library and Standards BoosterPaks™. **Guest access does not include entry to any organization-specific data or reports.**

**Role of the Account Executive**
The Joint Commission assigns an account executive to an organization after receiving its E-App and nonrefundable deposit. This person serves as the primary contact between the organization and The Joint Commission. He or she coordinates survey planning and handles policies, procedures, accreditation 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 630-792-5070 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 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.

Please note that an initial payment requirement exists for new, very small, single-service home care organizations seeking accreditation. This is an upfront payment that covers the costs associated with the full three-year accreditation cycle, including on-site survey fees and annual fees. This payment is due at the time the initial application is submitted. Additional details are available under the FAQ “New Initial Payment Requirement for Home Care Organizations Seeking Joint Commission Accreditation for the First Time.” Questions may also be directed to Margherita Labson, executive director, Home Care Accreditation Program, at 630-792-5284 or MLabson@jointcommission.org.

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

For Hospice, an average daily census (ADC) of 1 to 10; for Home Health, an ADC of 1 to 30; for Pharmacy, an ADC of 1 to 30; for DMEPOS, an ADC of 1 to 50.
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 2 outlines specific exceptions to unannounced surveys and the length of advance notice or threshold, if applicable.

Table 2. Exceptions to Unannounced Triennial Surveys††

<table>
<thead>
<tr>
<th>Subject</th>
<th>Exception</th>
<th>Threshold</th>
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<tbody>
<tr>
<td>Initial surveys</td>
<td>Announced (unless deemed status or recognition requires an unannounced survey)</td>
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<tr>
<td>Early Survey Policy—1st survey</td>
<td>Announced</td>
<td></td>
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<tr>
<td>Early Survey Policy—2nd survey</td>
<td>Announced (unless deemed status or recognition requires an unannounced survey)</td>
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<tr>
<td>Organizations undergoing ICM Option 2 and Option 3 surveys</td>
<td>Announced (unless the organization requests the survey to be unannounced)</td>
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<tr>
<td>Department of Defense facilities</td>
<td>7-day notice</td>
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<tr>
<td>An organization that has only one of the following services (unless deemed status requirements specify unannounced surveys):</td>
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<tr>
<td>Home health/personal care/support services</td>
<td>7-day notice</td>
<td>Average daily census, 1 to 30</td>
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<tr>
<td>Hospice</td>
<td>7-day notice</td>
<td>Average daily census, 1 to 10</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>7-day notice</td>
<td>Average daily census, 1 to 50</td>
</tr>
<tr>
<td>Home medical equipment services (unless the organization is using The Joint Commission to meet Medicare DMEPOS requirements)</td>
<td>7-day notice</td>
<td>Average daily census, 1 to 50</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

††In this table, 7 days refers to 7 business days.
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.

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‡‡‡These include all events conducted for Medicare certification purposes through The Joint Commission’s available deemed status or Medicare recognition options.
site to view the event details. The organization will also receive a separate e-mail by 7:30 A.M. in the organization’s local time zone (for organizations within the United States and its territories) on the morning of the event with the same information listed above.

**3. Short-Notice Events.** Seven business days prior to the scheduled event, The Joint Commission will post on the organization’s secure Joint Commission Connect site the letter of introduction, the survey agenda, and the biography and picture of each surveyor assigned to conduct the event. Once the notification—which serves as the official notice of the upcoming event—has been posted, an e-mail notification will be sent to the individuals listed as chief executive officer and primary accreditation/certification contact on the organization’s extranet. This e-mail will advise that an event has been scheduled and instruct the contact(s) to log in to the Joint Commission Connect site to view the event details. The organization will also receive a separate e-mail by 7:30 A.M. in the organization’s local time zone (for organizations within the United States and its territories) on the morning of the event with the same information listed above.

Organizations that are eligible for short notice will no longer receive a phone call from a Joint Commission representative notifying them that the event has been scheduled.

**Gaining Consent for the Visit to the Patient’s Home**

The organization must obtain the patient’s consent for the home visit by the surveyor. If the organization chooses to seek written consent, the sample consent form (Figure 2) is an example of what a home care organization can use for a surveyor to visit a home during an on-site survey. (Note: A home care organization is not required by The Joint Commission to use this form.)
The Accreditation Process

Figure 2. A sample consent form allowing a Joint Commission surveyor to observe a home visit.

**Consent for Home Visit by Joint Commission Surveyor(s) (Sample)**

______ (name of your organization) is committed to providing the highest quality of care possible to its patients. To demonstrate that commitment, we are seeking accreditation by The Joint Commission, a nationally recognized quality review organization. As part of the accreditation process, field representatives (also called surveyors) of The Joint Commission must observe the care provided to patients in their home.

We are asking for your assistance by allowing one or two representatives of The Joint Commission to come with our staff member(s) to your home and observe the care and services we provide to you. Your participation is purely voluntary. Refusal to allow the surveyor to visit your home will not affect the care or services we provide to you in any way.

By signing this document, you agree to allow one or two representative(s) of The Joint Commission to accompany our staff during a visit in your home. You agree to allow this individual to observe the care and services provided to you or your family member by our staff while in the home and to ask questions about the care and services you are receiving from our home care organization.

__________________________  ___________________________
Signature                  Date

Print name of patient or family member

**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. For organizations using The Joint Commission for deeming purposes, this will include at least one clinical surveyor. The composition of an organization’s survey team is based on the information provided in its E-App.

On surveys with more than one surveyor, one of the surveyors is designated as the team leader. The team leader is responsible for integration, coordination, and communication of on-site survey activities. In addition to being one of the surveyors conducting the survey, the team leader serves as the primary point of on-site contact between the organization and The Joint Commission. Among other responsibilities, the team leader leads the opening conference and the daily and exit briefings.
Survey Agenda
The Joint Commission reviews the data in a home care organization’s E-App and posts a sample agenda on the organization’s secure Joint Commission Connect site. Also available on the secure site is the Survey Activity Guide, which includes a list of initial materials the surveyor will request to review at the onset of the survey.

The organization’s Joint Commission account executive will contact the home care organization and provide the anticipated number of days and number of surveyors that will be assigned for the on-site survey. On the first day of an on-site survey, the surveyor(s) will work with the home care organization to ensure the schedule considers the organization’s operations and needs. During the survey, the surveyor(s) will work to minimize any disruption to 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 home care organization will briefly explain its structures, mission, vision, and relationship with the community. This provides the surveyor(s) with baseline information about the organization that can help focus subsequent survey activities.

Surveyor Planning Session. During this session, the surveyor(s) will review data and information about the home care organization to plan the survey agenda. This will include any information from previously conducted Joint Commission activities and

§§§ 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.
other home care organization 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 home care organization
- Assess the interrelationships among disciplines or services/programs and the important functions in the care, treatment, and 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.

**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* previous section) 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 home care organization 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.

**Competence Assessment.** This review activity focuses on the home care organization’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 and Emergency Management.** This session is an opportunity for the surveyor and home care organization to review and evaluate the following:
- The processes in place for managing risk in the physical environment (for example, safety and security, fire safety, hazardous materials and wastes, medical equipment)
- Emergency management processes, such as identifying risks, interactions with other health care organizations, interactions and communication with the community, and drills, critiques, and performance improvement
- Discuss the four phases of emergency management: mitigation, preparedness, response, and recovery
- Review and discuss organization plans for managing critical areas of their operations so that they can effectively respond regardless of the emergency

**Life Safety Code® Building Assessment.** This session is conducted only for inpatient hospice. In addition to determining the degree of compliance with relevant *Life Safety Code* requirements, the surveyor will evaluate the effectiveness of processes for the following:
- Maintaining fire safety equipment and fire safety building features
- Identifying and resolving *Life Safety Code* problems
- Developing and implementing activities to protect occupants during periods when a building does not meet the *Life Safety Code* or during construction periods
- Maintaining and testing emergency power systems
- Maintaining and testing medical gas and vacuum systems

**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 for DMEPOS organizations

Regulatory Review. During this session, the surveyor will verify that licensing and services provided by the home care organization comply with the CMS Quality Standards (applicable to DMEPOS organizations only).

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 3 contains home care–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.

<table>
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<th>Tracer</th>
<th>Applicability</th>
<th>Objectives</th>
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| Equipment and Supply Management             | Home medical equipment organizations               | □ Learn how the organization processes equipment and supplies from initial receipt through decommissioning  
                                                |                                                    | □ Evaluate the implementation effectiveness for specific pieces of equipment  
                                                |                                                    | □ Identify process-level and possibly system-level issues contributing to failed equipment/supply management  |
| Fall Reduction                              | Home health, home medical equipment, hospice, and personal care organizations | □ Learn how the organization evaluates the patient’s risk for falls  
                                                |                                                    | □ Evaluate the action taken to reduce the risk of falling in a targeted tracer for a patient at high risk for falling  
                                                |                                                    | □ Understand the organization’s plan for reducing the risk of injury, should a fall occur  
                                                |                                                    | □ Identify process-level and possibly system-level issues contributing to a high rehospitalization rate  |
| Hospital Readmission                        | Medicare-certified home health organizations        | □ Evaluate the action taken to reduce the home care organization readmission rate  |

continued on next page
Table 3. (continued)

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<th>Applicability</th>
<th>Objectives</th>
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<td>- Evaluate the accuracy of medication reconciliation and education, a leading cause of rehospitalization</td>
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<td>- Identify process-level and possibly system-level issues contributing to a high rehospitalization rate</td>
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**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 home care organization. The tracer methodology is a way to analyze a home care organization’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 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 a patient who is on a high-risk medication or piece of equipment
- **For organizations electing the Community-Based Palliative Care certification option:** Patients that are identified as receiving community-based palliative care services in their place of residence.

**Note:** These patients may also be receiving home health or other home care services, but the focus of the tracer will be on the CBPC services provided to the patient.

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Please see the Survey Activity Guide on the Joint Commission Connect site for more detailed information on other program-specific criteria for tracer selection.
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 home care organization’s processes and practices. In conducting a patient’s tracer, the surveyor(s) will follow specific patients through the home care organization’s processes. A surveyor will not only examine the individual components of a system but will also evaluate how the components of a system interact with each other. In other words, a surveyor will look at the care, treatment, or services provided by each department/unit/program and service, as well as how departments/units/programs and services work together. The surveyor(s) may start where the patient is currently located. This usually occurs via a visit to the patient in his or her home. However, care may be observed or traced in other settings, such as a retail location or clinic for DME organizations or in an ambulatory suite for a pharmacy that provides ambulatory infusion services. The surveyor(s) will observe the provision of care and then 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.

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.

**Risk Areas**

A surveyor conducting any type of tracer at a home care organization might notice something that requires a more in-depth look. At that point, the surveyor will look at all processes at a system level by asking more detailed questions or spending more time looking at a particular risk area. The focused evaluation includes processes or procedures that, if not planned or implemented correctly, have significant potential for affecting/impacting patient safety. One example of a topic that surveyors might need to explore in more detail at home care organizations is contracted services.

Surveyors will assess and display the risk associated with findings by utilizing the SAFER Matrix. Survey findings will be plotted on the SAFER Matrix according to the likelihood the RFI could cause harm to patients, staff, and/or visitors and the scope at which the RFI was observed.
System Tracer Activity

System tracers explore one specific system or process across the organization, focusing, when possible, on the experiences of specific 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. In contrast, 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” or process within the organization based on information from individual tracers. Points of discussion in the interactive session include the following:

- The flow of the process across the home care organization, 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 specifically conducted as distinct sessions varies based on survey length, but the data use system tracer is performed on every home care organization 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 home care organization 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 home care organization’s infection control processes. The goals of this session are to assess the home care organization’s compliance with the relevant infection control standards, identify infection control issues that require further exploration, and determine actions that may be necessary to address any identified risks and improve the safety of patients.
Medication Management. The medication management individual-based system tracer explores the home care organization’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 address or location, and diagnoses/conditions, as appropriate. The surveyor(s) may request assistance from home care organization staff for selection of appropriate tracer patients. As the surveyor(s) moves through the operations of a home care organization, 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

- 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:

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After the Preliminary Denial of Accreditation decision has been confirmed by the Joint Commission’s executive leadership, the organization has five days to notify The Joint Commission if it wishes to appeal the decision. If this is the case, The Joint Commission’s Review and Appeal Procedures apply. Emergency intervention refers to any safety measure implemented to preserve life, whether related to Life Safety Code deficiencies or another Immediate Threat to Health or Safety situation. When referring to specific Life Safety Code issues, these interventions would be called interim life safety measures, which are defined as “a series of 11 administrative actions intended to temporarily compensate for significant hazards posed by existing National Fire Protection Association 101-2012 Life Safety Code deficiencies or construction activities.”
Took immediate action to completely remedy the situation
- Adopted systems changes to prevent a future recurrence of the problem

If the organization demonstrates that it has taken corrective action, The Joint Commission will conduct an abatement survey to validate the implementation of the corrective action and that the immediate threat situation is no longer present.

The results of the abatement survey will help The Joint Commission determine whether to remove the Preliminary Denial of Accreditation decision (assuming there are no other reasons for the Preliminary Denial of Accreditation). Therefore, the sooner an organization eliminates the Immediate Threat to Health or Safety situation, the shorter the period of time the organization may be in Preliminary Denial of Accreditation.

Upon resolution of an Immediate Threat to Health or Safety situation, the organization’s accreditation status may change from Preliminary Denial of Accreditation (PDA) to a time-limited PDA and Accreditation with Follow-up Survey and remain as such until an accreditation follow-up survey is conducted to assess the organization’s sustained implementation of appropriate corrective actions.

See Figure 3 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.
Process Flow for Immediate Threat to Health or Safety (ITHS) Situations

Survey is conducted during survey, surveyors identify an ITHS situation. Surveyor consults with The Joint Commission’s central office staff. Central office staff discusses the situation with The Joint Commission’s president or his designee. The Joint Commission president agrees with the ITHS and places the organization in Preliminary Denial of Accreditation (PDA).

Organization receives alternative accreditation decision based on survey findings.

PDA decision is presented to executive leadership. The organization is notified of PDA decision and ITHS process is explained. Executive leadership confirms PDA decision.

YES

Organization is notified of Executive leadership’s decision and its right to appeal provided The Joint Commission is notified within five days.

Organization appeals PDA decision.

YES

Organization appeals PDA decision.

YES

APPEAL process

NO

Denial of Accreditation becomes final after 5 days.

Denial of Accreditation becomes final after 5 days.

NO

Organization receives alternative accreditation decision.

PDA process continues.

PDA process continues.

Organization notifies The Joint Commission that it has abated the ITHS situation.

NO

YES

Organization notifies The Joint Commission that it has abated the ITHS situation.

YES

PDA decision is posted on Quality Check and governmental/licensure agencies are notified.

PDA decision is changed to Accreditation with Follow-up Survey (AFS) decision.

AFS process is invoked.

The ITHS situation no longer exists.

YES

The ITHS situation no longer exists.

The Joint Commission conducts an statement survey.

Organization notifies The Joint Commission that it has abated the ITHS situation.

The organization is notified of Executive leadership’s decision and its right to appeal provided The Joint Commission is notified within five days.

The Joint Commission’s president agrees with the ITHS and places the organization in Preliminary Denial of Accreditation (PDA).
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 an organization does not receive any RFIs, its accreditation decision is rendered at the same time that the organization’s preliminary Summary of Survey Findings Report is available, and it is effective the day after the completion of the survey. If an organization does receive RFIs, then its accreditation decision is rendered following the submission of an acceptable ESC report. (See the “Accreditation Effective Date” section and the “Evidence of Standards Compliance [ESC] Process” section for more information.)

After the Survey
This section includes information relevant to an organization that has recently participated in an accreditation survey. Material includes information on scoring, the types of accreditation decisions, the ESC and clarification processes, how to request the review of an accreditation decision, how to appeal an accreditation decision, and how to use and display an accreditation award.

The Scoring Process
The performance expectations for determining if a standard is in compliance are included in its Elements of Performance (EPs). If an EP is determined to be out of compliance, then it will be cited as a Requirement for Improvement (RFI). Each RFI is placed in the SAFER Matrix according to how likely it is that the RFI will harm 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 4 is a representation of the SAFER Matrix.

![SAFER Matrix](image)

**Figure 4. 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.

Sustaining standards compliance can be challenging for organizations; however, it is important to remember that a home care organization must demonstrate a track record of standards compliance at the time of resurvey—unlike at the time of initial survey—to avoid receiving an RFI related to track record.
To prepare the home care organization for the triennial survey, leaders and managers should work together to ensure that any performance improvement priorities identified by leadership have been implemented and that their progress has been monitored and recorded. Evaluating and reporting on the results of these initiatives helps leaders confirm whether agency resources have been used appropriately.

For more information, please contact the Standards Interpretation Group (SIG) by calling 630-792-5900 or by completing the Standards Online Submission Form at https://web.jointcommission.org/sigsubmission/sigquestionform.aspx.

**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 will be posted on the organization’s secure extranet site within 10 business days of the survey’s completion.
- If RFIs are cited, the organization has a 60-day window to submit an ESC report to address correction of the RFIs.
- Organizations that receive a PDA02 decision must submit a POC (instead of an ESC) within 10 business days; a validation survey is conducted within 60 days to confirm that the POC has been implemented and the organization is in full compliance.
The “Joint Commission Findings” section of the Accreditation Survey Findings Report includes RFIs and associated findings cited during the on-site survey. In addition, Joint Commission EPs that are initially identified as less-than-fully compliant but corrected before the conclusion of the survey are designated as Observed but Corrected On-site (OCD). Although the OCD 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 5 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.

†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.
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.

![Decision Outcomes Diagram](image)

**Figure 5.** Continuum of survey activity outcomes for organizations seeking renewal of accreditation.

**Decision Outcomes for Organizations Seeking Initial Accreditation**

For organizations undergoing their first, or initial, Joint Commission survey, the decision process may result in only two possible outcomes—Accredited or Denial of Accreditation. Initial organizations receive an Accredited decision when they are in compliance with all applicable requirements at the time of the on-site survey or when they have successfully addressed all RFIs in an ESC within 60 days; if they do not successfully address all RFIs in an ESC within 60 days, they receive a Denial of Accreditation decision. During the 60-day time frame, the decision is pending and the process is as follows:

- Organizations found out of compliance with *Joint Commission requirements* during their initial survey may voluntarily withdraw from the accreditation process with no decision rendered if they have not yet submitted their ESC in the allotted time. If they do not withdraw, initial organizations must submit corrective action through an
ESC. 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 home care organization that details the action(s) that it took to bring itself into compliance with a standard. The ESC report is available for completion on the organization’s secure *Joint Commission Connect* site at the same time that the home care organization’s Summary of Survey Findings report is posted.

After the survey, the surveyor(s) transmits his or her survey findings to the Joint Commission’s Central Office. The organization’s official Accreditation Survey Findings Report will be posted on its secure *Joint Commission Connect* site within 10 business days of completing a survey.

Every standard found not in compliance at the time of survey will generate an RFI. When a home care organization receives an RFI, it can choose to go directly to corrective action or to try and clarify the accuracy of the RFI. The home care organization must submit either a successful clarification or a corrective ESC for every RFI cited in an organization’s Accreditation Survey Findings Report (see the “Standards Clarification” section). Challenging specific surveyor observations will not result in the automatic removal of an RFI. The 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 6 provides a representation of possible ESC follow-up activities for RFIs of varying risk levels.

<table>
<thead>
<tr>
<th>SAFER Matrix Placement</th>
<th>Required Follow-Up Activity</th>
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</table>
| HIGH/LIMITED, HIGH/PATTERN, HIGH/WIDESPREAD | • 60-day Evidence of Standards Compliance (ESC) that details the action(s) taken to come into compliance with the standards  
• ESC will also include two additional areas surrounding the following:  
  1. Leadership Involvement  
  2. Preventive Analysis  
• Finding will be highlighted for potential review by surveyors on subsequent on-site surveys up to and including the next full survey. |
| MODERATE/PATTERN, MODERATE/WIDESPREAD | |
| MODERATE/LIMITED, LOW/PATTERN, LOW/WIDESPREAD | • 60-day Evidence of Standards Compliance (ESC) that details the action(s) taken to come into compliance with the standards |
| LOW/LIMITED | |

Figure 6. SAFER Matrix placement and required follow-up activities.

**Standards Clarification**

After a survey event, organizations have the opportunity to submit clarifying ESC if they believe that their organization was in compliance with a particular standard at the time of survey. (This process does not include EPs initially identified as noncompliant but corrected before the survey’s conclusion. Also not included in this process is the placement of a finding within the SAFER Matrix; that is, an organization can clarify the finding as a whole but cannot change where the finding is placed within the matrix.)

The “clarification” is part of the ESC process and must be submitted within 10 business days following the posting of the organization’s report on the Joint Commission Connect site. The submission of a clarification does not negate the requirement for submission of a corrective ESC within 60 days if the clarification does not remove the RFI, nor does it
provide an organization with additional time to submit its ESC. Therefore, if an organization submits clarification and still has to submit an ESC, the organization will have up to 60 days in total to submit both the clarification and the corrective ESC.

When submitting clarifying ESCs after a survey event, it is important to follow the directions in the submission tool. Address each prompt, detailing why the organization was in compliance at the time of survey. Remember to address the EP as well as the actual surveyor observation. (A finding of “lack of required documentation at the time of survey” is not eligible for clarification because documentation must be available for review at the time of survey—not after the survey.)

**Corrective ESC**

An acceptable corrective ESC report must detail the following:

- **Compliance at the EP level**
- **Action(s), along with the final date of such action(s), that the organization took to bring itself into compliance with a requirement**
- **Title of the staff member ultimately responsible for implementing the corrective actions and sustaining compliance**
- **The plan for sustaining compliance**
- **Leadership involvement in the corrective action and sustained compliance plan (for those RFIs within the high-risk boxes on the SAFER Matrix, see Figure 6)**
- **Preventive analysis (for those RFIs within the high-risk boxes on the SAFER Matrix, see Figure 6)**

An acceptable ESC report is due within 60 calendar days following the posting of the Accreditation Survey Findings Report (unless the organization is recommended for a PDA02 decision, in which case it must submit a POC within 10 business days and undergo a validation survey within 60 days). The required time frame will be specified in the survey report. Following a successful submission of the ESC report, the organization receives an accreditation decision. However, the organization’s accreditation decision is retroactive to the day after the last day of the survey, unless the organization is undergoing its first Joint Commission survey. The accreditation effective date for an organization that undergoes an initial survey is the date on which an acceptable ESC was submitted, if the organization has any RFIs. If there are no RFIs, the effective date is the day after the last day of the survey.

If the organization implements acceptable actions to address its RFIs, the organization’s accreditation decision is Accredited.
The organization’s ESC submission(s) will be evaluated by Central Office staff using the same scoring guidelines used by the 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 home care organization has demonstrated resolution of all
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RFIs. If the home care organization has not met a rule for Accreditation with Follow-up Survey or Preliminary Denial of Accreditation, and the ESC submission(s) is determined to be acceptable, its decision will be Accredited.

**On-Site ESC.** Usually the ESC will be an electronic submission to The Joint Commission; however, on occasion, a review of the ESC may also be conducted on site by a surveyor. If an on-site evaluation is required to assess compliance with the relevant standards following electronic submission, a copy of the home care organization’s electronic ESC is provided to the surveyor conducting the on-site ESC. The on-site ESC process provides the opportunity to evaluate the organization’s success in correcting the issues. It also allows the surveyor to provide coaching and guidance to the organization, supporting its efforts to achieve and maintain compliance with the standards.

A final decision letter will be posted to the home care organization’s secure, password-protected **Joint Commission Connect** site when its ESC has been reviewed and an accreditation decision has been rendered. A Quality Report will then be posted on Quality Check on The Joint Commission’s website. For more information, see “The Joint Commission Quality Report” (QR) chapter.

**Accreditation Award Display and Use**

The Joint Commission provides each accredited organization with one certificate of accreditation per accreditation program. There is no charge for the initial certificate(s). Additional certificates may be purchased. Such requests should be sent to the certificate coordinator in the Division of Accreditation and Certification Operations at The Joint Commission.

The certificate and all copies remain The Joint Commission’s property. They must be returned if either of the following situations occurs:

- The organization is issued a new certificate, reflecting a name change
- The organization’s accreditation decision is changed, withdrawn, or denied for any reason

Accreditation award certificates include language about educating 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. 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 home health or hospice organizations 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 recommends them for Medicare certification. The letter includes the provider’s name, NPI, Medicare Provider Number (MPN), and the date of the deemed status survey. It also explains the role of the Joint Commission in the Medicare certification process and highlights the provider’s continued success in meeting accreditation standards.
The Accreditation Process

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. Home health or hospices 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 home care organizations. These standards are displayed within the FSA tool with a special risk icon. The FSA tool enables organizations to conduct their own self-assessment of standards compliance throughout the triennial accreditation cycle.

