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

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What’s New
January 2018 CAMAC 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 CAMAC since its previous update. Major changes to requirements, accreditation policies and procedures, and other important information in this update include the following:

- 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

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

Effective January 1, 2018

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

*Life Safety Code® is a registered trademark of the National Fire Protection Association, Quincy, MA.*
Accreditation Process Information: Clarified that the “Patient Safety Systems” (PS) chapter does not contain new standards or requirements

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

Figure 2: Updated figure

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 ambulatory care organizations

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 to check Ambulatory Buzz blog for ambulatory care accreditation updates
- Added bullet about e-Alerts subscriptions for new content and updates

Standards Questions: Updated guidance for submitting questions

Made minor editorial changes

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 under the Contingency Diagram and Potential Problem Analysis (PPA)

Made minor editorial changes

Appendix: Revised to align with standards changes throughout the manual:

Accreditation Requirements

Accreditation Participation Requirements (APR)

No changes
Environment of Care (EC)

Effective January 1, 2018

- EC.01.01.01, EPs 3–8: Renumbered as EPs 4–9, respectively
- EC.01.01.01, new EP 3: Added requirement for a library of information regarding inspection, testing, and maintenance of its equipment and systems
- EC.02.03.01, EP 9: Revised to require staff and licensed independent practitioners to be periodically instructed on and informed of duties under the written fire response plan; clarified a copy of the plan must be readily available by moving it from former Note 2 into the EP; and updated NFPA reference in the remaining Note
- EC.02.03.01 new, EP 11: Added requirement for periodic evaluations of potential surgical fire hazards and written fire prevention and response procedures
- EC.02.03.01, new EP 12: Added requirement regarding precautions to implement when flammable germicides or antiseptics are used
- EC.02.03.01, new EP 13: Added requirement for organizations to meet the fire protection requirements related to Chapter 15 of NFPA 99–2012
- EC.02.03.03, EP 1: Removed standards reference to LS.03.01.70, EP 6
- EC.02.03.03, EP 3: Revised requirement to make all quarterly fire drills unannounced and revised Note to direct user to full text of listed reference
- EC.02.03.05, EPs 1, 7, 14, and 17: Revised NFPA references
- EC.02.03.05, EP 20: Revised to include testing of sliding and rolling fire doors and revised Note to direct user to full text of listed reference
- EC.02.03.05, EP 25: Updated NFPA references
- EC.02.03.05, new EP 27: Added requirement for monthly testing of elevators with fire fighters’ emergency operations and applied a ★ icon
- EC.02.03.05, new EP 28: Added requirement listing the documentation requirements of maintenance, testing, and inspection activities for EC.02.03.05, EPs 1–20 and 25 and applied a ★ icon
- EC.02.04.03, new EP 8: Added requirement addressing equipment listed for use in oxygen-enriched atmospheres
- EC.02.04.03, new EP 10: Added requirement for occupancies containing hyperbaric facilities to meet the requirements of Chapter 14 of NFPA 99–2012
- EC.02.04.03, EPs 14 and 17–24: Renumbered as EPs 27 and 18–25, respectively
- EC.02.04.03, new EP 26: Added requirement for organizations to perform equipment maintenance on the anesthesia apparatus(es)
- EC.02.04.03, new EP 27: Added requirement for organizations to meet the electrical equipment related requirements in Chapter 10 of NFPA 99–2012
- EC.02.05.01, new EP 2: Added requirement for building systems to be designed to meet the National Fire Protection Association’s Categories 1–4 requirements
- EC.02.05.01, EPs 3, 4, and 6–11: Renumbered as EPs 4, 5, and 7–12, respectively
- EC.02.05.01, EP 19: Clarified that ambient temperature be not less than 40°F
- EC.02.05.01, new EP 20: Added requirement regarding the classification of operating rooms as wet procedure locations and the resulting necessary precautions and documented inspections; applied a ☰ icon
- EC.02.05.01, new EP 21: Added requirement regarding the categories of electrical distribution in the organization
- EC.02.05.01, new EP 22: Added requirement regarding electrical receptacles and cover plates
- EC.02.05.01, new EP 23: Added requirement regarding power strips in a patient care vicinity and non–patient care rooms
- EC.02.05.01, new EP 24: Added requirement addressing the temporary use of extension cords
- EC.02.05.01, new EPs 25 and 26: Added three new requirements addressing areas designated for administration of general anesthesia using medical gases or vacuums in accordance with specific NFPA references
- EC.02.05.03, EPs 1–3: Revised NFPA references
- EC.02.05.03, EPs 4 and 5: Renumbered as EPs 5 and 6 and revised NFPA references
- EC.02.05.03, new EP 4: Added requirement for illumination of means of egress in new buildings equipped with or requiring the use of life support systems
- EC.02.05.03, EP 6: Renumbered as EP 7; removed urgent care areas from the list; revised NFPA references
- EC.02.05.03, EP 10: Renumbered as EP 11 and updated NFPA references
- EC.02.05.03, new EP 12: Added requirement for equipment designated to be powered by emergency power supply to be energized by the organization’s design
- EC.02.05.03, new EP 14: Added requirement for a policy to provide emergency backup for essential medication dispensing equipment and applied a ☰ icon
EC.02.05.03, new EP 15: Added requirement for a policy to provide emergency backup for essential refrigeration for medications and applied a \( \text{\CHECK} \) icon

EC.02.05.05, EP 7: Renumbered as EP 8

EC.02.05.05, new EP 7: Added requirement for the testing of any installed line isolation monitors (LIM) and applied a \( \text{\CHECK} \) icon

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; revised Note to direct user to full text of listed references; added NFPA reference

EC.02.05.07, EP 2: Revised to require an organization to perform a functional test of battery-powered lights and egress and exit signs for a duration depending on existing or new/renovated construction; added a standards cross-reference and NFPA references

EC.02.05.07, EP 4: Revised Note to direct user to full text of listed reference

EC.02.05.07, EP 5: Clarified that an organization’s test of the emergency generator begins with a cold start and added an NFPA reference

EC.02.05.07, EP 6: Added NFPA reference

EC.02.05.07, EP 7: Revised to include manual transfer switches when an organization is testing and added NFPA reference

EC.02.05.07, EP 9: Removed the limitation to test the generator providing emergency power only for services listed at EC.02.05.03, EPs 5 and 6

EC.02.05.07, EP 10: Added Note 2 with an NFPA reference for additional guidance

EC.02.05.09, EP 1: Renumbered as EP 7 and revised to include waste anesthetic gas disposal (WAGD) and support gas systems on the inventory and to address the inventory of critical components, documentation requirements, and qualifications of persons maintaining the systems

EC.02.05.09, new EP 1: Added requirement requiring organizations to designate a warning system category for each medical gas and vacuum systems in which failure is likely to cause major injury or death

EC.02.05.09, EPs 2 and 3: Renumbered as EPs 8 and 9, respectively

EC.02.05.09, new EP 2: Added requirement for all alarm systems used for medical gas and vacuum systems to comply with the category 1–3 warning system requirements
EC.02.05.09, new EP 3: Added requirement for designing, fabricating, testing, and marking containers, cylinders, and tanks according to NFPA requirements

EC.02.05.09, EP 4: Renumbered as EP 10 and expanded the list of required elements to address in the organization’s policy on all cylinders within the organization; updated and added NFPA references

EC.02.05.09, new EP 4: Added requirement for precautionary labeling for locations containing only oxygen or medical air

EC.02.05.09, EP 5: Renumbered as EP 11 and clarified labeling requirements of piped medical gas and vacuum systems, including shutoff valves; added NFPA references

EC.02.05.09, new EP 5: Added requirement for precautionary labeling of, planning for, and allowed storage in cylinder storage rooms

EC.02.05.09, EP 6: Renumbered as EP 12 and updated NFPA references

EC.02.05.09, new EP 6: Added requirement regarding criteria for establishing the threshold pressure considered empty for cylinders with an integral pressure gauge and handling cylinders according to the NFPA references

EC.02.05.09, EP 7: Renumbered as EP 14

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

EC.02.06.05, EP 3: Revised to include general maintenance when assessing construction risks

EC.03.01.01, new EP 1: Added requirement for competency and continuing education for staff

EC.03.01.01, EP 2: Removed reference to HR.01.04.01, EP 1

Made minor editorial changes

Emergency Management (EM)

Effective November 12, 2017

Chapter Outline: Added new entry "IV. Integrated Emergency Management Program (EM.04.01.01)"

Added new or revised requirements for deemed ambulatory surgical centers and for federally qualified health centers and rural health clinics to align with revised requirements from the US Centers for Medicare & Medicaid Services (CMS), including icons as appropriate:

- EM.01.01.01, new EP 9
EM.02.01.01, new EPs 7, 10–12, 14, 15
EM.02.02.01, new EPs 4, 7, 12, 20–23
EM.02.02.03, new EP 9
EM.02.02.07, new EPs 7, 11–14
EM.02.02.11, new EPs 12, 13
EM.03.01.03, new EP 10
New Standard EM.04.01.01, its Introduction, and new EPs 1–3
EM.02.02.03, EP 3: Revised to include examples of nonmedical supplies
EM.02.02.11, EP 3: Added cross-reference to new EM.02.02.03, EP 9

Human Resources (HR)

Effective January 1, 2018
- Chapter Outline: Revised lines I.A and I.B
- Standard HR.01.01.01: Renumbered as HR.01.02.05
- HR.01.01.01, EPs 10–13: Renumbered as HR.01.02.05, EPs 10–13, respectively
- Standards HR.01.02.01 and HR.01.02.05: Combined and renumbered as Standard HR.01.01.01, related to defining and verifying staff qualifications
- HR.01.02.01, EP 1: Renumbered as HR.01.01.01, EP 1, and updated standards cross references
- HR.01.02.05, EPs 1 and 2: Combined and numbered as HR.01.01.01, EP 2
- HR.01.02.05, EP 3: Renumbered as HR.01.01.01, EP 3, and removed standards cross reference
- HR.01.02.05, EPs 4, 5, and 7: Renumbered as HR.01.01.01, EPs 4, 5, and 7, respectively
- HR.01.02.05, EPs 19 and 20: Renumbered as HR.01.01.01, EPs 32 and 33, respectively, and updated standards cross references
- HR.01.02.07, EPs 1 and 2: Updated standards cross references
- HR.01.02.07, EP 5: Revised to require staff to supervise, not oversee the supervision of, students
- HR.01.04.01, EPs 1 and 2: Combined and numbered as EP 1
- HR.01.04.01, EPs 3–6: Combined and numbered as EP 3
- HR.01.05.03, EPs 1 and 4: Combined and numbered as EP 1
- HR.02.01.03, EP 1: Combined with EPs 22 and 23 and numbered as EP 1
- HR.02.01.03, EPs 7–9: Combined and numbered as EP 7
Comprehensive Accreditation Manual for Ambulatory Care

- HR.02.01.03, EPs 11–18: Combined and numbered as EP 11
- HR.02.01.03, EPs 22 and 23: Combined with and numbered as EP 1
- HR.02.01.03, EPs 27 and 28: Combined and numbered as EP 27
- HR.02.01.03, new EP 35: Added requirement for granting initial or revised privileges to physicians responsible for interpreting sleep studies and applied a icon
- HR.02.01.05, EP 2–5, 7, and 8: Combined and numbered as EP 2
- HR.02.02.01, EPs 1–5: Combined and numbered as EP 1
- Standard HR.02.03.01: Clarified that requirement for a fair hearing and appeal process relates to adverse credentialing and privileging decisions
- HR.02.03.01, EPs 1–5: Combined and numbered as EP 1
- Made minor editorial changes

Infection Prevention and Control (IC)

Effective January 1, 2018
- IC.01.01.01, EP 3: Updated standards cross reference
- IC.01.03.01, EPs 1–3: Combined and numbered as EP 1
- IC.01.03.01, EP 5: Renumbered as EP 3
- IC.01.04.01, EPs 1–5: Combined and numbered as EP 1
- IC.01.05.01, EP 6: Removed standards cross references
- IC.02.01.01, EP 7: Removed standards cross reference
- IC.02.03.01, EPs 2 and 3: Combined and numbered as EP 2
- IC.02.04.01, EPs 2 and 6: Removed standards cross references
- IC.03.01.01, EPs 1–5: Combined and numbered as EP 1
- Made minor editorial changes

Information Management (IM)

Effective November 12, 2017
- IM.01.01.03, new EP 5: Added requirement for deemed ambulatory surgical centers and for federally qualified health centers and rural health clinics to implement a system of medical documentation during an emergency that preserves patient information and applied a icon

Leadership (LD)
Effective January 1, 2018

- LD.01.03.01, EP 3: Removed standards cross reference
- Introduction to Oversight of Care, Treatment, or Services Provided Through Contractual Agreement, Standard LD.04.03.09: Added a second circumstance under which licensed independent practitioners need not be credentialed and privileged following the process described in the HR chapter
- Made minor editorial changes

Life Safety (LS)

Effective January 1, 2018

- LS.01.01.01, EP 6: Added NFPA reference
- LS.03.01.10, EP 1: Revised to include additional information about allowable sprinkler protection and construction type
- LS.03.01.10, EP 2: Renumbered as EP 4 and revised to refer to fire-rated walls (not construction); updated NFPA references; added new Note regarding the classification of ambulatory surgical centers as ambulatory health care occupancies
- LS.03.01.10, new EP 2: Added requirement regarding materials used in the construction of interior nonbearing walls in Types I or II construction
- LS.03.01.10, EPs 3–9: Renumbered as EPs 5–11, respectively
- LS.03.01.10, new EP 3: Added requirement to incorporate Chapters 20, 21, and 43 or NFPA 101-2012 when building rehabilitation occurs
- LS.03.01.20, EPs 1, 5, 6, 8–10, and 13–15: Renumbered as EPs 2, 6, 7, 9–11, 14, 15, and 17, respectively
- LS.03.01.20, new EP 1: Added requirement regarding the latching or locking of doors in a means of egress
- LS.03.01.20, EP 2: Renumbered as EP 3 and revised to address the walking surface and clearance at the exit discharge
- LS.03.01.20, EP 3: Deleted EP
- LS.03.01.20, EP 4: Renumbered as EP 5 and revised to address 34-inch door openings
- LS.03.01.20, new EP 4: Added requirement for the capacity of the means of egress to comply with NFPA 101-2012
LS.03.01.20, EP 7: Renumbered as EP 8 and clarified a floor’s exits must be remote from each other and accessible from every part of the floor; added information about smoke compartment egress requirements and required exits for patient care suites larger than 2500 square feet

LS.03.01.20, EP 11: Renumbered as EP 12 and clarified illumination of means of egress must be both adequate and automatic

LS.03.01.20, EP 12: Renumbered as EP 13 and added information regarding emergency lighting

LS.03.01.20, new EP 16: Added requirement for illumination for new buildings equipped with or requiring the use of life support systems

LS.03.01.30, EP 1: Added NFPA reference

LS.03.01.30, EP 4: Renumbered as EP 5 and revised to provide specific guidance on the storage and handling of alcohol-based hand rubs; updated NFPA reference

LS.03.01.30, new EP 4: Added requirement for the protection of flammable, combustible, or hazardous materials that are considered as a severe hazard

LS.03.01.30, EPs 5–7, 9, and 12–14: Renumbered as EPs 7–9, 11, 13–15, respectively

LS.03.01.30, new EP 6: Added requirement for commercial cooking equipment

LS.03.01.30, EP 8: Renumbered as EP 10 and added NFPA reference

LS.03.01.30, EP 10: Renumbered as EP 12 and revised to include specifications for smoke compartments for varying size compartments and conditions for adjoining occupancy

LS.03.01.30, EP 11: Deleted EP

LS.03.01.30, EP 15: Renumbered as EP 16 and included additional requirements for doors in new buildings

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

LS.03.01.34, EP 1: Renumbered as EP 7

LS.03.01.34, new EP 1: Added requirement for installation of a fire alarm system in accordance with listed codes

LS.03.01.34, EP 2: Revised to address detection in areas not continuously occupied and protected and in new buildings

LS.03.01.34, EPs 3 and 4: Renumbered as EPs 8 and 9 and updated NFPA references

LS.03.01.34, new EP 3: Added requirement for manual alarm boxes
- LS.03.01.34, new EP 4: Added requirement regarding occupant notification in new buildings
- LS.03.01.34, EP 5: Deleted EP
- LS.03.01.34, new EP 5: Added requirement regarding occupant notification in existing buildings
- LS.03.01.34, EP 6: Renumbered as EP 10
- LS.03.01.34, new EP 6: Added requirement for automatic activation of required fire alarm control functions
- LS.03.01.40, EP 2: Revised existing EP to address existing high-rise buildings and added requirement for new high-rise buildings
- LS.03.01.40, new EP 3: Added requirement for organization to meet all other Life Safety Code extinguishing requirements related to NFPA 101-2012: 20/21.3.5
- LS.03.01.50, EPs 1–4: Renumbered as EPs 5, 7, 8, and 10, respectively
- LS.03.01.50, new EP 1: Added requirement for equipment using gas or related gas piping to comply with listed codes
- LS.03.01.50, new EP 2: Added requirement regarding the installation of heating, ventilation, and air conditioning
- LS.03.01.50, new EP 3: Added requirement regarding the design and installation of any heating device
- LS.03.01.50, new EP 4: Added requirement listing the provisions for suspended unit heaters
- LS.03.01.50, new EP 6: Added requirement related to escalators, dumbwaiters, and moving walks
- LS.03.01.50, new EP 9: Added requirement for installation of waste chutes
- LS.03.01.70, EP 1: Updated NFPA reference
- LS.03.01.70, EPs 3–5: Renumbered as EPs 5, 6, and 8, respectively
- LS.03.01.70, new EP 3: Added requirement for draperies, curtains, and other loosely hanging fabric
- LS.03.01.70, new EP 4: Added requirement for upholstered furniture and mattresses in buildings without sprinkler protection
- LS.03.01.70, EP 6: Renumbered as EP 9 and removed standards cross reference
- LS.03.01.70, new EP 7: Added requirement for the testing of new and existing engineered smoke control systems
- Made minor editorial changes
Medication Management (MM)

Effective January 1, 2018

- Standard MM.01.01.03, Rationale: Clarified the risks of high-alert and hazardous drugs and medications and added information about hazardous medications; updated website
- MM.01.01.03, EP 1: Updated website references in the footnote
- MM.04.01.01, EP 1: Added signed and held orders to list of types of medication orders in the Note
- MM.08.01.01, new EP 16: Added requirement to have a policy to describe the types of medication overrides when automatic dispensing cabinets are used and applied a ☰ icon
- Made minor editorial changes

National Patient Safety Goals (NPSG)

Effective January 1, 2018

- NPSG.03.06.01, EP 5: Deleted a standards cross reference
- NPSG.07.01.01, EPs 1 and 2: Updated standards cross references
- Made minor editorial changes

Provision of Care, Treatment, and Services (PC)

Effective January 1, 2018

- PC.01.01.01, EP 7: Deleted standards cross reference
- PC.01.03.01, EP 1: Deleted standards cross reference
- PC.02.01.09, EP 4: Updated standards cross reference
- Made minor editorial changes

Performance Improvement (PI)

Effective January 1, 2018

- PI.03.01.01, EP 2: Added a standards cross reference

Record of Care, Treatment, and Services (RC)

Effective January 1, 2018

- RC.02.01.01, EP 2: Revised to include documentation of the date and time medication is administered and applied a ☰ icon
RC.02.01.01, EP 4: Revised standards cross references

Rights and Responsibilities of the Individual (RI)

Effective January 1, 2018

Chapter Outline: Removed reference to Standard RI.01.03.03 in line I.C
RI.01.01.01, EPs 2 and 3: Combined and numbered as EP 2
RI.01.01.03, EPs 2 and 3: Updated standards cross references
RI.01.02.01, EPs 3 and 7: Combined and renumbered as EP 4
RI.01.02.01, EP 6: Renumbered as EP 2 and updated standards cross reference
RI.01.02.01, EPs 20 and 21: Combined and numbered as EP 20
RI.01.03.01, EPs 1–3, 6 and 13: Combined and numbered as EP 1
RI.01.03.01, EPs 7, 9, and 11: Combined and renumbered as EP 2
Standard RI.01.03.03: Deleted standard
RI.01.03.03, EP 1: Renumbered as RI.01.03.01, EP 3, and clarified consent is obtained in advance; added Note 2 exempting security cameras
RI.01.03.05, EPs 4–7: Combined and numbered as EP 4
RI.01.04.01, EPs 1 and 2: Combined and numbered as EP 1
RI.01.05.01, EPs 1, 4, 5, and 8: Combined and numbered as EP 1
RI.01.07.01, EPs 1 and 2: Combined and numbered as EP 1
Made minor editorial changes

Transplant Safety (TS)

Effective January 1, 2018
TS.03.03.01, EP 2: Deleted standards cross reference

Waived Testing (WT)

No changes

Accreditation Process Information

The Accreditation Process (ACC)

Currently effective
Tailored Survey Policy: Added footnote clarifying that contractual arrangements are evaluated for tailoring applicability on a case-by-case basis
Comprehensive Accreditation Manual for Ambulatory Care

- 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 footnote clarifying circumstances in which accredited organizations are not charged a deposit.
- During the Survey: Updated to reflect that “off-shift” survey activities could occur during early morning (as well as evening, night, and weekend) hours as necessary.
- Survey Notification: Added language stating that organizations should plan their procedure schedule to align with surveyor observation.
- 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 5. SAFER Matrix placement and required follow-up activities: Revised language to align with updated Evidence of Standards Compliance (ESC) format.
- Corrective ESC: Updated to include the components of leadership involvement and preventive analysis.
Additional Surveys: Included adding an optional certification as a reason for conducting an extension survey

Made minor editorial changes

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
Comprehensive Accreditation Manual for Ambulatory Care

- Added new rule PDA11 on what happens when the Immediate Threat to Health or Safety abatement survey has not demonstrated implementation of sufficient corrective action
- Added new rule DA06 regarding organizations that receive a Preliminary Denial of Accreditation (PDA) decision in two sequential surveys

Standards Applicability Process (SAP)

Effective November 12, 2017
- Added the following requirements to applicable settings:
  - EM.01.01.01, EP 9
  - EM.02.01.01, EPs 7, 10–12, 14, 15
  - EM.02.02.01, EPs 4, 7, 12, 20–23
  - EM.02.02.03, EP 9
  - EM.02.02.07, EPs 7, 11–14
  - EM.02.02.11, EPs 12, 13
  - EM.03.01.03, EP 10
  - EM.04.01.01, EPs 1–3
- Deleted EC.02.05.01, EP 27

Effective January 1, 2018
- Revised to align with standards changes throughout the manual:

Sentinel Events (SE)

Effective January 1, 2018
- Definition of Sentinel Event: Updated link in “severe, temporary harm” footnote
- Responding to Sentinel Standards: Deleted paragraph referencing Standard RI.01.02.01 and EP 21
- Appendix: Deleted Standard RI.01.02.01 and EP 21
- Made minor editorial changes

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

Made minor editorial changes

Required Written Documentation (RWD)

Effective November 12, 2017
- Added the following EPs to applicable settings:
  - EM.01.01.01, EP 9
  - EM.02.01.01, EPs 7, 10–12, 14, 15
  - EM.02.02.01, EPs 4, 7, 12, 20–23
  - EM.02.02.03, EP 9
  - EM.02.02.07, EPs 7, 11–14
  - EM.02.02.11, EPs 12, 13
  - EM.04.01.01, EPs 1–3
  - IM.01.01.03, EP 5

Effective January 1, 2018
- Added the following EPs to applicable settings:
  - EC.02.03.05, EPs 27 and 29
  - EC.02.05.01, EP 20
  - EC.02.05.03, EPs 14 and 15
  - EC.02.05.05, EP 7
  - HR.02.01.03, EP 35
  - MM.08.01.01, EP 16
  - RC.02.01.01, EP 2
- Renumbered multiple documentation requirements to match standards changes throughout the manual

Early Survey Policy (ESP)

Effective November 12, 2017
- Added the following requirements:
  - EM.01.01.01, EP 9
Effective January 1, 2018

- Renumbered and consolidated multiple EPs to match standards changes throughout the manual
- Added the following EPs:
  - EC.02.03.01, EPs 11–13
  - EC.02.03.05, EPs 27 and 28
  - EC.02.04.03, EPs 8 and 10
  - EC.02.05.01, EP 2
  - EC.02.05.01, EPs 20–27
  - EC.02.05.03, EP 7, 12, 14, 15
  - EC.02.05.05, new EP 7
  - EC.02.05.09, new EPs 1–6, 13
  - EC.03.01.01, EP 1
  - HR.02.01.03, EP 35
  - LS.03.01.10, new EP 3
  - LS.03.01.20, new EPs 1, 4, 16
  - LS.03.01.30, new EPs 4 and 6
  - LS.03.01.34, new EPs 1, 3–6
  - LS.03.01.50, new EPs 1–4, 6, 9
  - LS.03.01.70, new EPs 3, 4, 7
  - MM.08.01.01, EP 16

- Deleted the following EPs:
  - EC.02.05.01, EP 27
  - Former LS.03.01.20, EP 3
  - LS.03.01.30, EP 11
  - Former LS.03.01.34, EP 5
Effective January 1, 2018
- Revised to align with standards changes throughout the manual:

Glossary

Effective January 1, 2018
- Made minor editorial changes

Index

Effective January 1, 2018
- Replaced index
Comprehensive Accreditation Manual

2017 Update 2
CAMAC for Ambulatory Care
Effective January 1, 2018

Standards
Elements of Performance
Scoring
Accreditation Policies

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

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Printed in the U.S.A. 5 4 3 2 1

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ISSN: 1084-3566

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

The “Introduction: How The Joint Commission Can Help You Move Toward High Reliability” (INTRO) chapter is an introduction to Joint Commission accreditation and a user’s guide to understanding how the Comprehensive Accreditation Manual for Ambulatory Care (CAMAC) 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 Ambulatory Care Accreditation Program.
2. Part II explains the organization and content of the CAMAC.
3. Part III explains how you can use the CAMAC 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 Ambulatory Care Accreditation Program and the structure and content of the CAMAC. 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 ambulatory care organization is committed to providing the highest quality services. It also sets you apart from other ambulatory care organizations offering the same types of care, treatment, or services.

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

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

- **Helps health care organizations become high reliability organizations:** The Joint Commission offers numerous resources and information to help ambulatory 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 ambulatory care organizations to use Robust Process Improvement® (RPI®) tools and methodologies (such as Lean, Six Sigma, and change management) to systematically improve processes and avoid common, crucial failures.

- **Enhances staff education:** The accreditation process is designed to be educational. Joint Commission surveyors share best practice approaches and strategies that may help your ambulatory 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 ambulatory care organization move toward highly reliable care, treatment, or services. Through The Joint Commission, your ambulatory 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 ambulatory 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 ambulatory 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 Ambulatory Care Accreditation Program is designed to help ambulatory 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 Ambulatory Care Accreditation Program

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

Addressing Complex Issues in Ambulatory Care

There are many factors that affect patient outcomes in ambulatory care organizations. For example, a sufficient number of staff members to support patient needs. This will help address complex issues such as medication safety and increases in patient visit volumes. Staffing can also impact equipment safety and infection prevention. Likewise, having educated and competent staff positively impacts the organization’s ability to assess, plan, and deliver safe, high-quality patient care.

Some of the greatest challenges for ambulatory care organizations are addressing complex issues such as performance improvement, safety culture, and credentialing/privileging. Staff and leadership are additionally challenged to embrace and implement person-centered practices in ambulatory care organizations, moving away from institution- or provider-centric practices.

The Ambulatory 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 ambulatory care organizations begin to develop strategies to address the most complex issues and identified key vulnerabilities in the patient care experience.

Note: Table 1 does not address all of the issues facing leaders in ambulatory care organizations.
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 your organization’s readiness going forward.

II. About the Comprehensive Accreditation Manual for Ambulatory Care

The CAMAC (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 an ambulatory care organization provides (see the “Identifying Applicable Standards” section in this chapter). The CAMAC includes all the information an ambulatory care organization needs to achieve and
Comprehensive Accreditation Manual for Ambulatory Care

maintain continuous compliance with the Joint Commission’s accreditation and optional specialty certification standards. The manual also will help ambulatory care organizations engage in continuous performance improvement and will guide staff in developing processes to provide the highest quality of safe care, treatment, or services.

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

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

The Joint Commission website offers e-Alerts for new content or updates. For more information, visit https://www.jointcommission.org/ealerts/. Sign up for or update e-Alerts subscriptions at http://www.jointcommission.org/thickbox/NewsletterSign-Up.aspx.

Changes to the standards can be made for a variety of reasons, but they are always done with input from accredited organizations, health care professionals, providers, subject matter experts, consumers, government agencies, and/or employers and are informed by the scientific literature. New standards are added only if they relate to patient safety or quality of care and/or have a positive impact on health outcomes, can be accurately and readily measured, and relate to important issues that clearly support high-quality care, treatment, or services. Standards may also be revised in response to law and regulation changes.
Although The Joint Commission may announce revisions to accreditation standards throughout the year, those changes are made to the E-dition generally only twice a year: in the spring (with changes applicable July 1) and in the fall (with changes applicable January 1 of the following year). Accredited organizations receive one complimentary subscription to the E-dition as long as they maintain accreditation. The print version of the CAMAC manual is published once a year in the fall and a print update service is available to keep your manual current through the year. The manual, its updates, and its abridged version (Standards for Ambulatory Care) 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 CAMAC 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.

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<td>ASC</td>
<td>ambulatory surgical center</td>
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Table 2. Acronyms Used in This Manual

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<tr>
<td>LS</td>
<td>“Life Safety” chapter</td>
</tr>
<tr>
<td>LTA</td>
<td>Limited, Temporary Accreditation</td>
</tr>
<tr>
<td>MM</td>
<td>“Medication Management” chapter</td>
</tr>
<tr>
<td>NPSG</td>
<td>National Patient Safety Goal (also a chapter in this manual)</td>
</tr>
</tbody>
</table>

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

*Table 2. (continued)*

**continued on next page**
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>OQPS</td>
<td>Office of Quality and Patient Safety</td>
</tr>
<tr>
<td>OSHA</td>
<td>Occupational Safety and Health Administration</td>
</tr>
<tr>
<td>PC</td>
<td>“Provision of Care, Treatment, and Services” chapter</td>
</tr>
<tr>
<td>PCMH</td>
<td>Primary Care Medical Home</td>
</tr>
<tr>
<td>PDA</td>
<td>Preliminary Denial of Accreditation</td>
</tr>
<tr>
<td>PFI</td>
<td>Plan for Improvement</td>
</tr>
<tr>
<td>PI</td>
<td>“Performance Improvement” chapter</td>
</tr>
<tr>
<td>POA</td>
<td>Plan of Action</td>
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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>
</tr>
<tr>
<td>RC</td>
<td>“Record of Care, Treatment, and Services” chapter</td>
</tr>
<tr>
<td>RCA</td>
<td>root cause analysis</td>
</tr>
<tr>
<td>RFI</td>
<td>Requirement for Improvement</td>
</tr>
<tr>
<td>RI</td>
<td>“Rights and Responsibilities of the Individual” chapter</td>
</tr>
<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>
<tr>
<td>SE</td>
<td>“Sentinel Events” chapter</td>
</tr>
<tr>
<td>SIG</td>
<td>Standards Interpretation Group</td>
</tr>
<tr>
<td>SOC™</td>
<td>Statement of Conditions™</td>
</tr>
<tr>
<td>TS</td>
<td>“Transplant Safety” chapter</td>
</tr>
<tr>
<td>WT</td>
<td>“Waived Testing” chapter</td>
</tr>
</tbody>
</table>

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
Accreditation Requirements
The first section of this manual contains the accreditation standards for the Ambulatory Care Accreditation Program, which consists of Joint Commission standards, EPs, NPSGs, and other requirements applicable to all organizations accredited in the Ambulatory 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.

“Human Resources” (HR): Outlines processes for evaluating and verifying qualifications, competence, training and education, and credentialing and privileging of staff, physicians, and licensed independent practitioners.

“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 ambulatory care organizations.

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

“National Patient Safety Goals” (NPSG): Includes specific actions that organizations are expected to take to prevent medical errors, such as those caused by inaccurate patient identification or medication errors and harm associated with health care-associated infections.
“Provision of Care, Treatment, and Services” (PC): Covers four basic areas: planning care, implementing care, special conditions, and discharge or transfer.

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

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

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

“Transplant Safety” (TS): Focuses on the development and implementation of policies and procedures for safely acquiring, receiving, storing, and issuing tissues.

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

This manual also contains an optional certification standards chapter, “Primary Care Medical Home Certification Option” (PCMH), as described further in the “Accreditation Process Information” section.

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

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

“The Accreditation Process” (ACC): Provides information about the Joint Commission’s accreditation process, including the application process, types of surveys, Tailored Survey Policy, Intracycle Monitoring (ICM), and Focused Standards Assessment (FSA).
The chapter also describes all components of the accreditation process, including the survey agenda, tracer methodology, the Joint Commission’s Information Accuracy and Truthfulness Policy, and the Public Information Policy. Details of the scoring and decision process, including the Accreditation Decision Rules, Evidence of Standards Compliance, and the review and appeal process, are also explained.

“Standards Applicability Process” (SAP): Provides a list of the standards/requirements that are applicable to your ambulatory care organization based on the particular service types provided including ambulatory surgical centers, endoscopy, medical centers, dental centers, diagnostic/therapeutic, diagnostic imaging services, diagnostic sleep centers, kidney care/dialysis, telehealth (nonsurgical and surgical), episodic care, occupational/worksite health, urgent/immediate care, and convenient care. This user-friendly format allows you to quickly identify the services, as you identified them in your E-App, and related standards that apply to your ambulatory care organization.

“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.
Identifying Applicable Standards
The print version of the CAMAC includes all Joint Commission standards that apply to all organizations accredited under the Ambulatory 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 that are choosing to pursue certification as a primary care medical home are preceded by the following boldface lead-in phrase: **For ambulatory care organizations that elect The Joint Commission Primary Medical Care Home option.** Or, standards that apply only to ambulatory surgical centers using The Joint Commission for Medicare/deemed status are preceded by the phrase: **For ambulatory surgical centers that elect to use The Joint Commission deemed status option.** If you are unsure about the standards in the print manual that apply to your ambulatory care organization, please review the SAP chapter.

In contrast, the E-dition on your Joint Commission Connect extranet site displays *only* the standards applicable to your organization as identified in your E-App. The E-App gives your organization the ability to select the specific settings that describe your ambulatory care organization and the specific services you provide. This selection, in turn, drives the standards applied to your organization by surveyors during the on-site survey process.
To view your organization’s services in E-dition, click “Service Profile” on the top navigation bar. Check with your Joint Commission account executive if you have questions or to help ensure your E-App is complete and accurate.

Some ambulatory care organizations provide care, treatment, or services that are covered under more than one accreditation program and manual (for example, a community health center may provide behavioral health care services that fall under the behavioral health care program or may provide moderate complexity laboratory services applicable to the laboratory program as well as the CAMAC). The Joint Commission will work with your organization to determine whether standards from this and/or other accreditation manuals are applicable.

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

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

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

3. Critical Access Hospital (Comprehensive Accreditation Manual for Critical Access Hospitals): A hospital that offers limited services and is located more than 35 miles from a hospital or another critical access hospital, or is certified by the state as being a necessary provider of health care services to residents in the area. It maintains no more than 25 beds that could be used for inpatient/swing bed care. A critical access hospital provides acute inpatient care for a period that does not exceed, on an annual average basis, 96 hours per patient. A critical access hospital can also have a psychiatric and/or rehabilitation distinct part unit; each unit can have up to 10 beds.
4. Home Care (Comprehensive Accreditation Manual for Home Care): Organizations that provide home health services, personal care and support services, pharmacy services including infusion services and/or mail order and specialty pharmacies, long term care pharmacies and freestanding infusion centers, durable medical equipment services, and hospice services.

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

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

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

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

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

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

- **Overview:** The overview is located at the beginning of each chapter. The overview explains the chapter’s purpose and the principles on which the standards were built.
- **Chapter outline:** This part shows how the chapter is laid out and provides a frame of reference for the numbering of standards.
- **Introduction:** Some standards (or cluster of standards) have an introduction at the beginning, which provides information about the standard’s origin and any issues that surround it.
Standards: Standards (also known as requirements) are statements that define the performance expectations and/or structures or processes that must be in place for organizations to provide safe, high-quality care, treatment, and services.

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

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

Elements of performance (EPs): EPs are statements that detail the specific performance expectations and/or structures or processes that must be in place for an organization to provide high-quality care, treatment, and services. EPs are scored and determine an organization’s overall compliance with a standard. The EPs are numbered sequentially under each standard: EP 1, EP 2, EP 3, and so on. Some EPs in standards common across accreditation programs may not apply specifically to ambulatory 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 Ambulatory 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.
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Standard
A statement that, when achieved, facilitates safe, quality care, treatment, or services

Rationale
Additional text that describes the purpose of the requirement/standard

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. (See also EC.02.02.01, EP 8)

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

Figure 2. Components of a standards chapter in the print manual. The components are further described in the “Understanding the Icons Used in the Manual” section.
Understanding the Icons Used in the Manual

You will notice features in the manual that will help you navigate the standards. Icons used throughout the accreditation requirements chapters provide clarity and ease of use.

The following icons can be found in this manual:

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

- The risk icon R identifies specific risks by accreditation program (not program segment). Risk is assessed by a system’s proximity to the patient, probability of harm, severity of harm, and number of patients at risk. Risk categories identified by The Joint Commission are related to National Patient Safety Goals, accreditation program–specific risk areas, and RFIs identified during current accreditation cycle survey events. The print manual will show a single icon at the EP level for the National Patient Safety Goals and accreditation program–specific risk areas that are required to be addressed during the ICM process through the FSA. The third risk category—related to an organization’s own RFIs—will appear only in the ICM Profile on the organization’s Joint Commission Connect extranet site.
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 CAMAC 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 CAMAC or Standards for Ambulatory Care, requesting permission to make copies of your print manual, or purchasing a site license for the E-dition to make accreditation standards more widely available to staff.

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: Are the appropriate team members consulted when necessary to determine whether a patient needs to be transferred or admitted? Does my organization have consistent processes in place for patient follow-up post-operatively?
Monitor closely the general Joint Commission website for free tools and resources provided. For example, in July 2016 The Joint Commission published a “Compliance Checklist for Diagnostic Imaging” at https://www.jointcommission.org/compliance_checklist_for_diagnostic_imaging/. For organizations that want to elect the Joint Commission’s Primary Care Medical Home (PCMH) certification option, a self-assessment tool is available at https://www.jointcommission.org/joint_commission_primary_care_medical_home_self-assessment_tool__/


Turn accreditation standards into PowerPoint presentations, handouts, study aids, posters, or other staff education materials. They also can be rewritten as quizzes, tests, or worksheets to determine staff understanding.

Use the ICM profile and FSA tool on your Joint Commission Connect extranet site to prepare for your initial survey or maintain compliance between surveys (see Figure 3). Contact your account executive for support.

Compile information on your performance improvement activity for discussion during your on-site survey.

Form a team to develop creative ways to assess, achieve, and maintain standards compliance, such as the following:
- Question of the week or month
- Standards-related posters
- Column in a weekly all-staff newsletter or electronic bulletin board

Speak to other accredited program coordinators. To find other accredited programs, go to http://www.qualitycheck.org and search by organization, service/setting, state, city, or zip code.

Conduct a gap analysis for the activities required by the standards and evaluate your organization against each standard. Identify whether the standard is being (or has been) met or not met.
KEY MILESTONES IN THE ACCREDITATION PROCESS

Joint Commission Activities

- Full on-site survey is conducted using tracer methodology
- Summary of findings left for organization
- FSA activated for submission (due by month 12)
- On-site resurvey is scheduled (between months 18 and 36)
- Triennial accreditation cycle begins again

Accredited Organization Activities

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

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FSA, Focused Standard 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 (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 ambulatory 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:
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- Survey Planning Tools: Helpful information including a survey activity list, documentation list, and survey preparation notes to help you plan for the logistics and operational needs of an on-site survey.
- Survey Activity Guide: A resource to help you prepare for survey, including an abstract of each survey activity with logistical needs, session objectives, an overview of the session, and suggested participants.
- SAFER Matrix™ Information: A collection of resources to provide organizations with information related to the new Survey Analysis for Evaluating Risk™ (SAFER) process.
- Intracycle Monitoring (ICM) Profile: To assist with continuous compliance efforts, this profile identifies high-risk areas and utilizes the FSA tool to identify related standards marked with a risk icon.
- 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.
- 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/ahc_requirements.aspx) regularly for any revisions to ambulatory 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.
- Check the *Ambulatory Buzz* blog (https://www.jointcommission.org/ambulatory_buzz), a monthly source for ambulatory care accreditation updates, commentary, and more.

**IV. Get Extra Help**

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

**Getting Started with Accreditation**

Organizations not yet accredited can call Business Development at 630-792-5286 for information about:

- The benefits of Joint Commission accreditation and optional certifications
- Information about obtaining accreditation and optional certifications
- Request for initial application
Account Executive
Accredited organizations can call their assigned account executive at 630-792-3007 for information or with questions about the following:

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

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

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

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

Standards Questions
SIG provides answers to frequently asked questions online at https://www.jointcommission.org/standards_information/jcfaq.aspx. If you cannot find an answer to your question, accredited organizations may submit a question 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 CAMAC free of charge by e-mailing a request to permissions@jcrinc.com.

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

**Introduction**

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

The intent of this “Patient Safety Systems” (PS) chapter is to provide organization leaders 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 organizations to improve health care systems to protect patients. The first obligation of health care is to “do no harm.” Therefore, this chapter is focused on the following three guiding principles:

1. Aligning existing Joint Commission standards with daily work in order to engage patients and staff throughout the health care system, at all times, on reducing harm.
2. Assisting health care organizations with advancing knowledge, skills, and competence of staff and patients by recommending methods that will improve quality and safety processes.
3. Encouraging and recommending proactive quality and patient safety methods that will increase accountability, trust, and knowledge while reducing the impact of fear and blame.

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

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

- Ensuring reliable processes

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* The Institute of Medicine defines quality as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. **Source:** Committee to Design a Strategy for Quality Review and Assurance in Medicare, Institute of Medicine. *Medicare: A Strategy for Quality Assurance*, vol. 1. Lohr KN, editor. Washington, DC: The National Academies Press, 1990.

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Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
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 an organization that aims to increase the reliability of its complex systems while making risk of patient harm apparent and removing that risk. Joint Commission–accredited organizations should be continually focused on eliminating systems failures and human errors that may cause harm to patients, families, and staff.1,2

The ultimate purpose of The Joint Commission’s accreditation process is to enhance quality of care and patient safety. Each requirement or standard, the survey process, the Sentinel Event Policy, and other Joint Commission initiatives are designed to help organizations reduce variation, reduce risk, and improve quality. 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.

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

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

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

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

This chapter does the following:
- Describes an integrated patient safety system
- Discusses how organizations can develop into learning organizations
- Explains how organizations can continually evaluate the status and progress of their patient safety systems
- Describes how organizations can work to prevent or respond to patient safety events (Sidebar 1, below, defines key terminology)
- Serves as a framework to guide organization leaders as they work to improve patient safety in their organizations
- Contains a list of standards and requirements related to patient safety systems (which will be scored as usual in their original chapters)
- Contains references that were used in the development of this chapter

This chapter refers to a number of Joint Commission standards. Standards cited in this chapter are formatted with the standard number in boldface type (for example, “Standard RI.01.01.01”) and are accompanied by language that summarizes the standard. For the full text of a standard and its element(s) of performance (EP), please see the Appendix beginning on page PS-23.

Sidebar 1. Key Terms to Understand

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

†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.
Sidebar 1. (continued)

- Severe temporary harm
- Close call or “near miss,” “no harm,” or “good catch”: A patient safety event that did not cause harm as defined by the term sentinel event.
- Hazardous (or “unsafe”) condition(s): A circumstance (other than a patient’s own disease process or condition) that increases the probability of an adverse event.

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

### Becoming a Learning Organization

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

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

Organization 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
- Providing the resources and training necessary to take on improvement initiatives

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

Without the support of organization leaders, 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 organization.

Safety Culture

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

The safety culture of an 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. 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.\(^1\) Organizations will have varying levels of safety culture, but all should be working toward a safety culture that has the following qualities:

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

A safety culture operates effectively when the organization fosters a cycle of trust, reporting, and improvement.\(^10,15\) In organizations that have a strong safety culture, health care providers trust their coworkers and leaders to support them when they identify and report a patient safety event.\(^10\) When trust is established, staff are more likely to report patient safety events, and organizations can use these reports to inform their improvement efforts. In the trust-report-improve cycle, leaders foster trust, which enables staff to report, which enables the organization to improve.\(^10\) In turn, staff see that their reporting contributes to actual improvement, which bolsters their trust. Thus, the trust-report-improve cycle reinforces itself.\(^10\) (See Figure 1. The Trust-Report-Improve Cycle with Robust Process Improvement® (RPI®).)
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 organization are addressed, so as not to inhibit others from reporting safety concerns. Leaders should both educate staff and hold them accountable for professional behavior. This includes the adoption and promotion of a code of conduct that defines acceptable behavior as well as behaviors that undermine a culture of safety. The Joint Commission’s Standard LD.03.01.01, EP 4, requires that leaders develop such a code.

Intimidating and disrespectful behaviors disrupt the culture of safety and prevent collaboration, communication, and teamwork, which is required for safe and highly reliable patient care. Disrespect is not limited to outbursts of anger that humiliate a member of the health care team; it can manifest in many forms, including the following:

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

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

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

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

A Fair and Just Safety Culture

A fair and just safety culture is needed for staff to trust that they can report patient safety events without being treated punitively. In order to accomplish this, 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 are harmed, and reactive risk reduction
attempts to prevent the recurrence of problems that have already caused patient harm.\textsuperscript{10,15} A fair and just culture takes into account that individuals are human, fallible, and capable of mistakes, and that they work in systems that are often flawed. In the most basic terms, a fair and just culture holds individuals accountable for their actions but does not punish individuals for issues attributed to flawed systems or processes.\textsuperscript{14,18,19} Refer to Standard \textbf{LD.04.01.05}, EP 4, which requires that staff are held accountable for their responsibilities.

It is important to note that for some actions for which an individual is accountable, the individual should be held culpable and some disciplinary action may then be necessary. (See Sidebar 2, below, for a discussion of tools that can help leaders determine a fair and just response to a patient safety event.) However, staff should never be punished or ostracized for reporting the event, close call, hazardous condition, or concern.

\begin{center}
\textbf{Sidebar 2. Assessing Staff Accountability}
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The aim of a safety culture is not a "blame-free" culture but one that balances learning with accountability. To achieve this, it is essential that leaders assess errors and patterns of behavior in a manner that is applied consistently, with the goal of eliminating behaviors that undermine a culture of safety. There has to exist within the 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 below) that provide rationales, tools, and techniques that will assist an organization in creating a formal decision process to determine what events should be considered blameworthy and require individually directed action in addition to systems-level corrective actions. The use of a formal process will reinforce the culture of safety and demonstrate the organization’s commitment to transparency and fairness.

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

\textbf{References}

\emph{continued on next page}
Sidebar 2 (continued)


Data Use and Reporting Systems
An effective culture of safety is evidenced by a robust reporting system and use of measurement to improve. When 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. 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 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.\textsuperscript{20–24}

In addition to those mentioned earlier in this chapter, a number of standards relate to the reporting of safety information, including Performance Improvement (PI) Standard PL.01.01.01, which requires 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.

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
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- Educate staff on identifying patient safety events that should be reported
- Provide timely feedback regarding actions taken on patient safety events

**Effective Use of Data**

**Collecting Data**
When 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. The effective use of data enables organizations to identify problems, prioritize issues, develop solutions, and track to determine success. Objective data can be used to support decisions, influence people to change their behaviors, and to comply with evidence-based care guidelines.

The Joint Commission and the Centers for Medicare & Medicaid Services (CMS) both require organizations to collect and use data related to certain patient care outcomes and patient harms. Some key Joint Commission standards related to data collection and use require organizations to do the following:

- Collect information to monitor conditions in the environment (Standard EC.04.01.01)
- Identify risks for acquiring and transmitting infections (Standard IC.01.03.01)
- Use data and information to guide decisions and to understand variation in the performance of processes supporting safety and quality (Standard LD.03.02.01)
- Have an organizationwide, integrated 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)
- 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 an 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 organization to monitor the performance of a system, detect variation, and identify opportunities to improve. This can help the organization not only understand the current performance of organization systems but also can help it predict its performance going forward.
Analyzing data with tools such as run charts, statistical process control (SPC) charts, and capability charts helps an organization determine what has occurred in a system and provides clues as to why the system responded as it did. Table 1, following, describes and compares examples of these tools. Please note that several types of SPC charts exist; this discussion focuses on the XmR chart, which is the most commonly used.
### Table 1. Defining and Comparing Analytical Tools

<table>
<thead>
<tr>
<th>Tool</th>
<th>When to Use</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Run Chart&lt;sup&gt;1&lt;/sup&gt;</td>
<td>- When the organization needs to identify variation within a system</td>
<td><img src="image1.png" alt="Run Chart Example" /></td>
</tr>
<tr>
<td></td>
<td>- When the organization needs a simple and straightforward analysis of a system</td>
<td></td>
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<tr>
<td></td>
<td>- As a precursor to an SPC chart</td>
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<tr>
<td>Statistical Process</td>
<td>- When the organization needs to identify variation within a system and find indicators of why the variation occurred</td>
<td><img src="image2.png" alt="Statistical Process Control Chart Example" /></td>
</tr>
<tr>
<td>Control Chart&lt;sup&gt;2&lt;/sup&gt;</td>
<td>- When the organization needs a more detailed and in-depth analysis of a system</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- When the organization needs to determine whether a process will function as expected, according to requirements or specifications</td>
<td><img src="image3.png" alt="Capability Chart Example" /></td>
</tr>
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</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):^27–29

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

A Proactive Approach to Preventing Harm

Proactive risk reduction prevents harm before it reaches the patient. By engaging in proactive risk reduction, an organization can correct process problems in order to reduce the likelihood of experiencing adverse events.

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

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

- Identification of actionable common causes
- Avoidance of unintended consequences
■ Identification of commonalities across departments/services/units
■ Identification of system solutions

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

A proactive approach to hazardous conditions should include an analysis of the related systems and processes, including the following aspects:‡

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

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

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

The Joint Commission addresses proactive risk assessments at Standard **LD.04.04.05**, EP 11, which recommends using the results of proactive risk assessments to improve safety.

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

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

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

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

Tools for Conducting a Proactive Risk Assessment

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

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

Potential problem analysis (PPA) is a systematic method for determining what could go wrong in a plan under development. The problem causes are rated according to their likelihood of occurrence and the severity of their consequences. Visit https://healthit.ahrq.gov/health-it-tools-and-resources/evaluation-resources/workflow-assessment-health-it-toolkit/all-workflow-tools for more information.

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

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

A patient-centered approach to care can help 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 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 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.

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.

A number of Joint Commission standards address patient rights and provide an excellent starting point for 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 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 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 an organization’s comprehensive systematic analysis as well as the action plan to help the organization prevent the hazardous or unsafe conditions from occurring again.
- **Joint Commission Center for Transforming Healthcare**: A Joint Commission not-for-profit affiliate that offers highly effective, durable solutions to health care’s most critical safety and quality problems to help organizations transform into high reliability organizations. For specific quality and patient problems, the Center’s Targeted Solutions Tool* (TST*) guides organizations through a step-by-step process to measure their organization’s performance, identify barriers to excellence, and direct them to proven solutions. To date, a TST has been developed for each of the following: hand hygiene, hand-off communications, and wrong-site surgery. For more information, visit http://www.centerfortransforminghealthcare.org.

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

- **National Patient Safety Goals**: The Joint Commission’s yearly patient safety requirements based on data obtained from the Joint Commission’s Sentinel Event Database and recommended by a panel of patient safety experts. (For a list of the current National Patient Safety Goals, go to https://www.jointcommission.org/ahc_2016_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 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.

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
- **Speak Up™ program**: The Joint Commission’s campaign to educate patients about health care processes and potential safety issues and encourage them to speak up whenever they have questions or concerns about their safety. (For more information and patient education resources, go to http://www.jointcommission.org/speakup.)

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

- **Leading Practice Library**: Available for accredited or certified organizations through Joint Commission Connect, organizations can access an online library of solutions to help improve safety. The searchable documents in the library are actual solutions that have been successfully implemented by 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 a process(es) for continually monitoring, internally reporting, and investigating the following:
   - Problems and incidents related to risks addressed in the environment of care management plans
   - Injuries to patients or others within the organization’s facilities
   - Occupational illnesses and staff injuries
   - Incidents of damage to its property or the property of others

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

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

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

2. Problems and incidents related to each of the environment of care management plans.
3. Injuries to patients or others within the organization’s facilities.
4. Occupational illnesses and staff injuries.
5. Incidents of damage to its property or the property of others.

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

### Standard EC.04.01.03

The organization analyzes identified environment of care issues.

#### Element of Performance for EC.04.01.03

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

### Standard EC.04.01.05

The organization improves its environment of care.

#### Element of Performance for EC.04.01.05

1. The organization takes action on the identified opportunities to resolve environmental safety issues.

### Human Resources (HR)

#### Standard HR.01.05.03

Staff participate in ongoing education and training.

#### Elements of Performance for HR.01.05.03

1. ☐ Staff participate in ongoing education and training to maintain or increase their competency and, as needed, when staff responsibilities change. Staff participation is documented.

For ambulatory surgical centers that elect to use The Joint Commission deemed status option: Staff participate in ongoing education and training with respect to their roles in the fire response plan. (For information on staff’s roles in the fire response plan, see EC.02.03.01, EP 10.)
14. The organization verifies and documents that technologists who perform diagnostic computed tomography (CT) examinations participate in ongoing education that includes annual training on the following:
- Radiation dose optimization techniques and tools for pediatric and adult patients addressed in the Image Gently® and Image Wisely® campaigns
- Safe procedures for operation of the types of CT equipment they will use

Note 1: Information on the Image Gently and Image Wisely initiatives can be found online at http://www.imagegently.org and http://www.imagewisely.org, respectively.

Note 2: This element of performance does not apply to CT systems used for therapeutic radiation treatment planning or delivery, or for calculating attenuation coefficients for nuclear medicine studies.

Note 3: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.

25. The organization verifies and documents that technologists who perform magnetic resonance imaging (MRI) examinations participate in ongoing education that includes annual training on safe MRI practices in the MRI environment, including the following:
- Patient screening criteria that address ferromagnetic items, electrically conductive items, medical implants and devices, and risk for nephrogenic systemic fibrosis (NSF)
- Proper patient and equipment positioning activities to avoid thermal injuries
- Equipment and supplies that have been determined to be acceptable for use in the MRI environment (MR safe or MR conditional)§
- MRI safety response procedures for patients who require urgent or emergent medical care
- MRI system emergency shutdown procedures, such as MRI system quench and cryogen safety procedures
- Patient hearing protection
- Management of patients with claustrophobia, anxiety, or emotional distress

§ Terminology for defining the safety of items in the magnetic resonance environment is provided in ASTM F2503 Standard Practice for Marking Medical Devices and Other Items for Safety in the Magnetic Resonance Environment (http://www.astm.org).
Standard HR.02.01.03
The organization grants initial, renewed, or revised clinical privileges to individuals who are permitted by law and the organization to practice independently.

Elements of Performance for HR.02.01.03
7. Before granting renewed or revised privileges to a licensed independent practitioner, the organization does following:
   - Reviews information from any of its performance improvement activities pertaining to professional performance, judgment, and clinical or technical skills.
   - Evaluates the results of any peer review of the individual's clinical performance.
   - Reviews any clinical performance in the organization that is outside acceptable standards.

Infection Prevention and Control (IC)

Standard IC.01.03.01
The organization identifies risks for acquiring and transmitting 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 infection surveillance and control data
3. The organization prioritizes the identified risks for acquiring and transmitting 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.02.03.01

Leaders regularly communicate with each other on issues of safety and quality.

Elements of Performance for LD.02.03.01

1. Leaders discuss issues that affect the organization and the population(s) it serves, including the following:
   - Performance improvement activities
   - Reported safety and quality issues
   - Proposed solutions and their impact on the organization’s resources
   - Reports on key quality measures and safety indicators
   - Safety and quality issues specific to the population served
   - Input from the population(s) served
2. The organization establishes time frames for the discussion of issues that affect the organization and the population(s) it 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.
2. Leaders are able to describe how data and information are used to create a culture of safety and quality.
3. The organization uses processes to support systematic data and information use.
4. Leaders provide the resources needed for data and information use, including staff, equipment, and information systems.
5. The organization uses data and information in decision making that supports the safety and quality of care, treatment, or services. (See also PI.02.01.01, EP 8)
6. The organization uses data and information to identify and respond to internal and external changes in the environment.
7. Leaders evaluate how effectively data and information are used throughout the organization.

Standard LD.03.03.01

Leaders use organizationwide planning to establish structures and processes that focus on safety and quality.

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.
Standard LD.03.04.01
The organization communicates information related to safety and quality to those who need it, including staff, licensed independent practitioners, patients, families, and external interested parties.
Elements of Performance for LD.03.04.01
1. Communication processes foster the safety of the patient and the quality of care.
2. 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 management.
5. Communication supports safety and quality throughout the organization. (See also LD.04.04.05, EPs 6 and 12)
6. When changes in the environment occur, the organization communicates those changes effectively.
7. Leaders evaluate the effectiveness of communication methods.

Standard LD.03.05.01
Leaders implement changes in existing processes to improve the performance of the organization.

Elements of Performance for LD.03.05.01
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. The management of change and performance improvement supports both safety and quality throughout the organization.
6. The organization’s internal structures can adapt to changes in the environment.
7. Leaders evaluate the effectiveness of processes for the management of change and performance improvement.
Standard LD.03.06.01

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

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

Standard LD.04.01.01

The organization complies with law and regulation.

Elements of Performance for LD.04.01.01

1. (❼) 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.

   **Note:** 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 law. *(See also WT.01.01.01, EP 1; WT.04.01.01, EP 1)*

2. The organization provides care, treatment, or services in accordance with licensure requirements, laws, and rules and regulations.
3. Leaders act on or comply with reports or recommendations from external authorized agencies, such as accreditation, certification, or regulatory bodies.

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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.
15. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The organization complies with part 493 of the Code of Federal Regulations.

*Note:* Part 493 of the Code of Federal Regulations requires organizations who perform laboratory testing to maintain compliance with the Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88).

19. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** Organizations that do not provide their own laboratory services have procedures for obtaining routine and emergency laboratory services from a certified laboratory in accordance with part 493 of the Code of Federal Regulations. The referral laboratory is certified in the associated specialties and subspecialties needed to perform tests ordered.

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**Standard LD.04.01.05**

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

**Elements of Performance for LD.04.01.05**

2. Programs, services, or sites providing patient care are directed by one or more qualified professionals or by a qualified licensed independent practitioner with clinical privileges.

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

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, or sites.

11. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The organization evaluates how effectively the primary care clinician and the interdisciplinary team work in partnership with the patient to support the continuity of care and the provision of comprehensive and coordinated care, treatment, or services.
13. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option**: If radiologic services are provided by the ambulatory surgical center, the governing body must appoint an individual qualified in accordance with state law and organizational policies who is responsible for making certain that all radiologic services are provided in accordance with law and regulation.

**Note:** The Joint Commission elements of performance that relate to laws and regulations for radiologic services are outlined in the ambulatory surgical center crosswalk on E-dition.

**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)

2. Leaders give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities. (*See also* PI.01.01.01, EPs 4, 6–8, 14, and 15)

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

4. Performance improvement occurs organizationwide.

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

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

16. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option**: The infection control program is an integral part of the ambulatory surgical center’s quality assessment and performance improvement program.
17. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The governing body makes certain that the quality assessment and performance improvement program is defined, implemented, and maintained.

18. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The governing body makes certain that adequate staff, time, information systems, and training are allocated to the quality assessment and performance improvement program.

19. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The governing body makes certain that the performance improvement data collection methods, frequency, and details are appropriate.

20. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The ambulatory surgical center sets priorities for its performance improvement activities that affect health outcomes, patient safety, and quality of care.

21. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The ambulatory surgical center develops an ongoing, data-driven quality assessment and performance improvement program.

22. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The ambulatory surgical center implements its quality assessment and performance improvement program.

23. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The ambulatory surgical center maintains its quality assessment and performance improvement program.

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

   **Note:** Patient involvement may include activities such as participating on a quality committee.

26. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** Leaders establish priorities that consider the incidence, prevalence, and severity of high-volume, high-risk, or problem-prone areas found in performance improvement activities.
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.

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. *(See also PI.03.01.01, EP 10)*

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

6. The leaders provide and encourage the use of systems for blame-free internal reporting of a system or process failure, or the results of a proactive risk assessment. *(See also LD.03.04.01, EP 5; LD.04.04.03, EP 3; PI.03.01.01, EP 10)*

   **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. *(See also PI.03.01.01, EP 10)*

   **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; PI.03.01.01, EP 10)*

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

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

Standard MM.07.01.03
The 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.
   
   **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. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** All adverse drug events are reported to the physician (as defined in section 1861(r) of the Social Security Act) responsible for the patient and are documented in the clinical record.

5. The organization implements its process for responding to adverse drug events, significant adverse drug reactions, and medication errors.
   
   **Note:** This element of performance is also applicable to sample medications.

Standard MM.08.01.01
The organization evaluates the effectiveness of its medication management system.

**Note:** This evaluation includes reconciling medication information. (Refer to NPSG.03.06.01 for more information)
Elements of Performance for MM.08.01.01

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

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

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

   **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 system.

   **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 system.

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

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

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

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

Performance Improvement (PI)

**Standard** PI.01.01.01

The organization collects data to monitor its performance.

**Elements of Performance for PI.01.01.01**

1. The leaders set priorities for data collection. *(See also* LD.04.04.01, EP 1)

2. The organization identifies the frequency for data collection.

The organization collects data on the following:
3. Performance improvement priorities identified by leaders. (*See also* LD.04.04.01, EP 1)

4. Operative or other procedures that place patients at risk of disability or death. (*See also* LD.04.04.01, EP 2)

5. All significant discrepancies between preoperative and postoperative diagnoses, including pathologic diagnoses.

6. Adverse events related to using moderate or deep sedation or anesthesia. (*See also* LD.04.04.01, EP 2)

7. The use of blood and blood components. (*See also* LD.04.04.01, EP 2)

8. All confirmed transfusion reactions. (*See also* LD.04.04.01, EP 2)

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

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

16. Patient perception of the safety and quality of care, treatment, or services.

28. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The organization, with the participation of the medical staff, collects data on the medical necessity of procedures.

29. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The organization, with the participation of the medical staff, collects data on the appropriateness of care.

36. ⑦ **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The ambulatory surgical center documents the improvement projects it is conducting. The documentation includes, at a minimum, the reason(s) for implementing the project and a description of the project’s results.

**For organizations that elect The Joint Commission Primary Care Medical Home option:** The organization collects data on the following:

40. Disease management outcomes.

41. Patient access to care within time frames established by the organization.
42. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The organization collects data on the following:
- Patient experience and satisfaction related to access to care, treatment, or services and communication
- Patient perception of the comprehensiveness of care, treatment, or services
- Patient perception of the coordination of care, treatment, or services
- Patient perception of the continuity of care, treatment, or services

(Refer to PI.01.01.01, EP 16)

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

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

**Standard PI.02.01.01**

The 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.

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

**Note 1:** While the CTDIvol, DLP, and SSDE are useful indicators for monitoring radiation dose indices from the CT machine, they do not represent the patient's radiation dose.

**Note 2:** This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.
8. The organization uses the results of data analysis to identify improvement opportunities. *(See also LD.03.02.01, EP 5)*

11. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The number and scope of distinct improvement projects conducted annually reflects the scope and complexity of the ambulatory surgical center’s services and operations.

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**Standard PI.03.01.01**
The organization improves performance.

**Elements of Performance for PI.03.01.01**

2. The organization takes action on improvement priorities. *(See also MM.08.01.01, EP 6)*

4. The organization takes action when it does not achieve or sustain planned improvements.

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

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

**Standard RI.01.01.01**
The organization respects patient rights.

**Elements of Performance for RI.01.01.01**

1. The organization has written policies on patient rights.
2. Information about patient rights is available to the patient. (See also RI.01.01.03, EPs 1–3)

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

5. The organization respects the patient’s right to and need for effective communication. (See also RI.01.01.03, EP 1)

6. 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 1–4)

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; HR.02.02.01, EP 4; PC.01.02.07, EP 1)

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.

13. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The organization respects the patient’s right to receive care in a safe setting.

**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 3 and 5)

2. The organization provides interpreting and translation services, as necessary. (See also RI.01.01.01, EP 2)
Note: For organizations that elect The Joint Commission Primary Care Medical Home option: Language interpreting options may include trained bilingual staff, contract interpreting services, or employed language interpreters. These options may be provided in person or via telephone or video. The documents translated, and the languages into which they are translated, are dependent on the organization’s patient population.

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)

4. For ambulatory surgical centers that elect to use The Joint Commission deemed status option: The ambulatory surgical center provides the patient or his or her surrogate decision-maker with verbal and written notice of the patient’s rights prior to the start of the surgical procedure in a language and manner that the patient or his or her surrogate decision-maker understands.

5. For ambulatory surgical centers that elect to use The Joint Commission deemed status option: The ambulatory surgical center posts a copy of its notice of patient rights in a location where it is likely to be noticed by patients. The notice of rights includes contact information for reporting complaints to the state agency and the website for the Office of the Medicare Beneficiary Ombudsman.

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

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)

4. 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.

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

31. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The organization respects the patient’s right to make decisions about the management of his or her care.

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

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

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**Standard RI.01.03.01**

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

**Elements of Performance for RI.01.03.01**

1. The organization follows a written policy on informed consent that describes the following:
   - The specific care, treatment, or services that require informed consent
   - Circumstances that would allow for exceptions to obtaining informed consent
   - 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; the likelihood of the patient achieving his or her goals; and any potential problems that might occur during recuperation.

Reasonable alternatives to the patient’s proposed care, treatment, 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.

15. For ambulatory surgical centers that elect to use The Joint Commission deemed status option: Informed consent is obtained before a treatment or procedure is performed.

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 that specify whether the organization will honor advance directives. The organization communicates its policies on advance directives to patients upon request.

7. For ambulatory surgical centers that elect to use The Joint Commission deemed status option: Prior to the start of the surgical procedure the ambulatory surgical center provides the patient or his or her surrogate decision-maker with written information concerning its policies on advance directives, including a description of applicable state health and safety laws and, if requested, official state advance directive forms.

10. Upon request, the organization shares with the patient possible sources of help in formulating advance directives.

Standard RI.02.01.01

The organization informs the patient about his or her responsibilities related to his or her care, treatment, or services.

Element of Performance for RI.02.01.01

2. The organization informs the patient about his or her responsibilities.
**Note:** Information about patient responsibilities can be shared verbally, in writing, or both.
Accreditation Participation Requirements (APR)

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

For an organization seeking accreditation for the first time, compliance with most of the Accreditation Participation Requirements (APRs) is assessed during the initial survey, including the Early Survey Policy Option. Please note that APR.09.01.01 and APR.09.02.01 are not assessed during the initial survey. For the accredited 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 — Not applicable to ambulatory care

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

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

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

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

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

APR.01.01.01

The organization submits information to The Joint Commission as required.

Element of Performance for APR.01.01.01

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

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

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

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

APR.01.02.01

The organization provides accurate information throughout the accreditation process.

**Rationale for APR.01.02.01**

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

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

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

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

APR.01.03.01

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

Element of Performance for APR.01.03.01

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

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

APR.02.01.01

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

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

APR.03.01.01

The organization fulfills requirements for Focused Standards Assessment.

Rationale for APR.03.01.01

The Focused Standards Assessment (FSA) helps organizations incorporate The Joint Commission standards into routine daily operations. When organizations use the FSA tool to self-assess, monitor, and improve services, 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.05.01.01**
The organization allows The Joint Commission to review the results of external evaluations from publicly recognized bodies.

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

**Element of Performance for APR.05.01.01**

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

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

**Element of Performance for APR.06.01.01**

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

**Note:** Consulting services include, but are not limited to, the following:
- Helping the organization to meet Joint Commission standards
- Helping the organization to complete its Focused Standards Assessment (FSA)
- Assisting the organization in 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 have 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.
Comprehensive Accreditation Manual for Ambulatory Care
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 the following 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, and maintenance of medical equipment and contingencies when equipment fails.
- Utilities. This section addresses inspection and testing of operating components, control of airborne contaminants, and management of disruptions (refer to Standard IM.01.01.03).

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

### Other Issues for Consideration

1. The organization that provides care, treatment, or services in space it does not own (for example, in leased or complimentary space) may want to communicate with the property owner about maintenance expectations for building equipment and features not under its control. For example, an organization may need access to the maintenance documents. This organization and the property owner may want to discuss any building or equipment problems that could adversely affect the safety or health of 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

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- Every 6 months = 6 months from the last event, plus or minus 20 days
- Quarterly/every quarter = every three months, plus or minus 10 days
- Monthly/30-day intervals/every month = 12 times a year, once per calendar month
- Every week = once per calendar week
Chapter Outline

I. Plan (EC.01.01.01)

II. Implement
   A. Safety and Security (EC.02.01.01, EC.02.01.03)
   B. Hazardous Materials and Waste (EC.02.02.01)
   C. Fire Safety (EC.02.03.01, EC.02.03.03, EC.02.03.05)
   D. Medical Equipment (EC.02.04.01, EC.02.04.03)
   E. Utilities (EC.02.05.01, EC.02.05.03, EC.02.05.05, EC.02.05.07, EC.02.05.09)
   F. Other Physical Environment Requirements (EC.02.06.01, EC.02.06.05)

III. Staff Demonstrate Competence (EC.03.01.01)

IV. Monitor and Improve (EC.04.01.01, EC.04.01.03, EC.04.01.05)
Standards, Rationales, and Elements of Performance

Standard EC.01.01.01
The organization plans activities to minimize risks in the environment of care.

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

Note 2: For ambulatory surgical centers 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 3: For further information on waiver and equivalency requests, see https://www.jointcommission.org/life_safety_code_information_resources/ and NFPA 99-2012: 1.4.

Rationale for EC.01.01.01
Risks are inherent in the environment because of the types of care provided and the equipment and materials that are necessary to provide that care. The best way to manage these risks is through a systematic approach that involves the proactive evaluation of the harm that could occur. By identifying one or more individuals to coordinate and manage risk assessment and reduction activities—and to intervene when conditions immediately threaten life and health—organizations can be more confident that they have minimized the potential for harm.

Risks in the environment include safety and security for people, equipment, and other material; the handling of hazardous materials and waste; the potential for fire; the use of medical equipment; and utility systems. Written management plans help the organization manage risks. These plans are not the same as operational plans, but they do provide a framework for managing the environment of care. These plans should also address the scope and objectives of risk assessment and management, describe the responsibilities of individuals or groups, and give time frames for specific activities identified in the plan.

Note: It is not necessary to have a separate plan for each of the areas identified in the standard; the plans may all be contained in a single document.
Elements of Performance for EC.01.01.01

1. Leaders identify an individual(s) to manage risk, coordinate risk reduction activities in the physical environment, collect deficiency information, and disseminate summaries of actions and results.

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

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

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

The organization has a written plan for managing the following:

4. The environmental safety of everyone who enters the organization’s facilities.

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

6. Hazardous materials and waste.

7. Fire safety.

8. Medical equipment.

9. Utility systems.

Standard EC.02.01.01

The organization manages safety and security risks.

Rationale for EC.02.01.01

Safety and security risks are present in most health care environments. These risks affect all individuals in the organization—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. Safety incidents are most often accidental. On the other hand, security incidents are often intentional. Security protects individuals and property...
against harm or loss. Examples of security risks include workplace violence, theft, and unrestricted access to medications. Security incidents are caused by individuals from either outside or inside the organization.

**Elements of Performance for EC.02.01.01**

1. © The organization implements its process to identify safety and security risks associated with the environment of care that could affect patients, staff, and other people coming to the organization’s facilities.

   **Note:** Risks are identified from internal sources such as ongoing monitoring of the environment, results of root cause analyses, results of proactive risk assessments of high-risk processes, and from credible external sources such as Sentinel Event Alerts.

3. The organization takes action to minimize identified safety and security risks in the physical environment.

6. The organization manages safety risks related to entering and exiting the organization.

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

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

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

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

Standard EC.02.01.03
The organization prohibits smoking.

Element of Performance for EC.02.01.03
1. Smoking is not permitted in the organization.

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

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 (for example cleaning products, solvents, pesticides), compressed gases, 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). However, other substances such as blood are covered by this standard.

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)

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)*

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

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

7. The organization minimizes risks associated with the selection and use of hazardous energy sources.

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

8. The organization minimizes risks associated with disposing of hazardous medications. *(See also MM.01.01.03, EPs 1–3)*

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

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

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

   **Note:** *Law and regulation determine the frequency of monitoring hazardous gases and vapors as well as acceptable ranges.*

11. *For managing hazardous materials and waste, the organization has the permits, licenses, manifests, and safety data sheets required by law and regulation.*

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

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*† 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.*
14. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The ambulatory surgical center checks radiology staff, according to time frames it defines, for radiation exposure, using exposure meters or badge tests. The dates of the checks and amount of exposure are documented.

15. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The radiologic services, including ionizing radiology procedures, are free from hazards for patients and staff.

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

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

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

**Standard EC.02.03.01**

The organization manages fire risks.

**Elements of Performance for EC.02.03.01**

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

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

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

9. **The organization has a written fire response plan that describes the specific roles of staff and licensed independent practitioners during a fire, including when and how to sound fire alarms, how to contain smoke and fire, how to use a fire extinguisher, how to assist and relocate patients, and how to evacuate to areas of**
refuge. Staff and licensed independent practitioners are periodically instructed on and kept informed of their duties under the plan. A copy of the plan is readily available with the telephone operator or security.

**Note:** For full text, refer to NFPA 101-2012: 20/21.7.1; 7.2.

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

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

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

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

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

**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 in each building defined as an ambulatory health care occupancy by the Life Safety Code. (See also LS.01.02.01, EP 11)
Note 1: Evacuation of patients during drills is not required.

Note 2: When drills are conducted between 9:00 P.M. and 6:00 A.M., the organization may use alternative methods to notify staff instead of activating audible alarms.

Note 3: In leased or rented facilities, drills need be conducted only in areas of the building that the organization occupies.

2. The organization conducts fire drills every 12 months from the date of the last drill in each area that is defined as a business occupancy by the Life Safety Code and in which care, treatment, or services are provided, or quarterly for ambulatory surgical centers seeking accreditation for Medicare certification.

Note 1: In leased or rented facilities, drills need be conducted only in areas of the building that the organization occupies.

Note 2: In sites that are used on average 70 hours or less per month, the organization may choose either to review the fire response plan or to conduct a fire drill every 12 months. This note does not apply to ambulatory surgical centers that elect to use The Joint Commission deemed status option.

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: 20/21: 7.1; 7.2; 7.3.

5. The organization critiques fire drills.

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

Note: This standard does not require organizations to have the types of fire safety equipment and building features described below. However, if these types of equipment or features exist within the building, then the following maintenance, testing, and inspection requirements apply.
Elements of Performance for EC.02.03.05

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

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

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

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

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

   **Note 2:** Mechanical water-flow devices (including, but not limited to, water motor gongs) 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. (❼) Every 12 months, the organization tests duct detectors, heat detectors, manual fire alarm boxes, and smoke detectors on the inventory. The results and completion dates are documented.

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

4. (❼) Every 12 months, the organization tests visual and audible fire alarms, including speakers and door-releasing devices on the inventory. The results and completion dates are documented.  

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

5. (❼) Every 12 months the organization tests fire alarm equipment on the inventory for notifying off-site fire responders. The results and completion dates are documented.
Note: For additional guidance on performing tests, see NFPA 72-2010: Table 14.4.5.

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

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

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

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

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

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

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

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

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

Note: For additional guidance on performing tests, see NFPA 25-2011: 13.7; Table 13.1.1.2.

11. ☐ For automatic sprinkler systems: Every 12 months, the organization tests fire pumps under flow. The results and completion dates are documented.

Note: For additional guidance on performing tests, see NFPA 25-2011: 8.3.3.
12. Every 5 years, the organization conducts hydrostatic and water-flow tests for standpipe systems. The results and completion dates are documented.

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

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

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


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

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

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

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

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

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

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

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

**Note:** For additional guidance on hydrostatic testing, see NFPA 1962-2008: Chapter 7 and NFPA 25-2011: Chapter 6.
18. The organization operates fire and smoke dampers one year after installation and then at least every 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 guidance on performing tests, see NFPA 90A-2012: 6.4.1.

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

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

25. The organization has written documentation of annual inspection and testing of door assemblies by individuals who can demonstrate knowledge and understanding of the operating components of the door being tested. Testing begins with a pre-test visual inspection; testing includes both sides of the opening.

**Note:** For additional guidance on testing of door assemblies, see NFPA 101-2012: 7.2.1.5.10.1; 7.2.1.5.11; NFPA 80-2010: 4.8.4; 5.2.1; 5.2.3; 5.2.4; 5.2.6; 5.2.7; 6.3.1.7; NFPA 105-2010: 5.2.1.

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

28. Documentation of maintenance, testing, and inspection activities for 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

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
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.02.04.01
The organization manages medical equipment risks.

Elements of Performance for EC.02.04.01

2. The organization maintains either a written inventory of all medical equipment or a written inventory of selected equipment categorized by physical risk associated with use (including all life-support equipment) and equipment incident history. The organization evaluates new types of equipment before initial use to determine whether they should be included in the inventory. For ambulatory surgical centers and outpatient surgical departments that elect to use The Joint Commission deemed status option: The organization maintains a written inventory of all medical equipment.

3. The organization identifies the activities and frequencies for maintaining, inspecting, and testing for all medical equipment on the inventory. Various maintenance strategies may be used to ensure reliable performance (for example, predictive maintenance, reliability-centered maintenance, interval-based inspections, corrective maintenance, or metered maintenance). Defined intervals may be based on criteria such as manufacturers’ recommendations, risk levels, and current organization experience. For ambulatory surgical centers and outpatient surgical departments that elect to use The Joint Commission deemed status option: The organization identifies the activities and frequencies for maintaining, inspecting, and testing for all medical equipment on the inventory. These activities and frequencies must follow manufacturers’ recommendations or other federal or state requirements.

5. The organization monitors and reports all incidents in which medical equipment is suspected in or attributed to the death, serious injury, or serious illness of any individual, as required by the Safe Medical Devices Act of 1990.
6. The organization has written procedures to follow when medical equipment fails, including using emergency clinical interventions and backup equipment.

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

**Standard EC.02.04.03**
The organization inspects, tests, and maintains medical equipment.

**Elements of Performance for EC.02.04.03**

1. Before initial use of medical equipment on the medical equipment inventory, the organization performs safety, operational, and functional checks.

2. The organization inspects, tests, and maintains all high-risk equipment. These activities are documented. **R**  
   **Note:** High-risk equipment includes life-support equipment.

3. The organization inspects, tests, and maintains non-high-risk equipment identified on the medical equipment inventory. These activities are documented.

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

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

8. Equipment listed for use in oxygen-enriched atmospheres is clearly and permanently labeled (withstands cleaning/disinfecting) as follows:
   - Oxygen-metering equipment, pressure-reducing regulators, humidifiers, and nebulizers are labeled with name of manufacturer or supplier.
   - Oxygen-metering equipment and pressure reducing regulators are labeled “OXYGEN–USE NO OIL.”
   - Labels on flowmeters, pressure-reducing regulators, and oxygen-dispensing apparatuses designate the gases for which they are intended.
   - Cylinders and containers are labeled in accordance with Compressed Gas Association (CGA) C-7.
(For full text, refer to NFPA 99-2012: 11.5.3.1)

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

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

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

19. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** Emergency equipment is maintained by qualified staff.

20. **For diagnostic computed tomography (CT) services:** At least annually, a diagnostic medical physicist does the following:

   - Measures the radiation dose (in the form of volume computed tomography dose index [CTD[vol]]) produced by each diagnostic CT imaging system for the following four CT protocols: adult brain, adult abdomen, pediatric brain, and pediatric abdomen. If one or more of these protocols is not used by the organization, other commonly used CT protocols may be substituted.
   - Verifies that the radiation dose (in the form of CTD[vol]) produced and measured for each protocol tested is within 20 percent of the CTD[vol] displayed on the CT console. The dates, results, and verifications of these measurements are documented.

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

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

   **Note 3:** Medical physicists are accountable for these activities. They may be assisted with the testing and evaluation of equipment performance by individuals who have the required training and skills, as determined by the physicist. (For more information, refer to HR.01.02.01, EP 1; HR.01.02.05, EP 20; HR.01.02.07, EPs 1 and 2; HR.01.06.01, EP 1; LD.03.06.01, EP 4.)
21. ⃝ For diagnostic computed tomography (CT) services: At least annually, a diagnostic medical physicist conducts a performance evaluation of all CT imaging equipment. The evaluation results, along with recommendations for correcting any problems identified, are documented. The evaluation includes the use of phantoms to assess the following imaging metrics:

- Image uniformity
- Slice thickness accuracy
- Slice position accuracy (when prescribed from a scout image)
- Alignment light accuracy
- Table travel accuracy
- Radiation beam width
- High-contrast resolution
- Low-contrast resolution
- Geometric or distance accuracy
- CT number accuracy and uniformity
- Artifact evaluation

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

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

22. ⃝ At least annually, a diagnostic medical physicist or magnetic resonance imaging (MRI) scientist conducts a performance evaluation of all MRI imaging equipment. The evaluation results, along with recommendations for correcting any problems identified, are documented. The evaluation includes the use of phantoms to assess the following imaging metrics:

- Image uniformity for all radiofrequency (RF) coils used clinically
- Signal-to-noise ratio (SNR) for all coils used clinically
- Slice thickness accuracy
- Slice position accuracy
- Alignment light accuracy
- High-contrast resolution
- Low-contrast resolution (or contrast-to-noise ratio)
- Geometric or distance accuracy
- Magnetic field homogeneity
- Artifact evaluation

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

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

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

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

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

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

**Note 1:** The following tests are recommended, but not required, for PET scanner testing: sensitivity, energy resolution, and count-rate performance.

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

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

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

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

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

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

Note: For ambulatory surgical centers that elect to use The Joint Commission deemed status option: The organization meets the applicable provisions of the Health Care Facilities Code Tentative Interim Amendment (TIA) 12-5.

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 the activities and frequencies for maintaining, inspecting, and testing for all operating components of utility systems. Various maintenance strategies may be used to ensure reliable performance (for example, predictive maintenance, reliability-centered maintenance, interval-based inspections, corrective maintenance, or metered maintenance). Defined intervals may be based on criteria such as manufacturers’ recommendations, risk levels, and current organization experience.

For ambulatory surgical centers and outpatient surgical departments that elect to use The Joint Commission deemed status option: The organization identifies the activities and frequencies for maintaining, inspecting, and testing for all operating components of utility systems. These activities and frequencies must follow manufacturers’ recommendations or other federal or state requirements.

5. For ambulatory surgical centers and outpatient surgical departments that elect to use The Joint Commission deemed status option: The organization provides ventilation, temperature, and humidity levels in accordance with the levels established in the American Society of Heating, Refrigerating and Air Conditioning Engineers (ASHRAE) standards followed during initial construction or subsequent major renovations, alterations, or modernizations of the facility.
7. In areas designed to control airborne contaminants (such as biological agents, gases, fumes, dust), the ventilation system provides appropriate pressure relationships, air-exchange rates, filtration efficiencies, relative humidity, and temperature. 

**Note:** Areas designed for control of airborne contaminants include spaces such as all classes of operating rooms, special procedure rooms that require a sterile field, caesarean delivery rooms, rooms for patients diagnosed with or suspected of having airborne communicable diseases (for example, airborne infection isolation rooms, rooms for patients with pulmonary or laryngeal tuberculosis, bronchoscopy treatment rooms), patients in “protective environment” rooms (for example, rooms for patients receiving bone marrow transplants), laboratories, pharmacies, sterile supply/processing rooms, and other sterile spaces. For further information, refer to Guidelines for Design and Construction of Health Care Facilities, 2014 edition, administered by the Facility Guidelines Institute and published by the American Society for Healthcare Engineering (ASHE).

8. The organization maps the distribution of its utility systems.

9. The organization labels utility system controls to facilitate partial or complete emergency shutdowns.

**Note 1:** Examples of utility system controls that should be labeled are utility source valves, utility system main switches and valves, and individual circuits in an electrical distribution panel.

**Note 2:** For example, the fire alarm system’s circuit is clearly labeled as Fire Alarm Circuit; the disconnect method (that is, the circuit breaker) is marked in red; and access is restricted to authorized personnel. Information regarding the dedicated branch circuit for the fire alarm panel is located in the control unit. For additional guidance, see NFPA 101-2012: 20/21.3.4.1; 9.6.1.3; NFPA 72-2010: 10.5.5.2.

10. The organization has written procedures for responding to utility system disruptions.

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

12. The organization’s procedures address performing emergency clinical interventions during utility system disruptions.
13. The organization responds to utility system disruptions as described in its procedures.

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

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

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

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

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

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

(For full text, refer to NFPA 99-2012: 3.3.138; 6.3.2.2.10; 6.6.2.2.2; 6.6.3.1.1)
22. Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered are tested after initial installation, replacement, or servicing. In pediatric locations, receptacles in patient rooms (other than nurseries), bathrooms, play rooms, and activity rooms are listed tamper-resistant or have a listed cover. Electrical receptacles or cover plates supplied from the life safety and critical branches have a distinctive color or marking. (For full text, refer to NFPA 99-2012: 6.3.2; 6.3.3; 6.3.4; 6.4.2.2.6; 6.5.2.2.4.2; 6.6.2.2.3.2)

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

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

25. Areas designated for administration of general anesthesia (specifically, inhaled anesthetics) using medical gases or vacuum are in accordance with NFPA 101-2012: 8.7 and NFPA 99-2012 as follows:

- Zone valves are located immediately outside each anesthetizing location for medical gas or vacuum, readily accessible in an emergency, and arranged so shutting off any one anesthetizing location will not affect others.
- Area alarm panels are installed to monitor all medical gas, medical-surgical vacuum, and piped waste anesthetic gas disposal (WAGD) systems. Alarm panels include visual and audible sensors and are in locations that provide for surveillance, including medical gas pressure decreases of 20% and vacuum decreases of 12-inch gauge HgV (mercury vacuum).
- Alarm sensors are installed either on the source side of individual room zone valve box assemblies or on the patient/use side of each of the individual zone valve box assemblies.

(For full text, refer to NFPA 101-2012: 20/21.3.2.3; NFPA 99-2012: 5.1.4.8.7; 5.1.9.3)
26. Areas designated for administration of general anesthesia (specifically, inhaled anesthetics) using medical gases or vacuum are in accordance with NFPA 101-2012: 8.7 and NFPA 99-2012 as follows: The essential electrical system’s (EES) critical branch supplies power for task illumination, fixed equipment, select receptacles, and select power circuits. The EES equipment system supplies power to the ventilation system. (For full text, refer to NFPA 101-2012: 20.21.3.2.3; NFPA 99-2012: 6.4.2.2.4.2)

**Standard EC.02.05.03**

The organization has a reliable emergency electrical power source.

**Elements of Performance for EC.02.05.03**

1. **For ambulatory surgical centers and outpatient surgical departments that elect to use The Joint Commission deemed status option:** For facilities that were constructed, or had a change in occupancy type, or have undergone an electrical system upgrade since 1983, the organization has a Type 1 or Type 3 essential electrical system in accordance with NFPA 99, 2012 edition. This essential electrical system must be divided into three branches, including the life safety branch, critical branch, and equipment branch. Both the life safety branch and the critical branch are kept independent of all other wiring and equipment, and they transfer within 10 seconds of electrical interruption. Each branch has at least one automatic transfer switch. For additional guidance, see NFPA 99-2012: 6.4.2.2.

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

2. Alarm systems, as required by the *Life Safety Code*.  
   **Note:** For guidance in establishing a reliable emergency power system (that is, an essential electrical distribution system), see NFPA 99-2012: 6.4.1.1; 6.4.2.2; 6.4.4.1.1; NFPA 110-2010: 4.1; Table 4.1(b).

3. Exit route and exit sign illumination, as required by the *Life Safety Code*.  
   **Note:** For guidance in establishing a reliable emergency power system (that is, an essential electrical distribution system), see NFPA 99-2012: 6.4.1.1.6; 6.4.2.2; NFPA 110-2010: 4.1; Table 4.1(b).
4. New buildings equipped with or requiring the use of life support systems (electro-mechanical or inhalation anesthetics) have illumination of means of egress, emergency lighting equipment, exit, and directional signs supplied by the life safety branch of the electrical system described in NFPA 99. (For full text, refer to NFPA 101-2012: 18.2.9.2; 18.2.10.5; NFPA 99-2012: 6.4.2.2)

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

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

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

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

   **Note:** For ambulatory surgical centers and outpatient surgical departments that elect to use The Joint Commission deemed status option: See NFPA 99-2012: 6.4.1.1; 6.4.2.2; NFPA 110-2010: 4.1; Table 4.1(b) for guidance in establishing a reliable emergency power system (that is, an essential electrical distribution system).

7. Areas in which loss of power could result in patient harm, including operating rooms and recovery rooms.

   **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).

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.

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

8. The 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 ambulatory surgical centers 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 performs a functional test of battery-powered lights on the inventory required for egress and exit signs for a duration of 1½ hours. For new construction, renovation, or modernization, battery-powered lighting in locations where deep sedation and general anesthesia are administered is tested annually for 30 minutes. The test results and completion dates are documented. (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 clinical records) should be properly tested and maintained in accordance with manufacturers’ recommendations.

Note 2: Level 1 SEPSS are intended to automatically supply illumination or power to critical areas and equipment essential for safety to human life. Included are systems that supply emergency power for such functions as illumination for safe exiting, ventilation where it is essential to maintain life, fire detection and alarm systems, public safety communications systems, and processes where the current interruption would produce serious life safety or health hazards to patients, the public, or staff.

Note 3: Class defines the minimum time for which the SEPSS is designed to operate at its rated load without being recharged.

For additional guidance, see NFPA 111-2010: 8.4.

4. At least weekly, the organization inspects the emergency power supply system (EPSS), including all associated components and batteries. The results and completion dates of weekly inspections are documented. (For full text, refer to NFPA 110-2010: 8.3.1; 8.3.3; 8.3.4; 8.4.1)

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

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

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

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

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

9. At least once every 36 months, 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 organization inspects, tests, and maintains medical gas and vacuum systems.

Note 1: This standard does not require organizations to have the medical gas and vacuum systems discussed below. However, if an organization has these types of systems, then the following inspection, testing, and maintenance requirements apply.
**Note 2:** Piped medical gas systems include oxygen, nitrous oxide, medical air, carbon dioxide, helium, nitrogen, instrument air and mixtures thereof. Piped vacuum systems include both medical-surgical vacuum and waste anesthetic gas disposal (WAGD) systems.

**Rationale for EC.02.05.09**
Medical gas and vacuum systems must be reliable. Testing these systems increases the likelihood of detecting reliability problems and reduces the risk of losing this critical resource.

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

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

   Note: For additional guidance, refer to NFPA 99-2012: 5.1.3.5.12.
9. The organization’s emergency oxygen supply connection is installed in a manner that allows a temporary auxiliary source to connect to it.

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

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

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

13. At no time is transfilling done in any patient care room. A designated area is used away from any section of the 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 organization 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 ambulatory surgical centers 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.

7. For ambulatory surgical centers and outpatient surgical departments that elect to use The Joint Commission deemed status option: The organization provides separate waiting and postanesthesia recovery areas.

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

20. Areas used by patients are clean. R

**Standard EC.02.06.05**
The organization manages its space during demolition, renovation, or new construction.

**Note:** These elements of performance are applicable to all occupancy types.

**Rationale for EC.02.06.05**
In addition to fire safety, there are other hazards and risks resulting from demolition, renovation, or new construction that must be addressed. It is important to plan and conduct risk assessments before construction begins. Authoritative guidelines and state regulations can provide valuable information to guide demolition, renovation, or new construction.

**Elements of Performance for EC.02.06.05**

1. When planning for new, altered, or renovated space, the organization uses one of the following design criteria:

   ▪ State rules and regulations
Guidelines for Design and Construction of Health Care Facilities, 2014 edition, administered by the Facility Guidelines Institute and published by the American Society for Healthcare Engineering (ASHE) When the above rules, regulations, and guidelines do not meet specific design needs, use other reputable standards and guidelines that provide equivalent design criteria.

2. When planning for demolition, construction, renovation, or general maintenance, the organization conducts a preconstruction risk assessment for air quality requirements, infection control, utility requirements, noise, vibration, and other hazards that affect care, treatment, and services.

**Note:** See LS.01.02.01 for information on fire safety procedures to implement during construction or renovation.

3. The organization takes action based on its assessment to minimize risks during demolition, construction, renovation, or general maintenance.

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

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

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

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

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1 For additional guidance on shielding designs and radiation protection surveys, see National Council on Radiation Protection and Measurements Report No. 147 (NCRP-147).
Standard **EC.03.01.01**
Staff and licensed independent practitioners are familiar with their roles and responsibilities relative to the environment of care.

**Rationale for EC.03.01.01**
People are the key to successfully managing risks in the physical environment. Plans and procedures are of no value if those who work in the organization do not know how to follow them. Everyone who works in the organization is responsible for safety, and it is important for them to know how to identify and minimize risks, what actions to take when an incident occurs, and how to report it.

**Elements of Performance for EC.03.01.01**
1. Staff responsible for the maintenance, inspection, testing, and use of medical equipment, utility systems and equipment, fire safety systems and equipment, and safe handling of hazardous materials and waste are competent and receive continuing education and training.
2. Staff and licensed independent practitioners can describe or demonstrate actions to take in the event of an environment of care incident.

**Introduction to Standard EC.04.01.01**
Most organizations are able to manage their physical spaces because they typically use all areas on a daily basis, making it easier for staff to monitor environment of care issues. Monitoring includes keeping track of injuries to patients or others accessing the organization; occupational illness and injuries to staff; property damage or loss; security incidents involving patients, staff, or others accessing the organization; hazardous materials and waste spills and exposures; and fire safety equipment and utility management problems, failures, or use errors.

Quickly identifying and resolving actual and potential environment of care problems is crucial. Organizations are often able to resolve environmental issues without formal reporting processes. However, when reporting processes are more informal, the organization faces a greater risk of overlooking important patterns or trends. Staff reports and their resolution can be a sign of how comprehensively and effectively the risk
assessments, as described in the management plans, have been conducted. Consistently investigating and resolving staff reports about environmental issues can lead to safer delivery of care, treatment, or services.

**Standard EC.04.01.01**

The organization collects information to monitor conditions in the environment.

**Elements of Performance for EC.04.01.01**

1. The organization establishes a process(es) for continually monitoring, internally reporting, and investigating the following:
   - Problems and incidents related to risks addressed in the environment of care management plans
   - Injuries to patients or others within the organization’s facilities
   - Occupational illnesses and staff injuries
   - Incidents of damage to its property or the property of others

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

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

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

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

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

4. Occupational illnesses and staff injuries.

5. Incidents of damage to its property or the property of others.

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

**Standard EC.04.01.03**

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

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

Standard EC.04.01.05

The organization improves its environment of care.

Element of Performance for EC.04.01.05

1. The organization takes action on the identified opportunities to resolve environmental safety issues.
Emergency Management (EM)

Overview
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 Management Plan (EMP). This planning results in the EMP document, which may reflect response strategies that range from continuing a full scope of services, to rescheduling non-urgent appointments, to closing temporarily. After the EMP is in place, it must be tested through staged emergency response exercises in order to evaluate its effectiveness. Adjustments to the EMP 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 EMP document (described in Standard EM.02.01.01 and subsequent standards) to define its response to emergencies and to help position it for recovery after the emergency has passed.

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
- Safety and security
- Staff responsibilities
- Utilities
- Patient clinical and support 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 Management Plan that is scalable to emergencies that may escalate in complexity, scope, or duration. For the most extreme type of emergencies—disasters—additional human resources may be necessary. Organizations can choose to assign responsibilities to volunteer practitioners or to privilege volunteer licensed independent practitioners when such volunteers are essential for meeting patient care needs. 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 Management Plan (EM.01.01.01)

II. The Plan for Response and Recovery
   A. General Requirements (EM.02.01.01)
   B. Specific Requirements
      1. Communications (EM.02.02.01)
      2. Resources and Assets (EM.02.02.03)
      3. Security and Safety (EM.02.02.05)
      4. Staff (EM.02.02.07)
      5. Utilities (EM.02.02.09)
      6. Patients (EM.02.02.11)
      7. Disaster Volunteers
         a. Volunteer Licensed Independent Practitioners (EM.02.02.13)
         b. Volunteer Practitioners (EM.02.02.15)

III. Evaluation (EM.03.01.03)

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

Standard EM.01.01.01
The organization engages in planning activities prior to developing its Emergency Management 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, the organization needs to engage in planning activities that prepare it to form its Emergency Management Plan. These activities include identifying risks, and considering its potential emergencies in developing strategies for preparedness. Because some emergencies that impact an organization originate in the community, the organization needs to take advantage of opportunities where possible to collaborate with relevant parties in the community.

Elements of Performance for EM.01.01.01

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

2. The organization identifies potential emergencies and the direct and indirect effects that these emergencies may have on the need for its services or its ability to provide those services. (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:** Mitigation, preparedness, response, and recovery are the four phases of emergency management. They occur over time: Mitigation and preparedness generally occur before an emergency, and response and recovery occur during and after an emergency.

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

9. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option and for rural health clinics and federally qualified health centers:** The Emergency Management 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 Management Plan.

**Note:** The organization’s Emergency Management Plan (EMP) is designed to coordinate its communications, resources and assets, safety and security, staff responsibilities, utilities, and patient clinical and support activities during an emergency (refer to Standards EM.02.02.01, EM.02.02.03, EM.02.02.05, EM.02.02.07, EM.02.02.09, and EM.02.02.11). Although emergencies have many causes, the effects on these areas of the organization and the required response effort may be similar. This “all hazards” approach supports a general response capability that is sufficiently nimble to address a range of emergencies of different duration, scale, and cause. For this reason, the plan’s response procedures address the prioritized emergencies but are also adaptable to other emergencies that the organization may experience.
Rationale for EM.02.01.01
A successful response effort relies on a comprehensive and flexible Emergency Management Plan that guides decision making regarding how the organization will respond to emergencies, including plans to continue to serve patients or to close in specified circumstances. The plan also supports decision making at the onset of an emergency and as an emergency evolves. While the Emergency Management Plan can be 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 Management Plan.

2. The organization has a written Emergency Management Plan that describes the response procedures to follow when emergencies occur. (See also EM.03.01.03, EP 5)
   
   **Note:** The response procedures address the prioritized emergencies but can also be adapted to other emergencies that the organization may experience. Response procedures could include the following:
   - Maintaining or expanding services
   - Conserving resources
   - Curtailing services
   - Supplementing resources from outside the local community
   - Closing the organization to new patients
   - Staged evacuation
   - Total evacuation

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

5. The Emergency Management Plan describes the processes for initiating and terminating the organization’s response and recovery phases of 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 Management Plan identifies the individual(s) responsible for activating the response and recovery phases of the emergency response.

7. For ambulatory surgical centers that elect to use The Joint Commission deemed status option: The Emergency Management 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 ambulatory surgical centers that elect to use The Joint Commission deemed status option and for rural health clinics and federally qualified health centers: The Emergency Management Plan, including the communication plan, must be reviewed and updated at least annually.

11. For ambulatory surgical centers that elect to use The Joint Commission deemed status option and for rural health clinics and federally qualified health centers: The Emergency Management 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 ambulatory surgical centers that elect to use The Joint Commission deemed status option and for rural health clinics and federally qualified health centers: The Emergency Management 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

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
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 ambulatory surgical centers that elect to use The Joint Commission deemed status option: The ambulatory surgical center 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 ambulatory surgical centers that elect to use The Joint Commission deemed status option: For organizations that plan to provide services during an emergency: The Emergency Management Plan addresses a means to shelter staff and volunteers on site who remain in the organization, including essential space, utilities, and supplies, and criteria for who can be sheltered on site.

Standard EM.02.02.01
As part of its Emergency Management Plan, the organization prepares for how it will communicate during emergencies.

Rationale for EM.02.02.01
The 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 Management Plan describes how staff will be notified that emergency response procedures have been initiated.

3. The Emergency Management Plan describes how the organization will notify external authorities that emergency response measures have been initiated.

4. For ambulatory surgical centers that elect to use The Joint Commission deemed status option: The Emergency Management Plan describes the following:

   How the organization will communicate with external authorities during an ongoing emergency.

For ambulatory surgical centers that elect to use The Joint Commission deemed status option and for rural health clinics and federally qualified health centers: The Emergency Management Plan describes the following:

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

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

14. The organization establishes backup communication systems or technologies for use in the event that internal or external systems fail during an emergency.

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

20. For ambulatory surgical centers that elect to use The Joint Commission deemed status option and for rural health clinics and federally qualified health centers: As part of its communication plan, the organization maintains the names and contact information of the following:

   - Staff
   - Physicians

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

Other potential response partners (depending upon services provided, these may be rural health clinics, federally qualified health centers, or other sources of collaboration or assistance)

- Entities providing services under arrangement
- Relevant federal, state, tribal, regional, and local emergency preparedness staff

### 21. For ambulatory surgical centers that elect to use The Joint Commission deemed status option and for rural health clinics and federally qualified health centers:

- The Emergency Management Plan describes the following:
  - The organization’s primary and alternate means of communicating with staff and federal, state, tribal, and local emergency management agencies
  - 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 and ability to provide assistance to the authority having jurisdiction, the incident command center, or designee

**Note:** Depending upon the type of emergency, the authority having jurisdiction might be the municipal, county, or state health department, or another governmental entity.

### 22. For ambulatory surgical centers that elect to use The Joint Commission deemed status option and for rural health clinics and federally qualified health centers:

- 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).

### 23. For ambulatory surgical centers that elect to use The Joint Commission deemed status option:

- The Emergency Management Plan describes the following:
  - The organization’s arrangements for communicating necessary clinical information on patients under the organization’s care with other health care providers in order to maintain continuity of care

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
A method, in the event of an evacuation, to release patient information to family or others designated by the patient, as permitted under law and regulation at 45 CFR 164.510(b)(1)(ii)

**Standard EM.02.02.03**

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

**Note:** All organizations are required to respond to a patient’s immediate care and safety needs if an emergency occurs with patients on site.

**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. **For organizations that plan to provide service during an emergency:** The Emergency Management Plan describes how the organization will obtain and replenish medications and related supplies that will be required in response to an emergency.

2. **For organizations that plan to provide service during an emergency:** The Emergency Management Plan describes how the organization will obtain and replenish medical supplies that will be required in response to an emergency.

3. **For organizations that plan to provide service during an emergency:** The Emergency Management Plan describes how the organization will obtain and replenish nonmedical supplies (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.

4. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The Emergency Management Plan describes the following: The organization’s arrangements for transporting some or all patients; 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. **For organizations that plan to provide service during an emergency:** The organization implements the components of its Emergency Management Plan that require advance preparation to provide for resources and assets during an emergency. (See also EM.02.02.11, EP 1)

**Standard EM.02.02.05**

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

**Rationale for EM.02.02.05**

Although patients are ambulatory and in most cases are able to provide for their own safety during an emergency, organization staff have a responsibility to take action to protect patients if an emergency occurs while patients are on site. This includes protecting patients from exposure to hazardous conditions or materials and making provisions for isolation and decontamination, when appropriate.

**Elements of Performance for EM.02.02.05**

1. The Emergency Management Plan describes how internal security and safety will be provided during an emergency.

5. **For organizations that plan to provide services during an emergency:** The Emergency Management Plan describes how the organization will provide for radioactive, biological, and chemical isolation and decontamination.

10. The organization implements the components of its Emergency Management Plan that require advance preparation to support internal security and safety during an emergency.

**Standard EM.02.02.07**

As part of its Emergency Management Plan, the organization prepares for how it will manage staff during an emergency.
Rationale for EM.02.02.07
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 Management Plan describes the following:

1. How the organization will manage staff during emergencies.
2. The roles and responsibilities of staff during an emergency.
3. The process for assigning staff to all essential staff functions.
4. The Emergency Management Plan identifies the individual(s) to whom staff report in emergencies.
5. For ambulatory surgical centers that elect to use The Joint Commission deemed status option and for rural health clinics and federally qualified health centers: The organization trains staff for their assigned emergency response roles.
6. For organizations that plan to provide services during an emergency: The Emergency Management Plan describes how the organization will identify licensed independent practitioners, staff, and authorized volunteers during emergencies. (See also EM.02.02.13, EP 3; EM.02.02.15, EP 3)
    Note: This identification could include identification cards, wristbands, vests, hats, or badges.
7. The organization implements the components of its Emergency Management Plan that require advance preparation to manage staff during an emergency.
8. For ambulatory surgical centers that elect to use The Joint Commission deemed status option and for rural health clinics and federally qualified health centers: The organization has a system to track the location of on-duty staff during an emergency.
9. For rural health clinics and federally qualified health centers: The Emergency Management Plan describes how volunteers and state and federally designated health care professionals will be incorporated into the staffing strategy for...
addressing a surge in needs during an emergency. The staffing strategy 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. ① For ambulatory surgical centers that elect to use The Joint Commission deemed status option and for rural health clinics and federally qualified health centers: 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. Staff demonstrate knowledge of emergency procedures through participation in drills and exercises, as well as post-training tests, participation in instructor-led feedback (for example, questions and answers), or other methods determined and documented by the organization.

14. ① For ambulatory surgical centers that elect to use The Joint Commission deemed status option: The Emergency Operations Plan describes the use of volunteers in an emergency, including emergency staffing strategies, such as the role and process for integration of state or federally designated health care professionals to address surge needs during an emergency.

**Standard EM.02.02.09**

As part of its Emergency Management 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. **For organizations that plan to provide services during an emergency:** The Emergency Management Plan describes how the organization will provide for alternative means of meeting essential building utility needs.

   **Note:** Examples of potential utility problems might include disruptions to piped medical gas systems, failure of backup generators, and water pipe rupture.

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

**Standard EM.02.02.11**

As part of its Emergency Management 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 Management Plan describes how the organization will manage activities related to patient care, treatment, or services. (See also EM.02.02.03, EP 12)

   **Note:** Activities related to care, treatment, or services might include scheduling, modifying, or discontinuing services; controlling information about patients; making referrals; transporting patients; and providing security.

3. The Emergency Management Plan describes how the organization will evacuate its occupied space. (See also EM.02.02.03, EP 9)

11. The organization implements the components of its Emergency Management Plan that require advance preparation to manage patients during an emergency.
12. For ambulatory surgical centers that elect to use The Joint Commission deemed status option and for rural health clinics and federally qualified health centers: The organization has a system to track the location of patients sheltered on site during an emergency. This system includes documentation of the name and location of the receiving facility or alternate site in the event a patient is relocated during the emergency.

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

13. For ambulatory surgical centers that elect to use The Joint Commission deemed status option and for rural health clinics and federally qualified health centers: Procedures for evacuating patients from the organization 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 Standards EM.02.02.13 and EM.02.02.15

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

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

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

**Standard EM.02.02.13**

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

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

**Elements of Performance for EM.02.02.13**

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

2. The organization identifies, in writing, those individuals responsible for granting disaster privileges to volunteer licensed independent practitioners.

3. The organization determines how it will distinguish volunteer licensed independent practitioners from other licensed independent practitioners. *(See also EM.02.02.07, EP 9)*
4. The organization describes, in writing, how it will oversee the performance of volunteer licensed independent practitioners who are granted disaster privileges (for example, by direct observation, mentoring, clinical record review).

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

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

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

8. Primary source verification of licensure occurs as soon as the disaster is under control or within 72 hours from the time the volunteer licensed independent practitioner presents him- or herself to the organization, whichever comes first. If primary source verification of a volunteer licensed independent practitioner’s licensure cannot be completed within 72 hours of the practitioner’s arrival due to extraordinary circumstances, the organization documents all of the following:
   - Reason(s) it could not be performed within 72 hours of the practitioner’s arrival
   - Evidence of the licensed independent practitioner’s demonstrated ability to continue to provide adequate care, treatment, or services
   - Evidence of the organization’s attempt to perform primary source verification as soon as possible

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

Note: Primary source verification of licensure is not required if the volunteer licensed independent practitioner has not provided care, treatment, or services under the disaster privileges.
Standard EM.02.02.15

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

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

Elements of Performance for EM.02.02.15

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

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

3. The organization determines how it will distinguish volunteer practitioners who are not licensed independent practitioners from its staff. (See also EM.02.02.07, EP 9)

4. The organization describes, in writing, how it will oversee the performance of volunteer practitioners who are not licensed independent practitioners who have been assigned disaster responsibilities. Examples of methods for overseeing their performance include direct observation, mentoring, and clinical record review.

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

Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances

Confirmation by organization staff with personal knowledge of the volunteer practitioner’s ability to act as a qualified practitioner during a disaster

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

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

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

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

9. If, due to extraordinary circumstances, primary source verification of licensure of the volunteer practitioner cannot be completed within 72 hours of the practitioner’s arrival, it is performed as soon as possible.
Note: Primary source verification of licensure, certification, or registration is not required if the volunteer practitioner has not provided care, treatment, or services under his or her assigned disaster responsibilities.

Standard EM.03.01.03
The organization evaluates the effectiveness of its Emergency Management Plan.

Rationale for EM.03.01.03
The organization conducts exercises to assess the Emergency Management Plan’s appropriateness; adequacy; and the effectiveness of logistics, human resources, training, policies, procedures, and protocols. Exercises should stress the limits of the plan to support assessment of the organization’s preparedness and performance. The design of the exercise should reflect likely disasters but should test the organization’s ability to respond to the effects of emergencies on its capabilities to provide care, treatment, and services.

Elements of Performance for EM.03.01.03
1. As an emergency response exercise, the organization activates its Emergency Management Plan twice a year at each site included in the plan.

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

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

   Note 3: Tabletop sessions, though useful, are not acceptable substitutes for these exercises.

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

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

* The Life Safety Code® is a registered trademark of the National Fire Protection Association, Quincy, MA. Refer to NFPA 101-2000 for occupancy classifications.
5. Emergency response exercises incorporate likely disaster scenarios that allow the organization to evaluate its handling of communications, resources and assets, security, staff, utilities, and patients. \( \text{(See also EM.02.01.01, EP 2)} \)

10. For ambulatory surgical centers that elect to use The Joint Commission deemed status option and for rural health clinics and federally qualified health centers: During emergency response exercises, the organization monitors its management of the following: Staff roles and responsibilities.

13. Representatives from administrative, support, and clinical services participate in the evaluation of all emergency response exercises and all responses to actual emergencies.

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

16. The organization modifies its Emergency Management Plan based on its evaluation of emergency response exercises and responses to actual emergencies. \( \text{Note: When modifications requiring substantive resources cannot be accomplished by the next emergency response exercise, interim measures are put in place until final modifications can be made.} \)

17. Subsequent emergency response exercises reflect modifications and interim measures as described in the modified Emergency Management Plan.

**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 ambulatory surgical centers that elect to use The Joint Commission deemed status option and for rural health clinics and federally qualified health centers: 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 ambulatory surgical centers that elect to use The Joint Commission deemed status option and for rural health clinics and federally qualified health centers: 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

2. For ambulatory surgical centers that elect to use The Joint Commission deemed status option and for rural health clinics and federally qualified health centers: The organization has implemented communication procedures for emergency planning and response activities in coordination with the system’s integrated emergency preparedness program.

3. For ambulatory surgical centers that elect to use The Joint Commission deemed status option and for rural health clinics and federally qualified health centers: 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 can be coordinated with the system’s integrated program (for example, acquiring or storing clinical supplies, assigning staff to the local health care coalition to create joint training protocols, and so forth)
   - The 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
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 is on the job, human resources must provide for the assessment of staff competence and performance.

This chapter also addresses the organization’s responsibility to credential and privilege licensed independent practitioners and provide them with orientation and a fair hearing and appeal process.

Chapter Outline

I. Staff
   A. Qualifications (HR.01.01.01, HR.01.02.07)
   B. Staffing (HR.01.02.05)
   C. Orientation (HR.01.04.01)
   D. Training and Education (HR.01.05.03)
   E. Competence (HR.01.06.01)
   F. Evaluation of Performance (HR.01.07.01)

II. Licensed Independent Practitioners
   A. Credentialing and Privileging (HR.02.01.03, HR.02.01.05)
   B. Orientation (HR.02.02.01)
   C. Fair Hearing and Appeal (HR.02.03.01)
   D. Additional Standards for Services Offered Through a Telemedical Link (HR.02.04.01, HR.02.04.03)

III. Primary Care Medical Home — Qualifications (HR.03.01.01)
Standards, Rationales, and Elements of Performance

Standard HR.01.01.01
The organization defines and verifies staff qualifications.

Elements of Performance for HR.01.01.01

1. The organization defines staff qualifications specific to their job responsibilities. 
   (See also HR.01.01.01, EP 32; IC.01.01.01, EP 3)
   
   **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. 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.

   **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.
5. Staff comply with applicable health screening as required by law and regulation or organization policy. Health screening compliance is documented.

7. Before providing care, treatment, or services, the organization confirms that nonemployees who are brought into the organization by a licensed independent practitioner to provide care, treatment, or services have the same qualifications and competencies required of employed individuals performing the same or similar services at the organization.

**Note 1:** This confirmation can be accomplished either through the organization’s regular process or with the licensed independent practitioner who brought in the individual.

**Note 2:** When the care, treatment, or services provided by the nonemployee are not currently performed by anyone employed by the organization, leadership consults the appropriate professional organization guidelines for the required credentials and competencies.

32. Technologists who perform diagnostic computed tomography (CT) exams have advanced-level certification by the American Registry of Radiologic Technologists (ARRT) or the Nuclear Medicine Technology Certification Board (NMTCB) in computed tomography or have one of the following qualifications:
   - State licensure that permits them to perform diagnostic CT exams and documented training on the provision of diagnostic CT exams or
   - Registration and certification in radiography by ARRT and documented training on the provision of diagnostic CT exams or
   - Certification in nuclear medicine technology by ARRT or NMTCB and documented training on the provision of diagnostic CT exams

*(See also HR.01.01.01, EP 1; HR.01.02.07, EPs 1 and 2)*

**Note 1:** This element of performance does not apply to CT exams performed for therapeutic radiation treatment planning or delivery, or for calculating attenuation coefficients for nuclear medicine studies.

**Note 2:** This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.
33. The organization verifies and documents that diagnostic medical physicists who support computed tomography (CT) services have board certification in diagnostic radiologic physics or radiologic physics by the American Board of Radiology, or in Diagnostic Imaging Physics by the American Board of Medical Physics, or in Diagnostic Radiological Physics by the Canadian College of Physicists in Medicine, or meet all of the following requirements:

- A graduate degree in physics, medical physics, biophysics, radiologic physics, medical health physics, or a closely related science or engineering discipline from an accredited college or university.
- College coursework in the biological sciences with at least one course in biology or radiation biology and one course in anatomy, physiology, or a similar topic related to the practice of medical physics.
- Documented experience in a clinical CT environment conducting at least 10 CT performance evaluations under the direct supervision of a board-certified medical physicist.

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

**Standard HR.01.02.05**

The organization has the necessary staff to support the care, treatment, or services it provides.

**Elements of Performance for HR.01.02.05**

10. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The organization directs and staffs nursing services to meet patient needs.

11. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The organization delineates patient care, treatment, or service responsibilities for all nursing personnel.

12. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** Nursing services follow recognized standards of practice.

13. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** A registered nurse is available to provide emergency treatment whenever a patient is present in the organization. (*See also PC.02.01.09, EP 4*)
Note: Available refers to on the premises and sufficiently free from other duties, allowing the registered nurse to respond rapidly to emergency situations.

**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. *(See also HR.01.01.01, EP 32)*

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. *(See also HR.01.01.01, EP 32)*

3. For organizations that elect The Joint Commission Primary Care Medical Home option: The primary care clinician and the interdisciplinary team members function within their scope of practice and in accordance with privileges granted. *(For more information, refer to Standards HR.01.06.01 and HR.02.01.03)*

4. Staff supervise students when they provide patient care, treatment, or services as part of their training.

**Introduction to Standard HR.01.04.01**

Orientation is a process that gives the organization the opportunity to inform staff and licensed independent practitioners about its values, culture, and procedures. It is very important that staff begin working with an understanding of how their jobs contribute to patient safety and the quality of care, treatment, or services the organization provides. Some important questions that can be answered for staff through orientation include how to prevent and control infections, how to exhibit sensitivity to cultural diversity, and how to respect patient rights.

**Standard HR.01.04.01**

The organization provides orientation to staff.
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, or services; the environment of care; and infection control.

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
   - Sensitivity to cultural diversity based on their job duties and responsibilities
   - Patient rights, including ethical aspects of care, treatment, or services and the process used to address ethical issues based on their job duties and responsibilities

Completion of this orientation is documented.

Introduction to Standard HR.01.05.03

Education and training are important because they help maintain a competent workforce. The standard uses the terms education and training because these words are often used interchangeably. Generally, education can be thought of as the development of knowledge and training as the development of skills. However, the standard does not contain requirements specific to education and requirements specific to training. Instead, it speaks to areas in which staff should receive education or training depending on staff and organization needs. These areas include education and training specific to changes in staff responsibilities, the needs of the patient population, and the need and way(s) to report unanticipated adverse events.

Education and training can be provided through in-person instruction, demonstration, or independent study and can, of course, make use of computer technology.

While not required by the standard, some things an organization may want to look at in order to identify areas for development of education and training include the following:
Results of performance improvement initiatives that point to the need for staff education and training

- Staff needs identified through competence assessments or performance evaluations
- Topics that are particularly critical to patient safety
- Changes in technology or practices

**Standard HR.01.05.03**
Staff participate in ongoing education and training.

**Elements of Performance for HR.01.05.03**

1. ⓕ Staff participate in ongoing education and training to maintain or increase their competency and, as needed, when staff responsibilities change. Staff participation is documented.

   *For ambulatory surgical centers that elect to use The Joint Commission deemed status option:*

   Staff participate in ongoing education and training with respect to their roles in the fire response plan. (For information on staff’s roles in the fire response plan, see EC.02.03.01, EP 10.)

14. ⓕ The organization verifies and documents that technologists who perform diagnostic computed tomography (CT) examinations participate in ongoing education that includes annual training on the following:
Radiation dose optimization techniques and tools for pediatric and adult patients addressed in the Image Gently® and Image Wisely® campaigns

Safe procedures for operation of the types of CT equipment they will use

**Note 1:** Information on the Image Gently and Image Wisely initiatives can be found online at [http://www.imagegently.org](http://www.imagegently.org) and [http://www.imagewisely.org](http://www.imagewisely.org), respectively.

**Note 2:** This element of performance does not apply to CT systems used for therapeutic radiation treatment planning or delivery, or for calculating attenuation coefficients for nuclear medicine studies.