The Joint Commission identifies critical systems/processes that could lead to adverse effects if they become weak or fail. Risk is assessed by a system’s proximity to the 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 home care organizations incorporate Joint Commission standards as part of routine operations and ongoing quality improvement efforts, supporting a continuous accreditation process. A home care organization has...
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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)\(^1\) 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**

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\(^1\)A Plan of Action details the action(s) an organization will take to come into compliance with each standard identified as not compliant.
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Sidebar 2. (continued)

- Organizations that choose an Option 2 on-site survey will be charged a fee.
- The organization requests either an announced or unannounced FSA survey.
- Surveyor conducts the FSA survey using tracer methodology and identified accreditation program-specific risk areas; all standards are subject to review.
- Surveyor leaves a written report of findings with the organization.
- SAFER Matrix is included during on-site visit and embedded within report.
- Within 30 calendar days of the survey, organization submits POAs for each noncompliant standard through the historical FSA tool.
- Organization may elect to participate in a conference call with SIG to discuss the POAs. If a conference call is not requested, the data will be reviewed by SIG. If SIG determines a conference call is needed, the organization will be contacted.
- SIG reviews and approves POAs during conference call.

FSA Option 3

- Organizations that choose an Option 3 on-site survey will be charged a fee.
- The organization requests either an announced or unannounced FSA survey.
- Surveyor conducts the FSA survey using tracer methodology and identified accreditation program-specific risk areas; all standards are subject to review.
- SAFER Matrix is included during on-site visit.
- Surveyor delivers an oral report of findings at the closing conference of the on-site survey. No written report of findings will be left at the organization.

The FSA will affect an organization’s accreditation decision only if the organization fails to participate in the FSA process, whether the Full FSA or one of the three options, or an Immediate Threat to Health or Safety situation is identified through the FSA process and a special survey is conducted. If you need more information while completing the FSA, please contact your account executive at 630-792-3007.

Plan of Action (POA)

A POA is a detailed description of how an organization plans to bring into compliance any standard identified as “not compliant” in the FSA. The POA must include the planned action to be taken and target implementation dates.
Sentinel Event Follow-Up
Accredited home care organizations are expected to identify and respond appropriately to all sentinel events. The home care organization is required to conduct a thorough and credible comprehensive systematic analysis and develop a corrective action plan in a manner and time frame acceptable to The Joint Commission as specified in the Sentinel Event Policy and submit them to The Joint Commission or otherwise provide evidence of an acceptable response to the sentinel event. (See the “Sentinel Events” [SE] chapter for more information.)

Notifying The Joint Commission About Organization Changes
Accreditation is neither automatically transferred nor continued if significant changes occur within a home care organization. Home care organizations 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 home care organization may undergo a change that modifies the information reported in its E-App (see APR.01.03.01 in the APR chapter). Home care organizations must notify The Joint Commission promptly, in writing, when an additional service or location is contemplated so any potential impact to accreditation can be determined. 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 home care organization must update its E-App within 30 calendar days. Information that must be reported includes any of the following:
- A change in ownership
- A change in location

An organization is considered to have “contemplated” a change when leadership within the organization has approved moving forward with the proposed change and identified a time frame for implementing that change.
The Accreditation Process

■ 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
■ Addition or deletion of DMEPOS products provided

The Joint Commission may conduct an additional survey at a later date if its surveyor or survey team arrives at the home care organization and discovers that a change was not reported. The Joint Commission may also survey any unreported services and sites addressed by its standards during the survey as appropriate. The Joint Commission makes the final accreditation decision for the home care organization only after surveying all or an appropriate sample of all services, programs, and sites provided by the organization for which The Joint Commission has standards. Information reported in the E-App is subject to The Joint Commission’s Information Accuracy and Truthfulness Policy.

Changes to the Site of Care, Treatment, or Services†
When an inpatient hospice offers its services or programs at a new location or in a significantly altered physical plant, the organization must evaluate for Life Safety Code deficiencies and document the corrective actions (to be completed within 60 days of notification to The Joint Commission) and Interim Life Safety Measures (ILSM) implemented to protect the building occupants while the deficiencies are being corrected. Failure to provide timely notification to The Joint Commission of these conditions may result in the organization’s loss of accreditation. If the corrective actions cannot be accomplished within 60 days of notification to The Joint Commission, the organization will need to contact its Account Executive.

Mergers, Consolidations, and Acquisitions
In the case of a merger, consolidation, or acquisition, The Joint Commission may decide that the organization responsible for services must have a survey. If, after an organization receives an accreditation decision, the organization’s structure changes whereby one or more of its services, programs, or related home care organizations are no longer part of the organization that was originally surveyed, the service, program, or related organization is no longer included in the organization’s accreditation.

†Applicable to inpatient hospice only.
See the “Extension Surveys” section for more information on what The Joint Commission expects to accomplish on these surveys.

**Accreditation Status of Organizations That Cease Services After a Disaster**

Following a disaster that requires a Joint Commission–accredited organization to cease the provision of services for a period of time, The Joint Commission will work with the affected organization to address the impact that the cessation of services will have on the organization’s accreditation status and to ensure that the organization is prepared to provide safe, quality care upon resumption of services. If after six months the organization cannot resume services, The Joint Commission will discontinue the accreditation of the organization. The impact of the cessation of services for a period of time on the accreditation status of organizations that experience a disaster is described below.

**Cease Services Up to 30 Days.** For organizations that resume services within the first 30 days after a disaster and/or the organization’s decision to cease operations, the organization’s original Joint Commission accreditation status will stay in effect. The time frame for complying with any outstanding Joint Commission requirements (such as the FSA or ESC) will pause until the organization resumes operation. In most cases, The Joint Commission will not need to survey the affected organization to reassess its level of standards compliance. If The Joint Commission decides to conduct a survey, however, the organization’s accreditation decision will be driven by the interim survey findings.

**Cease Services Up to 90 Days.** For organizations that resume services from 31 to 90 days after a disaster, The Joint Commission will conduct an extension survey to determine the organization’s accreditation status. The circumstances surrounding the organization’s closure will determine the survey’s length and scope.

**Cease Services Up to Six Months.** For organizations that resume services from 91 days up to six months after a disaster, The Joint Commission will require an on-site survey to assess the environment of care. This survey will preferably take place one to two weeks after services are resumed. These organizations must receive clearance to operate from the fire marshal, if appropriate, and other local/state authorities before resuming services. In addition, The Joint Commission will conduct a second on-site survey

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1 Can be natural or man-made; any situation that causes cessation of services.
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 organizations that do not resume services within six months after a disaster or decide to cease operations, The Joint Commission will discontinue its accreditation. If the organization resumes services, it must reapply to become accredited. In such cases, the accreditation process will involve at least two surveys. The first survey will be conducted at the organization’s request and will assess the organization’s ability to provide safe patient care. The organization may qualify for an accreditation award as a result of this survey. However, at this point the organization 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 organizations as Accredited up to six months after a disaster, unless interim survey findings dictate otherwise.

While working with affected home care organizations in the aftermath of a catastrophic event, The Joint Commission will be sensitive to these organizations’ needs and will work with responsible state and federal agencies to help reestablish the organizations’ operations as well as their qualification for accreditation.

If, following a disaster, a home care organization provides services at an alternate site, The Joint Commission will determine whether an extension survey or a full survey is required based on the scope of services being provided at the alternate site and the expected period of time that the services will be provided at the site.

If your home care organization is affected by a natural disaster, please notify your home care organization’s account executive as soon as possible. Once notified, The Joint Commission can cancel any accreditation-related events and offer assistance, if needed. If you don’t know who serves as your home care organization’s assigned account executive, please call 630-792-3007.

The above policy outlines a framework that The Joint Commission will generally follow when an organization is required to cease services for a period of time following a disaster. Depending on the unique circumstances of each situation, The Joint Commission may
choose to modify this approach accordingly. In addition, The Joint Commission may coordinate its response with local, state, and/or federal officials having jurisdiction over the organization, as appropriate.

Accreditation Status of Organizations That Cease Services or Do Not Have Patients for a Period of Time

Joint Commission–accredited organizations 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 an organization ceases to provide patient care services, it is required to notify The Joint Commission. The Joint Commission will work with the affected organization to address the impact that the cessation of services or the lack of patients will have on the organization’s accreditation status and to ensure that the organization is prepared to provide safe, quality care upon resumption of services. If after six months the organization cannot resume services, The Joint Commission will terminate the accreditation of the organization.

Up to 60 Days. If a home care organization does not have any patients for up to 60 days, The Joint Commission will continue the organization’s current accreditation status.

Up to Six Months. If a home care organization 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 organization’s current accreditation status only if the organization has an extension survey. This extension survey would generally take place as soon as possible in accordance with the organization’s request. The purpose of this survey is to evaluate the home care organization’s capability for resuming services and whether it is performing at current accreditation levels. If the organization refuses an extension survey, the accreditation will be terminated.

More Than Six Months. If a home care organization does not have any patients for six months or longer, The Joint Commission will terminate the organization’s accreditation. If the home care organization resumes services, it will have to reapply for accreditation and have a full survey in order to evaluate its current compliance with Joint Commission standards.
Reentering the Accreditation Process
For a previously accredited organization to be designated as “new,” it must not have participated in the accreditation process during the previous four months. If an organization is reentering the accreditation process before four months have passed, it must demonstrate a continuous 12-month track record of compliance with the standards.

Additional Surveys
This section describes additional surveys that may occur during the accreditation cycle, including extension surveys, for-cause surveys, and other follow-up surveys.

Extension Surveys
The Joint Commission conducts an extension survey when an accredited home care organization acquires a new service/program/DMEPOS product/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 home care organization is still appropriate under the changed conditions. The results of an extension survey may affect the organization’s accreditation status.

An extension survey is conducted at an accredited organization or at a site that is owned and operated by the organization if the accredited organization’s current accreditation is not due to expire for at least 9 months and when at least one of the following conditions is met:
- Changed ownership and has a significant number of changes in the management and clinical staff or operating policies and procedures
- Offered services at a new location or in a significantly altered physical plant
- Expanded capacity to provide services by 50% or more, as measured by 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
- Provided additional DMEPOS products with applicable standards that were not included in the prior survey
- Chose to apply for the Community-Based Palliative Care certification program option between triennial surveys
An extension survey will be conducted within 6 months to allow the organization time to bring a new service or site up to the accredited home care organization’s standard of performance. If the hospice or home health organization uses Joint Commission accreditation for deemed status purposes, the results of the extension survey will immediately affect its accreditation status. If the home care organization does not include a hospice or home health service that uses 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 organization for 12 months following the acquisition. The newly acquired component will be considered accredited during that period. After the extension survey, any outstanding standards compliance problems in the acquired component(s) are reflected in the accreditation decision of the acquiring organization.

**Note:** Extension surveys for DMEPOS organizations will be conducted within 120 days, according to law and regulation.

**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 organization (see APR.02.01.01 in the APR chapter).

**Note:** While The Joint Commission may conduct a for-cause survey within a full survey (as these surveys may be referred to the full survey team for investigation), for-cause unannounced surveys should not be confused with the regular unannounced surveys described in the “Survey Notification” section.

Such a survey can either include all the organization’s services or only those areas where a serious concern may exist.

A for-cause survey 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:** An organization is charged for a for-cause survey. An organization can determine the cost of such a survey by calling the Joint Commission’s Pricing Unit at 630-792-5115.

The Joint Commission may deny an organization accreditation if the organization does not allow The Joint Commission to conduct an unscheduled or unannounced survey (see APR.02.01.01 in the APR chapter).
Random Validation of Evidence of Standards Compliance
On an annual basis, a 2% random sample of all organizations that have been required to submit an ESC will be selected for an unannounced on-site validation survey that will take place soon after the ESC submission. The purpose of this survey is to maintain the credibility of the ESC process by validating statements made in the ESC submission. The surveyor will evaluate areas that were the subject of each RFI to determine whether the corrective actions were implemented as stated.

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) home care organization or a home care organization that is seeking a new CCN, then The Joint Commission cannot make a recommendation to CMS that the home care organization be Medicare certified. The home care organization will have to undergo an additional unannounced initial Medicare survey to evaluate whether it meets Medicare requirements. For existing deemed status home care organizations: 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 home care organization’s implementation of corrective action to demonstrate compliance with the Condition(s) of Participation in question. If this survey is unsuccessful, the home care organization 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.

Interim Home Health Medicare Deemed Status Survey
For home health agencies that use the deemed status survey option, The Joint Commission will randomly perform unannounced interim deemed status surveys for continued Medicare certification purposes as required by CMS. The survey will focus on the home health agency’s compliance with the Medicare Conditions of Participation and related Joint Commission requirements. The length of the survey will be based on the
unduplicated annual admissions for the agency. The home health agency is required to correct any Medicare deficiencies or Joint Commission RFIs within the time frames identified in the final report.

**Note:** A home health agency is charged for an interim home health Medicare deemed status survey, regardless of the outcome. A home health agency 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 home health agency accreditation if the agency does not allow The Joint Commission to conduct an unscheduled or unannounced survey (see APR.02.01.01 in the APR chapter).

### 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 home care organizations follow.

**Note:** Accreditation decision rules are numbered sequentially across all Joint Commission accreditation programs. Some accreditation decision rules do not apply to home care organizations 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 home care organization is in compliance with all standards at the time of the on-site survey or has successfully addressed all RFIs in its first ESC submission and does not meet any rules for other accreditation decisions.
The home care organization, as a result of an on-site follow-up survey, is compliant with the original survey RFIs.

Note: Should additional RFIs be identified, appropriate decision rules apply.

Community-Based Palliative Care Certification
The following rules will be used for Joint Commission–accredited home care organizations that choose to apply for Community-Based Palliative Care Certification:

CBPC01 A Joint Commission–accredited organization will be certified for the Community-Based Palliative Care program if it is in compliance with all Community-Based Palliative Care Certification standards at the time of the on-site survey.

CBPC02 A Joint Commission–accredited organization will not be certified for the Community-Based Palliative Care program if it has not successfully addressed all Community-Based Palliative Care Certification RFIs in its ESC submission.

CBPC03 A Joint Commission–accredited organization will not be certified for the Community-Based Palliative Care program if it does not meet all Joint Commission standards for Community-Based Palliative Care 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 home care organization has demonstrated compliance with the selected standards used in the first survey conducted under the Early Survey Policy.

Evidence of Standards Compliance (ESC)
An ESC will be required when one or more of the following conditions are met:

ESC01 A home care organization has one or more noncompliant standards at the time of a survey event.
ESC02  A home care organization that fails to successfully address all RFI 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.

Medicare Survey
A Medicare survey will be performed when the following condition is met:

CLD01  The home care organization has one or more Conditions of Participation scored as a Condition-level deficiency.

**Note:** This rule applies only to home care organizations that use accreditation for deemed status purposes. Home care organizations 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. Home care organizations 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 home care organization does not permit the performance of any survey by The Joint Commission. (APR.02.01.01, EP 1)

DA03  The home care organization has failed to submit payment for survey fees or annual fees.

DA04  The home care organization has repeatedly failed to submit an ESC.

DA05  A home care organization 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 home care organization undergoing its first Joint Commission survey. (APR.09.04.01, EP 1)

DA07  The Joint Commission is reasonably persuaded that the home care organization submitted falsified documents or misrepresented information in any way in seeking to achieve accreditation. If accreditation is denied following implementation of this rule, the home care organization shall be prohibited from participating in the accreditation process for a period of one year unless the president of The Joint Commission, for good cause, waives all or a portion of this waiting period. (APR.01.02.01, EP 1)

DA08  The home care organization undergoing its first Joint Commission survey fails to successfully address all RFIs in an ESC after two opportunities.

DA09  The home care organization 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 organizations that use accreditation for deemed status purposes.

DA10  The home care organization’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 home care organization 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)

DA11  The home care organization does not possess a license, certificate, and/or permit, as or when required by applicable law and regulation, to provide the health care services for which the home care organization is seeking accreditation. (LD.04.01.01, EP 1)

Decision Rules for Organizations Seeking Reaccreditation
Accredited
Accreditation will be recommended when one or more of the following conditions are met:

A01 The home care organization is in compliance with all standards at the time of the on-site survey or has successfully addressed all RFIs in its first ESC submission and does not meet any rules for other accreditation decisions.

A02 The home care organization, as a result of an on-site follow-up survey, is compliant with the original survey RFIs.

Note: Should additional RFIs be identified, appropriate decision rules apply.

Community-Based Palliative Care Certification
The following rules will be used for Joint Commission–accredited home care organizations that choose to apply for Community-Based Palliative Care Certification:

CBPC01 A Joint Commission–accredited organization will be certified for the Community-Based Palliative Care program if it is in compliance with all Community-Based Palliative Care Certification standards at the time of the on-site survey.

CBPC02 A Joint Commission–accredited organization will not be certified for the Community-Based Palliative Care program if it has not successfully addressed all Community-Based Palliative Care Certification RFIs in its ESC submission.

CBPC03 A Joint Commission–accredited organization will not be certified for the Community-Based Palliative Care program if it does not meet all Joint Commission standards for Community-Based Palliative Care 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 home care organization has one or more noncompliant standards at the time of a survey event.

ESC02 A home care organization that fails to successfully address all RFIs in an ESC may be required to submit a second ESC.
Medicare Survey

A Medicare survey will be performed when the following condition is met:

**CILD01** The home care organization has one or more Conditions of Participation scored as a Condition-level deficiency.

**Note:** This rule applies only to home care organizations that use accreditation for deemed status purposes. Home care organizations 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. Home care organizations 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 home care organization demonstrates systemic patterns, trends, and repeat findings with standards.

**AFS03** The home care organization fails to successfully address all RFIs in an ESC after two opportunities.

**AFS05** The home care organization, which has failed to resolve one or more of its original RFIs, may be scheduled for a second Accreditation with Follow-up Survey.

**AFS06** The home care organization fails to participate in Intracycle Monitoring requirements.

**AFS08** The home care organization 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 organizations that elect to 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 home care organization 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)

Note: Except as provided under rule PDA03.

**AFS10**  
The home care organization has failed to develop and implement the interim life safety measures (ILSM) policy and its criteria associated with evaluation and compensation for increased safety. (LS.01.02.01, EP 1)

Note 2: This rule applies to hospice inpatient facilities only.

**AFS11**  
If the Immediate Threat to Health or Safety abatement survey through direct observation or other determining method has demonstrated that the organization has implemented sufficient corrective action of the Immediate Threat, executive leadership may change the decision to Accreditation with Follow-up Survey.

**AFS12**  
There is some evidence that the home care organization may have engaged in possible fraud or abuse.

**AFS13**  
If a home care organization that has met the PDA02 decision rule has implemented sufficient corrective action as evidenced through an on-site validation survey, executive leadership may change the decision to Accreditation with Follow-up Survey.

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**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 home care organization. (APR.09.04.01, EP 1)

**PDA02**  
The home care organization’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 home care organization’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 home care organization 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)

PDA04  The home care organization does not possess a license, certificate, and/or permit, as or when required by applicable law and regulation, to provide the health care services for which the home care organization is seeking accreditation. (LD.04.01.01, EP 1)

PDA05  The Joint Commission is reasonably persuaded that the home care organization submitted falsified documents or misrepresented information in any way in seeking to achieve or retain accreditation. If accreditation is denied following implementation of this rule, the home care organization shall be prohibited from participating in the accreditation process for a period of one year unless the president of The Joint Commission, for good cause, waives all or a portion of this waiting period. (APR.01.02.01, EP 1)

PDA06  The home care organization with a decision of Accreditation with Follow-up Survey has failed to resolve all RFIs after two opportunities.

PDA09  The home care organization 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 organizations that use accreditation for deemed status purposes.

PDA10  The home care organization’s patients have been placed at risk for a serious adverse outcome because there is some evidence that the organization may have engaged in possible fraud or abuse.

PDA11  If the Immediate Threat to Health or Safety abatement survey through direct observation or other determining method has not demonstrated that the home care organization has implemented sufficient corrective action of the Immediate Threat, executive leadership will continue the decision of Preliminary Denial of Accreditation.
Denial of Accreditation
Denial of Accreditation will be recommended when one or more of the following conditions are met:

**DA01** The home care organization does not permit the performance of any survey by The Joint Commission. (APR.02.01.01, EP 1)

**DA02** The home care organization has failed to resolve an Accreditation with Follow-up Survey status prior to withdrawing from the accreditation process.

**DA03** The home care organization has failed to submit payment for survey fees or annual fees.

**DA04** The home care organization has failed to submit an ESC or a Plan of Correction.

**DA05** A home care organization in the sustaining improvement program fails to participate in Joint Commission intervention.

**DA06** A home care organization 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.
The Accreditation Process

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 7 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 a validation survey to confirm implementation of the POC

If the validation survey is successful, the HCO receives a time-limited PDA decision with a decision of Accreditation with Follow-up Survey (AFS) thereafter. The HCO will have its next triennial survey within 18-20 months.

If the validation survey is unsuccessful, the HCO will receive a PDA decision.

*Patients are placed at risk for a serious adverse outcome(s) due to significant and pervasive patterns, trends, and/or repeat findings
+Organizations will have the right to appeal this decision

Figure 7. PDA02 decision process flow.

Process for Organizations That Meet Decision Rule PDA04

If a home care organization does not possess a license, certificate, and/or permit, when required by applicable law and regulation, to provide the health care services for which it is seeking accreditation, Joint Commission staff may initiate the Preliminary Denial of Accreditation process under decision rule PDA04.

The process for Preliminary Denial of Accreditation in such circumstances is as follows:

- If at the time of survey the home care organization does not have a required license, certificate, or permit, the home care organization will be notified that it meets a rule for Preliminary Denial of Accreditation and The Joint Commission will initiate such action.
- The home care organization will also be notified that if it obtains the required license, certificate, or permit or is able to provide proof of application during the clarification process, the PDA decision will be removed but the RFI will remain in the survey report.

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
The Accreditation Process

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

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.
Sentinel Events (SE)

I. Sentinel Events
The Joint Commission adopted a formal Sentinel Event Policy in 1996 to help home care organizations that experience serious adverse events improve safety and learn from those sentinel events. Careful investigation and analysis of patient safety events, as well as strong corrective actions that provide effective and sustained system improvement, is essential to reduce risk and prevent patient harm. The Sentinel Event Policy explains how The Joint Commission partners with organizations 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, or services in a staffed around-the-clock care setting or within 72 hours of discharge, including from the 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, or services


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CAMHC, January 2018
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 organization, including oral, vaginal, or anal penetration or fondling of the patient’s sex organ(s) by another individual’s hand, sex organ, or object. One or more of the following must be present to determine that it is a sentinel event:

- Any staff-witnessed sexual contact as described above
- Admission by the perpetrator that sexual contact, as described above, occurred on the premises
- Sufficient clinical evidence obtained by the organization to support allegations of unconsented sexual contact

Invasive procedures, including surgery, on the wrong patient, 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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- 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 home care organization is uncertain that a patient safety event is a sentinel event as defined by The Joint Commission, the event will be presumed to be a patient safety event and not a sentinel event unless determined otherwise through further investigation or the presentation of relevant information. Patient safety events require analysis and should be shared with the Office of Quality and Patient Safety through an organization response (see the “Patient Safety Systems” [PS] chapter).

All sentinel events must be reviewed by the organization, and are subject to review by The Joint Commission. Accredited organizations are expected to identify and respond appropriately to all sentinel events (as defined by The Joint Commission) occurring in the organization or associated with services that the organization provides. An appropriate response includes all of the following:

*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," January 2018 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 organization leadership
- Immediate investigation
- Completion of a comprehensive systematic analysis for identifying the causal and contributory factors
- Strong corrective actions derived from the identified causal and contributing factors that eliminate or control system hazards or vulnerabilities and result in sustainable improvement over time
- Time line for implementation of corrective actions
- Systemic improvement

Sentinel events are one category of patient safety events. A patient safety event is an event, incident, or condition that could have resulted or did result in harm to 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 home care organization determines how it will respond to patient safety events that do not meet the Joint Commission’s definition of sentinel event. Adverse events shall prompt notification of organization leaders, investigation, and corrective actions, in accordance with the organization’s process for responding to patient safety events that do not meet the definition of sentinel event. An adverse event may or may not result from an error.

No-harm events, close calls, and hazardous conditions are tracked and used as opportunities to prevent harm, in accordance with the organization’s process for responding to patient safety events that do not meet the definition of sentinel event. (See also Leadership [LD] Standard LD.04.04.05, element of performance [EP] 3, which
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, or services and in preventing unintended harm
2. To focus the attention of an organization that has experienced a sentinel event on understanding the factors that contributed to the event (such as underlying causes, latent conditions and active failures in defense systems, or organization culture), and on changing the organization’s culture, systems, and processes to reduce the probability of such an event in the future
3. To increase the general knowledge about patient safety events, their contributing factors, and strategies for prevention
4. To maintain the confidence of the public, clinicians, and organizations that patient safety is a priority in accredited organizations.

III. Responding to Sentinel Events

Standards

Each Joint Commission accreditation manual contains standards that relate specifically to the management of sentinel events. (See the Appendix to this chapter for related standards.)

Standard LD.04.04.05, element of performance (EP) 7, requires each accredited organization to define patient safety event for its own purposes and to communicate this definition throughout the organization. This definition must encompass sentinel events as defined by The Joint Commission. An accredited organization is encouraged to include in its definition events, incidents, and conditions in which no or only minor harm occurred to a patient. The organization determines how it will respond to patient safety events that do not meet the definition of sentinel event.
Comprehensive Systematic Analysis
As indicated above, appropriate response to a sentinel event includes the completion of a comprehensive systematic analysis for identifying the causal and contributory factors. Root cause analysis, which focuses on systems and processes, is the most commonly used form of comprehensive systematic analysis used to identify the factors that underlie a sentinel event.

An organization may use other tools and methodologies to conduct its comprehensive systematic analysis. The Joint Commission encourages an organization to contact the patient safety specialist assigned to the event or to call the Office of Quality and Patient Safety at 630-792-3700 if it has questions regarding using the tools discussed above or other tools it is considering. (See the “Review of Comprehensive Systematic Analyses and Corrective Action Plans” section for further discussion of acceptability.)

Corrective Action Plan
The product of the comprehensive systematic analysis is a corrective action plan. The corrective action plan identifies the strategies that the organization intends to implement in order to reduce the risk of similar events occurring in the future. The identified actions should eliminate or control system hazards or vulnerabilities that have been identified by the comprehensive systematic analysis. Analysis teams should identify at least one stronger or intermediate strength action when possible (see Figure 3 on page 17 of the National Patient Safety Foundation [NPSF] RCA2: Improving Root Cause Analyses and Actions to Prevent Harm report at http://c.ymcdn.com/sites/www.npsf.org/resmgr/PDF/RCA2_v2-online-pub_010816.pdf for more information on strength of action). The plan must address the following:

- Identification of corrective actions to eliminate or control system hazards or vulnerabilities directly related to causal and contributory factors
- Responsibility for implementation
- Time lines for completion
- Strategies for evaluating the effectiveness of the actions
- Strategies for sustaining the change
Reporting a Sentinel Event to The Joint Commission

Each organization is strongly encouraged, but not required, to report to The Joint Commission any patient safety event that meets the Joint Commission definition of sentinel event. An organization benefits from self-reporting in the following ways:

- The Joint Commission can provide support and expertise to the organization during the review of a sentinel event.
- A review with the Office of Quality and Patient Safety provides the opportunity for the organization to collaborate with a patient safety specialist who is likely to have reviewed similar events.
- Reporting raises the level of transparency in the organization and helps promote a culture of safety.
- Reporting conveys the organization’s message to the public that it is doing everything possible, proactively, to prevent similar patient safety events in the future.

Further, reporting the event enables the addition of the “lessons learned” from the event to be added to The Joint Commission’s Sentinel Event Database, thereby contributing to the general knowledge about sentinel events and to the reduction of risk for such events in many other organizations.

The value of this review is reflected by the fact that more than 75% of sentinel events reported to The Joint Commission are self-reported by the organizations that experienced the events. Alternatively, The Joint Commission may become aware of a sentinel event by some other means such as communication from a patient, a family member, an employee of the organization, a surveyor, or through the media.

Self-reporting a sentinel event is not required and there is no difference in the expected response, time frames, or review procedures, whether the organization voluntarily reports the event or The Joint Commission becomes aware of the event by some other means. If an organization wishes to report to The Joint Commission an occurrence of a sentinel event, the organization will be asked to complete a form accessible through its Joint Commission Connect™ extranet site. From this site, place the cursor over “Continuous Compliance Tools.” A dropdown list will appear. From this list, select “Self Report Sentinel Event.”

If The Joint Commission becomes aware of a sentinel event that was not reported by the organization to The Joint Commission, the organization CEO (or designee) is contacted, and a preliminary assessment of the sentinel event is made. An event that
occurred more than one year before the date The Joint Commission became aware of the event will not, in most cases, be reviewed under the Sentinel Event Policy. In such a case, a written response will be requested from the organization, including a summary of the processes that were designed to prevent similar occurrences.

**Required Response to a Sentinel Event**

All sentinel events must be reviewed by the organization, whether or not they are reported to The Joint Commission. In addition, if The Joint Commission becomes aware (either through voluntary self-reporting or otherwise) of a sentinel event that meets the criteria of this policy and the event has occurred in an accredited organization, the organization is expected to do the following:

- Prepare a thorough and credible comprehensive systematic analysis and corrective action plan within 45 business days of the event or of becoming aware of the event.
- Submit to The Joint Commission its comprehensive systematic analysis and corrective action plan, or otherwise provide for Joint Commission evaluation its response to the sentinel event using an approved methodology within 45 business days of the known occurrence of the event. The Joint Commission will determine whether the comprehensive systematic analysis and corrective action plan are acceptable.

The fact that an organization has experienced a sentinel event will not impact its accreditation decision. However, willful failure to respond appropriately to the sentinel event could have such an impact. For instance, if the organization fails to submit a comprehensive systematic analysis within an additional 45 days following its due date, its accreditation decision may be impacted. In these instances, patient safety specialists in the Office of Quality and Patient Safety, along with the medical director and patient safety officer, would recommend the chief medical officer and the executive leadership of The Joint Commission change the organization’s accreditation status.

**Submission of Comprehensive Systematic Analyses and Corrective Action Plans**

An organization that reports a sentinel event must submit the comprehensive systematic analysis, including the resulting corrective action plan that describes the organization’s risk reduction strategies as well as how the effectiveness of those strategies will be evaluated. This information is submitted electronically and will be reviewed in a
conference call involving Joint Commission staff and organization staff (Alternative–0). Documents shall not include the names of caregivers and patients involved in the sentinel event.

If the organization has concerns about waiving confidentiality protections as a result of sending the comprehensive systematic analysis documents to The Joint Commission, the following four optional alternative approaches to a review of the organization’s response to the sentinel event are acceptable:

1. A review of the comprehensive systematic analysis and corrective action plan documents brought to Joint Commission headquarters by organization staff, then taken back to the organization on the same day (Alternative–1). This can also be performed via web-based video conferencing with a patient safety specialist who is located at The Joint Commission (Web-Alternative). When the web-based video conference is used, the organization’s participants remain at the organization.

2. An on-site meeting at the organization with a Joint Commission patient safety specialist to review the comprehensive systematic analysis and corrective action plan (Alternative–2). This can also be performed via web-based video conferencing with a patient safety specialist who is located at The Joint Commission (Web-Alternative).

3. An on-site review with a Joint Commission patient safety specialist to review the corrective action plan and relevant documentation (Alternative–3). The patient safety specialist may ask questions regarding the comprehensive systematic analysis, but will not review that document itself. For purposes of this review activity, relevant documentation includes, at a minimum, any documentation relevant to the organization’s process for responding to sentinel events and the corrective action plan resulting from the analysis of the subject 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 organization uses in responding to sentinel events
      ■ The relevant policies and procedures preceding and following the organization’s review of the specific event, and the implementation thereof, sufficient to permit inferences about the adequacy of the organization’s response to the sentinel event
b. A standards-based survey that traces a patient’s care, treatment, or services and the organization management functions relevant to the sentinel event under review

Each of these options will result in a fee to the organization to cover the average direct costs of the option. Inquiries about the fee should be directed to the Joint Commission’s Pricing Unit at 630-792-5115.

The Joint Commission must receive a request for review of an organization’s response to a sentinel event using any of these options within five business days of the self-report of a sentinel event or of the initial communication by The Joint Commission to the organization that it has become aware of a sentinel event.

**Review of Comprehensive Systematic Analyses and Corrective Action Plans**

A comprehensive systematic analysis will be reviewed for thoroughness, credibility, and acceptability. A home care organization’s comprehensive systematic analysis should identify system vulnerabilities so that they can be eliminated or mitigated. The analysis should not focus on individual health care worker performance, but should seek out underlying systems-level causations that were manifest in personnel-related performance issues. **To help adhere to these characteristics it is recommended, but not required that the following guidelines be considered when developing causative factor statements:**

- Clearly show the cause-and-effect relationship.
- Use specific and accurate descriptors for what occurred, rather than negative and vague words.
- Human errors must have a preceding cause.
- Violations of procedure are not root causes, but must have a preceding cause.
- Failure to act is only causal when there is a preexisting duty to act.

To be thorough, the comprehensive systematic analysis must include the following:

- The analysis repeatedly asks a series of “Why” questions, until it identifies the systemic causal factors associated with each step in the sequence that led to the sentinel event.


The analysis focuses on systems and processes, not solely on individual performance.

A determination of the human and other factors most directly associated with the sentinel event and the process(es) and systems related to its occurrence.

The analysis of the underlying systems and processes through the series of “Why” questions determines where redesign might reduce risk.

An inquiry into all areas appropriate to the specific type of event.

An identification of risk points and their potential contributions to this type of event.

A determination of potential improvement in processes or systems that would tend to decrease the likelihood of such events in the future, or a determination, after analysis, that no such improvement opportunities exist.

To be credible, the comprehensive systematic analysis must do the following:

- Include participation by a process owner, who is not a member of the response team; typically this is a senior leader of the organization or a designee.‡‡
- Each action recommended by a review team should be approved or disapproved, preferably by the CEO or alternatively by another relevant member of top management. If an action is disapproved the reason for its disapproval should be shared with the comprehensive systematic analysis and action team so that the constraint can be understood and another developed by the team to replace it if the system vulnerability is not otherwise effectively addressed in the corrective action plan.§§
- Include 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:

‡‡A senior leader is not necessarily required to be actively involved in the day-to-day work of the comprehensive systematic analysis team. However, the team should report to the senior leader or designee, and he or she should be involved in deciding or approving the actions the organization will take as a result of the comprehensive systematic analysis.

Identifies and implements actions to eliminate or control systems hazards or vulnerabilities

It is recommended but not required that review teams should attempt to identify actions that are likely to reduce the risk or prevent the event from recurring and, if that is not possible, reduce the severity or consequences if it should recur.

It is recommended that the review team use a tool that will assist in identifying stronger actions that provide effective and sustained system improvement. A tool such as the Action Hierarchy can help organizations evaluate the strength of the corrective actions identified in their comprehensive systematic analysis. The US Department of Veterans Affairs National Center for Patient Safety developed this tool in 2001.

Identifies, in situations in which improvement actions are planned, who is responsible for implementation, when the action will be implemented, how the effectiveness of the actions will be evaluated, and how the actions will be sustained.

Identifies at least one stronger or intermediate strength action for each comprehensive systematic analysis.

All comprehensive systematic analyses and corrective action plans will be considered and treated as confidential by The Joint Commission.

Follow-up Activities

After The Joint Commission has determined that an organization has conducted an acceptable comprehensive systematic analysis (for example, root cause analysis) and developed an acceptable corrective action plan, The Joint Commission will notify the organization that the comprehensive systematic analysis and corrective action plan are acceptable and will assign an appropriate follow-up activity. This will be a mutually agreed-upon documentation of sustained improvement and reduction of risk, which may include one or more sentinel event Measure(s) of Success (SE MOS).

IV. The Sentinel Event Database

The third goal of the Sentinel Event Policy is to increase the general knowledge about patient safety events, their contributing factors, and strategies for prevention. To achieve this, The Joint Commission collects and analyzes data from the review of sentinel events,

and their comprehensive systematic analyses, corrective action plans, and follow-up activities. These data and information comprise the content of the Joint Commission’s Sentinel Event Database.

The Sentinel Event Database is also a major component of the evidence base for developing and maintaining the Joint Commission’s National Patient Safety Goals. The database also informs the development prevention advice to organizations through Sentinel Event Alert or other media. For these purposes, The Joint Commission uses de-identified aggregate data relating to root causes, contributing factors, and risk-reduction strategies. The Joint Commission is committed to developing and maintaining this Sentinel Event Database in a fashion that will protect the confidentiality of the organization, the caregiver, and the 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 organization leaders.

VI. Optional On-Site Review of a Sentinel Event

An initial on-site review of a sentinel event will usually not be conducted unless it is determined that a potential ongoing Immediate Threat to Health or Safety exists. An Immediate Threat to Health or Safety is a threat that represents the most immediate risk and has or may potentially have serious adverse effects on the health or safety of 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 organization will be billed a sufficient charge, based on an established fee schedule, to cover the costs of conducting such a survey.
VII. Disclosable Information
If The Joint Commission receives an inquiry about the accreditation decision of an organization that has experienced a sentinel event, the organization’s current accreditation status will be reported in the usual manner without making reference to the sentinel event. If the inquirer specifically references the particular sentinel event, The Joint Commission will acknowledge that it is aware of the event and currently is working or has worked with the organization through the sentinel event review process.

VIII. The Joint Commission’s Response
Patient safety specialists from The Joint Commission assess the acceptability of the organization’s response to the sentinel event, including the thoroughness and credibility of any comprehensive systematic analysis information reviewed and the organization’s corrective action plan. (Root cause analysis is the most commonly used method of comprehensive systematic analysis.) If the comprehensive systematic analysis and corrective action plan are found to be thorough and credible, patient safety specialists from The Joint Commission will notify the organization and assign one or more or other mutually agreed-upon documentation of sustained improvement and reduction of risk, such as SE MOS. (See the “Sentinel Event Measures of Success [SE MOS]” section below for more details.)

A patient safety specialist from The Joint Commission will provide consultation to the organization if the response is unacceptable, and will allow an additional 15 business days beyond the original submission period for the organization to resubmit its response. If the response is still unacceptable, the organization’s accreditation decision may be impacted.

IX. Sentinel Event Measures of Success (SE MOS)
The organization’s follow-up activity may be conducted through the SE MOS process. An SE MOS is a numerical or quantifiable measure, ideally with a numerator and denominator, that indicates whether a planned action was effective and sustained. The SE MOS is due on a mutually agreed-upon date.

If an SE MOS is used, the following information would apply:
If an SE MOS is submitted on time but does not meet pre-established levels of compliance, the patient safety specialist from The Joint Commission will request an additional four months of data. If the second set of data does not meet pre-established levels of compliance, the organization’s accreditation decision may be impacted.

If submission of an SE MOS is 90 or more days late, the organization’s accreditation status may be impacted.

X. Handling Sentinel Event–Related Documents
Handling of any submitted systematic analysis and corrective action plan is restricted to specially trained staff in accordance with procedures designed to protect the confidentiality of the documents.

At the time the review of the de-identified comprehensive systematic analysis is entered into the Sentinel Events Database, the original documents will be destroyed, as well as any copies. However, upon request the original documents may be returned to the organization. The information contained in any electronically submitted comprehensive systematic analysis tool will be de-identified after the review is completed.

The corrective action plan resulting from the analysis of the sentinel event will initially be retained long enough to serve as the basis for appropriate follow-up activities, such as the SE MOS or other mutually agreed-upon documentation of sustained improvement. After the corrective action plan has been implemented and meets the established levels of compliance, The Joint Commission will destroy and delete the corrective action plan. If the SE MOS was submitted electronically, the information will likewise be de-identified upon completion of the review.

XI. Oversight of the Sentinel Event Policy
The executive leadership of The Joint Commission is responsible for approval of this policy and overseeing its implementation. In addition to reviewing and deciding individual cases involving changes in an organization’s accreditation decision, Joint Commission staff will periodically audit the comprehensive systematic analysis and documentation of follow-up activities. For the purpose of these audits, The Joint Commission temporarily retains random de-identified samples of these documents. Upon completion of the audit, these documents are also destroyed.
For more information about the Joint Commission’s Sentinel Event Policy, visit the Joint Commission’s website at http://www.jointcommission.org or call the Office of Quality and Patient Safety at 630-792-3700.

XII. Survey Process

When conducting an accreditation survey, The Joint Commission seeks to evaluate the organization’s compliance with the applicable standards, National Patient Safety Goals, and Accreditation Participation Requirements, and to assess the organization’s performance based on those requirements. Surveyors are instructed not to search for or investigate sentinel events during an accreditation survey or to inquire about sentinel events that have been reported to The Joint Commission. However, surveyors may assess an organization’s performance improvement practices, such as its processes for responding to a sentinel event.

If, in the course of conducting any survey activities, a potential serious patient safety event is newly identified, the surveyor will take the following steps:

- Inform the organization CEO that the event has been identified
- Inform the CEO the event will be reported to The Joint Commission for further review and follow-up under the provisions of the Sentinel Event Policy

Surveyors are not authorized to review the comprehensive systematic analysis documents and determine credibility, thoroughness, or acceptability because they are limited to applying the related standards and elements of performance to assess performance improvement practices, such as processes for responding to safety events, adverse events, hazardous unsafe conditions, close calls, and sentinel events.

The surveyor makes no determination of whether or not the event is a sentinel event and does not focus on or explore the event further, but rather will hand off further discussion to a patient safety specialist in the Office of Quality and Patient Safety. Surveyors are not authorized to investigate sentinel events. The patient safety specialist will contact the organization after all survey activity is entirely completed to explore the event and determine whether or not submission of a comprehensive systematic analysis is required. If so, the organization will proceed with the steps described after an event is determined to be a sentinel event. (See the “Required Response to a Sentinel Event” section in this chapter.)
During the on-site survey, the surveyor(s) will assess the organization’s compliance with sentinel event–related standards in the following ways (see Standard LD.04.04.05 in the Appendix):

- Review the organization’s process for responding to a sentinel event
- Interview the organization’s leaders and staff about their expectations and responsibilities for identifying, reporting on, and responding to sentinel events

**Appendix. Accreditation Requirements Related to Sentinel Events**

The following standard and associated elements of performance (EPs) are related to sentinel events:

**Leadership (LD)**

**Standard LD.04.04.05**

The organization has an organizationwide, integrated patient safety program.

**Elements of Performance for LD.04.04.05**

1. The leaders implement an organizationwide patient safety program.

   **Note 1:** *For home health agencies and hospices that elect to use The Joint Commission deemed status option:* The governing body is ultimately accountable for the development, implementation, maintenance, and evaluation of the patient safety program.

   **Note 2:** *For home health agencies that elect to use The Joint Commission deemed status option:* The patient safety program establishes, implements, and maintains clear expectations for patient safety.

   **Note 3:** *For hospices that elect to use The Joint Commission deemed status option:* This program is evaluated annually.

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

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

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

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

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)*

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

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

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

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

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

14. Leaders facilitate mandatory reporting of significant adverse events, and voluntary reporting of such events to programs in which the organization participates.

   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.

15. For home health agencies and hospices that elect to use The Joint Commission deemed status option: The organization tracks adverse patient events, analyzes their causes, and implements preventive actions and mechanisms that include feedback and learning throughout the organization.
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 home care organization’s performance on National Patient Safety Goals, as well as special recognitions and achievements.

This chapter provides an overview of Quality Reports—what they are, how and when they are developed, how organizations can respond to them, and how the public and organizations can access and use them.

For the purpose of readability and ease of use, this chapter is organized in a question-and-answer format. The chapter includes information on the following:

- A description of the Quality Report and the information it contains
- A description of The Joint Commission’s Quality Check® website and its special features
- Guidelines for submitting a commentary
- Marketing and communication guidelines for using Quality Reports

What Is The Joint Commission Quality Report?
The Joint Commission Quality Report provides accreditation information about the home care organization. The Joint Commission provides Quality Reports to surveyed home care organizations and makes them available to the public on The Joint Commission’s Quality Check website.
What Will My Quality Report Contain?
The Quality Report features two major components.

Summary of Quality Information. This section provides the following information:
- Accreditation decision including the effective date of the decision. This portion also identifies any additional programs in the organization that are accredited by The Joint Commission, if applicable.

Quality Indicators. Quality Indicators include National Patient Safety Goals, which are a series of specified actions that accredited organizations are expected to take in order to prevent medical errors. All organizations providing related relevant services are required to comply with the National Patient Safety Goals. See Figure 1 for the legend of National Patient Safety Goal Quality Indicator symbols.

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Figure 1. Legend of National Patient Safety Goal Quality Indicator Symbols

What Is Quality Check?
Quality Check is a directory of the more than 20,000 Joint Commission–accredited and certified health care organizations and programs throughout the United States. You can access Quality Check at http://www.qualitycheck.org.

These features are included on Quality Check:
- Enhanced search functionality that allows the user to search for a health care organization by the following criteria:
  - Joint Commission–assigned organization number (HCO ID)
  - City, state, or zip code

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
Type of service provided

Accreditation or Certification program—This includes certified programs, home care providers, hospitals, laboratories, behavioral health care organizations, nursing care centers, office-based surgery practices, and ambulatory care organizations

Organization name—This includes Legal Business Name, as well as Doing Business As (DBA) Name (the DBA may be what consumers are most likely to know)

A search results page that displays any organization that matched the user’s search criteria. Also included on this page are filter options, which allow the user to narrow search results by state, services, deemed or CMS–recognition programs, accreditation or certification programs.

**Is a Quality Report Available for My Accredited Home Care Organization?**

Yes. The amount of information available on the report depends on the type of home care organization surveyed. A complete directory of all Joint Commission–accredited organizations is available through Quality Check’s website (http://www.qualitycheck.org).

Historical Quality Reports (when applicable) can also be accessed on Quality Check. The Joint Commission’s Customer Service Department (630-792-5800) can also address queries about Quality Report availability for an organization and can provide lists of all available reports.

**Can My Home Care Organization Comment on Its Quality Report?**

Yes. The Joint Commission offers each organization the opportunity to provide its perspective on its Quality Report commentary. Your home care organization has the option of submitting a commentary of up to two pages. Submission of the commentary is voluntary.
How Does My Home Care Organization Submit a Commentary?
If your home care organization chooses to submit a commentary, it may do so by completing an online form that is accessed through your organization’s secure Joint Commission Connect™ extranet site. After your organization submits the form, Joint Commission staff will review the submitted commentary for appropriateness, and then “Accept” the document for posting with the Quality Report on Quality Check. If the submitted commentary does not meet appropriateness guidelines, Joint Commission staff will notify your organization and allow you to resubmit a revised and approved copy.

Are There Any Criteria That Must Be Met in a Commentary?
The commentary must meet the following criteria:

- Only one commentary is permitted per home care organization, regardless of the number of the organization’s accredited services evaluated in a survey.
- The commentary is limited to a maximum of two pages.
- The commentary does not mention surveyors by name or use defamatory or libelous language.

The commentary may be updated at any time by submitting a revised commentary through your organization’s Joint Commission Connect site.

What Are the Marketing and Communication Guidelines for Using Quality Reports?
The Joint Commission recognizes your home care organization’s right to communicate your accreditation decision to interested individuals. Indeed, many home care organizations across the country point with pride to Joint Commission accreditation as a “seal of approval” of their efforts to provide high-quality care, treatment, or services. In fact, The Joint Commission offers a Gold Seal of Approval™ for health care organizations to use to publicize their accreditation. Guidelines for use of the Gold Seal are available on The Joint Commission’s website (http://www.jointcommission.org/accreditation/goldseal_downloads.aspx).
However, your home care organization must also communicate responsibly. A home care 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 home care organization may not engage in any false or misleading advertising with respect to the accreditation award. Any such advertising may be grounds for denying or revoking accreditation (see APR.08.01.01 in the “Accreditation Participation Requirements” [APR] chapter).

**Guidelines for Publicizing Joint Commission Accreditation**

The Joint Commission requires that an accredited organization accurately describe to the public the nature and meaning of its accreditation and its decision award. Any accredited home care organization that materially misleads the public about any matter relating to its accreditation may have to undertake appropriate corrective advertising or risk loss of accreditation.

Guidelines for publicizing accreditation include the following:

- If your home care organization 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 an organization with multiple service components, such as a home care organization with an ambulatory care component, and The Joint Commission did NOT review your ambulatory care component, you must insert the following language into your materials: “This award excludes ambulatory care services.”

- Accreditation does not “endorse” or “guarantee” a home care organization’s quality or safety of care, nor does it “prove,” “assure,” or “testify” that a home care organization provides high-quality, safe care. Such language should not be used in your materials.

- Correctly state the home care organization’s accreditation accomplishment. To say that your home care organization is the “first” or the “only” home care organization in the area to receive accreditation or a specific accreditation designation may not be true and can be misleading.