**Note 3:** This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.

25. The organization verifies and documents that technologists who perform magnetic resonance imaging (MRI) examinations participate in ongoing education that includes annual training on safe MRI practices in the MRI environment, including the following:

- Patient screening criteria that address ferromagnetic items, electrically conductive items, medical implants and devices, and risk for nephrogenic systemic fibrosis (NSF)
- Proper patient and equipment positioning activities to avoid thermal injuries
- Equipment and supplies that have been determined to be acceptable for use in the MRI environment (MR safe or MR conditional)†
- MRI safety response procedures for patients who require urgent or emergent medical care
- MRI system emergency shutdown procedures, such as MRI system quench and cryogen safety procedures
- Patient hearing protection
- Management of patients with claustrophobia, anxiety, or emotional distress

† Terminology for defining the safety of items in the magnetic resonance environment is provided in ASTM F2503 Standard Practice for Marking Medical Devices and Other Items for Safety in the Magnetic Resonance Environment (http://www.astm.org).
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.

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.

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 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.

5. ☐ Staff competence is initially assessed and documented as part of orientation.

6. ☐ Staff competence is assessed and documented once every three years, or more frequently as required by organization policy or in accordance with law and regulation.

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.

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.

5. When a licensed independent practitioner brings a nonemployee individual into the organization to provide care, treatment, or services, the organization reviews the individual’s competencies and performance at the same frequency as individuals employed by the organization.

Note: This review can be accomplished either through the organization’s regular process or with the licensed independent practitioner who brought staff into the organization.
Introduction to Standard HR.02.01.03

One of the most important and difficult responsibilities of an organization is deciding whether licensed independent practitioners are competent to provide quality, safe patient care. Before the organization can grant privileges, it must ascertain that licensed independent practitioners have the necessary credentials to perform their privileges. To grant privileges to licensed independent practitioners, the organization must collect, verify, and assess information related to their credentials, including current licensure, relevant training, current competence, and the ability to perform the clinical privileges that they have requested.

Verifying current licensure tells the organization that licensed independent practitioners are appropriately licensed to practice as required by state and/or federal law. Before granting initial, renewed, or revised privileges and at the time of licensure expiration, the organization documents required current licensure of a licensed independent practitioner using primary sources, if available.

Verifying relevant training tells the organization about licensed independent practitioners’ clinical knowledge and skills. This verification must be obtained from the primary source of each specific credential. Primary sources include the specialty certifying boards and letters from professional schools, and from postgraduate education or postdoctoral programs for completion of training. When it is not possible to obtain verification from the primary source, the organization may use reliable secondary sources, provided that the organization documents its attempt to contact the primary source. An example of a reliable secondary source would be another organization that has documented primary source verification of the applicant’s credentials.

The organization is also responsible for evaluating current challenges to licensure or registration; voluntary and involuntary relinquishment of licensure and registration; voluntary and involuntary termination of medical staff membership at another organization; voluntary and involuntary limitation, reduction, or loss of clinical privilege; and any professional liability actions that resulted in a final judgment against the applicant. This kind of information can be obtained through self-reporting by the practitioner, the Federation of State Medical Boards, and queries to the National Practitioner Data Bank.

Standard HR.02.01.03

The organization grants initial, renewed, or revised clinical privileges to individuals who are permitted by law and the organization to practice independently.
Elements of Performance for HR.02.01.03

1. The organization follows a process, approved by its leaders, to grant initial, renewed, or revised privileges and to deny privileges.

2. Before granting initial privileges, the organization verifies the identity of the individual seeking privileges by viewing a valid picture identification issued by a state or federal agency (for example, a driver’s license or passport).

3. Before granting initial or revised privileges, the organization uses primary sources when documenting training specific to the privileges requested.

Note 1: The verification of relevant training informs the organization of the licensed independent practitioner’s clinical knowledge and skill set. Verification must be obtained from the primary source of the specific credential. Primary sources include the specialty certifying boards approved by the American Dental Association for a dentist’s board certification, letters from professional schools (for example, medical, dental, nursing) and letters from postgraduate education or postdoctoral programs for completion of training. Designated equivalent sources include, but are not limited to, the following:

- The American Medical Association (AMA) Physician Masterfile for verification of a physician’s US and Puerto Rico medical school graduation and residency completion
- The American Board of Medical Specialties (ABMS) for verification of a physician’s board certification
- The Educational Commission for Foreign Medical Graduates (ECFMG) for verification of a physician’s graduation from a foreign medical school
- The American Osteopathic Association (AOA) Physician Database for predoctoral education accredited by the AOA Bureau of Professional Education, postdoctoral education approved by the AOA Council on Postdoctoral Training, and Osteopathic Specialty Board Certification
- The Federation of State Medical Boards (FSMB) for all actions against a physician’s medical license
- The American Academy of Physician Assistants (AAPA) Profile for physician assistant education, provided through the AMA Physician Profile Service (https://profiles.ama-assn.org/amaprofiles/)

Note 2: A primary source of verified information may designate to an agency the role of communicating credentials information. The designated agency then becomes acceptable to be used as a primary source.
Note 3: An external organization (for example, a credentials verification organization [CVO]) or a Joint Commission–accredited health care organization functioning as a CVO may be used to collect credentialing information. Both of these organizations must meet the CVO guidelines listed in the Glossary.

Note 4: When it is not possible to obtain information from the primary source, reliable secondary sources may be used. A reliable secondary source could be another health care organization that has documented primary source verification of the applicant’s credentials.

4. All licensed independent practitioners that provide care possess a current license, certification, or registration, as required by law and regulation. ❄

5. Before granting initial, renewed, or revised privileges and at the time of licensure expiration, the organization documents required current licensure of a licensed independent practitioner using primary sources, if available.

Note 1: A primary source of verified information may designate to an agency the role of communicating credentials information. The designated agency then becomes acceptable to be used as a primary source.

Note 2: An external organization (for example, a credentials verification organization [CVO]) or a Joint Commission–accredited health care organization functioning as a CVO may be used to collect credentialing information. Both of these organizations must meet the CVO guidelines listed in the Glossary.

Note 3: Verification of current licensure with the primary source through a secure electronic communication or by telephone is acceptable if this verification is documented.

6. Before granting initial, renewed, or revised privileges to a licensed independent practitioner, the organization’s leadership documents current evidence, which includes peer and/or faculty recommendations, of the individual’s ability to perform the privileges requested.

7. Before granting renewed or revised privileges to a licensed independent practitioner, the organization does following:
   - Reviews information from any of its performance improvement activities pertaining to professional performance, judgment, and clinical or technical skills.
- Evaluates the results of any peer review of the individual’s clinical performance.
- Reviews any clinical performance in the organization that is outside acceptable standards.

Before granting initial, renewed, revised, or temporary privileges to a licensed independent practitioner, leadership evaluates the following:

10. The applicant’s written statement that no health problems exist that could affect his or her ability to perform the requested privileges.

**Note:** Organizations should consider the applicability of the Americans with Disabilities Act to their credentialing and privileging activities, and, if applicable, review their policies and procedures. In addition, federal entities are required to comply with the Rehabilitation Act of 1974.

11. Before granting initial, renewed, or revised privileges to a licensed independent practitioner, leadership evaluates the following:
- Any challenges to licensure or registration

**Note:** The challenges addressed here are those that are in the process of an active investigation by the state licensing board.
- Any voluntary and involuntary relinquishment of license or registration
- Any voluntary and involuntary termination of medical staff membership at another organization
- Any voluntary or involuntary limitation, reduction, or loss of clinical privileges
- Any professional liability actions that resulted in a final judgment against the applicant
- Information from the National Practitioner Data Bank
- Whether the requested privileges are consistent with the population served by the organization
- Whether the requested privileges are consistent with the site-specific care, treatment, or services provided by the organization

19. Before granting renewed or revised privileges to a licensed independent practitioner, the organization confirms the licensed independent practitioner’s adherence to organization policies, procedures, rules, and regulations.

20. The organization uses current, written, privileging information as the basis for granting or denying all privileges for licensed independent practitioners.
21. The organization grants initial, renewed, or revised privileges for no longer than a two-year period.

24. The organization notifies the requesting practitioner about the decision to grant, renew, or deny requested privileges. The notification may be in either written or electronic format.

25. The scope and content of patient services provided by a licensed independent practitioner is limited to the granted initial, renewed, or revised privileges.

27. **For organizations providing telemedicine services to patients at a hospital:** Before granting renewed or revised privileges, leaders do the following:
   - Evaluate the comparison of relevant practitioner-specific data to aggregate data
   - Evaluate morbidity and mortality data

   **Note:** Leaders chosen to evaluate credentialing and privileging information of a licensed independent practitioner who provides services through a telemedical link should, whenever possible, represent disciplines and expertise consistent with the privileges being sought.

29. **For organizations providing telemedicine services to patients at a hospital:** The organization obtains peer recommendations from practitioners who are in the same professional discipline as the applicant requesting privileges and who have personal knowledge of the applicant’s ability to practice.

30. **For organizations providing telemedicine services to patients at a hospital:** Peer recommendations for applicants requesting privileges include information on the applicant’s relevant training and experience, current competence, and health status.

31. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** Medical staff members are legally and professionally qualified for the positions to which they are appointed.

32. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** Medical staff members are legally and professionally qualified to perform the privileges granted.
33. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** Physicians who perform surgery in the ambulatory surgical center have been granted clinical privileges to do so by the ambulatory surgical center’s governing body.

34. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** Medical staff are accountable to the governing body.

35. ☐ Before granting initial or revised privileges to physicians responsible for interpreting sleep studies, the organization verifies that they have at least one of the following qualifications:
   - Certification in Sleep Medicine by the American Board of Sleep Medicine (ABSM) or by a member board of either the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA)
   - A completed fellowship in sleep medicine through an Accreditation Council for Graduate Medical Education (ACGME)–accredited program. Following the completed fellowship, certification in sleep medicine is completed within two examination cycles through the American Board of Sleep Medicine (ABSM) or a member board of either the American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA).

**Standard HR.02.01.05**

The organization may grant temporary privileges.

**Elements of Performance for HR.02.01.05**

1. ☐ The organization follows a process for granting temporary privileges to licensed independent practitioners new to the organization or to meet important patient needs.

2. ☐ Before the organization grants temporary privileges either to a licensed independent practitioner new to the organization or to meet important patient needs, the organization does the following:
   - Uses primary source verification to document current licensure
   - Uses primary source verification to document current competency
   - Uses primary source verification to document the individual’s training
   - Evaluates practitioner-specific information from the National Practitioner Data Bank
   - Evaluates any involuntary termination of medical staff membership at another organization

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
- Evaluates any voluntary or involuntary limitation, reduction, or loss of clinical privileges

**Note 1:** A primary source of verified information may designate to an agency the role of communicating credentials information. The designated agency then becomes acceptable to be used as a primary source.

**Note 2:** An external organization (for example, a credentials verification organization [CVO]) or a Joint Commission–accredited health care organization functioning as a CVO may be used to collect credentialing information. Both of these organizations must meet the CVO guidelines listed in the Glossary.

9. The administrator or the administrator’s designee grants temporary privileges either to licensed independent practitioners new to the organization or to meet important patient needs upon recommendation of clinical leadership or the medical director.

10. Temporary privileges for licensed independent practitioners new to the organization do not exceed 120 days.

**Standard HR.02.02.01**

The organization provides orientation to licensed independent practitioners.

**Elements of Performance for HR.02.02.01**

1. The organization orient its licensed independent practitioners to key safety content it identifies before they provide 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, the environment of care, and infection control.

3. The organization orient licensed independent practitioners on the following:
   - Relevant policies and procedures
   - Their specific responsibilities, including those related to infection prevention and control and assessing and managing pain
   - Sensitivity to cultural diversity based on their specific responsibilities

   Completion of this orientation is documented.

**Standard HR.02.03.01**

The organization has a fair hearing and appeal process for addressing adverse credentialing and privileging decisions.

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
Elements of Performance for HR.02.03.01

1. The organization has a fair hearing and appeal process that includes the following:
   - Allows the scheduling of hearings and appeals
   - Identifies the procedures for hearings and appeals
   - Defines the composition of the hearing committee
   - Allows adverse decisions to be appealed

6. The organization consistently applies its fair hearing and appeal process.

Standard HR.02.04.01

For organizations providing telemedicine services to patients at a hospital: Leadership implements a process to identify and manage matters of individual health or impairment for licensed independent practitioners that is separate from actions taken for disciplinary purposes.

Elements of Performance for HR.02.04.01

1. For organizations providing telemedicine services to patients at a hospital: The organization educates staff and licensed independent practitioners about how to recognize risk criteria for illness and impairment in licensed independent practitioners.

2. For organizations providing telemedicine services to patients at a hospital: The organization has a process for licensed independent practitioners to refer themselves for evaluation, diagnosis, and treatment of illness or impairment.

3. For organizations providing telemedicine services to patients at a hospital: The organization has a process for staff and licensed independent practitioners to confidentially report concerns about a perceived illness or impairment of a licensed independent practitioner.

4. For organizations providing telemedicine services to patients at a hospital: The organization has a process to refer licensed independent practitioners who have an illness or impairment to internal or external professional resources for evaluation, diagnosis, and treatment of the concern or condition.
5. **For organizations providing telemedicine services to patients at a hospital:** The organization has a process to protect the confidentiality of a licensed independent practitioner who seeks a referral or who is referred for assistance, except as limited by applicable law, ethical obligation, or when the health and safety of a patient is threatened.

6. **For organizations providing telemedicine services to patients at a hospital:** The organization has a process to evaluate the credibility of a complaint, allegation, or concern about the possible illness or impairment of a licensed independent practitioner.

7. **For organizations providing telemedicine services to patients at a hospital:** The organization has a process to monitor the licensed independent practitioner receiving treatment and the safety of his or her patients until treatment is completed and, if required, periodically thereafter.

8. **For organizations providing telemedicine services to patients at a hospital:** The organization has a process for staff and licensed independent practitioners to report to leadership instances in which a licensed independent practitioner is providing unsafe care.
9. **For organizations providing telemedicine services to patients at a hospital:**
   Leadership has a process to initiate appropriate action if a licensed independent practitioner fails to complete required treatment.

**Standard HR.02.04.03**

**For organizations providing telemedicine services to patients at a hospital:** The organization has a process for focused review of a licensed independent practitioner’s performance.

**Elements of Performance for HR.02.04.03**

1. **For organizations providing telemedicine services to patients at a hospital:** The organization defines the special circumstances requiring a focused review of a licensed independent practitioner’s performance.

2. **For organizations providing telemedicine services to patients at a hospital:** The organization’s leaders are involved in the focused review process.

3. **For organizations providing telemedicine services to patients at a hospital:** The focused review process includes a method for selecting focused review panels.

4. **For organizations providing telemedicine services to patients at a hospital:** The focused review process includes time frames for conducting focused review activities.

5. **For organizations providing telemedicine services to patients at a hospital:** The focused review process includes the circumstances that require external peer review.

6. **For organizations providing telemedicine services to patients at a hospital:** The focused review process includes evaluation of clinical privileges for individuals whose performance is under review.

7. **For organizations providing telemedicine services to patients at a hospital:** The focused review process includes provisions for participation by the licensed independent practitioner whose performance is being reviewed.

8. **For organizations providing telemedicine services to patients at a hospital:** The focused review process includes communicating to the appropriate parties the findings, recommendations, and any actions taken to improve practitioner performance.
9. **For organizations providing telemedicine services to patients at a hospital:** The organization follows its focused review process.

**Standard HR.03.01.01**

*For organizations that elect The Joint Commission Primary Care Medical Home option:*

Qualified individuals serve in the role of primary care clinician.

**Element of Performance for HR.03.01.01**

1. **For organizations that elect The Joint Commission Primary Care Medical Home option:** Primary care clinicians have the educational background and broad-based knowledge and experience necessary to handle most medical and other health care needs of the patients who selected them. This includes resolving conflicting recommendations for care. A primary care clinician is a doctor of medicine or doctor of osteopathy, or an advanced practice nurse or physician assistant practicing in collaboration with a doctor of medicine or doctor of osteopathy. The term “collaboration” in this context means that health care providers work together to meet the needs of the patient. It is not the intent of this requirement to impose additional restrictions on the scope of practice of an advanced practice nurse, nor is it meant to preempt applicable state law. (For more information, refer to Standards HR.01.06.01 and HR.02.01.03)
Infection Prevention and Control (IC)

Overview
When most health care professionals think of infection prevention and control measures, they think of the need to prevent and control hospital–acquired infections. However, the ambulatory care setting has its own needs for infection prevention and control. Even though patients do not generally stay overnight at ambulatory care centers or undergo the kind of extensive care typically received in a hospital or nursing and rehabilitation center, ambulatory care staff do encounter health care–associated infections, sometimes received elsewhere, that need to be controlled.

Certainly, all ambulatory care centers, regardless of location, should be on the lookout for infections. The types of infections they are likely to encounter depend heavily on the specific risks faced by the organization’s location, the population it serves, and the services it provides. For example, most ambulatory care centers know to be on the alert for cases of Methicillin-resistant Staphylococcus aureus (MRSA) and other multidrug-resistant infections. Ambulatory care centers that serve particular populations, such as those on college campuses, are likely to encounter other types of infections such as sexually transmitted diseases (STDs), while those working with prison populations are likely to encounter patients with acquired immunodeficiency syndrome (AIDS) and tuberculosis. Centers working in low income areas may encounter higher rates of patients with community-acquired infections, while ambulatory care centers working primarily with the elderly are likely to encounter higher rates of pneumonia. Clearly, infection prevention and control is important to all ambulatory care centers and all staff, regardless of position, need to observe proper infection prevention and control techniques at all times.

To help reduce the possibility of acquiring and transmitting an infection, ambulatory care centers should establish a systematic infection prevention and control program. The activities the organization adopts 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 an ambulatory health care practitioner might encounter, including a sudden influx of potentially infectious patients. The standards are designed to assist ambulatory care centers, both large and small, in developing and maintaining an effective program that covers a wide range of situations.

These standards address activities of planning, implementation, and evaluation and are based on the following conditions necessary to establish and operate an effective infection prevention and control program. Every ambulatory care center, regardless of its size or the services it provides, should do the following:

- Recognize that its infection prevention and control program plays a major role in its efforts to improve patient safety and quality of care
- Demonstrate leadership’s commitment to infection prevention and control by endorsing and participating in the organization’s efforts to control infection, provide resources, and encourage improvement
- See that staff collaborate with each other when designing and implementing the infection prevention and control program
- Regularly assess its infection prevention and control program by using an epidemiological approach that consists of surveillance, data collection, analysis, and trend identification
- Coordinate its program with the larger community
- Take into account that the potential exists for an infection outbreak so extensive that it overwhelms the ambulatory care center’s resources
Chapter Outline

I. Planning
   A. Responsibility (IC.01.01.01)
   B. Resources (IC.01.02.01)
   C. Risks (IC.01.03.01)
   D. Goals (IC.01.04.01)
   E. Activities (IC.01.05.01)
   F. Influx (IC.01.06.01)

II. Implementation
   A. Activities (IC.02.01.01)
   B. Medical Equipment, Devices, and Supplies (IC.02.02.01)
   C. Transmission of Infections (IC.02.03.01)
   D. Influenza Vaccinations (IC.02.04.01)

III. Evaluation and Improvement (IC.03.01.01)
Standards, Rationales, and Elements of Performance

Introduction to Standards IC.01.01.01 Through IC.01.06.01 – Planning

For any infection prevention and control activities to be effective, they need to be well managed. Toward that end, the ambulatory care center assigns one or more people to be responsible for the development of the activities and their daily implementation. Large, complex ambulatory care centers may want to employ a contractor or consultant. Smaller organizations may do well by simply designating a current employee. Each 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 knowledge in infection prevention and control and other staff members who can perform a risk assessment and then build activities based upon their risks. The individual responsible for infection prevention and control may want to consult with community leaders and other outside infection control experts who can provide important information about the ambulatory care center’s population and associated health risks.

The results of the ambulatory care center’s infection risk assessment should be prioritized, 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 patients and the community. These goals should lead to focused activities, based on relevant professional guidelines and sound practices.

Standard IC.01.01.01

The organization identifies the individual(s) responsible for infection prevention and control.

Elements of Performance for IC.01.01.01

3. The organization assigns responsibility for the management of infection prevention and control activities. (See also HR.01.01.01, EP 1; LD.03.06.01, EP 3)
5. For ambulatory surgical centers that elect to use The Joint Commission deemed status option: The infection control program is under the direction of a designated and qualified professional who has training in infection control.

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)
2. The organization provides for laboratory resources when needed to support infection prevention and control activities.
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 transmitting 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 infection surveillance and control data
2. The organization prioritizes the identified risks for acquiring and transmitting 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 transmitting infections.

Note: See NPSG.07.01.01 for hand hygiene guidelines.

Element of Performance for IC.01.04.01
1. The organization’s written infection prevention and control goals include the following:
   - Addressing its prioritized risks
   - Limiting unprotected exposure to pathogens

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
Limiting the transmission of infections associated with procedures
Limiting the transmission of infections associated with the use of medical equipment, devices, and supplies
Improving compliance with hand hygiene guidelines (See also NPSG.07.01.01, EP 1)

Standard IC.01.05.01
The 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.

For ambulatory surgical centers that elect to use The Joint Commission deemed status option: The organization considers, selects, and implements nationally recognized infection control program guidelines.

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 method for investigating outbreaks of infectious disease within the organization. (See also IC.02.01.01, EP 5)

6. Everyone who works in the organization has responsibilities for preventing and controlling infection.

9. For ambulatory surgical centers that elect to use The Joint Commission deemed status option: The organization plans infection prevention and control activities, including surveillance, to minimize, reduce, or eliminate the risk of infection and communicable diseases. These activities are documented.

11. For ambulatory surgical centers that elect to use The Joint Commission deemed status option: The infection control program includes a plan of action for preventing, identifying, and managing infections and communicable diseases and for immediately implementing corrective and preventive measures that result in improvement.

Standard IC.01.06.01
The organization prepares to respond to an influx of potentially infectious patients.

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
Elements of Performance for IC.01.06.01

2. The organization obtains current clinical and epidemiological information from its resources regarding new infections that could cause an influx of potentially 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 influx of potentially infectious patients.

4. The organization describes, in writing, how it will respond to an influx of potentially infectious patients. (See also EM.01.01.01, EP 2)

Note: One acceptable response is to decide not to accept patients.

Introduction to Standards IC.02.01.01 Through IC.02.03.01 – Implementation

The activities of infection prevention and control should be practical and involve collaboration between staff. Everyone who works in the organization should have a role and hold each other accountable. Important infection prevention and control information should be available to both staff and patients. Standard and transmission-based precautions should be used, and any outbreak of infection within the organization should be investigated.

Standard IC.02.01.01

The organization implements infection prevention and control activities.

Elements of Performance for IC.02.01.01

1. The organization implements its planned infection prevention and control activities and practices, including surveillance, to reduce the risk of infection. R

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) R

* 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).
Note: Standard precautions are infection prevention and control measures to protect against possible exposure to infectious agents. These precautions are general and applicable to all patients.

3. The organization implements transmission-based precautions† in response to the pathogens that are suspected or identified within the organization’s service setting and community.

Note: Transmission-based precautions are infection prevention and control measures to protect against exposure to a suspected or identified pathogen. These precautions are specific and based on the way the pathogen is transmitted. Categories include contact, droplet, airborne, or a combination of these precautions.

5. The organization investigates outbreaks of infectious disease within the organization. (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)

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.

† For further information regarding transmission-based precautions, refer to the website of the Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/hai/ (Infection Control in Healthcare Settings).
9. The organization reports infection surveillance, prevention, and control information to local, state, and federal public health authorities in accordance with law and regulation. R

10. When the organization becomes aware that it transferred a patient who has an infection requiring monitoring, treatment, and/or isolation, it informs the receiving organization.

11. When the organization becomes aware that it received a patient from another organization who has an infection requiring action, and the infection was not communicated by the referring organization, it informs the referring organization.

Note: Infections requiring action include those that require isolation and/or public health reporting or those that may aid in the referring organization’s surveillance.

Standard IC.02.02.01

The organization reduces the risk of infections associated with medical equipment, devices, and supplies.

Rationale for IC.02.02.01

The Centers for Disease Control and Prevention (CDC) estimate that 46.5 million surgical procedures are performed in hospitals and ambulatory settings each year; this includes approximately 5 million gastrointestinal endoscopies. Each of these procedures involves contact with a medical device or surgical instrument. A major risk of all such procedures is the introduction of pathogens that can lead to infection. Additionally, many more people are at risk of developing an infection from contact with medical equipment, devices, or supplies while seeking other health services. Failure to properly clean, disinfect, or sterilize, and use or store medical equipment, devices, and supplies, not only poses risks for the person seeking health services, but also carries the risk for person-to-person transmission of infections.

There are numerous steps involved in the cleaning, disinfecting, and sterilizing of medical equipment, devices, and supplies. It is critical that health care workers follow standardized practices to minimize infection risks related to medical equipment, devices, and supplies. In order to maintain a reliable system for controlling this process, organizations pay attention to the following:

- Orientation, training, and competency of health care workers who are processing medical equipment, devices, and supplies
- Levels of staffing and supervision of the health care workers who are processing medical equipment, devices, and supplies
- Standardization of process regardless of whether it is centralized or decentralized
- Reinforcing the process (for example, the use of placards which list the steps to be followed, according to manufacturer’s guidelines)
- Ongoing quality monitoring

**Elements of Performance for IC.02.02.01**

The organization implements infection prevention and control activities when doing the following:

1. Cleaning and performing low-level disinfection of medical equipment, devices, and supplies.⁵

⁵ For further information regarding cleaning and performing low-level disinfection of medical equipment, devices, and supplies, refer to the website of the Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/hicpac/Disinfection_Sterilization/acknowledg.html.
Note: Low-level disinfection is used for items such as stethoscopes and blood glucose meters. Additional cleaning and disinfecting is required for medical equipment, devices, and supplies used by patients who are isolated as part of implementing transmission-based precautions.

2. Performing intermediate and high-level disinfection and sterilization of medical equipment, devices, and supplies.\[See also EC.02.04.03, EP 4\] R

Note: Sterilization is used for items such as implants and surgical instruments. High-level disinfection may also be used if sterilization is not possible, as is the case with flexible endoscopes.

3. Disposing of medical equipment, devices, and supplies. R

4. Storing medical equipment, devices, and supplies. R

5. When reprocessing single-use devices, the organization implements infection prevention and control activities that are consistent with regulatory and professional standards. R

**Standard IC.02.03.01**

The organization works to prevent the transmission of infectious disease among patients, licensed independent practitioners, and staff.

**Elements of Performance for IC.02.03.01**

1. The organization makes screening for exposure and/or immunity to infectious disease available to licensed independent practitioners and staff who may come in contact with infections at the workplace.

2. When licensed independent practitioners or staff have, are suspected of having, or have been occupationally exposed to an infectious disease that puts others at risk, the organization provides them with or refers them for assessment and potential testing, prophylaxis/treatment, or counseling.

\[For further information regarding performing intermediate and high-level disinfection of medical equipment, devices, and supplies, refer to the website of the Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/hicpac/Disinfection_Sterilization/acknowledg.html (Sterilization and Disinfection in Healthcare Settings).\]
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).

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 applicable to staff and licensed independent practitioners only when care, treatment, or services are provided on site. When care, treatment, or services are provided off site, such as with telemedicine or telephone consultation, this standard is not applicable to off-site staff and licensed independent practitioners.

Elements of Performance for IC.02.04.01

1. The 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 offers the influenza vaccination on site to licensed independent practitioners and staff or facilitates their obtaining the influenza vaccination off site.

4. The organization includes in its infection control plan the goal of improving influenza vaccination rates. (For more information, refer to Standard IC.01.04.01.)

5. The organization sets incremental influenza vaccination goals, consistent with achieving the 90% rate established in the national influenza initiatives for 2020.


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 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 collects and reviews the reasons given by staff and licensed independent practitioners for declining the influenza vaccination. This collection and review occurs at least annually.

8. The organization improves its vaccination rates according to its established, internal goals at least annually. (For more information, refer to Standards PI.02.01.01 and PI.03.01.01.)

9. The organization provides influenza vaccination rate data to organization leaders at least annually.

**Introduction to Standard IC.03.01.01—Evaluation and Improvement**

Evaluation and improvement of the infection prevention and control activities are important steps in the ambulatory care center’s efforts to control and prevent infection. Infection prevention and control practices should become a routine part of the care, treatment, or services the ambulatory care center provides to patients. They expect and deserve hygienic and safe care even if their contact with the ambulatory care center does not extend beyond a single visit. 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 its infection prevention and control activities annually and whenever risks significantly change. The evaluation includes a review of the following:
   - The infection prevention and control prioritized risks
   - The infection prevention and control goals (See also NPSG.07.01.01, EP 2)
   - Implementation of infection prevention and control activities
Outcomes of 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 the evaluation when revising the prioritized risks, goals, and activities for preventing and controlling infection.
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)
Standards, Rationales, and Elements of Performance

Introduction to Standard IM.01.01.01
Planning is the most critical part of the organization’s information management process and requires the collaborative involvement of all levels and areas of the organization. The organization’s plan for information management considers the full spectrum of data generated and used by the organization; financial data, human resources data, supply inventories, and health information are examples of the different types of data that are considered in the information management planning process. Planning for the management of information does not necessarily result in a single, comprehensive written information management plan; however, planning does establish clear relationships between the organization’s needs and its goals. In addition to the organization’s goals, the organization’s mission, services, staff, patient safety practices, modes of service delivery, resources, and technology are considered during the information management planning process.

The flow of information within the organization, as well as to and from external organizations, is another important consideration for information management planning. Planning takes into account the data and information required to support relationships with outside providers, services, contractors, purchasers, and payers. By identifying internal and external information needs, organizations can make information available when and where it is needed. Organizations that understand the flow of information can achieve efficient data collection and distribution, along with effective security of health information.

Standard IM.01.01.01
The 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 Management Plan, conducting regularly scheduled data backups, and testing data restoration procedures.

Regardless of whether an organization uses a paper-based system or an electronic system, a plan to address the process for information continuity, including knowledge-based information, should be in place. Organizations that plan for maintaining access to electronic information systems by using various electronic backup and 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)
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. For ambulatory surgical centers that elect to use The Joint Commission deemed status option and for rural health clinics and federally qualified health centers: The organization implements a system of medical documentation that preserves patient information during an emergency.

Note: For ambulatory surgical centers that elect to use The Joint Commission deemed status option: The organization must comply with Section 45 of the Code of Federal Regulations parts 160 and 164, generally known as the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules.

* 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).
2. The organization implements its policy on the privacy of health information. (See also RI.01.01.01, EP 7)

**Note:** For ambulatory surgical centers that elect to use The Joint Commission deemed status option: The organization must comply with Section 45 of the Code of Federal Regulations parts 160 and 164, generally known as the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules.

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)

**Note:** For ambulatory surgical centers that elect to use The Joint Commission deemed status option: The organization must comply with Section 45 of the Code of Federal Regulations parts 160 and 164, generally known as the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules.

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)

**Note:** For ambulatory surgical centers that elect to use The Joint Commission deemed status option: The organization must comply with Section 45 of the Code of Federal Regulations parts 160 and 164, generally known as the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules.
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.

Note: For ambulatory surgical centers that elect to use The Joint Commission deemed status option: The organization must comply with Section 45 of the Code of Federal Regulations parts 160 and 164, generally known as the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules.
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.

   **Note:** For ambulatory surgical centers that elect to use The Joint Commission deemed status option: The organization must comply with Section 45 of the Code of Federal Regulations parts 160 and 164, generally known as the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules.

6. The organization protects health information against loss, damage, unauthorized alteration, unintentional change, and accidental destruction.

7. The organization controls the intentional destruction of health information.

**Standard IM.02.02.01**

The organization effectively manages the collection of health information.

**Rationale for IM.02.02.01**

Within the organization, health information can come from multiple sources. The use of standardized formats and terminology can help clarify information that is used by different individuals for various purposes. Capturing data in standardized language can lead to greater data integrity and reliability, as well as 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.
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Note 2: The prohibited list applies to all orders, preprinted forms, and medication-related documentation. Medication-related documentation can be either handwritten or electronic.

Introduction to Standard IM.02.02.03
Standardizing the collection of data, a concept that is supported by the requirements of Standard IM.02.02.03, helps with the effective dissemination of data and information. Consistency in data collection systems (paper-based, electronic, or a combination) creates the foundation for retrieving and disseminating data and information in the most useful format. For information about data collection and dissemination, visit the websites of the Office of the National Coordinator for Health Information Technology (ONC) (http://www.healthit.gov/) and the Certification Commission for Healthcare Information Technology (CCHIT) (http://www.cchit.org).

Standard IM.02.02.03
The 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.
13. **For organizations in California that provide computed tomography (CT) services:**
The organization complies with radiation event reporting requirements specified in section 115113 of the California Health and Safety Code.

**Standard IM.03.01.01**
Knowledge-based information resources are available, current, and authoritative.

**Element of Performance for IM.03.01.01**

1. The organization provides access to knowledge-based information resources during hours of operation. *(See also IM.01.01.03, EP 2)*
Leadership (LD)

Overview
The safety and quality of care, treatment, or services depend on many factors, including the following:

- A culture that fosters safety as a priority for everyone who works in the organization
- The planning and provision of services that meet the needs of 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 populations? 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 diagnostic procedures or physical therapy.

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)
   D. Leaders’ Knowledge (LD.01.07.01)

II. Leadership Relationships
   A. Mission, Vision, and Goals (LD.02.01.01)
   B. Communication Among Leaders (LD.02.03.01)

III. Organization Culture and System Performance 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)
   C. Meeting Patient Needs (LD.04.03.01, 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)
Leadership Structure

Standards, Rationales, and Elements of Performance

Introduction to Leadership Structure, Standards LD.01.01.01 Through LD.01.07.01

Each organization, regardless of its complexity, has a structured leadership. Many leadership responsibilities directly affect the provision of care, treatment, or services, as well as the day-to-day operations of the organization. In some cases, these responsibilities will be shared among leaders, and in other cases, a particular leader has primary responsibility. 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.

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.

12. For ambulatory surgical centers that elect to use The Joint Commission deemed status option: The ambulatory surgical center has a governing body that assumes full legal responsibility for the operation of the ambulatory surgical center.

22. For ambulatory surgical centers that elect to use The Joint Commission deemed status option: The governing body is responsible for the following:
   - Determining, implementing, and monitoring policies governing the organization’s total operation and establishing expectations for safety throughout the organization.

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

- Defining, implementing, monitoring, and maintaining quality assurance and performance improvement activities
- Addressing identified priorities for quality assurance and performance improvement activities
- Evaluating the effectiveness of quality assurance and performance improvement activities

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.

Standard LD.01.07.01
Individual leaders have the knowledge needed for their roles in the organization or they seek guidance to fulfill their roles.

Elements of Performance for LD.01.07.01

2. Leaders are oriented to all of the following:
   - The organization’s mission and vision
   - The organization’s safety and quality goals
   - The organization’s structure and the decision-making process
   - The development of the budget as well as the interpretation of the organization’s financial statements
   - The population(s) served by the organization and any issues related to that population(s)
   - The individual and interdependent responsibilities and accountabilities of leaders as they relate to supporting the mission of the organization and to providing safe and quality care
   - Applicable law and regulation

3. Governance provides leaders with access to information and training in areas where they need additional skills or expertise.
Introduction to Leadership Relationships, Standards LD.02.01.01 and LD.02.03.01

How well leaders work together and manage conflict affects an organization’s performance. In fulfilling its role, the governance involves senior managers and leaders of the clinical staff in governance and management functions.

Good relationships thrive when leaders work together to develop the mission, vision, and goals of the organization; encourage honest and open communication; and address conflicts of interest.

Standard LD.02.01.01

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

Rationale for LD.02.01.01

The primary responsibility of leaders is to provide for the safety and quality of care, treatment, or services. The purpose of the organization’s mission, vision, and goals is to define how the organization will achieve safety and quality. The leaders are more likely to be aligned with the mission, vision, and goals when they create them together. The common purpose of the organization is most likely achieved when it is understood by all who work in or are served by the organization.

Elements of Performance for LD.02.01.01

1. Leaders work together to create the organization’s mission, vision and goals.
2. The organization’s mission, vision, and goals guide the actions of leaders.
3. Leaders communicate the mission, vision, and goals to staff and the population(s) the organization serves.

Standard LD.02.03.01

Leaders regularly communicate with each other on issues of safety and quality.
**Rationale for LD.02.03.01**
Leaders, who provide for safety and quality, must communicate with each other on matters affecting the organization and those it serves. The safety and quality of care, treatment, or services depend on open communication. Ideally, this will result in trust and mutual respect among those who work in the organization.

**Elements of Performance for LD.02.03.01**
1. Leaders discuss issues that affect the organization and the population(s) it serves, including the following:
   - Performance improvement activities
   - Reported safety and quality issues
   - Proposed solutions and their impact on the organization’s resources
   - Reports on key quality measures and safety indicators
   - Safety and quality issues specific to the population served
   - Input from the population(s) served

2. The organization establishes time frames for the discussion of issues that affect the organization and the population(s) it serves.

**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. 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.

**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.

**Standard LD.03.04.01**
The organization communicates information related to safety and quality to those who need it, including staff, licensed independent practitioners, patients, families, and external interested parties.
Rationale for LD.03.04.01
Effective communication is essential among individuals and groups within the 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 management.
5. Communication supports safety and quality throughout the organization. *(See also LD.04.04.05, EPs 6 and 12)*
6. When changes in the environment occur, the organization communicates those changes effectively.
7. Leaders evaluate the effectiveness of communication methods.

Standard LD.03.05.01
Leaders implement changes in existing processes to improve the performance of the organization.

Rationale for LD.03.05.01
Change is inevitable, and agile organizations are able to manage change and rapidly execute new plans. The ability of leaders to manage change is necessary for performance improvement, for successful innovation, and to meet environmental challenges. The organization integrates change into all relevant processes so that its effectiveness can be sustained, assessed, and measured.

Elements of Performance for LD.03.05.01
1. Structures for managing change and performance improvements exist that foster the safety of the 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. The management of change and performance improvement supports both safety and quality throughout the organization.

6. The organization’s internal structures can adapt to changes in the environment.

7. Leaders evaluate the effectiveness of processes for the management of change and performance improvement.

**Standard LD.03.06.01**

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

**Rationale for LD.03.06.01**

The safety and quality of care, treatment, or services are highly dependent on the people who work in the organization. The mission, scope, and complexity of services define the design of work processes and the skills and number of 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)*

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

5. Those who work in the organization adapt to changes in the environment.
6. Leaders evaluate the effectiveness of those who work in the organization to promote safety and quality.

**Introduction to Operations, Standards LD.04.01.01 Through LD.04.04.09**

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 or services that support patient safety and quality care, treatment, or services. Policies, procedures, resources, or 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.

   **Note:** 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 law. (See also WT.01.01.01, EP 1; WT.04.01.01, EP 1)

2. The organization provides care, treatment, or services in accordance with licensure requirements, laws, and rules and regulations.

3. Leaders act on or comply with reports or recommendations from external authorized agencies, such as accreditation, certification, or regulatory bodies.

* 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.
15. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The organization complies with part 493 of the Code of Federal Regulations.

**Note:** Part 493 of the Code of Federal Regulations requires organizations who perform laboratory testing to maintain compliance with the Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88).

19. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** Organizations that do not provide their own laboratory services have procedures for obtaining routine and emergency laboratory services from a certified laboratory in accordance with part 493 of the Code of Federal Regulations. The referral laboratory is certified in the associated specialties and subspecialties needed to perform tests ordered.

**Standard LD.04.01.03**
The organization develops an annual operating budget and, when needed, a long-term capital expenditure plan.

**Elements of Performance for LD.04.01.03**

1. Leaders solicit comments from those who work in the organization when developing the operational and capital budgets.

3. The operating budget reflects the organization’s goals and objectives.

4. Governance approves an annual operating budget and, when needed, a long-term capital expenditure plan.

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

**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, or sites providing patient care are directed by one or more qualified professionals or by a qualified licensed independent practitioner with clinical privileges.

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

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, or sites.

11. For organizations that elect The Joint Commission Primary Care Medical Home option: The organization evaluates how effectively the primary care clinician and the interdisciplinary team work in partnership with the patient to support the continuity of care and the provision of comprehensive and coordinated care, treatment, or services.

13. For ambulatory surgical centers that elect to use The Joint Commission deemed status option: If radiologic services are provided by the ambulatory surgical center, the governing body must appoint an individual qualified in accordance with state law and organizational policies who is responsible for making certain that all radiologic services are provided in accordance with law and regulation.

Note: The Joint Commission elements of performance that relate to laws and regulations for radiologic services are outlined in the ambulatory surgical center crosswalk on E-dition.

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.

2. The organization manages the implementation of policies and procedures.
10. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The organization establishes policies and procedures approved by the governing body for overseeing and evaluating the clinical activities of nonphysician practitioners who are assigned patient care responsibilities.

**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.

8. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The organization’s medical staff and governing body coordinate, develop, and revise policies and procedures that identify the types of emergency equipment required for use in operating rooms. *(See also PC.02.01.09, EP 10)*

**Standard LD.04.02.01**

The leaders address any conflict of interest involving licensed independent practitioners and/or staff that affects or has the potential to affect the safety or quality of care, treatment, or services.

**Elements of Performance for LD.04.02.01**

1. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The leaders define conflict of interest involving licensed independent practitioners or staff. This definition is in writing.
2. 🔴 The leaders develop a written policy that defines how the organization will address conflicts of interest involving licensed independent practitioners and/or staff.

3. Existing or potential conflicts of interest involving licensed independent practitioners and/or staff, as defined by the organization, are disclosed.

4. The organization reviews its relationships with other care providers, educational institutions, manufacturers, and payers to determine whether conflicts of interest exist and whether they are within law and regulation.

5. Policies, procedures, and information about the relationship between care, treatment, or services and financial incentives are available upon request to all patients, and those individuals who work in the organization, including staff and licensed independent practitioners.

6. 🔴 For ambulatory surgical centers that elect to use The Joint Commission deemed status option: The ambulatory surgical center discloses, where applicable, physician financial interests or ownership in the facility in accordance with 42 CFR Part 420. This disclosure information is in writing.

**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.

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.

7. Patients receive information about charges for which they will be responsible.

10. 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.

25. For ambulatory surgical centers that elect to use The Joint Commission deemed status option: The ambulatory surgical center reviews and amends the scope of procedures that the organization can perform, according to a timeframe determined by the organization.

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 means 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. 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. This standard does not apply to contracted services that are not directly related to patient care. In addition, contracts for consultation or referrals are not subject to the requirements in Standard LD.04.03.09. However, regardless of whether or not a contract is subject to this standard, the actual performance of any contracted service is evaluated at the other standards in this manual appropriate to the nature of the contracted service.

**Monitoring Contracted Services**

The expectations that leaders set for the performance of contracted services should reflect basic principles of risk reduction, safety, staff competence, and performance improvement. The requirements outlined in Standards HR.01.06.01, EC.01.01.01, EC.02.01.01, and PI.01.01.01 can provide ideas for setting expectations related to these topics. Additional ideas for expectations can also come from the elements of performance (EPs) found in specific standards applicable to the contracted service. Although leaders have the same responsibility for oversight of contracted services outside the 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 medical records
- Review of incident reports
- Review of periodic reports submitted by the individual or organization providing services under contractual agreement
Leadership

- 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 leaders anticipate the renegotiation or termination of a contractual agreement, planning needs to occur so that the continuity of care, treatment, or services is not disrupted.

Credentialing and Privileging

In most cases, each licensed independent practitioner providing services through a contractual agreement must be credentialed and privileged by the organization using his or her services, following the process described in the “Human Resources” (HR) chapter.

However, there are two special circumstances when this is not required:
- Off-site services provided by a Joint Commission–accredited contractor.
- Services provided by a pathologist through a contracted reference laboratory compliant with CLIA (Clinical Laboratory Improvement Amendments) regulations.

Standard LD.04.03.09

Care, treatment, or services provided through contractual agreement are provided safely and effectively.

Elements of Performance for LD.04.03.09

1. Clinical leaders have an opportunity to provide advice about the sources of clinical services to be provided through contractual agreement.

2. The organization describes, in writing, the nature and scope of services provided through contractual agreements.

3. Designated leaders approve contractual agreements.

4. Leaders monitor contracted services by establishing expectations for the performance of the contracted services.
Note: When the organization contracts with another accredited organization for patient care, treatment, or services to be provided off site, it can do the following:

- Verify that all licensed independent practitioners who will be providing patient care, treatment, or services have appropriate privileges by obtaining, for example, a copy of the list of privileges.
- Specify in the written agreement that the contracted organization will ensure that all contracted services provided by licensed independent practitioners will be within the scope of their privileges.

5. Leaders monitor contracted services by communicating the expectations in writing to the provider of the contracted services.

Note: A written description of the expectations can be provided either as part of the written agreement or in addition to it.

6. Leaders monitor contracted services by evaluating these services in relation to the organization’s expectations.

7. Leaders take steps to improve contracted services that do not meet expectations.

Note: Examples of improvement efforts to consider include the following:

- Increase monitoring of the contracted services.
- Provide consultation or training to the contractor.
- Renegotiate the contract terms.
- Apply defined penalties.
- Terminate the contract.

8. When contractual agreements are renegotiated or terminated, the organization maintains the continuity of patient care.

10. Reference and contract laboratory services meet the federal regulations for clinical laboratories and maintain evidence of the same.

Standard LD.04.04.01

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

Elements of Performance for LD.04.04.01

1. Leaders set priorities for performance improvement activities and patient health outcomes. (See also PI.01.01.01, EPs 1 and 3)
2. Leaders give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities. (See also PI.01.01.01, EPs 4, 6–8, 14, and 15)
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3. Leaders reprioritize performance improvement activities in response to changes in the internal or external environment.

4. Performance improvement occurs organizationwide.

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

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

16. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The infection control program is an integral part of the ambulatory surgical center’s quality assessment and performance improvement program.

17. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The governing body makes certain that the quality assessment and performance improvement program is defined, implemented, and maintained.

18. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The governing body makes certain that adequate staff, time, information systems, and training are allocated to the quality assessment and performance improvement program.

19. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The governing body makes certain that the performance improvement data collection methods, frequency, and details are appropriate.

20. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The ambulatory surgical center sets priorities for its performance improvement activities that affect health outcomes, patient safety, and quality of care.

21. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The ambulatory surgical center develops an ongoing, data-driven quality assessment and performance improvement program.

22. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The ambulatory surgical center implements its quality assessment and performance improvement program.
23. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The ambulatory surgical center maintains its quality assessment and performance improvement program.

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

   **Note:** Patient involvement may include activities such as participating on a quality committee.

26. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** Leaders establish priorities that consider the incidence, prevalence, and severity of high-volume, high-risk, or problem-prone areas found in performance improvement activities.

**Standard LD.04.04.03**

New or modified services or processes are well designed.

**Elements of Performance for LD.04.04.03**

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. (*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.*

5. The organization’s design of new or modified services or processes incorporates information about sentinel events.
7. Leaders involve staff and patients in the design of new or modified services or processes.

**Introduction to Standard LD.04.04.05**

This standard describes a safety program that integrates safety priorities into all processes, functions, or services within the organization, including patient care, support, and contract services. It addresses the responsibility of leaders to establish an organizationwide safety program; to proactively explore potential system failures; to analyze and take action on problems that have occurred; and to encourage the reporting of adverse events and close calls (“near misses”), both internally and externally. The organization’s culture of safety and quality supports the safety program (refer to Standard LD.03.01.01).

This standard does not require the creation of a new structure or office in the organization. It only emphasizes the need to integrate patient-safety activities, both existing and newly created, with the organization’s leadership, which is ultimately responsible for this integration.

**Standard LD.04.04.05**

The organization has an organizationwide, integrated patient safety program.

**Elements of Performance for LD.04.04.05**

1. The leaders implement an organizationwide patient safety program.
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. (*See also* PI.03.01.01, EP 10)
Note: Responses might include continuing to provide care, treatment, or services to those affected, containing the risk, and preserving factual information for subsequent analysis.

6. The leaders provide and encourage the use of systems for blame-free internal reporting of a system or process failure, or the results of a proactive risk assessment. (See also LD.03.04.01, EP 5; LD.04.04.03, EP 3; PI.03.01.01, EP 10)

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. (See also PI.03.01.01, EP 10)

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; PI.03.01.01, EP 10)*

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. The leaders encourage external reporting of significant adverse events, including voluntary reporting programs in addition to mandatory programs.
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Note: Examples of voluntary programs include The Joint Commission Sentinel Event Database and the US Food and Drug Administration (FDA) MedWatch. Mandatory programs are often state initiated.

Standard LD.04.04.09
The organization uses clinical practice guidelines to design or to improve processes that evaluate and treat specific diagnoses, conditions, or symptoms.

Rationale for LD.04.04.09
Clinical practice guidelines can improve the quality, utilization, and value of health care services. Clinical practice guidelines help practitioners and patients make decisions about preventing, diagnosing, treating, and managing selected conditions. These guidelines can also be used in designing clinical processes or in checking the design of existing processes. The organization identifies criteria that guide the selection and implementation of clinical practice guidelines so that they are consistent with its mission and priorities. Sources of clinical practice guidelines include the Agency for Healthcare Research and Quality, the National Guideline Clearinghouse, and professional organizations.

Elements of Performance for LD.04.04.09
1. The organization uses clinical practice guidelines to design or improve processes that evaluate and treat specific diagnoses, conditions, or symptoms.

2. The organization identifies criteria that guide the selection and implementation of guidelines to design or improve processes that evaluate and treat specific diagnoses, conditions, or symptoms.

3. The organization manages and evaluates the implementation of the guidelines to design or improve processes that evaluate and treat specific diagnoses, conditions, or symptoms.

4. The leaders of the organization review and approve the clinical practice guidelines that have been selected to design or improve processes that evaluate and treat specific diagnoses, conditions, or symptoms.

5. The organization monitors and reviews clinical practice guidelines for their effectiveness and modifies them as needed.
Comprehensive Accreditation Manual for Ambulatory Care
Life Safety (LS)

Overview
This chapter applies to sites of care that are considered ambulatory care occupancies. The National Fire Protection Agency’s (NFPA) *Life Safety Code®* (101-2012) defines an ambulatory care occupancy as a building or part of a building in which anesthesia or outpatient services are provided to four or more outpatients at the same time, making them incapable of saving themselves in emergencies. This chapter also applies to all ambulatory surgical centers seeking accreditation for Medicare certification purposes, regardless of the number of patients who are incapable of saving themselves in the event of an emergency within the organization.

When the ambulatory care organization occupies space in a building that it does not own, The Joint Commission will assess that space and all exits from that space to the outside at grade level. The Joint Commission will also expect to see that the ambulatory care organization works with the landlord to make sure that supporting building systems comply with the *Life Safety Code*. Examples of such systems include fire alarms and automatic sprinklers.

About This Chapter
Fire is a concern for everyone, but it is a special concern in ambulatory care 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 constitutes the content of this chapter. These standards focus on the importance of a fire-safe environment and buildings; however, The Joint Commission recognizes that people are equally important in reducing the risk of fire. The responsibilities of managing a safe environment (for example, identifying fire risks, conducting fire drills, maintaining fire protection equipment) by those who work in the organization are addressed in the “Environment of Care” (EC) chapter.

*Life Safety Code®* is a registered trademark of the National Fire Protection Association, Quincy, MA.
From time to time, building codes are updated to incorporate new technology that often cannot easily be introduced into older buildings. These settings tend to rely more on passive systems (such as doors and walls) for fire protection. In new buildings, fire protection is more often provided by active systems, such as fire alarms and automatic sprinkler systems. Existing ambulatory care occupancy requirements are found in Chapter 21 of the Life Safety Code (101-2000). New ambulatory care occupancy requirements are found in Chapter 20 of the Life Safety Code.

The Joint Commission uses the 2012 edition of the NFPA’s Life Safety Code as the source for the key structural components that help protect people during a fire. Each Element of Performance (EP) contains a reference to the Life Safety Code. A reference is also provided in those rare cases when a different edition or NFPA code is used as a source. The Life Safety Code may contain provisions to the requirements in this chapter. Compliance with these provisions is considered as meeting the Life Safety Code and is acceptable to The Joint Commission.

This chapter addresses a number of topics contained in the Life Safety Code, including the following:

- General life safety design and building construction
- The means of egress, including design of space, travel distances, egress illumination, and signage
- 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 — Not applicable to ambulatory care

III. Ambulatory Health Care Occupancy
   A. All Ambulatory Health Care Occupancy Buildings
      1. General Building Requirements (LS.03.01.10)
      2. Means of Egress Requirements (LS.03.01.20)
      3. Protection (LS.03.01.30)
         a. Fire Alarm (LS.03.01.34)
         b. Extinguishment (LS.03.01.35)
      4. Special Provisions (LS.03.01.40)
      5. Building Services (LS.03.01.50)
      6. Operating Features (LS.03.01.70)
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 1:** This standard applies to sites of care where four or more patients at the same time are provided either anesthesia or outpatient services that render patients incapable of saving themselves in the event of an emergency in the organization.

**Note 2:** This standard applies to all ambulatory surgical centers and outpatient surgical departments seeking accreditation for Medicare certification purposes, regardless of the number of patients rendered incapable.
Elements of Performance for LS.01.01.01

1. The organization assigns an individual(s) to assess compliance with the Life Safety Code and manage the Statement of Conditions (SOC) when addressing survey-related deficiencies.

Note: For ambulatory surgical centers that elect to use The Joint Commission deemed status option: The organization complies with the 2012 Life Safety Code.

2. In time frames defined by the organization, the organization performs a building assessment to determine compliance with the “Life Safety” (LS) chapter.

3. The organization maintains current and accurate drawings denoting features of fire safety and related square footage. Fire safety features include the following:
   - Areas of the building that are fully sprinklered (if the building is partially sprinklered)
   - Locations of all hazardous storage areas
   - Locations of all fire-rated barriers
   - Locations of all smoke-rated barriers
   - Sleeping and non-sleeping suite boundaries, including the size of the identified suites
   - Locations of designated smoke compartments
   - Locations of chutes and shafts
   - Any approved equivalencies or waivers

4. When the organization plans to resolve a deficiency through a Survey-Related Plan for Improvement (SPFI), the organization meets the 60-day time frame.

Note 1: If the corrective action will exceed the 60-day time frame, the organization must request a time-limited waiver within 30 days from the end of survey.

Note 2: If there are alternative systems, methods, or devices considered equivalent, the organization may submit an equivalency request using its Statement of Conditions (SOC).

Note 3: For further information on waiver and equivalency requests, see https://www.jointcommission.org/life_safety_code_information_resources/ and NFPA 101-2012: 1.4.
6. The organization does not remove or minimize an existing life safety feature when such feature is a requirement for new construction. Existing life safety features, if not required by the *Life Safety Code*, can be either maintained or removed. (For full text, refer to NFPA 101-2012: 4.6.12.2; 4.6.12.3; 20/21.7.9)

**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 1:** *This standard applies to sites of care where four or more patients at the same time are provided either anesthesia or outpatient services that render patients incapable of saving themselves in the event of an emergency in the organization.*

**Note 2:** *This standard applies to all ambulatory surgical centers and outpatient surgical departments seeking accreditation for Medicare certification purposes, regardless of the number of patients rendered incapable.*

**Elements of Performance for LS.01.02.01**

2. When the organization identifies *Life Safety Code* deficiencies that cannot be immediately corrected or during periods of construction, the organization evacuates the building or notifies the fire department (or other emergency response group) and initiates a fire watch when a fire alarm system is out of service more than 4 out of 24 hours or a sprinkler system is out of service more than 10 hours in a 24-hour period in an occupied building. Notification and fire watch times are documented. (For full text, refer to NFPA 101-2012: 9.6.1.6; 9.7.6; NFPA 25-2011: 15.5.2)

When the organization identifies *Life Safety Code* deficiencies that cannot be immediately corrected or during periods of construction, the organization does the following:

3. Posts signage identifying the location of alternative exits to everyone affected.

4. Inspects exits in affected areas on a daily basis. The organization determines when these inspections are needed.

5. Provides temporary but equivalent fire alarm and detection systems for use when a fire system is impaired. The organization determines when these systems are needed.
6. Provides additional firefighting equipment. The organization determines when to provide this equipment.

7. Uses temporary construction partitions that are smoke-tight, or made of noncombustible or limited-combustible material that will not contribute to the development or spread of fire. The organization determines when to use these partitions.

8. Increases surveillance of buildings, grounds, and equipment, giving special attention to construction areas and storage, excavation, and field offices. The organization determines when to increase surveillance.

9. Enforces storage, housekeeping, and debris-removal practices that reduce the building’s flammable and combustible fire load to the lowest feasible level. The organization determines when these practices are needed.

10. Provides additional training to those who work in the organization on the use of firefighting equipment. The organization determines when to provide additional training.

11. Conducts one additional fire drill per quarter. The organization determines when these additional fire drills are needed. (See also EC.02.03.03, EP 1)

12. Inspects and tests temporary systems monthly. The completion date of the tests is documented. The organization determines when these inspections and tests are needed.

13. The organization conducts education to promote awareness of building deficiencies, construction hazards, and temporary measures implemented to maintain fire safety. The organization determines when this education is needed.

14. The organization trains those who work in the organization to compensate for impaired structural or compartmental fire safety features. The organization determines when this training is needed.

Note: Compartmentalization is the concept of using various building components (for example, fire-rated walls and doors, smoke barriers, fire-rated floor slabs) to prevent the spread of fire and the products of combustion so as to provide a safe means of egress to an approved exit. The presence of these features varies, depending on the building occupancy classification.
15. The organization’s policy allows the use of other ILSMs not addressed in EPs 2–14.

Note 1: The organization’s ILSM policy addresses Life Safety Code Requirements for Improvement (RFI) that are not immediately corrected during survey.

Note 2: The “other” ILSMs used are documented by selecting “other” and annotating the associated text box in the organization’s Survey-Related Plan for Improvement (SPFI) within the Statement of Conditions™ (SOC).

Standard LS.03.01.10

Building and fire protection features are designed and maintained to minimize the effects of fire, smoke, and heat.

Note 1: This standard applies to sites of care where four or more patients at the same time are provided either anesthesia or outpatient services that render patients incapable of saving themselves in an emergency in the organization.

Note 2: This standard applies to all ambulatory surgical centers seeking accreditation for Medicare certification purposes, regardless of the number of patients rendered incapable.

Note 3: In leased facilities, the elements of performance of this standard apply only to the space in which the accredited organization is located; all exits from the space to the outside at grade level; and any Life Safety Code building systems that support the space (for example, fire alarm system, automatic sprinkler system).

Rationale for LS.03.01.10

Space 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.

When remodeling or designing a new building or space, 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.