- When referring to The Joint Commission, use the name “The Joint Commission.”
For further information on publicizing your accreditation or using the Gold Seal of Approval, home care organizations may contact The Joint Commission’s Corporate Marketing Department by visiting our website at https://www.jointcommission.org/accreditation/celebrating_your_accreditation.aspx, or see the “Award Display and Use” section in “The Accreditation Process” (ACC) chapter.

**Guidelines for Publicizing the National Patient Safety Goals®**

The Joint Commission established the National Patient Safety Goals in 2002 to help accredited organizations prevent specific 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 organization’s compliance with the National Patient Safety Goals include the following:

- You may state that your home care organization is in compliance with the goals but you must state when that was validated. Acceptable examples include, “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 home care organization must be in compliance with all applicable goals in order to receive a “check mark” ☑ on the summary page of your Quality Report. Tell your patients to “look for the check mark” when evaluating health care providers.

- If your home care organization fails to comply with one or more of the goal requirements and receives a “minus symbol” ☒ on its Quality Report summary page, you may still publicize your compliance but only with the goals and requirements with which you comply. In this instance, you may not imply compliance with all applicable goals.

For more information, please visit our website: https://www.jointcommission.org/accreditation/guidelines_for_publicizing_npsg_compliance.aspx.
Required Written Documentation (RWD)

This chapter provides you with a list of elements of performance (EPs) that require written documentation. You may find it useful to use this document as a checklist to maintain continuous compliance with the requirements.

The Joint Commission’s focus is on performance and implementation rather than documentation. The standards, consequently, require documentation only when it is essential. The documentation icon—○—is used to identify data collection and documentation requirements that are in addition to information found in the patient 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 patient record. Other examples in which the documentation icon is applied are EPs that require a policy, a written plan, a license, evidence of testing, data, performance improvement reports, medication labels, Material Safety Data Sheets, and meeting minutes. Documentation can be on paper or in an electronic format.

Although documentation is important, the primary emphasis of the survey will be on how your organization carries out the functions described in the Comprehensive Accreditation Manual for Home Care (CAMHC). The surveyors may use a combination of data sources, including interviews with leaders of the organization, staff, patients, and patients’ family members; visits to patient care settings; and review of documentation to arrive at an assessment of the organization’s compliance with a standard.

**Note:** This list is meant to be a guide for you in preparing for the survey. The names and format of specific documents may vary from organization to organization.
# List of EPs Requiring Written Documentation for Home Care by Service Delivery Mode

## Home Health

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Required Written Documentation

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CAMHC, January 2018
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## Durable Medical Equipment—Facility Based

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Early Survey Policy (ESP)

A home care organization 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 home care organization must undergo two surveys, both of which would be announced unless the organization is seeking accreditation for deemed status purposes. The first survey would cover a limited selection of standards. The second survey would be a full survey. For a detailed explanation of the Early Survey Policy, please see “The Accreditation Process” (ACC) chapter in this manual.

The following tables list the selected home care elements of performance (EPs) and requirements that are applicable to a first survey when an organization has chosen the Early Survey Policy Option.

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Community-Based Palliative Care Certification (CBPC)

Overview
Home health and/or hospice organizations seeking quality distinction for their community-based palliative care program/services must meet the standards in the “Community-Based Palliative Care Certification” (CBPC) chapter. Community-based palliative care is specialized home care services for patients with serious illnesses. Regardless of setting, the goal of palliative care is to improve the patient’s quality of life by relieving the symptoms, pain, and stress of their illness. Palliative care is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment. Community-based palliative care is provided by an interdisciplinary team of doctors, nurses, and other home care professionals and staff. These health care providers work together to optimally coordinate the patient’s care to ensure the patient remains safely and comfortably in his or her place of residence.

Many home care organizations that provide home health and/or hospice services have developed palliative care programs to meet the needs of chronically ill patients who may or may not qualify for home health services, but need the physical and psychosocial support that palliative care services can provide outside of the hospital setting. The CBPC standards and elements of performance (EPs) are based on the 2013 Clinical Practice Guidelines for Quality Palliative Care, 3rd ed; the National Hospice and Palliative Care Organization’s Standards of Practice for Pediatric Palliative Care and Hospice (2010); and other current palliative care professional literature.

The standards and EPs in the CBPC chapter apply only to those patients receiving community-based palliative care services provided by the home health and hospice organizations described above.

Note: The standards in the CBPC chapter also appear throughout the manual and are integrated into the applicable standards chapters.
Accreditation Participation Requirements (APR)

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

Element of Performance for APR.01.02.01

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

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

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

Note 3: For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: This standard also applies to the organization throughout the certification process.

Standard APR.01.03.01
The organization reports any changes in the information provided in the application for accreditation and any changes made between surveys.

Element of Performance for APR.01.03.01

1. The organization notifies The Joint Commission in writing within 30 days of a change in ownership, control, location, capacity, or services offered.
Note 1: When the organization changes ownership, control, location, capacity, or services offered, it may be necessary for The Joint Commission to survey the organization again. If the organization does not provide written notification to The Joint Commission within 30 days of these changes, the organization could lose its accreditation.

Note 2: The hospice, home health agency, or DMEPOS supplier is also required to disclose to the Centers for Medicare & Medicaid Services or the Medicare administrative contractor or fiscal intermediary, the names and addresses of its owners, those with a controlling interest in the organization, or any subcontractor in which the organization directly or indirectly has a 5% or more ownership interest. The home health agency must also disclose the name and business address of the corporation, association, or other company that is responsible for the management of the home health agency, and the names and addresses of the chief executive officer and the chairperson of the board of directors of that corporation, association, or other company responsible for the management of the home health agency.

Note 3: For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The organization reports any changes in the information provided in the application for certification and any changes made between surveys.

Standard APR.06.01.01
Applicants and accredited organizations do not use Joint Commission employees to provide accreditation-related consulting services.

Element of Performance for APR.06.01.01

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

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

- Helping the organization to meet Joint Commission standards
- Helping the organization to meet Joint Commission Community-Based Palliative Care certification standards
- Helping the organization to complete its Focused Standards Assessment (FSA)
- Assisting the organization in remedying areas identified in its FSA as needing improvement
- Conducting mock surveys
Standard APR.11.01.01
For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The organization accurately represents its certification status and the facilities and services to which Joint Commission certification applies.

Elements of Performance for APR.11.01.01

1. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The organization’s advertising accurately reflects the scope of facilities and services that are certified by The Joint Commission.

2. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The organization does not engage in any false or misleading advertising about its certification award.

Standard APR.11.02.01
For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The organization uses performance measures relevant to the services provided and populations served.

Elements of Performance for APR.11.02.01

1. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: A minimum of 4 performance measures must be identified by the program.

2. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: A minimum of 2 of the 4 identified performance measures must be clinical in nature.

3. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: Organizations seeking this certification are required to have collected performance measure data for a minimum of 4 months prior to the initial on-site certification survey.

4. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The organization collects performance measure data; analyzes the data internally; and generates run charts, control charts, or other appropriate applicable performance improvement tools, showing monthly data points, for use in performance improvement activities.
Standard APR.11.03.01
For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The organization submits performance measurement data to The Joint Commission on a routine basis.

Elements of Performance for APR.11.03.01

1. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The organization continues to use a measure if data suggests an unstable pattern of performance or identifies an opportunity for improvement.

2. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The organization changes to a new measure if data reflects continuing stable and satisfactory performance.

3. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The organization makes its performance measure data available during on-site certification reviews.

4. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The organization submits data on performance measures to The Joint Commission upon request at the time of the intracycle and recertification reviews.

Human Resources (HR)

Standard HR.01.01.01
The organization defines and verifies staff qualifications.

Elements of Performance for HR.01.01.01

27. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: Program staff have palliative care education, experience, training, and/or certification consistent with the program’s policies and its philosophy and scope of care, treatment, and services. (For more information, refer to HR.01.02.01, EPs 1 and 3)
28. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: For programs that provide care for pediatric patients: Members of the interdisciplinary team have expertise in providing care for children.

29. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: For programs that provide care for pediatric patients: Health care professionals with experience in the developmental stages and needs of infants, children, and adolescents perform and document the psychosocial and developmental assessment.

Standard HR.01.02.07
The organization determines how staff function within the organization.

Elements of Performance for HR.01.02.07

9. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: Program staff are knowledgeable about their roles and responsibilities relative to patient safety in the home.

10. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The program’s core interdisciplinary team is comprised of the following:
   - Physician(s) (doctor of medicine or osteopathy) who has specialized training in palliative care and/or hospice care; clinical experience in palliative medicine and/or hospice care; or is board-certified or board-eligible for certification in Hospice and Palliative Medicine
   - Registered nurse(s) or advanced practice nurse(s) who has training in palliative care and/or hospice care; clinical experience in hospice or palliative care; or one who has, or is eligible for, palliative care certification
Chaplain(s) who has training in palliative care and/or hospice care; experience in hospice or palliative care; or one who has or is eligible for board certification; or, a spiritual care professional(s) who has training in palliative care and/or hospice care or experience in hospice or palliative care

Note: The program may choose to have a full- or part-time chaplain or spiritual care provider on staff, utilize a chaplain or spiritual care provider from another program within the organization (such as the hospital or hospice), or utilize chaplains and/or spiritual care providers in the local community (including parish nurses). The patient also has the right to involve his or her personal spiritual care provider (such as a pastor, priest, rabbi, or religious leader) rather than the program’s chaplain.

Social worker(s) who has training in palliative care and/or hospice care; experience in hospice or palliative care; or one who has, or is eligible for, palliative care certification

Note: The program may choose to have a full- or part-time social worker on staff, utilize a social worker from another program within the organization (such as the hospital or hospice), or utilize social workers from other organizations in the community if they are available.

11. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: Based on the care, treatment, and services provided, the population served, and the patient’s and family’s needs, the palliative care program’s interdisciplinary team may utilize additional individuals from other health care disciplines.

12. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The program defines in writing the interdisciplinary team members’ responsibilities.
Standard HR.01.04.01
The organization provides orientation to staff.

Elements of Performance for HR.01.04.01

24. ☐ For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The program provides or facilitates access to orientation for the interdisciplinary team members, program staff, and volunteers as needed to fulfill their responsibilities. The orientation plan and specific content are defined by the program leaders and include, but are not limited to, the following areas:
- The domains of palliative care

Note: The eight domains of palliative care are described in the Clinical Practice Guidelines for Quality Palliative Care by the National Consensus Project for Quality Palliative Care, 3rd ed. (2013).
- Assessment and management of pain and other physical symptoms
- Assessment and management of psychological symptoms and psychiatric diagnoses
- Communication skills
- Cross-cultural knowledge and skills
- Information on specific population(s) served
- Grief and bereavement
- Ethical principles that guide provision of palliative care
- Community resources for patients and families
- Hospice care

Note: Orientation may be provided over a period of time and in a variety of methods, including live and video presentations; electronic or written materials; clinical experience with a preceptor or mentor; or education at a seminar or other organization.

25. ☐ For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: For programs that provide care for pediatric patients: The program provides access to pediatric-specific orientation and ongoing education for the interdisciplinary team members, staff, and volunteers that provide care for pediatric patients.
Standard HR.01.05.03
Staff participate in ongoing education and training.

Elements of Performance for HR.01.05.03
27. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** Program leaders identify and respond to the specific learning needs of the interdisciplinary team and program staff. This includes determining education topics and number of hours of continuing education and providing or arranging for needed education. (For more information, refer to HR.01.05.03, EP 5)

Standard HR.01.06.01
Staff are competent to perform their responsibilities.

Elements of Performance for HR.01.06.01
26. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** Program leaders, or designees, determine and evaluate the qualifications, training, and experience of individuals who are considered for membership on the program interdisciplinary team and staff. (For more information, refer to HR.01.02.07, EP 10)

27. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** Program leaders assess each program staff member’s competence to perform job responsibilities through observation within program-defined time frames. This assessment is documented. (For more information, refer to HR.01.06.01, EP 1)

**Information Management (IM)**

Standard IM.02.01.03
The organization maintains the security and integrity of health information.

Elements of Performance for IM.02.01.03
10. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program informs staff and patients about its policy on privacy and security of health information.
**Standard IM.02.02.01**
The organization effectively manages the collection of health information.

**Elements of Performance for IM.02.02.01**

5. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program assists the patient in collecting, organizing, and communicating important health information that is needed by staff to provide safe, quality care.

**Standard IM.03.01.01**
Knowledge-based information resources are available, current, and authoritative.

**Elements of Performance for IM.03.01.01**

7. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program assists staff in obtaining palliative care references that are necessary for the patient’s care and self-management and information on community resources that are available to the patient and family.

**Leadership (LD)**

**Standard LD.01.03.01**
Governance is ultimately accountable for the safety and quality of care, treatment, or services.

**Elements of Performance for LD.01.03.01**

23. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program defines its leaders’ accountabilities. (For more information, refer to LD.04.01.05, EP 3)

24. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program defines its scope of care, treatment, and services.

25. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The organization provides program leaders with opportunities for sharing best practices with leaders of other palliative care programs.
26. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program evaluates whether its activities for identifying and minimizing risks to patients meets its objectives.

**Standard LD.02.01.01**

The mission, vision, and goals of the organization support the safety and quality of care, treatment, or services.

**Elements of Performance for LD.02.01.01**

6. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program leaders describe the philosophy that guides its provision of care, treatment, and services. The program’s philosophy is aligned with the organization’s mission.

7. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** Program leaders and organization leaders work together to formulate the program’s goals for providing care, treatment, and services to patients.

8. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program’s leaders are empowered by the organization’s leaders to provide care, treatment, and services.

**Standard LD.03.02.01**

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

**Elements of Performance for LD.03.02.01**

8. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program uses patient satisfaction data that are specific to the care, treatment, and services it provides in order to improve care of patients and families.
Standard LD.03.03.01
Leaders use organizationwide planning to establish structures and processes that focus on safety and quality.

Elements of Performance for LD.03.03.01

8. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program leaders communicate with and educate the organization in order to gain recognition of and support for the program.

9. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program leaders secure the resources it requires from the organization in order to meet the scope of care, treatment, and services it provides.

10. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** Organization and program leaders support participation in continuing education by providing or facilitating access to ongoing continuing education in palliative care for the interdisciplinary team members and program staff.

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

Elements of Performance for LD.03.04.01

8. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** Upon request, the program provides the public with information about its performance improvement activities.

*Note: This information can be general in nature and consist of patient satisfaction data or general information about how the program improves its performance.*
Standard LD.03.06.01
Those who work in the organization are focused on improving safety and quality.

Elements of Performance for LD.03.06.01

10. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program has dedicated leadership and staff necessary to meet the scope of care, treatment, and services it provides.

11. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program leaders coach and mentor staff in order to improve their ability to provide care, treatment, and services in a manner that builds mutual trust with the patient and family.

12. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** Program leaders provide clinical support and guidance to promote staff’s confidence in their ability to provide palliative care for patients.

13. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program provides for emotional support for leaders, members of the interdisciplinary team, staff, and volunteers.

   **Note:** Emotional support is especially important in helping manage the stress of caring for seriously ill palliative care patients and their families.

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

Elements of Performance for LD.04.01.05

14. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program makes staff throughout the organization aware of the program’s objectives and the process for referring patients to the program.

15. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** Program leaders integrate the care, treatment, and services provided by the program with those of the organization.
Standard LD.04.01.07
The organization has policies and procedures that guide and support patient care, treatment, or services.

Elements of Performance for LD.04.01.07
11. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The program has policies and procedures that support its clinical practices.

Standard LD.04.03.03
The organization provides for its planned scope and level of care, treatment, or services.

Elements of Performance for LD.04.03.03
34. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: Programs have a process for making referrals to one or more hospices that will accept palliative care patient referrals.

Standard LD.04.03.09
Care, treatment, or services provided through contractual agreement are provided safely and effectively.

Elements of Performance for LD.04.03.09
24. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: Program leaders evaluate care, treatment, and services provided through contractual arrangement to ascertain whether the scope and level of care, treatment, and services are consistently provided. (For more information, refer to LD.04.03.09, EP 4)

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

Elements of Performance for LD.04.04.01
27. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The program has a written performance improvement plan.
28. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The program sets performance improvement priorities and describes how the priorities are adjusted in response to unusual or urgent events.

29. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The program plans process and performance improvement activities to encompass multiple disciplines and/or settings.

30. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The program implements its performance improvement plan.

31. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The program’s performance improvement plan, including its data analysis, is communicated at least annually to the organization’s leaders.

Standard LD.04.04.03
New or modified services or processes are well designed.

Elements of Performance for LD.04.04.03

8. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: Program leaders create opportunities for staff to participate in the design of the care, treatment, and services provided.

Standard LD.04.04.09
For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The program uses current clinical practice guidelines and evidence-based practices to guide the provision of palliative care services.

Note: Clinical practice guidelines and evidence-based practices include both nationally recognized guidelines and practices, as well as guidelines and practices developed by individual organizations to address their particular circumstances.
Element of Performance for LD.04.04.09

7. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The program reviews and revises its clinical practices in response to changes in evidence-based national guidelines or expert consensus, or results of its performance improvement activities.

Provision of Care, Treatment, and Services (PC)

Standard PC.01.01.01
The organization accepts the patient for care, treatment, or services based on its ability to meet the patient’s needs.

Elements of Performance for PC.01.01.01

49. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The program has a process to identify patients for whom community-based palliative care services are indicated and communicates this to appropriate staff and interdisciplinary team members.

Standard PC.01.02.01
The organization assesses and reassesses its patients.

Elements of Performance for PC.01.02.01

44. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The patient’s preferences about how he or she wants to receive information is communicated to staff across the care continuum who are involved in the patient’s care.

45. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: Program staff evaluate and revise the plan of care to meet the patient’s and family’s ongoing needs and document the revisions in the patient’s medical record.

46. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: A member of the interdisciplinary team conducts and documents an initial patient assessment, including a clinical assessment that is defined by the program and based on the patient’s needs.
47. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** As part of the initial assessment, the interdisciplinary team assesses and documents the patient’s pain, dyspnea, constipation, and other symptoms; standardized scales should be used when they are available. The scope of this assessment is defined by the program and based on patient needs.

48. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** As part of the initial assessment, the interdisciplinary team assesses and documents the patient’s functional status. The scope of this assessment is defined by the program and based on patient needs.

49. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** As part of the initial assessment, the interdisciplinary team completes and documents a psychosocial assessment of the patient and family. The scope of this assessment is defined by the program and based on patient needs.

50. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** As part of the initial assessment, the interdisciplinary team identifies and documents the cultural, spiritual, and religious beliefs and practices important to the patient and family that influence care, treatment, and services. The scope of this assessment is defined by the program and based on patient needs.

51. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** As part of the initial assessment, the interdisciplinary team assesses and documents the patient’s anxiety, stress, grief, coping, and other psychological symptoms using standardized scales when they are available. The scope of this assessment is defined by the program and based on patient needs.

52. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** For programs that provide care for pediatric patients: Assessment of infants, children, and adolescents must consider both the age and cognitive development of the patient.
Standard PC.01.02.03
The organization assesses and reassesses the patient and his or her condition according to defined time frames.

Elements of Performance for PC.01.02.03

27. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The interdisciplinary team completes the initial assessment within its defined time frame.

28. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The interdisciplinary team reassesses the patient on a regular basis, including whenever there is a change in the patient’s condition or goals, when there is a change in the patient’s or family’s preferences, and as defined by the program. The reassessment is documented in the patient’s medical record.

29. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The interdisciplinary team assesses and then refers patients with symptoms of psychiatric diagnoses such as depression, anxiety, and suicidal ideation.

Standard PC.01.03.01
The organization plans the patient’s care.

Elements of Performance for PC.01.03.01

49. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The documented plan of care is developed and updated by the interdisciplinary team in collaboration with the patient, his or her family, and other health care providers involved in the care of the patient.

50. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The plan of care is based on the patient’s assessed needs in conjunction with the patient’s strengths, limitations, values, and goals.

51. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program communicates the plan of care to staff involved in the patient’s care.
52. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program arranges spiritual care as needed by the patient and family through the program’s chaplain or spiritual care provider, through the patient’s own relationship(s) with clergy, or through community spiritual care resources.

53. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program has a process for providing or making referrals for bereavement services for the patient’s family prior to the patient’s death.

   **Note:** *The process includes attention to children and adolescents who are family members of the patient.*

54. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program leaders and staff participate in the evaluation of the provision of care, treatment, and services.

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**Standard PC.02.01.01**

The organization provides care, treatment, or services for each patient.

**Elements of Performance for PC.02.01.01**

20. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program delivers care, treatment, and services according to the patient’s individualized plan of care.

21. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program has a process to provide the patient with or refer the patient for emergency/urgent care.

22. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The interdisciplinary team provides compassionate care consistent with the patient’s quality of life needs, while preserving the patient’s comfort and dignity.
23. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The interdisciplinary team manages the patient’s physical symptoms according to the patient’s plan of care by utilizing pharmacological and/or nonpharmacological methods according to their effectiveness in minimizing pain and suffering. These symptoms include, but are not limited to, the following:
- Anorexia
- Confusion
- Constipation
- Dyspnea
- Fatigue
- Insomnia
- Nausea
- Pain
- Restlessness

24. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The patient’s psychological symptoms, including anxiety, stress, delirium, behavioral changes, and anticipatory grief are managed according to the patient’s plan of care.

**Standard PC.02.01.05**
The organization provides interdisciplinary, collaborative care, treatment, or services.

**Elements of Performance for PC.02.01.05**

33. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** For programs that provide care for pediatric patients: The interdisciplinary team provides family-centered care for the child and family.

34. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program and the organization promote and support a collaborative and trusting environment.

35. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** Program leaders facilitate communication among the interdisciplinary team members and other organization staff who are involved in the patient’s care.
36. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The program demonstrates teamwork among the interdisciplinary team members and other organization staff who are involved in the patient’s care.

37. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: Patients and staff mutually agree upon patient-centered goals of care.

38. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: Patients’ co-occurring conditions, if present, are managed.

Note: If the patient’s co-occurring conditions are managed by the patient’s primary care physician, or staff from a setting(s) outside the program, the information necessary for its management is communicated to program staff and settings across the continuum of care.

**Standard PC.02.02.01**

The organization coordinates the patient’s care, treatment, or services based on the patient’s needs.

**Elements of Performance for PC.02.02.01**

24. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: Program staff assist patients and families with identifying and accessing community resources that are available to meet patients’ physical, psychosocial, and spiritual needs.

Note: Examples of such resources may include, but are not limited to, community service providers, transportation companies, legal assistance, local school personnel, respite care providers, and spiritual care providers.

25. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: Staff have the patient’s health information available for use in clinical decision making to provide care, treatment, and services.
For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: In order to coordinate care, the program facilitates the exchange of the patient’s health information among staff, both internal and external to the program, and with other health care providers and organizations involved in the patient’s care.

Note: If the patient’s primary care physician is involved in the care of the patient, the program should communicate with the physician to plan and coordinate the patient’s care.

For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The interdisciplinary team conducts regular patient care conferences with its members and other program staff members as needed to discuss patient-centered goals of care, disease prognosis, and advance care planning. The frequency of these patient care conferences is defined by the program and based on the needs of the patients.

Note: Patient care conferences include members of the interdisciplinary team and other program staff members as required to meet the needs of the program’s patients and families. These conferences may be done in a variety of formats, including face-to-face meetings, teleconference, or videoconference.

Standard PC.02.02.05

The organization provides the patient with access to care, treatment, or services during non-business hours.

Elements of Performance for PC.02.02.05

5. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The program informs patients and families of how to access care, treatment, and services during business hours.

6. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The program informs patients and families of how to contact staff in the case of an emergent situation during or after business hours.
Standard PC.02.03.01
The organization provides patient education and training based on each patient’s needs and abilities.

Elements of Performance for PC.02.03.01
32. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program provides education and support to the patient and family based on their needs and the plan of care.

Standard PC.04.01.01
The organization has a process that addresses the patient’s need for continuing care, treatment, or services after discharge or transfer.

Elements of Performance for PC.04.01.01
28. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program has a process that addresses the patient’s need for continuing care, treatment, and services after discharge or transfer.

Standard PC.04.02.01
When a patient is discharged or transferred, the organization gives information about the care, treatment, or services provided to the patient to other service providers who will provide the patient with care, treatment, or services.

Elements of Performance for PC.04.02.01
9. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** At the time a patient is transferred to a different care setting, information about the patient’s goals, preferences, advanced care plan, and the patient’s clinical condition are communicated to staff in the new setting.

Performance Improvement (PI)
Standard PI.01.01.01
The organization collects data to monitor its performance.
Elements of Performance for PI.01.01

49. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program collects the data it needs to improve processes and outcomes.

50. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program uses consistent data sets, definitions, codes, classifications, and terminology.

51. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** Data collection is timely, accurate, complete, and relevant to the program.

52. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program selects valid, reliable performance measures based on evidence-based national guidelines or, in the absence of such guidelines, expert consensus, and in the absence of both, a review of the health care literature.

53. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program collects data related to processes and outcomes at the level of the individual patient.

54. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program collects patient satisfaction data that is specific to the care, treatment, and services it provides. (For more information, refer to LD.03.02.01, EP 8)

   **Note:** A variety of methods may be used to collect this data, such as an organization-wide patient satisfaction survey, a program-specific satisfaction survey, or a telephone survey of patients in the program.

55. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program monitors the quality of data collected.
Standard Pl.02.01.01
The organization compiles and analyzes data.

Elements of Performance for Pl.02.01.01

15. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** When useful, the program uses statistical tools and techniques to analyze data.

16. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program identifies and evaluates variables that affect outcomes.

17. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program uses its data analysis to improve and sustain its performance.

Standard Pl.03.01.01
The organization improves performance.

Elements of Performance for Pl.03.01.01

13. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** Patients have a defined role in the evaluation of the provision of care, treatment, and services.

Record of Care, Treatment, and Services (RC)

Standard RC.02.01.01
The patient record contains information that reflects the patient’s care, treatment, or services.

Elements of Performance for RC.02.01.01

31. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** If the patient has an advance directive, a copy is included in the patient’s medical record.
32. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** If the patient has expressed preferences for treatment as his or her disease progresses, the interdisciplinary team will document these preferences in the medical record.

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

**Standard RI.01.01.01**

The organization respects, protects, and promotes patients’ rights.

**Elements of Performance for RI.01.01.01**

33. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program provides care, treatment, and services in a manner that meets the patient’s communication needs.

34. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** While providing care, treatment, and services, program staff accommodate the patient’s and family’s cultural preferences and practices unless they are contraindicated or the accommodations affect the care of others.

**Standard RI.01.01.03**

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

**Elements of Performance for RI.01.01.03**

6. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** Program staff discuss with patients how they want to receive information, including the type of information, the method in which it is provided, which family members are to receive this information, and whether a surrogate decision-maker is involved in care, treatment, and services. (For more information on the role of surrogate decision-makers, see Standard RI.01.02.01.)
7. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: The program respects the patient’s right to be informed about his or her care by providing information in a manner tailored to the patient’s age, language, and ability to understand.

**Standard RI.01.02.01**

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

**Elements of Performance for RI.01.02.01**

36. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: Program staff educate the patient and family on disease processes and prognosis so that they are able to make informed care decisions.

37. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: In instances in which the patient has a designated surrogate decision-maker, a member of the interdisciplinary team documents the surrogate decision-maker’s name and contact information in the medical record.

38. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: For programs that provide care for pediatric patients: When developmentally appropriate, the child’s opinions and preferences are considered when making decisions and providing care.

39. For organizations that elect The Joint Commission Community-Based Palliative Care Certification option: For programs that provide care for pediatric patients: When developmentally appropriate and proper for the clinical circumstance, the program provides age-appropriate information about the child’s illness, as well as potential treatments and outcomes, to the child as decided by the child’s family.
Standard RI.01.05.01
The organization addresses patient decisions about care, treatment, or services received at the end of life.

Elements of Performance for RI.01.05.01

23. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** As defined by the program, staff provide information and education about advance care planning to the patient and family as appropriate to the patient’s clinical status, based on the patient’s expressed values, religious or spiritual beliefs, cultural practices, and preferences for care. This information is documented in the medical record and shared with the interdisciplinary team.

Standard RI.01.07.01
The patient and his or her family have the right to have complaints reviewed by the organization.

Elements of Performance for RI.01.07.01

30. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program encourages patients to express any concerns or complaints about their care to staff.

31. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** Program staff are aware of how to handle patients’ or families’ concerns or complaints about the program or their care.

32. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** The program’s leaders inform staff, patients, and families about the organization’s process to address concerns and resolve ethical concerns that may occur in the provision of community-based palliative care. (For more information, refer to Standard RI.01.07.01 and LD.04.02.03, EP 1.)

**Note:** Examples of ethical concerns that may occur include, but are not limited to, changing or withdrawing treatments, conflict with advance directives and advance care planning decisions, and use of sedation and pain medications.
**Standard RI.02.01.01**
The organization informs the patient about his or her responsibilities related to his or her care, treatment, or services.

**Elements of Performance for RI.02.01.01**

4. **For organizations that elect The Joint Commission Community-Based Palliative Care Certification option:** Program staff inform patients and families of their responsibility to provide information that is important to care, treatment, and services.
Appendix A: Medicare Requirements for Hospice (AXA)

Hospices seeking to obtain or maintain Medicare certification must meet all requirements for participation in the Medicare program. The standards and elements of performance in this manual meet or exceed the Conditions of Participation for hospices. For a complete list of all regulations that may apply, see Code of Federal Regulations, Title 42 at www.ecfr.gov/.

The following requirements and Conditions of Participation are covered in Joint Commission standards and EPs. However, your hospice should be familiar with specific Medicare language in order to make certain that compliance with the entire Medicare requirement can be demonstrated.

1. 489.102 Advance directives—Requirements for providers.
2. 418.110 Hospices that provide inpatient care directly. (Note: Several requirements at CFR 418.108 make reference to sections of CFR 418.110. Although CFR 418.110 is addressed by the standards in this manual, it is repeated here for ease in cross-referencing.)

Subpart I Advance Directives

Sec. 489.102 Requirements for providers.
(a) Hospitals, critical access hospitals, skilled nursing facilities, nursing facilities, home health agencies, providers of home health care (and for Medicaid purposes, providers of personal care services), hospices, and religious nonmedical health care institutions must maintain written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care, or patient care in the case of a patient in a religious nonmedical health care institution, by or through the provider and are required to:

(1) Provide written information to such individuals concerning—
(i) An individual’s rights under State law (whether statutory or recognized by the courts of the State) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate, at the individual’s option, advance directives. Providers are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. Providers are to update and disseminate amended information as soon as possible, but no later than 90 days from the effective date of the changes to State law; and

(ii) The written policies of the provider or organization respecting the implementation of such rights, including a clear and precise statement of limitation if the provider cannot implement an advance directive on the basis of conscience. At a minimum, a provider’s statement of limitation should:

(A) Clarify any differences between institution-wide conscience objections and those that may be raised by individual physicians;

(B) Identify the state legal authority permitting such objection; and

(C) Describe the range of medical conditions or procedures affected by the conscience objection.

(2) Document in a prominent part of the individual’s current medical record, or patient care record in the case of an individual in a religious nonmedical health care institution, whether or not the individual has executed an advance directive;

(3) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(4) Ensure compliance with requirements of State law (whether statutory or recognized by the courts of the State) regarding advance directives. The provider must inform individuals that complaints concerning the advance directive requirements may be filed with the State survey and certification agency;

(5) Provide for education of staff concerning its policies and procedures on advance directives; and

(6) Provide for community education regarding issues concerning advance directives that may include material required in paragraph (a)(1) of this section, either directly or in concert with other providers and organizations. Separate community education materials may be developed and used, at the discretion of providers. The
same written materials do not have to be provided in all settings, but the material should define what constitutes an advance directive, emphasizing that an advance directive is designed to enhance an incapacitated individual’s control over medical treatment, and describe applicable State law concerning advance directives. A provider must be able to document its community education efforts.

(b) The information specified in paragraph (a) of this section is furnished:

1. In the case of a hospital, at the time of the individual’s admission as an inpatient.

2. In the case of a skilled nursing facility, at the time of the individual’s admission as a resident.

3. In the case of a home health agency, in advance of the individual coming under the care of the agency. The HHA may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.

4. In the case of personal care services, in advance of the individual coming under the care of the personal care services provider. The personal care provider may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.

4. In the case of a hospice program, at the time of initial receipt of hospice care by the individual from the program.

(c) The providers listed in paragraph (a) of this section—

1. Are not required to provide care that conflicts with an advance directive.

2. Are not required to implement an advance directive if, as a matter of conscience, the provider cannot implement an advance directive and State law allows any health care provider or any agent of such provider to conscientiously object.

(d) Prepaid or eligible organizations (as specified in sections 1833(a)(1)(A) and 1876(b) of the Act) must meet the requirements specified in Sec. 417.436 of this chapter.

(e) If an adult individual is incapacitated at the time of admission or at the start of care and is unable to receive information (due to the incapacitating conditions or a mental disorder) or articulate whether or not he or she has executed an advance directive, then the provider may give advance directive information to the individual’s family or surrogate in the same manner that it issues other materials about policies and procedures.
to the family of the incapacitated individual or to a surrogate or other concerned persons in accordance with State law. The provider is not relieved of its obligation to provide this information to the individual once he or she is no longer incapacitated or unable to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.

**Sec. 418.110 Condition of participation: Hospices that provide inpatient care directly.**

A hospice that provides inpatient care directly in its own facility must demonstrate compliance with all of the following standards:

(a) Standard: Staffing. The hospice is responsible for ensuring that staffing for all services reflects its volume of patients, their acuity, and the level of intensity of services needed to ensure that plan of care outcomes are achieved and negative outcomes are avoided.

(b) Standard: Twenty-four hour nursing services.

(1) The hospice facility must provide 24-hour nursing services that meet the nursing needs of all patients and are furnished in accordance with each patient’s plan of care. Each patient must receive all nursing services as prescribed and must be kept comfortable, clean, well-groomed, and protected from accident, injury, and infection.

(2) If at least one patient in the hospice facility is receiving general inpatient care, then each shift must include a registered nurse who provides direct patient care.

(c) Standard: Physical environment. The hospice must maintain a safe physical environment free of hazards for patients, staff, and visitors.

(1) Safety management.

(i) The hospice must address real or potential threats to the health and safety of the patients, others, and property.

(ii) The hospice must have a written disaster preparedness plan in effect for managing the consequences of power failures, natural disasters, and other emergencies that would affect the hospice’s ability to provide care. The plan must be periodically reviewed and rehearsed with staff (including non-employee staff) with special emphasis placed on carrying out the procedures necessary to protect patients and others.
(2) Physical plant and equipment. The hospice must develop procedures for controlling the reliability and quality of—

(i) The routine storage and prompt disposal of trash and medical waste;
(ii) Light, temperature, and ventilation/air exchanges throughout the hospice;
(iii) Emergency gas and water supply; and
(iv) The scheduled and emergency maintenance and repair of all equipment.

(d) Standard: Fire protection.

(1) Except as otherwise provided in this section—

(i) The hospice must meet the applicable provisions and must proceed in accordance with the Life Safety Code (NFPA 101-2012 and Tentative Interim Amendments TIA 12–1, TIA 12–2, TIA 12–3, and TIA 12–4.)
(ii) Notwithstanding paragraph (d)(1)(i) of this section, corridor doors and doors to rooms containing flammable or combustible materials must be provided with positive latching hardware. Roller latches are prohibited on such doors.

(2) In consideration of a recommendation by the State survey agency or Accrediting Organization or at the discretion of the Secretary, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code, which would result in unreasonable hardship upon a hospice facility, but only if the waiver will not adversely affect the health and safety of the patients.

(3) The provisions of the adopted edition of the Life Safety Code do not apply in a State if CMS finds that a fire and safety code imposed by State law adequately protects patients in hospices.

(4) A hospice may place alcohol-based hand rub dispensers in its facility if the dispensers are installed in a manner that adequately protects against access by vulnerable populations.

(5) When a sprinkler system is shut down for more than 10 hours, the hospice must:

(i) Evacuate the building or portion of the building affected by the system outage until the system is back in service, or
(ii) Establish a fire watch until the system is back in service.
(6) Buildings must have an outside window or outside door in every sleeping room, and for any building constructed after July 5, 2016 the sill height must not exceed 36 inches above the floor. Windows in atrium walls are considered outside windows.

(e) Standard: Building Safety. Except as otherwise provided in this section, the hospice must meet the applicable provisions and must proceed in accordance with the NPFA 99-2012, Health Care Facilities Code and Tentative Interim Amendments TIA 12–2, TIA 12–3, TIA 12–4, TIA 12–5 and TIA 12–6.

(1) Chapters 7, 8, 12, and 13 of the adopted Health Care Facilities Code do not apply to a hospice.

(2) If application of the NFPA 99-2012 Health Care Facilities Code required under paragraph (e) of this section would result in unreasonable hardship for the hospice, CMS may waive specific provisions of the Health Care Facilities Code, but only if the waiver does not adversely affect the health and safety of patients.

(f) Standard: Patient rooms.

(1) The hospice must ensure that patient rooms are designed and equipped for nursing care, as well as the dignity, comfort, and privacy of patients.

(2) The hospice must accommodate a patient and family request for a single room whenever possible.

(3) Each patient’s room must—

(i) Be at or above grade level;

(ii) Contain a suitable bed and other appropriate furniture for each patient;

(iii) Have closet space that provides security and privacy for clothing and personal belongings;

(iv) Accommodate no more than two patients and their family members;

(v) Provide at least 80 square feet for each residing patient in a double room and at least 100 square feet for each patient residing in a single room; and

(vi) Be equipped with an easily-activated, functioning device accessible to the patient, that is used for calling for assistance.
(4) For a facility occupied by a Medicare-participating hospice on December 2, 2008, CMS may waive the space and occupancy requirements of paragraphs (f)(2)(iv) and (f)(2)(v) of this section if it determines that—

(i) Imposition of the requirements would result in unreasonable hardship on the hospice if strictly enforced; or jeopardize its ability to continue to participate in the Medicare program; and

(ii) The waiver serves the needs of the patient and does not adversely affect their health and safety.

(g) Standard: Toilet and bathing facilities. Each patient room must be equipped with, or conveniently located near, toilet and bathing facilities.

(h) Standard: Plumbing facilities. The hospice must—

   (1) Have an adequate supply of hot water at all times; and

   (2) Have plumbing fixtures with control valves that automatically regulate the temperature of the hot water used by patients.

(i) Standard: Infection control. The hospice must maintain an infection control program that protects patients, staff and others by preventing and controlling infections and communicable disease as stipulated in Sec. 418.60.

(j) Standard: Sanitary environment. The hospice must provide a sanitary environment by following current standards of practice, including nationally recognized infection control precautions, and avoid sources and transmission of infections and communicable diseases.

(k) Standard: Linen. The hospice must have available at all times a quantity of clean linen in sufficient amounts for all patient uses. Linens must be handled, stored, processed, and transported in such a manner as to prevent the spread of contaminants.

(l) Standard: Meal service and menu planning. The hospice must furnish meals to each patient that are—

   (1) Consistent with the patient’s plan of care, nutritional needs, and therapeutic diet;

   (2) Palatable, attractive, and served at the proper temperature; and

   (3) Obtained, stored, prepared, distributed, and served under sanitary conditions.
(m) Standard: Restraint or seclusion. All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.

(1) Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm.

(2) The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm.

(3) The use of restraint or seclusion must be—
(i) In accordance with a written modification to the patient’s plan of care; and

(ii) Implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospice policy in accordance with State law.

(4) The use of restraint or seclusion must be in accordance with the order of a physician authorized to order restraint or seclusion by hospice policy in accordance with State law.

(5) Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN).

(6) The medical director or physician designee must be consulted as soon as possible if the attending physician did not order the restraint or seclusion.

(7) Unless superseded by State law that is more restrictive—

    (i) Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed in accordance with the following limits for up to a total of 24 hours:

        (A) 4 hours for adults 18 years of age or older;

        (B) 2 hours for children and adolescents 9 to 17 years of age; or

        (C) 1 hour for children under 9 years of age; and

    After 24 hours, before writing a new order for the use of restraint or seclusion for the management of violent or self-destructive behavior, a physician authorized to order restraint or seclusion by hospice policy in accordance with State law must see and assess the patient.

    (ii) Each order for restraint used to ensure the physical safety of the non-violent or non-self-destructive patient may be renewed as authorized by hospice policy.

(8) Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.

(9) The condition of the patient who is restrained or secluded must be monitored by a physician or trained staff that have completed the training criteria specified in paragraph (n) of this section at an interval determined by hospice policy.
(10) Physician, including attending physician, training requirements must be specified in hospice policy. At a minimum, physicians and attending physicians authorized to order restraint or seclusion by hospice policy in accordance with State law must have a working knowledge of hospice policy regarding the use of restraint or seclusion.

(11) When restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others, the patient must be seen face-to-face within 1 hour after the initiation of the intervention—

(i) By a—

(A) Physician; or

(B) Registered nurse who has been trained in accordance with the requirements specified in paragraph (n) of this section.

(ii) To evaluate—

(A) The patient’s immediate situation;

(B) The patient’s reaction to the intervention;

(C) The patient’s medical and behavioral condition; and

(D) The need to continue or terminate the restraint or seclusion.

(12) States are free to have requirements by statute or regulation that are more restrictive than those contained in paragraph (m)(11)(i) of this section.

(13) If the face-to-face evaluation specified in Sec. 418.110(m)(11) is conducted by a trained registered nurse, the trained registered nurse must consult the medical director or physician designee as soon as possible after the completion of the 1-hour face-to-face evaluation.

(14) All requirements specified under this paragraph are applicable to the simultaneous use of restraint and seclusion. Simultaneous restraint and seclusion use is only permitted if the patient is continually monitored—

(i) Face-to-face by an assigned, trained staff member; or

(ii) By trained staff using both video and audio equipment. This monitoring must be in close proximity to the patient.
(15) When restraint or seclusion is used, there must be documentation in the patient’s clinical record of the following:

(i) The 1-hour face-to-face medical and behavioral evaluation if restraint or seclusion is used to manage violent or self-destructive behavior;

(ii) A description of the patient’s behavior and the intervention used;

(iii) Alternatives or other less restrictive interventions attempted (as applicable);

(iv) The patient’s condition or symptom(s) that warranted the use of the restraint or seclusion; and the patient’s response to the intervention(s) used, including the rationale for continued use of the intervention.

(n) Standard: Restraint or seclusion staff training requirements. The patient has the right to safe implementation of restraint or seclusion by trained staff.

(1) Training intervals. All patient care staff working in the hospice inpatient facility must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in restraint or seclusion—

(i) Before performing any of the actions specified in this paragraph;

(ii) As part of orientation; and

(iii) Subsequently on a periodic basis consistent with hospice policy.

(2) Training content. The hospice must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:

(i) Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion.

(ii) The use of nonphysical intervention skills.

(iii) Choosing the least restrictive intervention based on an individualized assessment of the patient’s medical, or behavioral status or condition.

(iv) The safe application and use of all types of restraint or seclusion used in the hospice, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia).
(v) Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary.

(vi) 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 hospice policy associated with the 1-hour face-to-face evaluation.

(vii) The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.

(3) Trainer requirements. Individuals providing staff training must be qualified as evidenced by education, training, and experience in techniques used to address patients’ behaviors.

(4) Training documentation. The hospice must document in the staff personnel records that the training and demonstration of competency were successfully completed.

(o) Standard: Death reporting requirements. Hospices must report deaths associated with the use of seclusion or restraint.

(1) The hospice must report the following information to CMS:

(i) Each unexpected death that occurs while a patient is in restraint or seclusion.

(ii) Each unexpected death that occurs within 24 hours after the patient has been removed from restraint or seclusion.

(iii) Each death known to the hospice that occurs within 1 week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient’s death. “Reasonable to assume” in this context 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) Each death referenced in this paragraph must be reported to CMS by telephone no later than the close of business the next business day following knowledge of the patient’s death.

(3) Staff must document in the patient’s clinical record the date and time the death was reported to CMS.
(p) The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.


(ii) TIA 12–2 to NFPA 99, issued August 11, 2011.

(iii) TIA 12–3 to NFPA 99, issued August 9, 2012.

(iv) TIA 12–4 to NFPA 99, issued March 7, 2013.

(v) TIA 12–5 to NFPA 99, issued August 1, 2013.


(viii) TIA 12–1 to NFPA 101, issued August 11, 2011.


(x) TIA 12–3 to NFPA 101, issued October 22, 2013.

(xi) TIA 12–4 to NFPA 101, issued October 22, 2013.

(2) [Reserved]
This page is blank due to revisions through the CAMHC update.
Additional Regulations

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, Medicare Administrative Contractor, or the Fiscal Intermediary. Hospices should be aware of the following additional regulations that require compliance.

418.20 Eligibility requirements.
418.21 Duration of hospice care coverage—Election periods.
418.22 Certification of terminal illness.
418.24 Election of hospice care.
418.25 Admission to hospice care.
418.26 Discharge from hospice care.
418.28 Revoking the election of hospice care.
418.30 Change of the designated hospice.
418.66 Condition of participation: Nursing services—Waiver of requirement that substantially all nursing services be routinely provided directly by a hospice.
418.74 Condition of participation: Waiver of requirement—Physical therapy, occupational therapy, speech-language pathology, and dietary counseling.
418.200 Requirements for Coverage.
418.202 Covered Services.
418.204 Special Coverage Requirements.

Sec. 418.20 Eligibility requirements.
In order to be eligible to elect hospice care under Medicare, an individual must be—

(a) Entitled to Part A of Medicare; and

(b) Certified as being terminally ill in accordance with Sec. 418.22.
Sec. 418.21 Duration of hospice care coverage—
Election periods.
(a) Subject to the conditions set forth in this part, an individual may elect to receive hospice care during one or more of the following election periods:

(1) An initial 90-day period;

(2) A subsequent 90-day period; or

(3) An unlimited number of subsequent 60-day periods.

(b) The periods of care are available in the order listed and may be elected separately at different times.

Sec. 418.22 Certification of terminal illness.
(a) Timing of certification—

(1) General rule. The hospice must obtain written certification of terminal illness for each of the periods listed in Sec. 418.21, even if a single election continues in effect for an unlimited number of periods, as provided in Sec. 418.24(c).

(2) Basic requirement. Except as provided in paragraph (a)(3) of this section, the hospice must obtain the written certification before it submits a claim for payment.

(3) Exceptions.

(i) If the hospice cannot obtain the written certification within 2 calendar days, after a period begins, it must obtain an oral certification within 2 calendar days and the written certification before it submits a claim for payment.

(ii) Certifications may be completed no more than 15 calendar days prior to the effective date of election.

(iii) Recertifications may be completed no more than 15 calendar days prior to the start of the subsequent benefit period.

(4) Face-to-face encounter. As of January 1, 2011, a hospice physician or hospice nurse practitioner must have a face-to-face encounter with each hospice patient whose total stay across all hospices is anticipated to reach the 3rd benefit period. The face-to-face encounter must occur prior to, but no more than 30 calendar days prior to, the 3rd benefit period recertification, and every benefit period recertification thereafter, to gather clinical findings to determine continued eligibility for hospice care.
(b) **Content of certification.** Certification will be based on the physician’s or medical director’s clinical judgment regarding the normal course of the individual’s illness. The certification must conform to the following requirements:

1. The certification must specify that the individual’s prognosis is for a life expectancy of 6 months or less if the terminal illness runs its normal course.

2. Clinical information and other documentation that support the medical prognosis must accompany the certification and must be filed in the medical record with the written certification as set forth in paragraph (d)(2) of this section. Initially, the clinical information may be provided verbally, and must be documented in the medical record and included as part of the hospice’s eligibility assessment.

3. The physician must include a brief narrative explanation of the clinical findings that supports a life expectancy of 6 months or less as part of the certification and recertification forms, or as an addendum to the certification and recertification forms.

   i. If the narrative is part of the certification or recertification form, then the narrative must be located immediately prior to the physician’s signature.

   ii. If the narrative exists as an addendum to the certification or recertification form, in addition to the physician’s signature on the certification or recertification form, the physician must also sign immediately following the narrative in the addendum.

   iii. The narrative shall include a statement directly above the physician signature attesting that by signing, the physician confirms that he/she composed the narrative based on his/her review of the patient’s medical record or, if applicable, his/her examination of the patient.

   iv. The narrative must reflect the patient’s individual clinical circumstances and cannot contain check boxes or standard language used for all patients.

   v. The narrative associated with the 3rd benefit period recertification and every subsequent recertification must include an explanation of why the clinical findings of the face-to-face encounter support a life expectancy of 6 months or less.
(4) The physician or nurse practitioner who performs the face-to-face encounter with the patient described in paragraph (a)(4) of this section must attest in writing that he or she had a face-to-face encounter with the patient, including the date of that visit. The attestation of the nurse practitioner or a non-certifying hospice physician shall state that the clinical findings of that visit were provided to the certifying physician for use in determining continued eligibility for hospice care.

(5) All certifications and recertifications must be signed and dated by the physician(s), and must include the benefit period dates to which the certification or recertification applies.

(c) Sources of certification.

(1) For the initial 90-day period, the hospice must obtain written certification statements (and oral certification statements if required under paragraph (a)(3) of this section) from—

   (i) The medical director of the hospice or the physician member of the hospice interdisciplinary group; and

   (ii) The individual’s attending physician, if the individual has an attending physician. The attending physician must meet the definition of physician specified in Sec. 410.20 of this subchapter.

(2) For subsequent periods, the only requirement is certification by one of the physicians listed in paragraph (c)(1)(i) of this section.

(d) Maintenance of records. Hospice staff must—

(1) Make an appropriate entry in the patient’s medical record as soon as they receive an oral certification; and

(2) File written certifications in the medical record.

Sec. 418.24 Election of hospice care.

(a) Filing an election statement. An individual who meets the eligibility requirement of Sec. 418.20 may file an election statement with a particular hospice. If the individual is physically or mentally incapacitated, his or her representative (as defined in Sec. 418.3) may file the election statement.

(b) Content of election statement. The election statement must include the following:

   (1) Identification of the particular hospice that will provide care to the individual.
(2) The individual’s or representative’s acknowledgement that he or she has been given a full understanding of the palliative rather than curative nature of hospice care, as it relates to the individual’s terminal illness.

(3) Acknowledgement that certain Medicare services, as set forth in paragraph (d) of this section, are waived by the election.

(4) The effective date of the election, which may be the first day of hospice care or a later date, but may be no earlier than the date of the election statement.

(5) The signature of the individual or representative.

c) Duration of election. An election to receive hospice care will be considered to continue through the initial election period and through the subsequent election periods without a break in care as long as the individual—

(1) Remains in the care of a hospice;

(2) Does not revoke the election; and

(3) Is not discharged from the hospice under the provisions of Sec. 418.26.

d) Waiver of other benefits. For the duration of an election of hospice care, an individual waives all rights to Medicare payments for the following services:

(1) Hospice care provided by a hospice other than the hospice designated by the individual (unless provided under arrangements made by the designated hospice).

(2) Any Medicare services that are related to the treatment of the terminal condition for which hospice care was elected or a related condition or that are equivalent to hospice care except for services—

   (i) Provided by the designated hospice:

   (ii) Provided by another hospice under arrangements made by the designated hospice; and

   (iii) Provided by the individual’s attending physician if that physician is not an employee of the designated hospice or receiving compensation from the hospice for those services.

(e) Re-election of hospice benefits. If an election has been revoked in accordance with Sec. 418.28, the individual (or his or her representative if the individual is mentally or physically incapacitated) may at any time file an election, in accordance with this section, for any other election period that is still available to the individual.
Sec. 418.25 Admission to hospice care.
(a) The hospice admits a patient only on the recommendation of the medical director in consultation with, or with input from, the patient’s attending physician (if any).

(b) In reaching a decision to certify that the patient is terminally ill, the hospice medical director must consider at least the following information:

1. Diagnosis of the terminal condition of the patient.
2. Other health conditions, whether related or unrelated to the terminal condition.
3. Current clinically relevant information supporting all diagnoses.

Sec. 418.26 Discharge from hospice care.
(a) Reasons for discharge. A hospice may discharge a patient if—

1. The patient moves out of the hospice’s service area or transfers to another hospice;
2. The hospice determines that the patient is no longer terminally ill; or
3. The hospice determines, under a policy set by the hospice for the purpose of addressing discharge for cause that meets the requirements of paragraphs (a)(3)(i) through (a)(3)(iv) of this section, that the patient’s (or other persons in the patient’s home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired. The hospice must do the following before it seeks to discharge a patient for cause:
   (i) Advise the patient that a discharge for cause is being considered;
   (ii) Make a serious effort to resolve the problem(s) presented by the patient’s behavior or situation;
   (iii) Ascertain that the patient’s proposed discharge is not due to the patient’s use of necessary hospice services; and
   (iv) Document the problem(s) and efforts made to resolve the problem(s) and enter this documentation into its medical records.
(b) Discharge order. Prior to discharging a patient for any reason listed in paragraph (a) of this section, the hospice must obtain a written physician’s discharge order from the hospice medical director. If a patient has an attending physician involved in his or her care, this physician should be consulted before discharge and his or her review and decision included in the discharge note.

(c) Effect of discharge. An individual, upon discharge from the hospice during a particular election period for reasons other than immediate transfer to another hospice—

   (1) Is no longer covered under Medicare for hospice care;

   (2) Resumes Medicare coverage of the benefits waived under Sec. 418.24(d); and

   (3) May at any time elect to receive hospice care if he or she is again eligible to receive the benefit.

(d) Discharge planning.

   (1) The hospice must have in place a discharge planning process that takes into account the prospect that a patient’s condition might stabilize or otherwise change such that the patient cannot continue to be certified as terminally ill.

   (2) The discharge planning process must include planning for any necessary family counseling, patient education, or other services before the patient is discharged because he or she is no longer terminally ill.

**Sec. 418.28 Revoking the election of hospice care.**

(a) An individual or representative may revoke the individual’s election of hospice care at any time during an election period.

(b) To revoke the election of hospice care, the individual or representative must file a statement with the hospice that includes the following information:

   (1) A signed statement that the individual or representative revokes the individual’s election for Medicare coverage of hospice care for the remainder of that election period.

   (2) The date that the revocation is to be effective. (An individual or representative may not designate an effective date earlier than the date that the revocation is made.)

(c) An individual, upon revocation of the election of Medicare coverage of hospice care for a particular election period—
(1) Is no longer covered under Medicare for hospice care;
(2) Resumes Medicare coverage of the benefits waived under Sec. 418.24(e)(2); and
(3) May at any time elect to receive hospice coverage for any other hospice election periods that he or she is eligible to receive.

Sec. 418.30 Change of the designated hospice.
(a) An individual or representative may change, once in each election period, the designation of the particular hospice from which hospice care will be received.
(b) The change of the designated hospice is not a revocation of the election for the period in which it is made.
(c) To change the designation of hospice programs, the individual or representative must file, with the hospice from which care has been received and with the newly designated hospice, a statement that includes the following information:
   (1) The name of the hospice from which the individual has received care and the name of the hospice from which he or she plans to receive care.
   (2) The date the change is to be effective.

Sec. 418.66 Condition of participation: Nursing services—Waiver of requirement that substantially all nursing services be routinely provided directly by a hospice.
(a) CMS may waive the requirement in Sec. 418.64(b) that a hospice provide nursing services directly, if the hospice is located in a non-urbanized area. The location of a hospice that operates in several areas is considered to be the location of its central office. The hospice must provide evidence to CMS that it has made a good faith effort to hire a sufficient number of nurses to provide services. CMS may waive the requirement that nursing services be furnished by employees based on the following criteria:
   (1) The location of the hospice’s central office is in a non-urbanized area as determined by the Bureau of the Census.
   (2) There is evidence that a hospice was operational on or before January 1, 1983 including the following:
      (i) Proof that the organization was established to provide hospice services on or before January 1, 1983.
(ii) Evidence that hospice-type services were furnished to patients on or before January 1, 1983.

(iii) Evidence that hospice care was a discrete activity rather than an aspect of another type of provider’s patient care program on or before January 1, 1983.

(3) By virtue of the following evidence that a hospice made a good faith effort to hire nurses:

(i) Copies of advertisements in local newspapers that demonstrate recruitment efforts.

(ii) Job descriptions for nurse employees.

(iii) Evidence that salary and benefits are competitive for the area.

(iv) Evidence of any other recruiting activities (for example, recruiting efforts at health fairs and contacts with nurses at other providers in the area).

(b) Any waiver request is deemed to be granted unless it is denied within 60 days after it is received.

(c) Waivers will remain effective for 1 year at a time from the date of the request.

(d) If a hospice wishes to receive a 1-year extension, it must submit a request to CMS before the expiration of the waiver period, and certify that the conditions under which it originally requested the initial waiver have not changed since the initial waiver was granted.

Sec. 418.74 Condition of participation: Waiver of requirement—Physical therapy, occupational therapy, speech-language pathology, and dietary counseling.

(a) A hospice located in a non-urbanized area may submit a written request for a waiver of the requirement for providing physical therapy, occupational therapy, speech-language pathology, and dietary counseling services. The hospice may seek a waiver of the requirement that it make physical therapy, occupational therapy, speech-language pathology, and dietary counseling services (as needed) available on a 24-hour basis. The hospice may also seek a waiver of the requirement that it provide dietary counseling directly. The hospice must provide evidence that it has made a good faith effort to meet the requirements for these services before it seeks a waiver. CMS may approve a waiver application on the basis of the following criteria:
(1) The hospice is located in a non-urbanized area as determined by the Bureau of the Census.

(2) The hospice provides evidence that it had made a good faith effort to make available physical therapy, occupational therapy, speech-language pathology, and dietary counseling services on a 24-hour basis and/or to hire a dietary counselor to furnish services directly. This evidence must include the following:

(i) Copies of advertisements in local newspapers that demonstrate recruitment efforts.

(ii) Physical therapy, occupational therapy, speech-language pathology, and dietary counselor job descriptions.

(iii) Evidence that salary and benefits are competitive for the area.

(iv) Evidence of any other recruiting activities (for example, recruiting efforts at health fairs and contact discussions with physical therapy, occupational therapy, speech-language pathology, and dietary counseling service providers in the area).

(b) Any waiver request is deemed to be granted unless it is denied within 60 days after it is received.

(c) An initial waiver will remain effective for 1 year at a time from the date of the request.

(d) If a hospice wishes to receive a 1-year extension, it must submit a request to CMS before the expiration of the waiver period and certify that conditions under which it originally requested the waiver have not changed since the initial waiver was granted.

**Sec. 418.200 Requirements for coverage.**

To be covered, hospice services must meet the following requirements. They must be reasonable and necessary for the palliation and management of the terminal illness as well as related conditions. The individual must elect hospice care in accordance with Sec. 418.24. A plan of care must be established and periodically reviewed by the attending physician, the medical director, and the interdisciplinary group of the hospice program as set forth in Sec. 418.56. That plan of care must be established before hospice care is provided. The services provided must be consistent with the plan of care. A certification that the individual is terminally ill must be completed as set forth in Sec. 418.22.
Sec. 418.202 Covered services.

All services must be performed by appropriately qualified personnel, but it is the nature of the service, rather than the qualification of the person who provides it, that determines the coverage category of the service. The following services are covered hospice services:

(a) Nursing care provided by or under the supervision of a registered nurse.

(b) Medical social services provided by a social worker under the direction of a physician.

(c) Physicians’ services performed by a physician as defined in Sec. 410.20 of this chapter except that the services of the hospice medical director or the physician member of the interdisciplinary group must be performed by a doctor of medicine or osteopathy.

(d) Counseling services provided to the terminally ill individual and the family members or other persons caring for the individual at home. Counseling, including dietary counseling, may be provided both for the purpose of training the individual’s family or other caregiver to provide care, and for the purpose of helping the individual and those caring for him or her to adjust to the individual’s approaching death.

(e) Short-term inpatient care provided in a participating hospice inpatient unit, or a participating hospital or SNF, that additionally meets the standards in Sec. 418.202 (a) and (e) regarding staffing and patient areas. Services provided in an inpatient setting must conform to the written plan of care. Inpatient care may be required for procedures necessary for pain control or acute or chronic symptom management.

Inpatient care may also be furnished as a means of providing respite for the individual’s family or other persons caring for the individual at home. Respite care must be furnished as specified in Sec. 418.108(b). Payment for inpatient care will be made at the rate appropriate to the level of care as specified in Sec. 418.302.

(f) Medical appliances and supplies, including drugs and biologicals. Only drugs as defined in section 1861(t) of the Act and which are used primarily for the relief of pain and symptom control related to the individual’s terminal illness are covered. Appliances may include covered durable medical equipment as described in Sec. 410.38 of this chapter as well as other self-help and personal comfort items related to the palliation or management of the patient’s terminal illness. Equipment is provided by the hospice for use in the patient’s home while he or she is under hospice care. Medical supplies include those that are part of the written plan of care.
(g) Home health aide services furnished by qualified aides as designated in Sec. 418.76 and homemaker services. Home health aides may provide personal care services as defined in Sec. 409.45(b) of this chapter. Aides may perform household services to maintain a safe and sanitary environment in areas of the home used by the patient, such as changing bed linens or light cleaning and laundering essential to the comfort and cleanliness of the patient. Aide services must be provided under the general supervision of a registered nurse. Homemaker services may include assistance in maintenance of a safe and healthy environment and services to enable the individual to carry out the treatment plan.

(h) Physical therapy, occupational therapy and speech-language pathology services in addition to the services described in Sec. 409.33 (b) and (c) of this chapter provided for purposes of symptom control or to enable the patient to maintain activities of daily living and basic functional skills.

(i) Effective April 1, 1998, any other service that is specified in the patient’s plan of care as reasonable and necessary for the palliation and management of the patient’s terminal illness and related conditions and for which payment may otherwise be made under Medicare.

**Sec. 418.204 Special coverage requirements.**

(a) Periods of crisis. Nursing care may be covered on a continuous basis for as much as 24 hours a day during periods of crisis as necessary to maintain an individual at home. Either homemaker or home health aide services or both may be covered on a 24-hour continuous basis during periods of crisis but care during these periods must be predominantly nursing care. A period of crisis is a period in which the individual requires continuous care to achieve palliation or management of acute medical symptoms.

(b) Respite care.

(1) Respite care is short-term inpatient care provided to the individual only when necessary to relieve the family members or other persons caring for the individual.

(2) Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days at a time.

(c) Bereavement counseling. Bereavement counseling is a required hospice service but it is not reimbursable.
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 Quality Report**  See Quality Report.

**accreditation survey**  An on-site evaluation of an organization to assess its level of compliance with applicable Joint Commission accreditation requirements and to make determinations regarding its accreditation status. The survey includes evaluation of documentation of compliance provided by organization staff; verbal information concerning the implementation of standards or examples of their implementation that enable a determination of compliance to be made; on-site observations by the surveyor(s); and an opportunity for education and consultation regarding standards compliance and performance improvement.

**accreditation survey findings**  Findings from an on-site evaluation conducted by Joint Commission surveyors that result in an organization’s accreditation decision.

**active pharmaceutical ingredient (API)**  Any substance or mixture of substances intended to be used in the compounding of a drug preparation, thereby becoming the active ingredient in that preparation and furnishing pharmacological activity by direct effect in the diagnosis, cure, mitigation, treatment, or prevention of disease or by affecting the structure and function of the body.

**administrator, home health agency**  For home health agencies that elect to use The Joint Commission deemed status option:

For individuals that began employment with the organization prior to July 13, 2017, the individual is a licensed physician, a registered nurse, or has training and experience in health service administration, and the individual has at least one year of supervisory or administrative experience in home health care or a related health care program.

For individuals that began employment with the organization on or after July 13, 2017, the individual is a licensed physician, a registered nurse, or holds an undergraduate degree, and the individual has experience in health service administration, with
at least one year of supervisory or administrative experience in home health care or a related health care program.

**advance care planning**  A voluntary process of communication between individuals and their health care providers to discuss, understand, reflect on, and plan for future health care decisions for a time when individuals are not able to make their own health care decisions.

**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.

**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.

**adverse medication event**  See adverse drug event (ADE).

**adverse medication reaction**  See adverse drug reaction (ADR).

**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.

**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.

**ante-area**  An International Organization for Standardization (ISO) Class 8 or cleaner area where staff hand hygiene and garbing procedures and other activities that generate high-particulate levels are performed. The ante-area is the transition area between the unclassified area of the facility and the buffer area. The ante-area is sometimes referred to as an anteroom when solid doors and walls are present.

**anteroom**  Transition area between the general area and the room containing the primary engineering controls. Hand hygiene, garbing, staging of components, order entry, and other particle-generating activities are performed in the anteroom. For
sterile compounding, the anteroom meets International Organization for Standardization (ISO) Class 7 conditions.

**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.

**aseptic technique** A process by which separate sterile components (for example, drugs, containers, or closures) are brought together under conditions that maintain their sterility. The components can either be purchased as sterile or, when starting with nonsterile components, can be separately sterilized prior to combining (for example, by membrane filtration or autoclave).

**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.

**audiologist** For home health agencies that elect to use The Joint Commission deemed status option: A person who:

(a) Meets the education and experience requirements for a Certificate of Clinical Competence in audiology granted by the American Speech-Language-Hearing Association; or
(b) Meets the educational requirements for certification and is in the process of accumulating the supervised experience required for certification.

**batch** More than one unit of a compounded sterile preparation (CSP) prepared in a single process and intended to have uniform characteristics and quality, within specified limits.

**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.

**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.

**bereavement counseling** For hospices that elect to use The Joint Commission deemed status option: Emotional, psychosocial, and spiritual support and services
provided before and after the death of the patient to assist with issues related to grief, loss, and adjustment.

**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.

**beyond-use date (BUD)** The date after which a compounded preparation should not be used; determined from the date the preparation is compounded.

**biologica** Medicines made from living organisms and their products, including serums, vaccines, antigens, and antitoxins.

**biological safety cabinet (BSC)** A ventilated cabinet with unidirectional, high-efficiency particulate air (HEPA)–filtered airflow and HEPA–filtered exhaust to protect the worker from hazardous drugs. A BSC used to prepare a compounded sterile preparation (CSP) must be capable of providing an International Organization for Standardization (ISO) Class 5 environment for preparation of the CSP.

**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).

**branch office** For home health agencies that elect to use The Joint Commission deemed status option: An approved location or site from which a home health agency provides services within a portion of the total geographic area served by the parent agency. The parent home health agency must provide supervision and administrative control of any branch office. It is unnecessary for the branch office to independently meet the conditions of participation as a home health agency.

**buffer area** An International Organization for Standardization (ISO) Class 7 (or ISO Class 8 if using an isolator) or cleaner area where the primary engineering control (PEC) that generates and maintains an ISO Class 5 environment is physically located.

**bulk component containers** A conventionally manufactured sterile product for parenteral use that contains many single doses intended for use in a pharmacy admixture program. A pharmacy bulk package may either be used to prepare admixtures for infusion or, through a sterile transfer device, for the filling of empty sterile syringes.

**care coordination** Assistance provided to individuals served, patients, or their authorized representatives in planning and organizing behavioral health, home health, and other relevant community resources.

**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.

certificate of analysis A report from the supplier of a component, container, or closure that accompanies the supplier’s material and contains the specifications, results of all analyses, and a description of the material.

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.

chemotherapy glove A medical glove that meets the American Society for Testing and Materials (ASTM) Standard Practice (D6978-05-2013) for Assessment of Resistance of Medical Gloves to Permeation by Chemotherapy Drugs.

child A person between 0 and 12 years of age, or as determined by applicable law and regulation.

Class I biological safety cabinet (BSC) A BSC that protects staff and the environment but does not protect the product/preparation. Staff protection is provided at a minimum velocity of 75 linear feet per minute of unfiltered room air drawn through the front opening and across the work surface. The air is then passed through a high-efficiency particulate air (HEPA) and ultra-low penetration air (ULPA) filters either into the room or to the outside in the exhaust plenum, providing environmental protection.

Class II biological safety cabinet (BSC) Partial barrier system that relies on the movement of air to provide staff, environmental, and product/preparation protection. Staff and product/preparation protection is provided by the combination of inward and downward airflow captured by the front grille of the cabinet. Side-to-side cross-contamination of products/preparations is minimized by the internal downward flow of high-efficiency particulate air (HEPA) and ultra-low penetration air (ULPA) filtered air moving toward the work surface and then drawn into the front and rear intake grilles. Environmental protection is provided when the cabinet exhaust air is passed through HEPA and ULPA filters.

Class III biological safety cabinet (BSC) The Class III BSC is designed for working with highly infectious microbiological agents and other hazardous operations. It provides maximum protection for the environment and the worker. It is a gas-tight enclosure with a viewing window that is secured with locks and/or requires the use of tools to open. Both supply and exhaust air are high-efficiency particulate air (HEPA) and ultra-low penetration air...
(ULPA) filtered. Exhaust air must pass through a HEPA and an ULPA filter in series before discharge to the outdoors.

**clean room** A room in which the concentration of airborne particles is controlled through directional airflow and high-efficiency particulate air (HEPA)–filtered air supply to meet a specified airborne particulate cleanliness class. Microorganisms in the environment are monitored so that a microbial level for air, surface, and staff are not exceeded for a specified International Organization for Standardization (ISO)–classified space.

**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 manager** For home health agencies that elect to use The Joint Commission deemed status option: A person who is a licensed physician, physical therapist, speech-language pathologist, occupational therapist, audiologist, social worker, or a registered nurse.

**clinical monitoring or consultant pharmacist services** Professional care and services provided by a legally qualified pharmacist. This includes the assessment of the appropriateness of medication orders, the ongoing evaluation and review of the patients’ or residents’ medication regimen and pharmaceutical care plan, ongoing monitoring of medication effects in individual patients or residents, provision of drug information, oversight of the medication management process to improve safety, and other cognitive medication-related services.

**clinical note (home health)** For home health agencies that elect to use The Joint Commission deemed status option: Notation of a contact with a patient that is written and timed describing signs and symptoms, treatment, drugs administered and the patient’s reaction or response, and any changes in physical or emotional condition during a given period of time.

**clinical note (hospice)** For hospices that elect to use The Joint Commission deemed status option: Notation of contact with the patient or family that is written and dated by any person providing services and that describes signs and symptoms, treatments, and medications administered. This notation includes the patient’s reaction or response, and any changes in his or her physical, emotional, psychosocial, or spiritual condition during a given period of time.

**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 respiratory services**  The provision of health care services by respiratory care practitioners or respiratory therapists to individuals in their place of residence, associated with provision of home medical equipment services. This includes, but is not limited to, performing assessments and testing, administration of treatment, provision of education, and/or monitoring of the patient’s respiratory status.

**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.

**closed-system vial transfer device (CSTD)**  A drug transfer device that mechanically prohibits the transfer of environmental contaminants into the system and the escape of hazardous drug or vapor concentrations outside of the system.

**community-based palliative care**  Palliative care that is provided outside of the hospital setting and primarily delivered in the patient’s place of residence. This type of care is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment.

**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.

**compassionate care**  Medical, emotional, and spiritual care for persons with terminal diseases or injuries in order to reduce pain and suffering and make them as comfortable as possible.

**complex organization**  An organization accredited by The Joint Commission under more than one accreditation manual.

**component**  1. A constituent part, element, or ingredient; a part of a mechanical or electrical system.

2. For medication compounding: Any ingredient used in the compounding of a drug preparation, including any active ingredient or added substance that is used in its preparation.

**compounded preparation**  A nonsterile or sterile drug or nutrient preparation that is compounded in a licensed pharmacy or
other health care–related facility pursuant to the order or anticipation of an order from a licensed prescriber.

**compounded sterile preparation (CSP)**
A preparation intended to be sterile that is created by combining, diluting, pooling, or otherwise altering a drug product or bulk drug substance. A product produced by reconstituting a conventionally manufactured product for an individual patient strictly in accordance with the directions contained in the approved labeling provided by the product manufacturer is not considered a CSP.

**compounder** A professional who meets licensing requirements of his or her state to perform compounding pursuant to a prescription or medication order by a licensed prescriber.

**compounding** The preparation, mixing, assembling, altering, packaging, and labeling of a drug, drug-delivery device, or device in accordance with a licensed practitioner’s prescription, medication order, or initiative based on the practitioner/patient/pharmacist/compounder relationship in the course of professional practice. Compounding includes the following:

- Preparation of drug dosage forms for both human and animal patients
- Preparation of drugs or devices in anticipation of prescription drug orders based on routine, regularly observed prescribing patterns
- Reconstitution or manipulation of commercial products that may require the addition of one or more ingredients
- Preparation of drugs or devices for the purposes of or incidental to chemical analysis, teaching, or research (clinical or academic)
- Preparation of drugs and devices for prescriber’s office use where permitted by federal and state law

**Description of Nonsterile Compounding Categories:**

- Simple: Making a preparation that has a United States Pharmacopeia (USP) compounding monograph or appears in a peer-reviewed journal article that contains specific quantities of all components, compounding procedure and equipment, and stability data for that formulation with appropriate beyond-use dates; or reconstituting or manipulating commercial products that may require the addition of one or more ingredients as directed by the manufacturer. Examples include captopril oral solution and indomethacin topical gel.
- Moderate: Making a preparation that requires special calculations or procedures (such as calibration of dosage-unit mold cavities) to determine quantities of components per preparation or per individualized dosage units; or making a preparation for which stability data for that specific formulation are not available.
Examples include morphine sulfate suppositories, diphenhydramine hydrochloride troches, and mixing two or more manufactured cream products when the stability of the mixture is not known.