Elements of Performance for LS.03.01.10

1. Buildings meet requirements for construction type and height. In Types I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit
sprinklers. All new buildings contain approved automatic sprinkler systems. Existing buildings contain approved automatic sprinkler systems as required by the construction type. (For full text, refer to NFPA 101-2012: 20/21.1.6.1–20/21.1.6.6; 20/21.3.5)

2. Interior nonbearing walls in Types I or II construction are constructed of noncombustible or limited-combustible materials. Interior nonbearing walls that are required to have a minimum of two-hour fire resistance rating are made with fire retardant–treated wood and enclosed within noncombustible or limited-combustible materials, provided they are not used as shaft enclosures. (For full text, refer to NFPA 101-2012: 20.1.6.3; 20.1.6.4; 21.1.6.3; 21.1.6.4)

3. When building rehabilitation occurs, the organization incorporates NFPA 101-2012: Chapters 20, 21, and 43. (For full text, refer to NFPA 101-2012: Chapter 43; 20/21.1.1.4; 4.6.7)

4. Ambulatory occupancies located in multioccupancy buildings are separated from health care occupancies by two-hour fire-rated walls and from business occupancies by one-hour fire-rated walls. (For full text, refer to NFPA 101-2012: 20/21.1.3; 20/21.3.7.1)

Note: Per Centers for Medicare & Medicaid Services’ regulation, ambulatory surgical centers are classified as ambulatory health care occupancies, regardless of the number of patients served. (For full text, refer to NFPA 101-2012: 20/21.1.3.2; 20/21.3.7.1)

5. Fire barriers are continuous from outside wall to outside wall or from one fire barrier to another, or a combination thereof, including continuity through all concealed spaces, such as those found above a ceiling, including interstitial spaces. For those fire barriers terminating at the bottom side of an interstitial space, the construction assembly forming the bottom of the interstitial space must have a fire resistance rating not less than that of the fire barrier. (For full text, refer to NFPA 101-2012: 8.3.1.2)

6. The fire protection rating for opening protectives in fire barriers, fire-rated smoke barriers, and fire-rated smoke partitions is as follows:
   - Three hours in three-hour barriers and partitions
   - Ninety minutes in two-hour barriers and partitions
   - Forty-five minutes in one-hour barriers and partitions
   - Twenty minutes in ½-hour barriers and partitions
Labels on fire door assemblies must be maintained in legible condition. (For full text, refer to NFPA 101-2012: 8.3.4.2; Table 8.3.4.2; 8.3.3.2.3; NFPA 80-2010: 5.2.13.3)

**Note:** For ambulatory surgical centers 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.

7. Doors within walls and floors that are required to be fire rated have functioning hardware, including positive latching devices and self-closing or automatic-closing devices. Gaps between meeting edges of door pairs are no more than 1/8-inch wide, and undercuts are no larger than 3/4 of an inch. Blocking or wedging open fire-rated doors is prohibited. Doors required to be fire rated in the walls do not have unapproved protective plates greater than 16 inches from the bottom of the door. (For full text, refer to NFPA 101-2012: 8.3.3.1; NFPA 80-2010: 4.8.4.1; 5.2.13.3; 6.3.1.7; 6.4.5)

8. Doors requiring a minimum fire rating of 3/4 of an hour are free of coverings, decorations, or other objects applied to the door face. Informational signs, which are applied with adhesive only, are allowed provided that the informational signage does not exceed 5% of the door face area. (For full text, refer to NFPA 80-2010: 4.1.4)

9. Ducts penetrating the walls and floors with a fire-resistance rating of less than three hours are protected by dampers that are fire rated for 1 1/2 hours; penetrations of three hours or greater are protected by fire dampers that are fire rated for three hours. (For full text, refer to NFPA 101-2012: 8.3.5.7; 9.2.1; NFPA 90A-2012: 5.4)

10. The space around pipes, conduits, bus ducts, cables, wires, air ducts, or pneumatic tubes penetrating the walls or floors are protected with an approved fire-rated material.

**Note:** Non-approved polyurethane expanding foam is not an accepted fire-rated material for this purpose. (For full text, refer to NFPA 101-2012: 8.3.5)


**Standard LS.03.01.20**

The organization maintains the integrity of the means of egress.
**Note 1:** This standard applies to sites of care where four or more patients at the same time are provided either anesthesia or outpatient services that render patients incapable of saving themselves in an emergency in the organization.

**Note 2:** This standard applies to all ambulatory surgical centers seeking accreditation for Medicare certification purposes, regardless of the number of patients rendered incapable.

**Note 3:** In leased facilities, the elements of performance of this standard apply only to the space in which the accredited organization is located; all exits from the space to the outside at grade level; and any Life Safety Code building systems that support the space (for example, fire alarm system, automatic sprinkler system).

**Rationale for LS.03.01.20**
Because patients are ill and in many cases cannot escape the danger of fire on their own, buildings in which patients are cared for must be designed and maintained so that patients can be moved to safe places in the building (instead of evacuated to a place outside the building).

Means of egress are corridors, stairways, and doors that allow individuals to leave a building or to move between specific spaces in a building. They allow individuals to escape from fire and smoke, and, therefore, are an integral part of a fire protection strategy. The organization should make sure that a sufficient number of exits exist and that they are configured to provide protection from fire. It is important that egress doors are not locked in a way that restricts passage to safety.

**Elements of Performance for LS.03.01.20**

1. Doors in a means of egress are not equipped with a latch or lock that requires the use of a tool or key from the egress side, unless a compliant locking configuration is used, such as a delayed-egress locking system as defined in NFPA 101-2012: 7.2.1.6.1 or access-controlled egress door assemblies as defined in NFPA 101-2012: 7.2.1.6.2. Elevator lobby exit access door locking is allowed if compliant with 7.2.1.6.3. (For full text, refer to NFPA 101-2012: 20/21.2.2)

2. Any door required to be self-closing, including those in an exit stair enclosure, may be held open provided there is an automatic release device that closes the door in response to the manual fire alarm system, loss of power, and smoke detectors. (For full text, refer to NFPA 101-2012: 20/21.2.2.4; 20/21.2.2.5; 7.2.1.8.2)
3. Exits discharge to the outside at grade level or through an approved exit passageway that is continuous and provides a level walking surface. The exit discharge is a hard-packed, all-weather travel surface that is free from obstructions and terminates at a public way or at an exterior exit discharge. (For full text, refer to NFPA 101-2012: 20/21.2.1; 20/21.2.7; 38/39.2.7; 7.1.7; 7.1.10.1; 7.2.6; 7.7)

4. The capacity of the means of egress complies with NFPA 101-2012: 7.3. (For full text, refer to NFPA 101-2012: 20/21.2.3.1)

5. Exit corridors or passageways serving as a means of egress are 44 (or more) inches wide. Doors opening in the means of egress from diagnostic or treatment areas are 32 inches wide (unless the existing door opening is 34 inches). (For full text, refer to NFPA 101-2012: 20/21.2.3.2; 2.3.4)

6. Exits, exit accesses, and exit discharges are clear of obstructions or impediments to the public way, such as clutter (for example, equipment, carts, furniture), construction material, and snow and ice. (For full text, refer to NFPA 101-2012: 7.1.10.1)

7. Exit access doors and exit doors are free of mirrors, hangings, or draperies that might conceal, obscure, or confuse the direction of exit. (For full text, refer to NFPA 101-2012: 20/21.2.1; 7.5.2.2.1)

8. Each floor of a building has at least two exits that are remote from each other and accessible from every part of the floor. Each smoke compartment has two distinct egress paths to exits that do not require entry into the same adjacent smoke compartment. Patient care suites larger than 2,500 square feet have two exits remotely located from each other. (For full text, refer to NFPA 101-2012: 20/21.2.4.2; 7.4; 38/39.2.4)

9. In new buildings protected throughout by an approved automatic sprinkler system, dead-end corridors are no longer than 50 feet. In new buildings not provided with automatic sprinklers throughout, dead-end corridors are no longer than 20 feet. In existing buildings, dead-end corridors are no longer than 50 feet. (For full text, refer to NFPA 101-2012: 20/21.2.5; 38/39.2.5.2)

10. The travel distance from any point in a room to an exit is 150 feet or less; the travel distance is 200 feet or less in buildings protected throughout by an approved automatic sprinkler system. (For full text, refer to NFPA 101-2012: 20/21.2.6)
11. Nothing is stored in any exit enclosure. (For full text, refer to NFPA 101-2012: 20/21.2.1; 7.2.2.5)

12. Means of egress are automatically and adequately illuminated at all points, including angles and intersections of corridors and passageways, stairways, stairway landings, exit doors, and exit discharges. (For full text, refer to NFPA 101-2012: 20/21.2.8; 7.8)

13. Illumination in the means of egress, including exit discharge, is arranged so that failure of any single lighting unit will not result in darkness (less than 0.2 foot-candles of illumination). Emergency lighting of at least 1½-hours duration is provided automatically in accordance with NFPA 101-2012: 7.9. (For full text, refer to NFPA 101-2012: 20/21.2.8; 7.8.1.4)

14. Signs reading “NO EXIT” are posted on doors to stairs in areas that are not conforming exits and that may be mistaken for exits. (For full text, refer to NFPA 101-2012: 20/21.2.10; 7.10.8.3)

15. Exit signs are visible when the path to the exit is not readily apparent. Signs are adequately lit and have letters that are 4 or more inches high or 6 inches high if externally lit. (See NFPA 101-2012: 20/21.2.10; 7.10.5)

16. New buildings equipped with or requiring the use of life support systems (electromechanical or inhalation anesthetics) have illumination for the following: means of egress, emergency lighting equipment, exit, and directional signs supplied by the life safety branch of the electrical system described in NFPA 99-2012. (For full text, refer to NFPA 101-2012: 20.2.9.2; NFPA 99-2012: 6.4.2.2.3)


Standard LS.03.01.30
The organization provides and maintains building features to protect individuals from the hazards of fire and smoke.

Note 1: This standard applies to sites of care where four or more patients at the same time are provided either anesthesia or outpatient services that render patients incapable of saving themselves in an emergency in the organization.

Note 2: This standard applies to all ambulatory surgical centers seeking accreditation for Medicare certification purposes, regardless of the number of patients rendered incapable.
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**Note 3:** In leased facilities, the elements of performance of this standard apply only to the space in which the accredited organization is located; all exits from the space to the outside at grade level; and any Life Safety Code building systems that support the space (for example, fire alarm system, automatic sprinkler system).

**Rationale for LS.03.01.30**

Fire and smoke are concerns in organizations because of the inability of some patients to evacuate. The effects of fire and smoke can be contained when sections of a building are separated into multiple compartments and when interior finishes are controlled. Smoke and fire can travel through openings in a building. Necessary openings may include heating, ventilating, and air conditioning (HVAC) systems and elevator shafts, and organizations should design and maintain these openings to contain smoke and fire.

**Elements of Performance for LS.03.01.30**

1. In new construction, vertical openings, including exit stairs, are enclosed by one-hour fire-rated walls when connecting three or fewer floors and two-hour fire-rated walls when connecting four or more floors. Existing vertical openings, including exit stairs, are enclosed with a minimum of one-hour fire-rated construction. (For full text, refer to NFPA 101-2012: 20/21.3.1; 8.6; 8.6.5; 38/39.3.1)

   **Note:** These vertical openings include, but are not limited to, shafts (including elevator, light, and ventilation), communicating stairs, ramps, trash chutes, linen chutes, and utility chases.

2. In buildings, exit stairs connecting three or fewer floors are fire rated for one hour; exit stairs connecting four or more floors are fire rated for two hours. (For full text, refer to NFPA 101-2012: 20/21.3.1; 38/39.3.1; 8.6.5)

3. All hazardous areas are enclosed with one-hour fire-rated walls with ¾-hour fire-rated doors; or hazardous areas have sprinkler systems and are constructed to resist the passage of smoke with doors equipped with self-closing or automatic-closing devices. (For full text, refer to NFPA 101-2012: 20/21.3.2; 38/39.3.2; 8.7; NFPA 80-2010: 4.8.4.1; 6.3.1.7; 6.5)

4. Laboratories using quantities of flammable, combustible, or hazardous materials that are considered as a severe hazard are protected in accordance with NFPA 101-2012: 8.7 and NFPA 99-2012 requirements. (For full text, refer to NFPA 101-2012: 20/21.3.2.2)
5. Alcohol-based hand rubs (ABHR) are stored and handled in accordance with NFPA 101-2012: 8.7.3.1, unless all of the following conditions are met:
   - Corridor is at least six feet wide
   - ABHR does not exceed 95% alcohol
   - Maximum individual dispenser capacity is 0.32 gallon of fluid (0.53 gallon in suites) or 18 ounces of NFPA Level 1–classified aerosols
   - Dispensers have a minimum of four feet of horizontal spacing between them
   - Dispensers are not installed within one inch of an ignition source
   - If floor is carpeted, the building is fully sprinkler protected
   - Operation of the dispenser complies with NFPA 101-2012: 20/21.3.2.6(11)
   - ABHR is protected against inappropriate access
   - Not more than an aggregate of 10 gallons of fluid or 135 ounces of aerosol are used in a single smoke compartment outside a storage cabinet, excluding one individual dispenser per room
   - Storing more than five gallons of fluid in a single smoke compartment complies with NFPA 30

6. Commercial cooking equipment is installed per NFPA 96-2011, unless only used for food warming or limited cooking. (For full text, refer to NFPA 101-2012: 20/21.3.2.4; 20/21.3.2.5; 9.2.3)

7. Wall and ceiling interior finishes of exits and enclosed corridors are rated Class A or B for limiting smoke development and the spread of flames. (For full text, refer to NFPA 101-2012: 20/21.3.3; 38/39.3.3.2; 10.2.3)

8. Newly installed interior floor finishes in exits and enclosed corridors have a Class I or II radiant flux rating. (For full text, refer to NFPA 101-2012: 20/21.3.3; 10.2.7)

9. In new construction, openings in vision panels or doors are permitted without protection provided the openings are installed at or below one half the distance from the floor to the room ceiling and do not exceed 20 square inches. In rooms protected throughout by an approved automatic sprinkler system, the aggregate area of openings is limited to 80 square inches. In existing construction, openings are not limited. (For full text, refer to NFPA 101-2012: 20.3.6.2)

Note: Openings may include, but are not limited to, mail slots and pass-through windows in areas such as laboratory, pharmacy, and cashier stations.
10. In new construction, corridors that provide access to exits are separated from
other areas by one-hour fire-rated barriers unless otherwise permitted by NFPA
101-2012: 38.3.6.1.

**Note:** For existing construction, there are no requirements. (For full text, refer to
NFPA 101-2012: 20.3.6.2; 38.3.6.1)

11. Ambulatory health care space must be separated from other tenants with a one-
hour fire resistance-rated barrier, constructed from the floor slab below to the
floor or roof above. Doors in the barrier are 1\(\frac{3}{4}\) inch thick, solid bonded (or
equivalent), self-closing, and have positive latching. Doors are kept in the closed
position except when in use. Windows in the barrier comply with NFPA 101-
2012: 8.3. (For full text, refer to NFPA 101-2012: 20/21.3.7.1; 8.3)

12. At least two smoke compartments are provided for every story unless one of the
following conditions are met:

- Facility is less than 5,000 square feet and protected by an approved smoke
detection system
- Facility is less than 10,000 square feet and protected by an approved,
supervised sprinkler system per NFPA 101-2012: 9.7
- Adjoining occupancy is used as a smoke compartment if all of the following
conditions are met:
  - Separating wall has a fire-resistive rating of one hour
  - Doors in the one-hour fire-rated wall are 1\(\frac{3}{4}\)” thick
  - Doors in the one-hour fire-rated wall are self-closing
  - Windows in the one-hour fire-rated wall are fixed fire window assemblies
    per NFPA 101-2012: 8.3
  - The ambulatory health care facility is less than 22,500 square feet
  - Access from the ambulatory health care facility is unrestricted to another
    occupancy

(For full text, refer to NFPA 101-2012: 20/21.3.7.2)

13. Smoke barriers extend from the floor slab to the upper floor or roof slab above,
through any concealed spaces (such as those above suspended ceilings and
interstitial spaces), continuously from exterior wall to exterior wall. All
penetrations are sealed. New smoke barriers are constructed of one-hour fire-
rated materials. (For full text, refer to NFPA 101-2012: 20/21.3.7.5; 20/
21.3.7.6)
14. Ducts that penetrate smoke barriers, are protected by approved smoke dampers that close when a local smoke detector is activated. The detector is located either within the duct system or in the corridor.

**Note:** In buildings with a fully ducted HVAC system and protected throughout by an approved automatic sprinkler system, dampers are not required. (For full text, refer to NFPA 101-2012: 20/21.3.7.6; 8.5.5)

15. Fixed fire window assemblies in smoke barrier walls or doors are fire rated for 20 minutes and are 25% or less of the size of the fire barrier in which they are installed.

**Note:** Existing window installations that have wired glass or fire-rated glazing, are 1,296 square inches in size or smaller, and are set in approved metal frames are acceptable. (For full text, refer to NFPA 101-2012: 20/21.3.7.7, 8.3.3)

16. Doors in smoke barriers are constructed of 1¾ inch or thicker solid-bonded wood core (or equivalent) and are self-closing or automatic-closing. For new buildings, doors are required to swing in the direction of egress travel; rabbets, bevels, or astragals are at meeting edges; and stops are at the head and sides of door frames. Center mullions are prohibited in smoke barrier door openings. (For full text, refer to NFPA 101-2012: 20/21.3.7.9; 20/21.2.2.4; 20.3.7.9; 20.3.7.10; 3.7.13; 3.7.14)


**Standard LS.03.01.34**

The organization provides and maintains fire alarm systems.

**Note 1:** This standard applies to sites of care where four or more patients at the same time are provided either anesthesia or outpatient services that render patients incapable of saving themselves in an emergency in the organization.

**Note 2:** This standard applies to all ambulatory surgical centers seeking accreditation for Medicare certification purposes, regardless of the number of patients rendered incapable.

**Note 3:** In leased facilities, the elements of performance of this standard apply only to the space in which the accredited organization is located; all exits from the space to the outside at grade level; and any *Life Safety Code* building systems that support the space (for example, fire alarm system, automatic sprinkler system).
Elements of Performance for LS.03.01.34

1. A fire alarm system is installed with systems and components to provide effective warning of fire in any part of the building in accordance with NFPA 70-2012, National Electric Code, and NFPA 72-2010, National Fire Alarm Code.

2. The master fire alarm control panel is located in an area with a smoke detector or in an area that is continuously occupied and protected, which is an area enclosed with one-hour fire-rated walls and ¾-hour fire-rated doors. In areas not continuously occupied and protected, a smoke detector is installed at each fire alarm control unit. In a new building, detection is also installed at notification appliance circuit power extenders and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. (For full text, refer to NFPA 101-2012: 20/21.3.4.1; 9.6)

3. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit and 200 feet of travel distance is not exceeded. (For full text, refer to NFPA 101-2012: 20/21.3.4.2.1; 20/21.3.4.2.2; 9.6.2.5)

4. For new buildings, occupant notification is provided automatically in accordance with NFPA 101-2012: 9.6.3 by audible and visual signals. Positive alarm sequence in accordance with 9.6.3.4 is permitted in buildings protected throughout by a sprinkler system. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of a fire. Annunciation zoning for the fire alarm and sprinklers is provided by audible and visual indicators; zones are not larger than 22,500 square feet per zone. (For full text, refer to NFPA 101-2012: 20.3.4.3–20.3.4.4; 9.6.4)

5. For existing buildings, occupant notification is provided automatically in accordance with NFPA 101-2012: 9.6.3 by audible and visual signals. Positive alarm sequence in accordance with 9.6.3.4 is permitted in buildings protected throughout by a sprinkler system. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of a fire. (For full text, refer to NFPA 101-2012: 21.3.4.3; 9.6.4; 9.7.1.1(1))
6. Activation of the required fire alarm control functions occurs automatically and is provided with an alternative power supply in accordance with NFPA 72-2010. (For full text, refer to NFPA 101-2012: 20/21.3.4.4; 9.6.1; 9.6.5)

7. The fire alarm signal automatically transmits to one of the following:
   - An auxiliary fire alarm system
   - Central station fire alarm system
   - A proprietary supervising station fire alarm system
   - A remote supervising station fire alarm system
   (For full text, refer to NFPA 101-2012: 20/21.3.4.3.2; NFPA 101-2012: 9.6.4)

8. The remote ancillary annunciator panel is in a location approved by the local fire department or its equivalent. (For full text, refer to NFPA 101-2012: 20/21.3.4.3, 9.6.3)

9. The fire alarm system contains an audible and visual evacuation signal throughout the building and provides occupant notification without delay. (For full text, refer to NFPA 101-2012: 20/21.3.4.3, 9.6.3)


**Standard LS.03.01.35**

The organization provides and maintains equipment for extinguishing fires.

**Note 1:** This standard applies to sites of care where four or more patients at the same time are provided either anesthesia or outpatient services that render patients incapable of saving themselves in an emergency in the organization.

**Note 2:** This standard applies to all ambulatory surgical centers seeking accreditation for Medicare certification purposes, regardless of the number of patients rendered incapable.

**Note 3:** In leased facilities, the elements of performance of this standard apply only to the space in which the accredited organization is located; all exits from the space to the outside at grade level; and any Life Safety Code building systems that support the space (for example, fire alarm system, automatic sprinkler system).

**Elements of Performance for LS.03.01.35**

1. For new construction, the fire alarm system monitors the components of any required approved automatic sprinkler system. (For full text, refer to NFPA 101-2012: 20/21.3.5.2; 9.7.1.1)
2. The fire alarm system is connected to water flow alarms of any required automatic sprinkler system. (For full text, refer to NFPA 101-2012: 20/21.3.4.4; 20/21.3.5; 9.7.1.1) R

3. Piping supports for approved automatic sprinkler systems are not damaged or loose. (For full text, refer to NFPA 101-2012: 20/21.3.4.4; NFPA 25-2011: 5.2.1; 5.2.2; 5.2.3)

4. Approved automatic sprinkler systems piping is not used to support any other item. (For full text, refer to NFPA 101-2012: 20/21.3.4.4; NFPA 25-2011: 5.2.2; NFPA 13-2010: 8.5.5.2; 8.5.5.3)

5. Sprinkler heads are not damaged and are free from corrosion, foreign materials, and paint. (For full text, refer to NFPA 101-2012: 20/21.3.4.4; NFPA 25-2011: 5.2.1; 5.2.2; NFPA 13-2010: 6.2.6.2; 6.2.7.1)

6. There is 18 inches or more of open space maintained below a sprinkler deflector to the top of storage.

   **Note:** Perimeter wall shelving may extend up to the ceiling when not located directly below a sprinkler head. (For full text, refer to NFPA 101-2012: 20/21.3.4.4; NFPA 25-2011: 5.2.1; 5.2.2; NFPA 13-2010: 8.5.5; 8.5.6)

7. The travel distance from any point to the nearest portable fire extinguisher is 75 feet or less. Portable fire extinguishers have appropriate signage, are installed in a cabinet or secured on a hanger made for the extinguisher, and are at least four inches off the floor. Those fire extinguishers that are 40 pounds or less are installed so the top is not more than 5 feet above the floor. (For full text, refer to NFPA 101-2012: 20/21.3.5.3; 9.7.4.1; NFPA 10-2010: 6.1.3; 6.2.1)


**Standard LS.03.01.40**

The organization provides and maintains special features to protect individuals from the hazards of fire and smoke.

**Note 1:** This standard applies to sites of care where four or more patients at the same time are provided either anesthesia or outpatient services that render patients incapable of saving themselves in an emergency in the organization.
Note 2: This standard applies to all ambulatory surgical centers seeking accreditation for Medicare certification purposes, regardless of the number of patients rendered incapable.

Note 3: In leased facilities, the elements of performance of this standard apply only to the space in which the accredited organization is located; all exits from the space to the outside at grade level; and any Life Safety Code building systems that support the space (for example, fire alarm system, automatic sprinkler system).

Elements of Performance for LS.03.01.40

1. Windowless buildings or portions of windowless buildings meet the requirements of NFPA 101-2012: 20/21.4; 11.7.

2. Existing high-rise buildings have approved automatic sprinkler systems that meet the requirements of NFPA 101-2012: 20/21.4; 11.8; 9.7.1.1(1), or they have an engineered life safety system complying with NFPA 101-2012: 39.4.2.1(2). New high-rise buildings comply with NFPA 101-2012: 11.8. (For full text, refer to NFPA 101-2012: 20/21.4; 11.8; 39.4.2.1)


Standard LS.03.01.50

The organization provides and maintains building services to protect individuals from the hazards of fire and smoke.

Note 1: This standard applies to sites of care where four or more patients at the same time are provided either anesthesia or outpatient services that render patients incapable of saving themselves in an emergency in the organization.

Note 2: This standard applies to all ambulatory surgical centers seeking accreditation for Medicare certification purposes, regardless of the number of patients rendered incapable.

Note 3: In leased facilities, the elements of performance of this standard apply only to the space in which the accredited organization is located; all exits from the space to the outside at grade level; and any Life Safety Code building systems that support the space (for example, fire alarm system, automatic sprinkler system).
**Elements of Performance for LS.03.01.50**

1. Equipment using gas or related gas piping complies with NFPA 54-2012, National Fuel Gas Code; electrical wiring and equipment complies with NFPA 70-2012, National Electric Code. Existing installations can continue in service provided there are no life-threatening hazards. (For full text, refer to NFPA 101-2012: 20/21.5.1; 9.1.1)

2. Heating, ventilation, and air conditioning comply with NFPA 101-2012: 9.2 and are installed in accordance with the manufacturers’ specifications. (For full text, refer to NFPA 101-2012: 20/21.5.2.1; 9.2)

3. Any heating device (other than a central heating plant) is designed and installed so combustible materials cannot be ignited by the device, and safety features stop fuel and shut down equipment if it experiences excessive temperature or ignition failure.

   **Note:** If fuel fired, the heating device is designed as follows:
   - Chimney or vent connected
   - Takes air for combustion from outside
   - Combustion system that is separate from occupied area atmosphere

   (For full text, refer to NFPA 101-2012: 20/21.5.2.2)

4. A suspended unit heater(s) is permitted provided the following conditions are met:
   - Not located in means of egress or in patient rooms
   - Located high enough to be out of reach of people in the area
   - Has a safety feature to stop fuel and shut down equipment if it experiences excessive temperature or ignition failure

   (For full text, refer to NFPA 101-2012: 20/21.5.2.2)

5. New elevators are equipped with all of the following: 
   - Firefighters service key recall and smoke detector automatic recall
   - Firefighters service emergency in-car key operation
   - Machine room smoke detectors
   - Elevator lobby smoke detectors

   Existing elevators meet these requirements when they have a travel distance of 25 feet or more above or below the level that best serves the needs of firefighters.

   (For full text, refer to NFPA 101-2012: 20/21.5.3; 9.4)
6. Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4. All existing escalators, dumbwaiters, and moving walks (including escalator emergency stop buttons and automatic skirt obstruction stop) conform to the requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. (For full text, refer to NFPA 101-2012: 20/21.5.3; 9.4.2)

7. The organization does not allow unvented fuel-fired heaters. (For full text, refer to NFPA 101-2012: 20/21.5.2.2)

8. All heating appliances are provided with safety features to stop the flow of fuel and turn off the appliance during times of excessive temperatures or ignition failure. (For full text, refer to NFPA 101-2012: 20/21.5.2.2)

9. Waste chutes are installed per NFPA 101-2012: 9.5 and meet the following requirements:
   - Walls, partitions, and inlet openings meet the requirements of NFPA 101-2012: 8.3.
   - Doors of chutes open to a room designed exclusively for accessing the chute opening.
   - Rooms used for accessing the chute opening(s) are separated from other spaces per NFPA 101-2012: 8.7.
   - Chutes are permitted to open into rooms not exceeding 400 cubic feet in size if the room is sprinkler protected and not used for storage.

   (For full text, refer to NFPA 101-2012: 20/21.5.4; 9.5; NFPA 82-2009)

   **Note:** Existing installations having properly enclosed and maintained chute openings are permitted to have inlets open to a corridor or normally occupied space.


**Standard LS.03.01.70**

The organization provides and maintains operating features that conform to fire and smoke prevention requirements.

**Note 1:** This standard applies to sites of care where four or more patients at the same time are provided either anesthesia or outpatient services that render patients incapable of saving themselves in an emergency in the organization.
Note 2: This standard applies to all ambulatory surgical centers departments seeking accreditation for Medicare certification purposes, regardless of the number of patients rendered incapable.

Note 3: In leased facilities, the elements of performance of this standard apply only to the space in which the accredited organization is located; all exits from the space to the outside at grade level; and any Life Safety Code building systems that support the space (for example, fire alarm system, automatic sprinkler system).

Elements of Performance for LS.03.01.70

1. In areas where smoking is permitted, ashtrays are safely designed and made of noncombustible material. Metal containers with self-closing cover devices in which ashtrays can be emptied are readily available to all areas where smoking is permitted. (For full text, refer to NFPA 101-2012: 20/21.7.4)

2. Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored; these areas have signs that read “NO SMOKING” or display the international symbol for no smoking. In facilities where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs that prohibit smoking in hazardous areas are not required. (For full text, refer to NFPA 101-2012: 18/19.7.4)

Note: The secondary sign exception is not applicable to medical gas storage areas.

3. Draperies, curtains (including cubicle curtains) and loosely hanging fabric comply with NFPA 101-2012: 10.3.1. (For full text, refer to NFPA 101-2012: 18/19.7.5.1; 18/19.3.5.11; 10.3.1)

Note: Exceptions include shower/bath curtains in addition to window coverings in patient sleeping rooms and in non-patient sleeping rooms located in sprinklered compartments where individual drapery or curtain panels do not exceed 48 square feet or total area does not exceed 20% of the wall.

4. In buildings without sprinkler protection, upholstered furniture purchased on or after July 5, 2016, meets Class I or char length and heat release criteria in accordance with NFPA 101-2012: 10.3.2.1 and 10.3.3. Mattresses purchased on or after July 5, 2016, meet char length and heat release criteria in accordance with NFPA 101-2012: 10.3.2.2 and 10.3.4. (For full text, refer to NFPA 101-2012: 20/21.7.5.2; 20/21.7.5.4)
5. The organization prohibits all combustible decorations unless they meet the criteria of NFPA 101-2012: 20/21.7.5.4.

6. Soiled linen and trash receptacles larger than 32 gallons (including recycling containers) are located in a room protected as a hazardous area. (For full text, refer to NFPA 101-2012: 20/21.7.5.5)

7. When installed, new engineered smoke control systems are tested in accordance with NFPA 92-2012, Standard for Smoke Control Systems. Existing engineered smoke control systems are tested in accordance with established engineering principles. (For full text, refer to NFPA 101-2012: 20/21.7.7)

8. Portable space heaters are prohibited in smoke compartments containing staff sleeping rooms and patient treatment areas. Non-sleeping rooms occupied by staff and employee areas separated from the corridor are permitted to have portable space heaters that contain heating elements not exceeding 212°F. (For full text, refer to NFPA 101-2012: 20/21.7.8)

Medication Management (MM)

Overview
Medication management is an important component in the palliative, symptomatic, and curative treatment of many diseases and conditions. However, medications are also capable of causing great harm if the incorrect dose or medication is inadvertently administered to a patient. To eliminate any potential harm that could be caused by medications, 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 include 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, organizations without pharmacy services will conduct the medication ordering process and will provide patients with prescriptions.

Effective and safe medication management also involves multiple services and disciplines working closely together. The medication management standards address activities involving various individuals within an organization’s medication management system, such as licensed independent practitioners and staff.

Additionally, an effective medication management system includes mechanisms for reporting potential and actual medication-related errors and a process to improve medication management processes and patient safety based on this information.
In essence, a well-planned and implemented medication management system supports patient safety and improves the quality of care by doing the following:

- Reducing variation, errors, and misuse
- Using evidence-based practices to develop medication management processes
- Managing critical processes to promote safe medication management throughout the organization
- Standardizing equipment and handling processes, including those for sample medications, across the organization to improve the medication management system
- Monitoring the medication management process for efficiency, quality, and safety

**About This Chapter**

The goal of the medication management standards is to provide a framework for an effective and safe medication management system. Effective and safe medication management is dependent on carefully implementing medication management processes based on the care, treatment, or services provided by the organization. Planning provides the groundwork for the following critical areas of performance outlined in this chapter:

- Managing high-alert and hazardous medications
- Selecting and procuring medications
- Storing medications
- Managing emergency medications
- Controlling medications brought into the organization by patients, their families, and licensed independent practitioners
- Managing medication orders
- Preparing medications
- Labeling medications
- Dispensing medications
- Retrieving recalled or discontinued medications
- Administering medications
- Managing investigational medications
- Monitoring patients’ reactions to medications
- Responding to real or potential adverse drug events, adverse drug reactions, and medication errors

Selected elements of performance (EPs) that are applicable to sample medications include a note that states, “This element of performance is also applicable to sample medications.” The Joint Commission is not endorsing the use of sample medications.
The note is only intended to identify which Medication Management EPs are applicable to sample medications for organizations that permit their use. Medication Management EPs that do not include this note are not applicable to sample medications.
Chapter Outline

I. Planning
   A. Medication Planning (MM.01.01.01, MM.01.01.03)
   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.05.01.15, MM.05.01.17, MM.05.01.19)

VI. Administration (MM.06.01.01, MM.06.01.05)

VII. Monitoring (MM.07.01.01, MM.07.01.03)

VIII. Evaluation (MM.08.01.01)
Standards, Rationales, and Elements of Performance

Standard MM.01.01

The organization plans its medication management processes.

Rationale for MM.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

1. The organization has a written policy that describes that the following information about the patient is accessible to licensed independent practitioners and staff who participate in the management of the patient’s medications:
   - Age
   - Sex
   - Diagnoses
   - Allergies
   - Sensitivities
   - Current medications
   - Height and weight (when necessary)
   - Pregnancy and lactation information (when necessary)
   - Laboratory results (when necessary)
   - Any additional information required by the organization

   *(See also IM.02.01.01, EP 3)*

   **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 licensed independent practitioners and staff who participate in the management of the patient’s medications.

   **Note 1:** This element of performance does not apply in emergency situations.

   **Note 2:** This element of performance is also applicable to sample medications.
3. For ambulatory surgical centers that elect to use The Joint Commission deemed status option: One individual is designated as responsible for pharmaceutical services.

**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. Ø The organization identifies, in writing, its high-alert and hazardous medications.(See also EC.02.02.01, EP 8) R

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† For a list of hazardous drugs, see [https://www.cdc.gov/niosh/docs/2016-161/pdfs/2016-161.pdf](https://www.cdc.gov/niosh/docs/2016-161/pdfs/2016-161.pdf).
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 EC.02.02.01, EP 8; MM.03.01.01, EP 9)
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3. The organization implements its process for managing high-alert and hazardous medications. *(See also EC.02.02.01, EPs 1 and 8)*

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

**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 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**

1. The organization develops criteria for determining which medications are available for dispensing or administering to patients.

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

2. The criteria for selecting medications are approved by the organization and include indications for use, effectiveness, and risks.

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

3. Before using a medication new to the organization, the organization determines a method to monitor the response of the patient. *(See also MM.07.01.01, EP 2)*
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.

Note: Sample medications are not required to be on this list.

5. The organization makes its written list of medications readily available to those involved in medication management.

6. The organization standardizes and limits the number of drug concentrations available in the organization.

7. The organization has a process to select and procure medications that are not on its list of medications.

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

8. The organization implements the 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. Medications designated as available for dispensing or administration are reviewed at least annually based on emerging safety and efficacy information.

10. The organization has a process to communicate medication shortages and outages to licensed independent practitioners and staff who participate in medication management.

11. The organization implements its process to communicate medication shortages and outages to licensed independent practitioners 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.

14. The organization has a process to communicate to licensed independent practitioners and staff who participate in medication management about the medication substitution protocols for shortages or outages.

Shading indicates a change effective July 1, 2017, unless otherwise noted in the What’s New.
15. The organization implements its process to communicate to licensed independent practitioners and staff who participate in medication management about the medication substitution protocols for shortages and outages.

**Standard MM.03.01.01**
The 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**

2. The organization stores medications according to the manufacturers’ recommendations.

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

3. 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.*

5. The organization safely handles medications between receipt by licensed independent practitioners or staff and administration of the medications.

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

6. 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. All stored medications and the components used in their preparation are labeled with the contents, expiration date, and any applicable warnings.

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

8. The organization removes all expired, damaged, and/or contaminated medications and stores them separately from medications available for administration.

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

18. The organization periodically inspects all medication storage areas.

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

**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 decide which, if any, emergency medications and their associated supplies will be readily accessible in patient care areas based on the population served.

2. Emergency medications and their associated supplies are readily accessible.

3. Whenever possible, emergency medications are available in unit-dose, age-specific, and ready-to-administer forms.

6. When emergency medications or supplies are used, the 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 are clear and accurate.

Elements of Performance for MM.04.01.01

1. The organization has a written policy that identifies the specific types of medication orders that it deems acceptable for use.

   **Note:** There are several different types of medication orders. Medication orders commonly used include the following:

   - As needed (PRN) orders: Orders acted on based on the occurrence of a specific indication or symptom
Standing orders: A prewritten medication order and specific instructions from the licensed independent practitioner to administer a medication to a person in clearly defined circumstances

Automatic stop orders: Orders that include a date or time to discontinue a medication

Titrating orders: Orders in which the dose is either progressively increased or decreased in response to the patient’s status

Taper orders: Orders in which the dose is decreased by a particular amount with each dosing interval

Range orders: Orders in which the dose or dosing interval varies over a prescribed range, depending on the situation or patient’s status

Signed and held orders: New prewritten (held) medication orders and specific instructions from a licensed independent practitioner to administer medication(s) to a patient in clearly defined circumstances that become active upon the release of the orders on a specific date(s) and time(s)

Orders for compounded drugs or drug mixtures not commercially available

Orders for medication-related devices (for example, nebulizers, catheters)

Orders for investigational medications

Orders for herbal products

Orders for medications at the end of an episode of care, or at discharge or transfer

The organization has a written policy that defines the following:

2. The required elements of a complete medication order.

3. When indication for use is required on a medication order.

4. The precautions for ordering medications with look-alike or sound-alike names.

5. Actions to take when medication orders are incomplete, illegible, or unclear.
7. If the organization uses preprinted medication order sheets, it updates them based on current evidence and practice.

8. The organization prohibits summary (blanket) orders to resume previous medications.

12. For ambulatory surgical centers that elect to use The Joint Commission deemed status option: Orders given verbally for medications and biologicals are followed by a written order signed by the prescribing physician.

13. The organization implements its policies for medication orders.

14. The organization requires an order from a doctor of medicine or osteopathy or, as permitted by law and regulation, organization-specific protocol(s) approved by a doctor of medicine or osteopathy to administer influenza and pneumococcal polysaccharide vaccines.

21. For organizations that elect The Joint Commission Primary Care Medical Home option: The primary care medical home uses an electronic prescribing process for at least 50% of allowable prescriptions.

22. For organizations that elect The Joint Commission Primary Care Medical Home option: The primary care medical home uses a computerized order entry system for at least 60% of medication orders.

**Standard MM.05.01.01**

The organization reviews the appropriateness of all medication orders for medications to be dispensed in the organization.

**Elements of Performance for MM.05.01.01**

1. The organization defines who can review medication orders or prescriptions for dispensed medications, and under what conditions this occurs, in accordance with law and regulation.

All medication orders are reviewed for the following:

4. Patient allergies or potential sensitivities.

5. Existing or potential interactions between the medication ordered and food and medications the patient is currently taking.

6. The appropriateness of the medication, dose, frequency, and route of administration.
7. Current or potential impact as indicated by laboratory values.
8. Therapeutic duplication.
9. Other contraindications.
11. After the medication order has been reviewed, all concerns, issues, or questions are clarified with the individual prescriber before dispensing.

**Standard MM.05.01.07**
The organization safely prepares medications.

**Note:** *This standard is applicable to all organizations that prepare medications for administration.*

**Elements of Performance for MM.05.01.07**

1. When an on-site licensed pharmacy is available, a pharmacist, or pharmacy staff under the supervision of a pharmacist, compounds or admixes all compounded sterile preparations except in urgent situations in which a delay could harm the patient or when the product’s stability is short.

2. Staff use clean or sterile techniques and maintain clean, uncluttered, and functionally separate areas for product preparation to avoid contamination of medications.

3. During preparation, staff visually inspect the medication for particulates, discoloration, or other loss of integrity. *(See also MM.03.01.05, EP 2; MM.06.01.01, EP 4)*

4. The organization uses a laminar airflow hood or other ISO Class 5 environment in the pharmacy for preparing intravenous (IV) admixture or any sterile product that will not be used within 24 hours.

**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.

   **Note 1:** An organization that exclusively uses a single medication in a patient care area can draw up or prepare multiple doses for later use as long as the medication is segregated and secured from all other medications in the organization (for example, a vaccine, flu shot) and the container holding the individual doses is labeled.

   **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.

   **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. The date prepared and the diluent for all compounded intravenous admixtures and parenteral nutrition formulas.

When preparing individualized medications for multiple patients, the label also includes the following:

7. The patient’s name.

8. The location where the medication is to be delivered. (See also NPSG.01.01.01, EP 1)

   **Note:** The location is not to be used as a patient identifier during administration of a medication, as indicated by NPSG.01.01.01, EP 1.

9. Directions for use and applicable accessory and cautionary instructions.
When an individualized medication(s) is prepared by someone other than the person administering the medication, the label includes the following:

10. The patient’s name.

11. The location where the medication is to be delivered. *(See also NPSG.01.01.01, EP 1)*

*Note:* The location is not to be used as a patient identifier during administration of a medication, as indicated by NPSG.01.01.01, EP 1.

12. Directions for use and applicable accessory and cautionary instructions.

**Standard MM.05.01.11**
The organization safely dispenses medications.

**Element of Performance for MM.05.01.11**

2. The organization dispenses medications and maintains clinical records in accordance with law and regulation, licensure, and professional standards of practice.

*Note 1:* Dispensing practices and recordkeeping include antidiversion strategies.

*Note 2:* This element of performance is also applicable to sample medications.

**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 or licensed pharmaceutical supplier to meet patient needs.

3. The organization implements its process for obtaining medications from a pharmacy or licensed pharmaceutical supplier.

**Standard MM.05.01.17**
The organization follows a process to retrieve recalled or discontinued medications.

*Note:* This standard is applicable to all organizations that dispense medications, including sample 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). (See also EC.02.01.01, EP 11)

   **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. (See also EC.02.01.01, EP 11)

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

3. When a medication is recalled or discontinued for safety reasons by the manufacturer or the US Food and Drug Administration (FDA), the organization notifies the prescribers and those who dispense or administer the medication. (See also EC.02.01.01, EP 11)

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

4. 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). (See also EC.02.01.01, EP 11)

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

Standard MM.05.01.19

The organization safely manages 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’s or organization’s control that includes procedures for preventing diversion.

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

3. The organization determines if and when outside sources are used for destruction of medications.

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

4. The organization implements its process for managing unused, expired, or returned medications.

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

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**Standard MM.06.01.01**

The organization safely administers medications.

**Elements of Performance for MM.06.01.01**

1. The organization defines, in writing, licensed independent practitioners and the clinical staff disciplines that are authorized to administer medication, with or without supervision, in accordance with law and regulation.

2. Only authorized licensed independent practitioners and clinical staff administer medications.

**Note:** *This does not prohibit self-administration of medications by patients, when indicated.*

Before administration, the individual administering the medication does the following:

3. Verifies that the medication selected matches the medication order and product label.

4. Visually inspects the medication for particulates, discoloration, or other loss of integrity. *(See also MM.03.01.05, EP 2; MM.05.01.07, EP 3)*

5. Verifies that the medication has not expired.

**Note:** *For ambulatory surgical centers that elect to use The Joint Commission deemed status option: The Centers for Medicare & Medicaid Services require ambulatory surgical centers to date multi-dose injectable*
medications that are used for more than one patient when they are opened, and discard them within 28 days of opening or according to the manufacturer's recommendations, whichever is more stringent.

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.

**Note: For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The Centers for Medicare & Medicaid Services require ambulatory surgical centers to use single dose (single-use) medication vials for only one patient.

8. Discusses any unresolved concerns about the medication with the patient’s licensed independent practitioner, prescriber (if different from the licensed independent practitioner), and/or staff involved with the patient’s care, treatment, or services.

9. Before administering a new medication, the patient or family is informed about any potential clinically significant adverse drug reactions or other concerns regarding administration of a new medication. *(See also PC.02.03.01, EP 10)*

13. Before administering a radioactive pharmaceutical for diagnostic purposes, staff verify that the dose to be administered is within 20% of the prescribed dose, or, if the dose is prescribed as a range, staff verify that the dose to be administered is within the prescribed range.

**Standard MM.06.01.05**
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 plan of care. 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 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 and accommodates 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 clinical record, relevant lab values, clinical response, and medication profile. (See also MM.02.01.01, EP 3)

   Note 1: Monitoring the patient’s response to medications is an important assessment activity for nurses, physicians, and pharmacists. In particular, monitoring the patient’s response to the first dose of a new medication is essential to the safety of the patient because any adverse reactions, including serious ones, are more unpredictable if the medication has never been used before with the patient.

   Note 2: This element of performance is also applicable to sample medications.

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.
   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. For ambulatory surgical centers that elect to use The Joint Commission deemed status option: All adverse drug events are reported to the physician (as defined in section 1861(r) of the Social Security Act) responsible for the patient and are documented in the clinical record.

5. The organization implements its process for responding to adverse drug events, significant adverse drug reactions, and medication errors.
   Note: This element of performance is also applicable to sample medications.

Standard MM.08.01.01
The organization evaluates the effectiveness of its medication management system.

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

Elements of Performance for MM.08.01.01
1. The organization collects data on the performance of its medication management system. (See also PI.01.01.01, EPs 14 and 15)
2. The organization analyzes data on its medication management system.

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 system.

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

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

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

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

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

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

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

Chapter Outline

National Patient Safety Goals

I. Goal 1—Improve the accuracy of patient identification.
   A. Use of Two Patient Identifiers (NPSG.01.01.01)
   B. Eliminating Transfusion Errors (NPSG.01.03.01)

II. Goal 3—Improve the safety of using medications.
    A. Labeling Medications (NPSG.03.04.01)
    B. Reducing Harm from Anticoagulation Therapy (NPSG.03.05.01)
    C. Reconciling Medication Information (NPSG.03.06.01)

III. Goal 7—Reduce the risk of health care-associated infections.
     A. Meeting Hand Hygiene Guidelines (NPSG.07.01.01)
     B. Preventing Surgical Site Infections (NPSG.07.05.01)

Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery™

I. Universal Protocol
   A. Conducting a Preprocedure Verification Process (UP.01.01.01)
   B. Marking the Procedure Site (UP.01.02.01)
   C. Performing a Time-Out (UP.01.03.01)
Requirements, Rationales, and Elements of Performance

Goal 1
Improve the accuracy of patient identification.

NPSG.01.01.01
Use at least two patient identifiers when providing care, treatment, or services.

Rationale for NPSG.01.01.01
Wrong-patient errors occur in virtually all stages of diagnosis and treatment. The intent for this goal is two-fold: first, to reliably identify the individual as the person for whom the service or treatment is intended; second, to match the service or treatment to that individual. Acceptable identifiers may be the individual’s name, an assigned identification number, telephone number, or other person-specific identifier.

Elements of Performance for NPSG.01.01.01
1. Use at least two patient identifiers when administering medications, blood, or blood components; when collecting blood samples and other specimens for clinical testing; and when providing treatments or procedures. The patient’s room number or physical location is not used as an identifier. (See also MM.05.01.09, EPs 8 and 11; NPSG.01.03.01, EP 1) R

2. Label containers used for blood and other specimens in the presence of the patient. (See also NPSG.01.03.01, EP 1) R

NPSG.01.03.01
Eliminate transfusion errors related to patient misidentification.

Elements of Performance for NPSG.01.03.01
1. Before initiating a blood or blood component transfusion: R
   - Match the blood or blood component to the order.
   - Match the patient to the blood or blood component.
   - Use a two-person verification process or a one-person verification process accompanied by automated identification technology, such as bar coding.

   (See also NPSG.01.01.01, EPs 1 and 2)
2. When using a two-person verification process, one individual conducting the identification verification is the qualified transfusionist who will administer the blood or blood component to the patient.

3. When using a two-person verification process, the second individual conducting the identification verification is qualified to participate in the process, as determined by the organization.

**Goal 3**

Improve the safety of using medications.

**NPSG.03.04.01**

Label all medications, medication containers, and other solutions on and off the sterile field in perioperative and other procedural settings.

**Note:** Medication containers include syringes, medicine cups, and basins.

**Rationale for NPSG.03.04.01**

Medications or other solutions in unlabeled containers are unidentifiable. Errors, sometimes tragic, have resulted from medications and other solutions removed from their original containers and placed into unlabeled containers. This unsafe practice neglects basic principles of safe medication management, yet it is routine in many organizations.

The labeling of all medications, medication containers, and other solutions is a risk-reduction activity consistent with safe medication management. This practice addresses a recognized risk point in the administration of medications in perioperative and other procedural settings. Labels for medications and medication containers are also addressed at MM.05.01.09.

**Elements of Performance for NPSG.03.04.01**

1. In perioperative and other procedural settings both on and off the sterile field, label medications and solutions that are not immediately administered. This applies even if there is only one medication being used.

   **Note:** An immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to a patient, and administers to that patient without any break in the process. Refer to NPSG.03.04.01, EP 5, for information on timing of labeling.
2. In perioperative and other procedural settings both on and off the sterile field, labeling occurs when any medication or solution is transferred from the original packaging to another container.

3. In perioperative and other procedural settings both on and off the sterile field, medication or solution labels include the following:
   - Medication or solution name
   - Strength
   - Amount of medication or solution containing medication (if not apparent from the container)
   - Diluent name and volume (if not apparent from the container)
   - Expiration date when not used within 24 hours
   - Expiration time when expiration occurs in less than 24 hours

   **Note:** The date and time are not necessary for short procedures, as defined by the organization.

4. Verify all medication or solution labels both verbally and visually. Verification is done by two individuals qualified to participate in the procedure whenever the person preparing the medication or solution is not the person who will be administering it.

5. Label each medication or solution as soon as it is prepared, unless it is immediately administered.

   **Note:** An immediately administered medication is one that an authorized staff member prepares or obtains, takes directly to a patient, and administers to that patient without any break in the process.

6. Immediately discard any medication or solution found unlabeled.

7. Remove all labeled containers on the sterile field and discard their contents at the conclusion of the procedure.

   **Note:** This does not apply to multiuse vials that are handled according to infection control practices.

8. All medications and solutions both on and off the sterile field and their labels are reviewed by entering and exiting staff responsible for the management of medications.
NPSG.03.05.01
Reduce the likelihood of patient harm associated with the use of anticoagulant therapy.

Note: This requirement applies only to organizations that provide anticoagulant therapy and/or long-term anticoagulation prophylaxis (for example, atrial fibrillation) where the clinical expectation is that the patient’s laboratory values for coagulation will remain outside normal values. This requirement does not apply to routine situations in which short-term prophylactic anticoagulation is used for venous thrombo-embolism prevention (for example, related to procedures or hospitalization) and the clinical expectation is that the patient’s laboratory values for coagulation will remain within, or close to, normal values.

Rationale for NPSG.03.05.01
Anticoagulation therapy can be used as therapeutic treatment for a number of conditions, the most common of which are atrial fibrillation, deep vein thrombosis, pulmonary embolism, and mechanical heart valve implant. However, it is important to note that anticoagulation medications are more likely than others to cause harm due to complex dosing, insufficient monitoring, and inconsistent patient compliance. This National Patient Safety Goal has great potential to positively impact the safety of patients on this class of medications and result in better outcomes.

To achieve better patient outcomes, patient education is a vital component of an anticoagulation therapy program. Effective anticoagulation patient education includes face-to-face interaction with a trained professional who works closely with patients to be sure that they understand the risks involved with anticoagulation therapy, the precautions they need to take, and the need for regular International Normalized Ratio (INR) monitoring. The use of standardized practices for anticoagulation therapy that include patient involvement can reduce the risk of adverse drug events associated with heparin (unfractionated), low molecular weight heparin, and warfarin.

Elements of Performance for NPSG.03.05.01
2. Use approved protocols for the initiation and maintenance of anticoagulant therapy. R
3. Before starting a patient on warfarin, assess the patient’s baseline coagulation status; for all patients receiving warfarin therapy, use a current International Normalized Ratio (INR) to adjust this therapy. The baseline status and current INR are documented in the clinical record. R
Note: The patient’s baseline coagulation status can be assessed in a number of ways, including through a laboratory test or by identifying risk factors such as age, weight, bleeding tendency, and genetic factors.

7. Provide education regarding anticoagulant therapy to prescribers, staff, patients, and families. Patient/family education includes the following:
   - The importance of follow-up monitoring
   - Compliance
   - Drug-food interactions
   - The potential for adverse drug reactions and interactions

8. Evaluate anticoagulation safety practices, take action to improve practices, and measure the effectiveness of those actions in a time frame determined by the organization.

Introduction to Reconciling Medication Information

The large number of people receiving health care who take multiple medications and the complexity of managing those medications make medication reconciliation an important safety issue. In medication reconciliation, a clinician compares the medications a patient should be using (and is actually using) to the new medications that are ordered for the patient and resolves any discrepancies.

The Joint Commission recognizes that organizations face challenges with medication reconciliation. The best medication reconciliation requires a complete understanding of what the patient was prescribed and what medications the patient is actually taking. It can be difficult to obtain a complete list from every patient in an encounter, and accuracy is dependent on the patient’s ability and willingness to provide this information. A good faith effort to collect this information is recognized as meeting the intent of the requirement. As health care evolves with the adoption of more sophisticated systems (such as centralized databases for prescribing and collecting medication information), the effectiveness of these processes will grow.
This National Patient Safety Goal (NPSG) focuses on the risk points of medication reconciliation. The elements of performance in this NPSG are designed to help organizations reduce negative patient outcomes associated with medication discrepancies. Some aspects of the care process that involve the management of medications are addressed in the standards rather than in this goal. These include coordinating information during transitions in care both within and outside of the organization (PC.02.02.01), patient education on safe medication use (PC.02.03.01), and communications with other providers (PC.04.02.01).

In settings where medications are not routinely prescribed or administered, this NPSG provides organizations with the flexibility to decide what medication information they need to collect based on the services they provide to patients. It is often important for clinicians to know what medications the patient is taking when planning care, treatment, 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. 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.
Note 1: The organization obtains the patient’s medication information at the beginning of an episode of care. 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 the patient. A good faith effort to obtain this information from the patient and/or other sources will be considered as meeting the intent of the EP.

2. Define the types of medication information to be collected in different settings and patient circumstances. R

   Note 1: Examples of such settings include primary care, urgent and emergent care, ambulatory surgery, convenient care, outpatient radiology, and diagnostic settings.

   Note 2: Examples of medication information that may be collected include name, dose, route, frequency, and purpose.

3. For organizations that prescribe medications: Compare the medication information the patient brought to the organization with the medications ordered for the patient by the organization in order to identify and resolve discrepancies. R

   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. For organizations that prescribe medications: Provide the patient (or family as needed) with written information on the medications the patient should be taking at the end of the episode of care (for example, name, dose, route, frequency, purpose). R

   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 at the end of an episode of care, or when the patient is discharged or transferred, refer to Standard PC.04.02.01.

5. For organizations that prescribe medications: Explain the importance of managing medication information to the patient at the end of the episode of care. R
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 PC.02.03.01 and PC.04.01.05.)

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 1) R
2. Set goals for improving compliance with hand hygiene guidelines. (See also IC.03.01.01, EP 1) R
3. Improve compliance with hand hygiene guidelines based on established goals. R
NPSG.07.05.01
Implement evidence-based practices for preventing surgical site infections.

Elements of Performance for NPSG.07.05.01

1. Educate staff and licensed independent practitioners involved in surgical procedures about surgical site infections and the importance of prevention. Education occurs upon hire, annually thereafter, and when involvement in surgical procedures is added to an individual’s job responsibilities.  

2. Educate patients, and their families as needed, who are undergoing a surgical procedure about surgical site infection prevention.  

3. Implement policies and practices aimed at reducing the risk of surgical site infections. These policies and practices meet regulatory requirements and are aligned with evidence-based guidelines (for example, the Centers for Disease Control and Prevention (CDC) and/or professional organization guidelines).  

4. As part of the effort to reduce surgical site infections:  
   - Conduct periodic risk assessments for surgical site infections in a time frame determined by the organization.  
   - Select surgical site infection measures using best practices or evidence-based guidelines.  
   - Monitor compliance with best practices or evidence-based guidelines.  
   - Evaluate the effectiveness of prevention efforts.  
   
   Note: Surveillance may be targeted to certain procedures based on the organization’s risk assessment.  

5. Measure surgical site infection rates for the first 30 or 90 days following surgical procedures based on National Healthcare Safety Network (NHSN) procedural codes. The organization’s measurement strategies follow evidence-based guidelines.  

   Note 1: Surveillance may be targeted to certain procedures based on the organization’s risk assessment.
Note 2: The NHSN is the Centers for Disease Control and Prevention’s health care-associated infection tracking system. NHSN provides facilities, states, regions, and the nation with data needed to identify problem areas, measure progress of prevention efforts, and ultimately eliminate health care-associated infections. For more information on NHSN procedural codes, see http://www.cdc.gov/nhsn/CPTcodes/ssi-cpt.html.

6. Provide process and outcome (for example, surgical site infection rate) measure results to key stakeholders.

7. Administer antimicrobial agents for prophylaxis for a particular procedure or disease according to methods cited in scientific literature or endorsed by professional organizations.

8. When hair removal is necessary, use a method that is cited in scientific literature or endorsed by professional organizations.

Introduction to the Universal Protocol for Preventing Wrong Site, Wrong Procedure, and Wrong Person Surgery

The Universal Protocol applies to all surgical and nonsurgical invasive procedures. Evidence indicates that procedures that place the patient at the most risk include those that involve general anesthesia or deep sedation, although other procedures may also affect patient safety. Organizations can enhance safety by correctly identifying the patient, the appropriate procedure, and the correct site of the procedure.

The Universal Protocol is based on the following principles:

- Wrong-person, wrong-site, and wrong-procedure surgery can and must be prevented.

* A limited number of National Patient Safety Goals contain requirements for practices that reflect current science and medical knowledge. In these cases, the element of performance refers to a practice that is cited in scientific literature or endorsed by professional organizations. This means that the practice used by the organization must be validated by an authoritative source. The authoritative source may be a study published in a peer-reviewed journal that clearly demonstrates the efficacy of that practice or endorsement of the practice by a professional organization(s) and/or a government agency(ies). It is not acceptable to follow a practice that is not supported by evidence or widespread consensus. During the on-site survey, surveyors will explore the source of the practices the organization follows.
A robust approach using multiple, complementary strategies is necessary to achieve the goal of always conducting the correct procedure on the correct person, at the correct site.

Active involvement and use of effective methods to improve communication among all members of the procedure team are important for success.

To the extent possible, the patient and, as needed, the family are involved in the process.

Consistent implementation of a standardized protocol is most effective in achieving safety.

The Universal Protocol is implemented most successfully in organizations with a culture that promotes teamwork and where all individuals feel empowered to protect patient safety. An organization should consider its culture when designing processes to meet the Universal Protocol. In some organizations, it may be necessary to be more prescriptive on certain elements of the Universal Protocol or to create processes that are not specifically addressed within these requirements.

Organizations should identify the timing and location of the preprocedure verification and site marking based on what works best for their own unique circumstances. The frequency and scope of the preprocedure verification will depend on the type and complexity of the procedure. The three components of the Universal Protocol are not necessarily presented in chronological order (although the preprocedure verification and site marking precede the final verification in the time-out). Preprocedure verification, site marking, and the time-out procedures should be as consistent as possible throughout the organization.
Note: Site marking is not required when the individual doing the procedure is continuously with the patient from the time of the decision to do the procedure through to the performance of the procedure.

UP.01.01.01
Conduct a preprocedure verification process.

Rationale for UP.01.01.01
Organizations should always make sure that any procedure is what the patient needs and is performed on the right person. The frequency and scope of the verification process will depend on the type and complexity of the procedure.

The preprocedure verification is an ongoing process of information gathering and confirmation. The purpose of the preprocedure verification process is to make sure that all relevant documents and related information or equipment are:

- Available prior to the start of the procedure
- Correctly identified, labeled, and matched to the patient’s identifiers
- Reviewed and are consistent with the patient’s expectations and with the team’s understanding of the intended patient, procedure, and site

Preprocedure verification may occur at more than one time and place before the procedure. It is up to the organization to decide when this information is collected and by which team member, but it is best to do it when the patient can be involved. Possibilities include the following:

- When the procedure is scheduled
- At the time of preadmission testing and assessment
- At the time of admission or entry into the facility for a procedure
- Before the patient leaves the preprocedure area or enters the procedure room

Missing information or discrepancies are addressed before starting the procedure.