- Complex: Making a preparation that requires special training, environment, facilities, equipment, and procedures to ensure appropriate therapeutic outcomes. Examples of possible complex preparation types include transdermal dosage forms, modified-release preparations, and some inserts and suppositories for systemic effects.

Description of Sterile Compounding Risk Levels:

- Low risk: Compounding that starts with sterile ingredients and devices using aseptic technique in an ISO Class 5 or higher quality of air. It must be a simple transfer of not more than three commercially manufactured sterile nonhazardous products from the original containers and not more than two entries into any one sterile container or package (such as a bag or vial). If sterility testing is lacking, low-risk compounded sterile preparations are stored for a maximum of 48 hours at a controlled room temperature between 20 and 25 degrees Celsius, 14 days at a cold temperature between 2 and 8 degrees Celsius, and for a maximum of 45 days at a freezing temperature between -10 and -25 degrees Celsius. Examples include transferring sterile liquids from manufacturer-sealed packages to sterile containers using sterile devices manipulating up to three manufactured products to create a sterile preparation.

- Medium risk: Compounding that starts with sterile ingredients in an ISO Class 5 or higher environment for multiple doses of sterile preparations for administration to either multiple patients or to a single patient. The compounding process uses aseptic technique and more than one transfer. If sterility testing is lacking, medium-risk compounded sterile preparations are stored for a maximum of 30 hours at a controlled room temperature between 20 and 25 degrees Celsius, 9 days at a cold temperature between 2 and 8 degrees Celsius, or 45 days at a freezing temperature between -10 and -25 degrees Celsius. Examples include compounding total parenteral nutrition (TPN) and filling infusion devices with multiple sterile products.

- High risk: Compounding that starts with nonsterile ingredients or non-sterile devices, or exposes sterile ingredients and devices to air quality below ISO Class 5 for more than one hour; or uses opened containers that are preservative-free and stored in an environment of less...
than ISO Class 5. If sterility testing is lacking, high-risk compounded sterile preparations are stored for a maximum of 24 hours at a controlled room temperature between 20 and 25 degrees Celsius, 3 days at a cold temperature between 2 and 8 degrees Celsius, and for a maximum of 45 days at a freezing temperature between -10 and -25 degrees Celsius. Examples include compounding a solution that will be terminally sterilized from nonsterile ingredients and manipulating sterile ingredients in a nonsterile device prior to sterilization.

**compounding area** A critical area within the International Organization for Standardization (ISO) Class 5 primary engineering control (PEC) where critical sites are exposed to unidirectional high-efficiency particulate air (HEPA)–filtered air, also known as first air.

**compounding aseptic containment isolator (CACI)** Designed for compounding sterile, nonhazardous pharmaceutical ingredients or preparations that shall be certified in accordance with Cleaning Equipment Trade Association-Compounding Isolator Testing Guide-002 (CETA-CAG-002). It is designed to maintain an aseptic compounding environment within the isolator throughout the compounding and material transfer processes. Air exchange into the isolator from the surrounding environment does not occur unless the air has first passed through a microbiologically retentive filter (high-efficiency particulate air [HEPA] minimum). A CAI is not used for the manipulation of hazardous drugs.

**compounding aseptic isolator (CAI)** An isolator specifically designed for compounding sterile, nonhazardous pharmaceutical ingredients or preparations that shall be certified in accordance with Cleaning Equipment Trade Association-Compounding Isolator Testing Guide-002 (CETA-CAG-002). It is designed to maintain an aseptic compounding environment within the isolator throughout the compounding and material transfer processes. Air exchanged with the surrounding environment does not occur unless it is first passed through a microbiologically retentive filter (high-efficiency particulate air [HEPA] minimum).

**compounding staff** Individuals participating in the compounding process who are competent in, knowledgeable of, and responsible for the preparation of hazardous drugs, using information from Standards MDCED.01 and MDCED.02, the organization’s policies and procedures, and instructions from the compounding supervisor.

**compounding supervisor** The individual who is responsible for developing and implementing appropriate procedures; overseeing facility compliance with Joint Com-
mission medication compounding requirements and other applicable laws, regulations, and standards; ensuring competency of staff; and assuring environmental control of the compounding areas.

**comprehensive assessment** For hospices that elect to use The Joint Commission deemed status option: A thorough evaluation of the patient’s physical, psychosocial, emotional, and spiritual status related to the terminal illness and related conditions. This assessment includes a thorough evaluation of the caregiver’s and family’s willingness and capability to care for the patient.

**comprehensive systematic analysis** A process for identifying basic or causal factors underlying variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis is one type of comprehensive systematic analysis.

**confidentiality** Protection of data or information from being made available or disclosed to any unauthorized person(s) or process(es).

**consultation** 1. Provision of professional advice or services. 2. A review of an individual’s problem by a second practitioner and the rendering of an opinion and advice to the referring practitioner. In most instances, the review involves the independent examination of the individual by the consultant. 3. For purposes of Joint Commission accreditation, advice that is given to staff members of surveyed organizations relating to compliance with standards and requirements that are the subject of the survey.

**container and closure system** The sum of packaging components that together contain and protect the dosage form. This includes primary packaging components and secondary packaging components, if the latter are intended to provide additional protection.

**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 health care professionals, among organizations, and over time.

**contract** A formal agreement for care, treatment, or services with an organization, agency, or individual that specifies the services, personnel, products, or space provided by, to, or on behalf of the organization and specifies the consideration to be expended in exchange.

**contracted services, home care** Services provided under a written agreement, that need not be a formal contract, between one organization and another facility, agency, vendor, or individual to provide care. The Joint Commission survey process will evaluate the provision of direct services and contracted services for which applicable standards exist.
**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.

**core services (hospice)**  For hospices that elect to use The Joint Commission deemed status option: Core services include physician services, nursing services, medical social services, and counseling. Except for physician services, Medicare-certified hospices must routinely provide all core services directly by hospice employees in a manner consistent with acceptable standards of practice. Physician services may be provided through contractual arrangement. (See 42 CFR 418.64)

**corrective maintenance**  See maintenance.

**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 timeframe 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 site**  A location that includes any component or fluid pathway surfaces (such as vial septa, injection ports, and beakers) or openings (such as opened ampules and needle hubs) that are exposed and at risk of direct contact with air (such as ambient room or high-efficiency particulate air [HEPA]-filtered), moisture (such as oral and mucosal secretions), or touch contamination.

**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).

**deemed status**  Status conferred by the Centers for Medicare & Medicaid Services (CMS) on an organization whose standards and survey process are determined by CMS to be equivalent to those of the Medicare program or other federal laws, such as the Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88). Accreditation is voluntary and seeking deemed status through accreditation is an option, not a requirement.

**dementia**  A deterioration of intellectual function associated with pathological changes in the brain that cause changes in behavior and personality. Dementia does not include loss of intellectual functioning caused by clouding consciousness, as in delirium, depression, or other functional mental disorders.

**dietary counseling**  For hospices that elect to use The Joint Commission deemed status option: Education and interventions provided to the patient and family regarding appropriate nutritional intake as the patient’s condition progresses. Dietary counseling is provided by qualified individuals, which may include a registered nurse, dietitian, or nutritionist, when identified in the patient’s plan of care.

**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.

**disinfectant**  A chemical agent used on inanimate surfaces and objects to destroy fungi, viruses, and bacteria, but not necessarily their spores.

**dispensing**  See medication management.

**disruptive and inappropriate behavior**  See behaviors that undermine a culture of safety.

**do-not-use abbreviations**  See prohibited abbreviations.
drug  See medication.

drug allergy  See medication allergy.

durable medical equipment (DME)
Medical equipment that is suitable for patient use outside of a medical facility and which can withstand repeated use. These items are generally not useful to an individual in the absence of a medical condition, illness, or injury. They are provided by the organization directly to the patient as sale, rental, or loaned items. Examples include, but are not limited to:

- Oxygen and respiratory equipment, including, but not limited to
- Oxygen concentrators, reservoirs, high-pressure cylinders, oxygen accessories and supplies, and oxygen conserving devices
- Home invasive mechanical ventilation therapy
- Non-invasive continuous positive airway pressure (CPAP)
- Bi-level positive airway pressure (Bi-PAP)
- Intermittent positive pressure breathing (IPPB)
- Respiratory Assist Devices (RAD)
- Nebulizers
- Power wheelchairs
- Manual wheelchairs
- Negative pressure wound therapy equipment
- Electric and manual hospital beds
- Support surfaces
- Walkers, canes, and crutches
- Commodes
- Bedpans and urinals
- Transcutaneous Electro-Nerve Stimulator (TENS) units
- Traction equipment
- Pneumatic compression devices
- Patient lifts and accessories
- Suction pumps (including breast pumps, postural drainage boards)
- Continuous Passive Motion (CPM) devices
- Speech generating devices
- Heat/cold applications
- Hemodialysis equipment
- Infusion pumps

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.

**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.

**employee**  For hospices that elect to use The Joint Commission deemed status option: A person who (1) works for the hospice and for whom the hospice is required to issue a W-2 form on his or her behalf; (2) if the hospice is a subdivision of an agency or organization, an employee of the agency or organization who is assigned to the hospice; or (3) a volunteer under the jurisdiction of the hospice.

**engineering control**  Primary, secondary, and supplemental devices designed to eliminate or reduce worker exposure to a chemical, biological, radiological, ergonomic, or physical hazard, and in the case of compounded sterile preparations (CSPs), to protect the compounded product from environmental contamination. Examples include ventilation controls such as biological safety cabinets (BSCs) or compounding aseptic containment isolators (CACIs), closed-system vial transfer device (CSTD), retracting syringe needles, and safety interlocks.

**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.

**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.

eye shields/protection Tight-fitting goggles that completely cover the eyes, eye sockets, and facial area immediately surrounding the eyes and provide protection from impact, dust, and splashes. Some eye shields/protection will fit over corrective lenses.

facility-based Patient services provided within a structure that is operated by the accredited organization (for example, hospice “short term inpatient care” centers, ambulatory infusion centers, storefront offices where wheelchairs are fitted).

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 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.

fire-rated Material that has undergone a test and is fire protection rated or fire resistance rated. Two examples of the concept of fire-rated include the following:

- fire resistance rating The time, in minutes or hours, that materials or assemblies have withstood a fire exposure, as determined by tests, or methods based on tests, prescribed by the National Fire Protection Association (NFPA).
- fire protection rating A designation indicating the duration of fire test exposure to which a fire door assembly or fire window assembly was exposed and for which it met all the acceptance criteria, as determined in accordance with NFPA 252, Standard Methods of Fire Tests of Door Assemblies, or NFPA 257, Standard on Fire Test for Window and Glass Block Assemblies.

fire-safety management Activities selected and implemented by the organization to assess and control the risks of fire, smoke, and other byproducts of combustion that could occur during the organization’s provision of care, treatment, or services.
fire watch  The assignment of a person or persons to an area for the express purpose of protecting occupants from fire or similar emergencies. Examples of this protection include:
- Notifying the fire department, the building occupants, or both of an emergency
- Preventing a fire from occurring
- Extinguishing small fires

**Focused Standards Assessment (FSA)**
A requirement of the accreditation process whereby an organization reviews its compliance with a selected subset of applicable Joint Commission accreditation requirements (including the applicable National Patient Safety Goals, a selection of standards that address accreditation program-specific high-risk areas, and the organization’s Requirements for Improvement [RFIs] from its last triennial survey); completes and submits to The Joint Commission a Plan of Action (POA) for any accreditation requirement with which it is not in full compliance; and chooses whether to engage in a telephone discussion with a member of the Standards Interpretation Group staff to determine the acceptability of the POA or discuss any other area of concern. Alternatives for a Full FSA submission include FSA Option 1 (attestation that an FSA was completed, but not 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.

**hazard communication labels** Written, printed, or graphic informational elements concerning a hazardous chemical that are affixed to, printed on, or attached to the immediate container of a hazardous chemical or to the outside packaging. For more information, see https://www.osha.gov/Publications/OSHA3636.pdf.

**hazardous drug** Drugs considered hazardous include those that exhibit one or more of the following six characteristics in humans or animals:
- Carcinogenicity
- Teratogenicity or other developmental toxicity
- Reproductive toxicity
- Organ toxicity at low doses
- Genotoxicity
- Structure and toxicity profiles of new drugs that mimic existing drugs determined hazardous by the above criteria.

**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.

**hazardous medication waste** Components (such as vials, ampules, IV bags) that once held hazardous medications.

**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.

**HEPA filtration**  HEPA (high-efficiency particulate air) filtration uses a dry-type filter in a rigid frame, having a minimum particle collection efficiency of 99.97% for 0.3µm mass-median diameter particles when tested at a rated air flow in accordance with Military Standard (MIL STD) 282 using Institute of Environmental Sciences and Technology (IEST) Standard RP-CC001.5.

**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.

**home health aide**  For home health agencies that elect to use The Joint Commission deemed status option: Effective for services furnished after August 14, 1990, a person who has successfully completed a State-established or other training program that meets the requirements of Sec. 484.36(a) and a competency evaluation program or State licensure program that meets the requirements of Sec. 484.36 (b) or (e), or a competency evaluation program or State licensure program that meets the requirements of Sec. 484.36 (b) or (e). An individual is not considered to have completed a training and competency evaluation program, or a competency evaluation program if, since the individual’s most recent completion of this program(s), there has been a continuous period of 24 consecutive months during none of which the individual furnished services for compensation, as described in Sec. 409.45.

**home health services**  Provision of any health care services by health care professionals to a patient in his or her place of residence. These services include, but are not limited to, patient assessments, provision of care, treatment, education, or counseling, and/or monitoring of the patient’s health status by nurses (both intermittent skilled and private duty), occupational therapists, physical therapists, speech-language pathologists, audiologists, social workers, dietitians, dentists,
physicians, and other licensed health care professionals in the patient’s home. It also includes the extension or follow-up of health care services provided by hospital professional staff in the patient’s home.

**hommaker services** For hospices that elect to use The Joint Commission deemed status option: Homemaker services provide assistance in maintaining a safe and healthy environment and help the individual carry out the treatment plan.

**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.

**hospice care** For hospices that elect to use The Joint Commission deemed status option: A comprehensive set of services identified and coordinated by an interdisciplinary group to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and/or family members, as delineated in a specific patient plan of care.

**human subject research** The use of humans in the systematic study, observation, or evaluation of factors for preventing, assessing, treating, and understanding an illness. The term applies to all behavioral and medical experimental research that involves human beings as experimental subjects.

**Immediate Threat to Health or Safety** A threat that represents immediate risk and has or may potentially have serious adverse effects on the health or safety of the patient, resident, or individual served. These threats are identified on site by the surveyor.

**infection** The transmission of a pathogenic microorganism to a host, with subsequent invasion and multiplication, with or without resulting symptoms of disease.
infection, epidemic  See epidemic.

informed consent  Agreement or permission accompanied by full notice about the care, treatment, or service that is the subject of the consent. 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 assessment  For hospices that elect to use The Joint Commission deemed status option: An evaluation of the patient’s physical, psychosocial, and emotional status related to the terminal illness and related conditions to determine the patient’s immediate care and support needs.

initial review  Certification review of an eligible program or service that has not been previously reviewed by The Joint Commission for at least four months or a certification review of an eligible program or service undergoing its first Joint Commission review.

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.

integrity test for filters  A test (for example, bubble-point test) performed after the filtration process to detect whether the integrity of a sterilizing-grade filter has been compromised.

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.
interdisciplinary team  A team of health care professionals with the education and experience necessary to collaborate and provide the specialized community-based palliative care, treatment, and services that meet the needs of the patient and 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.

International Organization for Standardization (ISO) class  An air-quality classification from the International Organization for Standardization.

interpreting services  A trans-language rendition of a spoken message in which the interpreter comprehends the source language and can speak comprehensively in the target language to convey the meaning intended in the source language. The interpreter knows health and health-related terminology and provides accurate interpretations by choosing equivalent expressions that convey the best matching and meaning to the source language and captures, to the greatest possible extent, all nuances intended in the source message.

interval-based maintenance  See maintenance.

Intracycle Monitoring (ICM)  A process to help accredited organizations at various touch points in the triennial accreditation cycle with their continuous compliance efforts. The process involves access to an ICM Profile available on the organization’s Joint Commission Connect™ extranet site. The ICM Profile identifies high-risk areas and related standards areas and displays them within a Focused Standards Assessment (FSA) tool, which allows organizations to conduct a self-assessment of 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.

investigational medication  A medication used as part of a research protocol or clinical trial.

isolator  An enclosure that provides high-efficiency particulate air (HEPA)-filtered International Organization for Standardization (ISO) Class 5 unidirectional air operated at a continuously higher pressure than its surrounding environment and is decontaminated using an automated system. It uses only decontaminated interfaces or rapid transfer ports for materials transfer.

knowledge-based information  A collection of stored facts, models, and information that can be used for ongoing staff development, for designing and redesigning processes, and for solving problems.
Knowledge-based information is found in the clinical, scientific, and management literature.

**label** A display of written, printed, or graphic matter on the immediate container of any article.

**labeling** A term that designates all labels and other written, printed, or graphic matter on an immediate container of an article or preparation, or on, or in, any package or wrapper in which it is enclosed, except any outer shipping container. The term “label” designates that part of the labeling on the immediate container.

**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.

**laminar airflow workbench (LAFW)** A device that is a type of laminar airflow system and provides an International Organization for Standardization (ISO) Class 5 or better environment for sterile compounding. The device provides a unidirectional high-efficiency particulate air (HEPA)-filtered airflow.

**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, clinical leaders, and staff members in leadership positions within the organization.

**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.

**licensed practical (vocational) nurse** For home health agencies that elect to use The Joint Commission deemed status option: A person who has completed a practical (vocational) nursing program, is licensed in the state where practicing, and furnishes services under the supervision of a qualified registered nurse.

**licensed practical nurse** For hospices that elect to use The Joint Commission deemed status option: A licensed practical nurse is a person who has completed a practical nursing program.
licensed professional  For hospices that elect to use The Joint Commission deemed status option: A person licensed to provide patient care services by the State in which services are delivered.

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.

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.

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).

**manufactured medication product** A pharmaceutical dosage form, usually the subject of a US Food and Drug Administration (FDA)–approved application, and manufactured under current good manufacturing practice conditions. Manufactured medication products are not compounded preparations.

**master formulation record (MFR)** A documentation record (recipe) that includes the following:

- Official or assigned name, strength, and dosage of the preparation
- Calculations needed to determine and verify quantities of components and doses of active pharmaceutical ingredients
- Description of all ingredients and their quantities
- Compatibility and stability information, including references when available

- Equipment needed to prepare the preparation, when appropriate
- Mixing instructions as follows:
  1. Order of mixing
  2. Mixing temperatures or other environmental controls
  3. Duration of mixing
  4. Other factors pertinent to the replication of the preparation as compounded
- Sample labeling information, which should contain the following (in addition to legally required information):
  1. Generic name and quantity or concentration of each active ingredient
  2. Assigned beyond-use date (BUD)
  3. Storage conditions
  4. Prescription or control number, whenever applicable

- Container used in dispensing
- Packaging and storage requirements
- Description of final preparation
- Quality control procedures and expected results

**maximum response time** The estimated time needed to arrive at an individual’s home in the presence of obstacles (for example, blizzards, storms, heavy traffic, vehicle breakdown, off-hours).

**means of egress** A continuous and unobstructed way of travel from any point in a building or other structure to a public way consisting of three separate and distinct parts: the exit access, the exit, and the exit discharge.
**means of escape**  A way out of a building that does not conform to criteria for an approved means of egress but does provide an alternative way out (for example, an unenclosed interior stair).

**media-fill test**  A simulation used to qualify processes and staff engaged in sterile compounding to ensure that the processes and staff are able to produce compounded sterile preparations (CSPs) without microbial contamination.

**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 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 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
Glossary

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

**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 history**  A delineation of the drugs used by an individual (both past and present), including prescribed and unprescribed drugs and alcohol, along with any unusual reactions to those drugs. See medication.

**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.

metered maintenance See maintenance.

mitigation, emergency Those activities an organization undertakes in attempting to reduce the severity and impact of a potential emergency. See also emergency.

multidisciplinary team A group of staff members composed of representatives from a range of professions, disciplines, or service areas.

multiple-dose container A container of sterile medication for parenteral administration (specifically, injection or infusion) that is designed to contain more than one dose of the medication. A multiple-dose container is usually required to meet the antimicrobial effectiveness testing criteria.

multiple location For hospices that elect to use The Joint Commission deemed status option: A Medicare-approved location from which the hospice provides the same full range of hospice care and services that is required of the hospice issued the certification number. A multiple location must meet all of the Conditions of Participation applicable to hospices.

near miss See close call.

negative pressure room A room that is at a lower pressure than the adjacent spaces and, therefore, the net flow of air is into the room.

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.

**noncore services (hospice)** For hospices that elect to use The Joint Commission deemed status option: Noncore services include physical therapy services; occupational therapy services; speech-language pathology services; hospice aide services; homemaker services; volunteers; medical supplies and medical appliances that are related to the patient’s terminal diagnosis and associated medical conditions; and short-term inpatient care (including respite care and interventions necessary for pain control and acute and chronic symptom management) in a Medicare-participating facility. Noncore services are provided in a manner consistent with current standards of practice, either directly by the hospice or under arrangements made by the hospice. (See also 42 CFR 418.70–78 and 42 CFR 418.100)

**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** Professional processes of assessment, diagnosis, planning, implementation, and evaluation, based on the art and science of nursing to promote health, its recovery, or a peaceful and dignified death. This includes, but is not limited to, assisting individuals, families, communities, and/or populations in understanding health needs and carrying out therapeutic plans and activities.

**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).

**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.
**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).

**occupational therapist** For home health agencies that elect to use The Joint Commission deemed status option: A person who—

(a)(1) Is licensed or otherwise regulated, if applicable, as an occupational therapist by the State in which practicing, unless licensure does not apply;

(2) Graduated after successful completion of an occupational therapist education program accredited by the Accreditation Council for Occupational Therapy Education (ACOTE) of the American Occupational Therapy Association, Inc. (AOTA), or successor organizations of ACOTE; and

(3) Is eligible to take, or has successfully completed the entry-level certification examination for occupational therapists developed and administered by the National Board for Certification in Occupational Therapy, Inc. (NBCOT).

(b) On or before December 31, 2009—

(1) Graduated after successful completion of an occupational therapy program accredited jointly by the committee on Allied Health Education and Accreditation of the American Medical Association and the American Occupational Therapy Association; or

(2) Is eligible for the National Registration Examination of the American Occupational Therapy Association or the National Board for Certification in Occupational Therapy.

(c) On or before January 1, 2008—

(1) Graduated after successful completion of an occupational therapy program accredited by the Accreditation Council for Occupational Therapy Education (ACOTE) of the American Occupational Therapy Association, Inc. (AOTA), or successor organizations of ACOTE; and

(2) Had 2 years of appropriate experience as an occupational therapist; and

(d) On or before December 31, 1977—

(1) Had 2 years of appropriate experience as an occupational therapist; and

(2) Had achieved a satisfactory grade on an occupational therapist proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.
(e) If educated outside the United States, must meet all of the following:

(1) Graduated after successful completion of an occupational therapist education program accredited as substantially equivalent to occupational therapist entry level education in the United States by one of the following:
   (i) The Accreditation Council for Occupational Therapy Education (ACOTE).
   (ii) Successor organizations of ACOTE.
   (iii) The World Federation of Occupational Therapists.
   (iv) A credentialing body approved by the American Occupational Therapy Association.

(2) Successfully completed the entry-level certification examination for occupational therapists developed and administered by the National Board for Certification in Occupational Therapy, Inc. (NBCOT).

(3) On or before December 31, 2009, is licensed or otherwise regulated, if applicable, as an occupational therapist by the State in which practicing.

occupational therapy assistant (home health) For home health agencies that elect to use The Joint Commission deemed status option: A person who—

(a) Meets all of the following:

(1) Is licensed, unless licensure does not apply, or otherwise regulated, if applicable, as an occupational therapy assistant by the State in which practicing.

(2) Graduated after successful completion of an occupational therapy assistant education program accredited by the Accreditation Council for Occupational Therapy Education, (ACOTE) of the American Occupational Therapy Association, Inc. (AOTA) or its successor organizations.

(3) Is eligible to take or successfully completed the entry-level certification examination for occupational therapy assistants developed and administered by the National Board for Certification in Occupational Therapy, Inc. (NBCOT).

(b) On or before December 31, 2009—

(1) Is licensed or otherwise regulated as an occupational therapy assistant, if applicable, by the State in which practicing; or any qualifications defined by the State in which practicing, unless licensure does not apply; or

(2) Must meet both of the following:

   (i) Completed certification requirements to practice as an occupational therapy assistant established by a credentialing organization approved by the American Occupational Therapy Association.

   (ii) After January 1, 2010, meets the requirements in paragraph (a) of this section.

(c) After December 31, 1977 and on or before December 31, 2007—

(1) Completed certification requirements to practice as an occupational therapy assistant established by a cre-
dentialing organization approved by the American Occupational Therapy Association; or

(2) Completed the requirements to practice as an occupational therapy assistant applicable in the State in which practicing.

(d) On or before December 31, 1977—

(1) Had 2 years of appropriate experience as an occupational therapy assistant; and

(2) Had achieved a satisfactory grade on an occupational therapy assistant proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.

(e) If educated outside the United States, on or after January 1, 2008—

(1) Graduated after successful completion of an occupational therapy assistant education program that is accredited as substantially equivalent to occupational therapist assistant entry level education in the United States by—

(i) The Accreditation Council for Occupational Therapy Education (ACOTE).

(ii) Its successor organizations.

(iii) The World Federation of Occupational Therapists.

(iv) By a credentialing body approved by the American Occupational Therapy Association; and

(2) Successfully completed the entry-level certification examination for occupational therapy assistants developed and administered by the National Board for Certification in Occupational Therapy, Inc. (NBCOT).

occupational therapy assistant (hospice) For hospices that elect to use The Joint Commission deemed status option:
An occupational therapy assistant is a person who meets all of the following:

(a) Is licensed or otherwise regulated as an occupational therapy assistant by the state in which he or she is practicing

(b) Graduated after successful completion of an occupational therapy assistant education program accredited by the Accreditation Council for Occupational Therapy Education (ACOTE) of the American Occupational Therapy Association, Inc. (AOTA) or its successor organizations

(c) Is eligible to take or has successfully completed the entry-level certification examination for occupational therapy assistants developed and administered by the National Board for Certification in Occupational Therapy, Inc. (NBCOT).

An individual receiving his or her license or certification on or before December 31, 2009, must meet the following:

(d) Is licensed or otherwise regulated as an occupational therapy assistant by the state in which he or she is practicing or has any other qualifications defined by the state in which practicing, unless licensure does not apply or

(e) Meets both of the following requirements: completed certification requirements established by a credentialing organization approved by the American...
Occupational Therapy Association, or after January 1, 2010, meets the requirements in (a) through (c).

An individual who completed certification or requirements to practice after December 31, 1977, and on or before December 31, 2007, must meet the following:

(f) Completed certification requirements to practice established by a credentialing organization approved by the American Occupational Therapy Association or

(g) Completed the requirements to practice as an occupational therapy assistant applicable in the state in which practicing.

An individual who completed his or her education or experience on or before December 31, 1977, must meet the following:

(h) Had two years of experience as an occupational therapy assistant and

(i) Achieved a satisfactory grade on an occupational therapy assistant proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.

An individual who was educated outside the United States on or after January 1, 2008, must meet the following:

(j) Graduated after successful completion of an occupational therapy assistant education program accredited as substantially equivalent to occupational therapy assistant entry level education in the United States by the Accreditation Council for Occupational Therapy Education (ACOTE), its successor organizations, The World Federation of Occupational Therapists, or a credentialing body approved by the American Occupational Therapy Association and

(k) Successfully completed the entry level certification examination for occupational therapy assistants developed and administered by the National Board for Certification in Occupational Therapy (NBCOT).

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.

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, brochures, telephone book listings, or websites; or representations in other published materials.

**orientation** A process used to provide initial training and information while assessing the competence of clinical staff relative to job responsibilities and the organization’s mission and goals.

**orthotics** Corrective appliances designed to provide external control, correction, or support of the body typically for the prevention or control of deformities that may hinder a person’s ease of movement.

**outbreak** The occurrence of more than the expected number of cases of disease, injury, or other health conditions among a specific group during a specified time frame.

**outcome 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.

**palliative care** For hospices that elect to use The Joint Commission deemed status option: Patient and family-centered care.
that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice.

**parent home health agency** For home health agencies that elect to use The Joint Commission deemed status option: The agency that provides direct support and administrative control of a branch office(s).

**pass-through** 1. A window-like opening, as one for passing items from one place to another.

2. For medication compounding: An enclosure with seals on interlocking doors that are positioned between two spaces for the purpose of minimizing particulate transfer while moving materials from one space to another.

**patient** An individual who receives care, treatment, or services. For hospice providers, the patient and family are considered a single unit of care. Synonyms used by various health care fields include client, resident, patient and family unit, consumer, health care consumer, customer, or beneficiary. When appropriate, the term patient may also refer to the “legally responsible individual.”

**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 individual’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.

**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.

**personal care and/or support services** Services that involve the provision of assistance because of a health-related condition with personal care, activities of daily living, or management of household routine by paraprofessional staff to a patient in his or her home. These services include the provision of services by home health aides, personal care aides, home attendants, nursing assistants, companions, and homemakers.

**personal protective equipment (PPE)** Items such as gloves, gowns, respirators, goggles, face shields, and others that protect individual workers from hazardous physical or chemical exposures.

**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 dispensing services** The dispensing of medications and medication-related supplies and equipment, as well as other related services, by a licensed pharmacy. These functions also include the provision of the professional services of a pharmacist as a component of the dispensing process to ensure appropriate and safe medication management (for example, prescription review, medication profile review, patient counseling, and so forth) as mandated by law and regulations, and standards of practice.

**pharmacy services** Pharmaceutical care and services involving the preparation and dispensing of medications and medication-related devices and supplies by a licensed pharmacy, with or without the provision of clinical or consultant pharmacist services.

**physical abuse** Intentional mistreatment of an individual that may cause physical injury. Examples include hitting, slapping, pinching, or kicking, and may also include attempts to control behavior through corporal punishment.

**physical therapist** For home health agencies that elect to use The Joint Commission deemed status option: A person who is licensed, if applicable, by the State in which practicing, unless licensure does not apply and meets one of the following requirements:

(a)(1) Graduated after successful completion of a physical therapist education program approved by one of the following:

(i) The Commission on Accreditation in Physical Therapy Education (CAPTE).

(ii) Successor organizations of CAPTE.

(iii) An education program outside the United States determined to be substantially equivalent to physical therapist entry-level education in the United States by a credentials evaluation organization approved by the American Physical Therapy Association or an organization identified in 8 CFR 212.15(e) as it relates to physical therapists; and

(2) Passed an examination for physical therapists approved by the State in which physical therapy services are provided.

(b) On or before December 31, 2009—

(1) Graduated after successful completion of a physical therapy curriculum approved by the Commission on Accreditation in Physical Therapy Education (CAPTE); or

(2) Meets both of the following:

(i) Graduated after successful completion of an education program determined to be substantially equivalent to physical therapist entry level education in the United States by a credentials evaluation organization approved by the American Physical Therapy Association or identified in 8 CFR 212.15(e) as it relates to physical therapists.

(ii) Passed an examination for physical therapists approved by the State in which physical therapy services are provided.

(c) Before January 1, 2008—
(1) Graduated from a physical therapy curriculum approved by one of the following:


(ii) The Committee on Allied Health Education and Accreditation of the American Medical Association.


(d) On or before December 31, 1977 was licensed or qualified as a physical therapist and meets both of the following:

(1) Has 2 years of appropriate experience as a physical therapist.

(2) Has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.

(e) Before January 1, 1966—

(1) Was admitted to membership by the American Physical Therapy Association; or

(2) Was admitted to registration by the American Registry of Physical Therapists; or

(3) Has graduated from a physical therapy curriculum in a 4-year college or university approved by a State department of education.

(f) Before January 1, 1966 was licensed or registered, and before January 1, 1970, had 15 years of full-time experience in the treatment of illness or injury through the practice of physical therapy in which services were rendered under the order and direction of attending and referring doctors of medicine or osteopathy.

(g) If trained outside the United States before January 1, 2008, meets the following requirements:

(1) Was graduated since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for Physical Therapy.

(2) Meets the requirements for membership in a member organization of the World Confederation for Physical Therapy.

**physical therapist assistant** For home health agencies that elect to use The Joint Commission deemed status option: A person who is licensed, unless licensure does not apply, registered, or certified as a physical therapist assistant, if applicable, by the State in which practicing, and meets one of the following requirements:

(a)(1) Graduated from a physical therapist assistant curriculum approved by the Commission on Accreditation in Physical Therapy Education of the American Physical Therapy Association; or if educated outside the United States or trained in the United States military, graduated from an education program determined to be substantially equivalent to physical therapist assistant entry level education in the United States by a credentials evaluation organ-
ization approved by the American Physical Therapy Association or identified at 8 CFR 212.15(e); and

(2) Passed a national examination for physical therapist assistants.

(b) On or before December 31, 2009, meets one of the following:

(1) Is licensed, or otherwise regulated in the State in which practicing.

(2) In States where licensure or other regulations do not apply, graduated on or before December 31, 2009, from a 2-year college-level program approved by the American Physical Therapy Association and, effective January 1, 2010 meets the requirements of paragraph (a) of this definition.

(c) Before January 1, 2008, where licensure or other regulation does not apply, graduated from a 2-year college-level program approved by the American Physical Therapy Association.

(d) On or before December 31, 1977, was licensed or qualified as a physical therapist assistant and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.

physician  For home health agencies that elect to use The Joint Commission deemed status option: A doctor of medicine, osteopathy, podiatry, optometry, or a doctor of dental surgery or dental medicine, or a chiropractor who meets the qualifications specified in 42 CFR 410.22 that is legally authorized to practice medicine and surgery by the state in which such function or action is performed.

For hospices that elect to use The Joint Commission deemed status option: 1. A doctor of medicine or osteopathy, including an osteopathic practitioner; a doctor of dental surgery or dental medicine; a doctor of podiatric medicine; or a doctor of optometry. 2a) Also includes a chiropractor who has, if licensed or authorized to practice before July 1, 1974, complies with the following: (i) had preliminary education equal to the requirements for graduation from an accredited high school or other secondary school, (ii) graduated from a college of chiropractic approved by the State’s chiropractic examiners after completing a course of study covering a period of not less than three school years or six months each year in actual continuous attendance, and covering adequate courses of study in the subjects of anatomy, physiology, symptomatology and diagnosis, hygiene and sanitation, chemistry, histology, pathology, and principles and practice of chiropractic, including clinical instruction in vertebral palpation, nerve tracing and adjusting; and (iii) passed an examination prescribed by the State’s chiropractic examiners covering these subjects. 2b) Also includes a chiropractor who has, if first licensed or authorized to practice after June 30, 1974, complies with the following: (i) had preliminary education equal to the requirements for graduation from an accredited high school or other secondary school; (ii) satisfactorily com-
completed two years of pre-chiropractic study at the college level; (iii) satisfactorily completed a four-year course of eight months each year offered by a college or school of chiropractic approved by the State’s chiropractic examiners and including at least 4,000 hours in courses in anatomy, physiology, symptomatology and diagnosis, hygiene and sanitation, chemistry, histology, pathology, principles and practice of chiropractic, and clinical instruction in vertebral palpation, nerve tracing and adjusting, plus courses in the use and effect of X-ray and chiropractic analysis; (iv) passed an examination prescribed by the State’s chiropractic examiners covering these subjects; and (v) attained 21 years of age.

physician designee  For hospices that elect to use The Joint Commission deemed status option: A doctor of medicine or osteopathy designated by the hospice who assumes the same responsibilities and obligations as the medical director when the medical director is not available.

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.

practical (vocational) nurse  For home health agencies that elect to use The Joint Commission deemed status option: A person who is licensed as a practical (vocational) nurse by the State in which she or he is practicing.

practice guidelines  See clinical practice guidelines.

practitioner  Any individual who is licensed and qualified to practice a health care profession (for example, physician, nurse, social worker, clinical psychologist, psychiatrist, respiratory therapist) and is
engaged in the provision of care, treatment, or services. See also licensed independent practitioner.

**predictive maintenance**  See maintenance.

**preparedness, emergency**  Activities an organization undertakes to build capacity and identify resources that may be used if an emergency occurs. See also emergency.

**prescribing or ordering**  See medication management.

**primary engineering control (PEC)**  A ventilated device that provides a prescribed environment for the exposure of critical sites, and when desired, protects workers and the environment from exposure to the compounds under manipulation. PECs used for manipulation of hazardous drugs are designed for containment.

**primary home health agency**  For home health agencies that elect to use The Joint Commission deemed status option: The agency that accepts the initial referral of a patient and provides services directly to the patient or via another health care provider under arrangements (as applicable).

**primary source**  The original source or an approved agent of that source of a specific credential that can verify the accuracy of a qualification reported by an individual practitioner. Examples include medical schools, nursing schools, graduate education, state medical boards, federal and state licensing boards, universities, colleges, and community colleges.

**privacy (of information)**  The right of an individual to limit the disclosure of personal information.

**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.

**proprietary agency**  For home health agencies that elect to use The Joint Commission deemed status option: A private profit-making agency licensed by the state.

**prosthetics**  An artificial extension that replaces a missing part of the body. Examples include, but are not limited to, customized prostheses and breast prostheses.

**protected health information**  Health information that contains information such that an individual person can be identified as the subject of that information.
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 agency  For home health agencies that elect to use The Joint Commission deemed status option: An agency operated by a state or local government.

public health nurse  For home health agencies that elect to use The Joint Commission deemed status option: A registered nurse who has completed a baccalaureate degree program approved by the National League for Nursing for public health nursing preparation or post-registered nurse study that includes content approved by the National League for Nursing for public health nursing preparation.

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.

pyrogen-free  A substance lacking sufficient endotoxins or other fever-inducing contamination to induce a febrile or pyrogenic response.

qualifications  Knowledge, education, training, experience, competency, licensure, registration, or certification related to specific responsibilities.

qualified home health aide  For home health agencies that elect to use The Joint Commission deemed status option: A person who has successfully completed one of the following:
- A training and competency evaluation program as specified in 42 CFR 484.80 (b) and (c)
- A competency evaluation program that meets the requirements of 42 CFR 484.80(c)
- A nurse aide training and competency evaluation program approved by the state as meeting the requirements of 42 CFR 483.151 through 483.154, in addition to a listing in good standing on the state nurse aide registry
- A state licensure program that meets the provisions of 42 CFR 484.80 (b) and (c)

qualified hospice aide  For hospices that elect to use The Joint Commission deemed status option: A person who has successfully completed one of the following:
- A training program and competency evaluation
- A competency evaluation as specified in 42 CFR 418.76(b) and (c)
- A competency evaluation as specified in 42 CFR 418.76 (c)
- A nurse aide training and competency evaluation program approved by the State as meeting the requirements of 42 CFR 483.151 through 483.154 and is listed in good standing on the State nurse aide registry
A State licensure program that meets 42 CFR 418.76 (b) and (c)

quality assurance  A system of procedures, activities, and oversight that ensures that operational and quality standards are consistently met.

quality control  1. 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.
2. For medication compounding: The sampling, testing, and documentation of results that, taken together, determine that specifications have been met before release of the preparation.

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 of life  An individual’s perception of his or her position in life in the context of his or her values and culture, goals, expectations, standards, and concerns. This perception is often affected in a complex way by the person’s physical health, psychological well-being, level of independence, personal beliefs, and relationships.

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.

quantitative result  A test result that is measured as a discrete number.

quarterly  Every three months, plus or minus 10 days.
**range orders** Orders in which the dose or dosing interval varies over a prescribed range, depending on the situation or the individual’s status.

**rationale for a standard** A short paragraph that explains the justification for a standard; that is, why the standard is important or how it contributes to quality and/or safety. A rationale is not scored, and not every standard has a rationale.

**read-back** A method used to ensure understanding of information being communicated, often used between members of a care, treatment, or service team. The process involves the receiver of a verbal or telephone order writing down the complete order or test result or entering it into a computer and then reading it back and receiving confirmation from the person who gave the order or test result.

**reassessment** Ongoing data collection, which begins on initial assessment, comparing the most recent data with the data collected at earlier assessments.

**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)** For home health agencies that elect to use The Joint Commission deemed status option: A graduate of an approved school of professional nursing, who is licensed as a registered nurse in the state where practicing.

**rehabilitation technology services** Services to enhance the lifestyle of physically challenged individuals through ongoing evaluation by trained rehabilitation technologists and/or orthotics/prosthetics technicians. These services include but are not limited to those related to customized mobility systems and seating and positioning systems. These services may be provided in the patient’s home, in rehabilitation clinics, in schools, or in the organization’s facility.

**release checks and tests** Testing performed to determine that a preparation meets required quality characteristics.

**reliability** 1. The ability of an item to perform a required function under stated conditions. 2. In performance measurement, consistency in results of a measure, including the tendency of the measure to produce the same results twice when it measures some entity or attribute believed not to have changed in the interval between
measurements. 3. Statistically, the degree to which scores are free from random error.

**reliability-centered maintenance**  See maintenance.

**repackaging**  The act of removing a conventionally manufactured sterile product from its original primary container and placing it into another primary container, usually of smaller size.

**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.

**representative**  For home health agencies that elect to use The Joint Commission deemed status option: The patient’s legal representative, such as a guardian, who makes health care decisions on the patient’s behalf, or a patient-selected representative who participates in making decisions related to the patient’s care or well-being, including but not limited to, a family member or an advocate for the patient. The patient determines the role of the representative, to the extent possible.

**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.

**respiratory care services**  Delivery of care to provide ventilatory support and associated services for individuals.

**respiratory equipment**  Medical equipment and associated supplies suitable for use in the home and other ambulatory settings and designed for the treatment of respiratory and respiratory-related problems. This equipment can withstand repeated use, and is rented or purchased by patients. Associated supplies are used in relation to the respiratory equipment and assist in the function and utilization. Examples include but are not limited to:

- Oxygen concentrators, reservoirs, high-pressure cylinders, oxygen accessories and supplies, and oxygen conserving devices
- Home invasive mechanical ventilation therapy
- Non-invasive continuous positive airway pressure (CPAP)
- Bi-level positive airway pressure (Bi-PAP)
- Intermittent positive pressure breathing (IPPB)

**respite care**  For hospices that elect to use The Joint Commission deemed status option: Short-term inpatient care provided to a patient only when necessary to relieve a family member(s) or other person(s) caring for patient. Respite care may be provided only on an occasional basis and may not be reimbursed for more than five consecutive days per Medicare coverage requirements. (See 42 CFR 418.204(b))
**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 hospices that elect to use The Joint Commission deemed status option:
   (1) 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. This does not include devices, such as prescribed orthopedic 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. Measures used to protect the patient from falling out of bed or to permit the patient to participate in activities without the risk of physical harm (such as a physical escort) are also not considered restraints.

(2) 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.

**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.

**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 data sheet (SDS)** An informational document that provides written or printed material concerning a hazardous chemical that is prepared in accordance with law and regulation (previously known as a Material Safety Data Sheet [MSDS]).

**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 hospices that elect to use The Joint Commission deemed status option: The involuntary confinement of a patient alone in a room or an area from which the patient is physically prevented from leaving.

**secondary engineering control (SEC)** Physically defined spaces such as buffer areas and anterooms.

**secure** In a locked container, in a locked room, or under constant surveillance.

**security** Protection of people and property against harm or loss (for example, workplace violence, theft, access to medications). Security incidents may be caused by persons from outside or inside the organization.

**security, information** Administrative, physical, and technical safeguards to prevent unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

**segregated compounding area** A designated, unclassified space, area, or room that contains a primary engineering control (PEC) and is suitable for preparation of Category 1 compounded sterile preparation (CSP) only.
**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.

**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.

**significant adverse drug reaction (ADR)**  An adverse medication reaction experienced by an individual that required intervention to preclude or mitigate harm or that requires monitoring to confirm that it resulted in no harm to the individual.

**significant adverse medication reaction**  See significant adverse drug reaction (ADR).

**significant medication error**  A medication error that reached an individual that required intervention to preclude or mitigate harm and/or that required monitoring to confirm that it resulted in no harm to the individual.

**simulation**  Computer hardware and software allowing realistic interactions and interventions to occur in programmed scenarios to evaluate clinical practitioner competence.

**single-dose containers**  A container of sterile medication for parenteral administration (that is, injection or infusion) that is designed for use with a single patient as a single injection/infusion. A single-dose container usually does not contain a preservative.

**skilled professional services**  For home health agencies that elect to use The Joint Commission deemed status option: Skilled professional services include nursing, physical therapy, speech-language pathology, occupational therapy, physician, and medical social work services.

**social work assistant**  For home health agencies that elect to use The Joint Commission deemed status option: A person who provides services under the supervision of a qualified social worker and has a baccalaureate degree in social work, psychology, sociology, or other field related to social work, and has had at least one year of social work experience in a health care setting; or has two years of appropriate experience as a social work assistant and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service, except that these determi-
nations of proficiency do not apply with respect to persons initially licensed by a state or seeking initial qualification as a social work assistant after December 31, 1977.

**social worker (home health)** For home health agencies that elect to use The Joint Commission deemed status option: A person who has a master’s or doctoral degree from a school of social work accredited by the Council on Social Work Education and has one year of social work experience in a health care setting.

**social worker (hospice)** For hospices that elect to use The Joint Commission deemed status option: A person who has at least a bachelor’s degree from a school accredited or approved by the Council on Social Work Education.

**specification**

1. A detailed description or assessment of a requirement, dimension(s), material(s), etc.

2. For medication compounding: The tests, analytical methods, and acceptance criteria to which a drug substance, drug product, compounded sterile preparation (CSP), component, container-closure system, equipment, or other material used in drug preparation must conform to be considered acceptable for its intended use.

**speech-language pathologist** For home health agencies that elect to use The Joint Commission deemed status option: A speech-language pathologist is qualified by one of the following:

1. Meets the education and experience requirements for a Certificate of Clinical Competence in speech pathology or audiology granted by the American Speech-Language-Hearing Association

2. Meets the educational requirements for certification and is in the process of accumulating the supervised experience required for certification

**spiritual care professional** A person with skills in assessing and responding to the spiritual needs and concerns of patients and families facing life-threatening illnesses and conditions. Spiritual care professionals should have education, training, and experience in the spiritual or pastoral care of adult and pediatric patients.

**stability**

1. The state or quality of being stable; resistance to change.

2. For medication compounding: The extent to which a preparation retains, within specified limits and throughout its period of storage and use, the same properties and characteristics that it possessed at the time of compounding.

**staff** As appropriate to their roles and responsibilities, all people who provide care, treatment, or services in the organization, 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.

**sterility testing**  A documented and established laboratory procedure for detecting viable microbial contamination in a sample or preparation.

**sterilization**  A process that destroys or eliminates all forms of microbial life (including spores) and is carried out by physical or chemical methods. Steam under pressure, dry heat, ethylene oxide gas, hydrogen peroxide gas plasma, and liquid chemicals are the principal sterilizing agents used in health care settings.

**sterilization by filtration**  Passage of a gas or liquid through a sterilizing-grade membrane to consistently yield filtrates that are sterile.

**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.

**subcontractor**  Separate firm with which the home care organization has entered into a mutually binding legal relationship. This legal relationship obligates the subcontracted firm to furnish defined services and the home care organization to provide payment for the received contracted services.

**summary report**  For home health agencies that elect to use The Joint Commission deemed status option: The compilation of the pertinent factors of a patient’s clinical notes that is submitted to the patient’s physician.
**supplies, mail order**  Items essential to carrying out the treatment of a patient’s condition, illness, or injury that are provided through a delivery service such as USPS, UPS, FedEx, etc.

**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.

**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, agree-
mens, and procedures, or may also be used to develop new plans, policies, agreements, and procedures.

**terminally ill**  For hospices that elect to use The Joint Commission deemed status option: The individual has a medical prognosis that his or her life expectancy is six months or less if the illness runs its normal course.

**terminal sterilization**  The application of a lethal process (that is, dry heat, steam, irradiation) to sealed containers for the purpose of achieving a predetermined sterility assurance level (SAL) of greater than $10^{-6}$ or a probability of less than 1 in 1 million of a nonsterile unit.

**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.

**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.

**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.

**unidirectional airflow**  Air within a primary engineering control (PEC) moving in a single direction in a uniform manner and at sufficient speed to sweep particles away from the direct compounding area or testing area.

**uniform data set**  An agreed-on and accepted set of terms and definitions constituting a core of data; a collection of related data items.

**unit dose**  Medication to be given to a particular patient at a specific time packaged in the exact dosage required for that time.

**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.

**verbal order** For home health agencies that elect to use The Joint Commission deemed status option: A physician order that is spoken to authorized staff and later put in writing for the purposes of documenting, as well as establishing or revising the patient’s plan of care.

**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.