Elements of Performance for UP.01.01.01

1. Implement a preprocedure process to verify the correct procedure, for the correct patient, at the correct site. ☑

   Note: The patient is involved in the verification process when possible.

2. ☑ Identify the items that must be available for the procedure and use a standardized list to verify their availability. At a minimum, these items include the following: ☑
Relevant documentation (for example, history and physical, signed procedure consent form, nursing assessment, and preanesthesia assessment)

- Labeled diagnostic and radiology test results (for example, radiology images and scans, or pathology and biopsy reports) that are properly displayed

- Any required blood products, implants, devices, and/or special equipment for the procedure

**Note:** The expectation of this element of performance is that the standardized list is available and is used consistently during the preprocedure verification. It is not necessary to document that the standardized list was used for each patient.

3. Match the items that are to be available in the procedure area to the patient.

**Introduction to UP.01.02.01**

Wrong site surgery should never happen. Yet it is an ongoing problem in health care that compromises patient safety. Marking the procedure site is one way to protect patients; patient safety is enhanced when a consistent marking process is used throughout the organization. Site marking is done to prevent errors when there is more than one possible location for a procedure. Examples include different limbs, fingers and toes, lesions, level of the spine, and organs. In cases where bilateral structures are removed (such as tonsils or ovaries) the site does not need to be marked.

Responsibility for marking the procedure site is a hotly debated topic. One position is that since the licensed independent practitioner is accountable for the procedure, he or she should mark the site. Another position is that other individuals should be able to mark the site in the interests of work flow and efficiency.

There is no evidence that patient safety is affected by the job function of the individual who marks the site. The incidence of wrong-site surgery is low enough that it is unlikely that valid data on this subject will ever be available. Furthermore, there is no clear consensus in the field on who should mark the site. Rather than remaining silent on the subject of site marking, The Joint Commission sought a solution that supports the purpose of the site mark. The mark is a communication tool about the patient for members of the team. Therefore, the individual who knows the most about the patient should mark the site. In most cases, that will be the person performing the procedure.
Recognizing the complexities of the work processes supporting invasive procedures, The Joint Commission believes that delegation of site marking to another individual is acceptable in limited situations as long as the individual is familiar with the patient and involved in the procedure. These include:

- Individuals who are permitted through a postgraduate education program to participate in the procedure
- A licensed individual who performs duties requiring collaborative or supervisory agreements with a licensed independent practitioner. These individuals include advanced practice registered nurses (APRNs) and physician assistants (PAs).

The licensed independent practitioner remains fully accountable for all aspects of the procedure even when site marking is delegated.

UP.01.02.01
Mark the procedure site.

Elements of Performance for UP.01.02.01

1. Identify those procedures that require marking of the incision or insertion site. At a minimum, sites are marked when there is more than one possible location for the procedure and when performing the procedure in a different location would negatively affect quality or safety.  

   **Note:** For spinal procedures, in addition to preoperative skin marking of the general spinal region, special intraoperative imaging techniques may be used for locating and marking the exact vertebral level.

2. Mark the procedure site before the procedure is performed and, if possible, with the patient involved.

3. The procedure site is marked by a licensed independent practitioner who is ultimately accountable for the procedure and will be present when the procedure is performed. In limited circumstances, the licensed independent practitioner may delegate site marking to an individual who is permitted by the organization to participate in the procedure and has the following qualifications:

   - An individual in a medical postgraduate education program who is being supervised by the licensed independent practitioner performing the procedure; who is familiar with the patient; and who will be present when the procedure is performed
A licensed individual who performs duties requiring a collaborative agreement or supervisory agreement with the licensed independent practitioner performing the procedure (that is, an advanced practice registered nurse [APRN] or physician assistant [PA]); who is familiar with the patient; and who will be present when the procedure is performed.

\textbf{Note:} The organization’s leaders define the limited circumstances (if any) in which site marking may be delegated to an individual meeting these qualifications.

4. The method of marking the site and the type of mark is unambiguous and is used consistently throughout the organization. \textbf{R}

\textbf{Note:} The mark is made at or near the procedure site and is sufficiently permanent to be visible after skin preparation and draping. Adhesive markers are not the sole means of marking the site.

5. 🟡 A written, alternative process is in place for patients who refuse site marking or when it is technically or anatomically impossible or impractical to mark the site (for example, mucosal surfaces or perineum). \textbf{R}

\textbf{Note:} Examples of other situations that involve alternative processes include:

- Minimal access procedures treating a lateraled internal organ, whether percutaneous or through a natural orifice
- Teeth
- Premature infants, for whom the mark may cause a permanent tattoo

\textbf{UP.01.03.01}

A time-out is performed before the procedure.

\textbf{Rationale for UP.01.03.01}

The purpose of the time-out is to conduct a final assessment that the correct patient, site, and procedure are identified. This requirement focuses on those minimum features of the time-out. Some believe that it is important to conduct the time-out before anesthesia for several reasons, including involvement of the patient. An organization may conduct the time-out before anesthesia or may add another time-out at that time. During a time-out, activities are suspended to the extent possible so that team members can focus on active confirmation of the patient, site, and procedure.
A designated member of the team initiates the time-out and it includes active communication among all relevant members of the procedure team. The procedure is not started until all questions or concerns are resolved. The time-out is most effective when it is conducted consistently across the organization.

Elements of Performance for UP.01.03.01

1. Conduct a time-out immediately before starting the invasive procedure or making the incision. 

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

   **Note:** For organizations providing telehealth surgical services: Based on current UP requirements, telehealth staff who are physically present in the operating room and participating in a surgical procedure are actively involved in the timeout.

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

4. During the time-out, the team members agree, at a minimum, on the following: 
   - Correct patient identity 
   - The correct site 
   - The procedure to be done

   **Note:** For organizations providing telehealth surgical services: Based on current UP requirements, telehealth staff who are physically present in the operating room and participating in a surgical procedure are actively involved in the timeout.

5. Document the completion of the time-out.

   **Note:** The organization determines the amount and type of documentation.
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 at the end of an episode of care or 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 to the end of an episode of care, or at 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
- Planning the patient’s operative or other high-risk procedures, including those that require the administration of moderate or deep sedation
- Caring for the patient who requires the use of restraint for non–behavioral health purposes
- Caring for the patient who requires the use of restraint or seclusion for behavioral health purposes
- Meeting the patient’s need for continuing care, treatment, or services at the end of an episode of care or at 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.01.02.07, PC.01.02.09, PC.01.02.15)
   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, PC.02.01.09, PC.02.01.21)
   B. Coordinating Care (PC.02.02.01, PC.02.02.03)
   C. Patient Education (PC.02.03.01)
   D. Primary Care Medical Home (PC.02.04.01, PC.02.04.03, PC.02.04.05)

III. Special Conditions
   A. Special Procedures (PC.03.01.01, PC.03.01.03, PC.03.01.05, PC.03.01.07)
   B. Restraint (PC.03.02.03, PC.03.02.07)

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)
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.

Element of Performance for PC.01.01.01

7. The organization accepts a patient for care, treatment, or services based on whether its scope of services can meet the patient’s needs.

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.

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 1:** The scope and content are dependent on whether the patient is making an initial or follow-up visit and whether the assessment is focused or comprehensive.

   **Note 2:** 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.

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.
9. At each patient’s visit, the organization documents updates to the patient’s condition.

**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. When warranted by the patient’s condition, the organization either conducts or refers the patient for a comprehensive pain assessment. (*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.
**Rationale for PC.01.02.09**

Family violence and child and elder abuse are frequently reported. A study published by the Centers for Disease Control and Prevention (CDC) estimates that “intimate partner abuse” results each year in 2 million injuries to women and 600,000 injuries among men. The National Center on Elder Abuse references a study that estimates that between 1 and 2 million Americans age 65 or older have been injured, exploited, or otherwise mistreated by someone on whom they depended for care or protection.

National Consensus Guidelines produced by The Family Violence Prevention Fund points out that “most Americans are seen at some point by a health care provider, and the health care setting offers a critical opportunity for early identification and even the primary prevention of abuse.” People who are victims of abuse or neglect may come to an organization for a variety of reasons. Sometimes the reason a patient seeks health care is not connected to his or her experience with abuse or neglect. By assessing patients who may be possible victims of abuse or neglect, health care organizations fulfill an important role in helping to protect patients.

**Elements of Performance for PC.01.02.09**

1. The organization has criteria to identify those patients who may be victims of physical assault, sexual assault, sexual molestation, domestic abuse, or elder or child abuse and neglect. (*See also* RI.01.06.03, EP 2)

   **Note:** Criteria can be based on age, sex, and circumstance.

2. To assist with referrals of possible victims of abuse and neglect, the 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 and neglect and about their roles in follow-up.

4. The organization uses its criteria to identify possible victims of abuse and neglect.

6. The organization internally reports cases of possible abuse and neglect. (*See also* RI.01.06.03, EP 3)

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7. The organization reports cases of possible abuse and neglect to external agencies, in accordance with law and regulation. (*See also* RI.01.06.03, EP 3)

**Standard PC.01.02.15**

The organization provides for diagnostic testing.

**Elements of Performance for PC.01.02.15**

2. Diagnostic testing and procedures are performed as ordered within time frames defined by the organization.

5. The organization documents the radiation dose index (computed tomography dose index [CTDIvol], dose length product [DLP], or size-specific dose estimate [SSDE]) on every study produced during a diagnostic computed tomography (CT) examination. The radiation dose index must be exam specific, summarized by series or anatomic area, and documented in a retrievable format.

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

**Note 2:** *This element of performance does not apply to systems used for therapeutic radiation treatment planning or delivery, or for calculating attenuation coefficients for nuclear medicine studies.*

**Note 3:** *This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.*

**Note 4:** *While the CTDIvol, DLP, and SSDE are useful indicators for monitoring radiation dose indices from the CT machine, they do not represent the patient’s radiation dose.*

10. **For organizations that provide diagnostic computed tomography (CT), magnetic resonance imaging (MRI), positron emission tomography (PET), or nuclear medicine (NM) services:** Prior to conducting a diagnostic imaging study, the organization verifies the following:

  - Correct patient
  - Correct imaging site
  - Correct patient positioning
  - **For CT only:** Correct imaging protocol
  - **For CT only:** Correct scanner parameters
Note: This element of performance does not apply to dental cone beam CT radiographic imaging studies performed for diagnosis of conditions affecting the maxillofacial region or to obtain guidance for the treatment of such conditions.

12. For organizations that provide diagnostic computed tomography (CT), magnetic resonance imaging (MRI), positron emission tomography (PET), or nuclear medicine (NM) services: The organization considers the patient’s age and recent imaging exams when deciding on the most appropriate type of imaging exam.

Note 1: Knowledge of a patient’s recent imaging exams can help to prevent unnecessary duplication of these examinations.

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

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.

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, reassessment, and results of diagnostic testing.
25. The organization establishes or adopts diagnostic computed tomography (CT) imaging protocols based on current standards of practice, which address key criteria including clinical indication, contrast administration, age (to indicate whether the patient is pediatric or an adult), patient size and body habitus, and the expected radiation dose index range.

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

26. Diagnostic computed tomography (CT) imaging protocols are reviewed and kept current with input from an interpreting physician, medical physicist, and lead imaging technologist to make certain that they adhere to current standards of practice and account for changes in CT imaging equipment. These reviews are conducted at time frames identified by the organization.

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

44. **For organizations that elect The Joint Commission Primary Care Medical Home option:** Patient self-management goals are identified, agreed upon with the patient, and incorporated into the patient’s treatment plan. (Refer to RI.01.02.01, EP 1)

45. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home uses clinical decision support tools to guide decision making. (For more information, refer to LD.04.04.09, EPs 1–5)

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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**

1. The organization provides the patient with care, treatment, or services according to his or her individualized plan of care.

16. **For organizations that elect The Joint Commission Primary Care Medical Home option:** Each patient has a designated primary care clinician.
18. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home uses a computerized order entry system for at least 30% of laboratory orders.

19. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home uses a computerized order entry system for at least 30% of radiology orders.

**Standard PC.02.01.03**

The organization provides care, treatment, and services as ordered or prescribed, and in accordance with law and regulation.

**Elements of Performance for PC.02.01.03**

1. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** Radiologic services are provided based on orders from practitioners with clinical privileges in accordance with professional standards of practice, or from other practitioners authorized by the medical staff and the governing body, consistent with state law.

20. Before taking action on a verbal order or verbal report of a critical test result, staff uses a record and “read back” process to verify the information.

**Standard PC.02.01.05**

The organization provides interdisciplinary, collaborative care, treatment, or services.

**Element of Performance for PC.02.01.05**

1. Care, treatment, or services are provided to the patient in an interdisciplinary, collaborative manner.

**Standard PC.02.01.07**

The organization safely administers blood and blood component(s).

**Elements of Performance for PC.02.01.07**

2. The organization’s written procedures for acquiring blood or blood component(s) include identifying the following:
   - The source of materials used during acquisition
   - The time frames for acquisition
   - Accountability for acquisition
   - On-site storage
12. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** Only physicians or registered nurses administer blood and blood component(s).

**Standard PC.02.01.09**

The organization plans for and responds to life-threatening emergencies.

**Elements of Performance for PC.02.01.09**

1. ☑ The organization has written policies and procedures for responding to life-threatening emergencies.

3. The organization responds to life-threatening emergencies according to its policies and procedures. ✓

4. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** Staff trained in emergency equipment use and cardiopulmonary resuscitation are available whenever a patient is in the ambulatory surgical center. *(See also HR.01.02.05, EP 13)* ✓

9. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** Emergency equipment is immediately available for use when needed to respond to emergencies. ✓
10. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The types of emergency equipment available are appropriate for the organization’s patient population and types of procedures performed. *(See also LD.04.01.11, EP 8)*

**Standard PC.02.01.21**

For organizations that elect The Joint Commission Primary Care Medical Home option:
The organization effectively communicates with patients when providing care, treatment, or services.

**Elements of Performance for PC.02.01.21**

1. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The primary care clinician and the interdisciplinary team identify the patient’s oral and written communication needs, including the patient’s preferred language for discussing health care.

   **Note:** Examples of communication needs include the need for personal devices such as hearing aids or glasses, language interpreters, communication boards, and translated or plain language materials. *(Refer to RC.02.01.01, EP 1)*

2. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The primary care clinician and the interdisciplinary team communicate with the patient during the provision of care, treatment, or services in a manner that meets the patient’s oral and written communication needs.

**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 has a process to receive or share patient information when the patient is referred to other internal or external 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.

10. When the organization uses external resources to meet the patient’s needs, it participates in coordinating the patient’s care, treatment, or services.

15. *For ambulatory surgical centers that elect to use The Joint Commission deemed status option:* Radiologic services may only be provided when they are integral to procedures offered by the ambulatory surgical center.

17. The organization coordinates care, treatment, or services within a time frame that meets the patient’s 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

7. Food and nutrition products are consistent with each patient’s care, treatment, or services.

11. Food and nutrition products are managed safely.
   
   **Note:** Safe management refers to sanitation, temperature, light, moisture, ventilation, and security.
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. At the end of an episode of care or at discharge, patients are often given 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.

4. The organization provides education and training to the patient based on his or her assessed needs.

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
   - Basic health practices and safety
   - Information on the safe and effective use of medications (See also MM.06.01.01, EP 9)
   - Nutrition interventions (for example, supplements) and modified diets
   - Discussion of pain, the risk for pain, the importance of effective pain management, the pain assessment process, and methods for pain management
   - Information on oral health
   - Information on the safe and effective use of medical equipment or supplies provided by the organization
   - Habilitation or rehabilitation techniques to help the patient reach maximum independence

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.

28. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The primary care clinician and the interdisciplinary team educate the patient on self-management tools and techniques based on the patient’s individual needs.

30. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The interdisciplinary team identifies the patient’s health literacy needs.

   **Note:** Typically this is an interactive process, the goal of which is to ascertain the patient’s capacity to process and understand basic health information needed to make appropriate health decisions.

31. **For organizations that elect The Joint Commission Primary Care Medical Home option:** Patient education is consistent with the patient’s health literacy needs.

**Standard PC.02.04.01**

**For organizations that elect The Joint Commission Primary Care Medical Home option:**

The patient has access to the organization 24 hours a day, 7 days a week.

**Note:** Access may be provided through a number of methods, including telephone, e-mail, websites, portals, and flexible hours.

**Elements of Performance for PC.02.04.01**

1. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The organization provides patients with the ability to do the following 24 hours a day, 7 days a week:
   - Contact the primary care medical home to obtain a same- or next-day appointment
   - Request prescription renewal
   - Obtain clinical advice for urgent health needs

2. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The organization offers flexible scheduling to accommodate patient care needs.

   **Note:** This may include open scheduling, same-day appointments, group visits, expanded hours, and arrangements with other organizations.
3. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The organization has a process to respond to patient urgent care needs 24 hours a day, 7 days a week.

4. **For organizations that elect The Joint Commission Primary Care Medical Home option:** Primary care medical home patients are provided online access to their health information within four business days after the information is available to the primary care clinician or interdisciplinary team. This information includes diagnostic test results, lab results, summary lists, and medication lists.

5. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The organization uses a certified electronic health record to provide appointment reminders to patients with two or more office visits in the last two years.

**Standard PC.02.04.03**

For organizations that elect The Joint Commission Primary Care Medical Home option: The organization is accountable for providing patient care. (Refer to Standard PC.02.04.05)

**Elements of Performance for PC.02.04.03**

1. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The organization manages transitions in care and provides or facilitates patient access to care, treatment, or services including the following:
   - Acute care
   - Management of chronic care
   - Preventive services that are age- and gender-specific
   - Behavioral health needs
   - Oral health care
   - Optical health
   - Urgent and emergent care
   - Substance abuse treatment
   - Rehabilitative services and equipment (examples include physical, occupational, and speech therapy and equipment such as orthotics, prosthetics, and wheelchairs)

**Note:** Some of these services may be obtained through the use of community resources as available, or in collaboration with other organizations.
2. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The organization provides care that addresses various phases of a patient’s lifespan, including end-of-life care.

3. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The organization provides disease and chronic care management services to its patients.

4. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The organization provides population-based care.

5. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The organization uses a certified electronic health record system to do the following:
   - Support the continuity of care, and the provision of comprehensive and coordinated care, treatment, or services
   - Document and track care, treatment, or services
   - Support disease management, including providing patient education
   - Support preventive care, treatment, or services
   - Create reports for internal use
   - Create and submit reports to external providers and organizations, including public health agencies, disease-specific registries, immunization registries, and other specialized registries
   - Facilitate electronic exchange of information among providers
   - Support performance improvement
   - Identify and provide patient-specific education resources

**Standard PC.02.04.05**

**For organizations that elect The Joint Commission Primary Care Medical Home option:**
The primary care clinician and the interdisciplinary team work in partnership with the patient to support the continuity of care and the provision of comprehensive and coordinated care, treatment, or services.

**Elements of Performance for PC.02.04.05**

1. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The organization identifies the composition of the interdisciplinary team. The team must include a doctor of medicine or doctor of osteopathy.
Note: The intent of this requirement is that while a doctor of medicine or doctor of osteopathy is always available to be part of the interdisciplinary team, his or her involvement in a patient’s care would be determined by the needs of the patient.

2. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The members of the interdisciplinary team provide comprehensive and coordinated care, treatment, or services and maintain the continuity of care.

   Note: The provision of care may include making internal and external referrals.

4. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The primary care clinician and the interdisciplinary team provide care for a panel of patients.

5. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The primary care clinician is responsible for making certain that the interdisciplinary team provides comprehensive and coordinated care, treatment, or services and maintains the continuity of care as described in EPs 6–12.

   Note: Coordination of care may include making internal and external referrals, developing and evaluating treatment plans, and resolving conflicts in the provision of care.

6. **For organizations that elect The Joint Commission Primary Care Medical Home option:** When a patient is referred to an external organization, the interdisciplinary team reviews and tracks the care provided to the patient.

7. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The interdisciplinary team acts on recommendations from internal and external referrals for additional care, treatment, or services.

8. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The interdisciplinary team participates in the development of the patient’s treatment plan.

9. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The interdisciplinary team works in partnership with the patient to achieve planned outcomes.

10. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The interdisciplinary team monitors the patient’s progress toward achieving treatment goals.
11. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The interdisciplinary team involves the patient in the development of his or her treatment plan.

12. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The interdisciplinary team assesses patients for health risk behaviors.

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**Introduction to Standards PC.03.01.01 Through PC.03.01.07**

The standards for sedation and anesthesia care apply when patients in any setting receive, for any purpose, by any of the following routes:

- General, spinal, or other major regional anesthesia
- Moderate or deep sedation (with or without analgesia) that, in the manner used, may be expected to result in the loss of protective reflexes

**Standard PC.03.01.01**

The organization plans operative or other high-risk procedures, including those that require the administration of moderate or deep sedation or anesthesia.

**Elements of Performance for PC.03.01.01**

2. In addition to the individual performing the procedure, a sufficient number of qualified staff are present to evaluate the patient, to provide the sedation and/or anesthesia, to help with the procedure, and to monitor and recover the patient.  

6. **For operative or other high-risk procedures, including those that require the administration of moderate or deep sedation or anesthesia:** The organization has equipment available to monitor the patient’s physiological status.

7. **For operative or other high-risk procedures, including those that require the administration of moderate or deep sedation or anesthesia:** The organization has equipment available to administer intravenous fluids and medications, and, if needed, blood and blood components.
**Standard PC.03.01.03**

The organization provides the patient with care before initiating operative or other high-risk procedures, including those that require the administration of moderate or deep sedation or anesthesia.

**Elements of Performance for PC.03.01.03**

1. Before operative or other high-risk procedures are initiated, or before moderate or deep sedation or anesthesia is administered: The organization conducts a presedation or preanesthesia patient assessment. *(See also RC.02.01.01, EP 2)*

4. Before operative or other high-risk procedures are initiated, or before moderate or deep sedation or anesthesia is administered: The organization provides the patient with preprocedural education, according to his or her plan for care.

5. Before operative and other high-risk procedures are initiated or before moderate or deep sedation or anesthesia is administered, the organization does the following: ***R***
   - Performs and documents a history and physical examination
   - Performs and documents diagnostic tests or other data
   - Ascertains and documents the preoperative diagnosis
   - Ascertains and documents the need to administer blood or blood component(s)

6. A history and physical examination of the patient is completed within 30 days before an operative or other high-risk procedure.

8. The organization reevaluates the patient immediately before administering moderate or deep sedation or anesthesia. *(See also RC.02.01.01, EP 2)*

9. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** A physician examines the patient immediately before surgery to evaluate the risks associated with moderate or deep sedation or anesthesia. ***R***

10. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The organization records into the patient’s clinical record the results of any preoperative diagnostic studies performed to evaluate the patient’s risks associated with anesthesia.
12. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** Anesthetics must be administered only by one of the following: a qualified anesthesiologist; a physician qualified to administer anesthesia; a certified registered nurse anesthetist or an anesthesiologist’s assistant; or a supervised trainee in an approved education program.

13. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** In cases in which a non-physician administers the anesthesia, the anesthetist (unless exempt) must be under the supervision of the operating physician and, in the case of an anesthesiologist’s assistant, under the supervision of an anesthesiologist.

   **Note:** An ambulatory surgical center may be exempt from the requirement for physician supervision of certified registered nurse anesthetists (CRNAs) as described in paragraph (b)(2) of 42 CFR 416.42 if the state in which the ambulatory surgical center is located submits a letter to the Centers for Medicare & Medicaid Services (CMS) signed by the governor, following consultation with the state’s Boards of Medicine and Nursing, requesting exemption from physician supervision of CRNAs. The letter from the governor must attest that he or she has consulted with state Boards of Medicine and Nursing about issues related to access to and the quality of anesthesia services in the state and has concluded that it is in the best interests of the state’s citizens to opt-out of the current physician supervision requirement, and that the opt-out is consistent with state law. The request for exemption and recognition of state laws as well as the withdrawal of the request may be submitted at any time, and they are effective upon submission.

14. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** A comprehensive medical history and physical assessment is completed for each patient by a physician (as defined in section 1861(r) of the Social Security Act) or other qualified practitioner, in accordance with applicable state health and safety laws, standards of practice, and organization policy.

15. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** Each patient has a presurgical assessment completed upon admission by a physician or other qualified practitioner, in accordance with applicable state health and safety laws, standards of practice, and organization policy. This assessment includes any changes in the patient’s condition since the patient’s most recent medical examination, and documentation of any allergies to drugs and biologicals.
16. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** A physician or other qualified practitioner, in accordance with applicable state health and safety laws, standards of practice, and organization policy, examines the patient immediately before surgery to evaluate patient risk for the procedure to be performed.

17. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The ambulatory surgical center completes the appropriate presurgical assessments for each patient, including all elements required for discharge.

**Standard PC.03.01.05**
The organization monitors the patient during operative or other high-risk procedures and/or during the administration of moderate or deep sedation or anesthesia.

**Element of Performance for PC.03.01.05**
1. During operative or other high risk procedures, including those that require the administration of moderate or deep sedation or anesthesia, the patient’s oxygenation, ventilation, and circulation are monitored continuously. *(See also RC.02.01.03, EP 8)*

**Standard PC.03.01.07**
The organization provides care to the patient after operative or other high-risk procedures and/or the administration of moderate or deep sedation or anesthesia.

**Elements of Performance for PC.03.01.07**
1. The organization assesses the patient’s physiological status immediately after the operative or other high risk procedure and/or as the patient recovers from moderate or deep sedation or anesthesia. *(See also RC.02.01.03, EP 8)*

2. The organization monitors the patient’s physiological status, mental status, and pain level at a frequency and intensity consistent with the potential effect of the operative or other high risk procedure and/or the sedation or anesthesia administered.

4. A qualified licensed independent practitioner discharges the patient from the recovery area or from the organization. In the absence of a qualified licensed independent practitioner, patients are discharged according to criteria approved by clinical leaders. *(See also RC.02.01.03, EPs 9 and 10)*
5. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** Each patient is evaluated by a physician (as defined in section 1861(r) of the Social Security Act), or an anesthetist (as defined by law and regulation) for proper recovery before discharge from the ambulatory surgical center.

6. Patients who have received sedation or anesthesia are discharged in the company of an individual who accepts responsibility for the patient.

9. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The ambulatory surgical center completes the appropriate postsurgical assessments for each patient, including all elements required for discharge.

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**Standard PC.03.02.03**

Written policies and procedures guide the organization’s safe use of restraint.

**Element of Performance for PC.03.02.03**

1. The organization’s written policies and procedures on the use of restraint specify the frequency, format, and content of entries in the patient’s clinical record for each episode of restraint. *(See also RC.02.01.05, EP 1)*

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**Standard PC.03.02.07**

The organization monitors patients who are restrained.

**Rationale for PC.03.02.07**

Monitoring is important because it determines:

- Whether the restraint has been correctly applied.
- Whether less restrictive methods are possible.
- Changes in the patient’s behavior or clinical condition needed to initiate the removal of restraints.
- The patient’s physical and emotional well-being.
- That the patient’s rights, dignity, and safety are maintained.

**Elements of Performance for PC.03.02.07**

1. The frequency and extent of monitoring patients who are restrained are determined by the following:

   - Organization policies and procedures
   - Protocols
- Individual orders
- The care setting
- Individual patient needs
- Applicable law and regulation

*(See also RC.02.01.05, EP 1)*

2. A patient in restraint is monitored either every two hours or more frequently if required by his or her needs and organization policy. *(See also RC.02.01.05, EP 1)*

3. Qualified staff monitor a patient in restraint.

   **Note:** Monitoring may occur using observation, interaction with the patient, or direct examination.

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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.

11. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The ambulatory surgical center has procedures for immediately transferring a patient who requires emergency care that is beyond its capability.

12. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** Patients are transferred to local hospitals that meet requirements for payment of emergency services.

   **Note:** CMS requires patients to be transferred to hospitals that are either participating in Medicare, or meet the requirements at 42 CFR 482.2 “Provision of emergency services by nonparticipating hospitals.”
13. For ambulatory surgical centers that elect to use The Joint Commission deemed status option: The ambulatory surgical center has a written transfer agreement with a hospital. In the absence of a transfer agreement, all physicians (as defined in section 1861(r) of the Social Security Act), who perform surgery at the ambulatory surgical center, have admitting privileges at the hospital.

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

2. The organization identifies any needs the patient may have for continuing psychosocial or physical care.

3. The patient, the patient’s family, licensed independent practitioners, 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 needs at the end of an episode of care, or at discharge or transfer, it promptly shares this information with the patient.

7. The organization educates the patient about how to obtain any continuing care, treatment, or services that he or she will need.

9. For ambulatory surgical centers that elect to use The Joint Commission deemed status option: The ambulatory surgical center informs all patients of their prescriptions, postoperative instructions, and physician contact information for follow-up care either in advance of their surgical procedure or prior to leaving the ambulatory surgical center. R
10. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The patient’s postsurgical needs are addressed and included in the discharge notes.

11. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The ambulatory surgical center provides each patient with written discharge instructions and overnight supplies.

12. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The ambulatory surgical center provides each patient with a follow-up appointment with a physician, as necessary.

13. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** Each patient has a discharge order signed by the physician who performed the surgery or procedure, in accordance with applicable state health and safety laws, standards of practice, and organization policy.

14. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** Patients are discharged from the ambulatory surgical center in the company of a responsible adult, unless the patient is exempted from this requirement by the attending physician.

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**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.

**Element of Performance for PC.04.02.01**

1. At the end of an episode of care, or 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
   - The patient’s physical and psychosocial status
   - A summary of care, treatment, or services it provided to the patient
   - The patient’s progress toward goals

**Note:** This bullet is not applicable to settings that do not provide continuing care, such as urgent care and convenient care clinics.
   - A list of community resources or referrals made or provided to the patient

*(See also PC.02.02.01, EP 1)*
A list of the patient’s current medications, including any allergies to medications
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 they are not analyzed. Analysis identifies trends, patterns, and performance levels that suggest opportunities for improvement. The organization can then make improvements based on the analysis. Of course, there is always the chance that analysis may reveal that more opportunities for improvement exist than an organization can manage at one time. In this case, leaders need to set priorities for improvement.
After a change has been made, the organization monitors that change by collecting and analyzing data to make sure the desired improvement is achieved and sustained. Organizations should identify the results that will signify sustained improvement. If the improvement does not meet expectations, the organization makes additional changes, and the cycle starts again. These principles of performance improvement also apply whenever the organization wants to design new processes, such as a new service or an information management system (see Standard LD.04.04.03).

The standards in this chapter address the fundamental principles of performance improvement: collecting data, analyzing them, and taking action to improve.
Chapter Outline

I. Data Collection (PI.01.01.01)
II. Data Analysis (PI.02.01.01)
III. Performance Improvement (PI.03.01.01)
Introduction to Standard PI.01.01.01
Data provide organizations with important information that can be used in a variety of ways. Collecting and analyzing data on performance, outcomes, and other activities can help the 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 the 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.

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

The organization collects data on the following:

3. Performance improvement priorities identified by leaders. (See also LD.04.04.01, EP 1)
4. Operative or other procedures that place patients at risk of disability or death. (See also LD.04.04.01, EP 2)
5. All significant discrepancies between preoperative and postoperative diagnoses, including pathologic diagnoses.
6. Adverse events related to using moderate or deep sedation or anesthesia. *(See also LD.04.04.01, EP 2)*

7. The use of blood and blood components. *(See also LD.04.04.01, EP 2)*

8. All confirmed transfusion reactions. *(See also LD.04.04.01, EP 2)*

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

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

16. Patient perception of the safety and quality of care, treatment, or services.

28. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The organization, with the participation of the medical staff, collects data on the medical necessity of procedures.

29. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The organization, with the participation of the medical staff, collects data on the appropriateness of care.

36. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The ambulatory surgical center documents the improvement projects it is conducting. The documentation includes, at a minimum, the reason(s) for implementing the project and a description of the project’s results.

**For organizations that elect The Joint Commission Primary Care Medical Home option:**

The organization collects data on the following:

40. Disease management outcomes.

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

42. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The organization collects data on the following:

   - Patient experience and satisfaction related to access to care, treatment, or services and communication
   - Patient perception of the comprehensiveness of care, treatment, or services
   - Patient perception of the coordination of care, treatment, or services
   - Patient perception of the continuity of care, treatment, or services

   *(Refer to PI.01.01.01, EP 16)*

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
46. The organization collects data on patient thermal injuries that occur during magnetic resonance imaging exams.

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

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.

A data display helps with analysis. There are many different ways to display data, including simple bar or pie charts or more sophisticated run or control charts. The display should match the question being studied. For example, something being studied over time might be displayed in a run chart or histogram. The display can be handwritten, created in simple spreadsheet software, or generated by more complex statistical software.

Standard PI.02.01.01

The organization compiles and analyzes data.

Elements of Performance for PI.02.01.01

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

6. The organization reviews and analyzes incidents where the radiation dose index (computed tomography dose index [CTDIvol], dose length product [DLP], or size-specific dose estimate [SSDE]) from diagnostic CT examinations exceeded expected dose index ranges identified in imaging protocols. These incidents are then compared to external benchmarks.
Note 1: While the CTDIvol, DLP, and SSDE are useful indicators for monitoring radiation dose indices from the CT machine, they do not represent the patient’s radiation dose.

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

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

11. For ambulatory surgical centers that elect to use The Joint Commission deemed status option: The number and scope of distinct improvement projects conducted annually reflects the scope and complexity of the ambulatory surgical center’s services and operations.

Standard PI.03.01.01
The organization improves performance.

Elements of Performance for PI.03.01.01

2. The organization takes action on improvement priorities. (See also MM.08.01.01, EP 6)

4. The organization takes action when it does not achieve or sustain planned improvements.

10. For ambulatory surgical centers that elect to use The Joint Commission deemed status option: The ambulatory surgical center implements preventive strategies throughout the facility targeting adverse patient events and makes certain that all staff are familiar with these strategies. (See also LD.04.04.05, EPs 5–7 and 12)

11. For organizations that elect The Joint Commission Primary Care Medical Home option: The organization uses the data it collects on the patient’s perception of the safety and quality of care, treatment, or services to improve its performance. This data includes the following:
   - Patient experience and satisfaction related to access to care, treatment, or services and communication
   - Patient perception of the comprehensiveness of care, treatment, or services
   - Patient perception of the coordination of care, treatment, or services
   - Patient perception of the continuity of care, treatment, or services
12. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The organization’s quality assurance and performance improvement activities demonstrate the following:

- Measurable improvement in patient health outcomes
- Improvements in patient safety by using quality indicators or performance measures associated with improved health outcomes
- Improvements in patient safety through efforts to identify and reduce medical errors
Overview
The “Record of Care, Treatment, and Services” (RC) chapter contains a wealth of information about the components of a complete clinical record. A highly detailed document when seen in its entirety, the record of care comprises all data and information gathered about a patient from the moment he or she enters the organization to the moment of discharge or transfer. As such, the record of care functions not only as a historical record of a patient’s episode(s) of care, but also as a method of communication between practitioners and staff that can facilitate the continuity of care and aid in clinical decision making.

In many organizations, patient care is episodic. The organization may only see the patient once or twice, depending on the patient’s need and the organization’s scope of services. For example, a diagnostic imaging center may only see the patient for magnetic resonance imaging (MRI). However, other organizations, such as college-based student health centers, may see a patient for a limited number of visits over a few years. In either case, the patient’s episode(s) of care must be carefully documented.

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 clinical record can find a comprehensive set of requirements for its contents. The separate components of a complete clinical record are listed and arranged within common groups (demographic, clinical, and additional information). This chapter also contains documentation requirements for screenings, assessments, and reassessments; pre- and postoperative procedures; the administration of moderate or deep sedation or anesthesia; restraint and
seclusion; the clinical procedures themselves; and discharge. Standards provide policies and procedures that guide the compilation, completion, authentication, retention, and release of records.
Chapter Outline

I. Plan
   A. Clinical Record Components (RC.01.01.01)
   B. Authentication (RC.01.02.01)
   C. Timeliness (RC.01.03.01)
   D. Audit (RC.01.04.01)
   E. Retention (RC.01.05.01)

II. Implement
   A. Care, Treatment, or Services (RC.02.01.01, RC.02.01.03, RC.02.01.05)
   B. Orders (RC.02.03.07)
Standards, Rationales, and Elements of Performance

Standard RC.01.01.01
The organization maintains complete and accurate clinical records.

Elements of Performance for RC.01.01.01

1. The organization defines the components of a complete clinical record.

5. The clinical record contains the information needed to support the patient’s diagnosis and condition.

6. The clinical record contains the information needed to justify the patient’s care, treatment, or services.

7. The clinical record contains information that documents the course and result of the patient’s care, treatment, or services.

8. The clinical record contains information about the patient’s care, treatment, or services that promotes continuity of care among providers.

Note: For organizations that elect The Joint Commission Primary Care Medical Home option: This requirement refers to care provided by both internal and external providers.

11. All entries in the clinical record are dated.

14. When needed to provide care, summaries of treatment and other documents provided by the organization are forwarded to other care providers.

Standard RC.01.02.01
Entries in the clinical record are authenticated.

Elements of Performance for RC.01.02.01

1. Only authorized individuals make entries in the clinical record.

2. The organization defines the types of entries in the clinical record made by nonindependent practitioners that require countersigning, in accordance with law and regulation.

3. The author of each clinical record entry is identified in the clinical record.

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
4. Entries in the clinical record are authenticated by the author. Information introduced into the clinical record through transcription or dictation is authenticated by the author.

   **Note 1:** Authentication can be verified through electronic signatures, written signatures or initials, rubber-stamp signatures, or computer key.

   **Note 2:** For paper-based records, signatures entered for purposes of authentication after transcription or for verbal orders are dated when required by law or regulation or organization policy. For electronic records, electronic signatures will be date-stamped.

5. The individual identified by the signature stamp or method of electronic authentication is the only individual who uses it.

**Standard RC.01.03.01**

Documentation in the clinical record is entered in a timely manner.

**Elements of Performance for RC.01.03.01**

1. The organization has a written policy that requires timely entry of information into the clinical record. *(See also PC.01.02.03, EP 1)*

2. The organization defines the time frame for completion of the clinical record.

3. The organization implements its policy requiring timely entry of information into the patient’s clinical record. *(See also PC.01.02.03, EP 2)*

**Standard RC.01.04.01**

The organization audits its clinical records.

**Element of Performance for RC.01.04.01**

1. According to a time frame it defines, the organization reviews its clinical records to confirm that the required information is present, accurate, legible, authenticated, and completed on time.

**Standard RC.01.05.01**

The organization retains its clinical records.

**Elements of Performance for RC.01.05.01**

1. The retention time of the clinical record is determined by its use and organization policy, in accordance with law and regulation.
Comprehensive Accreditation Manual for Ambulatory Care

Note: For ambulatory surgical centers that elect to use The Joint Commission deemed status option: The Centers for Medicare & Medicaid Services requires the ambulatory surgical center to retain the original or legally reproduced medical record for at least five years, including applicable films, scans, and other images.

8. Original clinical records are not released unless the organization is responding to law and regulation.

**Standard RC.02.01.01**
The clinical record contains information that reflects the patient’s care, treatment, or services.

**Elements of Performance for RC.02.01.01**

1. The clinical record contains the following demographic information:
   - The patient’s name, address, phone number, and date of birth and the name of any legally authorized representative
   - The patient’s sex, height, and weight
   - The legal status of any patient receiving behavioral health care services
   - The patient’s language and communication needs

   Note: If the patient is a minor, is incapacitated, or has a designated advocate, the communication needs of the parent or legal guardian, surrogate decision-maker, or legally authorized representative are documented in the clinical record.

2. The clinical record contains the following clinical information:
   - The patient’s initial diagnosis, diagnostic impression(s), or condition(s)
   - Any findings of assessments and reassessments (See also PC.01.02.01, EP 1; PC.03.01.03, EPs 1 and 8)
   - Any allergies to food
   - Any allergies to medications
   - Any conclusions or impressions drawn from the patient’s medical history and physical examination
   - Any diagnoses or conditions established during the patient’s course of care, treatment, or services
   - Any consultation reports
   - Any progress notes
   - Any medications ordered or prescribed
   - Any medications administered, including the strength, dose, route, date and time of administration
- Any access site for medication, administration devices used, and rate of administration
- The patient’s response to any medication administered
- Any adverse drug reactions
- Plans for care and any revisions to the plan for care
- Orders for diagnostic and therapeutic tests and procedures and their results

4. As needed to provide care, treatment, or services, the clinical record contains the following additional information:
   - Any advance directives

Note: For ambulatory surgical centers that elect to use The Joint Commission deemed status option: The organization documents in a prominent place in the clinical record whether or not the patient has advance directives in place.
   - Any informed consent
   - Any documentation of clinical research interventions distinct from entries related to regular patient care, treatment, or services (See also RI.01.03.05, EP 4)
   - Any records of communication with the patient, such as telephone calls or e-mail
   - Any referrals or communications made to internal or external care providers and community agencies
   - Any patient-generated information

21. The clinical record of a patient who receives urgent or immediate care, treatment, or services contains the following:
   - The time and means of arrival
   - Indication that the patient left against medical advice, when applicable
   - Conclusions reached at the termination of care, treatment, or services, including the patient’s final disposition, condition, and instructions given for follow-up care, treatment, or services
   - A copy of any information made available to the practitioner or medical organization providing follow-up care, treatment, or services

28. For organizations that elect The Joint Commission Primary Care Medical Home option: The clinical record contains the patient’s:
   - Gender, race, and ethnicity
   - Family history
   - Work history


- Blood pressure (for patients age 3 and older)
- Smoking status (for patients age 13 and older)

29. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The clinical record includes the patient’s self-management goals and the patient’s progress toward achieving those goals.

30. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The clinical record contains the patient’s preferred language for discussing health care.

**Standard RC.02.01.03**

The patient’s clinical record documents operative or other high-risk procedures and the use of moderate or deep sedation or anesthesia.

**Elements of Performance for RC.02.01.03**

1. The organization documents in the patient’s clinical record any operative or other high-risk procedure and/or the administration of moderate or deep sedation or anesthesia.

2. A licensed independent practitioner involved in the patient’s care documents the provisional diagnosis in the clinical record before an operative or other high-risk procedure is performed.

4. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The patient’s clinical record contains the results of preoperative diagnostic studies. The results are included in the patient’s clinical record prior to the start of the surgical procedure.

5. An operative or other high-risk procedure report is written or dictated upon completion of the operative or other high-risk procedure and before the patient is transferred to the next level of care.

   **Note 1:** *The exception to this requirement occurs when an operative or other high-risk procedure progress note is written immediately after the procedure, in which case the full report can be written or dictated within a time frame defined by the organization.*

   **Note 2:** *If the practitioner performing the operation or high-risk procedure accompanies the patient from the operating room to the next unit or area of care, the report can be written or dictated in the new unit or area of care.*
6. The operative or other high-risk procedure report includes the following information:
   - The name(s) of the licensed independent practitioner(s) who performed the procedure and his or her assistant(s)
   - The name of the procedure performed
   - A description of the procedure
   - Findings of the procedure
   - Any estimated blood loss
   - Any specimen(s) removed
   - The postoperative diagnosis

7. When a full operative or other high-risk procedure report cannot be entered immediately into the patient’s clinical record, a note is entered immediately. This note includes the name(s) of the primary surgeon(s) and his or her assistant(s), procedure performed and a description of each procedure finding, estimated blood loss, specimens removed, and postoperative diagnosis.

8. The clinical record contains the following postoperative information:
   - The patient’s vital signs and level of consciousness (See also PC.03.01.05, EP 1; PC.03.01.07, EP 1)
   - Any medications, including intravenous fluids and any administered blood, blood products, and blood components
   - Any unanticipated events or complications (including blood transfusion reactions) and the management of those events

9. The clinical record contains documentation that the patient was discharged from the recovery phase of the operation or procedure either by the licensed independent practitioner responsible for his or her care or according to discharge criteria. (See also PC.03.01.07, EP 4)

10. The clinical record contains documentation of the use of approved discharge criteria that determine the patient’s readiness for discharge. (See also PC.03.01.07, EP 4)

11. The postoperative documentation contains the name of the licensed independent practitioner responsible for discharge.

12. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The clinical record contains the discharge diagnosis.
13. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The patient’s medical history and physical assessment is placed in the patient’s medical record prior to the surgical procedure. 

14. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The patient’s postsurgical condition is assessed and documented in the medical record by a physician, other qualified practitioner, or registered nurse with, at a minimum, postoperative care experience, in accordance with applicable state health and safety laws, standards of practice, and organizational policy.

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**Standard RC.02.01.05**

The clinical record contains documentation of the use of restraint.

**Element of Performance for RC.02.01.05**

1. The organization documents the use of restraint in the clinical record, including the following:
   - Orders for use
   - Results of patient monitoring
   - Reassessment
   - Unanticipated changes in the patient’s condition

   *(See also PC.03.02.03, EP 1; PC.03.02.07, EPs 1 and 2)*

**Standard RC.02.03.07**

Qualified staff receive and record verbal orders.

**Elements of Performance for RC.02.03.07**

1. The organization identifies, in writing, the staff who are authorized to receive and record verbal orders, in accordance with law and regulation.

2. Only authorized staff receive and record verbal orders.

3. Documentation of verbal orders includes the date and the names of individuals who gave, received, recorded, and implemented the orders.

4. Verbal orders are authenticated within the time frame specified by law and regulation.
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)
   C. Informed Consent (RI.01.03.01, RI.01.03.05)
   D. Right to Know (RI.01.04.01, RI.01.04.03)
   E. End-of-Life Issues (RI.01.05.01)
   F. Personal Rights (RI.01.06.03)
   G. Services Provided by Organizations to Respect Patient Rights (RI.01.07.01)

II. Patient Responsibilities (RI.02.01.01)
Standards, Rationales, and Elements of Performance

Introduction to Standard RI.01.01.01
This standard focuses on how the 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 ways that staff and caregivers interact with the patient and involve him or her in care, treatment, or services.

Standard RI.01.01.01
The organization respects patient rights.

Elements of Performance for RI.01.01.01
1. The organization has written policies on patient rights.

2. Information about patient rights is available to the patient. (See also RI.01.01.03, EPs 1–3)

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

5. The organization respects the patient’s right to and need for effective communication. (See also RI.01.01.03, EP 1)

6. 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 1–4)

   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; HR.02.02.01, EP 4; PC.01.02.07, EP 1)
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.

13. For ambulatory surgical centers that elect to use The Joint Commission deemed status option: The organization respects the patient’s right to receive care in a safe setting.

**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 practitioners and 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 3 and 5)*

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

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

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)*

4. For ambulatory surgical centers that elect to use The Joint Commission deemed status option: The ambulatory surgical center provides the patient or his or her surrogate decision-maker with verbal and written notice of the patient’s rights prior to the start of the surgical procedure in a language and manner that the patient or his or her surrogate decision-maker understands.

5. For ambulatory surgical centers that elect to use The Joint Commission deemed status option: The ambulatory surgical center posts a copy of its notice of patient rights in a location where it is likely to be noticed by patients. The notice of rights includes contact information for reporting complaints to the state agency and the website for the Office of the Medicare Beneficiary Ombudsman.

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

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)

4. 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.

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

31. For organizations that elect The Joint Commission Primary Care Medical Home option: The organization respects the patient’s right to make decisions about the management of his or her care.

32. For organizations that elect The Joint Commission Primary Care Medical Home option: The organization respects the patient’s right and provides the patient the opportunity to do the following:
   - Obtain care from other clinicians of the patient’s choosing within the primary care medical home
   - Seek a second opinion from a clinician of the patient’s choosing
   - Seek specialty care

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

Standard RI.01.03.01
The 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 licensed independent practitioner or other licensed practitioners with privileges about the care, treatment, or services that the patient will receive. Informed consent is not merely a signed document. It is a process that considers patient needs and preferences, compliance with law and regulation, and patient education. Utilizing the informed consent process helps the patient to participate fully in decisions about his or her care, treatment, or 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
   - 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; the likelihood of the patient achieving his or her goals; and any potential problems that might occur during recuperation.
   - Reasonable alternatives to the patient’s proposed care, treatment, 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.

15. For ambulatory surgical centers that elect to use The Joint Commission deemed status option: Informed consent is obtained before a treatment or procedure is performed.

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
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 (See also RC.02.01.01, EP 4)
   - 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) responsible for his or her care, treatment, or services.

Elements of Performance for RI.01.04.01

1. The organization informs the patient of the following:
The name of the physician or other practitioner who has primary responsibility for his or her care, treatment, or services

The name of the physician(s) or other practitioner(s) who will provide his or her care, treatment, and services

7. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The organization allows the patient to select his or her primary care clinician.

**Standard RI.01.04.03**

**For organizations that elect The Joint Commission Primary Care Medical Home option:** The organization provides patients with information about the functions and services of the primary care medical home.

**Elements of Performance for RI.01.04.03**

1. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The organization provides information to the patient about: The mission, vision, and goals of the primary care medical home. (Refer to LD.02.01.01, EP 3)

   **Note:** This may include how it provides for patient-centered and team-based comprehensive care, a systems-based approach to quality and safety, and enhanced patient access.

2. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The organization provides information to the patient about: How the primary care medical home functions, its scope of care, and its types of services. (For more information, refer to Standards PC.01.01.01 and LD.01.03.01)

3. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The organization provides information to the patient about the following:
   - Selection of a primary care clinician
   - Involvement in his or her own treatment plan
   - Management of referrals
   - Coordination of care
   - Collaboration with patient-selected clinicians who provide specialty care or second opinions
   - Communication with the primary care medical home about health care concerns or other information
5. **For organizations that elect The Joint Commission Primary Care Medical Home option: The organization provides information to the patient about:** Patient responsibilities, including providing health history and current medications, and participating in self-management activities. (Refer to RI.02.01.01, EP 2)

6. **For organizations that elect The Joint Commission Primary Care Medical Home option: The organization provides information to the patient about:** The patient’s right to obtain care from other clinicians within the primary care medical home, to seek a second opinion, and to seek specialty care. (Refer to PC.02.03.01, EP 4; RI.01.01.03, EPs 1 and 3)

7. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home provides patients with information regarding the credentials and educational background of individuals serving in the role of primary care clinician.

### 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 that specify whether the organization will honor advance directives. The organization communicates its policies on advance directives to patients upon request.

2. ✐ For ambulatory surgical centers that elect to use The Joint Commission deemed status option: Prior to the start of the surgical procedure the ambulatory surgical center provides the patient or his or her surrogate decision-maker with written information concerning its policies on advance directives, including a description of applicable state health and safety laws and, if requested, official state advance directive forms.

10. Upon request, the organization shares with the patient possible sources of help in formulating advance directives.

### Standard RI.01.06.03

The patient has the right to be free from neglect; exploitation; and verbal, mental, physical, and sexual abuse.
**Elements of Performance for RI.01.06.03**

1. The 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.

2. The organization evaluates all allegations, observations, and suspected cases of neglect, exploitation, and abuse that occur within the organization. *(See also PC.01.02.09, EP 1)*

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)*

6. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The organization respects the patient’s right to be free from all forms of abuse or harassment.

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**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.

10. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The patient has the right to exercise his or her rights without being subject to coercion, discrimination, reprisal, or interruption of care that could adversely affect the patient.

11. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The patient has the right to voice grievances regarding treatment or care that are (or fail to be) furnished.

21. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The ambulatory surgical center establishes a written procedure for documenting the existence, submission, investigation, and disposition of a patient’s written or verbal grievance(s).
22. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** All allegations, violations, or grievances related to, but not limited to, mistreatment, neglect or verbal, mental, sexual or physical abuse, are immediately reported to a person in authority in the ambulatory surgical center.

23. ⚫ **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** All alleged violations or grievances related to, but not limited to, mistreatment, neglect or verbal, mental, sexual or physical abuse, are fully documented.

24. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** Substantiated allegations related to, but not limited to, mistreatment, neglect or verbal, mental, sexual or physical abuse, are reported to the state authority or the local authority, or both.

25. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The grievance process specifies time frames for review of the grievance and the provision of a response.
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26. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The ambulatory surgical center, in responding to the grievance, investigates all grievances made by a patient or the patient’s representative regarding treatment or care that is (or fails to be) furnished.

27. **For ambulatory surgical centers that elect to use The Joint Commission deemed status option:** The ambulatory surgical center documents how the grievance was addressed and provides the patient with written notice of its decision. The decision contains the name of an ambulatory surgical center contact person, the steps taken to investigate the grievance, the results of the grievance process, and the date the grievance process was completed.

**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 their plan of care, treatment, or services. They should also express any concerns about their ability to follow the proposed plan of care, treatment, or services.
- Accepting consequences. Patients should accept their share of responsibility for the outcomes of care, treatment, or services if they do not follow the care, treatment, or services plan.
- 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.

**Element of Performance for RI.02.01.01**

2. The organization informs the patient about his or her responsibilities.

   **Note:** Information about patient responsibilities can be shared verbally, in writing, or both.
Transplant Safety (TS)

Overview
Transplantation of tissues is sometimes the only option for treatment of a wide range of diseases. In the past 10 years, advances in transplantation have led to a greater success rate for transplanted tissues. More and more people receive transplants every year. Tissue transplants are used most often to enhance the lives of recipients; they are also used at times to save lives. Tissues that are transplanted include bones, tendons, corneas, heart valves, veins, and skin. A single donor can save many lives, as well as improve the quality of life for many more.

Transplantation is not free from risk. Transmission of infections from the donor to the recipient is a significant safety concern. With the increased number of tissue transplants, the number of opportunities for transmission of infectious pathogens has also increased. Instances of tissue-borne infection in recipients of donor tissues are well documented. Diseases with documented transmission from infected donors subsequent to transplant include, to name a few, HIV, hepatitis B and C, and Creutzfeldt-Jakob disease (CJD). Recipients may also contract bacterial or fungal infections through contamination during transportation, storage, or handling. The opportunity for transmission of infectious disease will continue to increase as the number of transplants continues to rise.

Effective communication of an adverse event directly related to tissue use is critical to patient safety. The organization may become aware of an adverse event directly related to tissue use through external notification or internal detection. Prompt investigation of each adverse event provides response and treatment to recipients affected by the infected tissue and could prevent further transplantation from an infected donor.

About This Chapter
The standards in this chapter focus on the development and implementation of policies and procedures for safe tissue transplantation.
Chapter Outline

I. Donating and Procuring Organs and Tissues — Not applicable to ambulatory care

II. Transplanting Organs — Not applicable to ambulatory care

III. Transplanting Tissues
   A. Standardized Procedures to Acquire, Receive, Store, and Issue Tissue (TS.03.01.01)
   B. Bi-directional Tracing of Tissues (TS.03.02.01)
   C. Tissue Adverse Events Investigation (TS.03.03.01)
Standards, Rationales, and Elements of Performance

**Introduction to Standards TS.03.01.01, TS.03.02.01, and TS.03.03.01**

The following standards apply to organizations that store or issue tissue. This includes any areas outside of the clinical laboratory that store or issue tissue; for example, surgery and outpatient centers or tissue banks. They apply to human and nonhuman cellular-based transplantable and implantable products whether classified by the US Food and Drug Administration (FDA) as a tissue or a medical device. Collagen and tissue products derived from plastics and polymers are not considered cellular-based products and are not evaluated under these standards.

Specific tissue transplant requirements apply to autologous tissue. This includes policies and procedures for identifying, tracking, storing, and handling autologous tissue, in addition to investigating tissue adverse events. Also, if the state in which an organization resides classifies something as tissue that falls outside the scope of The Joint Commission definition, the standards would apply.

**Examples of Tissue and Cell Products**
- Amnion/Amniotic Membrane
- Arteries
- Autologous Cells
- Autologous Tissue
- Bone
- Bone Marrow
- Bone Paste
- Bone Powder
- Bone Putty
- Cancellous Chips
- Cardiac (Heart) Valves (Aortic, Pulmonary)
- Cartilage
- Chondrocytes
- Cornea
- Demineralized Bone Matrix
- Dendritic Cells
- Dermal Matrix
- Dermis
- Dura Mater
- Embryo
- Fascia/Fascia Lata
- Hematopoietic Stem Cell
- Leukocytes
- Ligaments
- Limbal Graft
- Limbal Stem Cells
- Lymphocytes
- Marrow
- Membrane
- Meniscus
- Nerves
- Non-valved Conduits
- Oocyte/Ovarian Cells
- Ovarian Tissue
- Pancreatic Islet Cells
- Parathyroid
- Pericardium
- Peripheral Blood Stem Cells
- Progenitor Cells
- Sclera
- Semen, Sperm
- Skin
- Somatic Cells
- Tendons
- Testicular Tissue
- Therapeutic Cells (T-Cell Pheresis)/T-Cells
- Tissue (also Synthetic Tissue)
- Trachea
- Umbilical Cord Blood Stem Cells
- Vascular Graft
- Veins (Saphenous, Femoral, Iliac)
Other cellular- and tissue-based transplant or implant products whether classified by the FDA as a tissue or a medical device

Other tissues that are classified as tissues by state law and regulation

**Standard TS.03.01.01**
The organization uses standardized procedures for managing tissues.

**Elements of Performance for TS.03.01.01**

1. The organization assigns responsibility to one or more individuals for overseeing the acquisition, receipt, storage, and issuance of tissues throughout the organization.

   **Note:** *Responsibility for this oversight involves coordinating efforts to provide standardized practices throughout the organization. An organization may have a centralized process (one department responsible for the ordering, receipt, storage, and issuance of tissue throughout the organization) or a decentralized process (multiple departments responsible for the ordering, receipt, storage, and issuance of tissue throughout the organization).*

2. The organization develops and maintains standardized written procedures for the acquisition, receipt, storage, and issuance of tissues. *(See also TS.03.02.01, EP 5)*

3. The organization confirms that tissue suppliers are registered with the US Food and Drug Administration (FDA) as a tissue establishment and maintain a state license when required. *

   **Note:** *This element of performance does not apply to autologous tissue- or cellular-based products considered tissue for the purposes of these standards but classified as medical devices by the FDA.*

4. The organization follows the tissue suppliers’ or manufacturers’ written directions for transporting, handling, storing, and using tissue.

5. The organization documents the receipt of all tissues. *(See also TS.03.02.01, EPs 3 and 6)*

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* For US Food and Drug Administration (FDA) registration, the supplier registration status may also be checked annually by using the FDA’s online database: http://www.fda.gov/cber/tissue/tissregdata.htm.
7. ☐ The organization verifies at the time of receipt that package integrity is met and transport temperature range was controlled and acceptable for tissues requiring a controlled environment. This verification is documented. *(See also TS.03.02.01, EP 6)*

**Note 1:** If the distributor uses validated shipping containers, then the receiver may document that the shipping container was received undamaged and within the stated time frame.

**Note 2:** Tissues requiring no greater control than “ambient temperature” (generally defined as the temperature of the immediate environment) for transport and storage would not need to have the temperature verified on receipt.

8. ☐ The organization maintains daily records to demonstrate that tissues requiring a controlled environment are stored at the required temperatures. *(See also TS.03.02.01, EP 5)*

**Note 1:** Types of tissue storage include room temperature, refrigerated, frozen (for example, deep freezing colder than -40°C), and liquid nitrogen storage.

**Note 2:** Tissues requiring no greater control than “ambient temperature” (defined as the temperature of the immediate environment) for storage would not require temperature monitoring.

9. The organization continuously monitors the temperature of refrigerators, freezers, nitrogen tanks, and other storage equipment used to store tissues.

**Note 1:** Continuous temperature recording is not required but may be available with some continuous temperature monitoring systems.

**Note 2:** For tissue stored at room temperature, continuous temperature monitoring is not required.

10. Refrigerators, freezers, nitrogen tanks, and other storage equipment used to store tissues at a controlled temperature have functional alarms and an emergency back-up plan. ☐

**Note:** For tissue stored at room temperature, alarm systems are not required.

**Standard TS.03.02.01**
The organization traces all tissues bi-directionally.
Elements of Performance for TS.03.02.01

1. □ The organization’s records allow any tissue to be traced from the donor or tissue supplier to the recipient(s) or other final disposition, including discard, and from the recipient(s) or other final disposition back to the donor or tissue supplier. ❋

2. □ The organization identifies, in writing, the materials and related instructions used to prepare or process tissues.

3. □ The organization documents the dates, times, and staff involved when tissue is accepted, prepared, and issued. (See also TS.03.01.01, EP 6)

4. The organization documents in the recipient’s clinical record the tissue type and its unique identifier.

5. The organization retains tissue records on storage temperatures, outdated procedures, manuals, and publications for a minimum of 10 years. If required by state and/or federal laws, organizations may have to retain tissue records longer than 10 years. (See also TS.03.01.01, EPs 2 and 8)

6. The organization retains tissue records for a minimum of 10 years beyond the date of distribution, transplantation, disposition, or expiration of tissue (whichever is latest). If required by state and/or federal laws, organizations may have to retain tissue records longer than 10 years. Records are kept on all of the following:
   - The tissue supplier

   **Note:** For medical devices, the manufacturer may be the tissue supplier.
   - The original numeric or alphanumeric donor and lot identification
   - The name(s) of the recipient(s) or the final disposition of each tissue
   - The expiration dates of all tissues

   (See also TS.03.01.01, EPs 6 and 7)
7. The organization completes and returns tissue usage information cards requested by the tissue supplier.†

**Standard TS.03.03.01**

The organization investigates adverse events related to tissue use or donor infections.

**Elements of Performance for TS.03.03.01**

1. The organization has a written procedure to investigate tissue adverse events, including disease transmission or other complications that are suspected of being directly related to the use of tissue.

2. The organization investigates tissue adverse events, including disease transmission or other complications that are suspected of being directly related to the use of tissue.

3. As soon as the organization becomes aware of a post-transplant infection or other adverse event related to the use of tissue, it reports the infection or adverse event to the tissue supplier. R

4. The organization sequesters tissue whose integrity may have been compromised or that is reported by the tissue supplier as a suspected cause of infection. R

5. The organization identifies and informs tissue recipients of infection risk when donors are subsequently found to have human immunodeficiency virus (HIV), human T-lymphotropic virus-I/II (HTLV-I/II), viral hepatitis, or other infectious agents known to be transmitted through tissue. R

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† According to the Health Insurance Portability and Accountability Act (HIPAA) regulations regarding protected health information, “A covered entity may disclose protected health information for public health activities or other purposes to a person subject to the jurisdiction of the Food and Drug Administration (FDA) for the following purposes:

- To track products if the disclosure is made to a person required or directed by the FDA to track the product
- To enable product recalls, repairs or replacement (including locating and notifying individuals who have received products of product recalls, withdrawals, or other problems” (Refer to 45 CFR 164.512(b)(1)(iii)(B) and (C))
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, or CMS websites for the most up-to-date information regarding test categorization and complete CLIA ’88 requirements such as the following:

- 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 type of assurance about quality as they would if they
conducted the testing themselves. The following processes are not specific Joint 
Commission requirements and are provided only as examples of how organizations have 
dealt with these concerns in practice:

- Verification of competency by either confirming the patient has been previously 
  trained or observing the patient perform his or her first test
- Requiring the patient to perform quality control, if available for the meter, each day 
  results are used
- Correlation of the patient’s first glucose result with testing by a main laboratory
- Confirmation of all critical and nonlinear instrument values with testing by the 
  main laboratory
- Demonstration of proper equipment maintenance

**Note:** The Joint Commission requirements for laboratories or sites that perform nonwaived 
testing are located in the “Quality System Assessment for Nonwaived Testing” (QSA) chapter 
of the Comprehensive Accreditation Manual for Laboratory and Point-of-Care Testing.
Chapter Outline

I. Policies and Procedures (WT.01.01.01)

II. Identification of Staff Performing and Supervising Waived Testing (WT.02.01.01)

III. Competency of Staff Performing Waived Testing (WT.03.01.01)

IV. Performance of Quality Control Checks (WT.04.01.01)

V. Recordkeeping (WT.05.01.01)
Standards, Rationales, and Elements of Performance

Standard WT.01.01.01

Policies and procedures for waived tests are established, current, approved, and readily available.

Elements of Performance for WT.01.01.01

1. The director named on the Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88) certificate approves a consistent approach for when waived test results can be used for diagnosis and treatment and when follow-up testing is required. (See also LD.04.01.01, EP 1)

2. The person from the organization whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88) certificate, or a qualified designee, establishes written policies and procedures for waived testing that address the following:

- Clinical usage and limitations of the test methodology
- Need for confirmatory testing (for example, recommendations made by the manufacturer for rapid tests) and result follow-up recommendations (for example, a recommendation to repeat the test when results are higher or lower than the reportable range of the test)
- Specimen type, collection, and identification, and required labeling
- Specimen preservation, if applicable
- Instrument maintenance and function checks, such as calibration
- Storage conditions for test components
- Reagent use, including not using a reagent after its expiration date
- Quality control (including frequency and type) and corrective action when quality control is unacceptable
- Test performance
- Result reporting, including not reporting individual patient results unless quality control is acceptable
- Equipment performance evaluation

Note 1: Policies and procedures for waived testing are made available to testing personnel.
Note 2: The designee should be knowledgeable by virtue of training, experience, and competence about the waived testing performed.

3. If manufacturers’ manuals or package inserts are used as the policies or procedures for each waived test, they are enhanced to include specific operational policies (that is, detailed quality control protocols and any other institution-specific procedures regarding the test or instrument).

4. The person from the organization whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88) certificate, or a qualified designee, approves in writing policies and procedures for waived testing at the following times:
   - Before initial use of the test for patient testing
   - Periodically thereafter, as defined by the person whose name appears on the CLIA certificate but at least once every three years
   - When changes in procedures occur (for example, when manufacturers’ updates to package inserts include procedural changes or when a different manufacturer is used)

Standard WT.02.01.01

The person from the organization whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88) certificate identifies the staff responsible for performing and supervising waived testing.

Note 1: Responsible staff may be employees of the organization, contracted staff, or employees of a contracted service.

Note 2: Responsible staff may be identified within job descriptions or by listing job titles or individual names.

Elements of Performance for WT.02.01.01

1. The person from the organization whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88) certificate, or a qualified designee, identifies, in writing, the staff responsible for performing waived testing.

2. The person from the organization whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88) certificate, or a qualified designee, identifies in writing the staff responsible for supervising waived testing.
Standard WT.03.01.01

Staff 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 1: When a licensed independent practitioner performs waived testing that does not involve an instrument and the test falls within his or her specialty, the organization may use the credentialing and privileging process to document evidence of training and competency in lieu of annual competency assessment. In this circumstance, individual practitioner privileges include the specific waived tests appropriate to their scope of practice that they are authorized to perform. At the
discretion of the person from the organization whose name appears on the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) certificate or according to organization policy, more stringent competency requirements may be implemented.

**Note 2:** Provider-performed microscopy (PPM) procedures are not waived tests.

### Standard WT.04.01.01

The 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. *(R)*

   **Note:** If these elements are not defined by the manufacturer, the organization defines the frequency and number of levels for quality control.

4. For instrument-based waived testing, quality control checks are performed on each instrument used for patient testing per manufacturers’ instructions. *(R)*

5. For instrument-based waived testing, quality control checks require two levels of control, if commercially available.

### Standard WT.05.01.01

The organization maintains records for waived testing.
Elements of Performance for WT.05.01.01

1. Quality control results, including internal and external controls for waived testing, are documented.

   **Note 1:** Internal quality controls may include electronic, liquid, or control zone. External quality controls may include electronic or liquid.

   **Note 2:** Quality control results may be located in the clinical record.

2. Test results for waived testing are documented in the patient’s clinical record.

3. Quantitative test result reports in the clinical 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 clinical record. The result must have a notation directing the reader to the location of the reference intervals (normal values) in the clinical record.

4. Individual test results for waived testing are associated with quality control results and instrument records.

   **Note:** A formal log is not required, but a functional audit trail is maintained that allows retrieval of individual test results and their association with quality control and instrument records.

5. Quality control result records, test result records, and instrument records for waived testing are retained for at least two years.
The Accreditation Process (ACC)

Notices
The Joint Commission Connect™ extranet site is the primary means of communication by The Joint Commission. Any required notices to be given to an organization shall be sent to the organization via the organization’s secure Joint Commission Connect extranet site.

ACC Chapter Contents
This chapter introduces the Joint Commission’s accreditation process, beginning with general information about eligibility for accreditation and the application process, accreditation policies, and types of surveys. Details are then provided on what organizations can expect before, during, after, and between accreditation surveys. Finally, the chapter ends by listing the accreditation decision rules and outlining review and appeal procedures. This outline provides a way to easily navigate the chapter and find information quickly. This list contains a [CMS] icon next to sections that have content of special interest to ambulatory surgical centers that use Joint Commission accreditation for deeming purposes.

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Overview
The policies, procedures, and explanations of process described in this chapter apply to any health care organization interested in Joint Commission accreditation, whether it is applying for the first time or seeking continued accreditation. All ambulatory 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 ambulatory 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 ambulatory 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.

The organization has a facility license or registration to conduct its scope of services, if required by law.

The organization can demonstrate that it continuously assesses and improves the quality of its care, treatment, or services. This process includes a review by clinicians, including those knowledgeable in the type of care, treatment, or services provided at the organization.

The organization identifies the health care services it provides, indicating which care, treatment, or services it provides directly, under contract, or through some other arrangement.

The organization provides services that can be evaluated using Joint Commission standards.

The organization meets parameters for the minimum number of patients or volume of services required for organizations seeking Joint Commission accreditation for the first time or reaccreditation; that is, 10 patients served, with at least 2 active at the time of survey.

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.

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

†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.

‡A licensed independent practitioner is an individual permitted by law and by the organization to provide care, treatment, or 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 by organizational policy.
prepared to provide evidence of its compliance with each applicable standard. To attain accreditation, an organization must demonstrate compliance with the standards and their elements of performance (EPs).

In addition to using standards and EPs, The Joint Commission also surveys organizations by using APRs and the Joint Commission National Patient Safety Goals (see the APR and “National Patient Safety Goals” [NPSG] chapters, respectively). Used in conjunction with the standards, these requirements help assess an organization’s performance.

**Accreditation Policies**

This section provides information on the policies that govern the accreditation process for ambulatory 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), including laboratory services, that are organizationally and functionally integrated with the ambulatory care organization applying for accreditation (see the “Organizational and Functional Integration” section).

The Joint Commission will include another service, program, or related entity (that is, component), whether providing programs or services directly or through a contractual arrangement, in the survey of the applicant organization under the following circumstances:

- There are Joint Commission accreditation/certification requirements applicable to the component.
- There is organizational and functional integration between the component and the applicant organization.

The Joint Commission survey, assuming satisfactory compliance, provides one accreditation award for each accreditation program surveyed (for example, ambulatory physical health care, behavioral health care, home care, nursing care centers, and so forth).

---

1 Contractual arrangements are evaluated for tailoring applicability on a case-by-case basis.
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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5The laboratory must meet the requirements of decision rule FOC01 for the organization to be successfully accredited. See the “One-Month Survey” section in the “Accreditation Decision Rules” for the full requirement.

6A 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 credentialing and assigning of privileges or clinical responsibilities to licensed independent practitioners and/or
This page is blank due to revisions through the CAMAC update.
- 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 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.

A checklist to help determine whether organizational and functional integration exists is provided in Figure 1.
<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>
<td></td>
<td></td>
</tr>
<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>
<td></td>
<td></td>
<td></td>
</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>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>4. Management</strong>—Does the applicant organization manage operations of the component?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>5. Patient records</strong>—Is there an integrated patient record system?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>6. Performance improvement</strong>—Is there an integrated performance improvement program? Does the applicant organization have authority to implement performance improvement actions at component?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>7. Billing</strong>—Are the component’s services billed by the applicant organization?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>8. Public portrayal</strong>—Is there public portrayal of component as part of a parent organization through names, logos, or such?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:** Applicant organization needs minimum of one “Yes” response for organizational integration and three “Yes” responses for functional integration to include components as “sites” on the electronic application for accreditation (E-App).

**Figure 1.** Checklist to determine organizational and functional integration.
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 size of the system (see Table 1) and the risk level of the services provided (see Table 2).

Table 1. Sampling for System Surveys by Size

<table>
<thead>
<tr>
<th>Number of Sites in System</th>
<th>Survey Volume</th>
<th>Number of Sites in System</th>
<th>Survey Volume</th>
</tr>
</thead>
<tbody>
<tr>
<td>75 or fewer</td>
<td>All sites up to 19</td>
<td>200 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>
<td>201 or more</td>
<td>10% of sites up to a maximum of 30 sites</td>
</tr>
</tbody>
</table>

Note: This methodology does not apply to sites that provide surgery, general anesthesia, or moderate sedation; any of these sites within a system must be surveyed.

Table 2. Sampling for System Surveys by Risk

<table>
<thead>
<tr>
<th>High-Risk Services</th>
<th>Low-Risk Services</th>
</tr>
</thead>
</table>

Note: All sites that provide general anesthesia, moderate sedation, or surgery are considered high risk and will be sampled at a rate of 100%.
With system accreditation, the entire system undergoes the accreditation process during a concentrated period of time. Additionally, the entire system will be assigned a single, dedicated account executive.

Eligibility requires a minimum of four sites 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

| Cardiac catheterization and cardiology | Allergy |
| Cardiography medicine                  | Alternative medicine |
| Dentistry                               | Anesthesia practice that provides only local anesthesia |
| Endocardiography                        | Audiology |
| Endoscopy                               | Cardiac practice (noninvasive) |
| ENT procedures                          | Computed tomography |
| Freestanding ER                         | Computed tomography angiography |
| Gynecology and obstetrics               | Convenient care |
| Hematology                              | Dermatology |
| Infusion therapy                        | Diagnostic imaging |
| Interventional radiological procedures  | Direct primary care |
| In vitro fertilization                  | Family practice |
| Kidney care/dialysis                    | Gastroenterology |
| Lithotripsy                             | General practice |
| Mohs surgical procedures                | Internal medicine |
| Nuclear medicine                        | Mammography |
| Oncology                                | Magnetic resonance angiography |
| Ophthalmic surgery                      | Magnetic resonance imaging |
| Oral maxillofacial surgery              | Nuclear cardiology |
| Orthopedic surgery                      | Neurology |
| Pain management (invasive)              | Occupational/worksite health |
| Plastic surgery                         | Optometry practice |
| Podiatric surgery                       | Orthopedic medicine |
| Radiation oncology                      | Orthotic/prosthetics |
| Short stay—observation/recovery/infirmary | Otolaryngology |
| Telehealth surgical                     | Pain management (noninvasive) |
| Urgent care                             | Pediatric medicine |
| Urological procedures                   | Positron emission tomography |
| Urology                                 | Pharmacy dispensary |
| Vascular medicine                       | Podiatry |
| Vascular medicine                       | Pulmonary medicine |
| Vascular medicine                       | Rheumatology |
| Vascular medicine                       | Sleep diagnostics |
| Vascular medicine                       | Ultrasound |

Shading indicates a change effective July 1, 2017, unless otherwise noted in the What's New.
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 ambulatory care organizations, please contact Business Development, Ambulatory Care Accreditation Program, at 630-792-5286.

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**

An ambulatory surgical center 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 component of the survey is required by CMS. Once an organization is accredited by The Joint Commission through this process, CMS will determine the organization to be in compliance with federal requirements specified in the Conditions for Coverage for ambulatory surgical centers. 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.
This option, referred to as deemed status, applies only to an organization that meets the Medicare definition of an ambulatory surgical center and is eligible for Medicare certification, as determined by the federal regulations. The CMS applies the following specific definition for ambulatory surgical centers eligible to receive reimbursement for facility services from Medicare:

An ambulatory surgical center [ASC] means any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring ambulatory care hospitalization, and in which the expected duration of services would not exceed 24 hours following an admission, has an agreement with CMS to participate in Medicare as an ASC, and meets the conditions for coverage [CfCs] as defined by regulation. For purposes of deeming, CMS considers all applicants as ambulatory care organizations regardless of the number of patients under anesthesia at any given time.

Joint Commission accreditation is voluntary, and seeking deemed status through Joint Commission accreditation is an option, not a requirement. An ambulatory surgical center 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.

Advanced Diagnostic Imaging Accreditation Option

An Advanced Diagnostic Imaging (ADI) supplier may utilize any of four imaging modalities: magnetic resonance imaging (MRI), computed tomography (CT), positron emission tomography (PET), and nuclear medicine. The Joint Commission is a CMS-designated accreditor for organizations furnishing the technical component (TC) of ADI services that seek reimbursement for Medicare Part B payments. The ADI option is available for meeting CMS requirements; ambulatory care accreditation is required for an organization to be eligible for the ADI option. The Joint Commission’s standards for ADI meet all applicable CMS requirements and focus on the qualifications of medical personnel and medical directors, performance specifications for imaging equipment, and related quality assurance and quality control programs to ensure the safety, reliability, clarity, and accuracy of diagnostic imaging. ADI suppliers participating in the accreditation process with The Joint Commission will have an unannounced, on-site review to evaluate compliance with all pertinent Joint Commission standards.

Note: The CMS requirement does not apply to ADI services provided by hospital inpatient or outpatient services billing under the inpatient or outpatient prospective payment system.
Primary Care Medical Home Certification Option

The Joint Commission’s Primary Care Medical Home (PCMH) certification option helps ambulatory care organizations provide patient-centered, comprehensive, accessible, and coordinated care delivered by a primary care clinician working with an interdisciplinary care team. This voluntary certification is achieved by demonstrating compliance with all ambulatory care standards, plus an additional set of PCMH-only requirements that support the five operational characteristics of the PCMH model (see the “Primary Care Medical Home Certification Option” [PCMH] chapter). PCMH certification is an optional selection available as part of the application for accreditation; that is, ambulatory care accreditation is required for an organization to be eligible for PCMH certification.

PCMH initial surveys occurring with an initial ambulatory care accreditation survey will be announced, as the evaluation of PCMH requirements are integrated as part of the on-site survey process. PCMH certification can also be added to an existing ambulatory care accreditation through an extension survey. In an extension survey, the surveyor will conduct an unannounced on-site survey prior to the 18–36 month resurvey. Additional information about the PCMH certification option for ambulatory care organizations is available on The Joint Commission website at http://www.jointcommission.org/accreditation/pchi.aspx. The Joint Commission also offers similar certification for hospitals, critical access hospitals, and behavioral health care organizations.

Organizations that are requesting or that have achieved PCMH certification may access the Provider Information Tool via their E-App or Joint Commission Connect™ extranet site. This optional tool enables organizations to identify clinical providers who serve as staff at eligible PCMH sites. Depending on the location of the organization, this information may be used by payers for reimbursement or funding purposes.

In addition, PCMH-certified ambulatory care organizations must identify in the E-App which of their sites are PCMH-eligible. An eligible care delivery site is defined as a location where ongoing established relationships exist between a primary care clinician and a panel of patients. This site needs to provide ongoing and continuous primary care to a majority of its patients, irrespective of the location of the site or the population of patients being served.
Examples of sites that are not eligible include the following: administrative offices, dental-only practices, lab/phlebotomy–only, physical therapy services–only, opioid treatment programs, podiatric services–only, mental health services–only, and sites that primarily provide episodic or urgent medical care rather than ongoing and continuous primary care.

Detailing this information enables The Joint Commission to indicate on Quality Check which site(s) are PCMH-certified. This information may be used by payers for reimbursement or funding purposes.

**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 (defined below) of patients regardless of how long the organization has been in operation. The full scope of applicable standards is reviewed during the survey. The Joint Commission’s policy for assessing and monitoring organizations new to the accreditation process is as follows:

- If an organization new to the accreditation process demonstrates compliance with applicable Joint Commission accreditation requirements, the organization will receive accreditation.
- All organizations new to the accreditation process that become accredited after their initial survey will be included in a 2% “pool” of organizations undergoing a random unannounced on-site validation survey of their Evidence of Standards Compliance (ESC) (see the “Random Validation of Evidence of Standards Compliance” section for more information).
- The organization meets parameters for the minimum number of patients/volume of services required for organizations seeking Joint Commission accreditation for the first time or reaccreditation; that is, 10 patients served, with at least 2 active at the time of 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 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, reformattng, or content deletion of documents.

3. The organization may submit additional material that summarizes or otherwise explains original information submitted to The Joint Commission. These materials must be properly identified, dated, and accompanied by the original documents.

4. The Joint Commission conducts an evaluation when it has cause to believe that an accredited organization/certified program may have provided falsified information to The Joint Commission relevant to the accreditation/certification process. Except as otherwise authorized by the president of The Joint Commission, the evaluation may include an unannounced on-site survey. This survey uses special protocols designed to address the information determined by The Joint Commission to constitute possible falsification. It assesses the degree of actual organization compliance with the standards and EPs that are the subject of the allegation, if appropriate.

5. The Joint Commission takes action to deny accreditation/certification to an organization/program whenever The Joint Commission is reasonably persuaded that the organization/program has provided falsified information.

6. The Joint Commission may notify responsible federal and state government agencies of any organization/program subject to such action.

7. If an organization/program is denied accreditation/certification because it provided falsified information, The Joint Commission prohibits it from participating in the accreditation or certification process for a period of one year. The president of The Joint Commission, for good cause only as determined in his/her sole discretion, may
waive all or a portion of this waiting period. If an organization requests to participate in the accreditation/certification process prior to the completion of the one-year prohibition period and the president of The Joint Commission does honor the request, executive leadership will be so notified.

**Good Faith Participation in Accreditation/Certification**

The Joint Commission requires each organization seeking (re)accreditation or (re)certification to engage in the process in good faith. The Joint Commission may deny accreditation or certification to any organization that fails to participate in the process in good faith. The following are examples of actions interfering with good faith participation:

- **Deceiving The Joint Commission.** Compliance with the Information Accuracy and Truthfulness Policy requires a commitment on the part of the accredited organization/certified program not to deceive The Joint Commission in any aspect of the accreditation/certification process, such as during the completion of an application for accreditation/certification, during the Intracycle Monitoring (ICM) process, or during a survey/review.

- **Deceiving the public.** An accredited organization/certified program is not acting in good faith if it misleads the public about the meaning and limitations of accreditation/certification. Also, an accredited organization/certified program must not inaccurately suggest to the public that its accreditation/certification award applies to any unaccredited affiliated or otherwise related activities.

- **Retaliation.** The Joint Commission invites open communication from any accredited organization’s/certified program’s staff and recipients of care, treatment, and services about any standards compliance or other issues related to the accreditation/certification process. An organization’s/program’s good faith participation in the accreditation/certification process is questioned if the organization/program does any of the following:
  - Attempts to discourage such communication—for example, by taking disciplinary steps against an employee solely because that employee provides information to The Joint Commission
  - Threatens those who communicate with The Joint Commission with a defamation lawsuit based solely on what was said to The Joint Commission
- Allows the treatment or access to services of any individual or staff member to be adversely affected by his or her or a family member’s communication with The Joint Commission

- Standards compliance. If an organization’s program’s conduct reflects a lack of commitment to standards compliance, issues of good faith may be raised. For example, an intentional refusal to attempt to comply with a standard could suggest a cavalier view of the accreditation/certification process.

The good faith participation requirement applies continuously throughout the accreditation/certification process.

**Public Information Policy**

**Introduction**

The Joint Commission is committed to making relevant and accurate information about health care organizations available to interested parties. Information regarding a health care organization’s quality and safety can help organizations improve their services. This information may also help educate consumers and health care purchasers in making informed choices about health care. At the same time, it is important that confidentiality of certain information be maintained to encourage candor in the accreditation and certification processes. The Joint Commission’s primary vehicle for providing public information are Quality Check® and Quality Reports.

**Quality Check.** Quality Check is The Joint Commission’s website for making available descriptive and performance information about accredited organizations and certified programs.

**Quality Reports.** The Quality Reports located on Quality Check are publicly available and include relevant and useful information about the quality and safety of care provided in individual Joint Commission–accredited organizations and –certified 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.

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.

Denial of Accreditation decisions, for organizations that were in the accreditation renewal process, will be posted on the Quality Check website for a duration of one year from the rendering of the accreditation decision.
Release of Aggregate Data
The Joint Commission reserves the right to publish or release aggregate data. Protected health information will not be made publicly available. Performance data displayed on Quality Check are available to any interested party at no cost and may be downloaded electronically in a series of predefined report formats through a linked webpage called “Quality Data.”††

Information That Is Publicly Disclosed on Request

Release of Accreditation and Certification Information. In addition to information provided in Quality Reports, the following information may be obtained by writing or calling The Joint Commission:

- For organizations that were previously denied accreditation, are no longer certified, or withdrew from the accreditation/certification process:
  - The organization’s accreditation and/or certification history
  - Standards for which The Joint Commission had no or insufficient evidence of resolution when an organization withdrew from accreditation and was subsequently denied accreditation

Sentinel Event Information. As applicable, confirmation of the occurrence of a sentinel event at an accredited organization for the three-year period prior to the date of the request and The Joint Commission’s intent to apply its Sentinel Event Policy or other applicable procedures to this occurrence.

Release of Aggregate Complaint-Related Information. The Joint Commission addresses all incidents that pertain to alleged patient safety or quality of care issues within the scope of Joint Commission standards. Information about complaints‡‡ may be forwarded by the Centers for Medicare & Medicaid Services (CMS) or other federal or state agencies having oversight responsibilities for health care organizations, federal or state legislators or legislative committees on behalf of constituents, or may be received directly from patients, families, payers, or health care professionals. As used here, the term complaint includes potentially relevant reports that are received from federal or state agencies, identified in the media, or otherwise obtained by The Joint Commission. The Joint Commission will only disclose patient-identifiable information if authorized by the patient, as consistent with its business associate obligations, or otherwise authorized by

††This information is not available for ambulatory health care organizations and office-based surgery practices.
‡‡The term complaint refers to an alleged adverse event, unsafe condition, or concern.
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.

55 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.
The Accreditation Process

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:

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.
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.
Joint Commission Right to Clarify
The Joint Commission reserves the right to clarify information, even if the information involved would otherwise be considered confidential, when an organization disseminates inaccurate information regarding its accreditation/certification.

Confidential Information
The Joint Commission keeps information received or developed during the accreditation/certification process confidential, such as:

- The Official Accreditation Decision Report, unless its submission is required by a governmental agency (see “Data Release to Government Agencies and Organizations with Which The Joint Commission Performs Coordinated Survey Activities”), is required by organizations with which The Joint Commission performs coordinating surveys, or is requested by an accredited body with which The Joint Commission has a formal agreement (see “Data Release to Cooperative Accrediting Bodies”)
- Information learned from the organization before, during, or following the accreditation survey, which is used to determine compliance with specific accreditation standards
- An organization’s comprehensive systematic analysis and related documents prepared in response to a sentinel event or in response to other circumstances specified by The Joint Commission
- All other materials that may contribute to the accreditation/certification decision
- Written staff analyses and executive leadership minutes and agenda materials
- Any data from an organization’s participation in the intracycle monitoring process and related corrective action plan
- The identity of any individual who files a complaint about an accredited organization, except when the complaint is shared by The Joint Commission with a governmental entity, an organization with which The Joint Commission performs coordinated surveys, or accrediting organizations with which The Joint Commission has formal complaint-sharing agreements and the receiving organization has agreed to maintain the confidentiality of the complainant. In instances when the receiving organization cannot assure the confidentiality of the complainant, any complainant-identifying information shall be redacted by The Joint Commission prior to sharing.

This policy applies to all organizations with an accreditation and/or certification history, subject to any requirements of any applicable laws.
Process for Responding to a Complaint

The Joint Commission’s Office of Quality and Patient Safety (OQPS) triages and reviews complaints, concerns, and inquiries related to accredited health care organizations, as received from a variety of sources. These complaints may be submitted by patients, families, and health care providers; by state and federal agencies in the form of reports; or through information from the media. The term complaint therefore covers a broad spectrum of information received by the OQPS.

Upon Joint Commission review of a complaint, a number of actions may result. These include recording the information for trending purposes and possible action in the future, obtaining the involved health care organization’s response to the complaint, and/or conducting an immediate for-cause survey. If The Joint Commission determines that the organization should respond to the complaint, the organization will be so notified. The request for a response will be e-mailed to the organization’s CEO and posted to the organization’s Joint Commission Connect™ extranet site (a secure, password-protected website intended only for Joint Commission–accredited or –certified organizations and key stakeholders). The organization’s response to the complaint also takes place through its extranet site.

The complaint information posted on the Joint Commission Connect site may be either of the following:

- The complaint itself, if the complainant has given permission to do so
- A summary of the complaint, if the complainant requested anonymity

If an accredited organization is required to respond to the complaint, it is usually required to do so within 30 business days of being notified. For more serious issues, the organization may be required to respond to the complaint within 7 business days of being notified, or sooner. When a response in a short time frame is required, the organization will be so notified.

Once a response is received, it is evaluated for compliance with the Joint Commission’s standards, National Patient Safety Goals, and APRs, as applicable. If additional information is required, the organization will be notified.

When the organization’s response is complete and has been accepted, a letter indicating acceptance is e-mailed to the CEO, and the case is considered closed.
Early Survey Policy
An organization seeking Joint Commission accreditation for the first time may choose the Early Survey Policy option. An organization surveyed under the Early Survey Policy will have two surveys. Sidebar 1 lists key features of the Early Survey Policy.

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 date the successful ESC is submitted. If at six months the organization is not ready for the second survey, the organization’s Limited, Temporary Accreditation decision will expire.

Note: Limited, Temporary Accreditation is not recognized by CMS for Medicare certification purposes (but it may be required for state licensure).
Eligibility for Limited, Temporary Accreditation

The Early Survey Policy is available to any organization that is currently not accredited—except for those that have been denied accreditation. An organization must declare during the application process that it wishes to be surveyed under this policy.

The First Survey. When an organization chooses to be surveyed under the Early Survey Policy, The Joint Commission conducts two on-site surveys. The Joint Commission can conduct the first survey as early as two months before the organization begins its operations, provided that the organization meets the following criteria:

- It is licensed (according to law and regulation) or in the licensing process.
- The building in which the services will be offered or from which the services will be coordinated is identified, constructed, and equipped to support such services.
- It has identified its CEO or administrator, its director of clinical or medical services, and its nurse executive, if applicable.
- It has identified the date it will begin operations.

Generally, the first survey uses a limited set of standards and assesses only the organization’s physical facilities, policies and procedures, plans, and related structural considerations. For this reason, organizations surveyed under this policy are not recognized by CMS 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” [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 scheduling 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 ambulatory surgical centers 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 or –certified health care organization can register themselves for guest access. Guest access enables viewers to see the Leading Practice Library and Standards BoosterPaks™. Guest access does not include entry to any organization-specific data or reports.

Role of the Account Executive
The Joint Commission assigns an account executive to an organization after receiving its E-App and nonrefundable deposit. This person serves as the primary contact between the organization and The Joint Commission. He or she coordinates survey planning and
handles policies, procedures, accreditation 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 630-792-5286 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. In order to ensure that the correct standards are identified for each program, please work with your Joint Commission account executive to correctly complete your organization’s service profile in the E-App.
- 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, an ambulatory care organization and The Joint Commission must have a signed Business Associate Agreement before the

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# The Joint Commission does not charge a deposit for accredited health care organizations that are seeking a new tailored (or certification) program. Also, in instances where an “owner” of multiple health care organizations has at least five accredited entities in good standing, that entity will be eligible for a deposit waiver.
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 ambulatory 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. Because it believes in transparency regarding its fee structure, The Joint Commission also posts this information to the Joint Commission website at https://www.jointcommission.org/accreditation/ahc寻求_ambulatory_health_care.aspx.

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. For ambulatory care organizations that elect to use the optional PCMH certification, there will be an additional modest annual fee assessment for this certification. 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 conducting a survey. If a survey specialist is required to be on the survey team (see the “Life Safety Code® Surveyor Scope of Service” section), the organization’s invoice will reflect the additional fees to cover the costs of the survey specialist.

Organizations requiring additional surveys, such as to evaluate a patient safety event, will be assessed a separate on-site survey fee.

Electronic invoices will be posted to the organization’s secure Joint Commission Connect site and are due upon receipt. The Joint Commission accepts payment for all fees in any of the following ways:

- Electronic payment using Visa, MasterCard (credit or debit), American Express, Discover, or e-check by logging on the organization’s Joint Commission Connect accreditation home page and clicking on the “What’s Due” tab or by calling Accounts Receivable staff at 630-792-5662
- Check or money order by mail to PO Box 92775, Chicago, IL 60675-2775, or overnight to One Renaissance Boulevard, Oakbrook Terrace, IL 60181
- Wire transfer by calling Accounts Receivable staff at 630-792-5662

Failure to provide timely payment of any Joint Commission fees may result in the loss of accreditation. Letters of nonpayment are posted to the health care organization’s Joint Commission Connect extranet site. Failure to pay overdue amounts will result in a loss of accreditation with no opportunity for appeal or reinstatement. For help in making a payment, please contact Accounts Receivable staff at 630-792-5662.

**During the Survey**

During an accreditation survey, The Joint Commission evaluates an organization’s performance of functions and processes aimed at continuously improving patient outcomes. The survey process focuses on assessing performance of important patient-centered and organization functions that support the safety and quality of care, treatment, and services. This assessment is accomplished through evaluating an organization’s compliance with the applicable requirements in this manual, based on the following activities and information:

- Tracing the care, treatment, and services delivered to patients
- Verbal and written information provided to The Joint Commission
- On-site observations and interviews by Joint Commission surveyors
- Review of documents provided by the organization
Under this accreditation process, the full survey is the on-site evaluation piece of a continuous process. The accreditation process encourages organizations to embed the requirements into routine operations to achieve and maintain excellent operational systems on an ongoing basis. Initiatives such as the annual FSA facilitate this and also help identify and manage risk.

A survey is designed to be individualized to each organization, to be consistent, and to support the organization’s efforts to improve performance. The Joint Commission determines the length of a survey based on information supplied in the E-App that describes the organization’s size and scope of services. In addition, Joint Commission surveyors may conduct some survey activities during early morning, evening, night, and weekend hours, as necessary. These “off-shift” visits do not occur before the opening conference at the start of the survey.

**Survey Notification**

The Joint Commission generally conducts unannounced surveys between 18 and 36 months after an organization’s previous full survey, except for situations in which it would not be logical or feasible to conduct an unannounced survey. Table 3 outlines specific exceptions to unannounced surveys and the length of advance notice or threshold, if applicable.

<table>
<thead>
<tr>
<th>Table 3. Exceptions to Unannounced Triennial Surveys***</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Subject</strong></td>
</tr>
<tr>
<td>Initial surveys</td>
</tr>
<tr>
<td>Early Survey Policy—1st survey</td>
</tr>
<tr>
<td>Early Survey Policy—2nd survey</td>
</tr>
<tr>
<td>Organizations undergoing ICM Option 2 and Option 3 surveys</td>
</tr>
<tr>
<td>Department of Defense facilities</td>
</tr>
<tr>
<td>Bureau of Prisons facilities and contracted facilities</td>
</tr>
</tbody>
</table>

***In this table, 7 days refers to 7 business days.
Table 3. *(continued)*

<table>
<thead>
<tr>
<th>Subject</th>
<th>Exception</th>
<th>Threshold (as applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immigration facilities</td>
<td>7-day notice</td>
<td></td>
</tr>
<tr>
<td>Office-based surgery practices</td>
<td>7-day notice</td>
<td></td>
</tr>
<tr>
<td>Telehealth services</td>
<td>7-day notice</td>
<td></td>
</tr>
<tr>
<td>Sleep centers</td>
<td>7-day notice</td>
<td></td>
</tr>
<tr>
<td>Ambulatory surgery centers that are not using accreditation for deemed status purposes</td>
<td>7-day notice</td>
<td></td>
</tr>
<tr>
<td>An organization that has only one of the following services (unless deemed status requirements specify unannounced surveys):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery/anesthesia services</td>
<td>7-day notice</td>
<td></td>
</tr>
<tr>
<td>Medical/dental services</td>
<td>7-day notice</td>
<td>Fewer than 5,000 annual visits or less than 3 licensed independent practitioners</td>
</tr>
<tr>
<td>Specified diagnostic/therapeutic services††</td>
<td>7-day notice</td>
<td>Fewer than 3,000 annual visits or 4 or fewer licensed independent practitioners</td>
</tr>
<tr>
<td>Mobile diagnostic services</td>
<td>7-day notice</td>
<td></td>
</tr>
</tbody>
</table>

With an *unannounced survey*, an accredited organization will receive *no notice* of its survey date prior to the start of the survey. In concert with the unannounced survey process, the following procedures will be implemented:

- Accredited organizations will be able to identify, in their 27-month E-App, up to 15 days in their survey eligibility range (between 18 and 36 months after their last full survey) in which an unannounced survey should be avoided. Once the 27-month E-App has been submitted, these dates cannot be modified. These 15 days should not include federal holidays but may include regional events during which it may be difficult to conduct a survey. The Joint Commission will make every effort to accommodate the organization regarding avoiding these 15 days. However, The Joint Commission reserves the right to conduct a survey during an “avoid period.”

- An organization is required to demonstrate how it communicates on an ongoing basis to its public that if members of the public have any quality-of-care or safety concerns, they should notify The Joint Commission *(see APR.09.01.01 in the APR chapter)*.

††This includes allergy, alternative/complementary care, audiology, chiropractic medicine, diagnostic imaging, dialysis, hematology, infusion therapy, lithotripsy, orthotics/prosthetics, pain management, physical medicine, pulmonary medicine, and radiation oncology.
If an organization knows of a surveyor who works or has worked at the organization or a competing organization or has had personal experience with the survey or that represents a potential conflict, the organization is asked to identify the individual(s) in its E-App or notify The Joint Commission via phone or e-mail as soon as possible so that another surveyor may be assigned.

Organizations are notified of upcoming Joint Commission surveys according to which of the following three types of survey they are going to receive:

1. **Unannounced Events.** On the day of the unannounced survey, by 7:30 A.M. in the organization’s local time zone (for organizations within the United States and its territories), The Joint Commission will post on the organization’s secure Joint Commission Connect site the letter of introduction, the survey agenda, and the biography and picture of each surveyor assigned to conduct the event. Once the notification—which serves as the official notice of the upcoming event—has been posted, an e-mail notification will be sent to the individuals listed as chief executive officer, primary accreditation/certification contact, and corporate contact (if applicable) on the organization’s extranet. This e-mail will advise that an event has been scheduled for that day and instruct the contact(s) to log in to the Joint Commission Connect site to view the event details.

2. **Announced Events.** Thirty days prior to the scheduled announced event, The Joint Commission will post on the organization’s secure Joint Commission Connect extranet site the letter of introduction, the survey agenda, and the biography and picture of each surveyor assigned to conduct the event. Once this notification—which serves as the official notice of the upcoming event—has been posted, an e-mail notification will be sent to the individuals listed as chief executive officer and primary accreditation/certification contact on the organization’s extranet. This e-mail will advise that an event has been scheduled and instruct the contact(s) to log in to the Joint Commission Connect site to view the event details. The organization will also receive a separate e-mail by 7:30 A.M. in the organization’s local time zone (for organizations within the United States and its territories) on the morning of the event with the same information listed above.

3. **Short-Notice Events.** Seven business days prior to the scheduled event, The Joint Commission will post on the organization’s secure Joint Commission Connect site the letter of introduction, the survey agenda, and the biography and picture of each surveyor

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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.
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.**

Please note that the 7-day notice is a notification—not an opportunity to propose a new survey date. An organization that provides procedures requiring surveyor observation needs to plan its procedure schedule accordingly.

**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 ambulatory surgical centers using The Joint Commission for deeming purposes and in ambulatory surgical centers that meet the ambulatory health care occupancy definition, this will include surveyors both within the clinical and Life Safety Code arenas. The composition of an organization’s survey team is based on the information provided in its E-App.

On surveys with more than one surveyor, one of the surveyors is designated as the team leader. The team leader is responsible for integration, coordination, and communication of on-site survey activities. In addition to being one of the surveyors conducting the survey, the team leader serves as the primary point of on-site contact between the organization and The Joint Commission. Among other responsibilities, the team leader leads the opening conference and the daily and exit briefings.

**Life Safety Code® Surveyor Scope of Service**

A Life Safety Code Surveyor will join the survey team whenever Life Safety Code standards apply. The Life Safety Code Surveyor is responsible for evaluating specific environment of care and Life Safety Code accreditation criteria and educating the organization during the survey about related compliant and not compliant areas, opportunities for improvement, and remedial action that may be required.
The Accreditation Process

Survey Agenda
The Joint Commission reviews the data in an ambulatory 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(s) will request to review at the onset of the survey.

The organization’s Joint Commission account executive will contact the ambulatory 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 ambulatory 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 ambulatory 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 ambulatory 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_ambulatory/ for more detailed information on the survey process.
other ambulatory 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 from entry into the organization through the end of the episode of care
- 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
- Interview at least one patient and observe components of his or her care

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 section above) to determine standards compliance as it relates to care delivered to the selected patient, they also begin to learn about the organization’s overall systems. Information gathered during individual tracers is then considered from a multi-patient, cross-organizational perspective during system tracers for high-risk processes. See the “Tracer Methodology” section for more information.

**Program-Specific Tracers.** Program-specific tracers will be conducted if they apply to the organization being surveyed and at the surveyor’s discretion. These program-focused activities take place during the time noted on the agenda for individual tracer activity. See the “Tracer Methodology” section for more information.
**Issue Resolution.** This session provides an opportunity for the surveyor(s) to follow up on potential findings that could not be resolved in other survey activities.

**Surveyor Team Meeting/Planning Session.** This time is reserved for the surveyor(s) to review and analyze the information gathered throughout the day and plan for upcoming survey activities.

**Daily Briefings.** During the daily briefing session, the surveyor(s) will communicate to organization staff their observations on the previous day’s survey findings, including the placement of findings up to that point on the SAFER Matrix (note that placement of findings on the matrix is subject to change as the survey progresses and there may be additional findings).

If the organization has additional information that would demonstrate compliance with a standard that a surveyor has indicated may be an RFI, the organization should supply that information to the surveyor(s) as soon as possible.

**Leadership Session.** During the leadership session, surveyors will explore leadership’s responsibility for creating and maintaining the organization’s systems, infrastructure, and key processes that contribute to the quality and safety of 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

**Clinical Leadership and Staff Discussion.** This group session—only for federal Health Resources and Services Administration/Bureau of Primary Health Care–supported organizations—focuses on the involvement of clinical leaders and staff in the provision of care. This activity is intended to do the following:
- Begin a dialogue with the surveyor(s) about the quality and safety of care provided by the organization
- Address the continuum of care provided to the patients by the organization in its various clinics and locations with particular focus on the integration and coordination of processes
- Assess the interrelationships and communication between and among disciplines, departments, programs, services, or settings (as applicable) in the organization
- Provide an opportunity to confirm the surveyor’s observations and/or assessment of standards-based issues
- Identify potential opportunities for organizational improvement at the organization, system, or process level
- Provide consultation and education as time permits
- Discuss Primary Care Medical Home certification-related requirements, if the option is requested

**Governance Discussion.** This session—only for federal Health Resources and Services Administration/Bureau of Primary Health Care–supported organizations—focuses on the organization’s governance and is intended to address the following:

- The structure and composition of the governing body or Board of Directors
- The function, participation, and involvement of the governing body in the oversight and operation of the organization
- The level of communication among the governing body members
- The governing body’s perception of its role in the organization
- The knowledge of the governing body members with respect to federal law and regulation
- The governing body’s understanding of performance improvement approaches and methods and involvement in the organization’s approach to performance improvement
- Pertinent Leadership standards relevant to the governing body’s role in the organization
- Primary Care Medical Home certification survey process and related requirements, if the option is requested

**Environment of Care and Emergency Management.** This session is an opportunity for the surveyor and ambulatory care organization to review and evaluate the following:

- Processes in place for managing risk in the physical environment (for example, safety and security, fire safety, hazardous materials and waste, 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
- The four phases of emergency management: mitigation, preparedness, response, and recovery
- Organization plans for managing critical areas of operations so organization can effectively respond regardless of the emergency
**Life Safety Code Building Assessment.** This session is conducted for deemed status surveys and for ambulatory health care occupancy ambulatory surgical centers; however, it is not conducted for ambulatory surgical centers meeting criteria for business occupancy. 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

**Competence Assessment.** This review activity focuses on the ambulatory 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(s) will review these records to validate through documentation what he or she has heard from both leaders and staff related to the topic of initial and ongoing competence assessment.

**Credentialing/Privileging.** This activity will help the organization and the surveyor(s) identify specific issues and do the following:

- Evaluate the process the ambulatory care organization uses to collect relevant data for decisions for credentialing
- Evaluate the consistent implementation of the process for credentialing and assigning of clinical privileges, when applicable
- Evaluate processes for the granting of privileges or assignment of clinical privileges
- Determine whether practitioners practice within the limited scope of assigned clinical privileges
Link results of peer review and focused monitoring to the credentialing/privileging process
Identify vulnerabilities in credentialing and the assigning of clinical privileges

Surveyor Report Preparation. The surveyor(s) will use this time to evaluate placement of findings on the Survey Analysis for Evaluating Risk™ (SAFER™) Matrix as well as 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 Tracer
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) and compliance with relevant standards that impact patient safety.
The Accreditation Process

Table 4 includes the applicability and objectives for the Continuity of Care tracer, which is specific to ambulatory care organizations.

Note: The program-specific tracer occurs during the Individual Tracer Activity and only if it is applicable to the organization being surveyed.

<table>
<thead>
<tr>
<th>Tracer</th>
<th>Applicability</th>
<th>Objectives</th>
</tr>
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</table>
| Continuity of Care      | Medical/dental organizations only  
                          Settings in which the expectation is that ongoing continuous care will be provided to patients (based on organization size)  
                          Surveys that include the PCMH certification option | To evaluate the effectiveness of the organization’s process, from prescribing a diagnostic study to patient follow-up  
                          To identify process-level and possibly system-level issues contributing to missed follow-up of diagnostic studies  
                          For PCMH certification surveys: To evaluate the effectiveness of the organization’s processes for the referral and follow-up of patients to internal and external providers, services, and resources |

**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 ambulatory care organization. The tracer methodology is a way to analyze an ambulatory 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, individuals served by behavioral health care organizations who present at an ambulatory care facility in complex organizations)
Patients who will contribute greater understanding to system tracer topics (see the “System Tracer Activity” section), such as infection control or medication management

Patients receiving complex services, such as surgery or treatment for a chronic condition

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 ambulatory care organization’s processes and practices. In conducting a patient’s tracer, the surveyor(s) will follow specific patients through the ambulatory 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) usually starts where the patient is currently located. He or she can then move to where the patient first entered the organization’s systems; an area of care provided to the patient that may be a priority for that organization; or to any areas in which the patient received care, treatment, or services. The location and order will vary. Along the way, the surveyor(s) will speak with the health care staff member(s) who actually provided the care to that individual tracer patient—or, if that staff member(s) is not available, will speak with another staff member(s) who provides the same type of care, treatment, or services.

Also, the surveyor(s) will interview patients and, when appropriate, family members about the following:

- Coordination and timeliness of services provided
- Education, including discharge instructions
- Response time when a call bell is initiated or alarms ring, as warranted by care
- Perception of care
- Understanding of discharge instructions, if applicable
- Receipt of patient rights and information
- Staff compliance with NPSGs
- Validation of information learned during other survey activity
- Other issues relative to care, treatment, or services

Please see the Survey Activity Guide on the Joint Commission Connect for more detailed information on other program-specific criteria for tracer selection.
Further, during the individual tracer, the surveyor(s) may observe the following (including but not limited to):

- Care, treatment, or services provided to patients by clinicians (including physicians)
- Medication management processes (such as the preparation, dispensing, administration, storage, and control of medications)
- Infection control topics and processes (such as techniques for hand hygiene, sterilization of equipment, and disinfection)
- Process for planning care
- Environment as it relates to the safety of patients, staff, vendors, and visitors
- Quality control, maintenance, and testing performance of a lab (if there is one)

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 an organization might notice something that requires a more in-depth look. At that point, the surveyor will look at all processes at a system level by asking more detailed questions or spending more time looking at a particular risk area. The focused evaluation includes processes or procedures that, if not planned or implemented correctly, have significant potential for affecting/impacting patient safety. Examples of topics in organizations that surveyors might need to explore in more detail include, but are not limited to, diagnostic imaging and radiation safety.

Surveyors will assess and display the risk associated with findings by utilizing the SAFER Matrix. Survey findings will be plotted on the SAFER Matrix according to the likelihood the RFI could cause harm to patients, staff, and/or visitors and the scope at which the RFI was observed.

### System Tracer Activity

System tracers explore one specific system or process across the organization, focusing, when possible, on the experiences of specific patients or activities relevant to specific patients. This differs from individual tracers in that during individual tracers, the surveyor(s) follows a patient through his or her course of care, evaluating all aspects of care as opposed to a “system.” During the system tracer sessions, the surveyor(s) evaluates the system or process, including the integration of related processes and the coordination and communication among disciplines and departments in those processes.
A system tracer includes an interactive session (involving a surveyor and relevant staff members) in tracing a “system” within the organization based on information from individual tracers. Points of discussion in the interactive session include the following:

- The flow of the process across the ambulatory 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 conducted varies based on survey length, but the data use system tracer is performed on every ambulatory 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 ambulatory 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 ambulatory care organization’s infection control processes. The goals of this session are to assess the ambulatory 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 ambulatory 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 locations in the ambulatory care organization, and diagnoses/conditions, as appropriate. The surveyor(s) may request assistance from ambulatory care organization staff for selection of appropriate tracer patients. As the surveyor(s) moves around an ambulatory 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.

***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.
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 for Coverage, 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:

- 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.

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*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.”
The results of the abatement survey will help The Joint Commission determine whether to remove the Preliminary Denial of Accreditation decision (assuming there are no other reasons for the Preliminary Denial of Accreditation). Therefore, the sooner an organization eliminates the Immediate Threat to Health or Safety situation, the shorter the period of time the organization may be in Preliminary Denial of Accreditation.

Upon resolution of an Immediate Threat to Health or Safety situation, the organization’s accreditation status may change from Preliminary Denial of Accreditation (PDA) to a time-limited PDA and Accreditation with Follow-up Survey and remain as such until an accreditation follow-up survey is conducted to assess the organization’s sustained implementation of appropriate corrective actions.

See Figure 2 for a visual representation of the process flow for Immediate Threat to Health or Safety situations at organizations seeking reaccreditation.

**Immediate Threat to Health or Safety During Initial Survey**

There are only two possible outcomes—Accredited or Denial of Accreditation—for an organization undergoing its first, or initial, Joint Commission survey; therefore, initial organizations that have an Immediate Threat to Health or Safety situation will receive a Denial of Accreditation decision with no opportunity for an appeal. Once the Immediate Threat to Health or Safety situation is identified, the organization will not be able to withdraw from the accreditation process. In addition, The Joint Commission will notify CMS (if the organization had planned on using its Joint Commission accreditation for meeting deemed status requirements) or other licensing authority having jurisdiction that the organization was denied accreditation due to the Immediate Threat to Health or Safety. If the organization decides to reapply after the appropriate time interval (a minimum of four months), it will undergo a survey to demonstrate that it has abated the Immediate Threat to Health or Safety. This survey may be conducted before—or in conjunction with—the full survey.
Figure 2. Process flow for Immediate Threat to Health or Safety (ITHS) situations at organizations seeking reaccreditation.
The Accreditation Process

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 3 is a representation of the SAFER Matrix.

**Figure 3.** *Survey Analysis for Evaluating Risk (SAFER) Matrix.*

The SAFER Matrix is the visual representation of risk associated with survey findings. If a standard is not applicable (NA) to the organization, it will be marked “NA” and not placed within the SAFER Matrix.

**How Accreditation Decisions Are Made**

Accreditation decisions are made based on the premise that the immediacy of risk to quality of care and patient safety—as shown by noncompliance with Joint Commission standards and EPs—varies. All noncompliant EPs will be cited as RFIs. In addition, all RFIs must be addressed via the ESC submission process. The time frame for completing...
the ESC submission is within 60 calendar days. However, organizations recommended for Preliminary Denial of Accreditation decision PDA02 (as a result of patients being placed at risk for a serious adverse outcome due to significant and pervasive patterns, trends, and/or repeat findings) are required to submit a Plan of Correction (POC) within 10 business days instead of an ESC. A validation survey will be required within 60 days to confirm that the organization has implemented the POC and is in full compliance.

The organization’s accreditation decision will be held in abeyance pending submission of ESC within the established time frame. For situations that constitute more immediate risks to quality of care and patient safety, a more severe accreditation status will be applied. In these scenarios, the two accreditation classifications defined below will be utilized:

- Immediate Threat to Health or Safety
- Decision Rules

**Immediate Threat to Health or Safety.** Immediate Threat to Health or Safety situations that are identified on site have or may potentially have serious adverse effects on the health or safety of patients. Upon resolution of an Immediate Threat to Health or Safety situation, the organization’s accreditation status may change from Preliminary Denial of Accreditation to Accreditation with Follow-up Survey and remain as such until a follow-up survey is conducted to assess the organization’s sustained implementation of appropriate corrective actions.

Immediate Threat to Health or Safety situations are cited at Accreditation Participation Requirement APR.09.04.01, EP 1.

**Decision Rules.** Decision rules determine an accreditation decision that appropriately represents an organization’s overall performance as measured by noncompliance with the applicable standards. Decision rules are applied when a heightened risk to patient care and safety is determined as a result of on-site survey findings. There are times when situations will automatically trigger a recommendation for Preliminary Denial of Accreditation or Accreditation with Follow-up Survey based on such issues as loss of facility licensure, provision of care by unlicensed individuals who require such a license, and failure to implement corrective action in response to identified *Life Safety Code* deficiencies. In follow-up to these situations, organizations must demonstrate resolution of the situation through the ESC process. An on-site survey is conducted to validate implementation of corrective action.
For more information regarding decision rules, see the “Decision Rules for Organizations Seeking Reaccreditation” and “Decision Rules for Organizations Seeking Initial Accreditation” sections later in this chapter.

The Accreditation Decision Process

The goal of the accreditation decision and reporting approach is to focus attention on the issues that pose the greatest risk to quality of care, treatment, and services and to patient safety. Key elements of the accreditation decision process include the following:

- Levels of noncompliance with Joint Commission standards are identified on the SAFER Matrix.
- The surveyor(s) leaves a preliminary Summary of Survey Findings Report on site. (For special surveys, no report is left on site.)
- The Accreditation Survey Findings Report 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. Although the indicator recognizes issues as having been “fixed” before the conclusion of the survey, these RFIs remain in the survey report; that is, an ESC still needs to be completed for these findings.

Decision Categories for Organizations Seeking Accreditation Renewal

The Joint Commission’s decision categories are designed to help distinguish organizations with serious patterns and trends in the provision of care, treatment, or services—which require follow-up more quickly—from those with less serious compliance issues. There are four possible decision categories for organizations undergoing a Joint
Commission survey for reaccreditation.† Figure 4 illustrates the continuum of accreditation decisions possible following resurvey activity. The Joint Commission’s four accreditation decision categories for organizations seeking renewal of accreditation are as follows:

1. **Accredited.** The organization is in compliance with all applicable requirements at the time of the on-site survey or has successfully addressed all RFIs in an ESC within 60 days following the posting of the Accreditation Survey Findings Report and does not meet any other rules for other accreditation decisions.

2. **Accreditation with Follow-up Survey.** The organization is in compliance with all standards as determined by an acceptable ESC submission. A follow-up survey is required within six months to assess sustained compliance.

3. **Preliminary Denial of Accreditation.** There is justification to deny accreditation to the organization as evidenced by
   - An Immediate Threat to Health or Safety to patients or the public, and/or
   - Submission of falsified documents or misrepresented information, and/or
   - Lack of a required license or similar issue at the time of survey, and/or
   - Failure to resolve the requirements of Accreditation with Follow-up Survey, and/or
   - Significant noncompliance with Joint Commission standards.
   In some circumstances, a decision of Preliminary Denial of Accreditation is subject to review and appeal prior to the determination to deny accreditation. (See the “Appeal Procedures” section.)

4. **Denial of Accreditation.** The organization has been denied accreditation. All available review and appeal opportunities have been exhausted.

†There is a fifth decision category for organizations seeking initial accreditation: Limited, Temporary Accreditation. As explained in the “Early Survey Policy” section earlier in this chapter, an organization receives this decision if it demonstrates compliance with the limited set of standards surveyed in the first survey under the Early Survey Policy.
Decision Outcomes for Organizations Seeking Initial Accreditation

For organizations undergoing their 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 for Coverage—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 ambulatory 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](https://www.jointcommission.org) site at the same time that the ambulatory 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](https://www.jointcommission.org) site within 10 business days of completing a survey.

Every standard found not in compliance at the time of survey will generate an RFI. When an ambulatory 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 ambulatory 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 5 provides a representation of possible ESC follow-up activities for RFIs of varying risk levels.
The Accreditation Process

After a survey event, organizations have the opportunity to submit clarifying ESC if they believe that their organization was in compliance with a particular standard at the time of survey. (This process does not include EPs initially identified as noncompliant but corrected before the survey’s conclusion. Also not included in this process is the placement of a finding within the SAFER Matrix; that is, an organization can clarify the finding as a whole but cannot change where the finding is placed within the matrix.)

The “clarification” is part of the ESC process and must be submitted within 10 business days following the posting of the organization’s report on the Joint Commission Connect site. The submission of a clarification does not negate the requirement for submission of a corrective ESC within 60 days if the clarification does not remove the RFI, nor does it provide an organization with additional time to submit its ESC. Therefore, if an organization submits clarification and still has to submit an ESC, the organization will have up to 60 days in total to submit both the clarification and the corrective ESC.

When submitting clarifying ESCs after a survey event, it is important to follow the directions in the submission tool. Address each prompt, detailing why the organization was in compliance at the time of survey. Remember to address the EP as well as the actual...
surveyor observation. (A finding of “lack of required documentation at the time of survey” is not eligible for clarification because documentation must be available for review at the time of survey—not after the survey.)

**Corrective ESC**

An acceptable corrective ESC report must detail the following:

- **Compliance at the EP level**
- Action(s), along with the final date of such action(s), that the organization took to bring itself into compliance with a requirement
- Title of the staff member ultimately responsible for implementing the corrective actions and sustaining compliance
- The plan for sustaining compliance
- Leadership involvement in the corrective action and sustained compliance plan (for those RFIs within the high-risk boxes on the SAFER Matrix, see Figure 5)
- Preventive analysis (for those RFIs within the high-risk boxes on the SAFER Matrix, see Figure 5)

An acceptable ESC report is due within 60 calendar days following the posting of the Accreditation Survey Findings Report (unless the organization is recommended for a PDA02 decision, in which case it must submit a POC within 10 business days and undergo a validation survey within 60 days). The required time frame will be specified in the survey report. Following a successful submission of the ESC report, the organization receives an accreditation decision. However, the organization’s accreditation decision is retroactive to the day after the last day of the survey, unless the organization is undergoing its first Joint Commission survey. The accreditation effective date for an organization that undergoes an initial survey is the date on which an acceptable ESC was submitted, if the organization has any RFIs. If there are no RFIs, the effective date is the day after the last day of the survey.

If the organization implements acceptable actions to address its RFIs, the organization’s accreditation decision is Accredited.

The organization’s ESC submission(s) will be evaluated by Central Office staff using the same scoring guidelines used by the 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 ambulatory care organization has demonstrated resolution of all
RFIs. If the ambulatory 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 ambulatory care organization’s
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The Accreditation Process

电子ESC提供给现场检查员进行现场ESC。现场ESC过程提供了评估组织在纠正问题方面的成功机会。它还允许检查员向组织提供指导和支持，以支持其努力实现和维持与标准的合规性。

最终决定信件将被发布到该组织的安全、密码保护的Joint Commission Connect网站，当其ESC已被审查并作出认证决定时。质量报告将随后发布在The Joint Commission的网站上。如需更多信息，参见“The Joint Commission Quality Report” (QR) 章节。

Accreditation Award Display and Use

The Joint Commission 提供每项认证项目下每家认证组织一张认证证书。初始证书无须付费。额外的证书可以购买。此类请求应发送至认证和认证运营部门的证书协调员。The Joint Commission。

证书及所有副本由The Joint Commission所有。必须在以下情况下退还：
- 组织获得新证书，反映名称变更
- 组织的认证决定被改变、撤销或否认

认证证书包含教育患者及其家属如何联系The Joint Commission的语言。由The Joint Commission认证的组织必须准确向公众描述其认证及认证的性质（见APR.08.01.01 章节）。当组织收到认证证书时，The Joint Commission会发送组织用于描述认证的指南。

组织不得进行任何虚假或误导性的认证广告。此类广告可能成为The Joint Commission拒绝认证的理由。例如，组织不得将其认证代表为由The Joint Commission的任何机构成员授予。其中包括美国医疗保险医师协会，美国外科医师学会，美国牙科协会，美国医院协会和美国医疗协会。
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 ambulatory surgical centers that use Joint Commission accreditation for deemed status purposes, in addition to the official accreditation award letter, The Joint Commission will issue a Medicare recommendation letter to inform CMS that a new or existing Medicare provider has participated in a deemed status survey and that The Joint Commission is making a recommendation regarding Medicare certification as a result. The letter includes information on the dates of the survey, the outcome of the survey, the effective date of accreditation, and the locations included in the scope of the accreditation survey. The Joint Commission provides a copy of the letter to the CMS central office and appropriate regional office. The regional office then makes the final determination regarding the Medicare participation and the effective date of participation in accordance...
with the regulations at 42 CFR 489.13. Ambulatory surgical centers new to accreditation are encouraged to share the Medicare recommendation letter with their state survey agency.

**Advanced Diagnostic Imaging Letter**

Ambulatory care organizations that provide advanced diagnostic imaging (ADI) services and are determined to be in compliance with Joint Commission requirements for ADI will receive, in addition to the official accreditation award letter, a letter indicating their designation as an ADI provider.

**Primary Care Medical Home Certification Letter**

Ambulatory care organizations that select the Primary Care Medical Home Certification option and are determined to be in compliance with the additional Primary Care Medical Home requirements will receive, in addition to the official accreditation award letter, a letter indicating their Primary Care Medical Home certification as well as a certificate.

**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:
Comprehensive Accreditation Manual for Ambulatory Care

- 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 ambulatory 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 ambulatory care organizations incorporate Joint Commission standards as part of routine operations and ongoing quality improvement efforts, supporting a continuous accreditation process. An ambulatory care organization has access to its FSA tool on a continuous basis throughout its accreditation cycle. The FSA tool becomes available to an ambulatory care organization seeking accreditation for the first time after submitting its E-App and deposit. The FSA tool permits the ambulatory care organization to evaluate compliance with all applicable Joint Commission standards and EPs. For every noncompliant standard, the ambulatory care organization must identify a Plan of Action (POA) at the EP level, identifying how it plans to come into compliance with the requirement(s). By participating in the FSA, an ambulatory care organization will be better able to incorporate Joint Commission standards into routine operations, which in turn will help to ensure the provision of safe, high-quality care on an ongoing basis.

The FSA must be completed electronically through the Intracyle Monitoring (ICM) application located on the ambulatory care organization’s secure Joint Commission Connect site. The Joint Commission requires submission at the 12th and 24th month for general applications (and at the 12th month for lab applications). An FSA submission is not required the year the ambulatory care organization is scheduled for a full survey. Because full surveys can occur at any time between the 18th and 36th month of the triennial accreditation cycle, should a full survey occur before an ambulatory care organization’s anticipated FSA due date, the FSA due date will be reset accordingly. (Note that leadership of an organization with a PDA02 decision—a decision based on significant and pervasive patterns of noncompliant standards—is required to participate in the ICM process.) These submission intervals are valuable consultative and educational touch points to help organizations remain in continuous compliance with the standards and keep current with accreditation information. The tool and resources available are designed to provide educational support.

Organizations can select from one of the four ICM submission options. To accomplish a full submission, the minimum subset of standards coded with the icon must be scored as well as standards that have been scored as not compliant by the organization. Organizations submitting Option 1 conduct and score their standards self-assessment but elect not to submit the data to The Joint Commission; however, they may still engage in
a conference call with the Standards Interpretation Group to discuss topics of concern that are specific to their facility. Next are the on-site Option 2 and 3 surveys. These surveys are conducted by a Joint Commission surveyor for an additional fee. The Option 2 survey results in a written report of findings that the organization follows up with POAs as appropriate. An Option 3 survey provides the organization with a verbal report of survey findings but does not result in any historical written documentation.

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**

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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.
Sidebar 2. (continued)

- Organization uses the FSA tool to assess and score compliance with EPs for each applicable standard if it chooses to do so.
- Organization affirms that it has completed an assessment of its compliance with applicable EPs and developed POAs as necessary, but it does not submit data to The Joint Commission.
- Organization can submit standards-related issues in the ICM Profile for telephone discussion with SIG, if desired.

FSA Option 2

- Organizations that choose an Option 2 on-site survey will be charged a fee.
- The organization requests either an announced or unannounced FSA survey.
- Surveyor conducts the FSA survey using tracer methodology and identified accreditation program–specific risk areas; all standards are subject to review.
- Surveyor leaves a written report of findings with the organization.
- SAFER Matrix is included during on-site visit and embedded within report.
- 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 ambulatory care organizations are expected to identify and respond appropriately to all sentinel events. The ambulatory 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 an organization. Organizations must notify The Joint Commission promptly, in writing, when an additional service is contemplated so any potential impact to accreditation can be determined. 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, an organization may undergo a change that modifies the information reported in its E-App (see APR.01.03.01 in the APR chapter). Organizations must notify The Joint Commission promptly, in writing, when an additional service or location is contemplated so any potential impact to accreditation can be determined. Medicare-certified organizations must notify the Medicare Administrator Contractor promptly, in writing, when an additional service is contemplated.

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.

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
Once the change has actually occurred, the organization must update its E-App within 30 calendar days. Information that must be reported includes any of the following:

- A change in ownership
- A change in location
- A significant increase or decrease in the volume of services or individuals served
- The addition of a new type of health service, program, or site of care
- The deletion of an existing health service or site of care
- The acquisition of a new component
- The deletion of an existing component

The Joint Commission may conduct an additional survey at a later date if its surveyor or survey team arrives at the organization and discovers that a change was not reported. The Joint Commission may also survey any unreported services and sites addressed by its standards during the survey as appropriate. The Joint Commission makes the final accreditation decision for the organization only after surveying all or an appropriate sample of all services, programs, and sites provided by the organization for which The Joint Commission has standards. Information reported in the E-App is subject to The Joint Commission’s Information Accuracy and Truthfulness Policy.

**Changes to the Site of Care, Treatment, or Services**

When an organization offers its 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 ambulatory 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.
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.

1Can 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 ambulatory 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, an ambulatory 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 ambulatory care organization is affected by a natural disaster, please notify your ambulatory 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 ambulatory 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 an ambulatory 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 an ambulatory 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 ambulatory 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 an ambulatory care organization does not have any patients for six months or longer, The Joint Commission will terminate the organization’s accreditation. If the ambulatory 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. A new service includes the request for the Primary Care Medical Home certification option.

Extension Surveys
The Joint Commission conducts an extension survey when an accredited ambulatory care organization acquires a new service/program/site for which The Joint Commission has standards; significantly alters how it delivers care, treatment, or services; or adds an optional certification to the existing record. Extension surveys are done to ensure that the accreditation decision previously awarded to the organization is still appropriate under the changed conditions. The results of an extension survey may affect the organization’s accreditation status.

An extension survey is conducted at an accredited organization if its 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 (such as primary care medical home services)

An extension survey will be conducted within 6 months to allow the organization time to bring a new service or program up to the accredited ambulatory care organization’s standard of performance. If the ambulatory care organization uses Joint Commission accreditation for deemed status purposes, the results of the extension survey will immediately affect its accreditation status. If the ambulatory care organization does not
use accreditation for deemed status, the survey findings resulting from the extension survey are maintained separately from, and are not reflected in, the accreditation decision of the acquiring 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 organizations accredited under the Advanced Diagnostic Imaging (ADI) option 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 for Coverage 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) ambulatory surgical center or an ambulatory surgical center that is seeking a new CCN, then The Joint Commission cannot make a recommendation to CMS that the ambulatory surgical center be Medicare certified. The organization will have to undergo an additional unannounced initial Medicare survey to evaluate whether it meets Medicare requirements. For existing deemed status ambulatory 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 ambulatory care organization’s implementation of corrective action to demonstrate compliance with the Condition(s) for Coverage in question. If this survey is unsuccessful, the ambulatory 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.

**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 ambulatory care organizations follow.
Note: Accreditation decision rules are numbered sequentially across all Joint Commission accreditation programs. Some accreditation decision rules do not apply to ambulatory 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 ambulatory 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 ambulatory 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.

Primary Care Medical Home Certification
The following rules will be used for Joint Commission–accredited ambulatory care organizations that choose to apply for Primary Care Medical Home Certification:

PCMH01 A Joint Commission–accredited ambulatory care organization will be certified for the Primary Care Medical Home program if it is in compliance with all Primary Care Medical Home Certification standards at the time of the on-site survey.

PCMH02 A Joint Commission–accredited ambulatory care organization will not be certified for the Primary Care Medical Home program if it has not successfully addressed all Primary Care Medical Home Certification RFIs in its ESC submission.

PCMH03 A Joint Commission–accredited ambulatory care organization will not be certified for the Primary Care Medical Home program if it does not meet all Joint Commission standards for Primary Care Medical Home Certification either at the time of its on-site survey or following submission of an ESC.
Limited, Temporary Accreditation
Limited, Temporary Accreditation will be recommended when the following condition is met:

**LTA01** The ambulatory 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** An ambulatory care organization has one or more noncompliant standards at the time of a survey event.

**ESC02** An ambulatory care organization that fails to successfully address all RFIs in an ESC may be required to submit a second ESC.

**ESC03** An on-site evaluation may be scheduled to validate compliance with the relevant standards in a written ESC.

One-Month Survey
A one-month survey will be performed when the following condition is met:

**FOC01** A full laboratory survey will be conducted when an ambulatory care organization providing laboratory services cannot demonstrate to The Joint Commission that its laboratory accreditation decision is in good standing with a Joint Commission–recognized accredditor or the accreditation is more than 24 months old.

Medicare Survey
A Medicare survey will be performed when the following condition is met:

**CLD01** The ambulatory care organization has one or more Conditions for Coverage scored as a Condition-level deficiency.

*Note:* This rule applies only to ambulatory care organizations that use accreditation for deemed status purposes. Ambulatory 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. Ambulatory 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 ambulatory care organization does not permit the performance of any survey by The Joint Commission. (APR.02.01.01, EP 1)

**DA03** The ambulatory care organization has failed to submit payment for survey fees or annual fees.

**DA04** The ambulatory care organization has repeatedly failed to submit an ESC.

**DA05** An ambulatory 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 ambulatory care organization undergoing its first Joint Commission survey. (APR.09.04.01, EP 1)

**DA07** The Joint Commission is reasonably persuaded that the ambulatory 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 ambulatory 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 ambulatory care organization undergoing its first Joint Commission survey fails to successfully address all RFIs in an ESC after two opportunities.

**DA09** The ambulatory care organization fails its Medicare follow-up survey as a result of one or more Conditions for Coverage scored as a Condition-level deficiency.
Note: This rule applies only to organizations that use accreditation for deemed status purposes.

**DA10** The ambulatory 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 ambulatory 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; HR.02.01.03, EP 4)

**DA11** The ambulatory 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 ambulatory 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 ambulatory 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 ambulatory 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.

**Primary Care Medical Home Certification**
The following rules will be used for Joint Commission–accredited ambulatory care organizations that choose to apply for Primary Care Medical Home Certification:
PCMH01 A Joint Commission–accredited ambulatory care organization will be certified for the Primary Care Medical Home program if it is in compliance with all Primary Care Medical Home Certification standards at the time of the on-site survey.

PCMH02 A Joint Commission–accredited ambulatory care organization will not be certified for the Primary Care Medical Home program if it has not successfully addressed all Primary Care Medical Home Certification RFIs in its ESC submission.

PCMH03 A Joint Commission–accredited ambulatory care organization will not be certified for the Primary Care Medical Home program if it does not meet all Joint Commission standards for Primary Care Medical Home Certification either at the time of its on-site survey or following submission of an ESC.

Evidence of Standards Compliance (ESC)
An ESC will be required when one or more of the following conditions are met:

ESC01 An ambulatory care organization has one or more noncompliant standards at the time of a survey event.

ESC02 An ambulatory care organization that fails to successfully address all RFIs in an ESC may be required to submit a second ESC.

One-Month Survey
A one-month survey will be performed when the following condition is met:

FOC01 A full laboratory survey will be conducted when an ambulatory care organization providing laboratory services cannot demonstrate to The Joint Commission that its laboratory accreditation decision is in good standing with a Joint Commission–recognized accreditor or the accreditation is more than 24 months old.

Medicare Survey
A Medicare survey will be performed when the following condition is met:

CLD01 The ambulatory care organization has one or more Conditions for Coverage scored as a Condition-level deficiency.
Note: This rule applies only to ambulatory care organizations that use accreditation for deemed status purposes. 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. 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 ambulatory care organization demonstrates systemic patterns, trends, and repeat findings with standards.

**AFS03** The ambulatory care organization fails to successfully address all RFIs in an ESC after two opportunities.

**AFS05** The ambulatory 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 ambulatory care organization fails to participate in Intracycle Monitoring requirements.

**AFS08** The ambulatory care organization fails its Medicare follow-up survey as a result of one or more Conditions for Coverage scored as a Condition-level deficiency.

Note: This rule applies only to organizations that use accreditation for deemed status purposes.

**AFS09** An individual who does not possess a license, registration, or certification is providing or has provided health care services in the ambulatory 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; HR.02.01.03, EP 4)

Note: Except as provided under rule PDA03.

**AFS10** The ambulatory 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)

**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 ambulatory care organization may have engaged in possible fraud or abuse.

**AFS13** If an ambulatory 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.

### 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 ambulatory care organization. (APR.09.04.01, EP 1)

**PDA02** The ambulatory 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 ambulatory 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 ambulatory 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; HR.02.01.03, EP 4)

**PDA04** The ambulatory 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 ambulatory care organization is seeking accreditation. (LD.04.01.01, EP 1)

**PDA05** The Joint Commission is reasonably persuaded that the ambulatory 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 ambulatory 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 ambulatory care organization with a decision of Accreditation with Follow-up Survey has failed to resolve all RFIs after two opportunities.

**PDA09** The ambulatory care organization fails its second Medicare follow-up survey as a result of a one or more Conditions for Coverage scored as a Condition-level deficiency.

*Note:* This rule applies only to organizations that use accreditation for deemed status purposes.

**PDA10** The ambulatory 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 ambulatory 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:
The ambulatory care organization does not permit the performance of any survey by The Joint Commission. (APR.02.01.01, EP 1)

The ambulatory care organization has failed to resolve an Accreditation with Follow-up Survey status prior to withdrawing from the accreditation process.

The ambulatory care organization has failed to submit payment for survey fees or annual fees.

The ambulatory care organization has failed to submit an ESC or a Plan of Correction.

An ambulatory care organization in the sustaining improvement program fails to participate in Joint Commission intervention.

An ambulatory 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.

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 Intracyle Monitoring (ICM) process, which means that organizations that were recommended for a PDA at one time will not have the opportunity to merely attest that the organization is in compliance with Joint Commission standards between surveys.

For organizations that had a time-limited PDA, The Joint Commission will schedule the organization’s next unannounced triennial survey early within the 18- to 33-month period.

Should the organization’s next triennial survey result in a repeat Preliminary Denial of Accreditation, the organization will receive a Denial of Accreditation (DA) with the opportunity for an expedited appeal without a hearing.

See Figure 6 for a visual representation of the PDA02 decision process flow.
Preliminary Denial of Accreditation 02 (PDA02++) Process

Effective for Surveys Beginning January 1, 2017

- Patients are placed at risk for a serious adverse outcome(s) due to significant and pervasive patterns, trends, and/or repeat findings
- Organizations will have the right to appeal this decision

Survey is conducted

Within 10 business days from the end of the survey, the final report is posted on the health care organization’s (HCO’s) extranet site with a recommendation of PDA02

Within 10 business days of posted final report, the HCO will have the option to clarify inaccurate survey findings

Within 10 business days of the completion of the clarification process, the HCO is required to submit a Plan of Correction (POC)

Within approximately two months of the posted final report, the HCO will have a validation survey to confirm implementation of the POC

If the validation survey is successful, the HCO receives a time-limited PDA decision with a decision of Accreditation with Follow-up Survey (AFS) thereafter

The HCO will have the follow-up survey within 4 months of receiving its AFS decision to assess sustainability

The HCO will be required to participate in mandatory Intracycle Monitoring (ICM) process

The HCO will have its next triennial survey within 18-20 months

If the validation survey is unsuccessful, the HCO will receive a PDA decision.

*Patients are placed at risk for a serious adverse outcome(s) due to significant and pervasive patterns, trends, and/or repeat findings
+Organizations will have the right to appeal this decision

Figure 6. PDA02 decision process flow.

Process for Organizations That Meet Decision Rule PDA04

If an ambulatory 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 ambulatory care organization does not have a required license, certificate, or permit, the ambulatory care organization will be notified that it meets a rule for Preliminary Denial of Accreditation and The Joint Commission will initiate such action.
- The ambulatory 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.
The ambulatory care organization will not be presented to executive leadership unless it meets a decision for Preliminary Denial of Accreditation based on another decision rule.

Review and Appeal Procedures
After any Preliminary Denial of Accreditation decision, the organization has the right to ask in writing, within five (5) business days of being notified, for a hearing before a Review Hearing Panel. Failure to appeal results in a Denial of Accreditation.

Organizations that choose to appeal may submit additional materials for the Hearing Panel’s consideration. After the hearing, The Joint Commission reviews the findings of the Review Hearing Panel and either denies accreditation to the organization or selects an appropriate alternative accreditation decision.

The outline in this section details the review and appeal procedures for any accreditation decision.

I. Evaluation by Joint Commission Staff
A. Review and Determination by Joint Commission Staff. Following any survey activity, Joint Commission staff review survey findings, survey documents, and any other relevant materials or information received from any source. Joint Commission staff may take one of the following actions:

- Recommend that the organization be Accredited.
- Recommend that the organization receive Accreditation with Follow-up Survey.
- Recommend that the organization receive Preliminary Denial of Accreditation.
- Defer consideration while additional information regarding the organization’s compliance status is reviewed.
- Determine that the organization be granted Limited, Temporary Accreditation in accordance with the Early Survey Policy.
- Recommend that the organization initially be denied Limited, Temporary Accreditation in accordance with the Early Survey Policy.

B. Determination to Recommend Preliminary Denial of Accreditation. If Joint Commission staff, based on survey findings, survey documents, and any other relevant materials or information received from any source, determine in accordance with
approved decision rules to recommend that the organization receive Preliminary Denial of Accreditation, it will outline its findings and determination. The organization may take either of the following actions:

- Accept the findings and determination of the staff through submission of the ESC (or POC, if decision rule PDA02 is applicable).
- Submit to The Joint Commission, through the ESC (or POC, if decision rule PDA02 is applicable), any clarification of its compliance with Joint Commission standards at the time of the survey.

Joint Commission staff members review the organization’s submission of any additional information and shall, in accordance with approved decision rules, take one of the following actions:

- Recommend that the organization receive Accreditation with Follow-up Survey.
- Recommend that the organization receive Preliminary Denial of Accreditation.
- Recommend that the organization be Accredited.

C. Immediate Threat to Health or Safety. If the findings of any survey identify a condition that poses a threat to public or patient health or safety, the president of The Joint Commission, or his or her designee, may promptly decide that the organization be immediately placed in Preliminary Denial of Accreditation. This action and the findings that led to this action shall be reported by telephone and in writing to the organization’s chief executive officer and in writing to the authorities having jurisdiction.

II. Accreditation with Follow-up Survey
A. Survey to Determine Implementation of ESC. The Joint Commission conducts a survey of the organization to determine the degree to which deficiencies have been corrected or improvements implemented following a survey any time up to 6 months from the date the organization is notified of its Accreditation with Follow-up Survey decision. For existing Medicare-certified organizations using the deemed status option, any Medicare Condition-level deficiencies identified during the unannounced, on-site survey will require an unannounced Medicare Deficiency Follow-up Survey within 45 calendar days from the survey where the deficiency was identified.

B. Charges to the Organization. The full costs of all surveys shall be borne by the surveyed organization.
III. Review Hearings

A. Right to a Review Hearing. Upon request, an organization that has received a Preliminary Denial of Accreditation (PDA) is entitled to a review hearing. A PDA decision will become a Denial of Accreditation unless the organization makes a timely request for a review hearing to demonstrate why it should not be denied accreditation. If an appeal is requested, the organization remains in PDA status until The Joint Commission renders a final decision.

B. Purpose of the Review Hearing. The review hearing is an opportunity for an organization to present facts and/or arguments to a Review Hearing Panel comprising two outside health care professionals and one member of The Joint Commission’s Board of Commissioners. Presentations are limited to either of the following:

- Facts that were in error during the survey or post-survey processes
- Arguments that The Joint Commission did not follow its policies, procedures, or decision rules

C. Requesting a Review Hearing; Notice of Time and Place. An organization must submit a written request for a review hearing within five (5) business days of The Joint Commission’s notification of the final PDA decision. For the purpose of this section, the date of a notification is the date a notice was posted to the organization’s Joint Commission Connect extranet site. Within a reasonable period of time before the review hearing, The Joint Commission provides notice of the time and date of the review hearing. If the organization intends to submit a written response, or other documents limited to the parameters established above, such response and documents must be submitted at least five (5) business days prior to the review hearing. The Review Hearing Panel is under no obligation to consider late submissions.

D. Charges to the Organization. The organization will be charged a nonrefundable fee for the review hearing, as published in the accreditation and certification pricing schedule found on the Joint Commission Connect extranet site. The fee, along with any other outstanding invoices due to The Joint Commission, must be paid in full at the time an organization requests a review hearing.

E. Procedure for the Conduct of a Review Hearing. Review hearings are limited to three (3) hours. After introductions, Joint Commission staff will summarize the historical facts that led to the PDA decision. The organization will then have an opportunity to make its presentation to the Panel. The organization’s presentation should be limited to factual or procedural errors. The Panel may ask questions of the organization and of Joint Commission staff.
Hearings are not video/audio recorded. The organization may choose to retain a transcriptionist for the hearing at its own expense. The organization shall provide a copy of any transcript to The Joint Commission, at the organization’s expense, at or around the same time the transcript is made available to the organization. Transcripts of Joint Commission proceedings are confidential and shall remain confidential. Any disclosures to a third party require the express written permission of The Joint Commission.

F. Participants at the Review Hearing. A review hearing may proceed with only two of the three panel members present, provided one of the two is a member of the Board. Legal staff from The Joint Commission will be present to address procedural matters and will not ask questions of the organization’s representatives. Organizations are encouraged to limit representatives at the review hearing to individuals who are knowledgeable about the organization in the standards areas found noncompliant. An organization may choose to bring legal counsel and/or consultants; however, this type of representative is permitted to address procedural matters only and is not to speak on matters regarding substantive issues of the organization’s standards compliance or question Joint Commission staff.

G. Report of the Review Hearing. After a review hearing, the Review Hearing Panel will prepare and submit a written report that summarizes its findings on factual matters with a recommendation to The Joint Commission. The panel report may include a recommendation for one of the following accreditation decisions:

1. Denial of Accreditation
2. Time-Limited Preliminary Denial of Accreditation
3. Accreditation with Follow-up Survey
4. Full Accreditation

The Joint Commission shall send the organization a copy of the report approximately ten (10) business days before Joint Commission executive leadership reviews the written report. The organization will have an opportunity to comment on the report within five (5) business days of receipt. The Joint Commission is under no obligation to consider late submissions.
IV. Following a Review Hearing
A. Scope of Review. After the review hearing, The Joint Commission will consider the Review Hearing Panel’s findings and recommendation, the responses of the organization, any newly submitted documents limited to factual and/or procedural errors, and comments of staff, if any, to the Review Hearing Panel’s findings and recommendations.

B. Action by The Joint Commission. After review of the hearing report, The Joint Commission may accept, reject, or modify the Review Hearing Panel’s recommendation.

V. Final Review & Appeal Request
A. Final Review & Appeal Request. An organization that has received Denial of Accreditation or retained a time-limited PDA after having had a hearing is entitled to a Final Review & Appeal to members of The Joint Commission’s Board of Commissioners. The Joint Commission must receive the organization’s request for final review within five (5) business days after the organization receives notice of The Joint Commission’s decision following a hearing.

B. Composition and Participation. No member of the Final Review & Appeal will have participated in the decisions of The Joint Commission to this point but may, when convened for a final review and appeal, ask questions of Joint Commission staff and the Commissioner who served on the Review Hearing Panel, if available. Although the organization does not participate in the final review and appeal proceeding, it may submit a letter to the Board members.

C. Notice of Time and Procedure for Review. The Joint Commission shall provide notice of the date of the Final Review & Appeal meeting prior to the meeting. The organization may submit written comments to the Board members conducting the Final Review & Appeal along with any documents not previously submitted limited to factual or procedural errors made by The Joint Commission. Any documents must be submitted at least five (5) business days prior to the meeting and should specifically identify any relevant documents previously submitted for the purpose of demonstrating its compliance with standards or The Joint Commission’s failure to follow its policies, procedures, or decision rules.

D. Final Action. The Board members conducting the Final Review & Appeal shall review the decision of The Joint Commission, the organization’s responses, any materials specifically identified as relevant by the organization, and other information it deems relevant, and shall take either of the following actions:
Place the organization in Denial of Accreditation after finding that there is substantial evidence to support The Joint Commission’s decision.

Make an independent evaluation of The Joint Commission’s decision and then decide to grant Accreditation with Follow-up Survey or full Accreditation to the organization.

The action taken by the Board members conducting the Final Review & Appeal shall be the final accreditation decision of The Joint Commission.
Standards Applicability Process (SAP)

Ambulatory care organizations provide a wide range of care, treatment, or services in a variety of settings, and they even may deliver services on a mobile platform. (See the “Glossary” (GL) chapter for a definition of mobile delivery of health care services.) Not all of the standards/requirements in the CAMAC apply to all types of ambulatory care organizations. Based on the particular care, treatment, or services provided by your ambulatory care organization, you should use this grid to identify which standards/requirements are applicable.

Services are listed horizontally along the top of this grid. The standard/requirement and element of performance (EP) numbers are listed vertically. Applicability is indicated with an “X”.

The following services are listed in the Ambulatory Care Services applicability grid (starting on page SAP-2):
- Ambulatory Surgery Centers
- Endoscopy
- Medical Centers
- Dental Centers
- Diagnostic/Therapeutic
- Diagnostic Imaging Services
- Diagnostic Sleep Centers
- Kidney Care/Dialysis
- Telehealth/Nonsurgical
- Telehealth/Surgical
- Episodic Care
- Occupational/Worksite Health
- Urgent/Immediate Care
- Convenient Care
### Ambulatory Care Services Applicability

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

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

**CAMAC Update 2, January 2018**

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

SAP – 6

CAMAC Update 2, January 2018
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Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.

SAP – 8

CAMAC Update 2, January 2018
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Shading indicates a change effective July 1, 2017, unless otherwise noted in the What’s New.
### Standards Applicability Process

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**CAMAC Update 1, July 2017**

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### Comprehensive Accreditation Manual for Ambulatory Care

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

**SAP – 20**

**CAMAC Update 2, January 2018**

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

CAMAC Update 2, January 2018
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### Standards Applicability Process

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

CAMAC Update 2, January 2018

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## Standards Applicability Process

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

### Table of Standards Applicability

| Standard/Requirement Number | EP # | Ambulatory Surgery Centers | Endoscopy | Medical Centers | Dental Centers | Diagnostic/Therapeutic | Diagnostic Imaging Services | Diagnostic Sleep Centers | Kidney Care/Dialysis | Telehealth/Nonsurgical | Telehealth/Surgical | Episodic Care | Occupational/Worksite Health | Urgent/Immediate Care | Convenient Care |
|-----------------------------|------|----------------------------|-----------|-----------------|----------------|------------------------|-----------------------------|-------------------------|---------------------|----------------------|----------------------|--------------|-----------------------------|---------------------|----------------|----------------|
| 7                           | X    | X                          |           |                 |                |                        |                             |                         |                     |                      |                      |              |                             |                     |                |                |
| 8                           | X    | X                          |           |                 |                |                        |                             |                         |                     |                      |                      |              |                             |                     |                |                |
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| NPSG.07.01.01               | 1    | X                          | X         | X               | X               | X                      | X                           | X                       | X                    |                      |                      |              |                             |                     |                |                |
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|                             | 6    | X                          | X         | X               | X               | X                      | X                           | X                       | X                    |                      |                      |              |                             | X                   |                |                |
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|                             | 5    | X                          | X         | X               | X               | X                      | X                           |                         |                      |                      |                      |              |                             |                     |                |                |
| PC.01.01.01                 | 7    | X                          | X         | X               | X               | X                      | X                           | X                       | X                    |                      |                      |              |                             |                     |                |                |
| PC.01.02.01                 | 1    | X                          | X         | X               | X               | X                      | X                           | X                       | X                    |                      |                      |              |                             |                     |                |                |
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| PC.01.02.03                 | 1    | X                          | X         | X               | X               | X                      | X                           | X                       | X                    |                      |                      |              |                             |                     |                |                |
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### Comprehensive Accreditation Manual for Ambulatory Care

SAP – 24

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

CAMAC Update 1, July 2017

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Shading indicates a change effective July 1, 2017, unless otherwise noted in the What’s New.
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Sentinel Events (SE)

I. Sentinel Events
The Joint Commission adopted a formal Sentinel Event Policy in 1996 to help ambulatory 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 organization’s emergency department (ED)
- Unanticipated death of a full-term infant
- Discharge of an infant to the wrong family
- Abduction of any patient receiving care, treatment, or services

Sexual abuse/assault (including rape) as a sentinel event is defined as nonconsensual sexual contact involving a patient and another patient, staff member, or other perpetrator while being treated or on the premises of the 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)

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)
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 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 “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:

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Fire is defined as a rapid oxidation process, which is a chemical reaction resulting in the evolution of light and heat in varying intensities. A combustion process that results in smoldering condition (no flame) is still classified as fire. Source: National Fire Protection Association. *NFPA 901: Standard Classifications for Incident Reporting and Fire Protection Data.* Quincy, MA: NFPA, 2011.

Severe maternal morbidity is defined, by the American College of Obstetrics and Gynecology, the US Centers for Disease Control and Prevention, and the Society of Maternal-Fetal Medicine, as a patient safety event that occurs from the intrapartum through the immediate postpartum period (24 hours), requiring the transfusion of 4 or more units of packed red blood cells (PRBC) and/or admission to the intensive care unit (ICU). *Admission to the ICU* is defined as admission to a unit that provides 24-hour medical supervision and is able to provide mechanical ventilation or continuous vasoactive drug support. Ongoing vigilance to better identify patients at risk—and timely implementation of clinical interventions consistent with evidence-based guidelines—are important steps in the ongoing provision of safe and reliable care. Appropriate systems improvements can be informed by identifying occurrences of maternal morbidity, reviewing the cases, and analyzing the findings. For additional details, see “Update: Revised Definition of Severe Maternal Morbidity in Sentinel Event Policy,” June 2015 Perspectives.
A formalized team response that stabilizes the patient, discloses the event to the patient and family, and provides support for the family as well as staff involved in the event

- Notification of 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 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 common form of comprehensive systematic analysis used for identifying the factors that underlie a sentinel event.

An organization may use other tools and methodologies to conduct its comprehensive systematic analysis. The Joint Commission encourages the organization to contact the patient safety specialist assigned to the organization’s event or to call the Office of Quality and Patient Safety at 630-792-3700 if it has questions regarding using the tools discussed above or other tools it is considering. (See the “Review of Comprehensive Systematic Analyses and Corrective Action Plans” section for further discussion of acceptability.)

Corrective Action Plan
The product of the comprehensive systematic analysis is a corrective action plan. The corrective action plan identifies the strategies that the organization intends to implement in order to reduce the risk of similar events occurring in the future. The identified actions should eliminate or control system hazards or vulnerabilities that have been identified by the comprehensive systematic analysis. Analysis teams should identify at least one stronger or intermediate strength action when possible (see Figure 3 on page 17 of the National Patient Safety Foundation [NPSF] RCA2: Improving Root Cause Analyses and Actions to Prevent Harm report at http://c.ymcdn.com/sites/www.npsf.org/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 a sentinel event to The Joint Commission, the organization will be asked to complete a form accessible through its Joint Commission Connect™ extranet site. From this site, place the cursor over “Continuous Compliance Tools.” A dropdown list will appear. From this list, select “Self Report Sentinel Event.”

If The Joint Commission becomes aware of a sentinel event that was not reported by the organization to The Joint Commission, the organization’s CEO (or designee) is contacted, and a preliminary assessment of the sentinel event is made. An event that occurred more than one year before the date The Joint Commission became aware of
the event will not, in most cases, be reviewed under the Sentinel Event Policy. In such a case, a written response will be requested from the organization, including a summary of the processes that were designed to prevent similar occurrences.

**Required Response to a Sentinel Event**

All sentinel events must be reviewed by the organization, whether or not they are reported to The Joint Commission. In addition, if The Joint Commission becomes aware (either through voluntary self-reporting or otherwise) of a sentinel event that meets the criteria of this policy and the event has occurred in an accredited organization, the organization is expected to do the following:

- Prepare a thorough and credible comprehensive systematic analysis and corrective action plan within 45 business days of the event or of becoming aware of the event.
- Submit to The Joint Commission its comprehensive systematic analysis and corrective action plan, or otherwise provide for Joint Commission evaluation its response to the sentinel event using an approved methodology within 45 business days of the known occurrence of the event. The Joint Commission will determine whether the comprehensive systematic analysis and corrective action plan are acceptable.

The fact that an organization has experienced a sentinel event will not impact its accreditation decision. However, willful failure to respond appropriately to the sentinel event could have such an impact. For instance, if the organization fails to submit a comprehensive systematic analysis within an additional 45 days following its due date, its accreditation decision may be impacted. In these instances, patient safety specialists in the Office of Quality and Patient Safety, along with the medical director and patient safety officer, would recommend the chief medical officer and the executive leadership of The Joint Commission change the organization’s accreditation status.

**Submission of Comprehensive Systematic Analyses and Corrective Action Plans**

An organization that reports a sentinel event must submit the comprehensive systematic analysis, including the resulting corrective action plan that describes the organization’s risk reduction strategies as well as how the effectiveness of those strategies will be evaluated. This information is submitted electronically and will be reviewed in a
conference call involving Joint Commission staff and organization staff (Alternative–0). Documents shall not include the names of caregivers and 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 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. An 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

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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 representative 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.

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and their comprehensive systematic analyses, corrective action plans, and follow-up activities. These data and information form the content of the Joint Commission’s Sentinel Event Database.

The Sentinel Event Database is also a major component of the evidence base for developing and maintaining the Joint Commission’s National Patient Safety Goals. The database also informs the development prevention advice to organizations through Sentinel Event Alert or other media. For these purposes, The Joint Commission uses de-identified aggregate data relating to root causes, contributing factors, and risk-reduction strategies. The Joint Commission is committed to developing and maintaining this Sentinel Event Database in a fashion that will protect the confidentiality of the organization, the caregiver, and the 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, then the following information would apply:
If an SE MOS is submitted on time but does not meet pre-established levels of compliance, the patient safety specialist from The Joint Commission will request an additional four months of data. If the second set of data does not meet pre-established levels of compliance, the organization’s accreditation decision may be impacted.

If submission of an SE MOS is 90 or more days late, the organization’s accreditation status may be impacted.

X. Handling Sentinel Event–Related Documents

Handling of any submitted comprehensive systematic analysis and corrective action plan is restricted to specially trained staff in accordance with procedures designed to protect the confidentiality of the documents.

At the time the review of the de-identified comprehensive systematic analysis is entered into the Sentinel Events Database, the original documents will be destroyed, as well as any copies. However, upon request the original documents may be returned to the organization. The information contained in any electronically submitted comprehensive systematic analysis will be de-identified after the review is completed.

The corrective action plan resulting from the analysis of the sentinel event will initially be retained long enough to serve as the basis for appropriate follow-up activities, such as the SE MOS or other mutually agreed-upon documentation of sustained improvement. After the corrective action plan has been implemented and meets the established levels of compliance, The Joint Commission will destroy and delete the corrective action plan. If the SE MOS was submitted electronically, the information will likewise be de-identified upon completion of the review.

XI. Oversight of the Sentinel Event Policy

The executive leadership of The Joint Commission is responsible for approval of this policy and overseeing its implementation. In addition to reviewing and deciding individual cases involving changes in an organization’s accreditation decision, Joint Commission staff will periodically audit the comprehensive systematic analysis and documentation of follow-up activities. For the purpose of these audits, The Joint Commission temporarily retains random de-identified samples of these documents. Upon completion of the audit, these documents are also destroyed.
For more information about the Joint Commission’s Sentinel Event Policy, visit the Joint Commission’s website at http://www.jointcommission.org or call the Office of Quality and Patient Safety at 630-792-3700.

XII. Survey Process

When conducting an accreditation survey, The Joint Commission seeks to evaluate the organization’s compliance with the applicable standards, National Patient Safety Goals, and Accreditation Participation Requirements, and to assess the organization’s performance based on those requirements. Surveyors are instructed not to search for or investigate sentinel events during an accreditation survey or to inquire about sentinel events that have been reported to The Joint Commission. However, surveyors may assess an organization’s performance improvement practices, such as its processes for responding to a sentinel event.

If, during the course of conducting any survey activities, a potential serious patient safety event is newly identified, the surveyor will take the following steps:

- Inform the organization CEO that the event has been identified
- Inform the CEO the event will be reported to The Joint Commission for further review and follow-up under the provisions of the Sentinel Event Policy

Surveyors are not authorized to review the comprehensive systematic analysis documents to 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 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.
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. (*See also* PI.03.01.01, EP 10)

**Note:** Responses might include continuing to provide care, treatment, or services to those affected, containing the risk, and preserving factual information for subsequent analysis.
6. The leaders provide and encourage the use of systems for blame-free internal reporting of a system or process failure, or the results of a proactive risk assessment. (See also LD.03.04.01, EP 5; LD.04.04.03, EP 3; PI.03.01.01, EP 10)

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. (See also PI.03.01.01, EP 10)

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; PI.03.01.01, EP 10)
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. The leaders encourage external reporting of significant adverse events, including voluntary reporting programs in addition to mandatory programs.

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

Introduction
The Joint Commission Quality Report differentiates health care organizations based on accreditation decision categories and other related information. While the accreditation decision reflects the process for assessing an organization’s commitment to achieving continuous improvement in key areas of safety and quality, the Quality Report also reflects information about an ambulatory 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 ambulatory care organization. The Joint Commission provides Quality Reports to surveyed ambulatory 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 or certified 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](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.
Is a Quality Report Available for My Accredited Ambulatory Care Organization?
Yes. The amount of information available on the report depends on the type of ambulatory 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 Ambulatory 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 ambulatory care organization has the option of submitting a commentary of up to two pages. Submission of the commentary is voluntary.
How Does My Ambulatory Care Organization Submit a Commentary?
If your ambulatory 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 organization, regardless of the number of the organization’s accredited programs 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 ambulatory care organization’s right to communicate your accreditation decision to interested individuals. Indeed, many ambulatory care organizations across the country point with pride to Joint Commission accreditation as a “seal of approval” of their efforts to provide 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 ambulatory care organization must also communicate responsibly. An organization accredited by The Joint Commission must be accurate when describing to the public the nature and meaning of its accreditation including the public use of its Quality Report. An ambulatory care organization may not engage in any false or misleading advertising with respect to the accreditation award. Any such advertising may be grounds for 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 ambulatory 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 ambulatory care organization has sites or offers services that are not accredited, any reference to accreditation must clearly specify which sites/services are accredited. If you are an ambulatory care organization with multiple service components, such as an ambulatory care center with a long term care component, and The Joint Commission did NOT review your long term care component, you must insert the following language into your materials: “This award excludes long term care services.”

- Accreditation does not “endorse” or “guarantee” an ambulatory care organization’s safety or quality of care; nor does it “prove,” “assure,” or “testify” that an ambulatory care organization provides high-quality, safe care. Such language should not be used in your materials.

- Correctly state the ambulatory care organization’s accreditation accomplishment. To say that your ambulatory care organization is the “first” or the “only” ambulatory 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, 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 ambulatory care organization is in compliance with the goals but you must state when that was validated. For example, “We were last surveyed for compliance with the National Patient Safety Goals in 2016,” or “Our compliance with the National Patient Safety Goals was validated by The Joint Commission in 2017.”

- Your ambulatory 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 ambulatory care providers.

- If your ambulatory 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. You should use this list to identify the EPs that require written documentation for your particular service. The following services appear in this chapter:

- Ambulatory Surgical Centers (page RWD-3)
- Endoscopy (page RWD-6)
- Medical Centers (page RWD-8)
- Dental Centers (page RWD-11)
- Diagnostic/Therapeutic (page RWD-13)
- Diagnostic Imaging Services (page RWD-16)
- Diagnostic Sleep Centers (page RWD-18)
- Kidney Care/Dialysis (page RWD-20)
- Telehealth/Nonsurgical (page RWD-22)
- Telehealth/Surgical (page RWD-24)
- Episodic Care (page RWD-25)
- Occupational/Worksite Health (page RWD-28)
- Urgent/Immediate Care (page RWD-30)
- Convenient Care (page RWD-32)

The Joint Commission’s focus is on performance and implementation rather than documentation. The standards, consequently, require documentation only when it is essential. The documentation icon — is used to identify data collection and documentation requirements that are in addition to information found in the clinical record. For example, the documentation icon is applied to an EP that requires a written procedure, but the icon is not applied to an EP that lists the required components of the clinical 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.

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
CAMAC Update 2, January 2018
While documentation is important, the primary emphasis of the survey will be on how your organization carries out the functions described in the *Comprehensive Accreditation Manual for Ambulatory Care* (CAMAC). The surveyors may use a combination of data sources, including interviews with leaders of the organization, staff, patients, and patient 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 Ambulatory Care by Service

Ambulatory Surgical Centers

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#### Infection Prevention and Control (IC)
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Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
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### Rights and Responsibilities of the Individual (RI)

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What's New.
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MM.05.01.17, EP 1
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NPSG.03.06.01, EPs 1, 4

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PC.01.02.03, EP 1
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Record of Care, Treatment, and Services (RC)

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RI.01.03.01, EPs 1, 3
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Waived Testing (WT)

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Early Survey Policy (ESP)

An ambulatory 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 ambulatory 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 elements of performance (EPs) and requirements that are applicable to a first survey when an ambulatory care organization has chosen the Early Survey Policy option.

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**Accreditation Participation Requirements (APR)**

| APR.01.02.01, EP 1 | APR.06.01.01, EP 1 |
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| HR.01.06.01, EP 1 | |

### Infection Prevention and Control (IC)

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| IC.01.03.01, EPs 1, 3 | IC.02.04.01, EPs 1, 4, 6 |
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### Information Management (IM)

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| IM.01.01.03, EPs 1-4 | IM.02.02.01, EP 2 |
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### Leadership (LD)

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### Early Survey Policy

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Primary Care Medical Home Certification Option (PCMH)

Overview
This chapter describes the Primary Care Medical Home Model and the operational characteristics that serve as the foundation for the certification requirements. It also lists the standards and elements of performance that relate directly to the Primary Care Medical Home Model. Organizations interested in this optional certification need to comply with all applicable Ambulatory Care Accreditation Program requirements in addition to the standards and elements of performance listed in this chapter. See the “Standards Applicability Process” (SAP) chapter for a detailed guide to identifying all requirements applicable to your organization.

Primary Care Medical Home Model
The Joint Commission’s Primary Care Medical Home Model is based on the Agency for Healthcare Research and Quality’s (AHRQ) definition of a medical home. This definition describes a medical home as a model of primary health care that has the following core functions and attributes:

- Patient-centered care
- Comprehensive care
- Coordinated care
- Superb access to care
- Systems-based approach to quality and safety

These five operational characteristics, outlined beginning on page PCMH-2, also describe the components of the Joint Commission’s Primary Care Medical Home Model. They address the roles and functions of the patient, organization, primary care clinician, and interdisciplinary team. These individuals and entities are interdependent and, therefore, key to the provision of patient-centered, comprehensive, coordinated, accessible, and collaborative primary care services.
These operational characteristics serve as the basis for The Joint Commission’s primary care medical home requirements. Since this option is applicable only to accredited ambulatory care organizations, the characteristics outlined below were based on the AHRQ definition and are addressed through the applicability of both existing requirements and newly developed ambulatory care requirements for The Joint Commission’s Primary Care Medical Home optional certification.

I. Patient-Centered Care
The primary care medical home provides primary health care that is relationship-based with an orientation toward the whole person. Partnering with patients and their families requires understanding and respecting each patient’s unique needs, culture, values, and preferences. The primary care medical home practice actively supports patients in learning to manage and organize their own care at the level the patient chooses. Recognizing that patients and families are core members of the care team, primary care medical home practices ensure that patients are fully informed partners in establishing care plans.

Concepts addressed in the Joint Commission primary care medical home elements of performance include the following:
A. Patient-selected primary care clinician
B. Primary care clinician and interdisciplinary team work in partnership with the patient
C. Consideration of the patient’s cultural, linguistic, language, and educational needs and preferences
D. Patient involvement in establishing the treatment plan
E. Support for patient self-management

II. Comprehensive Care
The primary care medical home is accountable for meeting the large majority of each patient’s physical and mental health care needs, including prevention and wellness, acute care, and chronic care. Providing comprehensive care requires a team of care providers. This team includes physicians and, based on patient needs, advanced practice nurses, physician assistants, nurses, pharmacists, nutritionists, mental health workers, social workers, educators, and care coordinators. Although some primary care medical home
practices may bring together large and diverse teams of care providers to meet the needs of their patients, many others, including smaller practices, will build virtual teams linking themselves and their patients to providers and services in their communities.

Concepts addressed in the Joint Commission primary care medical home elements of performance include the following:
A. The provision of acute, preventive, and chronic care
B. Provision of continuous and comprehensive care
C. Team-based approach and the use of an interdisciplinary team to provide care
D. Use of internal and external resources to meet patient needs
E. Primary care clinician has the educational background and broad-based knowledge and experience necessary to handle most medical needs of the patient and resolve conflicting recommendations for care
F. Primary care clinician works collaboratively with the interdisciplinary team
G. Care that addresses various phases of a patient’s life span, including end-of-life care
H. Disease management

III. Coordinated Care
The primary care medical home coordinates care across all elements of the broader health care system, including specialty care, hospitals, home health care, and community services and support. Such coordination is particularly critical during transitions between sites of care, such as when patients are being discharged from the hospital. Primary care medical home practices also excel at building clear and open communication among patients and families, the medical home, and members of the broader care team.

Concepts addressed in the Joint Commission primary care medical home elements of performance include the following:
A. Use of internal and external resources to meet patient needs
B. Responsibility for care coordination
C. Team-based approach
IV. Superb Access to Care
The primary care medical home delivers accessible services with shorter waiting times for urgent needs, enhanced in-person hours, around-the-clock telephone or electronic access to a member of the care team, and alternative methods of communication such as e-mail and telephone. The medical home practice is responsive to patients’ preferences regarding access.

Concepts addressed in the Joint Commission primary care medical home elements of performance include the following:
A. Enhanced access, defined as responsiveness to patients’ preferences regarding access including timely response to and shorter wait times for urgent needs, flexible appointment hours and days of service, telephonic or electronic access to a member of the care team, and alternative methods of communication such as e-mail
B. Availability 24 hours a day, 7 days a week
C. Access for non-visit related patient needs
D. Access for patients with special communication needs

V. Systems-Based Approach to Quality and Safety
The primary care medical home demonstrates a commitment to quality and quality improvement through ongoing engagement in activities such as using evidence-based medicine and clinical decision support tools to guide shared decision making with patients and families, engaging in performance measurement and improvement, measuring and responding to patient experiences and patient satisfaction, and practicing population health management. Sharing robust quality and safety data and improvement activities publicly is also an important marker of a system-level commitment to quality.

Concepts addressed in the Joint Commission primary care medical home elements of performance include the following:
A. Population-based care
B. Use of a certified electronic health record and electronic prescribing
C. Primary care clinician and team members function within their scope of practice and in accordance with law and regulation and privileges granted
D. Use of evidence-based medicine and decision support tools
E. The provision of care to a panel of patients
F. Patient involvement in performance monitoring and improvement efforts
Standards, Rationales, Elements of Performance, and Scoring Specific to the Primary Care Medical Home Certification Option

The following is a list of standards and elements of performance that directly relate to the operational characteristics of the Primary Care Medical Home Model. They are presented here for your convenience without footnotes. Updated requirements appear in shaded text. If you have a question about a term used here, please check the Glossary as additional terms have been added.

I. Patient-Centered Care

Leadership (LD)

Standard LD.03.04.01

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

Elements of Performance for LD.03.04.01

1. Communication processes foster the safety of the patient and the quality of care.
2. Communication is designed to meet the needs of internal and external users.
3. Leaders provide the resources required for communication, based on the needs of patients, staff, and management.
4. Communication supports safety and quality throughout the organization. (See also LD.04.04.05, EPs 6 and 12)
5. When changes in the environment occur, the organization communicates those changes effectively.
6. Leaders evaluate the effectiveness of communication methods.
Standard LD.04.04.01
Leaders establish priorities for performance improvement. (Refer to the “Performance Improvement” [PI] chapter.)

Elements of Performance for LD.04.04.01

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

Note: Patient involvement may include activities such as participating on a quality committee.

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.

3. The organization’s design of new or modified services or processes incorporates information about potential risks to patients. (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.

7. Leaders involve staff and patients in the design of new or modified services or processes.

Provision of Care, Treatment, and Services (PC)

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, reassessment, and results of diagnostic testing.
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.
16. For organizations that elect The Joint Commission Primary Care Medical Home option: Each patient has a designated primary care clinician.

Standard PC.02.01.21
For organizations that elect The Joint Commission Primary Care Medical Home option: The organization effectively communicates with patients when providing care, treatment, or services.

Elements of Performance for PC.02.01.21
1. For organizations that elect The Joint Commission Primary Care Medical Home option: The primary care clinician and the interdisciplinary team identify the patient’s oral and written communication needs, including the patient’s preferred language for discussing health care.

Note: Examples of communication needs include the need for personal devices such as hearing aids or glasses, language interpreters, communication boards, and translated or plain language materials. (Refer to RC.02.01.01, EP 1)

2. For organizations that elect The Joint Commission Primary Care Medical Home option: The primary care clinician and the interdisciplinary team communicate with the patient during the provision of care, treatment, or services in a manner that meets the patient’s oral and written communication needs.

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
17. The organization coordinates care, treatment, or services within a time frame that meets the patient’s needs.
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.

4. The organization provides education and training to the patient based on his or her assessed needs.

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
   - Basic health practices and safety
   - Information on the safe and effective use of medications (*See also MM.06.01.01, EP 9*)
   - Nutrition interventions (for example, supplements) and modified diets
   - Discussion of pain, the risk for pain, the importance of effective pain management, the pain assessment process, and methods for pain management
   - Information on oral health
   - Information on the safe and effective use of medical equipment or supplies provided by the organization
   - Habilitation or rehabilitation techniques to help the patient reach maximum independence

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.

28. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The primary care clinician and the interdisciplinary team educate the patient on self-management tools and techniques based on the patient’s individual needs.

30. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The interdisciplinary team identifies the patient’s health literacy needs.
**Note:** Typically this is an interactive process, the goal of which is to ascertain the patient’s capacity to process and understand basic health information needed to make appropriate health decisions.

31. **For organizations that elect The Joint Commission Primary Care Medical Home option:** Patient education is consistent with the patient’s health literacy needs.

### Standard PC.02.04.01

For organizations that elect The Joint Commission Primary Care Medical Home option:

The patient has access to the organization 24 hours a day, 7 days a week.

**Note:** Access may be provided through a number of methods, including telephone, e-mail, websites, portals, and flexible hours.

### Elements of Performance for PC.02.04.01

4. **For organizations that elect The Joint Commission Primary Care Medical Home option:** Primary care medical home patients are provided online access to their health information within four business days after the information is available to the primary care clinician or interdisciplinary team. This information includes diagnostic test results, lab results, summary lists, and medication lists.

5. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The organization uses a certified electronic health record to provide appointment reminders to patients with two or more office visits in the last two years.

### Standard PC.02.04.05

For organizations that elect The Joint Commission Primary Care Medical Home option:

The primary care clinician and the interdisciplinary team work in partnership with the patient to support the continuity of care and the provision of comprehensive and coordinated care, treatment, or services.

### Elements of Performance for PC.02.04.05

9. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The interdisciplinary team works in partnership with the patient to achieve planned outcomes.
11. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The interdisciplinary team involves the patient in the development of his or her treatment plan.

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

#### Standard RC.02.01.01

The clinical record contains information that reflects the patient’s care, treatment, or services.

#### Elements of Performance for RC.02.01.01

1. The clinical record contains the following demographic information:
   - The patient’s name, address, phone number, and date of birth and the name of any legally authorized representative
   - The patient’s sex, height, and weight
   - The legal status of any patient receiving behavioral health care services
   - The patient’s language and communication needs

   **Note:** If the patient is a minor, is incapacitated, or has a designated advocate, the communication needs of the parent or legal guardian, surrogate decision-maker, or legally authorized representative are documented in the clinical record.

28. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The clinical record contains the patient’s:
   - Gender, race, and ethnicity
   - Family history
   - Work history
   - Blood pressure (for patients age 3 and older)
   - Smoking status (for patients age 13 and older)

29. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The clinical record includes the patient’s self-management goals and the patient’s progress toward achieving those goals.

30. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The clinical record contains the patient’s preferred language for discussing health care.
Rights and Responsibilities of the Individual (RI)

Standard RI.01.01.01
The organization respects patient rights.

Elements of Performance for RI.01.01.01

1. The organization has written policies on patient rights.

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

5. The organization respects the patient’s right to and need for effective communication. (See also RI.01.01.03, EP 1)

6. 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 1–4)

   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; HR.02.02.01, EP 4; PC.01.02.07, EP 1)

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.

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 3 and 5)
2. The organization provides interpreting and translation services, as necessary. (See also RI.01.01.01, EP 2)

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

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)

**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**

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)

4. 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.

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

- Outcomes of care, treatment, or services that the patient needs in order to participate in current and future health care decisions
- Unanticipated outcomes of the patient’s care, treatment, or services that are sentinel events as defined by The Joint Commission (Refer to the Glossary for a definition of sentinel event.)
31. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The organization respects the patient’s right to make decisions about the management of his or her care.

32. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The organization respects the patient’s right and provides the patient the opportunity to do the following:

- Obtain care from other clinicians of the patient’s choosing within the primary care medical home
- Seek a second opinion from a clinician of the patient’s choosing
- Seek specialty care

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

**Standard RI.01.03.01**

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

**Elements of Performance for RI.01.03.01**

1. ☐ The organization follows a written policy on informed consent that describes the following:
   - The specific care, treatment, or services that require informed consent
   - Circumstances that would allow for exceptions to obtaining informed consent
   - 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; the likelihood of the patient achieving his or her goals; and any potential problems that might occur during recuperation.
   - Reasonable alternatives to the patient’s proposed care, treatment, 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.
Standard RI.01.04.01
The organization respects the patient’s right to receive information about the individual(s) responsible for his or her care, treatment, or services.

Elements of Performance for RI.01.04.01
1. The organization informs the patient of the following:
   - The name of the physician or other practitioner who has primary responsibility for his or her care, treatment, or services
   - The name of the physician(s) or other practitioner(s) who will provide his or her care, treatment, and services

7. For organizations that elect The Joint Commission Primary Care Medical Home option: The organization allows the patient to select his or her primary care clinician.

Standard RI.01.04.03
For organizations that elect The Joint Commission Primary Care Medical Home option:
The organization provides patients with information about the functions and services of the primary care medical home.

Elements of Performance for RI.01.04.03
1. For organizations that elect The Joint Commission Primary Care Medical Home option: The organization provides information to the patient about: The mission, vision, and goals of the primary care medical home. (Refer to LD.02.01.01, EP 3)

   Note: This may include how it provides for patient-centered and team-based comprehensive care, a systems-based approach to quality and safety, and enhanced patient access.

2. For organizations that elect The Joint Commission Primary Care Medical Home option: The organization provides information to the patient about: How the primary care medical home functions, its scope of care, and its types of services. (For more information, refer to Standards PC.01.01.01 and LD.01.03.01)

3. For organizations that elect The Joint Commission Primary Care Medical Home option: The organization provides information to the patient about the following:
   - Selection of a primary care clinician

Shading indicates a change effective January 1, 2018, unless otherwise noted in the What’s New.
- Involvement in his or her own treatment plan
- Management of referrals
- Coordination of care
- Collaboration with patient-selected clinicians who provide specialty care or second opinions
- Communication with the primary care medical home about health care concerns or other information

5. **For organizations that elect The Joint Commission Primary Care Medical Home option: The organization provides information to the patient about:** Patient responsibilities, including providing health history and current medications, and participating in self-management activities. (Refer to RI.02.01.01, EP 2)

6. **For organizations that elect The Joint Commission Primary Care Medical Home option: The organization provides information to the patient about:** The patient’s right to obtain care from other clinicians within the primary care medical home, to seek a second opinion, and to seek specialty care. (Refer to PC.02.03.01, EP 4; RI.01.01.03, EPs 1 and 3)

**Standard RI.01.05.01**
The 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 that specify whether the organization will honor advance directives. The organization communicates its policies on advance directives to patients upon request.

10. Upon request, the organization shares with the patient possible sources of help in formulating advance directives.

**Standard RI.01.07.01**
The patient and his or her family have the right to have complaints reviewed by the 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.
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4. The organization reviews and, when possible, resolves complaints from the patient and his or her family.

II. Comprehensive Care

Human Resources (HR)

Standard HR.03.01.01
For organizations that elect The Joint Commission Primary Care Medical Home option:
Qualified individuals serve in the role of primary care clinician.

Element of Performance for HR.03.01.01
1. For organizations that elect The Joint Commission Primary Care Medical Home option: Primary care clinicians have the educational background and broad-based knowledge and experience necessary to handle most medical and other health care needs of the patients who selected them. This includes resolving conflicting recommendations for care. A primary care clinician is a doctor of medicine or doctor of osteopathy, or an advanced practice nurse or physician assistant practicing in collaboration with a doctor of medicine or doctor of osteopathy. The term “collaboration” in this context means that health care providers work together to meet the needs of the patient. It is not the intent of this requirement to impose additional restrictions on the scope of practice of an advanced practice nurse, nor is it meant to preempt applicable state law. (For more information, refer to Standards HR.01.06.01 and HR.02.01.03)

Provision of Care, Treatment, and Services (PC)

Standard PC.02.01.05
The organization provides interdisciplinary, collaborative care, treatment, or services.

Element of Performance for PC.02.01.05
1. Care, treatment, or services are provided to the patient in an interdisciplinary, collaborative manner.
Standard PC.02.04.03
For organizations that elect The Joint Commission Primary Care Medical Home option:
The organization is accountable for providing patient care. (Refer to Standard PC.02.04.05)

Elements of Performance for PC.02.04.03

1. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The organization manages transitions in care and provides or facilitates patient access to care, treatment, or services including the following:
   - Acute care
   - Management of chronic care
   - Preventive services that are age- and gender-specific
   - Behavioral health needs
   - Oral health care
   - Optical health
   - Urgent and emergent care
   - Substance abuse treatment
   - Rehabilitative services and equipment (examples include physical, occupational, and speech therapy and equipment such as orthotics, prosthetics, and wheelchairs)

   **Note:** Some of these services may be obtained through the use of community resources as available, or in collaboration with other organizations.

2. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The organization provides care that addresses various phases of a patient’s lifespan, including end-of-life care.

3. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The organization provides disease and chronic care management services to its patients.

Standard PC.02.04.05
For organizations that elect The Joint Commission Primary Care Medical Home option:
The primary care clinician and the interdisciplinary team work in partnership with the patient to support the continuity of care and the provision of comprehensive and coordinated care, treatment, or services.
Elements of Performance for PC.02.04.05

1. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The organization identifies the composition of the interdisciplinary team. The team must include a doctor of medicine or doctor of osteopathy.

   **Note:** The intent of this requirement is that while a doctor of medicine or doctor of osteopathy is always available to be part of the interdisciplinary team, his or her involvement in a patient’s care would be determined by the needs of the patient.

2. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The members of the interdisciplinary team provide comprehensive and coordinated care, treatment, or services and maintain the continuity of care.

   **Note:** The provision of care may include making internal and external referrals.

5. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The primary care clinician is responsible for making certain that the interdisciplinary team provides comprehensive and coordinated care, treatment, or services and maintains the continuity of care as described in EPs 6–12.

   **Note:** Coordination of care may include making internal and external referrals, developing and evaluating treatment plans, and resolving conflicts in the provision of care.

8. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The interdisciplinary team participates in the development of the patient’s treatment plan.

12. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The interdisciplinary team assesses patients for health risk behaviors.

Rights and Responsibilities of the Individual (RI)

**Standard RI.01.04.03**

For organizations that elect The Joint Commission Primary Care Medical Home option:
The organization provides patients with information about the functions and services of the primary care medical home.
Elements of Performance for RI.01.04.03

7. For organizations that elect The Joint Commission Primary Care Medical Home option: The primary care medical home provides patients with information regarding the credentials and educational background of individuals serving in the role of primary care clinician.

III. Coordinated Care

Human Resources (HR)

Standard HR.01.02.07

The organization determines how staff function within the organization.

Elements of Performance for HR.01.02.07

3. For organizations that elect The Joint Commission Primary Care Medical Home option: The primary care clinician and the interdisciplinary team members function within their scope of practice and in accordance with privileges granted. (For more information, refer to Standards HR.01.06.01 and HR.02.01.03)

Provision of Care, Treatment, and Services (PC)

Standard PC.01.03.01

The organization plans the patient’s care.

Elements of Performance for PC.01.03.01

44. For organizations that elect The Joint Commission Primary Care Medical Home option: Patient self-management goals are identified, agreed upon with the patient, and incorporated into the patient’s treatment plan. (Refer to RI.01.02.01, EP 1)
Standard PC.02.02.01
The 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 has a process to receive or share patient information when the patient is referred to other internal or external 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.

10. When the organization uses external resources to meet the patient’s needs, it participates in coordinating the patient’s care, treatment, or services.

17. The organization coordinates care, treatment, or services within a time frame that meets the patient’s needs.

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

5. The organization coordinates the patient education and training provided by all disciplines involved in the patient’s care, treatment, or services.

Standard PC.02.04.03
For organizations that elect The Joint Commission Primary Care Medical Home option:
The organization is accountable for providing patient care. (Refer to Standard PC.02.04.05)
Elements of Performance for PC.02.04.03

4. For organizations that elect The Joint Commission Primary Care Medical Home option: The organization provides population-based care.

5. For organizations that elect The Joint Commission Primary Care Medical Home option: The organization uses a certified electronic health record system to do the following:
   - Support the continuity of care, and the provision of comprehensive and coordinated care, treatment, or services
   - Document and track care, treatment, or services
   - Support disease management, including providing patient education
   - Support preventive care, treatment, or services
   - Create reports for internal use
   - Create and submit reports to external providers and organizations, including public health agencies, disease-specific registries, immunization registries, and other specialized registries
   - Facilitate electronic exchange of information among providers
   - Support performance improvement
   - Identify and provide patient-specific education resources

Standard PC.02.04.05

For organizations that elect The Joint Commission Primary Care Medical Home option: The primary care clinician and the interdisciplinary team work in partnership with the patient to support the continuity of care and the provision of comprehensive and coordinated care, treatment, or services.

Elements of Performance for PC.02.04.05

4. For organizations that elect The Joint Commission Primary Care Medical Home option: The primary care clinician and the interdisciplinary team provide care for a panel of patients.

6. For organizations that elect The Joint Commission Primary Care Medical Home option: When a patient is referred to an external organization, the interdisciplinary team reviews and tracks the care provided to the patient.

7. For organizations that elect The Joint Commission Primary Care Medical Home option: The interdisciplinary team acts on recommendations from internal and external referrals for additional care, treatment, or services.
10. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The interdisciplinary team monitors the patient’s progress toward achieving treatment goals.

**Standard PC.04.01.01**
The 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.

**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**

2. The organization identifies any needs the patient may have for continuing psychosocial or physical care.

3. The patient, the patient’s family, licensed independent practitioners, 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 needs at the end of an episode of care, or at discharge or transfer, it promptly shares this information with the patient.

7. The organization educates the patient about how to obtain any continuing care, treatment, or services that he or she will need.

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.

Element of Performance for PC.04.02.01

1. At the end of an episode of care, or 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
   - The patient’s physical and psychosocial status
   - A summary of care, treatment, or services it provided to the patient
   - The patient’s progress toward goals

Note: This bullet is not applicable to settings that do not provide continuing care, such as urgent care and convenient care clinics.
   - A list of community resources or referrals made or provided to the patient (See also PC.02.02.01, EP 1)
   - A list of the patient’s current medications, including any allergies to medications

Record of Care, Treatment, and Services (RC)

Standard RC.01.01.01
The organization maintains complete and accurate clinical records.
Elements of Performance for RC.01.01.01

5. The clinical record contains the information needed to support the patient’s diagnosis and condition.

7. The clinical record contains information that documents the course and result of the patient’s care, treatment, or services.

8. The clinical record contains information about the patient’s care, treatment, or services that promotes continuity of care among providers.

Note: For organizations that elect The Joint Commission Primary Care Medical Home option: This requirement refers to care provided by both internal and external providers.

11. All entries in the clinical record are dated.

14. When needed to provide care, summaries of treatment and other documents provided by the organization are forwarded to other care providers.

IV. Superb Access to Care

Provision of Care, Treatment, and Services (PC)

Standard PC.02.04.01

For organizations that elect The Joint Commission Primary Care Medical Home option: The patient has access to the organization 24 hours a day, 7 days a week.

Note: Access may be provided through a number of methods, including telephone, e-mail, websites, portals, and flexible hours.

Elements of Performance for PC.02.04.01

1. For organizations that elect The Joint Commission Primary Care Medical Home option: The organization provides patients with the ability to do the following 24 hours a day, 7 days a week:
   - Contact the primary care medical home to obtain a same- or next-day appointment
   - Request prescription renewal
   - Obtain clinical advice for urgent health needs
2. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The organization offers flexible scheduling to accommodate patient care needs.

   *Note: This may include open scheduling, same-day appointments, group visits, expanded hours, and arrangements with other organizations.*

3. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The organization has a process to respond to patient urgent care needs 24 hours a day, 7 days a week.

4. **For organizations that elect The Joint Commission Primary Care Medical Home option:** Primary care medical home patients are provided online access to their health information within four business days after the information is available to the primary care clinician or interdisciplinary team. This information includes diagnostic test results, lab results, summary lists, and medication lists.

V. **Systems-Based Approach to Quality and Safety**

**Leadership (LD)**

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

**Elements of Performance for LD.03.04.01**

1. Communication processes foster the safety of the patient and the quality of care.
2. 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 management.
5. Communication supports safety and quality throughout the organization. *(See also LD.04.04.05, EPs 6 and 12)*

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

7. Leaders evaluate the effectiveness of communication methods.

**Standard LD.04.01.05**

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

**Elements of Performance for LD.04.01.05**

11. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The organization evaluates how effectively the primary care clinician and the interdisciplinary team work in partnership with the patient to support the continuity of care and the provision of comprehensive and coordinated care, treatment, or services.

**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)*

2. Leaders give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities. *(See also PI.01.01.01, EPs 4, 6–8, 14, and 15)*

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

4. Performance improvement occurs organizationwide.

5. **For organizations that elect The Joint Commission Primary Care Medical Home option:** Ongoing performance improvement occurs organizationwide for the purpose of demonstrably improving the quality and safety of care, treatment, or services.
6. For organizations that elect The Joint Commission Primary Care Medical Home option: The interdisciplinary team actively participates in performance improvement activities.

Standard LD.04.04.03
New or modified services or processes are well designed.

Elements of Performance for LD.04.04.03

2. The organization’s design of new or modified services or processes incorporates the results of performance improvement activities.

4. The organization’s design of new or modified services or processes incorporates evidence-based information in the decision-making process.

Note: For example, evidence-based information could include practice guidelines, successful practices, information from current literature, and clinical standards.

5. The organization’s design of new or modified services or processes incorporates information about sentinel events.

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.

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. (See also PI.03.01.01, EP 10)

Note: Responses might include continuing to provide care, treatment, or services to those affected, containing the risk, and preserving factual information for subsequent analysis.
6. The leaders provide and encourage the use of systems for blame-free internal reporting of a system or process failure, or the results of a proactive risk assessment. (See also LD.03.04.01, EP 5; LD.04.04.03, EP 3; PI.03.01.01, EP 10)

**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. (See also PI.03.01.01, EP 10)

**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; PI.03.01.01, EP 10)
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. The leaders encourage external reporting of significant adverse events, including voluntary reporting programs in addition to mandatory programs.

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

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**Standard LD.04.04.09**

The organization uses clinical practice guidelines to design or to improve processes that evaluate and treat specific diagnoses, conditions, or symptoms.

**Elements of Performance for LD.04.04.09**

1. The organization uses clinical practice guidelines to design or improve processes that evaluate and treat specific diagnoses, conditions, or symptoms.

2. The organization identifies criteria that guide the selection and implementation of guidelines to design or improve processes that evaluate and treat specific diagnoses, conditions, or symptoms.

3. The organization manages and evaluates the implementation of the guidelines to design or improve processes that evaluate and treat specific diagnoses, conditions, or symptoms.

4. The leaders of the organization review and approve the clinical practice guidelines that have been selected to design or improve processes that evaluate and treat specific diagnoses, conditions, or symptoms.

5. The organization monitors and reviews clinical practice guidelines for their effectiveness and modifies them as needed.
Medication Management (MM)

**Standard MM.04.01.01**
Medication orders are clear and accurate.

**Elements of Performance for MM.04.01.01**

21. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home uses an electronic prescribing process for at least 50% of allowable prescriptions.

22. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home uses a computerized order entry system for at least 60% of medication orders.

Provision of Care, Treatment, and Services (PC)

**Standard PC.01.03.01**
The organization plans the patient’s care.

**Elements of Performance for PC.01.03.01**

45. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home uses clinical decision support tools to guide decision making. (For more information, refer to LD.04.04.09, EPs 1–5)

**Standard PC.02.01.01**
The organization provides care, treatment, or services for each patient.

**Elements of Performance for PC.02.01.01**

18. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home uses a computerized order entry system for at least 30% of laboratory orders.

19. **For organizations that elect The Joint Commission Primary Care Medical Home option:** The primary care medical home uses a computerized order entry system for at least 30% of radiology orders.
Performance Improvement (PI)

Standard PI.01.01.01

The organization collects data to monitor its performance.

Elements of Performance for PI.01.01.01

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

The organization collects data on the following:

3. Performance improvement priorities identified by leaders. *(See also LD.04.04.01, EP 1)*
4. Operative or other procedures that place patients at risk of disability or death. *(See also LD.04.04.01, EP 2)*
5. All significant discrepancies between preoperative and postoperative diagnoses, including pathologic diagnoses.
6. Patient perception of the safety and quality of care, treatment, or services.

For organizations that elect The Joint Commission Primary Care Medical Home option:
The organization collects data on the following:

40. Disease management outcomes.
41. Patient access to care within time frames established by the organization.
42. For organizations that elect The Joint Commission Primary Care Medical Home option: The organization collects data on the following:
   - Patient experience and satisfaction related to access to care, treatment, or services and communication
   - Patient perception of the comprehensiveness of care, treatment, or services
   - Patient perception of the coordination of care, treatment, or services
   - Patient perception of the continuity of care, treatment, or services

*(Refer to PI.01.01.01, EP 16)*
Standard Pl.02.01.01
The organization compiles and analyzes data.

Elements of Performance for Pl.02.01.01

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

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

Standard Pl.03.01.01
The organization improves performance.

Elements of Performance for Pl.03.01.01

2. The organization takes action on improvement priorities. (See also MM.08.01.01, EP 6)

4. The organization takes action when it does not achieve or sustain planned improvements.

11. For organizations that elect The Joint Commission Primary Care Medical Home option: The organization uses the data it collects on the patient’s perception of the safety and quality of care, treatment, or services to improve its performance. This data includes the following:

- Patient experience and satisfaction related to access to care, treatment, or services and communication
- Patient perception of the comprehensiveness of care, treatment, or services
- Patient perception of the coordination of care, treatment, or services
- Patient perception of the continuity of care, treatment, or services
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.

**Admitting privileges**  Authority issued to admit individuals to a health care organization. Individuals with admitting privileges may practice only within the scope of the clinical privileges granted by the organization’s governing body.

**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).

**ALARA**  An acronym for “as low as reasonably achievable,” which means making every reasonable effort to maintain exposures to ionizing radiation as far below NRC dose limits as practical.

**ambulatory health care**  Health services provided to individuals who are not confined to institutional beds as inpatients during the time services are rendered. Ambulatory care services are provided in many settings ranging from freestanding ambulatory surgery facilities, to primary care settings, to diagnostic radiology; outpatient behavioral health services are not included.

**ambulatory surgical center (ASC)**  Any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring hospitalization and in which the expected duration of services would not exceed 24 hours following an admission. The entity must have an agreement with Centers for Medicare & Medicaid Services (CMS) to participate in Medicare as an ASC, and must meet other specific conditions as designated by CMS.

**anesthesia and sedation**  The administration to an individual, in any setting, for any purpose, by any route, of medication to induce a partial or total loss of sensation for the purpose of conducting an operative or other procedure. Definitions of four levels of sedation and anesthesia include the following:

1. Minimal sedation (anxiolysis): A drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.

2. Moderate sedation/analgesia (“conscious sedation”): A drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. Reflex withdrawal from a painful stimulus is not considered a purposeful response. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

3. Deep sedation/analgesia: A drug-induced depression of consciousness during which patients cannot be easily aroused, but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.
4. Anesthesia: Consists of general anesthesia and spinal or major regional anesthesia. It does not include local anesthesia. General anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

**annual visits** A summation of outpatient visits made by patients within a 12-month period. For example, in a physician’s office, outpatient visits are counted as one visit for each patient day and per provider. If a patient visits a physician and has x-rays and a procedure performed, this is counted as one visit. If a patient visits two different providers within the same practice, this is counted as two visits.

**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.

**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.
applicant organization  An organization that is seeking either accreditation for the first time or re-accreditation.

application for accreditation  See E-App.

assessment  An objective evaluation or appraisal of an individual’s health status, including acute and chronic conditions. The assessment gathers information through collection of data, observation, and physical examination.

autologous tissue  Tissue intended for transplantation into the individual from whom the tissue was recovered. The recipient and donor are the same individual.

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.

best practices  Clinical, scientific, or professional practices that are recognized by a majority of professionals in a particular field as being exemplary. These practices are typically evidence based and consensus driven.

biologicals  Medicines made from living organisms and their products, including serums, vaccines, antigens, and antitoxins.

blind specimen  A sample with known value tested by personnel who do not know the expected result.

blood component  A fraction of separated whole blood (for example, red blood cells, plasma, platelets, granulocytes).

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 planning (or planning for care)  Individualized planning and provision of care, treatment, or services that address the needs, safety, and well-being of the patient or individual served. The plan, which formulates strategies, goals, and objectives, may include narratives, policies and procedures, protocols, practice guidelines, clinical paths, care maps, or a combination of these.

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.
certified electronic health record  A computerized medical record system that enables the documentation, sharing, and secure storage of patient data in a structured format which allows the information to be easily retrieved and transferred between settings of care and those participating in patient care. The system must meet criteria and comply with standards established by the Centers for Medicare & Medicaid Services and the Office of the National Coordinator for Health Information Technology.

child  A person between 0 and 12 years of age, or as determined by applicable law and regulation.

chronic care  The provision of care to individuals with long-standing, persistent diseases or conditions. It includes oversight and education activities specific to a disease or condition, and measures to encourage patient self-care, promote health, and prevent loss of function.

clinical decision support  Software designed to assist in clinical decision making. A clinical decision support system matches two or more characteristics of an individual patient to a computerized clinical knowledge base and provides patient-specific assessments or recommendations to the clinician. The clinician makes decisions based on clinical expertise, knowledge of the patient, and the information provided through the clinical decision support system. A clinical decision support system can be used at different points in the care process such as diagnosis, treatment, and posttreatment care, including the prediction of future events.

Clinical Laboratory Improvement Amendments of 1988 (CLIA ’88)  Federal legislation that created uniform federal standards for regulating laboratory testing. CLIA ’88 unified the disparate federal and state standards regulating clinical laboratories and extended government oversight to all testing facilities, including physician offices.

clinical leader  An individual with essential clinical knowledge who sets expectations, develops plans, and implements procedures to assess and improve the quality of the organization’s clinical and support functions and processes.

clinical practice guidelines  Tools that describe a specific procedure or processes found, through clinical trials or consensus opinion of experts, to be the most effective in evaluating and/or treating a mother and/or newborn, patient, resident, or individual served who has a specific symptom, condition, or diagnosis. Synonyms include practice parameter, protocol, clinical practice recommendation, preferred practice pattern, and guideline.

clinical privileges  Authorization granted by the appropriate authority (for example, the governing body) to a practitioner to provide specific care, treatment, or services in the organization within well-defined limits, based on the following factors: license, education, training, experience, competence, health status, and judgment.
clinical staff  Individuals such as employees, licensed independent practitioners, contractors, volunteers, or temporary agency personnel who provide or have provided clinical services to the organization’s patients, residents, or individuals served. See also staff.

close call  A patient safety event that did not reach the patient; also called near miss or good catch.

compartmentalization  The concept of using various building components (for example, fire walls and doors, smoke barriers, fire-rated floor slabs) to prevent the spread of fire and combustion and to provide a safe means of egress to an approved exit. The presence of these features varies depending on the building occupancy classification.

complex organization  An organization accredited by The Joint Commission under more than one accreditation manual.

comprehensive systematic analysis  A process for identifying basic or causal factors underlying variation in performance, including the occurrence or possible occurrence of a sentinel event. A root cause analysis is one type of comprehensive systematic analysis.

computed tomography dose index (CTDI or CTDIvol)  A measure of the radiation output of a computed tomography (CT) scanner. It represents CT radiation exposure to a test object and therefore does not represent the patient radiation dose.

computerized order entry system  An electronic method of documentation that enables the entry of clinical information such as orders for care, treatment, or services into a computer. It may also be referred to as a computerized provider order entry (CPOE) system.

confidentiality  Protection of data or information from being made available or disclosed to any unauthorized person(s) or process(es).

consultation  1. Provision of professional advice or services. 2. A review of an individual’s problem by a second practitioner and the rendering of an opinion and advice to the referring practitioner. In most instances, the review involves the independent examination of the individual by the consultant. 3. For purposes of Joint Commission accreditation, advice that is given to staff members of surveyed organizations relating to compliance with standards and requirements that are the subject of the survey.

consultation report  1. A written opinion by a consultant that reflects, when appropriate, an examination of the individual and the individual’s medical record(s). 2. Information given verbally by a consulting practitioner to a care provider that reflects, when appropriate, an examination of the individual. The individual’s care provider usually documents those opinions in the medical record.
continuing care Care provided over time in various settings, programs, or services and spanning the illness-to-wellness continuum.

continuity The degree to which the care of individuals is coordinated among 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 Services provided through a written agreement with another organization, agency, or person. The agreement specifies the services or personnel to be provided on behalf of the applicant organization and the fees to provide these services or personnel.

contractual agreement An agreement with any organization, group, agency, or individual for services or personnel to be provided by, to, or on behalf of the organization. Such agreements are defined in written form, such as in a contract, letter of agreement, or memorandum of understanding.

Cooperative Accreditation Initiative An initiative under which The Joint Commission relies on the process, findings, and decisions of other oversight accrediting organizations in circumstances where The Joint Commission would otherwise conduct potentially duplicative surveys of organizations seeking accreditation. Cooperative agreements are comparable to those of The Joint Commission. Entities that focus more on technical or clinical aspects of departments or services (for example, laboratory, rehabilitation units) are eligible for cooperative agreements because their accreditation requirements complement The Joint Commission’s by covering additional or more detailed aspects of care delivery.

coordination of care The process of coordinating care, treatment, or services provided by a health care organization, including referral to appropriate community resources and liaison with others (such as the individual’s physician, other health care organizations, or community services involved in care or services) to meet the ongoing identified needs of individuals, to ensure implementation of the plan of care, and to avoid unnecessary duplication of services.

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 time frame for agency responses to requests for information, and a summary overview of quality control processes related to data integrity, security, transmission accuracy, and technical specifications.
4. The user and agency agree on the format for transmitting credentials information about an individual from the CVO.
5. The user can easily discern what information transmitted by the CVO is from a primary source and what is not.
6. For information transmitted by the agency that can go out of date (for example, licensure, board certification), the CVO provides the date the information was last updated from the primary source.

7. The CVO certifies that the information transmitted to the user accurately represents the information obtained by it.
8. The user can discern whether the information transmitted by the CVO from a primary source is all the primary source information in the CVO’s possession pertinent to a given item or, if not, where additional information can be obtained.
9. The user can engage the CVO’s quality control processes when necessary to resolve concerns about transmission errors, inconsistencies, or other data issues that may be identified from time to time.
10. The user has a formal arrangement with the CVO for communicating changes in credentialing information.

**critical result**  Test result that is abnormal to a degree that may indicate a life-threatening situation (also known as critical value).

**critical test**  A test or examination that always requires rapid communication of results, whether those results are normal or abnormal.

**data integrity**  The accuracy, consistency, and completeness of data that are protected in some way from corruption, misuse, or accidental exposure to unauthorized users.

**data source**  A primary source used for data collection (for example, physical health and behavioral health information, personnel records, written agreements, safety incident log).
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.

dental services  Services provided by a dentist, or a qualified individual under the supervision of a dentist, to improve or maintain the health of an individual’s teeth, oral cavity, and associated structures.

dentist  An individual who has received either a doctor of dental surgery degree or a doctor of dental medicine degree and who is licensed to practice dentistry.

designated equivalent source  Selected agencies that have been determined to maintain a specific item(s) of credential(s) information that is identical to the information at the primary source. Designated equivalent sources include but are not limited to the following:

- The American Medical Association (AMA) Physician Masterfile for verification of a physician’s United States and Puerto Rican medical school graduation and postgraduate education completion
- The American Board of Medical Specialties (ABMS) for verification of a physician’s board certification
- The Educational Commission for Foreign Medical Graduates (ECFMG) for verification of a physician’s graduation from a foreign medical school
- The American Osteopathic Association (AOA) Physician Database for pre-doctoral education accredited by the AOA Bureau of Professional Education; post-doctoral education approved by the AOA Council on Postdoctoral Training; postdoctoral education approved by the Accreditation Council for Graduate Medical Education (ACGME); and Osteopathic Specialty Board Certification
- The Federation of State Medical Boards (FSMB) for all actions against a physician’s medical license
- The American Academy of Physician Assistants (AAPA) Profile for physician assistant education, provided through the AMA Physician Profile Service (https://profiles.ama-assn.org/amaprofiles/)

disaster  A type of emergency that, due to its complexity, scope, or duration, threatens the organization’s capabilities and requires outside assistance to sustain care, safety, or security functions.

discharge  The point at which an individual’s active involvement with an organization or program ends, and the organization or program no longer maintains active responsibility for the care of the individual. In ambulatory or office-based settings where episodes of care occur even though the organization continues to maintain active responsibility for the care of the individual,
discharge is the point at which any encounter or episode of care (that is, an office or clinic visit for the purpose of diagnostic evaluation or testing, procedures, treatment, therapy, or management) ends.

discharge planning A formalized process in a health care organization through which a program of continuing and follow-up care is planned and carried out for each patient.

dispensing See medication management.

disruptive and inappropriate behavior See behaviors that undermine a culture of safety.

do-not-use abbreviations See prohibited abbreviations.

dose length product (DLP) A measure of the radiation output of a computed tomography (CT) scanner. It factors in the length of the CT scan as well as the computed tomography dose index (CTDI). It provides an estimate of the radiation dose to a volume of tissue for a given patient in a clinical setting.

drug See medication.

drug allergy See medication allergy.

E-App An electronic form used for collecting information pertaining to the applicant organization. Information collected on this form will be used to determine the accreditation requirements applicable to the organization, the types of surveyors needed, the length of survey, and the survey fee.

Early Survey Policy A policy that permits an organization to achieve accreditation in a two-survey process. The first survey is limited in scope, and successful completion results in Preliminary Accreditation. 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.

electronic prescribing The use of an automated data entry system by an authorized prescriber to transmit a prescription directly to a participating pharmacy. It is also referred to as e-prescribing.

element of performance (EP) Specific action(s), process(es), or structure(s) that must be implemented to achieve the goal of a standard. The scoring of EP compliance determines an organization’s overall compliance with a standard.

emergency An unexpected or sudden event that significantly disrupts the organization’s ability to provide care, treatment, or services or the environment of care itself or that results in a sudden, significantly changed or increased demand for the organization’s services. Emergencies can be either human-made or natural (such as an
electrical system failure or a tornado), or a combination of both, and they exist on a continuum of severity.

**emergency, life-threatening**  A situation (for example, cardiac arrest, respiratory arrest) in which an individual may require resuscitation or other support to sustain life.

**Emergency Management Plan (EMP)**  The organization’s written document that describes the process it would implement for managing the consequences of emergencies, including natural and human-made disasters, that could disrupt the organization’s ability to provide care, treatment, or services.

**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 36 months**  Three years from the date of the last event, plus or minus 3 months.

**every 6 months**  Six months from the date of the last event, plus or minus 20 days.

**evidence-based guidelines**  Guidelines that have been scientifically developed based on recent literature review and are consensus driven.

**Evidence of Standards Compliance (ESC) report**  A report submitted by a surveyed organization, which details the action(s) that it took to bring itself into compliance with an accreditation requirement or clarifies why the organization believes that it was in compliance with the accreditation requirement for which it received a Requirement for Improvement. An ESC report must address compliance at the element of performance level.

**exploitation**  Taking unjust advantage of another for one’s own advantage or benefit.

**family**  A person or persons who play a significant role in an individual’s life. A family is a group of two or more persons united by blood or adoptive, marital, domestic partnership, or other legal ties. The family may also be a person or persons not legally related to the individual (such as a significant other, friend, or caregiver) whom the individual personally considers to be family. A family member may be the surrogate decision-maker if authorized to make care decisions for the individual should he or she lose decision-making capacity or choose to delegate decision making to another.

**ferromagnetic object**  An item that is highly attracted to magnets. Such items pose a significant risk if allowed to enter the magnetic resonance imaging (MRI) scanner room or the area immediately preced-
ing it. Ferromagnetic objects can become projectiles when they are rapidly drawn with considerable force toward the MRI unit. Examples of ferromagnetic items are those containing iron and nickel.

**fire-rated** Material that has undergone a test and is fire protection rated or fire resistance rated.

Two examples of the concept of fire-rated include the following:

- **fire resistance rating** The time, in minutes or hours, that materials or assemblies have withstood a fire exposure, as determined by tests, or methods based on tests, prescribed by the National Fire Protection Association (NFPA).

- **fire protection rating** A designation indicating the duration of fire test exposure to which a fire door assembly or fire window assembly was exposed and for which it met all the acceptance criteria, as determined in accordance with NFPA 252, Standard Methods of Fire Tests of Door Assemblies, or NFPA 257, Standard on Fire Test for Window and Glass Block Assemblies.

**fire 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 (onsite survey with documented findings), and Option 3 (onsite 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).
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.

hazardous materials and waste  Materials whose handling, use, and storage are guided or defined by local, state, or federal regulation, such as the Occupational Safety and Health Administration’s Regulations for Bloodborne Pathogens regarding the disposal of blood and blood-soaked items and the Nuclear Regulatory Commission’s regulations for the handling and disposal of radioactive waste. This also includes hazardous vapors (for example, glutaraldehyde, ethylene oxide, nitrous oxide) and hazardous energy sources (for example, ionizing or nonionizing radiation, lasers, microwave, ultrasound). Although The Joint Commission considers infectious waste as falling into this category of materials, federal regulations do not define infectious or medical waste as hazardous waste.

hazard vulnerability analysis (HVA)  A process for identifying potential emergencies and the direct and indirect effects these emergencies may have on the organization’s operations and the demand for its services.

health care–associated infection (HAI)  An infection acquired concomitantly by an individual who is receiving or who has received care, treatment, or services from a health care organization. The infection may or may not have resulted from the care, treatment, or services.

health information  Any information, oral or recorded, in any form or medium, that is created by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse that relates to past, present, or future physical or mental health or condition; the provision of health care; or payment for the provision of health care to an individual.
**health literacy** The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.

**health risk behaviors** Activities undertaken by an individual that have a negative impact on his or her health and increase the risk of disease or injury. Examples of health risk behaviors include substance abuse, tobacco use, inadequate exercise, poor dietary practices, and unsafe sexual activity.

**high-risk procedures or processes** A procedure or process that, if not planned and/or implemented correctly, has a significant potential for affecting the safety of a patient or an individual served.

**history and physical** Information gathered about an individual using a holistic approach for the purpose of establishing a diagnosis and developing a plan for care, treatment, or services to address physical health issues. The history may include information about previous illnesses; previous medical or surgical interventions and response to treatment; family health history; and social, cultural, economic, and lifestyle issues that may affect the individual’s health and well-being. The physical involves the physical examination of the individual’s body by the following means: inspection, palpation, percussion, and auscultation. When used in concert with behavioral health care services, the history and physical may be used to rule out physical causes for behavioral health conditions or to assess the impact of a medical diagnosis or treatment on a behavioral health condition.

**home care** The term that is generally used to refer to services provided in the home or in the community to recovering, disabled, or chronically ill persons and their families. These services may include some combination of professional health care services and personal care and supportive services. Professional health care services (also known as “skilled care”) may include physical and/or psychological assessment, nursing and medical care, medication teaching and administration, wound care, pain management, disease education and management, physical therapy, speech therapy, or occupational therapy. Home supportive care services (also known as “non-skilled care”) may include such things as light housekeeping, meal preparation, medication reminders, dressing, laundry, shopping, transportation, and companionship. In addition, home care can provide palliative care, respite care, hospice care, and other related services to those in need, including provision of medical equipment, medications, and supplies.

**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.
imaging protocol  The collection of settings and parameters used in the acquisition of medical images. Examples of settings and parameters include the clinical indication for the imaging exam, the use of contrast, patient positioning, and expected radiation dose ranges.

Immediate Threat to Health or Safety  A threat that represents immediate risk and has or may potentially have serious adverse effects on the health or safety of the patient, resident, or individual served. These threats are identified on site by the surveyor.

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 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.

in-service  Organized educational activity designed to enhance the skills of clinical staff relevant to their disciplines and job responsibilities.
**instrument, waived testing**  A waived testing device used for recording, measuring, or controlling. The levels of operation vary from manual steps to full automation, and specialized knowledge and skill are required.

**instrument-based waived testing**  Tests with analysis steps that rely on the use of an instrument to produce a test result of a patient, resident, or individual served.

**integrity**  The property that data or information have not been altered or destroyed in an unauthorized manner.

**interdisciplinary**  An approach to care that involves two or more disciplines or professions (for example, social services, specialist consultation, nursing, medicine, therapies, spiritual support) collaborating to plan, treat, or provide care or services to a mother and/or newborn, patient, resident, or individual served and/or that person’s family.

**interdisciplinary team**  An interdependent group of individuals representing two or more disciplines or professions working collaboratively to achieve the common goal of providing patient-centered, comprehensive care in the primary care medical home. The composition of the team will vary based on patient need. The interdisciplinary team within a Primary Care Medical Home must include a doctor of medicine or doctor of osteopathy, whose involvement in a patient’s care is determined by the needs of the patient. Other members of the team may include registered nurses, front office staff, care coordinators, and specialists.

**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.

**invasive procedure**  
The puncture or incision of the skin, insertion of an instrument, or insertion of foreign material into the body for diagnostic or treatment-related purposes. Examples of invasive procedures include central line and chest tube insertions, and cardiac catheterization. Venipuncture is not categorized as an invasive procedure.

**investigational medication**  
A medication used as part of a research protocol or clinical trial.

**knowledge-based information**  
A collection of stored facts, models, and information that can be used for ongoing staff development, for designing and redesigning processes, and for solving problems. Knowledge-based information is found in the clinical, scientific, and management literature.

**laboratory**  
A facility that is equipped to examine material derived from the human body to provide information for use in the diagnosis, prevention, or treatment of disease; also called clinical laboratory or medical laboratory.

**leader**  
An individual who sets expectations, develops plans, and implements procedures to assess and improve the quality of the organization’s governance, management, and clinical and support functions and processes. At a minimum, leaders include members of the governing body and medical staff, the chief executive officer and other senior managers, the nurse executive, clinical leaders, and staff members in leadership positions within the organization.

**licensed independent practitioner**  
An individual permitted by law and by the organization to provide care, treatment, and services without direction or supervision. A licensed independent practitioner operates within the scope of his or her license, consistent with individually granted clinical privileges. When standards reference the term licensed independent practitioner, this language is not to be construed to limit the authority of a licensed independent practitioner to delegate tasks to other qualified health care personnel (for example, physician assistants and advanced practice registered nurses) to the extent authorized by state law or a state’s regulatory mechanism or federal guidelines and organizational policy.

**licensure**  
A legal right that is granted by a government agency in compliance with a statute governing an occupation (such as medicine, nursing, psychiatry, or clinical social work) or the operation of an activity in a health care occupancy (for example, skilled nursing facility, residential treatment center, hospital).

**Life Safety Code®**  
A set of standards for the construction and operation of buildings intended to provide a reasonable degree of safety during fires. These standards are prepared, published, and periodically revised by the National Fire Protection As-
sociation and adopted by The Joint Commission to evaluate health care organizations under its life safety management program. See also occupancy.

**life-support equipment** Any device used for the purpose of sustaining life and whose failure to perform its primary function, when used according to the manufacturer’s instructions and clinical protocol, will lead to patient death in the absence of immediate intervention (for example, ventilators, anesthesia machines, heart-lung bypass machines, defibrillators).

**long term care** See nursing care center.

**look-alike/sound-alike medications** Similar medication names, either written or spoken, which may lead to potentially harmful medication errors when confused with each other.

**magnetic resonance (MR) conditional** An item that has been demonstrated to pose no known hazards in a specific magnetic resonance (MR) environment under specific conditions of use. Conditions that define the MR environment include static magnetic field strength, radiofrequency fields, specific absorption rate, and other factors. The item label must include the results of testing that characterize the behavior of the item in the MR environment. Any parameter that affects the safety of the item should be listed, and any condition that is known to produce an unsafe condition must be described.

**magnetic resonance (MR) safe** An item that poses no known hazards in all magnetic resonance (MR) environments. MR safe items are nonconducting, nonmetallic, and nonmagnetic items, such as a plastic Petri dish.

**maintenance** There are five types of maintenance — predictive, metered, corrective, interval-based, and reliability-centered:

1. **Predictive maintenance** - A type of maintenance strategy that provides the means to achieve reliability levels that exceed the performance of a piece of equipment or system. This strategy is designed to measure and track data significant to the piece of equipment or system. It confirms possible faults with the equipment, and specific repairs are completed before the equipment fails. Predictive analysis can be performed using advanced monitoring instruments and predictive software that collects data and performs an analysis. The data collected are analyzed, and corrective maintenance is performed when the equipment is performing outside the desired operating parameters.

2. **Metered maintenance** - Maintenance strategy based on the hours of run time or the number of times the equipment is used (for example, number of images processed).

3. **Corrective maintenance** - Maintenance strategy that restores a piece of equipment to operational status after equipment failure.
4. Interval-based maintenance - Maintenance done according to specific intervals (for example, calendar time, running hours). A number of periodic inspections or restoration tasks are completed, based on information/data obtained from the last equipment check.

5. Reliability-centered maintenance - A type of maintenance that begins with a failure mode and effects analysis to identify the critical equipment failure modes in a systematic and structured manner. The process then requires the examination of each critical failure mode to determine the optimum maintenance policy to reduce the severity of each failure.

The chosen type of maintenance strategy must take into account cost, safety, and environmental and operational consequences. Some functions are not critical and may be allowed to “run to failure,” while other functions must be preserved at all cost. Reliability-centered maintenance emphasizes the use of predictive maintenance techniques in addition to traditional preventive measures (metered, corrective, and interval based).

**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.

**means of egress**  A continuous and unobstructed way of travel from any point in a building or other structure to a public way consisting of three separate and distinct parts: the exit access, the exit, and the exit discharge.
Medical Reserve Corps (MRC) Units comprised of locally-based medical and public health volunteers who can assist their communities during emergencies, such as an influenza epidemic, a chemical spill, or an act of terrorism.

Medical staff The group of all licensed independent practitioners and other practitioners privileged through the organized medical staff process that is subject to the medical staff bylaws. This group may include others, such as retired practitioners who no longer practice in the organization but who wish to continue their membership in the group, courtesy staff, scientific staff, and so forth. See also medical staff, organized.

Medical supplies Medical items, usually of a disposable nature, such as bandages, sterile drapes, and suture materials. These supplies differ from permanent or durable items, such as medical equipment and devices.

Medication Any prescription medications, sample medications, herbal remedies, vitamins, nutraceuticals, vaccines, or over-the-counter drugs; diagnostic and contrast agents used on or administered to persons to diagnose, treat, or prevent disease or other abnormal conditions; radioactive medications, respiratory therapy treatments, parenteral nutrition, blood derivatives, and intravenous solutions (plain, with electrolytes and/or drugs); and any product designated by the Food and Drug Administration (FDA) as a drug. This definition of medication does not include enteral nutrition solutions (which are considered food products), oxygen, and other medical gases.

Medication allergy A state of hypersensitivity induced by exposure to a particular drug antigen resulting in harmful immunologic reactions on subsequent drug exposures, such as a penicillin drug allergy. See also medication.

Medication error A preventable event that may cause or lead to inappropriate medication use or patient or resident harm while the medication is in the control of the health care professional, patient, resident, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing; order communication; product labeling, packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use. See also significant medication error.

Medication expiration date The last date that a medication or product is to be used or administered.

Medication management The process an organization uses to provide medication therapy to individuals served by the organization. The components of the medication management process include the following:

- Procurement The task of obtaining selected medications from a source outside the organization. It does not include obtaining a medication from the organization’s own pharmacy, which is considered part of the ordering and dispensing processes.
- **storage** The task of appropriately maintaining a supply of medications on the organization’s premises.

- **secure** In locked containers, in a locked room, or under constant surveillance.

- **prescribing or ordering** The process of a licensed independent practitioner or prescriber transmitting a legal order or prescription to an organization, directing the preparing, dispensing, and administration of a specific medication to a specific individual. It does not include requisitions for medication supplies.

- **transcribing** The process by which an order from a licensed independent practitioner is documented either in writing or electronically.

- **preparing** Compounding, manipulating, or in some way getting a medication ready for administration, exactly as ordered by the licensed independent practitioner.

- **dispensing** Providing, furnishing, or otherwise making available a supply of medications to the individual for whom it was ordered (his or her representative) by a licensed pharmacy according to a specific prescription or medication order, or by a licensed independent practitioner authorized by law to dispense. Dispensing does not involve providing an individual a dose of medication previously dispensed by the pharmacy.

- **administration** The provision of a prescribed and prepared dose of an identified medication to the individual for whom it was ordered to achieve its pharmacological effect. This includes directly introducing the medication into or onto the individual’s body.

**medication reconciliation** The process of identifying the medications currently being taken by an individual. These medications are compared to newly ordered medications and discrepancies are identified and resolved.

**medications, high-alert** Medications that bear a heightened risk of causing significant harm to individuals when they are used in error.

**mental abuse** Intentional mistreatment of an individual that may cause psychological injury. Examples include humiliation, harassment, exploitation, and threats of punishment or deprivation.

**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.

**mobile delivery of health care services** The provision of health care services, staff, or equipment in the presence of the patient through a transportable or relocatable platform. This definition does not include telehealth, telemedicine, health care staffing, or mobile health technology services.

**multidisciplinary team** A group of staff members composed of representatives from a range of professions, disciplines, or service areas.
near miss  See close call.

neglect  The absence of the minimal services or resources required to meet basic needs. Neglect includes withholding or inadequately providing medical care and, consistent with usual care, treatment, and services, food and hydration (without approval from the individual, physician, or surrogate), clothing, or good hygiene. It may also include placing an individual in unsafe or unsupervised conditions. See also abuse.

nursing  The health profession dealing with nursing care and services as (1) defined by the Code of Ethics for Nurses with Interpretive Statements, Nursing’s Social Policy Statement, Nurses’ Bill of Rights, Scope and Standards of Nursing Practice of the American Nurses Association and specialty nursing organizations and (2) defined by relevant state, commonwealth, or territory nurse practice acts and other applicable laws and regulations.

nursing care center  Individuals receiving care in this setting require rehabilitative, supportive, or palliative care. This care may include time-limited medically complex or rehabilitative care, dementia-specific memory care, long term nursing care, and other specialty care services. These services may be provided within a hospital, in an organization affiliated with a hospital, or in a freestanding organization. Synonyms used by the health care field for this setting include nursing home, long term care facility, and skilled nursing facility (SNF).

nutrition, parenteral  Nutrients (such as protein, sugar, fat, and added vitamins and minerals as needed) that are provided intravenously, bypassing the digestive tract. Related terms are total parenteral nutrition (TPN), partial parenteral nutrition (PPN), and hyperalimentation (HA).

occupancy  The purpose for which a building or portion thereof is used or intended to be used. Depending on the organization, occupancies may include ambulatory health care occupancy, business occupancy, health care occupancy, and residential occupancy.

- ambulatory health care occupancy  An occupancy used to provide services or treatment to four or more patients (or one or more patients in an ambulatory surgical center that elects to use The Joint Commission deemed status option) at the same time that either (1) renders them incapable of providing their own means of self-preservation in an emergency or (2) provides outpatient surgical treatment requiring general anesthesia.

- business occupancy  An occupancy used to provide outpatient care, treatment, day treatment, or other services that does not meet the criteria in the ambulatory health care occupancy definition (for example, three or fewer individuals at the same time who are either rendered incapable of self-preservation in an emergency or are undergoing general anesthesia). For ambulatory surgical centers that elect to use The Joint Commission deemed status op-
tion, treatment of one or more incapacitated patients renders the area an ambulatory health care occupancy.

- **health care occupancy** An occupancy used for purposes such as medical or other treatment or care of persons suffering from physical or mental illness, disease, or infirmity; and for the care of infants, convalescents, or infirm aged persons. Health care occupancies provide sleeping facilities for four or more occupants and are occupied by persons who are mostly incapable of self-preservation because of age, physical or mental disability, or security measures not under the occupant’s control. Health care occupancies include hospitals, critical access hospitals, skilled nursing homes, and limited care facilities.

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

- **operative or other high-risk procedures** Operative or other invasive or noninvasive procedures that place the patient at risk; these procedures are performed to remedy an injury, ailment, defect, or dysfunction. The focus is on procedures and is not meant to include medications that place the patient at risk.

- **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 ap-
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.

**panel (primary care medical home)** For organizations that elect The Joint Commission Primary Care Medical Home option: A designated group of patients assigned to a specific primary care clinician.

**patient** An individual who receives care, treatment, or services. Synonyms used by various health care fields include resident, patient and family unit, individual served, consumer, health care consumer, customer, or beneficiary.

**patient identifiers** Information directly associated with an individual that reliably identifies the individual as the person for whom the service or treatment is intended. Acceptable identifiers may be the 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.

peer recommendation  Information submitted by a practitioner(s) in the same professional discipline as an applicant, reflecting his or her perception of the applicant’s clinical practice, ability to work as part of a team, and ethical behavior; or the documented peer evaluation of practitioner-specific data collected from various sources for the purpose of evaluating current competence.

performance improvement  The systematic process of detecting and analyzing performance problems, designing and developing interventions to address the problems, implementing the interventions, evaluating the results, and sustaining improvement.

phantom  An object used in medical imaging that simulates features of the human body. It is scanned or imaged and used to evaluate and analyze imaging equipment performance.

pharmacist  An individual who has a degree in pharmacy and is licensed and registered to prepare, preserve, compound, and dispense drugs and other chemicals.

pharmacy services  Pharmaceutical care and services involving the preparation and dispensing of medications and medication-related devices and supplies by a licensed pharmacy, with or without the provision of clinical or consultant pharmacist services.

physical abuse  Intentional mistreatment of an individual that may cause physical injury. Examples include hitting, slapping, pinching, or kicking, and may also include attempts to control behavior through corporal punishment.

physician  As defined by the Centers for Medicare & Medicaid Services in Sec. 1861.[42 U.S.C.1395x] of the Social Security Act:

The term “physician,” when used in connection with the performance of any function or action, means

(1) A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section 1101(a)(7)),

(2) A doctor of dental surgery or of dental medicine who is legally authorized to practice dentistry by the State in which he performs such function and who is acting within the scope of his license when he performs such functions,

(3) A doctor of podiatric medicine for the purposes of subsections (k), (m), (p)(1), and (s) of this section and sections 1814(a), 1832(a)(2)(F)(ii), and 1835 but only with respect to functions which he is legally authorized to perform as such by the State in which he performs them,

(4) A doctor of optometry, but only for purposes of subsection (p)(1) with respect to the provision of items or ser-
vices described in subsection (s) which he is legally authorized to perform as a doctor of optometry by the State in which he performs them, or

(5) A chiropractor who is licensed as such by the State (or in a State which does not license chiropractors as such, is legally authorized to perform the services of a chiropractor in the jurisdiction in which he performs such services), and who meets uniform minimum standards promulgated by the Secretary, but only for the purpose of sections 1861(s)(1) and 1861(s)(2)(A) and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation) which he is legally authorized to perform by the State or jurisdiction in which such treatment is provided. For the purposes of section 1862(a)(4) and subject to the limitations and conditions provided in the previous sentence, such term includes a doctor of one of the arts, specified in such previous sentence, legally authorized to practice such art in the country in which the inpatient hospital services (referred to in such section 1862(a)(4)) are furnished.

**physician assistant** An individual who practices medicine with supervision by licensed physicians, providing services ranging from primary medicine to specialized surgical care. The scope of practice is determined by state law, the supervising physician’s delegation of responsibilities, the individual’s education and experience, and the specialty and setting in which the individual works. When standards reference the term “licensed independent practitioner,” this language is not to be construed to limit the authority of a licensed independent practitioner to delegate tasks to other qualified health care personnel (for example, physician assistants and advanced practice registered nurses) to the extent authorized by state law or a state’s regulatory mechanism or federal guidelines and organizational policy.

**Plan for Improvement (PFI)** For purposes of Joint Commission accreditation, an organization’s written statement that details the procedures to be taken and time frames to correct existing *Life Safety Code* ® deficiencies. See also *Life Safety Code*, Statement of Conditions™ (SOC).

**Plan of Action (POA)** A plan detailing the action(s) that an organization will take in order to come into compliance with a Joint Commission accreditation requirement. A POA must be completed for each element of performance associated with a non-compliant accreditation requirement.

**podiatrist** An individual who has received the degree of doctor of podiatry medicine and who is licensed to practice podiatry.

**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.

**population-based care** The assessment, monitoring, and management of the health care needs and outcomes of identified groups of patients and communities, rather than individual patients. The goal of population-based care is to improve the health of the population, increase awareness of behavior-related health risks, promote healthy lifestyle activities and patient self-management, and decrease health care inequities.

**practice guidelines** See clinical practice guidelines.

**practitioner** Any individual who is licensed and qualified to practice a health care profession (for example, physician, nurse, social worker, clinical psychologist, psychiatrist, respiratory therapist) and is engaged in the provision of care, treatment, or services. See also licensed independent practitioner.

**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.

**preventive care** The provision of health care that focuses on disease prevention and health maintenance. It includes early diagnosis of disease as well as discovery and identification of individuals at risk for the development of specific health problems or in need of counseling or other necessary interventions to avert a health problem. Screening tests, health education, and immunization programs are common examples of preventive care.

**primary care clinician** A clinician operating within the primary care medical home who works collaboratively with an interdisciplinary team and in partnership with the patient to address the patient’s primary health care needs. Primary care clinicians have the educational background, broad-based knowledge, and experience necessary to handle most medical and other health care needs of the patients who have selected them, including resolving conflicting recommendations for care. The primary care clinician is selected by the patient and serves as the primary point of contact for the patient and family. A primary care clinician operating within the primary care medical home is a doctor of medicine or doctor of osteopathy, or an advanced practice nurse or physician assistant practicing...
in collaboration with a doctor of medicine or doctor of osteopathy. The term “collaboration” in this context means that health care providers work together to meet the needs of the patient. It is not the intent of this requirement to impose additional restrictions on the scope of practice of an advanced practice nurse, nor is it meant to preempt applicable state law.

**primary care medical home (PCMH)**  A model of primary health care that is based on five operational characteristics: patient-centered care; comprehensive care; coordinated care; superb access to care; and a system-based approach to quality and safety. They address the roles and functions of the patient, organization, primary care clinician, and interdisciplinary team. PCMH Certification is an optional certification that requires compliance with accreditation requirements plus an additional set of PCMH-specific requirements.

**primary source**  The original source or an approved agent of that source of a specific credential that can verify the accuracy of a qualification reported by an individual practitioner. Examples include medical schools, nursing schools, graduate education, state medical boards, federal and state licensing boards, universities, colleges, and community colleges.

**primary source verification**  Verification of an individual practitioner’s reported qualifications by the original source or an approved agent of that source. Methods for conducting primary source verification of credentials include direct correspondence, documented telephone verification, secure electronic verification from the original qualification source, or reports from credentials verification organizations (CVOs) that meet Joint Commission requirements. See also credentials verification organization (CVO).

**privacy (of information)**  The right of an individual to limit the disclosure of personal information.

**privileging**  The process whereby the specific scope and content of patient care services (that is, clinical privileges) are authorized for a health care practitioner by a health care organization based on evaluation of the individual’s credentials and performance. See also licensed independent practitioner.

**prohibited abbreviations**  A list of abbreviations, acronyms, symbols, and dose designations that are not to be used throughout the organization. For accreditation purposes, the prohibited list applies, at a minimum, to all orders and all medication-related documentation that is handwritten (including free-text computer entry) or on preprinted forms.

**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 Information Policy  A Joint Commission policy which specifies the information that The Joint Commission may release about accredited organizations. By submitting a signed accreditation contract, the organization is acknowledging that The Joint Commission may make available to the public the accreditation-related information in accordance with this policy.

qualifications  Knowledge, education, training, experience, competency, licensure, registration, or certification related to specific responsibilities.

quality control  A set of activities or techniques whose purpose is to ensure that all quality requirements are being met. The organization monitors processes and solves performance problems to achieve this purpose.

quality of care, treatment, or services  The degree to which care, treatment, or services for individuals and populations increases the likelihood of desired health or behavioral health outcomes. Considerations include the appropriateness, efficacy, efficiency, timeliness, accessibility, and continuity of care; the safety of the care environment; and the individual’s personal values, practices, and beliefs.

Quality Report  A publicly available report that includes relevant and useful information about the provision of safe quality care provided in individual Joint Commission–accredited and –certified organizations. Quality Reports are created at the organization level and contain information regarding an organization’s accreditation or certification status. These reports provide detailed information about an organization’s performance and how it compares to that of similar organizations; the organization’s accreditation and/or certification decision and the effective dates of the accreditation/certification award; the last full survey/review date and last on-site survey/review date; programs accredited and/or services certified by The Joint Commission, and programs or services accredited by other accrediting bodies; compliance with The Joint Commission’s National Patient Safety Goals; special quality awards, and for hospitals, performance on National Quality Improvement Goals. If an organization has achieved both Joint Commission certification and accreditation, its Quality Report will contain both certification and accreditation information; the organizations will also have a separate Certification Quality Report.

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)  A person who is licensed to practice professional nursing.

reliability-centered maintenance  See maintenance.

reportable range  The range of test values over which the relationship between the instrument, kit, or system’s measurement response is shown to be valid.

Requirement for Improvement (RFI)  A recommendation that is required to be addressed in an organization’s Evidence of Standards Compliance in order for the organization to retain its accreditation. Failure to adequately address an RFI after two opportunities may result in a recommendation to place the organization in Accreditation with Follow-up Survey.

response, emergency  Actions taken and procedures implemented by the organization when an emergency occurs. See also emergency.

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 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.

secure  In a locked container, in a locked room, or under constant surveillance.

security  Protection of people and property against harm or loss (for example, workplace violence, theft, access to medications). Security incidents may be caused by persons from outside or inside the organization.

security, information  Administrative, physical, and technical safeguards to prevent unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

self-administration  Independent use of a medication by a patient, resident, or individual served, including medications that may be held by the organization for independent use.

self-management  Activities performed by patients with one or more chronic conditions that enable them to take an active role in the management of their health care and improve their clinical outcomes.

semi-quantitative result  Results of tests that are more precise than qualitative tests (negative/positive results) but less precise than quantitative tests (numerical value), usually scored on a graded scale (for example, 1+, 2+, 3+).

sentinel event  A patient safety event (not primarily related to the natural course of the patient’s illness or underlying condition) that reaches a patient and results in death,
permanent harm, or severe temporary harm. Sentinel events are a subcategory of adverse events.

**sexual abuse**  Intentional mistreatment of a sexual nature of an individual that may cause physical and/or psychological injury. Examples include sexual harassment, sexual coercion, and sexual assault.

**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.

**size-specific dose estimate (SSDE)**  A measure of the radiation output of a computed tomography scanner. Along with the computed tomography dose index (CTDI), it factors in the patient’s size to provide a better estimate of the radiation dose to a volume of tissue for a given patient in a clinical setting.

**social worker**  An individual who provides a range of counseling, case management, and advocacy services to individuals served in various settings. Social workers may work in or with community-based programs, schools, residential and foster care programs, or independently as private practice psychotherapists. A social worker has at least a bachelor’s degree in social work plus documentation of any additional training, education, or experience commensurate with his or her responsibilities.

**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.
sterilization  The use of a physical or chemical procedure to destroy all microbial life, including highly resistant bacterial endospores.

stored emergency power supply systems (SEPSS)  Systems that automatically supply illumination or power to critical areas and equipment essential for safety to human life. Included are systems that supply emergency power for such functions as illumination for safe exiting, ventilation where it is essential to maintain life, fire detection and alarm systems, public safety communications systems, and processes where the current interruption would produce serious life safety or health hazards to patients, residents, individuals served, the public, or staff. Note: Other non-SEPSS battery back-up emergency power systems that an organization has determined to be critical for operations during a power failure (for example, laboratory equipment, electronic medical records) should be properly tested and maintained in accordance with manufacturer recommendations.

support services  Services provided in an individual’s place of residence on a per-visit or per-hour basis to meet the identified needs of an individual who requires assistance in the maintenance and management of household routines, such as cleaning or shopping. These services may include, but are not limited to, those provided by homemakers, chore service workers, or companions. These services may be provided directly or through contract with another organization or individual.

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 ser-
vices. A surveyor may be, but is not limited to, a licensed physician, surgeon, podiatrist, dentist, nurse, physician assistant, pharmacist, medical technologist, respiratory therapist, administrator, social worker, psychologist, or behavioral health care professional.

**tabletop exercise**  An exercise that involves key personnel discussing simulated scenarios and is used to assess plans, policies, and procedures. It is a discussion-based exercise that familiarizes participants with current plans, policies, agreements, and procedures, or may also be used to develop new plans, policies, agreements, and procedures.

**telehealth**  The use of electronic information and telecommunications technologies to support long-distance clinical health care, patient and professional health-related education, public health, and health administration.

**telemedicine**  The use of medical information exchanged from one site to another via electronic communication to improve patients’ health status. Telemedicine is a subcategory of telehealth.

**The Joint Commission**  An independent, not-for-profit organization dedicated to improving the safety and quality of health care through standards development, public policy initiatives, accreditation, and certification. The Joint Commission accredits and certifies more than 20,000 health care organizations and programs in the United States.

**time-out, invasive procedure**  An immediate pause by the entire surgical team to confirm the correct patient, procedure, and site.

**tissue**  Any group of cells that perform specific functions.

**tracer methodology**  A process surveyors use during the on-site survey to analyze an organization’s systems or processes for delivering safe, high-quality care by following an individual patient or resident through the organization’s care process in the sequence experienced by each individual. Depending on the setting, this process may require surveyors to visit multiple care programs and services within an organization or within a single program or service to “trace” the care rendered.

**transfer agreement**  A written understanding that provides for the reciprocal transfer of individuals between health care organizations.

**translation services**  A trans-language rendition of a written document in which the translator comprehends the source language and can write comprehensively in the target language to convey the meaning intended in the source language. The translator knows health and health-related terminology and provides accurate translations by choosing equivalent expressions that convey the best matching and meaning to the source language and captures, to the greatest possible extent, all nuances intended in the source document.
transmission-based precautions  Infection prevention and control measures to protect against exposure to a suspected or identified pathogen. These precautions are specific and based on the way the pathogen is transmitted. Categories include contact, droplet, airborne, and a combination of these.

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.

urgent care  The delivery of ambulatory medical care to patients who have an injury or illness that requires immediate care but is not serious enough to warrant a visit to an emergency room. Urgent care centers often have extended hours and typically see patients on a walk-in basis without a scheduled appointment. Care may include diagnostic and therapeutic services, on-site x-ray, laboratory testing, pharmacy, and laceration and fracture care.

utility systems  Building systems that provide support to the environment of care, including electrical distribution and emergency power; vertical and horizontal transport; heating, ventilating, and air conditioning (HVAC); plumbing, boiler, and steam; piped gases; vacuum systems; and communication systems, including data exchange systems.

variance  A measure of the difference in a set of observations; statistically, the square of the standard deviation.

waived testing  Tests that meet the Clinical Laboratory Improvement Amendments of 1988 (CLIA '88) requirements for waived tests and are cleared by the Food and Drug Administration for home use. These tests employ methodologies that are so simple and accurate that the likelihood of erroneous results is negligible, or they pose no risk of harm to the patient, resident, or individual served if the test is performed incorrectly. See also Clinical Laboratory Improvement Amendments of 1988 (CLIA '88).

weekly  Once every seven days, plus or minus two days.
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